

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

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200.000	PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) GENERAL INFORMATION	4-1-06
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201.000	Arkansas Medicaid Participation Requirements for Providers of the Program of All-Inclusive Care for the Elderly (PACE)	4-1-06
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The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model that enables individuals who are 55 years of age or older and certified by the state to need nursing facility care, to live as independently as possible. Through PACE, fragmented health care financing and delivery system comes together to serve the unique needs of the enrolled individual with chronic care needs. The population served by PACE is historically very frail. The PACE organization must provide all needed services to the PACE participant.

201.100	PACE Provider Enrollment Requirements	4-1-06
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In order to ensure quality and continuity of care, all PACE providers approved to receive Medicaid reimbursement for services provided must meet specific qualifications.

Prior to enrollment of an applicant as a PACE Provider, the following must occur:

- A. A provider application (Form DMS-652) and a contract (Form DMS-653) with the Arkansas Medicaid Program must be completed and submitted. [View or print a provider application \(Form DMS-652\), Medicaid contract \(Form DMS-653\) and Request for Taxpayer Identification Number and Certification \(W-9\).](#)
- B. A PACE application must be submitted to the Division of Aging and Adult Services (DAAS).
- C. A PACE provider application must be approved by the Centers for Medicare and Medicaid Services (CMS) and DAAS.
- D. A three-way Provider Agreement must be signed by the DAAS, CMS, and the provider.
- E. The PACE Organization must be licensed by the Arkansas Department of Health and Human Services, Long Term Care Section, as an Adult Day Health Care.

202.000	Staff Requirements (42 CFR §460.64)	4-1-06
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Staff members (employees or contractors) of the PACE Organization must meet the following conditions:

- A. Be legally authorized, which means currently licensed, certified or registered, if applicable, to practice in the state; and
- B. Only act within the scope of his or her authority to practice.

202.100	Staff Training (42 CFR §460.66)	4-1-06
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The PACE Organization must provide training to maintain and improve the skills and knowledge of each staff member with respect to the individual's specific duties that results in his or her continued ability to demonstrate the skills necessary for the performance of the position.

202.200	Staff Oversight Responsibility (42 CFR §460.71)	4-1-06
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- A. The PACE Organization must ensure that all employees and contracted staff providing care directly to participants demonstrate the skills, licensure, and/or certifications necessary for performance of their position.

1. The PACE Organization must provide all staff with an orientation that includes, at a minimum, the organization's mission, philosophy, policies on participant rights, emergency plan, ethics, and the PACE Program and any policies related to the job duties.
 2. The provider must develop a competency evaluation program that identifies those skills, knowledge and abilities that must be demonstrated by direct participant care staff.
 3. The competency program must be evidenced as completed before performing participant care and on an on-going basis by qualified professionals. Certification of the satisfactory completion of the competency program must be in the personnel files of all staff.
- B. The PACE Organization must develop a program to ensure that all staff furnishing direct participant care services:
1. Comply with any state or federal requirements for direct patient care staff in their respective settings;
 2. Comply with the requirements of 42 CFR §460.68(a) regarding persons with criminal convictions;
 3. Have verified current certifications or licenses for their respective positions;
 4. Are free of communicable diseases;
 5. Have been oriented to the PACE Program; and
 6. Agree to abide by the philosophy, practices and protocols of the PACE Organization.

203.000**Program Integrity****4-1-06**

A PACE Organization must have a formal process in place to gather information and must be able to respond in writing to a request from CMS and/or the State Administering Agency (SAA) for information regarding:

- A. Persons with criminal convictions.
- B. A PACE Organization must not employ individuals or contract with organizations or individuals:
 1. Who have been excluded from participation in the Medicare or Medicaid programs;
 2. Who have been 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 Social Security Act; or
 3. In any capacity where an individual's contact with participants would pose a potential risk because the individual has been convicted of physical, sexual, drug or alcohol abuse.
- C. Direct or indirect interest in contracts. No member of the PACE Organization's governing body or any immediate family member may have a direct or indirect interest in any contract that supplies any administrative or care-related service or materials to the PACE Organization.

203.100**Infection Control (42 CFR §460.74)****4-1-06**

- A. The PACE organization must follow accepted policies and standard procedures with respect to infection control, including at least the standard precautions developed by the Centers for Disease Control and Prevention.

