SERVICES

The Program of All-Inclusive Care for the Elderly (PACE) organization is able to coordinate the entire array of services to older adults with chronic care needs while allowing elders 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 organization must furnish care that meets the needs of each participant 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:

- Primary care services from a primary care provider as defined in 42 CFR 460.102(c), including services from the following:
    - Primary care physician;
    - Community Physician;
    - Physician assistant; or
    - Advanced practice registered nurse;
- Nursing Services;
- Social services from a Masters-level social worker;
- Restorative therapy services, including services from a Physical therapist or an Occupational therapist;
- Recreational therapy services;
- Personal care attendant and supportive services;

- Dietitian and nutritional counseling services; and
- Meals.

Service Limitations/Exclusions

The PACE organization becomes the sole service provider for Medicaid beneficiaries who enroll in a PACE organization. PACE beneficiaries may use the Primary Care Provider of their choice. PACE beneficiaries must use the PACE organization's provider network for all other health services.

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

- 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;
- 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);
- 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;
- Experimental medical, surgical, or other health procedures; and
- Services furnished outside of the United States except as follows:
    - In accordance with 42 CFR 424.122 and 424.124; and/or
    - 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 Centers for Medicare and Medicaid Services (CMS) and 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:

- Unnecessary duplication of services; and
- Impairing the financial and service viability of an existing program.

Upon enrollment, the PACE organization must:

- Inform potential beneficiaries that it offers Medicare Part D prescription drug coverage;
- Inform beneficiaries if they are in a PACE program, that they cannot enroll in a separate Medicare prescription drug plan. By joining a separate Medicare drug plan, the PACE beneficiary will lose his/her PACE health and prescription drug benefits; and
- 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 organization, the beneficiary must voluntarily disenroll from the PACE program.

The PACE organization must establish and implement a written Plan of 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 CFR 460.98. These services must be furnished in the following places:

- PACE center;
- Home of the beneficiary;
- Inpatient facilities; and
- 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 organization 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 organization.

The PACE organization must establish and implement a written Plan of Care to furnish 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 organization and the nursing facility.

The PACE organization 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, for final determination. A Louisiana Level of Care Eligibility Tool (LOCET) is not required when a PACE beneficiary enters a nursing facility.