CMS Manual System

Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE)

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 2 **Date: June 9, 2011**

NOTE: Transmittal 1, dated June 3, 2011, is rescinded and replaced by Transmittal 2 to remove from the transmittal, the number 3 preceding the word NEW/REVISED on the Transmittal page. Also, the implementation date of June 3, 2011, has been added to the transmittal, and the effective/implementation dates have been added to the manual instruction. In addition, the Filename: R.1SO has been changed to R.1PACE. All other information remains the same.

SUBJECT: Programs of All-Inclusive Care for the Elderly (PACE) Manual – Initial Release

I. SUMMARY OF CHANGES: PACE is a capitated benefit for frail elderly authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The BBA established PACE as a permanent entity within the Medicare program and enables states to provide PACE services to Medicaid beneficiaries as a state plan option. Operationally, the PACE program is unique as a three-way partnership between the Federal government, the State, and the PACE organization.

This is an initial release of Pub. 100-11, PACE Manual. The PACE manual provides further guidance on the PACE program as outlined in 42 CFR Part 460, the regulation implementing PACE statutory requirements. It is an Internet-only manual and may be accessed at the CMS Web site: http://www.cms.hhs.gov/manuals

NEW/REVISED MATERIAL - EFFECTIVE DATE: June 3, 2011
IMPLEMENTATION DATE: June 3, 2011

Note: Normally, red italic font identifies new material. However, because this release is a new manual, normal text font is used for the initial release.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	Chapters 1 to 17
N	Appendix

III. GENERAL INFORMATION

A. BACKGROUND:

In the 1970's the federal and state governments became increasingly interested in the development of community-based services. As a result, waivers of federal Medicaid requirements allowed state governments to experiment with fee-for-service programs for frail elderly and disabled beneficiaries. One such program was the Programs of All-Inclusive Care for the Elderly (PACE), which was developed at On Lok Senior Health Services in San Francisco through a series of demonstration projects. With a one-year grant from The Robert Wood Johnson Foundation (RWJF), On Lok initiated a project to determine the feasibility of replicating the model in other parts of the country and in 1986, Congress authorized waivers for ten replication sites. In 1987, the RWJF authorized start-up grants for replication sites and a grant to On Lok to provide technical assistance. The first replication sites initiated a three-waiver demonstration in 1990 and by 1994 there were ten operational replication sites. The PACE demonstration operated until PACE was established as a permanent Medicare program by the Balanced Budget Act of 1997 (BBA).

The PACE Protocol was first developed in 1990 as part of a cooperative effort involving staff from CMS then the Health Care Financing Administration Office of Research Development and Information, States participating in the PACE replication, and PACE sites. Most of the features of PACE continued from the demonstration into the permanent program, including the focus on the targeted population, the frail elderly, and the capitated funding mechanism.

In September 2006, CMS awarded $7.5 million in grant funds to organizations developing PACE in rural service areas. Fourteen organizations each received over $500,000 for the establishment of a PACE program in their area. This grant program was initiated through the Deficit Reduction Act of 2005. The funding was available through September 30, 2008, and was provided to all fourteen grantees that met the requirements as a PACE provider as demonstrated through the PACE provider application approval process.

Sections 1894(a)(3)(B) and 1934(a)(3)(B) of the Social Security Act (the Act) allowed private, for-profit entities to participate in PACE, subject to a demonstration waiver described in Sections 1894(h) and 1934(h) of the Act. For-profit entities wishing to participate in PACE applied for a demonstration waiver under Section 1894(h) and 1934(h) of the Act. While participating in the PACE for-profit demonstration, they must meet all requirements set forth in PACE regulations. The PACE organization is expected to retain all key administrative functions including marketing and enrollment, quality assurance and program improvement, and contracting for institutional providers and other key staff. On July 24, 2009, CMS issued a Federal Register Notice announcing a closing date of July 26, 2010 for submission of proposals for the PACE for-profit demonstration project. There are five for-profit PACE organizations and two pending approval.

There are currently approximately 20,000 participants in the PACE program in one of 80 operational PACE organizations in 30 States.

B. CHAPTER SUMMARY:

1. Chapter 1: **Introduction to PACE** – This chapter presents a brief history of the PACE program from its conceptual phase to its adoption. It also outlines the interaction between the participating entities, an overview of the model and program, and a summary of eligibility requirements, benefits, and payments.

2. Chapter 2: **Administrative Requirements** - The purpose of this chapter is to provide information about the requirements relating to organizational structure, the governing body and program integrity of the PACE organization as well as the relationships between entities. These requirements are essential to the PACE organization's ability to ensure the health and safety of the participants and provide a well functioning organizational environment in which appropriate care can occur.

3. Chapter 3: **Marketing** - This chapter provides guidance to the PACE organizations on CMS marketing requirements. Topics covered include: general marketing requirements and the marketing plan, the review and approval/disapproval process, timeframes, prohibited marketing activities, and Part D information.

4. Chapter 4: **Enrollment and Disenrollment** - This chapter discusses eligibility criteria and the enrollment process for the PACE program as provided in 42 CFR § 460.150. The eligibility criterion includes a requirement that a PACE eligible individual meet a specific level of care which is determined by the State Administering Agency and varies from state to state. State enrollment processes are separate from the processes identified in this manual and PACE organizations should consult their State Administering Agency for instruction. Subtopics include: eligibility, prohibited discrimination, enrollment and disenrollment, reinstatement, and retroactive enrollment and disenrollment.