The PACE organization must establish, implement, and maintain a documented infection control plan that meets the following requirements:

1. Ensures a safe and sanitary environment
 2. Prevents and controls the transmission of disease and infection
- B. Contents of infection control plan. The infection control plan must include, but is not limited to, the following:
1. Procedures to identify, investigate, control, and prevent infections in every center and in each participant's place of residence.
 2. Procedures to record any incidents of infection.
 3. Procedures to analyze the incidents of infection to identify trends and develop corrective actions related to the reduction of future incidents.

203.200 Transportation Services (42 CFR §460.76)

4-1-06

A PACE organization's transportation services must be safe, accessible, and equipped to meet the needs of the participant population.

- A. If the PACE organization owns, rents, or leases transportation vehicles, it must maintain these vehicles in accordance with the manufacturer's recommendations.
- B. If a contractor provides transportation services, the PACE organization must ensure that the vehicles are maintained in accordance with the manufacturer's recommendations.
- C. The PACE organization must ensure that transportation vehicles are equipped to communicate with the PACE center.
- D. The PACE organization must train all transportation personnel (employees and contractors) in the following:
 1. Managing the special needs of participants.
 2. Handling emergency situations.
- E. As part of the interdisciplinary team process, PACE organization staff (employees and contractors) must communicate relevant changes in a participant's care plan to transportation personnel.

203.300 Dietary Services (42 CFR §460.78)

4-1-06

Except as specified in paragraphs items B or C of this section, the PACE organization must provide each participant with a nourishing, palatable, well-balanced meal that meets the daily nutritional and special dietary needs of each participant.

- A. Each meal must meet the following requirements:
 1. Be prepared by methods that conserve nutritive value, flavor, and appearance;
 2. Be prepared in a form designed to meet individual needs; and
 3. Be prepared and served at the proper temperature.
- B. The PACE organization must provide substitute foods or nutritional supplements that meet the daily nutritional and special dietary needs of any participant who has any of the following problems:
 1. Refuses the food served;
 2. Cannot tolerate the food served; or

3. Does not eat adequately.
- C. The PACE organization must provide nutrition support to meet the daily nutritional needs of a participant, if indicated by his or her medical condition or diagnosis. Nutrition support consists of tube feedings, total parenteral nutrition, or peripheral parenteral nutrition.
- D. To ensure that conditions are sanitary, the PACE organization must do the following:
 1. Procure foods (including nutritional supplements and nutrition support items) from sources approved, or considered satisfactory, by Federal, State, Tribal, or local authorities with jurisdiction over the service area of the organization;
 2. Store, prepare, distribute, and serve foods (including nutritional supplements and nutrition support items) under sanitary conditions; and
 3. Dispose of garbage and refuse properly.

204.000 Participant Eligibility

4-1-06

The State of Arkansas will utilize essentially the same non-medical and medical eligibility criteria for the PACE participants as that used for determining eligibility for nursing facility services.

An individual who does not meet the non-medical criteria may participate in the PACE Program as private pay if he or she meets the same medical criteria as Medicaid eligibles.

204.100 Non-Medical Criteria

4-1-06

Medicaid eligibility for the PACE Program will be based on the following requirements:

- A. Age - 55 or older;
- B. Care Need – The participant must require one of the following four levels of nursing facility care: Intermediate I-S, I-A, II-B, and III-C;
- C. Citizenship - Must be a citizen of the U.S. or lawfully admitted alien;
- D. Residency - Must be a resident of the State of Arkansas and reside in the PACE program service delivery area;
- E. Social Security Enumeration required; and
- F. Safety of the Participant - Health and safety of the participant will not be jeopardized by living in the community.

204.200 Medical Criteria

4-1-06

PACE participants must meet one of the following criteria:

The individual is unable to perform either of the following:

- A. At least one (1) of the three (3) activities of daily living (ADL) of transferring and/or locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or,
- B. At least two (2) of the three (3) activities of daily living (ADL) of transferring and/or locomotion, eating or toileting without limited assistance from another person;
- C. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others;

- D. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.

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 set out in Sections 204.100 and 204.200 above.

205.000 Records PACE Providers Are Required to Keep (42 CFR §460.210) 4-1-06

205.100 Retention of Records 4-1-06

All medical records of PACE participants must be completed promptly, filed and retained for a minimum of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. The records must be available upon request for audit by an authorized representative of the Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit and representatives of the Department of Health and Human Services.

