LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

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

OAAS-MAN-23-002

# Table of Contents

# I. Purpose and Authority

This manual sets forth operational procedures for the Program for All-Inclusive Care for the Elderly (PACE), and is considered the authority, along with the Centers for Medicare & Medicaid Services (CMS) PACE Manual, LDH Medicaid PACE Provider Manual, the Louisiana Administrative Code (LAC) 50:XXIII and Title 42 Code of Federal Regulations (CFR) Part 460, under which the Office of Aging and Adult Services (OAAS) and the PACE providers must abide.

PACE is an optional Home and Community-Based Service under the Medicaid State Plan. The objectives of PACE are to:

- Enhance the quality of life and autonomy for frail, older adults;
- Enable frail, older adults to live independently in the community, rather than be institutionalized, as long as medically and socially feasible;
- Maximize the dignity and respect for older adults; and
- Preserve and support the older adult's family unit, as per the participant's wishes.

Using an individualized Plan of Care (POC), PACE provides comprehensive health care services based on the participant's individual needs with the goal of enabling PACE participants to continue to live in the community with proper support for as long as possible. Services provided to PACE participants can include any Medicare and Medicaid covered services, along with other services determined necessary, by the PACE interdisciplinary team (IDT), to maintain or restore PACE participants' independence in order to remain in their home. PACE participants receive all of their healthcare and long-term care services and supports through their PACE provider's network.

It is the responsibility of the PACE providers to ensure that their programs and facilities are operating in accordance with the requirements outlined in the rules, standards, statutes, regulations, and other documents as promulgated in accordance with state and federal law.

# II. Eligibility for PACE

There are three items that determine eligibility for PACE: Program Eligibility Requirements; Nursing Facility Level of Care (NFLOC); and Financial eligibility.

## A. Program Eligibility Requirements

1. Be 55 years of age or older;
2. Live in a PACE provider service area. Approved service areas can be found on the PACE Fact Sheet, OAAS-RC-09-006.
3. Have the capability to live in a community setting with PACE services without jeopardizing the individual's health or safety (See Section III).

## B. Nursing Facility Level of Care (NFLOC) Eligibility

Louisiana uses the interRAI Home Care (iHC) assessment to determine if an individual meets NFLOC, as established by the State of Louisiana. This assessment not only determines NFLOC, but also evaluates the needs, strengths, and preferences of the individual. PACE staff that conduct these assessments must be trained and certified by OAAS before completing the iHC assessments for potential PACE participants. OAAS offers iHC assessment and care planning trainings on a regular basis. The training schedule can be found at https://ldh.la.gov/page/assessment-and-care-planning-trainings. PACE assessors are not required to complete the care-planning portion of the OAAS training as PACE develops their own care plan that includes multi-disciplinary input.

For more information regarding NFLOC, refer to the OAAS Nursing Facility Level of Care Eligibility Manual, (OAAS-MAN-13-005).

## C. Financial Eligibility

PACE services are reimbursed by Medicaid, Medicare, private pay, or a combination of these payment sources. Long-Term Care (LTC) Medicaid eligibility is key to many participants being able to afford the PACE program. If a PACE participant is LTC Medicaid eligible, they are not required to pay any amount toward their services. This also holds true for someone who is dually eligible for LTC Medicaid and Medicare. If a PACE participant is only eligible for Medicare, the participant must pay the premium as determined by 42 CFR 460.186.

Any payment made for PACE services is paid directly to the PACE provider.

### 1. Medicaid Eligibility

Financial eligibility for Medicaid-funded programs is determined by Louisiana Medicaid. There are maximum income and resource limits announced each year by the Louisiana Department of Health (LDH) Medicaid division. Any Medicaid eligibility questions must be referred to the appropriate Louisiana Medicaid office. A PACE participant that is eligible for LTC Medicaid will not have out-of-pocket expenses for PACE, unless a participant uses unauthorized out-of-network services. Capitated Medicaid payments are made to the PACE providers monthly by Louisiana Medicaid and the rates are established through a methodology of an Amount that Would Otherwise be Paid (AWOP) if the participant were not receiving PACE services. PACE providers are paid per member, per month.

**2. Medicare and Medicaid Eligibility (Dual Eligibility)**

Medicare eligibility will be determined by the PACE provider and verified by the Long-Term Care Medicaid section. For participants who are eligible for Medicare and Medicaid, separate rates will be paid to the PACE provider by Louisiana Medicaid and CMS. The Medicare rate is determined by CMS and sent directly to the PACE provider from CMS. The majority of PACE participants are eligible for LTC Medicaid and Medicare.

**3. Medicare Eligibility**

Medicare will pay a rate directly to the PACE provider. A participant who is not eligible for LTC Medicaid, but is eligible for Medicare will pay a monthly premium to the PACE organization as per 42 CFR 460.186.

**4. Private Pay**

PACE providers are able to accept participants who are willing to pay PACE for their services out-of-pocket.

**NOTE: All PACE participants, regardless of payor source, are eligible to receive ALL services covered by Medicare and Medicaid, along with other services deemed needed by the IDT. Each PACE participant has an individualized POC developed by an interdisciplinary team. That POC includes the services that are specific to the PACE participant's needs.**

# III. Accessing PACE Services

## A. Completing the LOCET

All potential PACE participants must first complete a Level of Care Eligibility Tool (LOCET) screening through the Long Term Care (LTC) Access contractor, prior to participating in the iHC assessment that is performed by PACE staff. If the LOCET indicates that the individual preliminarily meets NFLOC, the LTC Access Contractor will link the applicant to the PACE provider using the Home and community Based Services (HCBS) tab in the OAAS Participant Tracking System (OPTS) and enter an end date of 120 calendar days in the future. The linkage referral in OPTS is completed at the time of the call between the participant (and/or the representative) and the LTC Access Contractor. The LTC Access Contractor will then email the PACE provider notifying them that the applicant has an approved LOCET and has been linked referral to their agency via OPTS.

If the applicant's LOCET results in a denial, the referral to the PACE provider will not occur; however, the PACE provider is notified of the LOCET denial and the individual's interest in PACE. A PACE referral will not be made unless the individual preliminarily meets NFLOC as per the completed LOCET.

Once an applicant has been determined to preliminarily meet NFLOC as per the completed LOCET, the PACE provider will perform the iHC assessment. NFLOC eligibility is not confirmed until the iHC assessment is completed and the iHC indicates that NFLOC is met.

## B. PACE Enrollment

**NOTE: If, at any time during the enrollment process, an applicant decides not to enroll in PACE, the PACE provider will alert the OAAS RO within 3 business days. OAAS RO will document this withdrawal appropriately in SharePoint.**

Once an individual indicates interest in the PACE program, the PACE provider will:

- Explain the PACE program requirements and services to the applicant.
- Review the PACE provider's enrollment agreement with the applicant and have them sign.
- Assess the applicant's needs using each IDT member's expertise.
- Arrange for the applicant to complete at least one in-person visit to the PACE center.
- Conduct at least one home visit with the applicant to assess their home environment.
- Determine NFLOC:
    - If the applicant has not completed a LOCET, refer them to the LTC Access Contractor (call 1-877-456-1146) to have a LOCET completed.
    - Once the applicant has completed a LOCET, and they are determined to preliminarily meet NFLOC, the PACE provider will continue with the process (see the "Completing the LOCET" section above for more details).
    - Conduct a face-to-face iHC assessment to confirm that the applicant meets NFLOC.
        - All information necessary to complete the iHC assessment **MUST** be gathered within 3 days of the Assessment Reference Date (ARD) which is the date of the in-person, iHC face-to-face contact.
        - The completed iHC assessment **MUST** be entered into OPTS within 5 business days from the date of completion.

- Review the iHC in OPTS. The PACE staff person that will be approving the iHC assessment must complete a thorough review of the assessment to make sure everything is accurate.