5. Chapter 5: **Participant Rights and Restraint Policies** – This chapter outlines the list of PACE participant rights, the PACE organization's responsibility to have a written participant Bill of Rights, and to inform the participant of those rights at the time of enrollment. It also clearly delineates the intent and use of restraints for PACE participants and requires the PACE organization to develop, use, and monitor compliance with restraint policies and procedures.

6. Chapter 6: **Services** – This chapter provides a list of PACE program services and a detailed description of each. Basic payment rules governing PACE, as well as emergency care, urgent care, and post stabilization care are covered, as well as each element of the standard set of services routinely delivered in the PACE program, which, at a minimum, include: primary care; social work services; restorative therapies, including physical and occupational therapy; personal care and supportive services; nutritional counseling; recreational therapy; and meals.

7. Chapter 7: **Service Delivery Settings** - The PACE organization must have a written plan and procedure specifying how the organization meets the individualized needs of each participant in all care settings 24-hours a day, every day of the year. This chapter addresses the physical environment of the PACE center, attendance, equipment and maintenance requirements, emergency equipment and fire safety, emergency and disaster preparedness, infection control, alternate care settings and institutional settings.

8. Chapter 8: **IDT, Assessment & Care Planning** - The intent of the first portion of chapter 8 is to clarify the regulatory requirements for the Interdisciplinary Team (IDT) as defined by the PACE regulations. It outlines the makeup of the IDT and their roles and responsibilities. It then covers development of plans of care, participant/caregiver involvement, progress notes, monitoring health status and documentation, revisions to plan of care, and continuous plan of care monitoring and evaluation.

9. Chapter 9: **Organization's Relationship With Health Care Providers** - This chapter deals with employed and contracted staff competencies, orientation, training, immunization and physical health, contract provisions, requirements of institutional contractors and practitioners or suppliers, special rules for emergency care, and documenting contractor compliance.

10. Chapter 10: **Quality Assessment and Performance Improvement** – This chapter defines the PACE quality assessment and performance improvement plan, quality assessment activities, reporting requirements, process for performing root cause analysis, Health Outcomes Survey – Modified (HOS-M), and additional required reporting.

11. Chapter 11: **Grievances and Appeals** – Chapter 11 defines grievances and appeals, then details internal processes, standard and expedited appeals, additional appeal rights, and Medicare- or Medicaid-only appeal rights.

12. Chapter 12: **Medical Records Documentation** – The first section of the chapter outlines the medical records documentation requirement, content, availability, and documentation of disruptive or threatening behavior for involuntary disenrollment; maintenance, safeguarding, and retention of records; HIPAA policy, and electronic record management.

13. Chapter 13: **Payments To PACE Organizations** - This chapter gives an overview of the policies and methods CMS follows in determining the amount of payment a PACE organization will receive for coverage of benefits for PACE participants who are enrolled in their plan as provided by 42 CFR § 460.180 of the PACE Regulations. Topics covered include: payment principles, PACE organization responsibilities, payment methodology, and PACE premiums.

14. Chapter 14: **Coordination Of Benefits** - The purpose of the Coordination of Benefits (COB) process is to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. This chapter covers Part C Medicare Secondary Payer provisions and Medicare Part D Coordination of Benefits (COB).

15. Chapter 15**: Organization Monitoring and Auditing** - The PACE program agreement is a three-way agreement between the PACE organization, CMS and the State Administering Agency. Monitoring and auditing are the responsibility of CMS and the State Administering Agency. Chapter 15 encompasses general monitoring and auditing requirements; the audit, post-audit, and disclosure of results processes; roles, duties, and responsibilities of the State Administering Agency; financial recordkeeping and reporting requirements, and Health Plan Management System (HPMS) quality data submission.

16. Chapter 16: **Sanctions, Enforcement Actions and Termination** - When compliance actions fail to achieve the desired result or an instance of non-compliance is especially egregious, CMS may take enforcement action. CMS recognizes that in addition to the sanctions, enforcement actions and termination set forth in this chapter, each State will have their own actions that may be implemented when a PACE organization is out of compliance. This chapter of the PACE Manual covers the following topics: types of enforcement and circumstances of use, violations for which CMS might impose sanctions, suspension of enrollment or payment, civil monetary penalties, additional actions, termination, transitional care, and termination procedures.

17. Chapter 17: **Application and Waiver Processes, and Program Agreement Requirements** – The first section of this chapter provides an overview of CMS and State Administering Agency roles and responsibilities. The next section covers the PACE provider application, expansion application, and Benefits Improvement and Protection Act (BIPA) 903 waivers. The third section covers State roles and addresses the PACE State Plan Amendment, State Readiness Review, and State contract. The fourth section details the contents of the three-way PACE program agreement and the final section stipulates that PACE organizations must coordinate with CMS and the SAA whenever a change in ownership is contemplated or planned.

18. Appendix I: **Glossary** – List of terms and acronyms used throughout the PACE Manual and in cited or referenced documents.

IV. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

V. ATTACHMENTS:

	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	One-Time Notification -Confidential
	Recurring Update Notification