26500 PACE - Program of All Inclusive Care for the Elderly 06-01-06

PACE, or Program of All Inclusive Care for the Elderly, is a comprehensive health and social services delivery system that provides and coordinates primary, preventive, acute and long term care services for individuals 55 years of age or older who need nursing facility care to live as independently as possible. PACE combines primarily Medicare and Medicaid financing to provide a wide array of services that focus on helping participants continue to live in the community. However, private pay participation in PACE is also an option. PACE services are provided in PACE Centers, in the home and in inpatient facilities.

Section 1934 of the Social Security Act, enacted in section 4802 of the Balanced Budget Act of 1997 established the Program of All Inclusive Care for the Elderly (PACE) as a Medicaid State plan option. The Division of Aging and Adult Services received a John Hartford Foundation grant, administered through the National PACE Association in March of 2002 to accelerate the implementation of PACE in Arkansas.

26510 Individuals Eligible for PACE 06-01-06

Persons who are eligible for PACE must meet all of the following requirements:

- Be fifty-five (55) years of age or older.
- Be certified to meet nursing home eligibility criteria.
- Be living in an area served by a PACE program.
- Be able to live in a community setting without jeopardizing his or her health or safety.
- Meet the eligibility requirements described in 26520 – 26561.

26520 Basic Eligibility Requirements 06-01-06

- Age - Must be aged 55 or over. Individuals under age 65 must establish disability through SSI/SSA or through the Medical Review Team (Re: MS 3323.3).

- Citizenship - Must be a citizen of the U.S. or a qualified alien. (Re. MS 6711).

- Residency - Must be a resident of the State of Arkansas (Re. MS 2200) and reside in the PACE program service delivery area.

- Social Security Enumeration - Enumeration is required (Re. MS 1390).

- Facility Care Need - The participant must require one of the four levels of nursing facility care: Skilled - S, Intermediate I - A, Intermediate II - B, Intermediate III - C.

- Cost Effectiveness - It must be demonstrated that the monthly capitation amount is less than the amount that would otherwise be paid if the individual was not enrolled in the PACE program. The Division of Aging and Adult Services will make this determination.

- Safety of the Participant - The health and safety of the participant will not be jeopardized by living in the community.

26530 Medical Criteria **06-01-06**

PACE participants must meet one of the three following criteria:

1. The individual is unable to perform either of the following:

   A. At least one of the three activities of daily living (ADL) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person.

   B. At least two of the three activities of daily living (ADL) of transferring/locomotion, eating or toileting without limited assistance from another person.

2. 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.

3. 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.

No individual who is otherwise eligible for PACE services will have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition that is temporary and expected to last no more than twenty-one days. However, the individual will not receive PACE services or benefits when subject to a condition or change of condition that would render the individual ineligible if expected to last more than twenty-one days.

NOTE: If an individual has a serious mental illness or has mental retardation, the individual will not be eligible for PACE unless he or she has medical needs unrelated to the diagnosis of serious mental illness or mental retardation and meets the medical criteria in the above sections. However, a diagnosis of severe mental illness or mental retardation will not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation and meeting the criteria shown above.

26540 Income 06-01-06

The financial criteria for ElderChoices will be used for PACE participants residing in the community. The financial criteria for nursing facility services will be used for PACE participants requiring nursing facility care.

The individual's income cannot exceed three times the current SSI payment standard. VA Aid and Attendance and VA CME/UME are not considered countable income. If the individual's income exceeds the current limit, eligibility may be met by establishing an Income Trust (Re. MS 3336.9).

Spousal impoverishment policy for income will apply to PACE participants both in the community and in a nursing facility (Re. MS 3337).

26550 Contribution to the Cost of Care 06-01-06

Post-eligibility treatment of income provisions will apply to PACE participants upon entry into a nursing facility using the procedures for Long Term Care Medicaid. For PACE participants in the community, there is no cost of care unless the individual has income over the income limit and has established an income trust.

The caseworker will calculate a patient liability amount for those PACE participants in nursing homes and those who are eligible through establishing an Income Trust. The PACE provider will collect and retain the patient liability. For individuals in nursing facilities, a personal needs allowance (PNA) equal to the current LTC PNA, any applicable community spouse allowances and/or family allowances and excess medical expenses will be deducted from the PACE participant's monthly income.