- Assist the applicant with completing the LTC Medicaid application.
  - PACE will assist the applicant with completing the LTC Medicaid application. LTC Medicaid eligibility is not a requirement for PACE services, but it makes PACE a more affordable service for many.
  - PACE will send the completed LTC Medicaid application with the 148-P to PACE@LA.gov. Medicaid requires 10 business days to perform the asset verification.

Medicaid will:

- Determine LTC Medicaid eligibility;
- If LTC Medicaid eligibility is not met, a Medicaid Decision Notice with appeal rights will be sent to the applicant, the OAAS RO and the PACE provider. A denial of LTC Medicaid eligibility is not a denial of PACE eligibility. A person can still enroll in PACE and pay privately.
- If LTC Medicaid eligibility is met, a Medicaid Decision Notice will be issued to the applicant, the OAAS RO, and the PACE provider.

  **NOTE: If an individual is determined to be Medicaid ineligible, but meet the PACE enrollment eligibility, they may still enroll in PACE and pay privately for services.**

The OAAS RO will:

- Upload all required documents into the applicant's e-file on SharePoint.
- Remove the end date from the OPTS HCBS tab for PACE.
- Confirm that NFLOC is met.
- Review the 148-P form and the enrollment packet to ensure the desired admission date is the 1st of the month following the month that PACE eligibility was approved.
- Complete the Bureau of Health Services Financing (BHSF) 142 form, Medicaid Notice of Medical Certification, for PACE enrollment.
- Email the completed BHSF 142 form to LTC Medicaid (PACE@LA.gov) by the 25th of the month, copying the PACE provider.

## 1. Approval of PACE Eligibility

- Completing the iHC to determine NFLOC - The PACE staff person that approves the iHC in OPTS is also responsible for making sure the iHC is accurate. The iHC should be approved in OPTS **before** sending the enrollment information to the OAAS RO.
    - Notify OAAS RO (See Appendix A for a complete list of OAAS ROs and their contact information) by email once the iHC assessment has been entered, completed, reviewed and approved by PACE staff in OPTS. The body of the email should indicate that NFLOC was met and on which Pathway (PW). Attach the signed enrollment agreement and the 148-P to the email. There should only be one email sent to the OAAS RO when requesting enrollment. Incomplete submissions will result in a delay of the approval process and 142 submission by the OAAS RO to LTC Medicaid.
    - If an applicant meets NFLOC on either the ADL or Cognitive PW, the 148-P and the signed enrollment agreement must be attached to the email notifying the OAAS RO of the applicant. This must be done by the **15th of the month** to ensure enrollment by the 1st of the following month.
    - If an applicant meets NFLOC on the Treatments and Conditions PW, Physician Involvement PW, or Skilled Rehabilitation Therapies PW, the required documentation showing that the PW was met must either be in the iHC notebook or uploaded to the iHC in OPTS. The documents should **not be** sent as attachments to the email. If all necessary information is not provided, enrollment will be delayed until the OAAS RO has the information needed to confirm that NFLOC is met. **The OAAS RO cannot proceed until proper documentation is provided.** This must be done by the **15th of the month** to ensure enrollment by the 1st of the following month.
    - If an applicant meets NFLOC on the Behavior PW, OPTS will provide acknowledgement that NFLOC is met.

      **NOTE: The Behavior PW was eliminated in 2016; however, if an applicant met this PW prior to the elimination, the applicant may be grandfathered into this PW under specific circumstances.**

- **Exception:** If PACE suspects that the potential participant meets NFLOC on the Service Dependency PW, the PACE provider will send an email to the OAAS RO so they may confirm that the Service Dependency PW was met **prior to** approving the iHC. There is no way for PACE staff to know this without OAAS confirmation.
    - If OAAS RO confirms that NFLOC is met in the Service Dependency PW, they will respond to the email stating that NFLOC is met. PACE staff will then approve the iHC in OPTS and send the 148-P and signed enrollment agreement to OAAS RO by email.
    - If OAAS RO cannot confirm that NFLOC was met on the Service Dependency PW, they will reply to the email stating that NFLOC is not met. The PACE staff may then begin the denial process.

- Determining whether or not a safe POC can be developed - Based on information gathered during the assessment process, the PACE provider will determine whether or not a safe POC can be developed that will allow an applicant to live safely in the community with PACE services.

  The PACE provider **MUST be able to** develop a POC that is adequate to ensure the participant's medical, physical, social and emotional needs. The determination of whether an applicant can be cared for in the community at the time of enrollment without jeopardizing their safety is bases on the PACE provider's evaluation and assessments of the enrollee. The following are issues to consider when making the determination:
    - Applicant does not have the capability to call for emergency assistance, or does not have the capability to determine when emergency assistance is needed.
    - A physician, familiar with the applicant's health and social history, has documented a condition that requires 24-hours, 7 days per week of skilled care.
    - The applicant's residence:
        - Has been condemned;

- Has been determined unsafe for habitation by the PACE provider (detailed documentation of this determination is required); or
- Poses a threat to the PACE staff due to:
  - Physical condition and integrity of the dwelling;
  - Evidence of abuse and/or neglect form other household members;
  - Criminal activities or behavior;
  - Illegal drug use in the home;
  - Brandishing of weapons; or
  - Dangerous pets or other animals in the home.

- The applicant exhibits health concerns that involve dangerous behavior(s) that would pose a threat to the individual, other PACE participants, or PACE staff.
- The applicant's current medical treatment or regimen requires 24-hours supervision and their care is more appropriately provided in an institutional setting (hospital or skilled nursing facility).

- If the PACE provider determines that a safe POC can be developed, the enrollment process of submitting the iHC information and 148-P to OAAS RO will continue as outlined above under "Approval of PACE Eligibility".

  **NOTE: If the OAAS RO does not receive the completed PACE enrollment packet by the required deadlines, Medicaid may not be able to process the enrollment so that services can begin on the 1st day of the month following the month OAAS RO received the completed packet. This will delay the applicant's PACE enrollment to the next 1st day of the month. The PACE enrollment date will ALWAYS be the 1st day of the month.**

**2. Denial of PACE Enrollment**

- NFLOC is not met.
  - If the applicant does not meet NFLOC, the PACE provider must alert the OAAS RO within 3 business days of the determination.
  - OAAS RO sends the applicant a denial notice with appeal rights and copies the PACE provider.

- If the applicant appeals this decision, the appeal will be heard by the Division of Administrative Law (DAL).
- OAAS RO staff will be present at the hearing to defend OAAS' NFLOC process.
- The PACE provider will be present at the hearing to defend the information contained in the iHC assessment.

- Safe POC Cannot be Developed – If, prior to enrollment, the PACE provider determines that an applicant's health and safety cannot be ensured with PACE services, the PACE provider shall submit the following to the OAAS PACE Program Manager within 5 business days of the decision:
  - Justification summary for the determination that health and safety cannot be ensured; and
  - Any and all assessments and medical records used to make the determination.
- The OAAS PACE Program Manager will review the information for completeness and prepare a referral form to be sent to the OAAS Service Review Panel (SRP). SRP is an internal OAAS panel that reviews all requests where there is a question about the appropriateness of an OAAS service.
- After reviewing the documentation, if SRP disagrees with the PACE provider and determines that with PACE services in place, a POC can be developed that is adequate to ensure that the applicant's physical, medical, social, and emotional needs are met, SRP will provide the PACE provider with:
  - Reasons why SRP believes that PACE services are adequate; and
  - Suggestions for services that would be sufficient to ensure a safe POC.
- After reviewing the documentation, if SRP agrees with the PACE provider that PACE services are not adequate for the applicant, SRP will send an email to the PACE provider acknowledging and agreeing with the health and safety concern.
- If the applicant is denied enrollment because their health or safety would be jeopardized by living in a community setting, the PACE provider **MUST**:

- Notify the individual in writing of the reason for the denial with notification of appeal rights through the fair hearing process;
- Provide a copy of the denial notice to the appropriate OAAS RO and the PACE Program Manager;
- Refer the individual to alternative services, as appropriate;
- Maintain supporting documentation of the reason for the denial;
- Notify CMS in the form and manner specified by CMS, and provide the documentation for review, as requested by the State and CMS; and
- Provide the documentation for review, as requested by the State and CMS.
- The PACE Program Manager will send the SRP decision to the OAAS RO for their records.

