



PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Chapter Thirty-Five of the Medicaid Services Manual

Issued May 1, 2012

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

**State of Louisiana
Bureau of Health Services Financing**

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OVERVIEW

The Program of All-Inclusive Care for the Elderly (PACE) is an optional home and community based service (HCBS) under the Medicaid State Plan. PACE operates under Medicare and Medicaid according to 42 CFR 460 and is a capitated, managed care program. The objectives of PACE are to:

1. Enhance the quality of life and autonomy for frail, older adults;
2. Enable frail elders to live independently in the community, rather than be institutionalized, as long as medically and socially feasible;
3. Maximize the dignity and respect for older adults; and
4. Preserve and support the older adult's family unit.

Each individual requesting PACE will undergo a functional eligibility screening that utilizes the Level of Care Eligibility Tool (LOCET), to determine if the individual meets nursing facility level of care (NFLOC) criteria.

PACE applicants who have been determined to meet the requirements listed above are assessed using a face-to-face interRAI Home Care (iHC) assessment. This purpose of the assessment is to:

1. Verify eligibility qualifications;
2. Determine if program requirements are met; and
3. Identify the individual's need for support in performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

The PACE provider must:

1. Provide comprehensive health care services based on the beneficiary's individual needs with the goal of enabling beneficiaries to continue living independently in the community. The PACE beneficiaries must receive all Medicare and Medicaid services solely through the PACE provider;

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2. Coordinate and provide all required services according to 42 CFR 460:90 as follows:
 - a. Needed preventative services;
 - b. Primary health services;
 - c. Acute services; and
 - d. Long term care (LTC) services; and
3. Establish and implement a written plan of care (POC) to deliver care that meets the needs of each beneficiary in all care settings 24 hours a day, every day of the year.

PACE includes all Medicare and Medicaid covered services and other services determined by the PACE interdisciplinary team (IDT) necessary to maintain or restore PACE beneficiaries' independence in order to remain in their homes or communities.

PACE providers:

1. Assume full financial risk for the beneficiary's care without limits on amount, duration, or scope of services; and
2. Are responsible for all care costs, even if the care costs exceed the monthly capitated payment they receive each month from Medicare and/or Medicaid.

Background Information

The PACE model of care is centralized on the belief that it is better for the well-being of older adults with chronic care needs and their families to be served in the community, whenever possible. In the early 1970s, a nonprofit corporation, On Lok Senior Health Services, was formed to create a community-based system of care that consisted of a comprehensive system of care combining housing and all necessary medical and social services.

In the mid-1980s, the Centers for Medicare and Medicaid Services (CMS) tested the model of care as a demonstration project. For most beneficiaries, the comprehensive service package permitted them to continue to live at home while receiving services rather than being in an institution.

The Balanced Budget Act (BBA) of 1997 established the PACE model as a permanently

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recognized provider type under both the Medicare and Medicaid programs and mandated that the quality of care be monitored. This enabled states to provide PACE services to Medicaid beneficiaries as a Medicaid State Plan option. In 2004, Louisiana included PACE as an optional benefit in the Medicaid program.

Purpose of this Chapter

The Louisiana Department of Health (LDH), the Bureau of Health Services Financing (BHSF), and/or the Office of Aging and Adult Services (OAAS) implements and monitors the PACE program/providers in accordance with the federal regulations in Title 42 Part 460 of the Code of Federal Regulations (CFR) and the Louisiana Administrative Code (LAC), Title 50, part XXIII. This provider manual chapter is intended to assist the PACE provider in understanding and correctly implementing federal and state PACE policies.

These regulations are established to ensure minimum compliance under the law, equity among those served, provision of authorized services and proper fund disbursement. If there is a conflict between manual chapter material and pertinent laws or regulations governing the Louisiana Medicaid program, the latter will take precedence.

This manual chapter is intended to provide PACE providers with the information necessary to comply with their vendor contract with the state of Louisiana. Full implementation of these regulations is necessary for a provider to remain in compliance with federal and state laws and department rules.

Providers should refer to the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website at: <http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf> for general information concerning topics relative to Medicaid provider enrollment and administration.

The LDH BHSF, OAAS, and Health Standards Section (HSS) are responsible for assuring oversight of the provision of services, licensure compliance and overall compliance with the rules and regulations.

Some services offered under the PACE program are provided by a Medicaid enrolled PACE provider that has a valid Adult Day Health Care (ADHC) license issued by LDH/HSS in accordance with the Louisiana licensing requirements for ADHC.

If the PACE provider uses their own staff to provide personal care attendant (PCA) services to PACE beneficiaries, the PACE provider must obtain a HCBS license under the PCA module from LDH/HSS.

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NOTE: The PACE provider oversees all services received by the PACE beneficiary using their own staff as well as an identified network of providers with whom PACE contracts.

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SERVICES

The Program of All-Inclusive Care for the Elderly (PACE) provider is able to coordinate the entire array of services for older adults with chronic care needs while allowing them to maintain independence in the home and/or community for as long as possible.

Services Provided

The PACE benefit package must include all Medicare and Medicaid covered services, in addition to other services determined necessary by the PACE interdisciplinary team (IDT) regardless of the source of payment. The PACE provider must deliver care that meets the needs of each beneficiary in all care settings 24 hours a day, every day of the year. As specified in 42 Code of Federal Regulations (CFR) 460.98(c), services must include, but are not limited to, the following:

1. Primary care services from a primary care provider as defined in 42 CFR 460.102(c), including services from one of the following:
 - a. Primary care physician (PCP);
 - b. Community physician;
 - c. Physician assistant; or
 - d. Advanced practice registered nurse;
2. Nursing services;
3. Social services from a Masters-level social worker;
4. Restorative therapy services, including services from a physical therapist or an occupational therapist;
5. Recreational therapy services;
6. Personal care attendant (PCA) and supportive services;
7. Dietitian and nutritional counseling services; and
8. Meals.

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Service Limitations/Exclusions

The PACE program becomes the sole service provider for Medicaid and/or Medicare beneficiaries who enroll in the PACE program. PACE beneficiaries must use the PACE provider's provider network for all health services. If allowed by the PACE provider, PACE beneficiaries may use the primary care provider of their choice.

In accordance with 42 CFR 460.96, the services that are excluded from coverage under the PACE program are as follows:

1. Any service that is not authorized by the IDT, even if it is listed as a required service, unless it is an emergency service as specified in 42 CFR 460.100;
2. Inpatient facility services for private room and private duty nursing services, (unless medically necessary) and non-medical items for personal convenience such as telephone, radio or television rental, (unless specifically authorized by the IDT as part of the beneficiary's plan of care (POC));
3. Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following a mastectomy;
4. Experimental medical, surgical, or other health procedures; and
5. Services furnished outside of the United States except as follows:
 - a. In accordance with 42 CFR 424.122 and 424.124; and/or
 - b. As permitted under the State's approved Medicaid Plan through a State Plan amendment.

Service Delivery

The PACE program agreement must define its service area by parish or zip code. This service area must be approved by the Centers for Medicare and Medicaid Services (CMS) and the Office of Aging and Adult Services (OAAS). CMS and OAAS must approve any change in the designated service area as required by 42 CFR 460.32(a)(1).

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CMS, in consultation with OAAS, may exclude an area that is already covered under another PACE program agreement to avoid the following:

1. Unnecessary duplication of services; and
2. Impairing the financial and service viability of an existing program.

Upon enrollment, the PACE provider must:

1. Inform potential beneficiaries that it offers Medicare Part D prescription drug coverage;
2. Inform beneficiaries if they are in a PACE program, that they cannot enroll in a separate Medicare Advantage plan. By joining a separate Medicare Advantage plan, the beneficiary will be considered to have voluntarily disenrolled from PACE and the PACE provider will no longer provide the beneficiary with any healthcare services, including prescription drug benefits; and
3. Provide comprehensive care to beneficiaries who need end-of-life care.

NOTE: If a beneficiary chooses to elect the hospice benefit from a certified hospice provider, the beneficiary must voluntarily disenroll from the PACE program.

The PACE provider must establish and implement a written POC that meets the needs of each beneficiary in all care settings, 24 hours a day, every day of the year, as specified in 42 CFR 460.98. These services are furnished in the following places:

1. PACE center;
2. Home of the beneficiary;
3. Inpatient facilities; and
4. Other referral service settings that the beneficiary may need.

NOTE: This does not change an individual’s PACE enrollment status or the capitation rate. The PACE provider shall be responsible for payment of the cost of the care in any setting.

A PACE beneficiary may need temporary or permanent placement in another health care setting

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and may be placed into a nursing facility that has a contract with the PACE provider.

The PACE provider must establish and implement a written POC to deliver care that meets the needs of the beneficiary in the nursing facility. During the beneficiary’s placement in the nursing facility, there must be coordination of care between the PACE provider and the nursing facility.

The PACE provider must notify OAAS Nursing Facility Admission or its designee of the nursing facility placement. A Level I Pre-Admission Screening and Resident Review (PASRR) is required before a PACE beneficiary is transferred to a nursing facility. The PACE physician shall complete the Level I PASRR. It must be documented on the front page of the PASRR that a PACE beneficiary is entering the nursing facility. If the Level I PASRR indicates mental illness or developmental disability, the case will be referred to the Level II authority, the Office of Behavioral Health or the Office for Citizens with Developmental Disabilities (OCDD), for final determination.

NOTE: A Louisiana Level of Care Eligibility Tool (LOCET) assessment is not required when a PACE beneficiary enters a nursing facility.

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BENEFICIARY REQUIREMENTS**Beneficiary Criteria**

As required by 42 Code of Federal Regulations (CFR) 460.150, the applicant must meet all of the following criteria to be eligible to enroll in the Program of All-Inclusive Care for the Elderly (PACE):

1. Be at least 55 years of age or older;
2. Reside in the approved PACE provider service area (designated by parish or zip code);
3. Meet nursing facility level of care (NFLOC) requirements as determined under the Louisiana State Medicaid plan and Louisiana Administrative Code (LAC), Title 50:II., §10154 and §10156; and
4. Be able to live in the community with PACE supports without jeopardizing their health or safety.

In addition, a potential PACE enrollee may be, but is not required to be, entitled to Medicare Part A, enrolled under Medicare Part B, or eligible for Medicaid.

The PACE provider must conduct a comprehensive health and safety assessment at the time of enrollment to ensure that the applicant's health, safety, or welfare will not be jeopardized by living in the community.

The following are issues to consider when making this determination:

1. Applicant does not have the capability to call for emergency assistance, or does not have the capability to determine when emergency assistance is needed;
2. Physician, familiar with the applicant's health and social history, has documented a condition that requires 24-hour/7-days per week skilled care;
3. Applicant's residence:
 - a. Has been condemned;
 - b. Has been determined unsafe by for habitation by the PACE provider (detailed documentation of specifics required); or

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- c. Poses a threat to PACE staff due to:
 - i. Physical condition and integrity of dwelling;
 - ii. Evidence of abuse and/or neglect from other household members;
 - iii. Criminal activities or behavior;
 - iv. Illegal drug use;
 - v. Brandishing of weapons; or
 - vi. Dangerous pets/animals.
- 4. Applicant exhibits health concerns that involve dangerous behavior(s) which would pose a threat to the individual, other PACE beneficiaries, or PACE staff; and
- 5. Applicant whose current medical treatment or regimen requires 24-hour supervision and whose care is more appropriately provided in an institutional setting (hospital or skilled nursing facility).

Medical Necessity

Louisiana, under the Medicaid State Plan, establishes NFLOC criteria to determine if an individual meets medical necessity for PACE. Louisiana utilizes scientifically-validated and reliability-tested screening and assessment tools upon initial application and at program eligibility redetermination periods. To enroll in PACE, applicants must meet and continue to meet NFLOC.

Applicants are initially screened for NFLOC by calling an Office of Aging and Adult Services (OAAS) designated toll-free number. The screening tool used is the Louisiana Level of Care Eligibility Tool (LOCET). The LOCET is a telephone screening process to determine whether an individual “presumptively” meets NFLOC. Also during the telephone call, applicants are informed of other available program options to ensure freedom of choice.

Following an approved LOCET, the PACE applicant must receive a face-to-face assessment to determine NFLOC criteria prior to PACE enrollment. The face-to-face assessment is the interRAI Home Care (iHC) assessment and supersedes the LOCET screening. OAAS certified assessors, either through OAAS or through certified PACE staff members, conduct the iHC.

If the individual does not meet NFLOC through the iHC assessment, the PACE provider must notify the OAAS Regional Office (RO), which shall make the final determination regarding the

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applicant's medical necessity.

Exceptions:

A LOCET is not required if the PACE applicant has an approved LOCET that was performed within the previous 30 calendar days. If the PACE applicant does not have a LOCET in the OAAS database, the applicant or their personal representative must complete a new LOCET to determine if the applicant meets NFLOC criteria.

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SECTION 35.3: BENEFICIARY RIGHTS AND RESPONSIBILITIES

BENEFICIARY RIGHTS AND RESPONSIBILITIES

Beneficiaries have specific rights and responsibilities that accompany eligibility and participation in the Medicaid programs. The Office of Aging and Adult Services (OAAS), or its designee, and the Program of All-Inclusive Care for the Elderly (PACE) providers must assist beneficiaries in exercising their rights and responsibilities.

