GLOSSARY

This is a list of acronyms, definitions and terms used in the Program of All-Inclusive Care for the Elderly (PACE) Manual Chapter.

Activities of Daily Living (ADL) – Those activities that are required by an individual for continued well-being, health and safety. This includes basic personal everyday activities as bathing, dressing, transfer, toileting, mobility, and eating.

Adult Day Health Care (ADHC) – A group program designed to meet the individual needs of functionally-impaired adults which is structured and comprehensive and provides a variety of health, social, and related support services at a licensed day site.

Appeal – The participant's action taken with respect to the PACE organization's non-coverage of, nonpayment for a service, including denials, reductions, or termination of services.

Applicant – An individual whose written application for Medicaid or Louisiana Department of Health(LDH) funded services has been submitted to DHH but whose eligibility has not yet been determined.

Assessment – The process of gathering and integrating formal and informal information relevant to the development of an individualized Plan of Care.

Audit – An external review of the PACE organization's practices and procedures to determine compliance with CMS program requirements.

Audit Team – A group of people comprised of Centers for Medicare and Medicaid Services (CMS), State administering agency staff (SAA), or other designees who are responsible to perform a PACE organization audit.

Balanced Budget Act of 1997 (BBA) – Established PACE model as a permanently recognized provider type under both the Medicare and Medicaid programs and mandated that the quality of care be monitored.

Beneficiary – An individual who has been certified for medical benefits by the Medicaid Program. A beneficiary certified for Medicaid services may also be referred to as a participant.

Bureau of Health Services Financing (BHSF) – The Bureau within LDH responsible for the state administration of the Louisiana Medicaid Program.

Centers for Medicare and Medicaid Services (CMS - formerly HCFA) – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid and Medicare programs.

Code of Federal Regulations (CFR) – A publication by the Federal government containing PACE requirements which organizations must comply with to receive payment under Medicaid/Medicare programs.

Complaint – see Grievance.

Confidentiality – The process of protecting a participant's or an employee's personal information, as required by the Health Insurance Portability and Accountability Act (HIPAA).

Contract year – Means the term of a PACE program agreement, which is a calendar year, except that a PACE organization's initial contract year may be from 12 to 23 months, depending on the effective date of program implementation (as determined by CMS).

Corrective Action Plan (CAP) – Written description of action a provider agency plans to take to correct identified deficiencies.

Corrective Action Requirement (CAR) – A term historically used in audit report requesting a CAP from the PACE organization in response to a deficiency.

Deemed Status – PACE participants who do not meet nursing facility level of care on annual reassessment, and who in the absence of continued coverage would be expected to meet the nursing facility level of care requirements within the next 6 months.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicaid Program and public health programs.

Division of Administrative Law (DAL) – The state agency responsible for the due process system ensuring the participant has an opportunity to contest certain decisions.

Enrollment – A determination made by LDH that a provider agency meets the necessary requirements to participate as a provider of Medicaid or other LDH-funded services. This is also referred to as provider enrollment or certification.

Fiscal Intermediary (FI) – The private fiscal agent with which LDH contracts to operate the Medicaid Management Information System. It processes Title XIX claims for Medicaid services provided under the Medicaid Assistance Program, issues appropriate payment and provides assistance to providers on claims.

Grievance – a complaint, either written or oral, expressing dissatisfaction with service delivery or the quality or care furnished.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Legislation passed in 1996 that addresses security and privacy of health data and requires CMS to establish national standards of electronic health care transactions and national identifiers for providers, health plans, and employer.

Health Plan Management System (HPMS) – A CMS internal health information system that collects, analyzes, integrates, and reports data to measure the PACE organization's performance and to develop and implement procedures to furnish data pertaining to the provision of care to external oversight entities in the manner and at the time intervals specified by CMS and SAA. The system monitors the operation; costs, quality, and effectiveness of the PACE program and establish payment rates.

Health Standards Section (HSS) – The office within the Department of Health and Hospitals responsible for the licensing and certification of providers.