  **NOTE: Once the denial letter with appeal rights has been sent, a new assessment should NOT be completed unless there was a change in the applicant's or participant's health status warranting a new assessment.**

# IV. PACE Services

## A. Mandatory Services

The following services are mandatory under PACE:

- All Medicare covered services;
- All Medicaid services provided in the approved Medicaid State Plan for Louisiana; and
- Other services determined necessary by the 11 member IDT to improve and maintain overall health status.

## B. Excluded Services

The following services are excluded under PACE:

- Cosmetic surgery that is not required to improve functioning or to repair an injury to a part of the body resulting from an accidental injury or for reconstruction following a mastectomy.
- Health procedures that are experimental.

- Services outside of the United States other than those permitted under Louisiana's Medicaid State Plan or those permitted according to 42 CFR 424.122 and 424.124.

### C. PACE Nursing Facility Services

A participant's physical, social, emotional and mental health could indicate that nursing facility services are the best alternative for that person. Nursing Facility services are services provided by the PACE provider after exhausting all possible options to help the person remain in the community. Nursing facility services can be provided for short-term or long-term stays depending on the needs of the individual. Discharge planning should always be part of the Nursing Facility Admissions (NFA) process. Nursing facility services, as with all PACE services, must be approved by the IDT.

A LOCET is **NOT** required when a PACE participant enters a nursing facility.

When nursing facility services are deemed appropriate, the PACE provider must:

- Have a justification prepared by the IDT that nursing facility services are the necessary option.
- Notify OAAS NFA of the intent to admit the PACE participant.
- Have the PACE medical staff complete a Level I Preadmission Screening and Resident Review (PASRR).
- Document on the front page of the PASRR that the participant is a PACE participant.
- If the Level I PASRR indicates a mental illness or developmental disability, the participant is referred to the appropriate Level II authority, either the Office of Behavioral Health (OBH) or OCDD for a final determination if needed specialized services.

  **NOTE: If nursing facility care is determined to be the service needed for a participant during the enrollment process, PACE services would not be appropriate for that individual. The person would be denied enrollment due to the participant requiring institutional services.**

## V. Annual Recertification for NFLOC

Federal regulations require that, at a minimum, PACE participants be reassessed annually to ensure that the PACE participant meets the NFLOC eligibility criteria.

Once PACE staff completes the annual recertification using the iHC:

- PACE staff will review the iHC and ensure that it is accurate, enter it into OPTS and approve the iHC which indicates that the PACE organization confirms accuracy.
- PACE staff will notify the OAAS RO that the iHC has been completed, entered into OPTS. The body of the email should indicate whether or not NFLOC is met, and if so, the PW that NFLOC was met on. The iHC should be approved before alerting the OAAS RO that the annual reassessment was completed.
    - If NFLOC is met on either the ADL or Cognitive PW, no other documentation is needed.
    - If a participant meets on the Treatments and Condition PW, the Physician Involvement PW, or the Skilled Rehabilitation Therapies PW, documentation showing that the PW was met must either be documented in the iHC notebook or uploaded to the iHC in OPTS. **The documents must not be attached to the email.**
    - If PACE suspects that the potential participant meets NFLOC on the Service Dependency PW, the PACE provider will send an email to the OAAS RO so they may confirm that the Service Dependency PW was met **prior to approving the iHC**. There is no way for PACE staff to know this without OAAS confirmation.
        - If OAAS RO confirms that NFLOC is met on the Service Dependency PW, RO will respond to the email stating the PW has been met.
        - If OAAS RO cannot confirm that NFLOC is met on the Service Dependency PW, then the discharge process will begin.
- If NFLOC is indicated as met and the required documentation is not attached, the participant will not be considered to have met NFLOC until the documentation is received by OAAS RO. OAAS RO will request the information needed and the PACE provider will have 5 business days to provide the documentation. If the information is not received by the deadline, OAAS RO will proceed with an involuntary discharge based on NFLOC not being met.
- If NFLOC is indicated as met and all documentation is provided, and a request for Permanent Waiver of Annual Recertification (OAAS-PF-13-009) is included, the process for approving/disapproving a Request for Permanent Waiver of Annual Recertification will be completed (see the Permanent Waiver of Annual Recertification section of this manual).
- If NFLOC is not met, OAAS RO will proceed with an involuntary discharge (see the PACE Disenrollment Section of this manual) unless there is a request for Deemed Continued Eligibility (OAAS-PF-13-009). If there is a request for Deemed Continued Eligibility, that process will be completed (see the Deemed Continued Eligibility section of this manual).

## VI. Permanent Waiver of Annual Recertification

While annual recertification of NFLOC eligibility is a federal requirement, federal regulations allow OAAS to permanently waive this requirement for a PACE participant, 42 CFR 460.160(b)(1). To permanently waive the annual recertification of NFLOC, which in Louisiana means completion of the iHC, OAAS must determine that there is no reasonable expectation of improvement in the participant's condition because of the severity of a chronic condition or due to the degree of impairment of functional capacity.

The PACE provider may request a Permanent Waiver of Annual Recertification at the time of the annual reassessment. To make this request, the participant must be an enrolled PACE participant and meet NFLOC on the annual reassessment.

**NOTE: Requests for Permanent Waiver of Annual Recertification CANNOT be made or granted upon initial enrollment to the PACE program unless the potential participant meets on the Service Dependency PW.**

When a PACE provider believes a Permanent Waiver of Annual Recertification is justified, the PACE provider will:

- Complete and submit the request on the PACE form for a Permanent Waiver of Annual Recertification (OAAS-PF-13-009), with clear justification and supporting documents to the OAAS RO, copying the OAAS PACE Program Manager, within 60 calendar days from the date of the participant's completed annual iHC assessment. PACE staff must ensure that NFLOC is met and ALL needed documentation is attached before making the request.
- Attach supporting documents, which can include:
    - A clear Justification Summary Statement from the appropriate IDT member(s) on the PACE form (OAAS-PF-13-009) that has the reason why the participant meets the permanent waiver of annual recertification criteria as described in this policy.
    - Supporting documentation from the participant's medical record and POC to support the Justification Summary Statement.
    - Supporting documentation that clearly demonstrates that the participant meets one or more of the following criteria:
        - The participant has a fragile medical condition(s) with no reasonable expectation of improvement due to the severity of the chronic condition or the degree of functional capacity (e.g. someone receiving dialysis treatments, quadriplegia, severe dementia, Alzheimer's disease, amyotrophic lateral sclerosis, Friedreich's ataxia, multiple sclerosis, severe/late stage Parkinson's disease, etc.)

- The participant had a significant increase in the severity of a chronic condition or functional capacity (e.g. nearing the end of life, living with a chronic or progressive irreversible disease).
- The participant is residing in a nursing facility for an indefinite stay with no expectation of the participant's condition improving.

- If additional information is requested by the OAAS RO, the PACE provider must submit the additional information within 5 business days from the date of the request. If OAAS RO does not receive the requested information within the required timeframe, OAAS RO will proceed with the denial of the Permanent Waiver of the Annual Recertification.

  **NOTE: Participants who meet solely on the Behavior PW are not eligible for a permanent waiver. Participants meeting on the Service Dependency PW will automatically be approved by the OAAS RO for a permanent waiver.**

Once the request for a permanent waiver is received, OAAS RO will:

- Review the submitted request for Permanent Waiver of Annual Recertification (OAAS-PF-13-009) Justification Summary Statement, the completed and approved iHC, and supporting documentation.
- Determine if the submitted Justification Summary Statement and supporting documentation is adequate to support the request.
- If the RO does not believe that the documentation supports approving the participant's permanent waiver of annual certification, more information can be requested and/or an in-person visit can be made by the RO staff.
- The following are examples that may cause the RO to question the need to grant a permanent waiver.
  - Participants that have an ADL Index score of 6 or lower on the iHC, unless the participant receives dialysis and is not expected to stop receiving dialysis or also meets on another PW.
  - Requests where an OAAS staff member determines that, based on the documentation provided, it is unclear if the person could improve and may not meet NFLOC or need PACE services the following year.