PACE providers:

1. Must assure that applicants and beneficiaries understand their available choices and the consequences of those choices; and
2. Are bound by their provider agreement with Medicaid to adhere to the following policies on beneficiary rights.

Each applicant who requests PACE has the option to designate a responsible representative to assist or act on their behalf in the process of accessing and/or maintaining PACE services. The beneficiary has the right to change their responsible representative at any time. The responsible representative may not concurrently serve as a responsible representative for more than 2 beneficiaries in a Medicaid Home and Community-Based Services (HCBS) program that is operated by the OAAS (unless an exception is granted by OAAS), which programs include, but are not limited to:

1. PACE;
2. Long Term-Personal Care Services (LT-PCS);
3. Community Choices Waiver (CCW); and
4. Adult Day Health Care (ADHC) Waiver.

Rights and Responsibilities Form

During enrollment, the PACE provider is responsible for reviewing the beneficiary's rights and responsibilities with the beneficiary and/or their personal representative as part of the initial intake process and at least annually thereafter. (The PACE providers' Rights and Responsibilities document must adhere to 42 CFR §460.110-114).

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Freedom of Choice of Providers

Beneficiaries have the freedom of choice (FOC) to select their health care providers from within the PACE network. When the beneficiary chooses a primary care provider (PCP), or chooses to change PCP, the beneficiary must contact the PACE provider.

Changing Providers

By choosing PACE as their provider, the beneficiary has exercised their FOC. Beneficiaries will receive all services through the PACE program. PACE providers may allow for a beneficiary to have a PCP or other specialist outside of their network, if the interdisciplinary team (IDT) believes this is what is best for the beneficiary's health.

Participation in Care

Each beneficiary must participate in the assessment and person-centered planning meetings with the appropriate PACE staff and in any other meeting involving decisions about services and supports to be provided. Person-centered planning will be utilized in developing all services and supports to meet the beneficiary's needs. By taking an active part in planning their services, the beneficiary is better able to utilize the available supports and services. The beneficiary is expected to participate in the planning process to the best of the beneficiary's ability so that services are delivered according to the approved person-centered plan of care (POC).

Voluntary Participation

Beneficiaries have the right to end their PACE services. If a beneficiary decides to no longer participate in the PACE program, the beneficiary shall notify the PACE provider as soon as possible. If the PACE provider is notified after the 25th day of the month, Medicaid disenrollment will not occur until the last day of the following month that the notice was given.

Quality of Care

Each PACE beneficiary has the right to be treated with dignity and respect and receive humane care and services from PACE providers and their contractors who have been trained and are qualified to provide care and services. In addition, PACE providers and their contractors are required to maintain privacy and confidentiality in all interactions related to the beneficiary's services.

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Beneficiaries have the right to be free from harm and abuse (mental, physical, or emotional abuse, neglect, excessive medication, involuntary seclusion, coercion, and any physical or chemical restraint imposed for discipline purposes or convenience and not required to treat the beneficiary's medical symptoms).

In cases where services are not delivered according to the approved POC, or there are allegations of abuse, neglect, exploitation, or extortion, the beneficiary must follow the reporting procedures and inform the provider and the appropriate authorities.

Beneficiaries, providers, and contractors must cooperate in the investigation and resolution of reported incidents/complaints.

Civil Rights

PACE providers must operate in accordance with Title VI and VII of the Civil Rights Act of 1964, as amended, with the Vietnam Veterans Readjustment Act of 1974, and with all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services (DHHS). This means that individuals are accepted and that all services and facilities are available to persons without regard to race, ethnicity, color, religion, age, sex, national origin, sexual orientation, mental or physical disability, and/or source of payment. Beneficiaries have the responsibility to cooperate with their PACE provider and PACE contractors by not requesting services that in any way violate these laws.

Notification of Changes

The Bureau of Health Services Financing (BHSF) is responsible for determining Medicaid financial eligibility for PACE beneficiaries. In order to maintain eligibility, beneficiaries and providers have the responsibility to inform BHSF of changes in the beneficiary's income, resources, address, and living situation.

OAAS or its designee is responsible for approving nursing facility level of care (NFLOC). The PACE provider has the responsibility to inform OAAS, or its designee, if the beneficiary no longer meets NFLOC according to criteria established by the Louisiana Department of Health (LDH).

Grievances/Complaints

The beneficiary has a responsibility to bring problems to the attention of PACE staff of contractors or to OAAS, or its designee, and to file a grievance/complaint without fear of restraint, retribution, retaliation, interference, coercion, discrimination, or discharge.

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PACE providers must have grievance procedures through which beneficiaries may voice complaints regarding the supports or services that they receive and the quality of the care provided.

Beneficiaries must be provided a copy of the grievance procedures, upon admission into the PACE program and annually thereafter.

Fair Hearings

Beneficiaries must be advised of their rights to appeal any action or decision resulting in non-coverage of services, non-payment of services, and denials, reductions, or termination of services in accordance with 42 CFR 460.122. A PACE provider must inform the beneficiary in writing of additional appeal rights available under Medicare or Medicaid. Medicaid-eligible beneficiaries who appeal through Medicaid shall have the appeal heard by the Division of Administrative Law (DAL) within the timeframes applicable to processing Medicaid appeals except in cases where federal PACE requirements require a more expeditious decision.

Beneficiaries must be provided a copy of the fair hearing procedures upon admission into the PACE program, at least annually, and whenever the IDT denies a request for services or payment. A PACE provider must also inform a participant, in writing, of additional appeal rights available under Medicare and/or Medicaid if an appeal/fair hearing is not resolved through the PACE hearing process.

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SERVICE ACCESS AND AUTHORIZATION**Accessing Services**

The Program of All-Inclusive Care for the Elderly (PACE) applicant/responsible representative must call the PACE provider located in their geographical area or the toll-free telephone number to the Office of Aging and Adult Services (OAAS) designated contractor for Louisiana Options in Long Term Care (LTC) and request completion of a Louisiana Level of Care Eligibility Tool (LOCET) screening. The LOCET is completed over the telephone by this contractor and it is a level of care (LOC) pre-enrollment screening tool. If the LOCET indicates that the applicant meets nursing facility level of care (NFLOC), the approval information is sent to the PACE provider in the applicant's geographical location. The PACE provider will then contact the applicant and begin the application process.

The PACE provider must create and maintain a log of all potential enrollees who request information and/or admission into the program. This log must include the following:

1. Initial call with the name and contact information for the potential enrollee;
2. All subsequent calls regarding the pre-application process with notes of the reason for the call;
3. Final outcome regarding whether the potential enrollee proceeded in the application process, or the potential enrollee was turned down and did not proceed with the application; and
4. Reason that the applicant was not selected to enroll in PACE, if applicable.

Provider Selection**Authorization Process**

When the applicant is linked to the PACE provider, the PACE intake process begins as follows:

1. PACE staff members conduct one or more face-to-face visits at the applicant's place of residence (home);

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2. The applicant makes one or more face-to-face visits to the PACE center;
3. PACE staff must explain the following to the applicant and/or their responsible representative:
 - a. PACE program;
 - b. PACE enrollment agreement by reviewing all elements of the agreement;
 - c. Requirement that the PACE provider would be the beneficiary’s sole service provider and clarification that the PACE provider guarantees access to services, but not a specific provider;
 - d. List of the employees of the PACE provider who furnish care and the most current list of contracted health care providers;
 - e. Monthly premiums, if any;
 - f. Medicaid spenddown/patient liability obligations; and
 - g. Post-eligibility treatment of income.
4. The applicant must sign a release to allow the PACE provider to obtain their medical and financial information and eligibility status for Medicare and Medicaid.

Eligibility Assessment

PACE staff must assess the applicant to ensure all eligibility requirements are met and the applicant can be cared for appropriately in a community setting. The criteria used to determine whether the individual’s health and safety would be jeopardized by living in the community setting, must be specified in the program agreement in accordance with LAC50.XXIII.501.

Assessment Criteria

1. The PACE interdisciplinary team (IDT) must conduct an initial in-person comprehensive assessment of each applicant. The information obtained through this assessment is used by the IDT to develop the beneficiary’s plan of care (POC) that adequately addresses all of the beneficiary’s physical, emotional, social, and medical care needs. The assessment process begins before enrollment, when the

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PACE provider evaluates whether a potential PACE beneficiary can be cared for appropriately in the program; and

NOTE: This comprehensive assessment is often accomplished by the effective date of enrollment but shall never be delayed more than a few days beyond that date. The POC must be developed within 30 calendar days of enrollment.

2. The PACE staff must also complete a face-to-face interRAI Home Care (iHC) assessment on the applicant to verify that the applicant continues to meet the NFLOC criteria. This assessment must be completed by a PACE staff member that has been trained and certified by OAAS to conduct these assessments. If the initial iHC assessment determines that the applicant does not meet NFLOC, the PACE provider must notify the OAAS Regional Office (RO) to request review of all enrollment data, including the iHC. OAAS RO will ensure the accuracy of the enrollment data and make the final determination regarding NFLOC. OAAS RO shall assure that all avenues of eligibility are explored prior to determining that an individual does not meet the required NFLOC. OAAS RO shall notify the PACE provider of the final determination.

When an enrollment is denied because the PACE applicant’s health and safety would be jeopardized by living in the community setting, or the applicant does not meet NFLOC, the PACE provider must submit the proposed denial with all documentation to OAAS within 5 business days of the decision. OAAS will make the final determination of the applicant’s eligibility.

NOTE: PACE must send these denials to OAAS for review/approval before notifying the applicant. OAAS must review these denials and respond to the PACE provider.

If OAAS agrees with the denial, the PACE provider must:

1. Notify the individual, in writing, of the reason for the denial (this notice must also include fair hearing rights);
2. Refer the individual to alternative services, as appropriate;
3. Maintain supporting documentation for the denial;
4. Notify the Centers for Medicare and Medicaid Services (CMS) through the reporting of the Data Elements in monitoring into CMS Health Plan Management System (HPMS); and
5. Make all applicant documentation available for review.

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When it has been determined that the applicant meets the eligibility requirements for PACE and decides to enroll in PACE, the beneficiary must sign and date the enrollment agreement that contains the following (at a minimum):

1. Name;
2. Gender;
3. Date of Birth (DOB);
4. Medicare status (Part A, Part B, or both) and number (if applicable);
5. Medicaid status and number (if applicable);
6. Other health insurance information (if applicable);
7. PACE mission and philosophy;
8. PACE eligibility criteria;
9. PACE enrollment and disenrollment conditions and procedures;
10. Beneficiary rights and responsibilities;
11. Description of PACE benefits and coverage and how services are obtained from the PACE provider;
12. Description of participant premiums, if any, and procedures for payment of premiums;
13. Description of the IDT;
14. Consumer advisory committee;
15. Contracted providers;

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16. Description of procedures for emergency services and urgently needed out-of-network services;
17. Description of out-of-service-area coverage;
18. Prescription drug coverage;
19. Notification that a Medicaid beneficiary and a beneficiary who is eligible for both Medicare and Medicaid are NOT liable for any premiums but may be liable for any applicable spend down/patient liability and any amounts due under the post-eligibility treatment of income process;
20. Notification that a Medicare beneficiary may neither enroll or disenroll at a Social Security office;
21. Notification that enrollment into the PACE program results in disenrollment from any other Medicare or Medicaid prepayment plan or optional benefit. Electing enrollment in any other Medicare or Medicaid prepayment plan or optional benefit, including the hospice benefit, after enrolling as a PACE participant is considered voluntary disenrollment from PACE. If a Medicaid-only or private pay beneficiary becomes eligible for Medicare after enrollment in PACE, the beneficiary will be disenrolled from PACE if the beneficiary elects to obtain Medicare coverage other than from the beneficiary's PACE provider;
22. Information on the consequences of subsequent enrollment in other optional Medicare or Medicaid programs following disenrollment from PACE;
23. Notification of a beneficiary's responsibility to inform the PACE provider of a move or lengthy absence from the PACE service area;
24. Acknowledgement that beneficiary understands the requirement that the PACE provider must be the sole service provider;
25. Statement that the PACE provider has an agreement with CMS and the Louisiana Department of Health (LDH)/OAAS that is subject to renewal on a periodic basis, and if the agreement is not renewed, the program will be terminated;

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- 26. Authorization for disclosure and exchange of personal information between CMS, its agents, LDH/OAAS, and the PACE provider;
- 27. Grievance and appeals procedures (including Medicare/Medicaid phone numbers to use in an appeal); and
- 28. Effective date of PACE enrollment.

NOTE: The beneficiary’s effective date of enrollment is the first day of the calendar month following the date on which the PACE provider receives the signed enrollment agreement, as long as OAAS has signed off on the beneficiary’s documents.

