SERVICES

The Program of All-Inclusive Care for the Elderly (PACE) provider is able to coordinate the entire array of services for older adults with chronic care needs while allowing them to maintain independence in the home and/or community for as long as possible.

Services Provided

The PACE benefit package must include all Medicare and Medicaid covered services, in addition to other services determined necessary by the PACE interdisciplinary team (IDT) regardless of the source of payment. The PACE provider must deliver care that meets the needs of each beneficiary in all care settings 24 hours a day, every day of the year. As specified in 42 Code of Federal Regulations (CFR) 460.98(c), services must include, but are not limited to, the following:

1. Primary care services from a primary care provider as defined in 42 CFR 460.102(c), including services from one of the following:
    a. Primary care physician;
    b. Community physician;
    c. Physician assistant; or
    d. Advanced practice registered nurse;
2. Nursing services;
3. Social services from a Masters-level social worker;
4. Restorative therapy services, including services from a physical therapist or an occupational therapist;
5. Recreational therapy services;
6. Personal care attendant and supportive services;
7. Dietitian and nutritional counseling services; and
8. Meals.

Service Limitations/Exclusions

The PACE program becomes the sole service provider for Medicaid and/or Medicare beneficiaries who enroll in the PACE program. PACE beneficiaries must use the PACE provider's provider network for all health services. If allowed by the PACE provider, PACE beneficiaries may use the primary care provider of their choice.

In accordance with 42 CFR 460.96, the services that are excluded from coverage under the PACE program are as follows:

1. Any service that is not authorized by the IDT, even if it is listed as a required service, unless it is an emergency service as specified in 42 CFR 460.100;

2. Inpatient facility services for private room and private duty nursing services, (unless medically necessary) and non-medical items for personal convenience such as telephone, radio or television rental, (unless specifically authorized by the IDT as part of the beneficiary's plan of care (POC));

3. Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following a mastectomy;

4. Experimental medical, surgical, or other health procedures; and

5. Services furnished outside of the United States except as follows:

    a. In accordance with 42 CFR 424.122 and 424.124; and/or

    b. As permitted under the State's approved Medicaid Plan through a State Plan amendment.

Service Delivery

The PACE program agreement must define its service area by parish or zip code. This service area must be approved by the Centers for Medicare and Medicaid Services (CMS) and the Office of Aging and Adult Services (OAAS). CMS and OAAS must approve any change in the designated service area as required by 42 CFR 460.32(a)(1).

CMS, in consultation with OAAS, may exclude an area that is already covered under another PACE program agreement to avoid the following:

1. Unnecessary duplication of services; and

2. Impairing the financial and service viability of an existing program.

Upon enrollment, the PACE provider must:

1. Inform potential beneficiaries that it offers Medicare Part D prescription drug coverage;

2. Inform beneficiaries if they are in a PACE program, that they cannot enroll in a separate Medicare Advantage plan. By joining a separate Medicare Advantage plan, the beneficiary will be considered to have voluntarily disenrolled from PACE and the PACE provider will no longer provide the beneficiary with any healthcare services, including prescription drug benefits; and

3. Provide comprehensive care to beneficiaries who need end-of-life care.

   NOTE: If a beneficiary chooses to elect the hospice benefit from a certified hospice provider, the beneficiary must voluntarily disenroll from the PACE program.

The PACE provider must establish and implement a written POC that meets the needs of each beneficiary in all care settings, 24 hours a day, every day of the year, as specified in 42 CFR 460.98. These services are furnished in the following places:

1. PACE center;

2. Home of the beneficiary;

3. Inpatient facilities; and

4. Other referral service settings that the beneficiary may need.

   NOTE: This does not change an individual's PACE enrollment status or the capitation rate. The PACE provider shall be responsible for payment of the cost of the care in any setting.

A PACE beneficiary may need temporary or permanent placement in another health care setting

and may be placed into a nursing facility that has a contract with the PACE provider.

The PACE provider must establish and implement a written POC to deliver care that meets the needs of the beneficiary in the nursing facility. During the beneficiary's placement in the nursing facility, there must be coordination of care between the PACE provider and the nursing facility.

The PACE provider must notify OAAS Nursing Facility Admission or its designee of the nursing facility placement. A Level I Pre-Admission Screening and Resident Review (PASRR) is required before a PACE beneficiary is transferred to a nursing facility. The PACE physician shall complete the Level I PASRR. It must be documented on the front page of the PASRR that a PACE beneficiary is entering the nursing facility. If the Level I PASRR indicates mental illness or developmental disability, the case will be referred to the Level II authority, the Office of Behavioral Health or the Office for Citizens with Developmental Disabilities (OCDD), for final determination.

NOTE: A Louisiana Level of Care Eligibility Tool (LOCET) assessment is not required when a PACE beneficiary enters a nursing facility.