

109 Pace

The Program of All-Inclusive Care for the Elderly (PACE) is a unique model of managed care service delivery for the frail elderly living in the community. It is a state plan program of comprehensive care that allows the frail elderly to live in their communities. The program brings together all the medical and social services needed for someone who otherwise might be in a nursing home. A team, including a physician, registered nurse, social worker, therapists and other health professionals, assesses the participant's needs, develops a comprehensive plan of care and provides for total care. Generally, services are provided in an adult day health center, but they may also be given in a participant's home, a hospital, a long-term care facility or a nursing home. Most PACE participants are dually eligible for Medicare and Medicaid benefits. Enrollment in PACE is voluntary and not limited to an individual who is either a Medicare or Medicaid recipient. All participants must be certified as meeting nursing facility level of care according to the criteria established by the state Medicaid Agency prior to enrollment. Once enrolled, PACE becomes the sole source of all Medicare and Medicaid-covered services, as well as any other items, or medical, social or rehabilitation services the PACE interdisciplinary team (IDT) determines a participant needs.

The PACE program receives a fixed monthly capitated payment from Medicare and Medicaid for each participant, depending on their Medicare and Medicaid eligibility. The payments remain the same during the contract year, regardless of the services a participant may need. The PACE provider assumes full financial risk for each participant enrolled in the program.

The purpose of providing PACE care to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care.

The policy provisions for PACE providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 53 and Part 460 of the Code of Federal Regulations.

109.1 Enrollment

109.1.1 CMS Enrollment and Agreement

An entity that wishes to become a PACE Organization (PO) must complete an application that describes how the entity meets all the requirements to be a PO. The application must first be submitted to Alabama Medicaid Agency (AMA) for review and approval, and then to CMS. AMA will provide the entity with an assurance that is to be submitted with the application sent to CMS by the entity, stating that the entity is qualified to be a PO and that AMA is willing to enter into an agreement with the entity. CMS will then evaluate the application based

on the information contained in the application, as well as information obtained by onsite visits conducted by AMA and/or CMS. CMS will notify the entity within 90 days from receipt of the application that the application is approved or denied, or that additional information is required. If additional information is requested, CMS will have an additional 90 days from receipt of the requested information to make a final decision. Once an application is approved, an agreement must be signed by the organization, the AMA, and an authorized official of CMS. The agreement is effective for one contract year, but may be extended each year unless any party chooses to terminate the agreement. At a minimum, the agreement must include the information required in 42 CFR 460.32.

109.1.2 AMA Enrollment

Once the three-way agreement has been signed by all parties, the entity is to submit a provider application to HP for enrollment as a Medicaid provider. HP will contact the appropriate staff of the Medicaid PACE Unit to verify that the entity has been approved to be a PACE provider. HP enrolls PACE providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code* and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion. Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a PACE provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for PACE related services.

NOTE:

The 10-digit NPI is required when filing a claim.

PACE providers are assigned a provider type of 64 (PACE Organization). The valid specialty for PACE providers is PACE Organization (645).

109.2 Benefits and Limitations

109.2.1 Federal Eligibility Requirements

As required by 42 CFR 460.150, an individual shall meet the following basic requirements to be eligible to enroll in PACE:

- be 55 years or older
- reside in an approved PACE service area
- meet the state’s Medicaid criteria for nursing facility level of care, and
- meet any additional program specific eligibility conditions imposed under the PACE program agreement, including the individual shall be safely served in the community

Medical Eligibility

The Medicaid Agency has delegated authority for initial and annual level of care determination to the PACE provider. Medicaid eligibility for PACE is based on current admission criteria for nursing facility care. Admission criteria are described in *Chapter 26, Nursing Facility, of the Alabama Medicaid Provider Manual and in the Alabama Medicaid Administrative Code, Chapter 10, 560-X-10-.10*. As the Operating Agency and State Administering Agency for PACE, Alabama Medicaid Agency (AMA) maintains ultimate authority and oversight of this process. AMA will prospectively review all initial and annual redetermination admission level of care determinations for certification before the participant is enrolled/continues to be enrolled in the PACE program. Redetermination of the participant eligibility follows the same procedure as a new enrollment.