After the beneficiary signs the PACE Enrollment Agreement, the PACE provider gives the beneficiary the following:

- 1. PACE membership card that indicates that individual is a PACE beneficiary and includes the phone number of the PACE provider;
- 2. Copy of the PACE enrollment agreement;
- 3. Emergency information to be posted in their home identifying the individual as a PACE beneficiary and explaining how to access emergency services; and
- 4. Stickers for the beneficiary’s Medicaid card, as applicable, which indicate that individual is a PACE beneficiary and includes the phone number of the PACE provider.

When it has been determined that the applicant meets the medical and functional eligibility and program requirements, the PACE provider must submit all enrollment documents to OAAS RO. OAAS RO submits the LDH Medicaid Program Notice of Medical Certification (Form 142) to Medicaid. Medicaid must determine financial eligibility. The PACE applicant is not officially enrolled until the PACE provider receives the Medicaid decision letter from Medicaid stating that the applicant meets Medicaid financial eligibility, unless the person has agreed to the monthly premium for those who are private pay or eligible for Medicare only.

The beneficiary is enrolled for the next year, unless the beneficiary:

- 1. Decides to voluntarily disenroll;

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2. Is involuntarily disenrolled; or
3. Passes away.

Voluntary Disenrollment

The beneficiary may request voluntary disenrollment from PACE without cause at any time.

The effective date of voluntary disenrollment is the first day of the month following the date on which the PACE provider received the voluntary disenrollment notice. However, if Medicaid does not receive the disenrollment notification by the 25th of the month, the beneficiary will remain enrolled as a PACE Medicaid beneficiary through the following month. Enrollment always ends on the last day of a month.

Involuntary Disenrollment

When the PACE provider is proposing to involuntarily disenroll a beneficiary from the PACE program, they must submit the documentation to OAAS RO for review/approval before PACE proceeds with the disenrollment.

Beneficiaries may be involuntarily disenrolled from the PACE program for the following reasons:

1. After a 30 calendar day grace period, the beneficiary fails to pay or make satisfactory arrangements to pay any premium due to the PACE provider and/or fails to pay or make satisfactory arrangements to pay any applicable Medicaid spend down/patients liability or any amount due under the post-eligibility treatment of income process;
2. The beneficiary engages in behavior that jeopardizes the beneficiary's health and safety or the safety of others;
3. The beneficiary with decision-making capacity, consistently refuses to comply with the POC, medical advice, or the terms outlined in the PACE enrollment agreement or to keep appointments;

NOTE: The PACE provider must document this behavior in the beneficiary's record along with all efforts to remedy the situation. The PACE provider also

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cannot disenroll a beneficiary on the grounds of non-compliant behavior if the behavior is related to a mental or physical condition of the beneficiary, unless the behavior jeopardizes the beneficiary’s health and safety and/or the safety of others.

4. The beneficiary moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE provider agrees to a longer absence due to extenuating circumstances;
5. The beneficiary no longer meet NFLOC and is not deemed eligible;
6. The PACE program agreement with CMS and LDH/OAAS is not renewed or is terminated; and/or
7. The PACE provider is unable to offer health care services due to the loss of state licenses or contracts with outside providers.

Once OAAS RO approves the involuntary disenrollment, the PACE provider must:

1. Use the most expedient process allowed under Medicare and Medicaid procedures, as outlined in the PACE program agreement;
2. Coordinate the disenrollment date between Medicare and Medicaid (for beneficiaries who are eligible for both Medicare and Medicaid);
3. Give appropriate advance notice to the beneficiary;
4. Continue to provide all needed services; and

NOTE: The beneficiary must continue to use the PACE provider’s services and PACE will remain responsible for all care identified in the POC until the date on which the PACE services are terminated.

5. Facilitate the beneficiary’s reinstatement into other Medicare and Medicaid programs after disenrollment by:
 - a. Making appropriate referrals and ensuring that medical records are made available to new providers within 30 calendar days; and

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- b. Working with CMS and OAAS to reinstate the beneficiary in other Medicaid programs for which the beneficiary is eligible.

The beneficiary's involuntary disenrollment will occur **AFTER** the PACE provider meets all of the requirements set forth above.

The effective date of involuntary disenrollment is the first day of the next month that begins 30 calendar days after the date on which the PACE provider sends the disenrollment notice with appeal rights, to the beneficiary.

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PROVIDER REQUIREMENTS

Provider participation in the Louisiana Medicaid program is voluntary. In order to participate in the Medicaid program as a Program of All-Inclusive Care for the Elderly (PACE) provider, the PACE provider must:

1. Meet all of the requirements, including Adult Day Health Care (ADHC) licensure, as established by state laws and rules promulgated by the Louisiana Department of Health (LDH);
2. Acquire a Home and Community-Based Services (HCBS) license under the Personal Care Attendant (PCA) module, if the PACE provider uses their own staff to provide PCA services to PACE beneficiaries;
3. Agree to abide by all rules, regulations, policies and procedures established by the Centers for Medicare and Medicaid Services (CMS), LDH and other state agencies if applicable; and
4. Comply with all of the terms and conditions for Medicaid enrollment.

PACE providers shall refer to Section 1.1 – Provider Requirements of the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website at:

<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf> for detailed information concerning topics relative to Medicaid provider enrollment.

PACE providers must attend all mandated meetings and training sessions as directed by LDH and/or its designee as a condition of enrollment and continued participation as a PACE provider.

A provider enrollment packet must be completed by the PACE provider.

Failure to comply with all regulations may result in any or all of the following:

1. Recoupment;
2. Sanctions;
3. Suspension of enrollment;
4. Suspension of payment; or

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5. Termination of the PACE program agreement.

PACE providers must not employ individuals or contract with organizations, providers or individuals who have been:

1. Excluded from participation in the Medicare or Medicaid programs;
2. Convicted of criminal offenses related to their involvement in Medicaid, Medicare, other health insurance or health care programs, or social service programs under title XX of the Act;
3. Convicted of specific crimes for any offense described in section 1128(a) of the Social Security Act;
4. Found guilty of abusing, neglecting, or mistreating individuals by a court of law or who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property; and/or
5. If the PACE provider determines that an individual's contact with participants would pose a potential risk because the individual has been convicted of one or more criminal offenses related to physical, sexual, drug, or alcohol abuse or use.

Provider Certifications/Recertification Requirements

The State Readiness Review, developed by CMS, is used by the Office of Aging and Adult Services (OAAS) to perform the readiness review of brand new non-operational PACE provider or relocation of PACE centers/providers. OAAS must conduct a provider readiness assessment prior to operation. OAAS reviews the PACE provider's policies and procedures, the design and construction of the building, emergency preparedness, compliance with Occupational Safety and Health Administration (OSHA), Food and Drug Administration (FDA), and life safety codes.

CMS and OAAS must conduct comprehensive annual reviews of PACE providers during the trial review period for the first 3 years of operation in order to ensure compliance with the PACE requirements. Review and analysis of the PACE provider's compliance may include but not limited to the following:

1. Observation of the PACE provider program operations;
2. Review of marketing;
3. Review of beneficiary services;

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- 4. Review of enrollment and disenrollment; and
- 5. Review of grievances and appeals.

CMS and/or OAAS send all review results to the PACE provider along with any recommendations for changes to its program.

- 1. The PACE provider must write a corrective action plan (CAP) that describes the details that will be taken to correct the identified deficiency(ies). When deficiencies are found, the PACE provider must take action through the following:
 - a. Ongoing monitoring of the PACE provider;
 - b. Reviews and audits of the PACE provider;
 - c. Complaints from PACE beneficiaries and/or caregivers; and
 - d. Any other instance CMS or OAAS identifies programmatic deficiencies requiring correction.
- 2. CMS and/or OAAS must make the review results available to the public, if requested;
- 3. The PACE provider must:
 - a. Post a notice that the review results and the corrective action plan/responses are available for viewing; and
 - b. Make the review results available for viewing in a place that is easily accessible to beneficiaries, their families, caregivers and their responsible representatives.

CMS or OAAS must monitor the effectiveness of the corrective actions. Failure by the PACE provider to correct the deficiencies, shall result in sanctions or termination.

Licensure and Specific Provider Requirements

PACE providers must:

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1. Be enrolled in the Medicaid program as a PACE provider;
2. Be licensed by the Health Standards Section (HSS) as an ADHC facility; and
3. Have a Medicaid provider agreement/provider number as a PACE provider.

Exceptions to Licensure Requirements

HSS will grant the following exceptions to the ADHC licensing requirements for PACE providers:

1. Waivers of ADHC licensing requirements as appropriate and allowed;
2. ADHC licensing requirement states that an ADHC center shall not admit more beneficiaries into care than the number specified on their license. PACE providers may enroll more beneficiaries into the PACE center than the ADHC license will allow; however, the PACE center must not exceed the licensed capacity on any day; and
3. ADHC licensing requirement states that a beneficiary who has not attended an ADHC center at least 36 days each quarter (every 3 months) shall not be eligible for ADHC services. A PACE beneficiary may have supports at their home during the day and may not need the daily support provided by the ADHC component of PACE. The frequency of a beneficiary's attendance at the PACE center is determined by the PACE interdisciplinary team (IDT) based on the needs and preferences of the beneficiary. Therefore, the beneficiary may not attend the center within the 36 days per quarter period and will not be disenrolled from the PACE program.

Provider Responsibilities

The PACE provider must:

1. Employ or contract a program director who is responsible for oversight and administration of the entity;
2. Employ or contract with a medical director who is responsible for the delivery of beneficiary care, for clinical outcomes and for the implementation, as well as oversight, of the quality improvement program;
3. Have a current organizational chart showing PACE provider staff members and

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relationships to any other organizational entities;

4. Notify CMS and OAAS, in writing, at least 14 calendar days before the change when the PACE provider is changing their organizational structure;
5. Notify CMS and OAAS, in writing, at least 60 calendar days before the anticipated effective date of the change when the PACE provider is planning a change of ownership;
6. Be operating under the control of an identifiable governing body that includes at least one beneficiary or a designated individual functioning as a governing body with full legal authority and responsibility for the following:
 - a. Governance and operation of the organization;
 - b. Development of policies consistent with mission;
 - c. Management and provision of all services, including the management of contractors;
 - d. Establishment of personnel policies that address adequate notice of termination by employees or contractors with direct patient care responsibilities;
 - e. Fiscal operation; and
 - f. Development of policies on beneficiary health and safety, including a comprehensive systemic operational plan to ensure the health and safety of beneficiaries.
7. Quality Improvement Plan (QIP) that specifies the following:
 - a. Identifies areas to improve or maintain the delivery of services and beneficiary care;
 - b. Develops and implements plans of actions to improve or maintain the quality of care; and
 - c. Documents and disseminates to PACE staff and contractors the results from the quality improvement activities.

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8. Establish a beneficiary advisory committee to provide advice to the governing body on matters that concern beneficiaries;

NOTE: Beneficiaries and beneficiary responsible representatives must constitute the majority of this committee. The beneficiary that serves on the governing body must also participate in this committee and acts as a liaison to the governing body and presents issues from this committee directly to the governing body.

9. Establish one or more committees, with community input, to accomplish the following:
- a. Evaluate data collected pertaining to quality outcome measures;
 - b. Address the implementation of and results from the QIP; and
 - c. Provide input related to ethical decision-making, including end-of-life issues and implementation of the Patient Self-Determination Act.
10. Be able to provide the complete service package regardless of frequency or duration of services;
11. Have a physical site and staff along with equipment to provide primary medical care (including nursing services), treatment, social services, team meetings, therapeutic recreation, personal care and supportive services, restorative therapies (including physical and occupational therapies), nutritional counseling, recreational therapy, and meals;
12. Have a defined service area;
13. Have the ability to manage the comprehensive care (including acute and long term) of a complex nursing facility eligible population 365 days a year, 24 hours per day, 7 days per week regardless of the setting;
14. Develop a provider network in order to provide/contract all required covered services and other services necessary to meet the beneficiary's needs;
15. Have policies and procedures that address handling any direct or indirect conflict of interest associated with the governing body, or any contracts that supply administrative or care-related service or materials to the PACE provider;
16. Have demonstrated fiscal soundness, as defined in 42 Code of Federal Regulations (CFR) 460.80 and 42 CFR 460.208;

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17. Have a formal written Beneficiary Bill of Rights, as defined in 42 CFR 460.110 and 42 CFR 460.112;
18. Have a process to address grievances and appeals as defined in 42 CFR 460.120 and 42 CFR 460.122;
19. Not discriminate against any beneficiary in the delivery of required PACE services based on race, ethnicity, national origin, religion, sex, age, mental, or physical disability or source of payment;
20. Follow accepted infection control policies and standard procedures, including at least the standard precautions developed by the Centers for Disease Control and Prevention (CDC);
21. Establish, implement, and maintain a documented infection control plan that:
 - a. Ensures a safe and sanitary environment;
 - b. Prevents and controls the transmission of disease and infection;
 - c. Specifies procedures that identifies, investigates, controls and prevents infections in the PACE centers and the beneficiary’s residence;
 - d. Identifies procedures to record any infection incidents; and
 - e. Specifies procedures to analyze the infection incidents that identify trends and develops corrective actions related to the reduction of future incidents.
22. Establish, implement, and maintain a documented marketing plan as described in 42 CFR 460.82. All marketing material, including any initial, revised or updated marketing material, must be reviewed and approved by CMS and OAAS;
23. Have written polices and implement procedures to ensure that the explanation of rights to the beneficiary, their responsible representative, and staff are fully explained and understood;

NOTE: The beneficiary’s rights must be in English and in any other principal languages of the community, as determined by the State.