    Examples:

    - A participant meets NFLOC on the Cognitive Performance PW, has a temporary diagnosis associated with cognitive issues such as a urinary tract infection (UTI) and has never shown cognitive deficits in the past;
    - A recent accident that increased the need for ADL assistance temporarily.

- Not approve a Permanent Waiver request for participants that meet NFLOC on only one of the following PW: the Physician Involvement, Treatments and Conditions or Skilled Rehabilitation Therapies unless the person is on dialysis with an indication that dialysis will continue indefinitely. Once the RO has sufficient information to make a decision, RO will respond to the PACE provider, copying the OAAS PACE Manager, indicating approval or a denial on the Request of Permanent Waiver of Annual Recertification (OAAS-PF-13-009). The RO will make a decision within 10 business days of having all needed documentation.

If OAAS RO determines that the participant **meets** the Permanent Waiver of Annual Recertification eligibility criteria, OAAS RO will:

- Notify the PACE provider, in an email via the Permanent Waiver of Annual Recertification form (OAAS-PF-13-009) copying the OAAS PACE Program Manager.
- Enter the following notation in the iHC Notebook of the participant's applicable iHC assessment in OPTS:

  **"Permanent Waiver of Annual Recertification eligibility met on insert date."**
- Upload the signed and dated OAAS-PF-13-009 into the documents section of the applicable e-file in SharePoint.
- Indicate on the SharePoint entry that the permanent waiver was approved and include the date of the approval.

  **NOTE: If the permanent waiver is granted, the PACE provider will no longer be required to conduct an annual iHC reassessment on that participant for level of care determination, unless requested by OAAS. Federally required IDT assessments and plan of care updates must continue to be performed at least every 180 calendar days to ensure that all needed services continue to be provided.**

If OAAS RO determines that the participant **does not** meet the Permanent Waiver of Annual Recertification eligibility criteria, RO will:

- Complete the PACE form (OAAS-PF-13-009) indicating the reason for the denial.
- Submit the completed form to the PACE provider, notifying PACE of the requirement to continue to assess the participant annually using the iHC to determine NFLOC.
- Enter the following notation in the participants applicable iHC notebook in OPTS:

  **"Request for Permanent Waiver of Annual Recertification eligibility criteria and supporting documentation, including the participant's POC, were reviewed by OAAS. Criteria for Permanent Waiver of Annual Recertification was NOT MET on insert date."**

The OAAS RO must also include in the iHC notebook all actions OAAS took in making this decision, e.g. documents reviewed, in-person visit to meet with PACE participant/staff, follow-up telephone conversations/emails requesting more information, etc. In lieu of a notebook entry, this information can be written on the form and uploaded as an attachment to the iHC.

- Upload the signed and dated OAAS-PF-13-009 into the documents section of the iHC.
- Indicate on the SharePoint entry that the permanent waiver request was denied and include the date of the denial.

The PACE provider may resubmit a request for permanent waiver of annual recertification with the next annual assessment, if the participant meets NFLOC. RO is responsible for confirming a PACE participant's NFLOC eligibility annually unless a permanent waiver of recertification is granted.

## VIII. Deemed Continued Eligibility

If a PACE participant does not meet NFLOC after the NFLOC annual recertification is completed using the iHC, PACE staff can request "Deemed Continued Eligibility", 42 CFR 460.160(b)(3), for the participant. Deemed Continued Eligibility is approved if the OAAS RO finds justification that the participant will meet NFLOC eligibility within the next 6 months if PACE services are not delivered. If approved, a participant is deemed continued eligible until the next annual reassessment/recertification. A participant cannot be granted Deemed Continued Eligibility two years in a row, so NFLOC must be met at the next annual recertification.

In cases where the PACE provider completes the annual iHC assessment and the participant **DOES NOT** meet NFLOC, but the PACE provider believes the participant meets the criteria for deemed continued eligibility, the PACE provider must submit the following:

- A Request for Deemed Continued Eligibility form (OAAS-PF-13-009) to OAAS RO, copying the OAAS PACE Program Manager, within 5 business days of determining that NFLOC is not met. The form shall include a brief Justification Summary with supporting documentation stating why, in the absence of PACE services, the participant would be expected to meet NFLOC within the next 6 months. Supporting documentation may include:
    - A copy of the participant's POC;
    - Medical Record showing a diagnosis of a chronic medical condition that can cause a functional decline due to fluctuation in severity of the condition (i.e. multiple sclerosis, diabetes, ataxia, etc.);

- Records showing a history of change in needs when services are discontinued; and/or
- Documentation noting the loss of a primary caregiver that has historically provided assistance with activities of daily living and instrumental activities of daily living.

If the form is not submitted within 7 business days, OAAS RO will proceed with a denial of eligibility and issue a discharge notice.

The OAAS RO will:

- Review the provided justification documentation to determine Deemed Continued Eligibility is warranted and that the participant:
  - Requires PACE services to assure health or safety in the community;
  - Requires PACE services to remain healthy due to a chronic condition; or
  - Would likely meet the eligibility criteria for a NF within the next 6 months without PACE services.
- Schedule an in-person visit to gather needed information to approve/disapprove the request, if information gathered from meeting the participant and seeing their home environment is needed to make the decision.
- Respond to the PACE request for Deemed Continued Eligibility with an approval, denial or a request for information within 10 business days of receipt of the request.
- Notify the PACE provider, copying the OAAS Program Manager, of the decision in writing on the Deemed Continued Eligibility form OAAS-PF-13-009.
- Indicate on the SharePoint entry form if the request is approved or denied with the date the action was taken
- Enter one of the following notations in the applicable iHC Notebook:
  - If approved: **"Deemed Continued Eligibility criteria met on insert date for continuation of PACE program until next annual reassessment, which is due by insert date.**
  - If not approved: **"Deemed Continued Eligibility criteria was not met on insert date.**
- Upload the signed and dated OAAS-PF-13-009 into the documents section of the iHC.
- If the participant does not meet NFLOC and does not meet the criteria for Deemed Continued Eligibility, OAAS RO will issue a discharge notice, with appeal rights, from PACE services to the participant, copying the PACE provider.

# IX. Medicaid Recertification

If a review of Medicaid eligibility shows that:

- A PACE participant continues to meet the requirement for LTC Medicaid, Medicaid will issue a notice to the participant stating that eligibility will continue and send a copy to the OAAS RO and the PACE provider.

  **OR**

- A PACE participant no longer meets the requirements for LTC Medicaid eligibility, Medicaid will issue a notice with appeal rights and send copies to the OAAS RO and the PACE provider.
  - The PACE provider will assist the person to provide documentation that shows that the participant is still eligible for Medicaid.
  - The PACE provider will let the participant know that their Medicaid ineligibility does not make them ineligible for PACE; however, if the participant chooses to continue receiving PACE services, the participant will be responsible for paying the monthly PACE payment.
  - If the participant does not have proper documentation and is no longer interested in PACE services, the PACE provider will issue a 148-P discharge and submit it to the OAAS RO and Medicaid.

# X. PACE Disenrollment

## A. Voluntary Disenrollment

A participant may request to voluntarily disenroll from PACE without cause at any time.

Disenrollment may be requested verbally or in writing. The PACE provider can request that the participant sign a prepared voluntary disenrollment agreement to ensure that everyone has an understanding of the consequences of disenrollment.

The effective date of disenrollment is on the first day of the month following the date the PACE provider receives the participant's notice of voluntary disenrollment.

A PACE provider must ensure that its employees or contractors do not engage in any practice that would reasonably be expected to have the effect of steering or encouraging disenrollment of participants due to a change in health status.

