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

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Kathryn Pittelkau PACE Policy Program Manager
360.725.2366 Kathryn.Pittelkau@dshs.wa.gov

TABLE OF CONTENTS

Program of All-Inclusive Care for the Elderly (PACE) 1
Table of Contents 1
Overview of Managed Care 2
Program of All-Inclusive Care for the Elderly (PACE) 2
Offering PACE as a Choice 2
Service Providers 3
Services 4
Eligibility 5
CARE Rules & PACE Enrollees 10
Payment 11
Disenrollment 11
Grievance, Appeals and Hearing Rights 13
Resources 14
Related WACs & eCFRs 14
Acronyms 14
Glossary 15
Revision History 15
Web Resources 15

OVERVIEW OF MANAGED CARE

The purpose of the managed care service delivery model is to integrate services an individual may need in one delivery system with one payment called a capitated payment. The managed care plan must furnish all of an individual's services included in the managed care contract using this capitated payment. This puts the managed care plan at risk for high-cost services as well as creates incentives to use prevention and pro-active techniques to keep a person well.

HCA, DSHS, and CMS have contracts with managed care entities. The contract between HCA, DSHS and/or CMS and the Managed Care entity details what services are covered in the contract and what the MCO is responsible for. Contract examples include:

- Apple Health (Medicaid)
- Program for all Inclusive care for the Elderly (DSHS & CMS)
- Medicare Advantage and D-SNP (CMS)

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE stands for Program of All-inclusive Care for the Elderly. It is an innovative Medicaid/Medicare program that provides frail individuals age 55 and older comprehensive medical and social services coordinated and provided by an interdisciplinary team of professionals in a community-based center and in their homes, helping program participants delay or avoid long-term nursing home care.

Each PACE participant receives customized care that is planned and delivered by a coordinated, interdisciplinary team of professionals working at the center. The team meets regularly with each participant and his or her representative in order to assess the participant's needs. A participant's care plan usually integrates some home care services from the team or residential placement with several visits each week to the PACE center, which serves as the hub for medical care, rehabilitation, social activities, and dining.

The PACE model was developed in San Francisco in the 1970s as ON LOK, the Chinese American community's alternative to nursing home placement. It was formally established by CMS as a permanent Medicare Advantage option in 1997.

Offering PACE as a Choice

The following elements are directed and required by legislation (SBH 1499) to ensure that PACE is provided as an option for possibly eligible clients living within a PACE available service area. At each assessment, AAA and HCS staff within the PACE service area will see a required question on Care Plan screen in CARE related to PACE. The question is:

"PACE is available in certain zip codes in the county the client resides, would the client like to receive more information about the PACE integrated managed care program?" Yes/No/Already enrolled.

Assessor is to ask client and respond to question accordingly. If response is "yes" and client resides in King County, it will ask an additional question if client has a preference as to which PACE program:

"If yes, are you interested in a particular PACE program?"

- **Providence PACE**
- **International Community Health Services**
- **PNW PACE**
- **No preference**

For clients whose response is "yes", PACE organizations will contact them to provide more information on PACE managed care.

Staff will no longer complete nor submit form 17-218 "PACE Request for More Information".

A report that has the "yes" responses compiled will be generated weekly to the PACE Organization (PO) of clients who indicated they would like more information about the PACE program. The PO will coordinate with the client and inform HCS/AAA should client choose to enroll and be accepted.

Staff Training

Training is set up and offered through the PACE Organization (PO) at regular intervals for both HCS and AAA staff. Trainings are meant to be interactive and jointly held. The PACE training link is provided below as an ongoing resource for HCS and AAA staff.

Please use Chrome for the below link:
http://intra.ALTSA.dshs.wa.gov/videos/PACE/story.html

Private Pay

HCS is also responsible for assessing individuals not eligible for Medicaid or Medicare who are interested in enrolling in PACE to determine initial functional eligibility as well as ongoing functional eligibility. These referrals generally come directly from PACE organization.

Service Providers

DSHS currently contracts with the PACE organizations (PO) Providence PACE, International Community Health Services (ICHS) and PNW PACE Partners (PNW PACE) to administer the PACE program.

To be enrolled in PACE the client must live in a zip code in the PO's service area.
Please see below the hyperlinked spreadsheet which notes PACE available Zip codes per County per PO:

Zip Codes per County Per PACE Organization

There are nine PACE centers in Washington State.

Providence PACE - Seattle
4515 Martin Luther King Way South
Seattle, WA 98108
(206) 320-5325

Providence PACE - West Seattle
4831 35th Ave. SW
Seattle, WA 98126
(206) 320-5325

Providence PACE - Redmond
8632 160th Ave. NE
Redmond, WA 98052
(206) 320-5325

Providence PACE - Spokane
6018 N Astor
Spokane, WA 98208
(509) 482-2475

Providence PACE - Renton
350 S 38th Ct
Renton, WA 98055
(206) 320-5325

Providence PACE – Kent
1404 Central Ave S
Kent, WA 98032
(206) 320-5325

Providence PACE - Everett
1615 75th Street SW
Everett, WA 98203
(206) 320-5325

International Community Health Services (ICHS)
939 Golf Drive South
Seattle, WA 98144
Phone: (425) 755-1100

Pacific Northwest PACE Partners (PNW PACE)
6442 Yakima Ave
Tacoma, WA
Phone: (253) 459-7270

Services

PACE provides its participants with all services covered by Medicare and Medicaid, without the limitations normally imposed by these programs. It also provides any other services deemed necessary by the interdisciplinary team that would allow program participants to remain in the community.