24. Have established, documented procedures to respond to and rectify a violation of

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a beneficiary’s rights;

25. Limit the use of chemical or physical restraints to the least restrictive method as described in 42 CFR 460.114;
26. Have a written plan and procedure for handling emergency situations in accordance with 42 CFR 460.84:
 - a. At least annually, the PACE provider must test, evaluate, and document the effectiveness of its emergency and disaster plans to ensure and maintain appropriate responses to situations and needs from both medical and non-medical emergencies; and
 - b. The PACE provider must have a documented plan to obtain emergency medical assistance from sources outside the center when needed.
27. Ensure that the minimum emergency equipment available for use at each PACE center includes easily portable oxygen, airways, suction, and emergency drugs, along with staff on the premises at all times who know how to use the equipment.
 - a. The PACE provider must establish, implement and maintain a written plan to ensure that all equipment is maintained in accordance with manufacturer’s recommendations.

National Voter Registration Act (NVRA)

In accordance with the National Voter Registration Act (NVRA) of 1993 and the Louisiana Revised Statute (LA RS) 18:116, the PACE provider must comply with all applicable federal and state NVRA requirements. The PACE provider’s NVRA requirements are outlined in the OAAS NVRA manual (OAAS MAN-14-001).

Emergency Preparedness

In accordance with 42 CFR 460.84 the PACE provider must comply with all applicable federal, state, and local emergency preparedness requirements. This includes:

1. Emergency plan that is reviewed and updated annually;
2. Policies and procedures which are reviewed and updated annually and address management of medical and nonmedical emergencies, including, but not limited to:

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- a. Fire;
 - b. Equipment, power or water failure;
 - c. Care related emergencies; and
 - d. Natural disasters.
3. Communication plan which is reviewed and updated annually;
 4. Training and testing plan. The PACE provider must develop and maintain an emergency preparedness training and testing program. The program must be reviewed and updated at least annually;
 5. Integrated healthcare systems. The PACE provider may choose to participate in another healthcare system’s coordinated emergency preparedness program;
 6. Transportation services that are safe, accessible and equipped to communicate with the PACE center and that meet the needs of the beneficiary;
 7. Owned, rented, or leased transportation vehicles in are maintained accordance with manufacturer’s recommendations; and

NOTE: If a contractor/provider provides transportation services, the PACE provider must ensure that the vehicles are maintained in accordance with manufacturer’s recommendations.

8. Training all transportation staff (employees and contractors/providers) to ensure that they can handle the beneficiary’s special needs and emergency situations.

Marketing

1. All Marketing materials used by the PACE providers must first be approved by CMS and LDH;
2. Gifts or payments to induce enrollment are prohibited; and
3. PACE providers are responsible for the activities of contracted individuals or entities who market on their behalf. PACE providers that choose to use contracted providers, individuals or entities for marketing purposes must develop a method to document training has been provided.

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Enrollment and Disenrollment

If there are changes in the PACE Enrollment Agreement information at any time during the beneficiary's enrollment, the PACE provider must:

1. Have the Enrollment Agreement reviewed and approved by OAAS and CMS, prior to use;
2. Give an updated copy of the information to the beneficiary; and
3. Explain the changes to the beneficiary and their representative or caregiver in a manner they understand.

A PACE provider must only involuntarily disenroll a PACE beneficiary from the PACE program, in accordance with 42 CFR 460.164, for the following reasons:

1. The beneficiary, after a 30 day grace period, fails to pay or make satisfactory arrangements to pay any applicable Medicaid spend down/patient liability or any amount due under the post-eligibility treatment of income process, as permitted under 42 CFR 460.7182 and 42 CFR 460.184;
2. The beneficiary engages in disruptive or threatening behavior;
3. The beneficiary moves out of the PACE service area or is out of the service area for more than 30 days, unless the PACE provider agrees to a longer absence due to extenuating circumstances;
4. The PACE program agreement with CMS and OAAS is not renewed or is terminated;
5. The PACE provider is unable to offer health care services due to the loss of state licenses or contracts with outside providers; and
6. The beneficiary is determined no longer to meet Medicaid state nursing facility level of care (NFLOC) requirements and is not deemed eligible. OAAS must make the final determination that the beneficiary no longer meets NFLOC and would not reasonably be expected to become eligible for PACE services within 6 months in the absence of continued coverage under the PACE program.

The following behaviors are behaviors considered disruptive or threatening behaviors for

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purposes of involuntary disenrollment as specified by 42 CFR 460.164(b) (1&2):

1. The behavior that jeopardizes their health or safety, or the safety of others;
2. Consistent refusal to comply with their individual plan of care (POC) or the terms of the PACE enrollment agreement by a beneficiary with decision making capacity, but not if the behavior is related to a mental or physical condition of the beneficiary unless the beneficiary's behavior jeopardizes their health or safety, or the safety of others. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments;
3. A beneficiary's caregiver who engages in disruptive or threatening behavior exhibits behavior that jeopardizes the beneficiary's health or safety, or the safety of the caregiver or others; and
4. Documentation of disruptive or threatening behavior. If a PACE provider proposes to disenroll a beneficiary who is disruptive or threatening, the PACE provider must document the following:
 - a. The reasons for proposing to disenroll the beneficiary; and
 - b. All efforts to remedy the situation.

Under the authority of Section 903 of the Benefits Improvement and Protection Act (BIPA), a PACE provider must have a CMS approved waiver to expand the request to involuntarily disenroll a beneficiary.

The PACE provider must document reasons for the involuntary disenrollment and all efforts to resolve the problem. Involuntary disenrollment shall occur only after all attempts at resolving the issues have been exhausted. The PACE provider must submit all documentation used to support the involuntary disenrollment to the Office of Aging and Adult Services Regional Office (OAAS RO) in accordance with 42 CFR 460.164(e).

PACE providers and OAAS must follow the involuntary disenrollment process if a PACE beneficiary is determined to meet any of the criteria for involuntary disenrollment from PACE services in accordance with [42 CFR 460.164](#).

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NOTE: For those beneficiaries being involuntarily disenrolled due to disruptive or threatening behavior, the PACE provider must provide documentation of the behavior(s) along with documentation of all efforts made to address the situation.

After determining a PACE beneficiary meets any of the involuntary disenrollment criteria, the PACE provider will notify OAAS of the proposed involuntary disenrollment and provide documentation sufficient to show that the beneficiary should be involuntarily disenrolled. OAAS will make a final determination as to whether the beneficiary should be involuntarily disenrolled. If OAAS agrees, the PACE provider will send the beneficiary a disenrollment notice with appeal rights. If OAAS disagrees with the PACE provider, the beneficiary will continue receiving services from the PACE program.

The PACE provider will follow their formal, written appeals process, including timely notification to the beneficiary regarding the involuntary disenrollment and applicable referrals/recommendations for alternate healthcare options.

In accordance with 42 CFR 460.164(a), involuntary disenrollments are effective on the first day of the next month that begins 30 calendar days after the day the PACE provider sends notice of the disenrollment to the beneficiary.

If not appealed or not appealed timely, PACE disenrollment will be effective on the date provided in the disenrollment notice.

If a beneficiary is involuntarily disenrolled due to not meeting NFLOC or due to losing Medicaid eligibility and choosing not to continue by a monthly fee, the PACE provider will not send the notice. If a beneficiary is disenrolled due to not meeting NFLOC, OAAS will send the notice. If a beneficiary loses Medicaid eligibility, Medicaid will send the notice.

As specified in 42 CFR 460.160(b), an annual interRAI Home Care (iHC) recertification assessment must be completed to reevaluate whether the beneficiary continues to meet NFLOC required under the state Medicaid plan for coverage of nursing facility services, unless the beneficiary has been granted permanent status. The PACE applicant must receive an iHC assessment by OAAS trained and certified PACE staff to verify that the applicant meets the required NF LOC criteria for enrollment in PACE.

In accordance with 42 CFR 460.160(b) (2), OAAS may determine that a PACE beneficiary, who no longer meets the State Medicaid NFLOC requirements, may be deemed to continue to be eligible for the PACE program until the next annual reevaluation. The PACE provider may request “deemed continued eligibility” based on the following criteria:

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1. The beneficiary no longer meets the NFLOC criteria but would reasonably be expected to become eligible within 6 months in the absence of continued coverage under the program; and
2. The beneficiary's medical record and POC support deemed continued eligibility.

The PACE provider must submit the request for Deemed Continued Eligibility Form (OAAS-PF-10-002) to the OAAS RO within 5 business days of notification of a PACE beneficiary not having met nursing facility.

The PACE IDT must submit a brief justification summary and supporting documentation from the beneficiary's medical record/POC that supports the request for Deemed Continued Eligibility Form (OAAS-PF-10-002). Supporting documentation includes any information that, in the absence of PACE services, the beneficiary would reasonably be expected to experience a decline in functional abilities or health to a degree that they would meet NFLOC criteria within 6 months.

Examples of supporting documentation include, but are not limited to:

1. Diagnosis of a chronic, and/or disabling condition;
2. Physician and/or nursing progress notes documenting the treatment of the chronic, and/or disabling condition(s);
3. Physician's orders and a list of services currently provided to the beneficiary (e.g. physical therapy, occupational therapy, dietary management, blood pressure checks, etc.); and
4. Frequency of medical appointments and/or frequency of medical treatments/interventions that point to unstable medical condition that must be treated, and or monitored to avoid complications.

OAAS RO shall review all documentation and respond within 10 business days upon the receipt of the request and all supporting documentation. OAAS RO may request an onsite visit to meet with the beneficiary, conduct its own NFLOC assessment and/or request additional information. The PACE provider must submit the requested information no later than 5 business days from the date of receipt of OAAS' request for the additional information. If OAAS does not receive the requested information within the 5 business days, OAAS shall proceed with the denial process.

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The PACE provider will be notified in writing via the Deemed Continued Eligibility Form (OAAS-PF-10-002) if the OAAS RO deems continued eligibility and enrollment will continue until the next annual reassessment.

OAAS RO shall make a notation in the iHC Notebook that deemed continued eligibility criteria was met on (date) for continuation of the PACE program until next annual iHC reassessment.

The PACE providers shall continue to conduct annual iHC reassessments for NFLOC and may request Deemed Continued Eligibility each year as appropriate.

LDH may permanently waive the annual recertification of NFLOC requirements for a beneficiary if it determines that there is no reasonable expectation of improvement or significant change in the beneficiary's condition because of the severity of a chronic condition. OAAS may request annual re-assessments to be completed on PACE beneficiaries to gather research information, as needed.

Staffing Requirements

The PACE provider must:

1. Not employ individuals, contract with organizations/providers or individuals who have been;
2. Excluded from participation in the Medicare and/or Medicaid programs;
3. Convicted of Medicare, Medicaid, or other health insurance or health care programs, or any social service program (under title XX of the act) related crimes;
4. Convicted of physical, sexual, drug or alcohol abuse in a capacity where an individual's contact with beneficiaries would pose a potential risk;
5. Found guilty of abusing, neglecting or mistreating individuals by a court of law or who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;
6. Convicted of specific crimes for any offense described in section 1128(a) of the Social Security Act;
7. Ensure that all members of the IDT have appropriate licenses or certifications under State law, and act within the scope of practice as defined by State laws; and

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8. Develop a training program for each personal care attendant (PCA) to establish the beneficiary's competency in furnishing personal care services (PCS) and specialized skills associated with the beneficiary's specific care needs.

NOTE: PCAs must exhibit competency before performing PCS.

The PACE provider must ensure that each member of its staff (employees or contractors/providers) that has direct contact with beneficiaries, must meet the following criteria:

1. Be legally authorized to practice in Louisiana (e.g. currently licensed, registered or certified, if applicable);
2. Only act within the scope of their authority to practice;
3. Have one year of experience working with frail or elderly population or if the individual has less than one year of experience but meets all other requirements as stated above, they must receive appropriate training from the PACE provider on working with a frail or elderly population upon hiring;
4. Meet a standardized set of competencies for the specific position description established by the PACE provider before working independently;
5. Be medically cleared for communicable diseases and have all immunizations up-to-date before engaging in direct beneficiary contact;
6. Demonstrate the skills necessary for performance of their position;
7. Comply with any State and/or Federal requirements for direct beneficiary care staff in their respective settings;
8. Be oriented to the PACE; and
9. Agree to abide by the philosophy, practices and protocols of the PACE provider.