Once the participant gives notice that they wish to voluntarily disenroll, the PACE provider will:

- Notify the OAAS RO in writing of the date of notice, the specific reason for disenrollment and the date of disenrollment for the participant making the request;
- Prepare and submit the Form 148-P discharge to OAAS RO and to LTC Medicaid that includes the reason for the voluntary disenrollment;
- Schedule a disenrollment meeting with the participant's team to take place prior to the date of disenrollment to determine where records should be sent and if any referrals are needed to assure continuity of health services;
- Request the participant complete an exit survey that gathers information that can be used to improve the quality of services.

The OAAS RO will:

- Process the Form 148-P for closure by electronically signing, saving and uploading the form to the Louisiana Medicaid Eligibility Determination System (LaMEDS).
- Disassociate the participant from the PACE provider in OPTS using the official date of disenrollment, which is always the 1st day of a month, and send the processed Form 148-P to the PACE provider and Medicaid.
- Document in the participant's activity log and file the documents in the participant's electronic file (e-file).
- Complete the disenrollment entry form in SharePoint adding the reason for the voluntary disenrollment in the comments section.

### B. Involuntary Disenrollment

PACE providers and OAAS must follow an involuntary disenrollment process if a PACE participant is determined to meet any of the criteria listed below for involuntary disenrollment from PACE services in accordance with 42 CFR 460.164.

- The participant, after a 30-day grace period, fails to pay or make satisfactory arrangements to pay any premium due the PACE provider.
- The participant, after a 30-day grace period, fails to pay or make satisfactory arrangements to pay any applicable Medicaid spend down liability or any amount due under the post-eligibility treatment of income process, as permitted under §§ 460.182 and 460.184.
- The participant or the participant's caregiver engages in disruptive or threatening behavior, as described in "Disenrollment Based on Disruptive or Threatening Behavior" later in this section.

- The participant is noncompliant with the plan of care, scheduled appointments and/or not heeding medical advice provided by the PACE provider as described in "Disenrollment due to Noncompliance" later in this section.
- The participant moves out of the PACE provider service area or is out of the service area for more than 30 consecutive days, unless the PACE provider agrees to a longer absence due to extenuating circumstances.
- The participant is determined to no longer meet the State Medicaid NFLOC requirements and is not deemed eligible (See "See Deemed Continued eligibility section).
- The participant is found to no longer meet the requirement for LTC Medicaid (See "Disenrollment based on loss of Medicaid" later in this section). **This is not an automatic involuntary disenrollment, and should be considered as a voluntary disenrollment by the PACE provider.**
- The PACE program agreement with CMS and LDH-OAAS is not renewed or is terminated.
- The PACE provider is unable to offer health care services due to the loss of State licenses or contracts with outside providers.

### C. Disenrollment Based on Disruptive or Threatening Behavior

For those participants being involuntarily disenrolled due to disruptive or threatening behavior as specified by 42 CFR 460.164, the PACE provider must provide documentation of the behavior(s) along with documentation of all efforts made to address the situation to the PACE Program Manager prior to acting on the disenrollment.

The PACE provider will:

- Notify the PACE Program Manager of the proposed involuntary disenrollment.
- Submit a summary of the disruptive behavior and the outcomes of such behavior along with the documented attempts to resolve the problem and the outcome of those attempts.
- Submit all documentation supporting the involuntary disenrollment to the PACE Program Manager.

The PACE Program Manager will:

- Review the involuntary disenrollment request and all supporting documentation. Perform an in-person visit to meet the participant or review documents, if warranted.

- Request more information, if needed, from the PACE provider within 3 business days of the request for involuntary disenrollment.
- Prepare and send a referral to the OAAS Service Review Panel (SRP).

SRP will:

- Review the documentation provided and make a decision regarding the proposed involuntary disenrollment within 10 business days.
    - If SRP disagrees with the PACE provider and believes that service to the participant should continue, SRP will provide the PACE provider with:
        - Reasons why SRP believes PACE services should continue;
        - Suggestions that could help remedy the situation.
        - The PACE Program Manager will instruct the PACE provider to continue services deemed necessary by the participant's POC, which should include input by the participant and the participant's family, as applicable.
    - If SRP agrees with the PACE provider regarding the involuntary discharge, SRP will send an email to the PACE provider acknowledging and agreeing with the proposed involuntary discharge.

The PACE provider will:

- Notify the participant in writing of the reason for the involuntary disenrollment with notification of appeal rights through the State Fair Hearing process, if applicable.
- Provide a copy of the disenrollment notice to the appropriate OAAS RO and the PACE Program Manager.
- Provide applicable referrals/recommendations for alternate healthcare options.
- Continue to provide PACE services at least until the participant is back in the Medicare and/or Medicaid systems.
- If an appeal is filed timely, continue services until a decision has been made.
- Maintain supporting documentation of the reason for involuntary discharge.
- Notify CMS in the form and manner specified by CMS.
- Provide the documentation for review, as requested by the state and CMS.

The PACE Program Manager will send the SRP decision to the RO for their records.

### D. Disenrollment Due to Non-Compliance

For those participants being involuntarily disenrolled due to non-compliant behavior as specified by 42 CFR 460.164, the PACE provider must provide documentation of the incidents along with documentation of all efforts made to address the situation to the OAAS PACE Program Manager.

The PACE provider will:

- Notify the OAAS PACE Program Manager of the proposed involuntary disenrollment.
- Submit a summary of the non-compliance and the outcomes of such behavior along with the all attempts to resolve the problem and the outcome of those attempts to the OAAS PACE Program Manager.
- Submit all documentation supporting the involuntary disenrollment to the OAAS PACE Program Manager.

The OAAS PACE Program Manager will:

- Review the involuntary disenrollment request and all supporting documentation. Perform an in-person visit to meet the participant or review documents, if warranted.
- Request more information from the PACE provider within 3 business days of the request for involuntary disenrollment.
- Prepare and submit a referral to the OAAS Service Review Panel (SRP).

SRP will:

- Review the documentation provided and make a decision regarding the proposed involuntary disenrollment within 10 business days.
  - If SRP disagrees with the PACE provider and believes that service to the individual should continue, SRP will provide the PACE provider with:
    - Reasons why SRP believes PACE services should continue; and
    - Suggestions that could help remedy the situation.
    - The PACE Program Manager will instruct the PACE provider to continue services deemed necessary by the participant's POC, which should include input by the participant and the participant's family, as applicable.
  - If SRP agrees with the PACE provider regarding the involuntary discharge, SRP will send an email to the PACE provider acknowledging and agreeing with the proposed involuntary discharge.

The PACE provider will:

- Notify the participant in writing of the reason for the involuntary disenrollment with notification of appeal rights through the State Fair Hearing process.
- Provide a copy of the disenrollment notice to the appropriate OAAS RO and the PACE Program Manager.
- Provide applicable referrals/recommendations for alternate healthcare options.
- Continue to provide PACE services at least until the participant is back in the Medicare and/or Medicaid systems.
- If an appeal is filed timely, continue services until a decision has been made.
- Maintain supporting documentation of the reason for involuntary discharge.
- Notify CMS in the form and manner specified by CMS.
- Provide the documentation for review, as requested by the state and CMS.

The OAAS PACE Program Manager will send the SRP decision to the OAAS RO for their records.

**E. Disenrollment Due to Not Meeting NFLOC (and Deemed Continued Eligibility is not requested/approved)**

If the reason for involuntary discharge is due to the participant not meeting NFLOC, a discharge notice with appeal rights will be issued by OAAS.

The PACE provider must:

- Notify the appropriate OAAS RO within 7 business days of the assessment reference date.
- Continue services until it is learned whether or not a timely appeal is filed.

OAAS RO will:

- Review the iHC to confirm that NFLOC is not met.
- Issue a discharge notice, with appeal rights, based on not meeting NFLOC.

**F. Disenrollment Due to Loss of Medicaid Eligibility (does not result in automatic disenrollment)**

If a person loses Medicaid eligibility, Medicaid will issue a notice with appeal rights notifying the person that Medicaid will no longer pay for PACE services. **Loss of Medicaid does not mean that someone is ineligible for PACE.**

The PACE provider should discuss with the person the benefits and costs to remain in PACE without Medicaid eligibility.