NOTE:

Initial enrollment in PACE and annual redetermination requires that the patient meet two criteria listed on PACE Form 12-001 (a-k). As a result, an individual who meets one or more ADL deficits under (k) must also meet an additional criterion from the list (a-j). All assessments submitted for PACE must include supporting documentation.

Four exceptions are noted:

- Criterion (a) and criterion (k)-7 are the same as they both involve medication administration. Only one may be used. Therefore, if an individual meets criterion (a), criterion (k)-7 may not be used as the second qualifying criterion.
- Criterion (g) and Criterion (k)-9 are the same as they both involve direction by a registered nurse. Only one may be used. Therefore, if an individual meets criterion (g), Criterion (k)-9 may not be used as the second qualifying criterion.
- Criterion (k) (3) cannot be used as a second criterion if used in conjunction with criterion (d) if the ONLY stoma (opening) is a Gastrostomy or PEG tube.
- Criterion (k) (4) cannot be counted as a second criterion if used in conjunction with criterion (d) if used for colostomy or ileostomy.

NOTE:

If an individual has a serious mental illness or has mental retardation, the individual will not be eligible for PACE unless the individual has medical needs unrelated to the diagnosis of serious mental illness or mental retardation and meets the criteria as set in Chapter 26, Nursing Facility, of the Alabama Medicaid Provider Manual.

The process for admission includes medical and financial eligibility determination:

- In accordance with 42 CFR 460.152(a) (3), prior to enrollment in PACE, Medicaid shall certify that the PACE applicant meets the state's nursing facility level of care criteria.
- The PACE organization shall submit the level of care screening tool each year to verify that the enrollee continues to meet nursing facility level of care requirements as required in 42 CFR 460.160 (b).
- The determination of level of care will be made by an RN of the PACE organization (PO), certification signed by the PO physician and forwarded on to the AMA PACE Unit RN. This is done prior to submission of Form 204/205 and Form 376. The Form 204/205 and Form 376 are to be mailed to the AMA PACE Unit RN. The PACE Unit RN will complete the Form 376 when the LOC has been approved, and will then forward Form 204/205 along with Form 376 to the appropriate Eligibility staff. For cases in which medical eligibility cannot be determined by the PACE Unit RN, the documents will be submitted to the Director of Managed Care for a determination to be made. For cases in which the Director is unable to make a determination, the documents will be submitted to the Alabama Medicaid Agency physician who will review and assess the documentation submitted.
- The earliest date of entitlement for Medicaid is the first day of the month of application for assistance, provided the individual meets all factors of eligibility for that month. The individual who is eligible on the first day of the month is entitled to Medicaid for the full month. It is the responsibility of the PO to verify Medicaid eligibility for participants on a monthly basis. There will be no retroactive benefits applied to initial enrollments in PACE.
- Financial determination is made by the Alabama Medicaid Agency, or the Social Security Administration (SSA). Upon determination of financial and medical eligibility the PO will submit required data electronically via the LTC software to Medicaid's fiscal agent to document dates of service to be added to the Level of Care file. Financial eligibility will be established in accordance with the *Alabama Medicaid Agency Administrative Code, Chapter 25*.

All PACE organizations are required to accurately complete and maintain the following documents related to level of care in the participants file (EMR) for Medicaid/CMS retrospective reviews.

- PACE Form 12-001. A written assessment used to determine a participant's current care needs. This assessment is used to assess each individual participant's functional, medical, social, environmental and behavioral status. Information obtained should be adequate enough to make a level of care decision with supporting documentation for all criteria selected. If criterion G, unstable medical condition is one of the established medical needs, the provider must maintain supporting documentation of the unstable condition requiring active treatment in the 90 days preceding enrollment.
- IDT assessments
- Plan of Care
- Any and all documentation that would support the Level of Care criteria selected on PACE Form 12-001.