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STAFFING AND TRAINING**Staff Qualifications**

Each member of the Program of All-Inclusive Care for the Elderly (PACE) provider's staff that has direct beneficiary contact (employee or contractor) must have a minimum of one year of experience working with a frail or elderly population and meet the staffing requirements as specified in 42 Code of Federal Regulations (CFR) 460.71. In addition to the staffing requirements, the PACE interdisciplinary team (IDT) must also include, but is not limited to, the following qualifications:

1. Primary care physician (PCP) must meet additional qualifications and conditions, as defined in 42 CFR 410.20;
2. Social worker must have a master's degree in social work from an accredited school of social work;
3. Dietitian must have a bachelor of science degree or advanced degree from an accredited college with major studies in food and nutrition or dietetics;
4. Registered nurse (RN) must be a graduate of a school of professional nursing;
5. Physical therapist (PT) must be a graduate of a physical therapy curriculum approved by the American Physical Therapy Association, the Committee on Allied Health Education and Accreditation of the American Medical Association, or the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or other equivalent organizations approved by Centers for Medicare and Medicaid Services (CMS);
6. Occupational therapist (OT) must be a graduate of an occupational therapy curriculum accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association or other approved equivalent organization, be eligible for the National Registration Examination of the American Occupational Therapy Association, have two years of experience as an OT and have achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except for the proficiency does not apply to

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persons initially licensed by a state or seeking initial qualification as an OT after December 31, 1977; and

7. Transportation driver must have a valid driver’s license with the proper classification to operate a van or bus in the state of operation and have the ability to transport and have experience in transporting individuals with special mobility needs.

Staff Responsibilities

The PACE provider must employ or contract, in accordance with 42 CFR 460.70, the following:

1. Program director who is responsible for oversight and administration of the entity; and
2. Medical director who is responsible for the delivery of beneficiary care, for clinical outcomes, and the implementation, as well as oversight, of the Quality Assessment and Performance Improvement (QAPI) program.

A PACE provider must comply with 42 CFR 460.102, to establish an 11 member IDT at each PACE center. Each beneficiary must be assigned to an IDT at the PACE center that the beneficiary attends. The IDT is responsible for conducting health assessments, care planning, and coordination of 24-hour care delivery.

The IDT members may be employed or contracted staff. If the PACE provider uses contracted staff, they must meet the same personnel requirements and perform the same responsibilities as employed IDT members.

The PACE IDT must include, at a minimum, the following members:

1. PCP;
2. RN;
3. PT;
4. OT;

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5. Recreational therapist or activity coordinator;
6. Masters level social worker;
7. Personal care attendant (PCA) or their representative;
8. Dietitian;
9. Transportation driver or their representative;
10. PACE center supervisor/manager; and
11. Home care liaison/coordinator.

Mid-level practitioner(s), such as Physician Assistant (PA) and Nurse Practitioners (NP), may be used to supplement the physician's care to beneficiaries, within the scope of practice authorized by the state, by assisting the physician with the delivery of clinical care. They may participate but must not replace the physician on the IDT or perform beneficiary assessments/reassessments.

The PACE IDT must conduct an initial in-person comprehensive assessment as described in 42 CFR 460.104(a) and periodic in-person reassessments as described in 42 CFR 460.104(c)(d). Beneficiary unscheduled reassessments by the IDT must be completed when there is a significant change in health or psychosocial status and the beneficiary or their designated representative believes that the beneficiary needs to initiate, eliminate, or continue a particular service. The IDT members must meet to consolidate the findings into the plan of care (POC).

The IDT members that must conduct the initial in-person assessment include the PCP, RN, master's level social worker, PT, OT, recreational therapist, dietitian, and home care coordinator. At the recommendation of the IDT, other professional disciplines (for example, speech-language pathology, dentistry, or audiology) may be included in the initial comprehensive assessment process.

The IDT, PCP, RN, and master's level social worker must conduct periodic health re-assessments at least every 6 months and more often if the beneficiary's condition dictates. Other IDT members or specialty practitioners actively involved in the beneficiary's POC will be expected to complete re-assessments, as needed.

The IDT must:

1. Develop the comprehensive POC within 30 calendar days of enrollment for each

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- beneficiary after completing the assessments as specified in 42 CFR 460.106;
2. Implement, coordinate and monitor the POC whether the services are furnished by PACE staff or contractors;
 3. Collaborate with the beneficiary or caregiver, or both, to ensure there is agreement with the POC and that the beneficiary's concerns are addressed; and
 4. Continuously monitor the beneficiary's health and psychosocial status, as well as the effectiveness of the POC through the provision of services, informal observation, input from the beneficiaries or caregivers, and communications among members of the IDT and other providers.

On at least a semi-annual basis, the IDT must reevaluate the POC, define outcomes and make revisions as necessary. Anytime there is a significant change in health status the POC must be updated. The PACE staff (employees and contractors), as part of the IDT process, must communicate relevant changes in a beneficiary's POC to transportation personnel as required by 42 CFR 460.76(e).

The PACE applicant must receive a face-to-face interRAI Home Care (iHC) assessment initially and then annually to verify that the applicant continues to meet the required nursing facility level of care (NFLOC) criteria for enrollment in PACE, unless a "permanent waiver" has been issued. The iHC must be completed only by OAAS iHC trained and certified PACE staff.

The PACE provider must designate an individual to coordinate and oversee implementation of the quality assessment and performance improvement activities as specified in 42 CFR 460.136(b). The quality improvement coordinator must encourage PACE beneficiaries and caregivers to be involved in quality assessment and performance activities, including information about their satisfaction with services.

The PACE provider must designate a staff member to ensure that all PACE staff furnishing care directly to beneficiaries demonstrate the skills necessary for performance of their position. The designated staff person must oversee the orientation program and competency evaluation program for direct-care employees and work with PACE contracted liaison to ensure compliance in accordance with 42 CFR 460.71(a) (4).

Orientation and Training

The PACE provider must provide to staff (employees and contractors) with an orientation that includes, at a minimum, the PACE provider's mission, philosophy, practices and protocols of the

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PACE provider, policies on beneficiary's rights, emergency plan, ethics, the PACE benefit, and any policies related to job duties of specific staff.

In addition, the orientation must include but not limited to:

1. Organizational chart;
2. Role of the team;
3. Standards of care and conduct;
4. QI program (including an overview, principles, and the staff role);
5. List of providers;
6. Personnel policies;
7. Body mechanics;
8. Care of the elderly;
9. Beneficiary safety;
10. Occupational Safety and Health Administration (OSHA), standard precautions, infection reporting, waste management; and
11. Health Insurance Portability and Accountability Act (HIPAA) laws in accordance with 42 CFR 460.200(e).

A PACE provider must develop a competency evaluation program that identifies those skills, knowledge and abilities that must be demonstrated by all direct beneficiary care staff as specified in 42 CFR 460.66(a). The competency program must be evidenced as completed before performing personal care services (PCS) independently and on an on-going basis. Certification of satisfactory completion of the competency program must be in the personnel files of all employees and contracted staff.

In accordance with 42 CFR 460.66 (b) & (c) the PACE provider must develop a training program for each employed and contracted PCA. The skills of each PCA must be evaluated upon hire to

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establish a baseline competency before providing PCS independently. A training plan must be specific to the competencies and deficiencies demonstrated.

OSHA training must be provided on hire and annually by a qualified trainer. This training must be given in an interactive session with a trainer present.

The PACE staff (employees and contractors) must be trained on the PACE provider’s grievance and appeals processes.

The PACE provider must:

1. Provide emergency training and periodic orientation to all staff (employees and contractors) and beneficiaries to ensure knowledge of emergency procedures, including informing beneficiaries what to do, where to go, and whom to contact in case of an emergency;
2. Have at least one staff member trained in cardiopulmonary resuscitation (CPR) during the hours the beneficiaries are in the PACE center;
3. Train all transportation personnel (employees and contractors) in managing the special needs of beneficiaries, how to and types of issues to communicate to the PACE center staff about beneficiaries, and in handling emergency situations as described in 42 CFR 460.76(d); and
4. Provide on-going training to maintain and improve the skills and knowledge of all PACE personnel (employee and contracted staff):
 - a. The annual training must be related to specific positions which include relevant topics:
 - i. The training needs to be staggered throughout the year to enable all staff to participate; and
 - ii. The training program needs to describe plans for in-service training, the methods of teaching (including handouts, pre and post-test if applicable, and the person/position conducting the training).

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RECORD KEEPING

Providers should refer to the Medicaid Services Manual, Chapter 1 General Information and Administration, Section 1.1 – Provider Requirements for additional information of record keeping at: <https://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>

Components of Record Keeping

All of the Program of All-Inclusive Care for the Elderly (PACE) provider records and reports, including, but not limited to, beneficiary health outcomes data, financial books and records, medical records, and personnel records, must be maintained in an accessible, standardized order and format at the PACE provider’s office site. The PACE provider must:

1. Have sufficient space, facilities and supplies to ensure effective record keeping;
2. Keep sufficient records to document compliance with Louisiana Department of Health (LDH) requirements for the beneficiary served and the provision of services; and
3. Make available all records that LDH, or its designee, finds necessary to determine compliance with any federal or state law, rule or regulation promulgated by LDH.

Retention of Records

In accordance with State and Federal laws records must be retained for the longest of the following periods:

1. In an accessible location for at least 6 years from the last entry date;
2. For medical records of disenrolled beneficiaries, 6 years after the date of disenrollment; and
3. If a litigation, a claim, a financial management review, or an audit arising from the operation of PACE is started before the expiration of the retention period, the PACE provider must retain the records until the completion of the litigation or resolution of the claim or audit findings.

Confidentiality and Protection of Records

PACE providers must:

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1. Abide by all applicable federal and state laws regarding confidentiality and disclosure for mental health records, medical records, and other beneficiary health information that qualifies as protected health information; and
2. Allow each beneficiary timely access, upon request, to review and copy their medical records and to request amendments to those records. In addition, the beneficiary must be given timely notice if the PACE provider intends to charge for copies of records.

All data, books, and records must be the property of the provider and secured against loss, tampering, destruction or unauthorized use.

NOTE: The PACE provider must have established written policies and procedures for safeguarding all data, books, and records against loss, destruction, unauthorized use, or inappropriate alteration.

PACE employees must not disclose or knowingly permit the disclosure of any information concerning the PACE provider, the beneficiaries or their families, directly or indirectly, to any unauthorized person. The PACE provider must safeguard the confidentiality of any information that might identify the beneficiary or their family.

The information may be released only in accordance with the following:

1. Court order;
2. Beneficiary's written informed consent for release of information;
3. Written consent of the individual to whom the beneficiary's rights have been devolved when the beneficiary has been declared legally incompetent; or
4. Compliance with the Federal Law, Confidentiality of Alcohol and Drug Abuse Patients Records (42 Code of Federal Regulations (CFR), Part 2).

The PACE provider must, upon request, make available information in the case records to the beneficiary or legally responsible representative. If, in the professional judgment of the administration of the PACE provider, the information contained in the record would be damaging to the beneficiary, that information may be withheld from the beneficiary except under court order.

The PACE provider may:

1. Charge a reasonable fee for providing the above records. This fee cannot exceed

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the community’s competitive copying rate; and

2. Use material from case records for teaching or research purposes, development of the governing body’s understanding and knowledge of the provider’s services, or similar educational purposes, as long as names are deleted and other similar identifying information is disguised or deleted.

Any electronic communication containing beneficiary specific identifying information sent by the PACE provider to another agency, or to LDH, must comply with regulations of the Health Insurance Portability and Accountability Act (HIPAA) and be sent securely via an encrypted messaging system.

Beneficiary records must be located at the PACE provider’s site.

NOTE: Under no circumstances should PACE providers allow staff to remove beneficiary records from the PACE provider’s site.

Review by State and Federal Agencies

PACE providers must allow the Centers for Medicare and Medicaid Services (CMS) and LDH to access all administrative, personnel, and beneficiary records as specified in 42 CFR 460.200(b). This access includes, but is not limited to, data and records, including beneficiary health outcomes, data, financial books and records, medical and personnel records.

Administrative Records

The PACE provider must maintain the following documents, at a minimum, in an administrative file:

1. PACE organizational structure;
2. Governing body;
3. Compliance oversight requirements;
4. Personnel qualifications;
5. Training materials;
6. Contract requirements;

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7. Marketing materials;
8. Policies pertaining to emergency preparedness;
9. Potential enrollee communication log;
10. Quality improvement program (QIP);
11. Policies consistent with the mission;
12. Management and provision of all services, including the management of contractors;
13. Personnel policies that address adequate notice of termination by employees or contractors with direct patient care responsibilities;
14. Fiscal operations, including fiscal reports; and
15. Policies on beneficiary health and safety, including a comprehensive, systemic operational plan to ensure the health and safety of beneficiaries.

All documents, policies and procedures must be in compliance with local, state and federal guidelines.

Personnel Records

Personnel records for each employee or contracted staff must contain, at a minimum, these components:

1. The application for employment and/or resume;
2. Criminal history and background checks by state and federal laws;
3. Documentation of proof of the following database checks upon hire and then every month thereafter:
 - a. Louisiana State Adverse Actions List Search; and
 - b. Office of Inspector General (OIG) List of Excluded Individuals.
4. Reference letters from former employer(s) and personal references or written documentation based on telephone contact with such references;

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5. Any required medical examinations;
6. Evidence of applicable professional credentials/certifications/licenses according to state law;
7. Personnel qualifications and/or experience documentation;
8. Annual performance evaluations;
9. Personnel actions, other appropriate materials;
10. Reports and notes relating to the individual's employment with the center;
11. The employee's starting and termination dates;
12. Required educational training for all disciplines including, but not limited to, orientation and annual trainings;
13. Documentation of the competency program (must be completed prior to caring for the beneficiary and on an ongoing basis);
14. Results of any written or oral testing; and
15. Documentation of medical clearance for communicable diseases and up-to-date immunizations.