If the participant chooses to disenroll from PACE, the PACE provider will submit the 148-P to the OAAS RO. OAAS RO will disassociate the person from the PACE

provider in OPTS on the first day of the next month and complete the disenrollment in SharePoint.

**NOTE: In accordance with 42 CFR 460.164(a), involuntary disenrollments are effective on the 1st day of the next month that begins 30 calendar days after the day the PACE provider sends notice of the disenrollment to the participant.**

For **ALL** disenrollments, PACE providers will complete the Form 148-P showing discharge.

- When any discharge occurs, voluntary or involuntary, the PACE staff will complete the Form 148-P showing the discharge from the PACE provider, including the reason for discharge. (If the disenrollment is voluntary, the PACE staff will state the reason.)
- PACE providers will send the completed 148-P to the PACE Program Manager, the OAAS RO, and to PACE@LA.gov.

**NOTE: Voluntary disenrollments are effective on the 1st day of the month following the participant's notification of disenrollment. Involuntary disenrollments are effective the 1st day of the next month that begins 30 days after the day the PACE organization sends the notice of the disenrollment to the participant.**

## XI. Complaints and Grievances

The PACE provider is required to have a grievance process, that complies with 42 CFR 460.120 for all complaints received whether that grievance/complaint is oral or in writing. The PACE provider **must**:

- Provide the written grievance procedure to the PACE participant at least annually;
- Document each grievance;
- Respond to and resolve grievances in a timely manner;
- Maintain confidentiality of a participant's grievance;
- Continue care during the grievance process;
- Analyze information and data derived from grievances to be included in the quality improvement program; and
- Provide details of each grievance and/or an aggregate grievance analysis and data to OAAS, as requested.

## XII. Appeals

PACE participants have the right to appeal service determination requests, eligibility determinations (i.e. NFLOC, enrollment denial and Medicaid eligibility), and involuntary

disenrollment. The PACE provider has an obligation to assist the person with filing an appeal and choosing the most appropriate route for the appeal.

The OAAS RO will send notices with appeal rights when PACE services are being denied based on the person not meeting NFLOC.

The PACE provider will send notices with appeal rights for denials of Service Determination Requests, disenrollment based on noncompliance, discharges based on disruptive behavior and denial of enrollment based on not being able to develop a safe POC.

Medicaid will send notices with appeal rights for applicants and PACE participants who do not meet LTC Medicaid eligibility.

The PACE provider's internal appeals process must adhere to 42 CFR 460.122, and include:

- How to file the internal appeal;
- Appointment of an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal to review the participant's appeal;
- Providing a written decision on the appeal to the participant no later than 30 calendar days after receiving the appeal; and
- A process for expedited appeals in situations where the PACE participant believes that not having the service would place the participant's life, or their ability to function in jeopardy.

If the PACE provider denies the appeal, the PACE participant has the right to file a second level appeal using the processes provided by LDH's Fair Hearing Process or by Medicare, depending on their eligibility for either. A participant with both Medicaid and Medicare must choose to file a fair hearing with either LDH's Fair Hearing Process or Medicare, but cannot use both.

The Internal PACE appeal does not have to be exhausted prior to filing an appeal with Louisiana DAL but it is strongly recommended that the PACE appeal process be completed before filing an appeal with DAL.

The PACE provider has the obligation of completing and submitting the Summary of Evidence packet to DAL, if an appeal with DAL is filed.

### A. Medicare Appeals

If a Service Determination Request is denied, reduced or terminated, a PACE participant who is Medicare eligible can request an appeal using the Medicare process. The participant must file with the independent review entity within 60 calendar days from the date of the decision by the internal PACE provider review. The PACE provider has an obligation to assist the individual with filing the appeal. A

participant cannot file an appeal through the Medicaid **AND** Medicare process, one or the other must be chosen.

### B. Medicaid Appeals

Medicaid appeals are heard by Louisiana's Division of Administrative Law (DAL). The following appeals could be heard by DAL:

- **Service Determination Request Appeals (SDR)**

  The PACE provider has an obligation to assist the participant with filing the appeal.

  If a timely appeal is filed with the DAL for a service being presently received, the PACE service(s) will continue until a decision is rendered. Appeal deadlines will be part of the written notice denying, reducing or terminating a service. Steps taken following the receipt of a timely appeal request include:

  - DAL will notify the participant, OAAS and the PACE provider of the pending appeal.
  - PACE staff will complete the Summary of Evidence (SOE) for the appeal hearings relative to a SDR, submitting a copy to the DAL and to the PACE Program Manager. The PACE provider staff will represent their decision to the DAL during the hearing.
  - Once a judgement is received, the PACE provider will comply with and implement any required action per the decision.

  If a timely appeal is not filed, services will be terminated or reduced effective the last day of the month that the discharge or denial/reduction of services was issued. If DAL upholds the PACE provider's decision, PACE participants can file a second level appeal in state court.

### C. NFLOC Not Met

The LDH Fair Hearing Appeals process through the Division of Administrative Law is also used for appeals related to PACE eligibility, including a NFLOC ineligibility determination.

- If a PACE participant or applicant chooses to file an appeal due to a denial of NFLOC, the appeal would be filed with the DAL. OAAS RO staff will complete the SOE for denial of PACE services for not meeting NFLOC. (OAAS RO staff must comply with OAAS Appeals SOE submission process).
- The PACE defends the iHC assessment contents during an appeal.

### D. PACE Provider is Not Able to Develop a Safe POC

If a PACE applicant that is Medicaid eligible is denied enrollment based on the PACE provider not being able to develop a safe POC, an appeal can be filed with DAL. The PACE provider prepares the summary of evidence and defends their decision to deny eligibility to the applicant.

**E. Denied Medicaid Eligibility**

If a PACE applicant or current PACE participant is denied Medicaid eligibility, the individual will receive a notice with appeal rights from Louisiana Medicaid. If an appeal is filed, the DAL will hear the appeal. The Summary of Evidence is prepared by Louisiana Medicaid.

**NOTE: A denial of Medicaid Eligibility does not mean that a person is ineligible for PACE services.**

If the DAL agrees with the PACE provider or OAAS regarding the adverse action, PACE services can be discontinued. However, a person does have the right to pursue another level of appeal in State Court. The PACE provider is not automatically obligated to continue services while that appeal is in process.

## VIII. Transfers Between HCBS Programs and OPTS Linkage

If an OAAS CCW or ADHC Waiver participant declines their waiver in order to participate in the PACE program, the participant will have 90 calendar days from the PACE enrollment date to request a voluntary disenrollment from PACE and apply for reinstatement back into the waiver program. After 90 calendar days from the PACE enrollment date, the individual will have to reapply to the OAAS Request for Services Registry (RFSR) in order to be eligible for another waiver offer.

An individual's iHC and LOCET data information is entered and saved in OPTS. To maintain confidentiality and remain HIPAA compliant, an individual's information in OPTS cannot be accessed/viewed until the individual is "linked" to the PACE provider via the HCBS tab in OPTS. By linking the individual, the PACE provider will have access to the individual's records in OPTS. To remove the PACE provider's access, an end date is entered in OPTS and the agency will no longer have access to the record after that date.

If an individual is in the PACE enrollment process and receives a waiver offer, the OAAS RO links the individual to an SCA in OPTS on the HCBS tab., The PACE end date **should not be adjusted** until the person has been enrolled in the PACE program or certified for waiver or decided for any reason to discontinue the PACE enrollment process.

- If the individual is linked to a PACE provider in OPTS, and decides not to enroll in PACE, the OAAS RO will:
    - Complete the 148-P and 142 form, and submit both forms to Medicaid.
    - Add the appropriate PACE provider end date on the HCBS tab in OPTS.

- If the individual is certified for waiver and voluntarily disenrolls from PACE, the OAAS RO office will:
    - Add the appropriate end date for PACE.
    - Not add an end date for the SCA.