Services provided by PACE include, but are not limited to:

- Primary care (including doctor, dental and nursing services)

- Prescription drugs
- Adult day health care
- Home and personal care services
- Nutrition services,
- Case management
- Hospital and nursing home care if and when needed.
- Transportation to and from the center and all off-site medical appointments

Eligibility

To participate in PACE, an individual must be 55 years of age or older, require NFLOC but be able to live `safely in the community at time of enrollment with the services of PACE and reside in the service area of a PO. PACE participants may disenroll from the program for any reason and those with Medicare or Medicaid who disenroll will be assisted in returning to their former or preferred health care coverage.

Both the PO and the client agree to the PACE enrollment by signing an enrollment agreement. This agreement means the client agrees to receive services exclusively through the PO and its contracted network.

This may mean that the participant will need to change providers including PCP.

Determining Eligibility

In Spokane, Pierce and Snohomish Counties, the breakdown of which entity handles ongoing PACE assessments is as follows:
AAA—in-home PACE clients
HCS—Residential PACE clients

HCS/AAA will assess clients and determine whether they:

- Are age 55 or older;
- Meet nursing facility level of care (NFLOC) as defined in WAC 388-106-0355;
- Reside in the PACE service area/or will at the time of enrollment; ***and***
- Are financially eligible per WAC 182-515-1505. (MAGI clients are financially eligible);
- Remain functionally eligible by Reassessing Clients (Annual or Significant Change)

The PO is responsible for notifying HCS/AAA of any significant changes in the client's condition:

1. Collaborate with the PACE social worker prior to each assessment. Review the previous assessment/SERs and information given by the PO before the visit.
2. Communicate with collateral contacts as needed to obtain information and include relevant parties to complete an accurate assessment.

3. Complete the face-to-face assessment. Be sure that you have:
    - Assigned the PO as the paid provider
    - Assigned relevant tasks to the PO. No provider schedule is necessary.
4. Verify financial eligibility at least annually, document on the Financial Screen in CARE and document in the file.
5. Once complete, move the assessment to current per procedures in Chapter 3 of the LTC Manual, send the CARE Assessment Details and Service Summary to the PO. Send Service Summary and CARE Results (when necessary) to client.
6. Extend PACE RAC, if applicable, for the new plan period (only available and needed if care plan is in-home).

Continued Functional Eligibility

PACE services can continue even though a PACE participant no longer meets State Medicaid NFLOC *if* the HCS case manager reasonably expects that the participant would again meet NFLOC in the next 6 months should PACE services end. This is called "deeming". "Deemed eligible for PACE" is what will display in care plan as the desired program choice in this situation.

State Staff Responsibilities:

1. HCS/AAA staff will continue to complete annual reassessments of all PACE participants. If the assessment results in the client not meeting NFLOC, staff will review the assessment and consider whether the:
    a. Participant's health status is maintained or benefited, at least partially, because of the services PACE currently provides; *and*
    b. Participant's health and/or functional status are likely to decline over the next six (6) months without PACE services.

    Examples of information that would support deeming of continued eligibility could include, but are not limited to:
    - Physician and/or nursing progress notes documenting the treatment and impact of a chronic/disabling condition;
    - List of services currently provided to the participant (OT, PT, dietary management, blood glucose/blood pressure checks, diabetic foot care, etc.);
    - Frequency of medical appointments and/or frequency of medical treatments/ interventions that point to an unstable medical condition that must be treated/ monitored regularly to avoid complications;
    - Decline or loss of mobility combined with cognitive decline or progression; etc.
2. If HCS/AAA case managers deem continued eligibility, they will continue to conduct full annual reassessments (and any significant change assessments) and determine NFLOC and/or that deeming criteria continues to be met.
3. If the client meets deeming criteria, staff will choose "Deemed Eligible for PACE" in the program drop down in CARE.

4. HCS/AAA staff will note in a CARE SER the decision to deem eligibility in the PACE program.
5. If HCS/AAA staff determine that a previously deemed participant no longer meets NFLOC or deemed continued eligibility or the client is not financially eligible for Medicaid a denial notice and appeal rights will be issued to the participant with a copy sent to the PO.
6. If the participant requests a Department administrative hearing to dispute the State's denial of continued eligibility, PACE services may continue until the appeal is heard and a decision is rendered. If the denial is upheld, the participant may be required to pay the cost of PACE services rendered after the initial denial effective date.
7. If a request for administrative hearing is not received, PACE enrollment will be terminated at the end of the month in which the PAN was issued if the PAN was issued at least 10 days prior to the end of the month; if PAN was issued less than 10 days prior to the end of the month, PACE enrollment will be terminated at the end of the following month.

