OVERVIEW

The Program of All-Inclusive Care for the Elderly (PACE) is an optional home and community based service (HCBS) under the Medicaid State Plan. PACE operates under Medicare and Medicaid according to 42 CFR 460 and is a capitated, managed care program. The objectives of PACE are to:

1. Enhance the quality of life and autonomy for frail, older adults;

2. Enable frail elders to live independently in the community, rather than be institutionalized, as long as medically and socially feasible;

3. Maximize the dignity and respect for older adults; and

4. Preserve and support the older adult's family unit.

Each individual requesting PACE will undergo a functional eligibility screening that utilizes the Level of Care Eligibility Tool (LOCET), to determine if the individual meets nursing facility level of care criteria (NFLOC).

PACE applicants who have been determined to meet the requirements listed above are assessed using a face-to-face interRAI Home Care (iHC) assessment. This purpose of the assessment is to:

1. Verify eligibility qualifications;

2. Determine if program requirements are met; and

3. Identify the individual's need for support in performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

The PACE provider must:

1. Provide comprehensive health care services based on the beneficiary's individual needs with the goal of enabling beneficiaries to continue living independently in the community. The PACE beneficiaries must receive all Medicare and Medicaid services solely through the PACE provider;

2. Coordinate and provide all required services according to 42 CFR 460:90 as follows:

    a. Needed preventative services;

    b. Primary health services;

    c. Acute services; and

    d. Long term care (LTC) services; and

3. Establish and implement a written plan of care (POC) to deliver care that meets the needs of each beneficiary in all care settings 24 hours a day, every day of the year.

PACE includes all Medicare and Medicaid covered services and other services determined by the PACE interdisciplinary team (IDT) necessary to maintain or restore PACE beneficiaries' independence in order to remain in their homes or communities.

PACE providers:

1. Assume full financial risk for the beneficiary's care without limits on amount, duration, or scope of services; and

2. Are responsible for all care costs, even if the care costs exceed the monthly capitated payment they receive each month from Medicare and/or Medicaid.

Background Information

The PACE model of care is centralized on the belief that it is better for the well-being of older adults with chronic care needs and their families to be served in the community, whenever possible. In the early 1970s, a nonprofit corporation, On Lok Senior Health Services, was formed to create a community-based system of care that consisted of a comprehensive system of care combining housing and all necessary medical and social services.

In the mid-1980s, the Centers for Medicare and Medicaid Services (CMS) tested the model of care as a demonstration project. For most beneficiaries, the comprehensive service package permitted them to continue to live at home while receiving services rather than being in an institution.

The Balanced Budget Act (BBA) of 1997 established the PACE model as a permanently

recognized provider type under both the Medicare and Medicaid programs and mandated that the quality of care be monitored. This enabled states to provide PACE services to Medicaid beneficiaries as a Medicaid State Plan option. In 2004, Louisiana included PACE as an optional benefit in the Medicaid program.

Purpose of this Chapter

The Louisiana Department of Health (LDH), the Bureau of Health Services Financing (BHSF), and/or the Office of Aging and Adult Services (OAAS) implements and monitors the PACE program/providers in accordance with the federal regulations in Title 42 Part 460 of the Code of Federal Regulations (CFR) and the Louisiana Administrative Code (LAC), Title 50, part XXIII. This provider manual chapter is intended to assist the PACE provider in understanding and correctly implementing federal and state PACE policies.

These regulations are established to ensure minimum compliance under the law, equity among those served, provision of authorized services and proper fund disbursement. If there is a conflict between manual chapter material and pertinent laws or regulations governing the Louisiana Medicaid program, the latter will take precedence.

This manual chapter is intended to provide PACE providers with the information necessary to comply with their vendor contract with the state of Louisiana. Full implementation of these regulations is necessary for a provider to remain in compliance with federal and state laws and department rules.

Providers should refer to the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website at: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf for general information concerning topics relative to Medicaid provider enrollment and administration.

The LDH BHSF, OAAS, and Health Standards Section (HSS) are responsible for assuring oversight of the provision of services, licensure compliance and overall compliance with the rules and regulations.

Some services offered under the PACE program are provided by a Medicaid enrolled PACE provider that has a valid Adult Day Health Care (ADHC) license issued by LDH/HSS in accordance with the Louisiana licensing requirements for ADHC.

If the PACE provider uses their own staff to provide personal care attendant (PCA) services to PACE beneficiaries, the PACE provider must obtain a HCBS license under the PCA module from LDH/HSS.

NOTE: The PACE provider oversees all services received by the PACE beneficiary using their own staff as well as an identified network of providers with whom PACE contracts.