205.200 Documentation Requirements (42 CFR §460.210) 4-1-06

All services provided to the PACE participant must be properly documented in the PACE participant's record and signed by the service provider at the time the service is delivered. At a minimum, the medical record must contain appropriate identifying information and documentation of all services furnished including the following:

1. A summary of emergency care and other inpatient or long-term care services
2. Services furnished by employees of the PACE Organization
3. Services furnished by contractors and their reports
4. Interdisciplinary assessments, reassessments, plans of care, treatment and progress notes that include the participant's response to treatment
5. Laboratory, radiological and other test reports
6. Medication records
7. Hospital discharge summaries, if applicable
8. Reports of contact with informal support (for example, caregiver, legal guardian, or next of kin)
9. Enrollment agreement
10. Physician orders
11. Discharge summary and Disenrollment justification, if applicable
12. Advance directives, if applicable
13. A signed release permitting disclosure of personal information
14. Accident and incident reports

205.300 Medicaid Field Audit Review of Records 4-1-06

All documentation must be available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business. No more than thirty (30) days will be allowed after the date on the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the 30-day period.

210.000 PROGRAM COVERAGE**4-1-06****211.000 Scope (42 CFR §460.92)****4-1-06**

A PACE Organization must establish and implement a written plan to furnish care that meets the needs of each participant in all care settings 24 hours per day, every day of the year.

The PACE benefit package for all participants, regardless of the source of payment, must include the following as prescribed by the interdisciplinary team assessment:

- A. All Medicaid-covered services, as specified in the State's approved Medicaid plan
- B. Interdisciplinary assessment and treatment planning
- C. Primary care, including physician and nursing services
- D. Social work services
- E. Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services
- F. Personal care and supportive services
- G. Nutritional counseling
- H. Recreational therapy
- I. Transportation
- J. Meals as required by the interdisciplinary team's plan of care
- K. Medical specialty services including, but not limited to the following:
 - 1. Anesthesiology,
 - 2. Audiology,
 - 3. Cardiology,
 - 4. Dentistry,
 - 5. Dermatology,
 - 6. Gastroenterology,
 - 7. Gynecology,
 - 8. Internal medicine,
 - 9. Nephrology,
 - 10. Neurosurgery,
 - 11. Oncology,
 - 12. Ophthalmology,
 - 13. Oral surgery,
 - 14. Orthopedic surgery,
 - 15. Otorhinolaryngology,
 - 16. Plastic surgery,
 - 17. Pharmacy consulting services,

18. Podiatry,
 19. Psychiatry,
 20. Pulmonary disease,
 21. Radiology,
 22. Rheumatology,
 23. General surgery,
 24. Thoracic and vascular surgery, and
 25. Urology.
- L. Laboratory tests, x-rays and other diagnostic procedures
- M. Drugs and biologicals
- N. Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items.
- O. Acute inpatient care, including the following:
1. Ambulance,
 2. Emergency room care and treatment room services,
 3. Semi-private room and board,
 4. General medical and nursing services,
 5. Medical surgical/intensive care/coronary care unit,
 6. Laboratory tests, x-rays and other diagnostic procedures,
 7. Drugs and biologicals,
 8. Blood and blood derivatives,
 9. Surgical care, including the use of anesthesia,
 10. Use of oxygen,
 11. Physical, occupational, respiratory therapies, and speech language pathology services, and
 12. Social services
- P. Nursing facility care
1. Semi-private room and board
 2. Physician and skilled nursing services
 3. Custodial care
 4. Personal care and assistance
 5. Drugs and biologicals
 6. Physical, occupational, recreational therapies, and speech-language pathology, if necessary
 7. Social services
 8. Medical supplies and appliances

- Q. Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

211.100 Emergency Care

4-1-06

- A. A PACE Organization must establish and maintain a written plan to handle emergency care. The plan must ensure that CMS, the State, and PACE participants are held harmless if the PACE Organization does not pay for emergency services.
- B. Emergency care is appropriate when services are needed immediately because of an injury or sudden illness, and the time required to reach the PACE organization or one of its contract providers would cause risk of permanent damage to the participant's health. Emergency services include inpatient and outpatient services that meet the following requirements:
1. Are furnished by a qualified emergency services provider, other than the PACE organization or one of its contract providers, either in or out of the PACE organization's service area.
 2. Are needed to evaluate or stabilize an emergency medical condition.
- C. 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:
1. Serious jeopardy to the health of the participant.
 2. Serious impairment to bodily functions.
 3. Serious dysfunction of any bodily organ or part.
- D. The organization must ensure that the participant or caregiver, or both, understand when and how to get access to emergency services.
- E. The plan must provide for the following:
1. An on-call provider, available 24-hours per day to address participant questions about emergency services and respond to requests for authorization of urgently needed out-of-network services and post stabilization care services following emergency services.
 2. Coverage of urgently needed out-of-network and post-stabilization care services when either of the following conditions are met:
 - a. The services are pre-approved by the PACE organization.
 - b. The services are not pre-approved by the PACE organization because the PACE organization did not respond to a request for approval within 1 hour after being contacted or cannot be contacted for approval.