NOTE: The PACE provider must retain an employee's personnel file for at least 3 years after the employee's termination of employment.

Beneficiary Medical Records

The PACE provider must maintain a single, comprehensive medical record for each beneficiary, in accordance with accepted professional standards. The medical record must be:

1. Complete;
2. Accurately documented;
3. Readily accessible;
4. Systemically organized;

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- 5. Available to all staff; and
- 6. Maintained and housed at the at the provider’s site.

At a minimum, the beneficiary’s medical record must include the following information and documentation as specified in 42 CFR 460.210:

- 1. Appropriate identifying information;
- 2. Documentation of all services furnished, including a summary of emergency care and other in-patient or nursing facility services;
- 3. Services furnished by employees at the PACE center;
- 4. Services furnished by contractors and their reports;
- 5. Interdisciplinary assessments, re-assessments, plans of care (POCs), treatments, and progress notes that include a response to treatment;
- 6. Laboratory, radiological, and other test reports;
- 7. Medication records;
- 8. Eligibility and re-certification records;
- 9. Reports of contact with non-professional, non-paid services, informal support provided by family, friends, and community/social network;
- 10. Enrollment agreement (signed and dated documents);
- 11. Physician orders;
- 12. A signed release permitting disclosure of personal information; and
- 13. Advance directives, hospital discharge summaries, discharge summaries, and/or disenrollment justification, if applicable.

NOTE: The actual incident report is not a required element of the beneficiary medical record. A narrative description of the care rendered during and subsequent to the incident must be documented in the progress notes of the interdisciplinary team (IDT) members rendering care. PACE providers must promptly transfer copies of the beneficiary’s medical record between

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treatment facilities.

Transfers and Closures/Discharges

Upon discharge or transfer, the PACE provider must submit a summary of the health record to the person or agency responsible for future planning/care of the beneficiary.

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REIMBURSEMENT**General Provisions for Reimbursement**

Program of All-Inclusive Care for the Elderly (PACE) services are financed primarily through Medicare and Medicaid capitated payments. PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. PACE providers must provide all needed services for PACE beneficiaries with the capitated funds. PACE providers assume full financial risk for the beneficiary's care without limits on amount, duration, or scope of services. The PACE provider shall be responsible for payment of the cost of the care in any setting.

The PACE capitation rate is set as a percentage of the upper payment limit (UPL) for what the State would have expected to pay under fee-for-services for enrollees. The rate shall not exceed 95 percent of the UPL. The UPL was established by utilizing all Medicaid payments for beneficiaries in the Nursing Facilities, Home and Community-Based Services (HCBS) Waiver programs: the Community Choices Waiver (CCW), Adult Day Health Care (ADHC) Waiver, and Long-Term Personal Care Services (LT-PCS), who met the PACE enrollment criteria, including meeting nursing facility level of care (NFLOC) requirement.

Claims data was collected for all such individuals, as was eligibility data. The 2 rate groups were established as follows:

1. Medicaid only; and
2. Dual Eligible.

Under Medicaid regulation, when an individual enters a nursing facility as a permanent Medicaid nursing facility resident, a determination of the individual's required contribution towards the cost of care is based on the individual's monthly income and allowable expenses, otherwise known as a "patient liability" (PLI) amount.

The PLI amount is a shared cost between the resident and Medicaid related to nursing facility placement. PLI amounts can vary greatly.

The PLI amount is paid to the PACE provider or contracted nursing facility. The PLI paid by the beneficiary will serve to discount the contracted rate paid by PACE to the nursing facility. The Louisiana Department of Health (LDH) has the right to audit the PACE provider's PLI documentation.

If PLI is not paid by the beneficiary, the beneficiary may be involuntarily disenrolled from the PACE program. In accordance with 42 Code of Federal Regulations (CFR) 460.164(a)(1) and

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state regulation, a beneficiary may be involuntarily disenrolled if the beneficiary fails to pay, or to make satisfactory arrangements to pay, any PLI due to the PACE provider after a 30 calendar day grace period.

The PACE provider must:

1. Make every opportunity available for beneficiaries to pay PLI and ensure that beneficiaries are not involuntarily disenrolled without good cause; and
2. Establish strict guidelines for the involuntary disenrollment process and follow all rules for involuntary disenrollment.

Involuntary disenrollment will occur only after all attempts at resolving the issues have been exhausted. The Office of Aging and Adult Services (OAAS) will continue to review each request for involuntary disenrollment on a case-by-case basis for approval or disapproval.

The PACE provider must:

1. Document reasons for the disenrollment and all efforts to resolve the problem; and
2. Provide beneficiaries with reasonable advance notice of disenrollment.

During the interim period between notifying the beneficiary of an upcoming disenrollment and the effective date of the disenrollment, the PACE provider must continue to furnish all needed services.

Policies Specific to Program Rules Federal and State

In accordance with federal and state regulations, the PACE provider or its contracted nursing facility must collect PLI for beneficiaries placed permanently/long term in a nursing facility.

A PACE provider may accept private-pay beneficiaries and shall collect a monthly premium from individuals who are Medicare-only. Medicare eligible beneficiaries who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, plus the Medicare capitation rate(s), as applicable, calculated by the Centers for Medicare and Medicaid Services (CMS), but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies.

Beneficiaries may be private pay if they choose the service, but do not meet the requirements for Medicare or Medicaid eligibility.

The PACE enrollees not qualifying for Medicaid (either private pay or those covered under long

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term care insurance) would pay an amount equivalent to the lowest applicable Medicaid capitated payment. A PACE provider may not charge a premium to a beneficiary who is eligible for both Medicare and Medicaid, or who is only eligible for Medicaid. PACE beneficiaries that do not meet Medicaid eligibility are still required to meet all established programmatic eligibility requirements.

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CLAIMS FILING

Program of All-Inclusive Care for the Elderly (PACE) providers do not file claims. PACE providers receive a capitated payment at the beginning of each month from Medicare and/or Medicaid or private pay funds, based on the beneficiary's eligibility. The fiscal intermediary (FI) identifies eligibles from the Medicaid Eligibility Data System (MEDS) beneficiary's file and pays a capitated rate based on eligibility.

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PROGRAM QUALITY AND OVERSIGHT

Services offered through the Program of All-Inclusive Care for the Elderly (PACE) are monitored to assure compliance with Centers for Medicare and Medicaid Services (CMS) and the Louisiana Department of Health (LDH) as well as applicable State and Federal rules and regulations. Oversight is conducted through licensure compliance and program monitoring.

The PACE provider must designate one staff member to coordinate and oversee implementation of quality assessment and performance improvement activities.

The PACE program agreement will outline the quality initiatives required. This includes:

1. Development of a Quality Assessment and Performance Improvement (QAPI) program;
2. Collecting Quality Data without Root Cause Analysis (RCA); and
3. Collecting Quality Data with RCA.

CMS and LDH/Office of Adult and Aging Services (OAAS) monitor outcomes through review of data submitted through CMS reporting systems, OAAS requests and onsite visits.

Quality Assessment and Performance Improvement Program

The PACE provider must develop, implement, maintain, and evaluate an effective data-driven QAPI program. It is important that the QAPI program reflects the full range of services furnished by the PACE provider. In developing the QAPI program, the PACE provider must use organizational data to identify and improve areas of poor performance and take actions to make performance improvements in all types of care.

PACE providers have the flexibility to develop the QAPI program that best meets their needs in order that they may fully meet the obligations to care for their beneficiaries. PACE providers must operate a continuous QAPI program that does not limit activity to only selected kinds of services or types of beneficiaries. The PACE provider must use the QAPI requirements to drive and prioritize continuous improvements.

The QAPI program must include, but is not limited to, the use of objective measures to demonstrate improved performance with regard to the following:

1. Utilization of PACE services, such as decreased inpatient hospitalizations and

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- emergency room visits;
- 2. Caregiver and beneficiary satisfaction;
- 3. Measure and evaluate caregiver and beneficiary satisfaction with care and services;
- 4. Outcome measures that are derived from data collected during assessments, including data on the following:
 - a. Physiological well-being;
 - b. Functional status;
 - c. Cognitive ability;
 - d. Social/behavioral functioning; and
 - e. Quality of life of beneficiaries.
- 5. Effectiveness and safety of staff provided and contracted services, including the following:
 - a. Competency of clinical staff;
 - b. Promptness of service delivery;
 - c. Achievement of treatment goals and measurable outcomes;
 - d. Non-clinical areas such as, beneficiary and caregiver complaints and grievances, transportation services, meals, life safety and environmental issues; and
 - e. Mechanisms to receive and address beneficiary and care giver complaints and grievances.

The QAPI program must be written into a Quality Improvement Plan (QIP) and at a minimum, the QIP must contain the following:

- 1. Identify areas in which to improve or maintain the delivery of services and beneficiary care;

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2. Develop and implement plans of action to improve or maintain quality of care; and
3. Document and disseminate the results of the QAPI activities to the PACE staff and contractors.

The QIP must be:

1. Submitted to OAAS, as requested; and
2. Reviewed by the PACE governing body, annually, and revised if necessary.

Quality Improvement Activities

The PACE providers must ensure that their program is consistently working on internal quality improvement activities by conducting the following:

1. Using a set of outcome measures to identify area of good or problematic performance;
2. Taking actions targeted at maintaining or improving care based on outcome measures;
3. Incorporating actions resulting in performance improvement into standards of practice for the delivery of care and periodically track performance to ensure that any performance improvements are sustained over time;
4. Setting priorities for performance improvement, considering prevalence and severity of identified problems and giving priority to improvement activities that affect clinical outcomes;
5. Immediately correcting any identified problem that directly or potentially threatens the health and safety of PACE beneficiaries; and
6. Ensuring that all interdisciplinary team (IDT) members, PACE staff and contractors are involved in the development and implementation of quality improvement activities and aware of the results of these activities.

The QAPI Coordinator must encourage PACE beneficiaries and their caregivers to be involved in quality improvement activities, including information pertaining to the satisfaction of their PACE services.

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Quality Committees

The PACE providers must establish one or more committees with community input that perform the following:

1. Evaluate the data collected that pertains to quality outcome measures;
2. Address the implementation of and results from the QIP; and
3. Provide input related to ethical decision making, including end-of-life issues and implementation of the “Patient Self-Determination Act.”

Quality Data without Root Cause Analysis

PACE providers are required to submit data elements for monitoring that are regularly reported by PACE providers via the Health Plan Management System (HPMS) PACE monitoring module.

PACE Quality Data without RCA apply specifically to the aggregate data such as: grievances and appeals; enrollments; disenrollments; prospective enrollees; re-admissions; falls without injury, etc. The HPMS database is regularly monitored by CMS and LDH/OAAS.

Quality Data with Root Cause Analysis

PACE providers are required to report events of unusual incidents that results in serious adverse beneficiary outcomes, or negative, regional, or local notoriety related to their PACE program. In these instances, the PACE provider must initiate the RCA investigation internally within 3 business days of identifying the incident. PACE providers are required to document all RCA information in the fields provided in the HPMS, as well as indicate what the beneficiary’s current status is at the conclusion of the RCA investigation.

Additional information regarding PACE Quality Data reporting requirements is outlined in the PACE Quality Monitoring and Reporting Guidance of April 2018.

Reviews and Monitoring

The PACE provider must take action to correct deficiencies identified during the reviews. CMS and/or OAAS monitors the effectiveness of the corrective action through the following:

1. Ongoing monitoring of the PACE provider;
2. Reviews and audits of the PACE provider;

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3. Complaints from PACE beneficiaries or caregivers; and
4. Any other instance CMS or the LDH/OAAS identifies programmatic deficiencies requiring correction.

Failure to correct deficiencies may result in sanctions or termination. Disclosure of the review results must be available as demonstrated by 42 Code of Federal Regulations (CFR) 460.196.

Results

The PACE providers must ensure that all IDT members, PACE staff, and contract providers are involved in the development and implementation of quality improvement activities and are given regular updates on Quality Improvement initiatives.

Corrective Actions

CMS and/or LDH/OAAS report the results of the reviews/audits to the PACE provider, along with any recommendations for changes to the provider's program. The PACE provider must write a corrective action plan, a description of the action that will be taken to correct the identified deficiency.

Sanctions, Enforcement Actions, and Termination

CMS and LDH/OAAS work together to ensure the benefits and services provided are of high quality and meet the requirements set forth in the statute and regulations. When compliance actions fail to achieve the desired result or an instance of non-compliance is especially egregious, CMS and/or LDH/OAAS may take enforcement action.

Some enforcement actions may include sanctions as follows:

1. Civil money penalties;
2. Suspension of payments;
3. Suspension of Enrollment; and
4. Termination of the contract (for a variety of offenses as they relate to the operation of the PACE program).