Financial Eligibility

Eligibility for enrollment in PACE is not restricted to an individual who is either a Medicaid recipient or a Medicare beneficiary. Individual's eligible for enrolling in the PACE program are those included in one of the categories listed below:

- Eligible for full Medicaid;
- Eligible for Medicare Part A;
- Enrolled under Medicare Part B;
- Dual eligibles for Medicaid and Medicare

Financial determinations are made by the Alabama Medicaid Agency, or the Social Security Administration (SSA), as appropriate.

Recipients can have Medicare, Medicaid, be dually eligible for Medicare/Medicaid or disabled with income not greater than 300% of the SSI Federal Benefit Rate.

Medicaid does not guarantee future eligibility. For this reason it is very important that providers must verify recipient eligibility on a monthly basis prior to providing a service. For more information refer to Chapter 3, Verifying Recipient Eligibility in the *Alabama Medicaid Provider Manual*.

Enrollment Denials

For any enrollment denial based on level of care, Alabama Medicaid will advise the PO in writing of its decision and the opportunity to request reconsideration of the decision via an Informal Conference so that they may present further information to establish medical eligibility. To request the Informal Conference the PO must submit a letter within 30 days of the date of the letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to Alabama Medicaid Agency, PACE Program Unit, P.O. Box 5624, Montgomery, AL 36103-5624.

If the Informal Conference results in an adverse decision, the PO is advised of the right to a Fair Hearing. To request the Fair Hearing the PO must submit a letter within 60 days of the date of the letter. This letter should be addressed to Alabama Medicaid Agency, PACE Program Unit, P.O. Box 5624, Montgomery, AL 36103-5624. If the Informal Conference results in a favorable decision, the enrollment procedures are followed.

Prior Approval

Prior approval of the medical level of care must be determined by AMA Medical Review staff. Documentation in support of the Level of Care and PACE Form 12-001 must be submitted to AMA PACE staff. An approval/denial will be faxed to the PACE provider within five working days of receipt of the request. The medical Level of Care must be approved prior to a financial determination. Refer to section 109.6 for additional information regarding PACE assessment requirements.

Enrollment Requirements

- When the participant meets the eligibility requirements and wants to enroll, he/she shall sign an Enrollment Agreement that contains the minimal information under 42 CFR 460.154
- The PACE organization must give a participant, upon signing the enrollment agreement, all of the information set forth in 42 CFR 460.156
- In accordance with 42 CFR 460.158, a participant's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed Enrollment Agreement
- In accordance with 42 CFR 460.160, the PACE enrollment continues until the participant's death, regardless of changes in health status, unless the participant voluntarily disenrolls in accordance with 42 CFR 460.162, or is involuntarily disenrolled in accordance with 42 CFR 460.164
- As indicated in 42 CFR 460.154 (p), each individual enrolling in PACE shall accept PACE as his or her sole source for services. This requirement must be included in the PACE Enrollment Agreement and the individual or legally responsible person must acknowledge acceptance of this requirement by signing a form approved by AMA

NOTE:

If a recipient is enrolled in a HCBS waiver program, receiving nursing facility services or in the Patient 1st managed care program, the PO must contact the appropriate operating agency or Alabama Medicaid staff for the associated program well enough in advance of the effective enrollment date in PACE, in order to allow enough time for the process of end dating the other benefit plan segment. If not done, this could delay enrollment of the recipient until the next calendar month.

Initial Level of Care Review

In accordance with 42 CFR 460.152 (a) (3) and as described above, prior to enrollment in PACE, Medicaid shall certify that the PACE applicant meets the state's nursing facility level of care criteria.

Annual Level of Care Review

The PACE organization shall submit the level of care screening tool each year to verify that the enrollee continues to meet nursing facility level of care requirements as required in 42 CFR 460.160 (b). The PACE Organization will submit documents to AMA for redetermination review up to 45 days before the annual date but no later than the 15th of the month before the annual date.