211.200 Exclusions

4-1-06

The following services are excluded from coverage under PACE:

- A. Any service that is not authorized by the interdisciplinary team, even if it is a required service, unless it is an emergency service;
- B. In an inpatient facility, private room and private duty nursing services (unless medically necessary), and non-medical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the interdisciplinary team as part of the participant's plan of care);

- C. 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 mastectomy;
- D. Experimental medical, surgical, or other health procedures; and
- E. Services furnished outside of the United States, except as follows:
 - 1. In accordance with §424.122 through 4424.124 of 42 CFR.
 - 2. As permitted under the State's approved Medicaid plan.

212.000 Participant Enrollment/Disenrollment 4-1-06

To enroll in the PACE program, an individual must meet the requirements specified in sections 204.000 through 204.200.

212.100 Enrollment 4-1-06

Participant enrollment into the PACE Program is voluntary. When an individual expresses the wish to enroll, the PACE provider will notify the DHHS-RN to schedule an eligibility assessment for nursing facility level of care.

The Division of Aging and Adult Services of the Department of Health and Human Services must assess the potential enrollee and concur that he or she meets the requirements for nursing facility care prior to enrollment. The Department of Health and Human Services (DHHS) -RN must certify that an assessment has been completed and it is safe for the participant to live in the community. The DHHS-RN will notify the local DHHS county office and the Provider Organization (PO) that all requirements have been met.

The PACE provider must explain to the potential enrollee that enrollment in PACE results in disenrollment in any other Medicare or Medicaid plan and the provider is required to complete an intensive assessment that includes a minimum of one home visit and one visit by the potential enrollee to the PACE center unless otherwise approved by CMS.

212.200 Disenrollment 4-1-06

Participants may voluntarily disenroll from the PACE program at any time for any reason.

Participants may be involuntarily disenrolled due to:

- A. Participant's failure to pay if he or she has a payment responsibility
- B. Participant's disruptive or threatening behavior
- C. Participant moves out of the PACE service delivery area
- D. Participant no longer meets the nursing facility level of care requirement
- E. The PACE program agreement with the Centers for Medicare and Medicaid Services (CMS) and the state is not renewed
- F. The PACE organization cannot provide the required services due to loss of licensure or contracts with outside providers

In order to involuntarily disenroll a participant, the PACE Organization must obtain the prior review and approval of the Department of Health and Human Services. The request to disenroll a participant and documentation to support the request must be sent to the DHHS- RN. The DHHS- RN will review the request and corresponding documentation and will make a recommendation to the DHHS- RN Supervisor and DHHS PACE Program Manager regarding

whether the PACE Organization should proceed with the involuntary disenrollment. The DHHS RN Supervisor, in consultation with PACE Program management will make a final determination regarding the appropriateness of the involuntary disenrollment and will notify the PACE Organization and the DHHS-RN.

The PACE Organization may request an administrative reconsideration pursuant to section 190.003. A request for administrative reconsideration must be directed to the Division of Aging and Adult Services (DAAS).

215.000 Interdisciplinary Teams 4-1-06

The PACE interdisciplinary team must meet regularly as indicated in the Provider Agreement between the PO, CMS, and DAAS to provide overall assessment of care needs and subsequent management, supervision and provision of care for eligible individuals.