  **NOTE: Disenrollment from PACE does not occur until the 1st day of the month after the disenrollment request.**

If an individual is actively enrolled in PACE and receives a waiver offer, the OAAS RO links the SCA in on the HCBS tab in OPTS and an end date for PACE services **should not be entered** until the person has been waiver certified.

- If the individual is not waiver certified (declines or does not meet wavier eligibility/requirements) the OAAS RO will enter an end date for the SCA link on the HCBS tab. An end date for PACE services will not be entered.
- If the individual elects to transfer from PACE to another HCBS waiver, the support coordinator, OAAS RO, Medicaid analyst and PACE provider will coordinate an end date for PACE (always the last day of the month) and the begin date/vendor payment date for the waiver program (any day after the last day of the month of PACE disenrollment). For the sake of continuity of care, it should be for the 1st day of the month with the understanding that there could be a delay in vendor payment date. The OAAS RO should enter the end date for the PO link on the HCBS tab on the date of discharge from the PACE program.

## IX. Transfers from One PACE Provider to another PACE Provider

There will be times when a PACE participant will move to another area served by a PACE provider. In these situations, parties at Medicaid, OAAS Regional office and the PACE provider should work together to make this move as seamless as possible. The goal should be to have the participant transfer with no break in services.

- **Participant's Responsibility**
    - Inform their current PACE provider that they are voluntarily disenrolling and they are interested in continuing PACE services with another provider.
    - Work with both PACE providers to assure a smooth transition.
- **Current PACE Provider's Responsibility**
    - Complete the 148-P discharge form and submit it to the appropriate OAAS RO.
    - Assist the participant, if necessary, with contacting the new PACE provider.
    - Inform the appropriate OAAS RO, PACE@LA.gov, and the new PACE provider that a participant wants to transfer to another PACE provider.

- Have the participant sign consent forms so that the current PACE provider may send the participant's records, including the deemed eligibility or permanent waiver status, to the new PACE provider.

- **New PACE Provider's Responsibility**
  - Be sure the participant has alerted the current PACE provider of their intent to disenroll.
  - Complete the 148-P enrollment form and submit to the appropriate OAAS RO informing them that the participant is transferring from another PACE provider.
  - Assist the participant with signing the PACE enrollment agreement.
- **Current OAAS Regional Responsibility**
  - Process the 148-P Discharge form and send it to PACE@LA.gov with a clear explanation that the participant is transferring to another PACE provider.
  - Add the new PACE provider to the HCBS tab in OPTS.
  - Close the current PACE provider on the HCBS tab in OPTS on the disenrollment date.
- **New OAAS Regional Office Responsibility**
  - Process the 148-P enrollment form and prepare the 142. Submit these documents to PACE@LA.gov with a clear explanation that the person is transferring from another PACE provider.
  - Determine if the participant is currently deemed eligible or has a permanent waiver. If they do, make sure that the new PACE provider is aware.
- **Medicaid Responsibility**
  - Disenroll the participant from the current PACE provider and enroll the participant in the new PACE provider on the same date so that there is no lapse in services.

### A. PACE-to-PACE Transfer Process (see Appendix B for a process flow chart)

1. Participant must alert the current PACE provider of their intent to disenroll. During this conversation, the current PACE provider should ask if the participant is moving to another area in Louisiana with access to PACE services. In this situation, the current PACE provider should inform the participant that they may still receive PACE services in their new location.
2. The current PACE provider will prepare the 148-P discharge form. The 148-P should be submitted to the appropriate OAAS RO and to Medicaid with a clear explanation that the participant intends to enroll with a new PACE provider. It is strongly suggested that the current PACE provider contact their designated

Medicaid enrollment staff to let them know that a participant is transferring to a new PACE provider.

3. The current PACE provider assists the participant with contacting the new PACE provider
4. The current PACE provider will have the participant sign consent forms so that the current PACE provider may send the participant's records, including the deemed eligibility or permanent waiver status, to the new PACE provider.
5. The current OAAS RO will process the 148-P discharge form and assign the new PACE provider the appropriate OPTS rights so that they can view the iHC assessment in OPTS using the HCBS tab. The current PACE provider's rights in OPTS should end on the date when enrollment to the new PACE provider begins.
6. The new PACE provider does not have to complete a new iHC assessment. However, the new PACE provider will use the date on the current iHC assessment to determine when the annual iHC must be completed.
7. The new PACE provider will complete the 148-P enrollment form and the PACE enrollment agreement. These documents must be submitted to the appropriate OAAS RO with a clear explanation that the participant is transferring from one PACE provider to another.
8. The new RO will complete the 142 and submit the form to PACE@LA.gov with a clear explanation that the participant is transferring from one PACE provider to another.
9. Medicaid will make the enrollment change; however, they do not have to complete a new Medicaid application. If possible, document should be submitted to Medicaid prior to the 3rd business day from the end of the month.

**NOTE: PACE enrollment and disenrollment must occur on the 1st day of the month. The goal is for the participant to transfer from the current PACE provider to the new PACE provider on the same day so there is no lapse in services.**

## X. Quality Improvement

PACE providers must have a designated Quality Improvement Coordinator and an established committee, with community input, to evaluate the data collected and address the implementation of the quality improvement plan (42 CFR 460 Subpart H).

## A. Quality Improvement Plan

A PACE provider must develop, implement, maintain, and continually evaluate an effective, data-driven quality assessment and performance improvement program. The program must reflect the full range of services furnished by the PACE provider.

A PACE provider must take actions that result in improvements in its performance in all types of care.

A PACE provider must have a written quality assessment and performance improvement plan. The PACE governing body must review the plan annually and revise it, if necessary.

At a minimum, the plan must specify how the PACE provider proposes to meet the following requirements:

- Identify areas to improve or maintain the delivery of services and patient care.
- Develop and implement plans of action to improve or maintain quality of care.
- Document and share with PACE staff and contractors the results from the quality assessment and performance improvement activities.

## B. Quality Improvement Program

The PACE providers quality improvement program must include the use of objective measures to demonstrate improved performance with regard to the following:

- Utilization of PACE services, such as showing a decrease in unplanned hospitalizations and emergency room visits.
- Caregiver and participant satisfaction.
- Outcome measures that are derived from data collected during assessments, including data on the following:
    - Physiological well-being;
    - Functional status;
    - Cognitive ability;
    - Social/behavioral functioning; and
    - Quality of life of participants.
- Effectiveness and safety of staff-provided and contracted services, including the following:
    - Competency of clinical staff;
    - Promptness of service delivery; and
    - Achievement of treatment goals and measurable outcomes.

# XI. Benefits Improvement and Protection Act (BIPA) 903 Waiver Requests

Section 903 of the Benefits Improvement and Protection Act (BIPA) of 2000 addresses flexibility in exercising the waiver authority provided under sections 1894(f)(2)(B) and 1934(f)(2)(B) of the Social Security Act. Section 903 of the BIPA allows for specific modifications or waivers of certain regulatory provisions to meet the needs of PACE providers.

## A. Provisions that Cannot be Waived

- The focus on frail, elderly qualifying individuals who require the level of care provided in a nursing facility;
- The delivery of comprehensive, integrated acute and long-term care services;
- The IDT approach to care management and service delivery;
- Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals; and
- The assumption by the provider of full financial risk.

## B. PACE Responsibilities

- Notify the OAAS PACE Program Manager via email of the intent to request a BIPA 903 Waiver and the reason for submittal a minimum of 10 business days prior to desired date of submission to CMS.
- Provide OAAS with the full written request within 5 business days of the desired date of submission to CMS.
- Respond to any questions, edits or requests for more information from OAAS staff regarding the BIPA 903 Waiver.
- Submit the BIPA 903 Waiver to CMS once written approval has been received from OAAS.

## C. OAAS Responsibilities

- Upon receipt of notification of the intent to submit, research the need for the BIPA 903 Waiver and request information that will be needed, if any, for OAAS approval.
- Review the final submission and provide approval or denial within 2 business days of the desired date of submission.
- Continue to work with the PACE provider if the request is denied by OAAS and more information or edits to the request would be needed for OAAS to be able to approve the BIPA 903 Waiver for submission.