Physical, Functional and Psychosocial Assessment/Plan of Care

Following certification by Medicaid that an eligible recipient meets nursing facility level of care requirements, the PACE interdisciplinary team (IDT), under the direction of the PACE medical director and in accordance with 42 CFR 460.104, must conduct a comprehensive assessment of the participant. The IDT must meet the following assessment requirements:

- An initial in-person comprehensive assessment must be completed promptly following enrollment by the:
 - Primary Care Physician
 - Registered Nurse
 - Social Worker
 - Physical therapist
 - Occupational therapist
 - Recreational therapist or activity coordinator
 - Dietician; and
 - Home care coordinator

At least semi-annually, an in-person assessment and treatment plan must be completed by the:

- Primary care physician
 - Registered nurse
 - Social worker
 - Recreational therapist/activity coordinator and
 - Other team members actively involved in the development or implementation of the participant's plan of care (e.g., home care coordinator, PT, OT or dietitian)
- Annually, an in-person assessment and treatment plan must be completed by the:
 - Physical therapist
 - Occupational therapist
 - Dietician and
 - Home care coordinator

Following the required assessments, the PACE program must develop a plan of care for each participant as required by 42 CFR 460.106. PACE organizations consolidate discipline specific plans into a single plan of care semi-annually through discussion and consensus of the IDT. The consolidated plan is then discussed and finalized with the PACE participant and/or his or her significant others.

Reassessments and treatment plan changes are completed when the health or psychosocial situation of the participant changes.

Reference Alabama Medicaid Agency Administrative Code Chapter 53, section 560-X-53-.07 for Participant Assessment and Plan of Care policy provisions.

Signature Requirement

Under Alabama's Uniform Electronic Transactions Act, effective January 1, 2002, Alabama law recognizes the validity of electronic signatures. For all Medicaid PACE Forms, the signature must be an original signature or an approved electronic signature of the recipient's attending physician/PACE physician. Provider certification is made via standardized electronic protocol.

Health and Safety Assessment

The primary consideration underlying the provision of services and assistance to this state's frail and elderly is their desire to reside in a community setting. However, enrollment in a Program of All Inclusive Care for the Elderly may be denied based upon the inability of the program to ensure the health, safety, and well-being of the individual under any of the following circumstances, based on assessment of the individual's mental, psychosocial and physical condition and functional capabilities:

- The individual is considered to be unsafe when left alone, with or without a Personal Emergency Response System
- The individual lacks the support of a willing and capable caregiver who must provide adequate care to ensure the health, safety and well-being of the individual during any hours when PACE services are not being provided
- The individual's needs cannot be supported by the system of services that is currently available
- The individual's residence is not reasonably considered to be habitable
- The individual's residence or residential environment is unsafe to the extent that it would reasonably be expected to endanger the health and safety of the individual, the individual's caregivers, or the PACE Organization's staff if PACE services are to be provided in the residence
- The individual's behavior is disruptive or threatening or is otherwise harmful (e.g., suicidal, injurious to self or others, or destructive of environment)
- There is a high risk or an existing condition of abuse, neglect or exploitation as evidenced by an assessment

The PACE program shall conduct a comprehensive health and safety assessment to ensure that the applicant's health, safety or welfare will not be jeopardized by living in the community. The assessment must include:

- An on-site evaluation of the applicants residence
- An evaluation of the applicant's social support system, including the willingness and capabilities of all informal caregivers; and
- An evaluation of whether the applicant can be safely transported to the PACE center

PACE Participant Rights

A PACE organization must have a written participant bill of rights designed to protect and promote the rights of each participant. Those rights include, at a minimum, the ones specified in 42 CFR 460.112:

- Respect and nondiscrimination
- Information disclosure
- Choice of providers within the PACE organization's network
- Access to emergency services
- Participation in treatment decisions
- Confidentiality of health information
- Complaints and appeals

Services

The PACE services for all participants, regardless of the source of payment, must include items and services as indicated under 42 CFR 460.90, 42 CFR 460.92 and 42 CFR 490.94 and Alabama Medicaid Agency Administrative Code, section 560-X-53.06.