For individuals in the community eligible through establishing an income trust, income in excess of the current LTC Medicaid limit will also be paid to the PACE provider. A personal needs allowance equal to the current LTC/PACE limit of three times the current SSI/SPA, plus any applicable spousal or family support or excess medical expenses will be deducted before making payment to the PACE provider.

26560 Resources 06-01-06

The resource guidelines for AABD Medicaid will apply (Re. MS 3330). Countable resources cannot exceed $2,000 for an individual, or $3,000 for a couple, when both apply. For individuals with an ineligible spouse, LTC spousal provisions will apply (Re. MS 3337).

26561 Transfer of Resources 06-01-06

The transfer of resources policy (RE. MS 3336.10) will be reviewed with the PACE applicant at the time he or she enters the program. Transfer of resources provisions will

apply only if the PACE participant enters a Long Term Care facility. If assets have been transferred during the look back period from the time of entry into the LTC facility, a period of ineligibility for PACE services will be imposed for uncompensated value based on the current divisor. The look back period will begin with the date of entry to the facility. It will be necessary for the PACE recipient to drop out of the PACE program when he or she enters a nursing facility when under a penalty for non-compensated transfer. When the penalty period ends, the individual may be considered for readmission to the PACE program. The transfer of resource penalty does not apply to PACE individuals in the community.

26570 Initial Application Process 06-01-06

Prospective PACE recipients can apply for PACE services through their local DHHS county offices, by referral from the PACE provider, or by referral from the DHHS RN. Regardless of the origin of the application, the prospective recipient must meet the medical and financial eligibility criteria outlined in MS 26500 – 26561. The final determination of eligibility will be communicated to the PACE provider by the DHHS RN or the county office caseworker.

If the initial application is made at the local DHHS county office, the caseworker will begin the application process and notify the DHHS-RN to complete the initial medical assessment.

The caseworker will determine if the applicant resides in the service area approved for the PACE organization to which the applicant is seeking enrollment. Application for PACE will be made on the DCO-777 or the DCO-215, Request for Assistance. A DCO-727, Disposal of Assets Disclosure, must be completed for individuals entering a LTC facility. The DCO-710 and DCO-713 will be completed for individuals with ineligible spouses. The DCO-712 will be used only when the individual enters a nursing facility or when an Income Trust is established.

The caseworker will send a DHHS-3330, Alternative Community Services Waiver Communications Form to the DHHS-RN within 2 days of the office interview to request completion of a medical assessment. The financial eligibility process will continue and may be made before or after the medical determination.

If the prospective PACE recipient makes the initial application with the PACE provider, the provider will contact the DHHS-RN to complete the initial medical assessment. The DHHS-RN will instruct the applicant to make application at the local DHHS county office for a determination of financial eligibility.

If the initial application for PACE is made with the DHHS-RN, the RN will complete the initial medical assessment and instruct the recipient to make application at the local DHHS county office for determination of financial eligibility.

The DHHS-RN will complete the in-home medical assessment of the applicant using the DHHS-703 within 10 working days of receiving the DCO referral on the DHHS-3330. The DHHS-RN will also verify that the applicant resides in the service area approved for the PACE organization. The DHHS-RN will then submit the DHHS-703 to the applicant's physician within 5 days after completing the home visit, and will submit a DHHS-3330 to the county office indicating that the assessment has been completed and sent to the physician for approval.

After the physician signs the DHHS-703, the DHHS-RN will submit it to OLTC Utilization Review. OLTC-UR will send a Decision for Nursing Home/Waiver Placement, DHHS-704, within 5 days to DAAS if all necessary information is available. DAAS will then send a copy of the DHHS-704 to the DHHS-RN and the County Office.

The DCO caseworker will make the final decision to approve or deny the application when the financial eligibility determination is made.

26580 Approval of Application 06-01-06

If the application is approved, the caseworker will notify the applicant by system notice. The caseworker will notify the DHHS-RN on the DHHS-3330 of the PACE eligibility date. A participant's enrollment in the PACE program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement. A PACE applicant may complete an enrollment application prior to the final medical and financial eligibility determination. However, the capitation payments will only be paid if the enrollee is found to be clinically and financially eligible for PACE. An ineligible applicant will be responsible for paying any charges for PACE services he or she has received.