# XII. Recordkeeping, Reports and Record Retention

## A. Recordkeeping

The PACE provider must have written policies to:

- Safeguard all data, books and records against loss, destruction, unauthorized use or inappropriate alteration;
- Safeguard the privacy of information that identifies a particular participant; and
- Grant participants timely access to their own records, upon request.

## B. Reports

The PACE provider must collect data, maintain records, and submit reports as required by CMS and LDH.

The PACE provider must submit all agency required reports to monitor the operation, cost, quality, and effectiveness of the program to CMS and LDH, as requested.

## C. Record Retention

In accordance with State and Federal laws, participant records **MUST** be retained for the longest of the following periods:

- In an accessible location for at least six (6) years from the last entry date 42 CFR 460.200;
- For medical records of disenrolled beneficiaries, six (6) years after the date of disenrollment 42 CFR 460.200; and
- If litigation, a claim, a financial management review, or an audit arising from the operation of PACE is started before the expiration of the retention period, the PACE provider must retain the records until the completion of the litigation or resolution of the claim or audit findings.

# XIII. Fiscal Soundness

A PACE provider must be fiscally sound according to 42 CFR 460.80 and as demonstrated by:

- Total assets are greater than total unsubordinated liabilities;
- Sufficient cash flow and adequate liquidity to meet obligation as they become due; and
- A net operating surplus or a financial plan for maintaining solvency.

A PACE provider must have an Insolvency plan to assure continuation of benefits to participants and protection of participants from liability for payment of fees that are the PACE provider's liability.

A PACE provider must have a plan to cover expenses, which can be done through insolvency insurance, hold harmless arrangement, letters of credit, guarantees, net worth, etc.

## XIV. OAAS Auditing/Monitoring

OAAS will meet with PACE providers each quarter to discuss and review topics, which can include, but are not limited to, the following:

- Enrollments;
- Voluntary disenrollments;
- Involuntary disenrollments;
- Requests for Deemed Continued Eligibility;
- Requests for Permanent Waiver status;
- Service Determination Requests;
- Grievances/Complaints;
- Licensing regulations;
- Service Delivery;
- Appeals; and/or
- Quality Improvement Plans.

OAAS may conduct other on-site or remote auditing/monitoring as determined necessary. OAAS will review Service Determination Requests with each PACE provider quarterly.

## XV. Criminal History Background Checks

PACE providers must complete criminal history background checks on employees upon hire. In addition employee names must be checked using the Louisiana Adverse Actions list and the Office of Inspector General (OIG) Excluded Individuals database upon hire, and monthly for the duration of employment.

- PACE providers must keep documentation showing that the list has been reviewed monthly. This can be done by printing or downloading the list and screening it against the PACE employee roster or any other way that works for the PACE provider. A statement that it was done will not be sufficient. There should be evidence that these database checks are completed monthly.
    - To use the Louisiana State Adverse Actions List, you use the following link https://adverseactions.ldh.la.gov/SelSearch/. When utilizing the Adverse Actions list, users have the option to run a single person or multi person search. Users also have the ability to export the entire list by clicking the "export" button.

This will export the list into an excel format, where the PACE provider can bump the list to see if any current employees appear.

- To use the OIG List of Excluded Individuals database, you use the following link https://oig.hhs.gov/exclusions/exclusions_list.asp. This link will take you to the LEIE Downloadable Databases where you can select the CSV file under LEIE Database for name comparison.

- In addition, PACE providers are required to have each employee complete the "Compliance Training for Covered Persons" upon hire and annually.
- When onsite monitoring is conducted by LDH, proof of monthly checks against Louisiana State Adverse Actions and the OIG List of Excluded Individuals list/databases will be requested and reviewed for compliance, as well as, reviewing employee training records to assure that the "Compliance Training for Covered Persons" is completed as required.

## XVI. Marketing Materials

**All PACE providers' marketing materials must be approved by CMS and OAAS as per federal guidance.**

Marketing materials are uploaded by the PACE provider into the CMS Health Plan Management System (HPMS) system for review by OAAS and CMS.

A prospective PACE provider shall not use marketing materials until there is a signed program agreement and the materials have been approved by CMS and OAAS.

Marketing materials must inform a prospective PACE participant that they must receive all needed health care services, including primary care and specialist physician services (other than emergency services), from the PACE provider or an entity authorized by the PACE provider. Marketing materials must state clearly that PACE participants may be fully and personally liable for the costs of unauthorized or out-of-PACE program agreement services.

Website content, including ongoing changes to the website, for each PACE provider must also be uploaded to CMS HPMS system for review and approval by OAAS and CMS. Websites must be compliant with the Americans with Disabilities Act and Section 508 of the Rehabilitation Act of 1973, as amended in 1998 (29 U.S.C. § 798, Section 508.

CMS and OAAS must review marketing materials within 45 calendar days of submission. Materials that are submitted and not reviewed within the 45-day timeline are deemed approved.

All marketing materials (written and online) must be in a font that is accessible to people with vision impairments. Examples of acceptable fonts are block style fonts such as Calibri, Arial and Verdana. All marketing material text must be in at least a 14 point font. Items such as

the issue date and other information not pertinent to the marketing information can be in a smaller font.

## XVII. Sanctions and Corrective Actions

If LDH determines that the PACE provider is found to be noncompliant with regulations, policies or procedures within 42 CFR 160, LDH will alert CMS to the alleged violation, which could lead to corrective action or sanctions by LDH, CMS or both.

If LDH determines that the PACE provider is found to be noncompliant with the PACE Medicaid Provider Manual, the Louisiana Administrative Code or the OAAS PACE Procedures manual, the PACE provider may be required to provide a Corrective Action Plan.

For egregious noncompliance or repeat offenses of any relevant laws or regulations, LDH may issue Sanctions as allowed for in the Louisiana Surveillance and Review System rule. (See LAC Title 50, Chapter 41).

## XVIII. National Voter Registration Act (NVRA)

PACE providers must abide by the guidelines established in the OAAS National Voter Registration Act (NVRA) Manual (https://ldh.la.gov/news/category/142). OAAS is designated as a "voter registration agency" because it provides services to people with disabilities; therefore, OAAS providers are expected to comply with the NVRA requirements.

# Appendix A – OAAS Regional Office Directory

Send all information to the appropriate OAAS Regional Office email inbox below:

| REGION # | EMAIL |
|---|---|
| **Region 1** | OAASRegion1.Waiver@LA.GOV<br>Includes Jefferson, Orleans, Plaquemines and St. Bernard parishes. |
| **Region 2** | OAASRegion2.Waiver@LA.GOV<br>Includes Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge and West Feliciana parishes. |
| **Region 3** | OAASRegion3.Waiver@LA.GOV<br>Includes Assumption, Lafourche, St. Charles, St. James, St. John, St. Mary and Terrebonne parishes. |
| **Region 4** | OAASRegion4.Waiver@LA.GOV<br>Includes Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin and Vermilion parishes. |
| **Region 5** | OAASRegion5.Waiver@LA.GOV<br>Includes Beauregard, Allen, Calcasieu, Jefferson Davis, and Cameron parishes. |
| **Region 6** | OAASRegion6.Waiver@LA.GOV<br>Includes Winn, Grant, Vernon, Rapides, La Salle, Catahoula, Avoyelles, and Concordia parishes. |
| **Region 7** | OAASRegion7.Waiver@LA.GOV<br>Includes Bienville, Bossier, Caddo, Claiborne, De Soto, Natchitoches, Red River, Sabine and Webster parishes. |
| **Region 8** | OAASRegion8.Waiver@LA.GOV<br>Includes Caldwell, Franklin, East Carroll, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union and West Carroll parishes. |
| **Region 9** | OAASRegion9.Waiver@LA.GOV<br>Includes Livingston, St. Helena, St. Tammany, Tangipahoa and Washington parishes. |

# Appendix B – PACE-to-PACE Transfer Process