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SECTION 35.10: PROGRAM QUALITY AND OVERSIGHT PAGE(S) 6

CMS may impose sanctions if the PACE provider commits any of the following violations:

1. Fails, substantially, to provide a beneficiary medically necessary items and services that are covered by PACE, if the failure adversely affected (or has substantial likelihood of adversely affecting) the beneficiary;
2. Involuntarily disenrolls a beneficiary in violation of 42 CFR 460.164;
3. Discriminates in enrollment or disenrollment among Medicare beneficiaries or Medicaid beneficiaries, or both, who are eligible to enroll in a PACE program, on a basis of an individual's health status or need for health care services;
4. Engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment, except as permitted by 42 CFR 460.150, by Medicare beneficiaries or Medicaid beneficiaries whose medical condition or history indicates a need for substantial future medical services;
5. Imposes premium charges on beneficiaries enrolled under Medicare or Medicaid that is more than the allowable amount;
6. Misrepresents or falsifies information that is furnished to CMS or the State or to an individual or any other entity under part 460;
7. Prohibits or otherwise restricts a covered health care professional from advising a beneficiary, who is a patient of the professional, about the beneficiary's health status, medical care, or treatment for the beneficiary's condition or disease, regardless of whether the PACE program provided benefits for that care or treatment, if the professional is acting within their lawful scope of practice;
8. Operates a physician incentive plan that does not meet the requirements of section 1876(i)(8) of the Social Security Act;
9. Employs or contracts with any individual who is excluded from the participation in Medicare and Medicaid under section 1128 or section 1128A of the Act (or with any entity that employs or contracts with that individual) for the provision of health care, utilization review, medical social work, or administrative services; and
10. Makes a payment to any individual or entity that is included on the preclusion list identified in 42 CFR 422.2.

CHAPTER 35: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

SECTION 35.11: GRIEVANCES/COMPLAINTS

GRIEVANCES/COMPLAINTS

The Program of All-Inclusive Care for the Elderly (PACE) provider must utilize the federal PACE complaints/grievances processes.

NOTE: The Louisiana Department of Health (LDH), may conduct unannounced complaint investigations on all licensed PACE providers, including all PACE centers and alternative care sites.

A grievance is a complaint, either written or oral, that is expressing dissatisfaction with service delivery or the quality of care provided.

PACE providers must:

1. Have an established formal written process to evaluate and resolve medical and non-medical grievances by beneficiaries, family members, or representatives;
2. Take appropriate corrective actions in response to grievances/complaints, when necessary;
3. Provide written information regarding their grievance process upon enrollment and at least annually;
4. Continue to provide all required services to the beneficiary during the grievance process;
5. Discuss and provide to the beneficiary, in writing, the specific timeframes for response and steps that will be taken to resolve the beneficiary's grievance; and
6. Maintain, aggregate and analyze the information on grievance proceedings and include this information in the Quality Assessment and Performance Improvement (QAPI) program.

All PACE staff (employees and contractors) who have contact with beneficiaries should be aware of, and understand, the basic procedures for receiving and documenting grievances in order to initiate the appropriate process for resolving beneficiary concerns.

At a minimum, the grievance process must include the following in written procedures:

1. How to file a grievance;

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SECTION 35.11: GRIEVANCES/COMPLAINTS**PAGE(S) 5**

2. Documentation of the grievance, including:
 - a. Date the grievance was received;
 - b. Nature of the grievance;
 - c. Letter of reference to timeframes/resolution;
 - d. Date of resolution of grievance; and
 - e. Date of notification of resolution provided to the beneficiary.
3. Response to, and resolution of, the grievance in a timely manner; and
4. Maintenance of the beneficiary's confidentiality throughout the process of the grievance and thereafter, to prevent unauthorized access.

Internal Appeals Process

Complaints concerning denial of services or service coverage must be handled as appeals. An appeal is when an action is taken by the PACE provider regarding non-coverage of, or non-payment for, a service, which includes denials, reductions, and terminations.

The PACE provider must have a formal written internal appeals process, with specified timeframes for response, to address non-coverage of, or non-payment for, services, including denials, reductions, and terminations.

The beneficiary must receive written information on the appeals process at enrollment and, at least annually thereafter, and whenever the interdisciplinary team (IDT) denies a request for services or payment.

The PACE provider's responses to, and resolution of the appeal must be no later than 30 calendar days after the PACE provider receives the appeal.

The PACE provider's internal appeal process must include, but is not limited to, the following:

1. Timely preparation and processing of a written denial of coverage or payment as provided in 42 Code of Federal Regulations (CFR) 460.104;
2. How a beneficiary files an appeal;
3. Documentation of a beneficiary's appeal;

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4. Appointment of an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal to review the beneficiary's appeal;
5. Responses to and resolution of, appeals expeditiously as beneficiary's health condition requires, but no later than 30 calendar days after the PACE provider receives the appeal; and
6. Maintenance of confidentiality of appeals.

All appeal decisions, including expedited appeals (see below), will be given to the beneficiary in writing. If after the internal appeal process, the PACE beneficiary is not satisfied with the determination, then an external appeal to Medicaid or Medicare may be requested and the PACE provider must forward the appeal to the appropriate external entity.

Expedited Appeals Process

An expedited internal appeals process should be available for situations of urgency when the PACE beneficiary believes not having the service would place their life, or their ability to function, is in jeopardy. The PACE provider must respond no later than 72 hours after they receive the appeal. The PACE provider may extend the 72 hour timeframe by up to 14 calendar days for either of the following reasons:

1. The beneficiary requests an extension; or
2. The PACE provider justifies with LDH/Office of Aging and Adult Services (OAAS) the need for additional information and how the delay is in the interest of the beneficiary.

External Appeals Process

The PACE provider must inform a beneficiary in writing of their appeal rights under Medicare or Medicaid, or both, assist the beneficiary in choosing which to pursue if both are applicable, and forward the appeal to the appropriate external entity. A PACE beneficiary that is eligible for both Medicaid and Medicare, must choose one of those systems to file an appeal. An appeal cannot be filed under both systems.

The PACE provider must submit proposed denial of enrollment determinations of applicants for health and safety reasons to the PACE Program Manager, and submit all involuntary disenrollment determinations of beneficiaries to OAAS Regional Office (RO) for review prior to notifying applicants/beneficiaries of such adverse decisions.

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SECTION 35.11: GRIEVANCES/COMPLAINTS**PAGE(S) 5**

Medicaid eligible beneficiaries who appeal through Medicaid must be handled by LDH Division of Administrative Law (DAL) within the timeframes applicable to processing Medicaid appeals, except in cases where federal PACE requirements require a more expeditious decision.

The OAAS RO must prepare the Summary of Evidence (SOE) for appeals involving either a PACE applicant being denied services due to not meeting the nursing facility level of care (NFLOC) or a PACE beneficiary being issued a discharge notice due to not meeting NFLOC.

If the initial e interRAI Home Care (iHC) assessment or re-assessment (involuntary disenrollment) determined the applicant/beneficiary does not meet NFLOC, the PACE provider must notify OAAS RO to request a final determination review of all enrollment data, including the iHC assessment. OAAS RO will ensure the accuracy of the enrollment data and make the final determination regarding NFLOC. OAAS RO is responsible for assuring that all avenues of eligibility have been explored prior to determining that an individual does not meet the required OAAS RO must notify the PACE provider of the final determination. When the PACE applicant/beneficiary does not meet NFLOC, OAAS RO must prepare the SOE for appeals. OAAS RO must issue a denial letter and appeal rights to the beneficiary and copy the PACE provider and LDH/OAAS. The PACE provider must provide the applicant with any referral sources that may be indicated.

If the PACE provider requests from the OAAS RO that a PACE beneficiary who does not meet NFLOC be deemed to have continued eligibility, OAAS RO will follow the process established in Section 35.5 of this manual.

If involuntary disenrollment is approved the PACE provider will follow their written appeals process. The PACE provider must provide beneficiaries with reasonable advanced notice of disenrollment and applicable referrals and recommendations for alternate healthcare options.

The PACE provider must continue to furnish all needed services until the beneficiary is back in the Medicare/Medicaid health systems as specified in 42 CFR 460.166.

The PACE provider must prepare the SOE in preparation for any appeals in which the PACE provider has made any adverse action determination that was appealed by the applicant/beneficiary, including enrollment denials of health and safety and service denials, reductions, and terminations.

For a Medicaid beneficiary, if the appeal is filed timely, the PACE provider must continue to furnish the disputed services until issuance of the final determination by the DAL is issued if the following conditions are met:

1. The PACE provider is proposing to terminate or reduce services currently being

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provided to the beneficiary; and

2. If a timely appeal is not filed, services will be terminated effective at the end of the month in which the denial notice was issued.

Reporting

The PACE provider must report grievances and appeals, quarterly, through the Health Plan Management System (HPMS), as indicated in the PACE program agreement.

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SECTION 35.12: ADMINISTRATIVE SANCTIONS**PAGE(S) 2**

ADMINISTRATIVE SANCTIONS**Sanctions, Enforcement Actions, and Termination**

The Centers for Medicare and Medicaid Services (CMS) and the state administering agency (SAA) have the ability to levy sanctions in the form of civil money penalties, a suspension of payments, and termination of the contract for a variety of offenses as they relate to the operation of the Program of All-Inclusive Care for the Elderly (PACE) program. In an exception to the Standards of Payment, any violation of the Adult Day Health Care (ADHC) regulations as otherwise promulgated that would warrant sanctions may be applied only to the ADHC component of PACE.

CMS and the SAA report the results of the reviews to the PACE provider, along with any recommendations for changes to their PACE program. The PACE provider must write a corrective action plan (CAP), a description of the action plan that will be taken to correct the identified deficiency.

The PACE provider must take action to correct deficiencies identified during the reviews as required by 42 Code of Federal Regulations (CFR) 460.194. CMS or SAA monitors the effectiveness of the corrective action. Failure to correct deficiencies may result in sanctions or termination. Disclosure of the review results must be available as demonstrated by 42 CFR 460.196.

CMS may impose any of the sanctions specified in 42 CFR 460.42 and 42 CFR 460.46 if the PACE provider commits any of the following violations:

1. Fails, substantially, to provide a beneficiary medically necessary items and services that are covered PACE services, if the failure adversely affected (or has substantial likelihood of adversely affecting) the beneficiary;
2. Involuntarily disenrolls a beneficiary in violation of 42 CFR 460.164;
3. Discriminates in enrollment or disenrollment among Medicare beneficiaries or Medicaid beneficiaries, or both, who are eligible to enroll in a PACE program, on a basis of an individual's health status or need for health care services;
4. Engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment, except as permitted by 42 CFR 460.150, by Medicare beneficiaries or Medicaid beneficiaries whose medical condition or history indicates a need for substantial future medical services;

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5. Imposes charges on beneficiaries enrolled under Medicare or Medicaid for premiums in excess of the premiums permitted;
6. Misrepresents or falsifies information that is furnished to CMS or the State under this part or to an individual or any other entity under this part;
7. Prohibits or otherwise restricts a covered health care professional from advising a beneficiary who is a patient of the professional about the beneficiary's health status, medical care, or treatment for the beneficiary's condition or disease, regardless of whether the PACE program provided benefits for that care or treatment, if the professional is acting within their lawful scope of practice;
8. Operates a physician incentive plan that does not meet the requirements of section 1876(i) (8) of the Act; and
9. Employs or contracts with any individual who is excluded from the participation in Medicare and Medicaid under section 1128 or section 1128A of the Act (or with any entity that employs or contracts with that individual) for the provision of health care, utilization review, medical social work, or administrative services.

CHAPTER 35: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

GLOSSARY

This is a list of acronyms, definitions and terms used in the Program of All-Inclusive Care for the Elderly (PACE) Manual Chapter.

Activities of Daily Living (ADL) – Those activities that are required by an individual for continued well-being, health and safety. This includes basic personal everyday activities such as bathing, dressing, transfer, toileting, mobility, and eating.

Adult Day Health Care (ADHC) – A structured and comprehensive group program designed to meet the individual needs of functionally-impaired adults and provide a variety of health, social, and related support services at a licensed day site.

Appeal – The participant’s action taken with respect to contesting the PACE organization’s non-coverage of, nonpayment for a service, including denials, reductions, or termination of services.

Applicant – An individual whose written application for Medicaid or Louisiana Department of Health (LDH) funded services has been submitted to LDH but whose eligibility has not yet been determined.

Assessment – The process of gathering and integrating formal and informal information relevant to the development of an individualized plan of care (POC).

Audit – An external review of the PACE provider’s practices and procedures to determine compliance with the Centers for Medicare and Medicaid Services (CMS) program requirements.

Audit Team – A group of people comprised of CMS, State administering agency (SAA) staff, or other designees who are responsible to perform a PACE provider’s audit.

Balanced Budget Act of 1997 (BBA) – Established PACE model as a permanently recognized provider type under both the Medicare and Medicaid programs and mandated that the quality of care be monitored.