Interdisciplinary Team (IDT) – A group of healthcare providers from different fields who work together to provide the best care or outcome for a participant by making recommendations in a team staffing for services or interventions targeted at those needs.

InterRAI Assessments – The assessment tool used by OAAS to determine initial and continued eligibility in PACE.

Level One Event – Refers to those data elements for monitoring that are regularly reported by PACE organizations via HPMS.

Level Two Event – Unusual incidents that result in serious adverse participant outcomes, or negative national or regional notoriety related to the PACE program.

Licensure – A determination by the HSS that a service provider agency meets the requirements of state law to provide services.

Louisiana Department of Health (LDH) – The state agency responsible for administering the state's Title XIX (Medicaid) Program and other health and related services including aging and adult services, public health, mental health, developmental disabilities, and addictive disorder services.

Medicaid – A federal-state financed medical assistance program that is provided under a State Plan approved under Title XIX of the Social Security Act.

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible beneficiaries.

Medicare – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

National PACE Association (NPA) – Non-profit membership organization that represents the interests of PACE organizations. These member organizations share the goal of promoting the availability of quality, comprehensive, and cost-effective health care services to frail older adults through the PACE and similar models of care.

Nursing Facility (NF) – A facility which meets the requirements of sections 1819 or 1919 (a) (b) (c) and (d) of the Social Security Act. A nursing facility provides long term care and placement for those individuals who meet the eligibility requirements.

Office of Aging and Adult Services (OAAS) – The office within LDH that is responsible for the management and oversight of certain Medicaid home and community-based state plan and waiver programs and protective services for adults ages 18 through 59.

OAAS Regional Office (RO) – One of nine administrative offices within the Office of Aging and Adult Services.

PACE Center – The facility which includes an adult day care, a primary clinic, and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining and which serves as the focal point for coordination and provision of most PACE services.

PACE Organization – The entity that has in effect a PACE program agreement to operate a PACE under this part.

PACE Program – An optional service under the Medicaid State Plan that is a capitated, managed care program.

PACE Beneficiary/Participant – An individual who is enrolled in the PACE program.

Patient Liability (PLI) – The amount a beneficiary is responsible for paying to a provider of PACE services.

Patient Self-Determination Act (PSDA) – This Act encourages all people to make choices and decisions now about the types and extent of medical care they want to accept or refuse should

they become unable to make those decisions due to illness.

Permanent Waiver of Annual Recertification - LDH may permanently waive the annual recertification of level of care requirements for a participant if it determines that there is no reasonable expectation of improvement or significant change in the participant's condition because of the severity of a chronic condition. The PACE provider shall continue performing annual assessments.

Plan of Care (POC) – The written documentation that outlines how PACE services are delivered to the beneficiary. A written plan developed by the interdisciplinary team that is based on assessment results and specifies services to be accessed and coordinated on the participant's behalf. It includes long-range goals, assignment of responsibility, and time frames for completion or review by the interdisciplinary team.

Primary Care Physician (PCP) – A physician, currently licensed by the Louisiana State Board of Medical Examiners who is responsible for the direction of the participant's overall medical care.

Program of All Inclusive Care for the Elderly (PACE) – a comprehensive and supportive services program designed to assist those 55 or older to remain at home and in the community.

Quality Assessment and Performance Improvement Program(QAPI) – An ongoing process to objectively and systematically monitor and evaluate the quality of services provided to PACE participants, to pursue opportunities to improve services, and to correct identified problems.

Sanction –Penalty applied for failure to comply with **State and federal PACE rules.**

Service Area – The geographically designated (by zip code/parish areas) region where PACE services are provided.

Services – This includes both items and services.

State Administering Agency (SAA) – The state agency responsible for administering the PACE program.

State Readiness Review (SRR) – The purpose of this review is to determine the organization's readiness to administer the PACE program and enroll and serve participants. Every application must meet all requirements of the SRR prior to enrolling participants.

Transition – The steps or activities conducted to support the passage of the participant from existing formal or informal services to the appropriate level of services, including disengagement from all services.

Trial Period – Means a PACE Program that is operated by a PACE provider under a PACE program agreement, the first 3 years under such an agreement.