215.100 Composition of the PACE Interdisciplinary Team (42 CFR §460.102) 4-1-06

The PACE interdisciplinary team must be composed of at least the following members:

- A. Primary care physician (PCP)
- B. Registered nurse (RN)
- C. Master Social worker (MSW)
- D. Physical therapist (PT)
- E. Occupational therapist (OT)
- F. Recreational therapist (RT)/activity coordinator
- G. Dietician
- H. PACE center supervisor
- I. Home care liaison
- J. Personal care attendant/aide
- K. Transportation staff/driver

215.200 Assessment/Treatment Plan 4-1-06

The interdisciplinary team is responsible for assessment, treatment planning and care delivery once the DHHS-RN has completed the initial eligibility assessment for nursing facility level of care. The team must meet the following assessment requirements:

- A. An initial in-person comprehensive assessment must be completed promptly following enrollment by the:
 1. Primary care physician
 2. Registered nurse
 3. Social worker
 4. Physical therapist, recreational therapist, occupational therapist or activity coordinator
 5. Dietitian
 6. Home care liaison

- B. At least semi-annually, an in-person assessment and treatment plan must be completed by the:
1. Primary care physician
 2. Registered nurse
 3. Social worker
 4. Recreational therapist/activity coordinator
- C. Annually, an in-person assessment and treatment plan must be completed by the:
1. Physical therapist or occupational therapist
 2. Dietitian
 3. Home care liaison

PACE organizations consolidate discipline specific plans into a single plan of care semi-annually through discussion and consensus of the interdisciplinary team. 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.

215.300 PACE Participant Appeal Process

4-1-06

When an adverse decision is received, the PACE participant may appeal. The appeal request must be in writing and received by the Appeals and Hearing Section of the Department of Health and Human Services within thirty (30) days of the date on the letter explaining the decision.

[View or print Appeals and Hearings Section contact information.](#)

220.000 Quality Assurance and Monitoring Activities

4-1-06

The Department of Health and Human Services 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. The annual on-site review will include but not be limited to a review of the PACE Organization's compliance with requirements in 42 CFR § 460, or its successor, in the following compliance areas:

1. Administrative
2. PACE Services
3. Participant Rights
4. Quality Assessment and Performance Improvement
5. Participant Enrollment and Disenrollment
6. Payment
7. Federal and State Monitoring
8. Data Collection
9. Record Maintenance
10. Reporting which includes a review of the marketing materials, financial reports, samples of documentation of proper licensure for PACE Organization staff, current contract arrangements to ensure the PACE Organization has the capability to provide all federally and state required services, and other items as deemed necessary to ensure compliance with state and federal requirements.

DHHS will be responsible for conducting an exit conference with the PACE Organization to discuss any review findings and to provide technical assistance in developing corrective action plans and to assist the PO in their efforts to implement the required corrections.

220.100 Monitoring by the Office of Long Term Care 4-1-06

Due to the requirement that PACE Organizations be licensed as Arkansas Adult Day Health Care Centers, the Office of Long Term Care will be conducting monitoring and oversight of the PACE Center operations. The Division of Aging and Adult Services will coordinate their on-site visits and monitoring with the Office of Long Term Care.

220.200 DHHS- RN Quality Monitoring Requirements 4-1-06

DHHS- RN's are also required to monitor at least 25% of their PACE caseload during each performance evaluation period (12 months). Of this 25%, at least 50% of those contacts must be face to face and must include interviews with participants and caregivers/participant representatives. In addition, one-half of these in person contacts must take place in the PACE center and the remaining contacts must take place in the participants' homes.

During each monitoring contact, questions must be asked regarding quality of care, provision of services, and compliance with the established plan of care. These monitoring requirements are in addition to those contacts made routinely by maintaining the caseload.

220.300 Internal DHHS Monitoring by RN Supervisor and PACE Program Manager 4-1-06

The DHHS-RN supervisors must review at least 10% of the charts for each DHHS- RN under their supervision during each performance evaluation period. These may be random selections or selections based on information documented in the chart. During these thorough reviews, the RN supervisors will note any deviations from policy and discuss with the RN and verify that for the period under review, the appropriate amount of PACE capitation payments have been paid for the participant charts under review. Charts are chosen at random based on the latest ANSWER Monthly Report. Random selections are made by the RN Supervisor based on assessments and reassessments, the start dates and the dates on the DHHS 703-Evaluation of Medical Need Criteria. The results of this review are shared with the PACE Program Manager so that the manager can assess program quality assurance issues.

Semi-annually, the DHHS-RN supervisors and the PACE Program Administrator must review charts selected at random from each nurse's caseload. The charts will be reviewed for compliance with program policy. In addition, the RN Supervisor and Program Administrators will review payment records to verify that capitation payments have been paid appropriately to the PACE Provider. The PACE Organization will make available charts for review at the PACE site or as requested by DHHS Review Staff.