Beneficiary – An individual who has been certified for medical benefits by the Medicaid program. A beneficiary certified for Medicaid services may also be referred to as a participant.

Bureau of Health Services Financing (BHSF) – The Bureau within LDH responsible for the state administration of the Louisiana Medicaid program.

Centers for Medicare and Medicaid Services (CMS) – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid and Medicare programs.

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Code of Federal Regulations (CFR) – A publication by the federal government containing PACE requirements with which providers must comply in order to receive payment under Medicaid/Medicare programs.

Complaint – See Grievance.

Confidentiality – The process of protecting a beneficiary’s or an employee’s personal information, as required by the Health Insurance Portability and Accountability Act (HIPAA).

Contract year – The term of a PACE program agreement, which is a calendar year, except that a PACE provider’s initial contract year may be from 12 to 23 months, depending on the effective date of program implementation (as determined by CMS).

Corrective Action Plan (CAP) – Written description of action a provider agency plans to take to correct identified deficiencies.

Corrective Action Requirement (CAR) – A term historically used in audit report requesting a CAP from the PACE provider in response to a deficiency.

Deemed Status – PACE participants who do not meet nursing facility level of care (NFLOC) on annual reassessment, and who, in the absence of continued coverage, would be expected to meet the NFLOC requirements within the next 6 months.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicaid program and public health programs.

Division of Administrative Law (DAL) – The state agency responsible for the due process system ensuring the beneficiary has an opportunity to contest certain decisions.

Enrollment – A determination made by LDH that a provider agency meets the necessary requirements to participate as a provider of Medicaid or other LDH-funded services. This is also referred to as provider enrollment or certification.

Fiscal Intermediary (FI) – The private fiscal agent with which LDH contracts to operate the Medicaid Management Information System. It processes Title XIX claims for Medicaid services provided under the Medicaid Assistance Program, issues appropriate payment and provides assistance to providers on claims.

Grievance – A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality or care furnished.

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Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Legislation passed in 1996 that addresses security and privacy of health data and requires CMS to establish national standards of electronic health care transactions and national identifiers for providers, health plans, and employer.

Health Plan Management System (HPMS) – A CMS internal health information system that collects, analyzes, integrates, and reports data to measure the PACE provider’s performance and to develop and implement procedures to furnish data pertaining to the provision of care to external oversight entities in the manner and at the time intervals specified by CMS and SAA. The system monitors the operation; costs, quality, and effectiveness of the PACE program and establish payment rates.

Health Standards Section (HSS) – The office within LDH responsible for the licensing and certification of providers.

Interdisciplinary Team (IDT) – A group of healthcare providers from different fields who work together to provide the best care or outcome for a participant by making recommendations in a team staffing for services or interventions targeted at those needs.

InterRAI Home Care (iHC) Assessments – The assessment tool used by the Office of Aging and Adult Services (OAAS) to determine initial and continued eligibility in the PACE program.

Level One Event – Refers to those data elements for monitoring that are regularly reported by PACE providers via HPMS.

Level Two Event – Unusual incidents that result in serious adverse participant outcomes, or negative national or regional notoriety related to the PACE program.

Licensure – A determination by HSS that a service provider agency meets the requirements of state law to provide services.

Louisiana Department of Health (LDH) – The state agency responsible for administering the state’s Title XIX (Medicaid) Program and other health and related services including aging and adult services, public health, mental health, developmental disabilities, and addictive disorder services.

Medicaid – A federal-state financed medical assistance program that is provided under a State Plan approved under Title XIX of the Social Security Act.

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and

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eligible beneficiaries.

Medicare – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

National PACE Association (NPA) – Non-profit membership organization that represents the interests of PACE providers. These member organizations share the goal of promoting the availability of quality, comprehensive, and cost-effective health care services to frail older adults through the PACE and similar models of care.

Nursing Facility – A facility which meets the requirements of sections 1819 or 1919 (a) (b) (c) and (d) of the Social Security Act. A nursing facility provides long term care and placement for those individuals who meet the eligibility requirements.

Office of Aging and Adult Services (OAAS) – The office within LDH that is responsible for the management and oversight of certain Medicaid Home and Community-Based Services (HCBS) State Plan and waiver programs and protective services for adults ages 18 through 59.

OAAS Regional Office (RO) – One of 9 administrative offices within OAAS.

PACE Center – The facility which includes ADHC, a primary clinic, and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining and which serves as the focal point for coordination and provision of most PACE services.

PACE Program – An optional service under the Medicaid State Plan that is a capitated, managed care program.

PACE Provider – The entity that has in effect a PACE program agreement to operate as a PACE provider.

PACE Beneficiary/Participant – An individual who is enrolled in the PACE program.

Patient Liability – The amount a beneficiary is responsible for paying to a provider for some of their PACE services.

Patient Self-Determination Act (PSDA) – This Act encourages all people to make choices and decisions now about the types and extent of medical care they want to accept or refuse should they become unable to make those decisions due to illness.

Permanent Waiver of Annual Recertification - LDH may permanently waive the annual recertification of level of care requirements for a beneficiary if it determines that there is no reasonable expectation of improvement or significant change in the beneficiary's condition because of the severity of a chronic condition. The PACE provider shall continue performing

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annual re-assessments.

Plan of Care (POC) – The written documentation that outlines how PACE services are delivered to the beneficiary. A written plan developed by the interdisciplinary team that is based on assessment results and specifies services to be accessed and coordinated on the participant's behalf. It includes long-range goals, assignment of responsibility, and time frames for completion or review by the interdisciplinary team.

Primary Care Physician (PCP) – A physician, currently licensed by the Louisiana State Board of Medical Examiners who is responsible for the direction of the beneficiary's overall medical care.

Program of All Inclusive Care for the Elderly (PACE) – A comprehensive and supportive services program designed to assist those 55 or older to remain at home and in the community.

Quality Assessment and Performance Improvement (QAPI) Program– An ongoing process to objectively and systematically monitor and evaluate the quality of services provided to PACE beneficiaries, to pursue opportunities to improve services, and to correct identified problems.

Sanction – Penalty applied for failure to comply with **State and federal PACE rules**.

Service Area – The geographically designated region (by zip code/parish areas) where PACE services are provided.

Services – This includes both items and services.

State Administering Agency (SAA) – The state agency responsible for administering the PACE program.

State Readiness Review (SRR) – The purpose of this review is to determine the PACE provider's readiness to administer the PACE program and enroll and serve beneficiaries. Every application must meet all requirements of the SRR prior to enrolling beneficiaries.

Transition – The steps or activities conducted to support the passage of the participant from existing formal or informal services to the appropriate level of services, including disengagement from all services.

Trial Period – This refers to a PACE program that is operated by a PACE provider under a PACE program agreement for the first 3 years under their agreement.

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APPENDIX B: CONTACT INFORMATON

CONTACT INFORMATION

Office Name	Type of Assistance	Contact Information
<p>Long Term Care (LTC) Access Contractor - Conduent</p>	<p>Performs the Level of Care Eligibility Tool (LOCET) and sends referrals to the PACE provider, if the caller voices an interest in PACE services.</p>	<p>LTC Access Services 2900 Westfork Drive, Suite 540 Baton Rouge, LA 70827 Phone #: 877-456-1146 TDD #: 877-544-9544 Fax #: 866-246-8511</p>
<p>Office of Aging and Adult Services (OAAS) State Office</p>	<p>Provides PACE policy clarification and receives complaints regarding pace programs.</p>	<p>Office of Aging and Adult Services P. O. Box 2031 Baton Rouge, LA 70821-2031 Phone #: 1.866.758.5035 Email: OAAS.Inquiries@la.gov</p>
<p>OAAS Regional Offices (OAAS RO)</p>	<p>Prepares the 142 and sends enrollment information to Medicaid; confirms that the nursing facility level of care (NFLOC) is met; reviews requests for permanent waiver of annual recertification; reviews requests for deemed continued eligibility; and reviews involuntary disenrollment requests.</p>	<p>https://ldh.la.gov/index.cfm/directory/category/141</p>
<p>Gainwell Technologies Provider Enrollment Unit (PEU)</p>	<p>Office to contact to report changes in provider ownership, address, telephone number or account information affection electronic funds transfer.</p>	<p>Gainwell Technologies Provider Enrollment Unit P.O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 or (225) 924-5040 http://www.lamedicaid.com/provweb1/Provider_Enrollment/ProviderEnrollmentIndex.htm</p>

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APPENDIX B: CONTACT INFORMATION

<p>Gainwell Technologies Provider Relations Unit</p>	<p>Office to contact to obtain assistance with questions regarding billing information and billing issues.</p>	<p>Gainwell Technologies Provider Relations Unit P.O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or (225) 924-5040 http://www.lamedicaid.com/provweb1/Provider_Support/provider_support_index.htm</p>
<p>Division of Administrative Law (DAL) - Louisiana Department of Health (LDH) Section</p>	<p>Office to contact to request a Medicaid appeal hearing.</p>	<p>Division of Administrative Law (DAL) – LDH Section Post Office Box 4189 Baton Rouge, LA 70821-4189 Physical: 1020 Florida Street Baton Rouge, LA 70802 Phone #: (225) 342-5800 Fax #: (225) 219-9823 https://www.adminlaw.state.la.us/</p>
<p>LDH - Health Standards Section (HSS)</p>	<p>Office to contact to report changes that affect provider license (e.g. address change, change of ownership, etc.). Office to contact when providers wish to request an informal hearing as the result of a provider’s receipt of a statement of deficient practice or file a complaint against a provider by a participant.</p>	<p>Health Standards Section P. O. Box 3767 Baton Rouge, LA 70821 Phone #: 1-800-660-0488</p>
<p>Medicaid Program Integrity</p>	<p>Office to contact to report Medicaid fraud</p>	<p>Provider Fraud Hotline #: 1-800-488-2917 Recipient Fraud Hotline #: 1-888-342-6207 Provider Fraud Fax #: (225) 216-6129 Recipient Fraud Fax #: (225) 389-2610 http://new.dhh.louisiana.gov/index.cfm/page/219</p>

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APPENDIX B: CONTACT INFORMATION

Adult Protective Services (APS)	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of adults ages 18-59 and emancipated minors.	1-800-898-4910
Elderly Protective Services (EPS)	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion involving adults age 60 and older.	1-833-577-6532

CHAPTER 30: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY**APPENDIX C – FORMS/LINKS****PAGE(S) 2****FORMS/LINKS**

The following documents, forms, links, and manuals are available on the following website addresses:

Form/Document/Website Name	Website Address
The Louisiana Department of Health (LDH) General Information and Administration Provider Manual (Chapter 1 of the Medicaid Services Manual)	http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf
The Office of Aging and Adult Services (OAAS) Emergency Preparedness Information for Providers	https://ldh.la.gov/index.cfm/newsroom/detail/1422
LDH/Health Standards Section (HSS): Adult Day Health Care (ADHC) Providers Personal Care Attendant (PCA) Providers	ADHC Providers: https://ldh.la.gov/index.cfm/page/2986 PCA Providers: https://ldh.la.gov/page/home-and-community-based-service-providers-hcbs
OAAS Program of All-Inclusive Care for the Elderly (PACE) Procedures Manual (OAAS-MAN-23-002)	https://ldh.la.gov/assets/docs/OAAS/Manuals/PACE-Manual.pdf
OAAS Nursing Facility Level of Care (NFLOC) Eligibility Manual (OAAS-MAN-13-005)	https://ldh.la.gov/assets/docs/OAAS/Manuals/LOCEligibilityManual.pdf
OAAS National Voter Registration Act (NVRA) Manual (OAAS-MAN-14-001)	https://ldh.la.gov/assets/docs/OAAS/NVRA/national-voter-registration-act-manual.pdf
OAAS PACE Fact Sheet (OAAS-RC-09-006)	https://ldh.la.gov/assets/docs/OAAS/publications/FactSheets/PACE-Fact-Sheet.pdf
Centers for Medicare and Medicaid Services (CMS) PACE Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019036
CMS PACE Website	https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PACE/PACE
CMS PACE Audits	https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PACE_Audits

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APPENDIX C – FORMS/LINKS

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CMS PACE Marketing Guidelines	https://www.cms.gov/files/document/pace-marketing-guidelines-updated-3-21-2022.pdf
Code of Federal Regulations (CFR) Title 42, Part 460 - PACE	https://ecfr.io/Title-42/cfr460_main
PACE Rule - Louisiana Administrative Code (LAC) Title 50: Part XXII.	
NFLOC Rule – LAC Title 50: Part II. Subpart. 3. Subchapter G.	
Health Plan Management System (HPMS)	https://hpms.cms.gov/app/ng/home/
Louisiana State Adverse Actions List Search	https://adverseactions.ldh.la.gov/SelSearch
Office of Inspector General (OIG) List of Excluded Individuals	https://exclusions.oig.hhs.gov/
Medicaid Services Chart	http://ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf
OAAS PACE Request for NFLOC - Deemed Continued Eligibility or Permanent Waiver of Annual Recertification form (OAAS-PF-13-009)	https://ldh.la.gov/assets/docs/OAAS/publications/policy/PACE-deemedcontinuedeligibilityorwaiver-form.pdf