Please note that approval for PACE is different from the other Medicaid categories. The caseworker may only access ANSWER to determine dates of eligibility or denial as PACE will not appear on the Mainframe. Also the participant will not receive a Medicaid card as benefits will be received through the PACE provider.

A capitated monthly payment will be generated to the PACE organization based on data received from the ANSWER system that indicates the number of individuals having the PACE aid category. There are four different payment rates based on rate category:

- Pre-65 Medicaid Only - individuals under age 65 having Medicaid only
- Pre-65 Dual Eligible - individuals under 65 having both Medicare and Medicaid
- Post-65 - those over age 65
- QMB Only

The caseworker will key the PACE approval to the ANSWER system. PACE providers will have service areas based on the client's Zip Code. ANSWER will assign the PACE provider to the eligible recipient. The PACE provider information will include a start

date, stop date, provider number add date and last change date. The caseworker as well as the DHHS-RN will assess each individual and determine whether the individual's place of residence and zip code fall within the service area of the PACE organization prior to eligibility determination and keying to ANSWER.

26590 Enrollment 06-01-06

Participant enrollment into the PACE Program is voluntary. The Division of Aging and Adult Services (DAAS) must assess the potential enrollee and concur that the client meets the requirements for nursing facility care prior to enrollment. The DHHS-RN must certify that an assessment has been completed and that it is safe for the participant to live in the community.

The PACE provider must explain to the potential enrollee that enrollment in PACE results in disenrollment in any other Medicare or Medicaid plan and that enrollment requires the completion of an intensive assessment that includes a minimum of one home visit and one visit by the potential PACE enrollee to the PACE center.

26591 Disenrollment

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

Participants may be involuntarily disenrolled due to:

- The participant's failure to pay if he/she has a payment responsibility.
- The participant's disruptive or threatening behavior.
- The participant moving out of the PACE service delivery area.
- The participant no longer meeting the nursing facility Level of Care requirement.
- The PACE organization cannot provide the required services due to loss of licensure or contracts with outside providers.
- A PACE program agreement is not renewed.

To involuntarily disenroll a participant, the PACE Organization must obtain the prior review and approval of the Division of Aging and Adult Services with 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 appeal an adverse decision to the DAAS.

26600 Provider Post-Enrollment Assessments 06-01-06

Upon enrollment, it is required that each PACE provider have an interdisciplinary team in place that is responsible for the overall assessment of care needs and subsequent management, supervision and provision of care for PACE participants. The team's membership consists of a primary care physician (PCP), registered nurse, social worker, physical therapist, occupational therapist, recreational therapist/activity coordinator, dietician, PACE center supervisor, home care coordinator, personal care attendant/aid, and a transportation staff/driver.

The interdisciplinary team is responsible for the assessment, treatment planning and care delivery of the PACE participant. PACE regulations establish the following assessment requirements:

- An initial in-person assessment must be completed by the Primary Care Physician, RN, Social Worker, Physical Therapist and/or Occupational Therapist, Dietician and the Home Care Liaison.

- At least semi-annually, an in-person assessment and treatment plan must be completed by the Primary Care Physician, RN, Social Worker and Recreational Therapist/Activity Coordinator.

- An annual in-person assessment and treatment plan must be completed by the Physical Therapist and/or Occupational Therapist, Dietician and Home Care Liaison.

PACE organizations will consolidate discipline specific plans into a single plan of care semi-annually through discussion and consensus of the interdisciplinary team. The consolidated plan will then be discussed and finalized with the PACE participant and his or her significant others. Reassessments and Treatment Plan changes will be completed when the health or psycho-social situation of the client changes.

26700 Reevaluations 06-01-06

Both financial and medical eligibility will be redetermined annually.

Medical eligibility will be redetermined by the DHHS-RN. Re-certifications will be conducted annually by the county office. Form DCO-777 and all other forms required at initial application will be completed.

DAAS will complete an annual Level of Care assessment on all PACE participants using the same assessment instruments and review and approval processes as the initial

assessment. DAAS may "deem eligible" those individuals who are determined to no longer meet the nursing facility Level of Care requirement, but who would reasonably be expected to meet nursing facility Level of Care within the next six months in the absence of continued coverage under PACE.