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1.0 Description of the Procedure, Product, or Service

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. Most PACE participants are dually eligible for Medicare and Medicaid benefits, and all are certified eligible for nursing facility level of care according to the standards established by the state Medicaid agency.

The PACE program utilizes monthly capitated payments from Medicare and Medicaid to provide an integrated and comprehensive medical and social service delivery system for elderly individuals who prefer to receive services in the community rather than at a nursing facility. PACE uses an interdisciplinary team to provide services at the PACE Center and to case manage the care and services provided to PACE participants by community providers.

The PACE program is located in the community and centered in a certified adult day health program. Services are provided on site and supplemented by in-home and referral services in accordance with each participant's needs.

2.0 Eligible Recipients

2.1 Eligibility Requirements for Participants

2.1.1 Financial Eligibility

To qualify for PACE, an individual shall meet financial eligibility requirements for Long-Term Care Medicaid/PACE established for North Carolina Medicaid by the Division of Medical Assistance (DMA), as documented in 10A NCAC 21B.0101 and .0102.

2.1.2 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:

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

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

PACE does not serve recipients 21 years of age or younger; therefore, the provisions of 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act] relating to Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children do not apply.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Medicaid pays a monthly capitation fee to the PACE organization for eligible recipients participating in the PACE program when the service is medically necessary and

- a. the individual meets Medicaid's requirements for nursing facility level of care, as determined by Medicaid's level of care screening tool (refer to **Subsection 5.5**);
- b. the level of care determination is confirmed by a comprehensive assessment conducted by the PACE organization (refer to **Subsection 5.6**); and
- c. the recipient meets the requirements indicated in **Subsection 2.1**.

3.3 Continuation of Service in the Absence of Criteria

A PACE participant may be deemed eligible if, following enrollment, the participant no longer meets nursing facility level of care criteria; but the state determines, in accordance with applicable regulations, that the absence of PACE services would result in a deterioration of the individual's health status to the point where the individual would again qualify for PACE within a six-month period following disenrollment.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

Medicaid does not pay a monthly capitation fee to the PACE organization when the participant does not meet the criteria in **Subsection 3.2** and **Subsection 3.3**.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

No prior approval is required for PACE enrollment; however, the need for nursing facility level of care must be confirmed by the state's Level of Care Review and the PACE organization's assessment as described in **Subsection 5.6**.

5.2 Enrollment Requirements

5.2.1 Enrollment Agreement

When the participant meets the eligibility requirements and wants to enroll, he or she shall sign an enrollment agreement that contains the minimal information under 42 CFR 460.154.

5.2.2 Enrollment Documentation

The PACE organization must give a participant, upon signing the enrollment agreement, all of the information set forth in 42 CFR 460.156.

5.2.3 Effective Date of Enrollment

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.

5.2.4 Continuation of Enrollment

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.

5.3 Sole Source of Services

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 DMA.

5.4 Participant Disenrollment from PACE

5.4.1 Voluntary Disenrollment

In accordance with 42 CFR 460.162, a PACE participant may voluntarily disenroll from PACE at any time without cause.

5.4.2 Involuntary Disenrollment

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

5.4.3 Procedures for Involuntary Disenrollment

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

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

5.4.4 Effective Date of Disenrollment

- a. The PACE provider 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).
- b. 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).
- c. 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 460.166).

5.5 Nursing Facility Level of Care Review

5.5.1 Initial Level of Care Review

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.

5.5.2 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).

5.6 Assessments

5.6.1 Physical, Functional, and Psychosocial Assessment

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.

5.6.2 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:

- a. the individual is considered to be unsafe when left alone, with or without a Personal Emergency Response System;
- b. 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;
- c. the individual's needs can not be supported by the system of services that is currently available;

- d. the individual's residence is not reasonably considered to be habitable; or
- e. 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 Organizations staff if PACE services are to be provided in the residence;
- f. the individual's behavior is disruptive or threatening or is otherwise harmful (e.g. suicidal, injurious to self or others, or destructive of environment); or
- g. 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:

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

5.7 Plan of Care

Following the required assessments, the PACE program must develop a plan of care on an Electronic Health Record (EHR) or form approved by DMA and submit it to DMA for approval. As required by 42 CFR 460.106 (d), the plan of care must be updated and submitted to DMA for approval semi-annually.

5.8 Benefit Package

The PACE benefit package 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.

5.9 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 that has a home care agency license under 10A NCAC 13J. or by community providers under contract with the PACE program in the manner as set forth in 42 CFR 460.70 and in compliance with 460.71. An individual licensed by the North Carolina Board of Nursing as a Registered Nurse shall provide supervision of the Nurse Aide as under 10A NCAC 13J.1110. The Nurse Aide providing direct care shall be registered as a Nurse Aide I or Nurse Aide II with DHSR and the NCBON.

5.10 Emergency Care Services

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

5.10.1 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.

5.10.2 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.

5.10.3 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.

5.10.4 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.

5.10.5 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.