Provision of Service

- As required by 42 CFR 460.32(a) (1), the PACE program must define its service area. The service area must be approved by AMA and CMS.
- As defined by 42 CFR 460.98(c), the minimum services that must be furnished at each PACE program include primary care, including physician and nursing services; social services, restorative therapies, including physical therapy and occupational therapy, personal care and supportive services, nutritional counseling, recreational therapy and meals, which serve as the focal point for coordination and provision of most PACE services.
- The PACE program must establish an interdisciplinary team (IDT) to provide care and case manage all of the services provided or arranged by the PACE program for each participant. The IDT must be composed of at least the following members:
 - a) Primary care physician
 - b) Registered Nurse
 - c) Master's-level social worker
 - d) Physical therapist
 - e) Occupational therapist
 - f) Recreational therapist or activity coordinator
 - g) Dietician
 - h) PACE center manager
 - i) Home care coordinator
 - j) Personal care attendant or his/her representative; and
 - k) Driver or his/her representative

In-Home and Referral Services

As required by 42 CFR 460.94, the PACE program must arrange for all in-home and referral services that may be required for each participant. In-home and referral services are furnished by a PACE organization or by a contracted provider with the PACE program in the manner as set forth in 42 CFR 460.70 and in compliance with 460.71.

Emergency Care Services

The PACE program must provide emergency care services in accordance with 42 CFR 460.100.

An emergency medical condition means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Serious jeopardy to the health of the participant
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency Services Care Plan

The PACE program must establish and maintain a written plan to handle emergency care at the PACE center and when the PACE participant is not at the PACE center. The plan must include procedures to access emergency care both in and out of the PACE service area. The PACE program must ensure that participants and caregivers know when and how to access emergency care services when not at the PACE center. The plan must ensure that CMS, AMA, and PACE participants are held harmless if the PACE Organization does not pay for emergency services.

Access to Emergency Care

In the case of an emergency medical condition, the PACE participant has the right to access the closest and most readily accessible qualified provider, in or out of the PACE service area, including hospital emergency room services.

Out-of-Service-Area Emergency Care

Emergency care while the PACE participant is out of the service area is covered by the PACE program and no prior approval is required.

Out-of-Service-Area Follow-up Care

Urgent care and care furnished to the PACE participant to stabilize his or her emergency medical condition that is provided outside the PACE service area must be prior approved by the PACE program.

Retrospective Reviews of Emergency Care

Evaluation of the participant's decision to use emergency services must be based on the prudent layperson standard and no higher standard may be adopted by the PACE program.

Cost of Emergency Care

Charges for all emergency care must be paid by the PACE program.

109.3 Participant Disenrollment from PACE

Voluntary Disenrollment

In accordance with 42 CFR 460.162, a PACE participant may voluntarily disenroll from PACE at any time without cause. The disenrollment date will not be effective until the participant is appropriately reinstated into other Medicaid programs and alternative services are arranged.

The PO is to notify AMA in writing by the 10th of each month of any voluntary disenrollments for the previous month. A copy of the request to voluntarily disenroll is to be submitted with the monthly report. Voluntary disenrollments are to also be reported on quarterly reports submitted to CMS and AMA.

Involuntary Disenrollment

A PACE participant may be involuntarily disenrolled for any of the following reasons established in 42 CFR 460.164:

- Failure to Pay: Any participant who fails to pay, or make satisfactory arrangements to pay any premiums due, to the PACE organization after a thirty-day grace period
- Disruptive or Threatening Behavior: A participant engages in disruptive or threatening behavior. Such behavior is defined as the following:
 - Behavior that jeopardizes the participant's own health or safety, or the safety of others; or a participant with decision-making capacity who consistently refuses to comply with his/her individual plan of care or the terms of the PACE enrollment agreement. Note that a PACE organization may not involuntarily disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior related to an existing mental or physical condition unless the participant's behavior is jeopardizing his/her health or safety or that of others. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments
- Relocation out of the service area: The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances
- Non-renewal or Termination of Program Agreement: The PACE organization's program agreement with CMS and AMA is not renewed or is terminated
- The participant is determined to no longer meet the Medicaid's nursing facility level of care requirements and is not deemed eligible

Procedures for Involuntary Disenrollment

In the event that a participant is involuntarily disenrolled, the PACE organization shall comply with 42 CFR 460.164.