Annually, the DHHS- RN Supervisors and the Program Administrator will accompany the DHHS- RNs on assessment and reassessment home visits. During these visits, the RN will be reviewed for interviewing techniques, compliance with program policy, compliance with medical criteria application and compliance with documentation requirements.

220.400 Monitoring by the Centers for Medicare and Medicaid Services (CMS) and the State Administering Agency (SAA) 4-1-06

In compliance with federal requirements, each PACE Organization will enter required information for nine (9) key indicators into the Health Plan Management System (HPMS), or any successor data elements or data system on a quarterly basis. Both CMS and the State Administering Agency (SAA) will use the data entered into HPMS or its successor system to monitor the ongoing operations of the PACE Organization and identify potential problems or unusual events

that may be the first indication of problems in patient care, site operations or financial solvency. These reviews will also be used to determine if further onsite monitoring will be necessary.

- A. The nine (9) key indicators are as follows:
 - 1. Routine Pneumococcal Immunizations
 - 2. Grievances & Appeals
 - 3. Enrollments
 - 4. Disenrollments
 - 5. Prospective Enrollees
 - 6. Unscheduled Hospitalizations
 - 7. Emergency (Unscheduled) Care
 - 8. Unusual Incidents for participants and the PACE site (such as falls, attempted suicides, staff criminal records, infectious diseases, food poisoning, participant injury, Medication errors, lawsuits, any type of restraint use, etc)
 - 9. Participant Deaths
- B. Other Required DHS Monitoring Reports:
 - 1. 45 day report - tracks all applications pending more than 45 days
 - 2. Capitation Payment Report – payment report to be used to verify if the appropriate amounts of capitation payments have been paid
 - 3. Monthly Reports - tracks all assessments, reassessments, monitoring contacts, mileage associated with home visits, and pending applications
 - 4. Provider Reports as indicated in the Provider Agreement.
 - 5. Average Days for Assessment Completion - tracks statewide average and each RNs length of time between receiving referral and completing home visit

230.000	PRIOR AUTHORIZATION	4-1-06
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Prior authorization of specific services does not apply to the PACE Program.

240.000	REIMBURSEMENT	4-1-06
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241.000	Method of Reimbursement	4-1-06
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PACE services are financed primarily through Medicaid and Medicare capitated payments. Providers must provide all needed services for PACE participants with the monthly capitated funds.

The PACE rates are based on the Upper Payment Limit (UPL) methodology. The historical fee-for-service population data is extracted for claims and eligibility for PACE eligible populations for more than one fiscal period. Data for participant aged, blind and disabled aid categories for those 55 or greater is used in the UPL and rate calculations. The level of care codes are limited to nursing facility level of care eligible or waiver level of care eligible (waivers included are the ElderChoices Waiver and the Adults with Physical Disabilities Waiver).

The base rates are calculated using calendar year base data. The base year data is trended forward using the historical claims and eligibility information extracted for the fee-for-service population. The recent trend rates are compared to linear regression model trend rates to

determine comparability, and to determine if any adjustments are necessary. The trend rates for future periods are expected to be consistent with the most recent cost-data available.

The UPL amounts are reduced by a percentage amount to establish the PACE capitation rate. The percentage (%) amount will be based on the anticipated reductions in health care service costs due to the implementation of the managed care PACE program. Reductions in costs are anticipated to be realized through a reduction in nursing facility and in-patient hospital costs. The UPL will be reset and recalculated every two years.

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

242.000 Rate Appeal Process

4-1-06

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel, established by the Director of the Division of Medical Services, which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services (DHHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

July 1, 2004

CATEGORICALLY NEEDED

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

 X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

 No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

1905(a)(26) and 1934

 X Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits-for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

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2. N/A The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

3. N/A The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

- 1. ___ SSI Standard
- 2. ___ Optional State Supplement Standard
- 3. ___ Medically Needy Income Standard
- 4. ___ The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

5. ___ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

6. ___ The amount is determined using the following formula:

7. X Not applicable (N/A)

(C.) Family (check one):

- 1. ___ AFDC need standard
- 2. ___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ___ The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

4. ___ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

5. ___ The amount is determined using the following formula:

6. ___ Other

7. X Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

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(C.) Family (check one):

- 1. AFDC need standard
- 2. Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

- 3. The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
- 4. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
- 5. The amount is determined using the following formula:

- 6. Other
- 7. Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. X State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A). X The following standard included under the State plan (check one):

- 1. SSI
- 2. Medically Needy
- 3. X The special income level for the institutionalized
- 4. Percent of the Federal Poverty Level: _____%
- 5. Other (specify): _____

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(B). N/A The following dollar amount: \$_____

Note: If this amount changes, this item will be revised.