5.10.6 Cost of Emergency Care

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

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall:

- a. meet Medicaid's qualifications for participation;
- b. be currently enrolled with N.C. Medicaid; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Note: For the purposes of this policy billing does not apply, however the criteria in **Section 6.0** must apply in order to receive payment. Refer to **Subsection 6.3**.

6.1 PACE Regulations

The PACE program must comply at all times with the federal PACE regulations specified in 42 CFR Parts 460; Programs of All-Inclusive Care for the Elderly (PACE).

6.2 Certification Requirements

As required by N.C. G.S 131D-6 and 10A NCAC 06S, the PACE center must be certified as an adult day health program by the North Carolina Division of Aging and Adult Services.

6.3 Capitated Payment and Amounts

6.3.1 Payment for PACE Participants

The state provides a prospective monthly capitated payment for each PACE participant who is eligible for Medicaid assistance, in accordance with Section 1934(d) of the Act and 42 CFR 460.180. The capitation payment amount is specified in the PACE program Agreement and is based on the amount the state would otherwise have paid under the State plan if the recipients were not enrolled in PACE.

6.3.2 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

- a. the organization has been approved by DMA as a PACE provider;
- b. the organization has been approved by CMS as a PACE provider; and
- c. all parties have properly executed the three-way agreement between CMS, DMA, and the PACE organization.

Since the PACE program is designed to serve individuals who are Medicare and Medicaid dually eligible and must accept the capitation payments from Medicare and Medicaid as payment in full for all services required by the participant.

6.3.3 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 or Medicaid-only beneficiaries.

7.0 Additional Requirements

7.1 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.

7.2 Reports to DMA

Sections 1894 and 1934 of the Social Security Act (the Act) allow states to impose additional requirements on PACE programs. As such, DMA requires PACE programs to provide copies of all participant Physical, Functional, and Psychosocial Assessments, and Health and Safety Assessments, and other reports and documents as may be appropriate to DMA on a form or in a format approved by DMA.

7.3 Provision of Service

7.3.1 Service Area

As required by 42 CFR 460.32(a)(1), the PACE program must define its service area. The service area must be approved by DMA and CMS.

7.3.2 PACE Center

As defined by 42 CFR 460.98(d)(1), the PACE program must establish an adult day health care program that includes a primary care clinic, areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining, which serve as the focal point for coordination and provision of most PACE services.

7.3.3 Interdisciplinary Care and Case Management

The PACE program must establish an 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 comprised of members as under 42 CFR 460.102(b).

7.4 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.

7.5 Medical Record Documentation

The PACE organization must maintain a single comprehensive medical record for each participant. At a minimum, the medical record must include the information and documentation specified in 42 CFR 460.210.

7.6 Medical Record Retention

In accordance with 42 CFR 460.200, medical records must be maintained in an accessible location for at least six years after the last entry date or six years after the date of disenrollment.

Note: If litigation, a claim, a financial management review, or an audit arising from the operation of the PACE program is started before the expiration of the retention period, the PACE organization must retain the records until the completion of the litigation or resolution of the claims or audit findings.

7.7 Claims and Encounter Forms

7.7.1 Claims

The PACE organization does not submit claims to Medicare or Medicaid for any service provided to PACE enrollments, in or out of the service area.

7.7.2 Encounter Forms

The PACE program is not required to submit encounter forms to Medicare or Medicaid.

8.0 Policy Implementation/Revision Information

Original Effective Date: February 1, 2008

Revision Information:

Date	Section Revised	Change
7/1/11	Section 1.0	Updated standard DMA policy template language and revised language related to LOC determination
7/1/11	Section 2.0	Updated standard DMA policy template language
7/1/11	Section 3.0	Updated standard DMA policy template language
7/1/11	Section 4.0	Updated standard DMA policy template language
7/1/11	Section 5.0	Cited Federal Regulations that address each specific section and removed extraneous language that is clearly stated in the cited Federal Regulation and some grammatical errors were corrected
7/1/11	Subsection 5.6.2	Revised Health, Safety and Well-being Criteria
7/1/11	Subsection 5.7	Added reference to Electronic Health Record and added requirement that POC be revised and submitted semi-annually
7/1/11	Subsection 5.9	Corrected Federal Regulation Citations
7/1/11	Section 6.0	Updated standard DMA policy template language, Corrected Federal Regulation Citations, and corrected grammatical errors.
7/1/11	Section 7.0	Updated standard DMA policy template language, cited Federal Regulations that address each specific section or subsection and removed extraneous language that is clearly stated in the cited Federal Regulation. Some grammatical errors were corrected and more appropriate terms were used to replace those words that were in the approved clinical coverage policy.

Attachment A: Claims-Related Information

Attachment A is not applicable to the PACE program

A. Claim Type

Not applicable.

B. Diagnosis Codes

Not applicable.

C. Modifiers

Not applicable.

D. Billing Units

Not applicable.

E. Place of Service

Not applicable.

F. Co-payments

Not applicable.

G. Reimbursement

Not applicable.