To involuntarily disenroll a participant, the PACE Organization must obtain the prior review and approval of AMA. The request to disenroll a participant and documentation to support the request must be sent to the AMA PACE Unit. The request and corresponding documentation will be reviewed and a final determination will be made regarding the appropriateness of the involuntary disenrollment. AMA will notify the PACE Organization of approval or denial of the involuntary disenrollment in writing.

The PACE organization must assist the individual in obtaining other care and services to meet his/her medical, functional, psychological, social and personal care needs.

The PO is to notify AMA in writing by the 10th of each month of any completed involuntary disenrollments for the previous month. Involuntary disenrollments are to also be reported on quarterly reports submitted to CMS and AMA.

Effective Date of Disenrollment

The PACE organization is required to ensure that the disenrollment date is coordinated between Medicare and Medicaid for participants who are dually eligible (42 CFR 460.166).

The PACE participant must continue to use and the PACE organization must continue to provide, PACE services up to the effective date of termination (42 CFR 460.166)

The disenrollment date must not become effective until the participant is appropriately reinstated into other Medicare and Medicaid programs and alternative services are arranged (42 CFR 460.168)

Fiscal Agent Enrollment/Disenrollment Notification

When there is both medical and financial approval, the enrollment date will be entered through the Long Term Care (LTC) notification software by the PACE provider. This software enables the provider to submit LTC enrollment/disenrollment notifications on behalf of PACE participants. Enrollment must be completed by the end of the month prior to the effective date for PACE. Example: participant enrolling effective March 1st must have the enrollment information entered in the LTC software program by February 28th. The system is set to automatically default to the first of the following month and PACE providers are not authorized to backdate.

Participants disenrolled from the PACE program must have disenrollment information submitted using the LTC Admission Notification Software within 48 hours. This would include disenrollment due to death, termination from the program or transfer to a Medicaid Waiver program.

Alabama LTC Admission Notification software is available at no charge to Alabama Medicaid providers. It provides installation procedures and a contact number for the HP Electronic Media Claims (EMC) Help Desk, whose commitment is to assist Alabama Medicaid providers with electronic eligibility, claims, and medical eligibility application submission. Access to the LTC Admission Notification Manual can be done via the

Alabama Medicaid web page at the following link:
http://medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7_AMMIS_LTC_Admission_Notification_Manual_Revised_8-26-13.pdf
and/or the Alabama Medicaid Provider Portal
(<https://www.medicaid.alabamaservices.org/alportal>) by navigating to
"Information" and click on "AL Links".

For additional support or questions contact the *EMC Helpdesk at-1-800-456-1242*.

109.4 Additional Requirements

Compliance

Providers shall comply with all applicable federal, state and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

Reports to AMA

A PACE Organization is responsible for collecting data, maintaining records, and submitting reports as required by CMS and AMA as outlined in 42 CFR 460, Subpart L. Quarterly reports are to be submitted to CMS through the HPMS system. A copy of the quarterly reports is to be submitted to AMA by secure email. Monthly reports for voluntary and involuntary disenrollments are to be submitted to AMA by secure email. AMA will notify the PACE Organization in writing if it is determined that additional information, or additional reports, are needed.

The following quarterly reports must be submitted to AMA by the 20th of the month following the end of the quarter:

- Routine Immunizations
- Grievances
- Appeals
- Enrollments
- Disenrollments
- Prospective Enrollees
- Readmissions
- Emergency (unscheduled) Care
- Unusual Incidents
- Participant Deaths

Quality Assessment and Performance Improvement Program

The PACE program must develop, implement, maintain, and evaluate an effective data-driven quality assessment and performance improvement (QAPI) program, with the minimum requirements as under 42 CFR 460.134.