(C). N/A The following formula is used to determine the needs allowance:

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

II. Rates and Payments

- A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service. See
 1. X Rates are set at a percent of fee-for-service costs
 2. ___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
 3. ___ Adjusted Community Rate (please describe)
 4. ___ Other (please describe)

- B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Mr. Robert Damler, FSA, MAAA
Principal and Consulting Actuary
Milliman, USA
111 Monument Circle, Suite 601
Indianapolis, IN 46204-5128

See Pages 37A and 37B for description of the reimbursement methodology for Program of All-Inclusive Care for the Elderly (PACE).

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Program of All-Inclusive Care for the Elderly (PACE) Reimbursement Methodology

The PACE rates are based on the Upper Payment Limit methodology. The historical fee-for-service population data is extracted for claims and eligibility for a PACE eligible populations for more than one fiscal period. Data for recipient aged, blind and disabled aid categories for those 55 or greater is used in the UPL and rate calculations. The level of care codes are limited to nursing facility level of care eligible or Waiver level of care eligible (waivers included are the ElderChoices Waiver and the Adults with Physical Disabilities Waiver).

The data includes both those that are eligible only for Medicaid and those that are eligible for both Medicaid and Medicare. In addition, this data includes only QMB-Plus and SLMB-Plus populations. The claims data includes all categories of service. The UPL and base rate information is also inclusive of patient liability.

The base rates are calculated using calendar year base data. The base year data is trended forward using the historical claims and eligibility information extracted for the fee-for-service population. The recent trend rates are compared to linear regression model trend rates to determine comparability, and to determine if any adjustments are necessary. The trend rates for future periods are expected to be consistent with historical rate changes rather than the more recent experience.

The following rate category groupings were developed for Arkansas: Pre-65 Medicaid Only, Pre-65 Dual Eligible, Post-65, and QMB Only. The UPL for QMB Only is based on actual expenditures for co-payments and deductibles for the base year period trended forward for inflation, and adjusted for investment income and administration expense. Due to the limited size population in the post-65 age group that was not Medicare eligible, it was determined that a Medicare eligibility rate for those over 65 would not improve predictability. The data did not reflect a necessity for a rate grouping for either geographic region or gender.

Claims completion factors are developed from the fee-for-service paid claims experience with the most recently available paid dates. Claims completion factors were developed for fourteen (14) primary groupings with comparable categories of service grouped for improved predictability. The completion factors were adjusted to exclude low and high outliers for each specific lag month.

The following adjustments are necessary in the development of the rates:

- Prescription Drug (PD) Rebate – Reduce PD expenditure data to reflect the rebate received by Arkansas.
- Investment Income – Reduce expenditure data by 0.2% for all Categories of Services (COS) to reflect an average payment lag of 2.49 months.
- Administration Expense – Increase expenditure data for all COS by 0.3% to reflect the cost of administration of the fee-for-service program.

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- **Co-payments for Medicaid services – Increase the expenditures to reflect co-payment amounts.**
- **PCCM Fees – Decrease the base expenditures to exclude the PCCM fees.**
- **Non-emergency Transportation – Currently under waiver, Arkansas contracts for non-emergency transportation services for all Medicaid recipients eligible for the benefit (nursing facility residents are not eligible). A composite rate is developed with adjustments to reflect the PACE population morbidity.**

The UPL amounts are reduced by a percentage amount to establish the PACE capitation rate. The Percentage (%) amount will be based on the anticipated reductions in health care service costs due to the implementation of the managed care PACE program. Reductions in costs are anticipated to be realized through a reduction in nursing facility and in-patient hospital costs.

The Upper Payment Limits (UPLs) will be rebased/recalculated every two years and the rebasing calculations will be completed for two State Fiscal Years (SFYs). Since the first UPLs and rates were calculated for SFYs 2005 and 2006, the first rebasing process will be completed for SFYs 2007 and 2008, which begin July 1, 2006 and July 1, 2007, respectively. The rebasing/recalculations will be completed in accordance with the methodology described above.

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C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

July 1, 2004

MEDICALLY NEEDY

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

_____ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

 X No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

1905(a)(26) and 1934

_____ Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)