AMA will conduct site visits annually in conjunction with CMS, or as needed, to review the quality of service provision by the PACE Organization. The annual site visit review will include a clinical and administrative component and a review of compliance with life safety codes.

Medical Record Documentation

Per 42 CFR 460.210(b) the PACE organization must maintain a single comprehensive medical record for each participant. The medical record shall contain the following:

- Appropriate identifying information
- Documentation of all services furnished, including the following:
 - A summary of emergency care and other inpatient or long-term care services
 - Services furnished by employees of the PACE center
 - Services furnished by contractors and their reports
- Interdisciplinary assessments, reassessments, plans of care, treatment, and progress notes that include the participant's response to treatment
- Laboratory, radiological and other test reports
- Medication records
- Hospital discharge summaries, if applicable
- Reports of contact with informal support (e.g., caregiver, legal guardian or next of kin)
- Enrollment Agreement
- Physician orders
- Discharge summary and disenrollment justification, if applicable
- Advance Directives, if applicable
- A signed release permitting disclosure of personal information.

Medical Record Retention

In accordance with 42 DFR 460.200, medical records must be maintained in an accessible location for at least six years after the last entry or six years after the date of disenrollment. The records must be available upon request for audit by an authorized representative of the Alabama Medicaid Agency, the state Medicaid Fraud Control Unit and representatives of CMS.

109.5 Capitated Payment and Amounts

The state provides a monthly capitated payment for each PACE participant who is eligible for Medicaid assistance, in accordance with 42 CFR 460.180. The capitation payment amount is specified in the PACE program agreement and is based on the amount AMA would otherwise have paid under the state plan if the recipients were not enrolled in PACE. The capitation payment must be accepted in full for Medicaid participants. The PACE Organization may not bill, charge, collect or receive any other form of payment for the participant unless based on the exceptions listed in 42 CFR 460.182(c).

Payment for Medicare and Medicaid Dually Eligible Recipients

In accordance with 42 CFR 460.180 and 42 CFR 460.182, a PACE program is eligible to receive monthly capitated payments from Medicaid for recipients who are Medicaid eligible or dually eligible for both Medicare and Medicaid when:

- The organization has been approved by AMA as a PACE provider
- The organization has been approved by CMS as a PACE provider; and
- All parties have properly executed the three-way agreement between CMS, AMA and the PACE organization

Private Pay Participants

Federal regulations (42 CFR 460.186) allow the PACE organization to accept private-pay participants and to collect a premium from individuals who are Medicare-only beneficiaries. A PACE organization may not charge a private pay participant an amount greater than the Medicaid capitated payment amount.

109.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are required to bill Medicaid claims electronically.

PACE providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claims correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

The PACE Organization will use the following procedure codes:

- T1015 for PACE participants in the community
- T1015 with modifier TF for PACE participants in the nursing facility

The date of service should be the first day of the month and only one unit should be entered.

109.7 Cost Sharing (Copayment)

Copayment does not apply to services provided by PACE providers.

109.8 Time-Limit for Filing for payment

Medicaid requires all claims for PACE to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

109.9 Diagnosis Codes

The *International Classification of Diseases- 9th Revision-Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and the providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

109.10 Place of Service Code

The following place of service code applies when filing claims for PACE:

POS Code	Description
99	Other place of service

109.11 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Electronic Media Claims (EMC) Submission	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Verifying Recipient Eligibility	Chapter 3

109.12 Resources to learn more about PACE

Code of Federal Regulations
42 CFR Part 460

www.gpoaccess.gov

National PACE Association

www.npaonline.org

CMS Website Resources:

CMS PACE Application:

https://www.cms.gov/PACE/06_ProviderApplicationandRelatedResources.asp

Application Review Guide

<https://www.cms.gov/PACE/Downloads/reviewguide.pdf>

109.13 CMS PACE Manual

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html>

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