Forms

AAA/HCS Case Managers are required to complete the following forms:

- **PAN** – Once you assess the client in CARE, you must send the client the Planned Action Notice. The Planned Action Notice for PACE clients must include information that tells the client:
  - They are eligible for services;
  - That PACE is the program of choice;
  - The number of personal care hours or daily rate they are eligible for.
- **Rights and Responsibilities**
- **Consent Form** – Complete when working with collateral contacts to gather/share information. The PO is an "HCLA paid provider".

Roles

Note: Clients are eligible for PACE services on the first of the month in which they are enrolled following the date the client is financially/functionally eligible. Clients can only be enrolled effective the first of the month.

HCS/AAA ASSESSOR	**Determine Eligibility** Complete the CARE assessment to determine functional eligibility (specifically nursing facility level of care) for long-term care services. If the client is functionally eligible for nursing facility level of care, offer PACE as an option for receiving services. **Client Seeks Enrollment** Once you receive confirmation from the client that they wish to enroll, provide a copy of the CARE Assessment Details and Service Summary to the PO for review.

	Enrollment Confirmed Once you received notification from PO that client will enroll in PACE: • Send a copy of the Service Summary and Assessment Details in "current" status to the PO (if not already done). The Service Summary does not have to be signed by the client or PO. • Send a Planned Action Notice (DSHS 14-405)* to the client or their representative stating the effective enrollment date along with Service Summary (and CARE Results if necessary) • *Below are current instructions for PAN per PACE enrollment: 1) Send PAN indicating PACE approval with the following PACE specific details a. Effective date is the first day of the month of PACE enrollment b. Select PACE as the 'Program. c. Enter CARE rate in the new amount field. d. PACE WACs will auto-populate when 'functionally eligible' is chosen related to PACE approval: 388-106-0700, 388-106-0705 • Send DSHS 14-443 to Financial with enrollment start date, and ProviderOne ID of PACE provider*, and indicate if it will be in-home or residential care. For the latter include the CARE daily rate. • * ProviderOne IDs of PACE providers: Providence PACE ProviderOne #: **105011001** ICHS ProviderOne #: **209579901** PNW PACE ProviderOne # **217922601** • Add PACE RAC in CARE. This will only be available if the setting is in-home. • End all ProviderOne authorizations for end of month prior to enrollment. • ProviderOne payment authorizations are not done by HCS. • Add PO as the "formal caregiver" in collateral contacts. • Assign all unmet and partially met tasks to the PO as paid provider on care plan support screen. • If client is receiving wellness education service under COPES complete interim to remove this treatment. This service is not available to clients in PACE. • If client is receiving ADH service under COPES and any ADLs are partially met and informally assigned to ADH provider, complete interim to make these ADLs unmet.
PUBLIC BENEFIT SPECIALIST	If not already established, determine financial eligibility for long-term care (PACE). Upon confirmed enrollment: **enter P1 ID of PO in ACES so award letters and all correspondence gets sent to the PO**.
PACE ORGANIZATION (PO)	**Prior to Enrollment** • Contact interested clients to discuss program • Schedule site visit and evaluation • Review CARE assessment **Enrollment Denied**

	• PO informs client and sends information to HQ with reason as to why **Enrollment Confirmed** • Notify HCS/AAA of enrollment decision including enrollment start date. • Send a monthly electronic enrollment file by the 23rd of the month for enrollment the following month that contains client enrollment effective dates to the PACE Program Manager with a cc to the HCS/AAA field supervisor. Enrollments only occur at the start of a given month. • Send disenrollment letters for enrollees with other coverage.
PACE HQ PROGRAM MANAGER	• Enroll the client into PACE via the ProviderOne system if eligible. • Review and evaluate any enrollment denials submitted by the PO.

Ongoing Client Management / Roles & Responsibilities

Case Management for PACE Clients

Once a client is enrolled in the PACE program, the PO assumes case management responsibilities.

Ongoing HCS/AAA SW Responsibilities	Ongoing PO Responsibilities
• Annual functional assessments • Significant change assessments • Verify financial eligibility for each face-to-face assessment • Coordination with PO case managers • Obtain medical records from PO • Process disenrollments • Communicate necessary info to financial as needed • Notify financial of SNF stays that go beyond 30 days	• Implement and oversee care plan • Day to day case management • Enlist, contract, and pay providers (including IPs) • Communicate changes to HCS (address, telephone #, milieu of care (including SNF placements) • Request significant change assessments (vetting request/reviewing current CARE first) • Staff cases with PO interdisciplinary team as needed • Distribute CARE assessment and plan of care to providers • Assist clients with eligibility reviews

HCS/AAA and PO Coordination

HCS/AAA and the PO must report the following client changes to one another when they occur:

- Admit or discharge from a nursing facility. HCS must notify financial if over 30 days;
- Need for home maintenance allowance (HMA). Requested by PO, HCS processes.
- Change in address or phone number;
- Change in plan of care which includes:
- Change in care setting (in home, residential, SNF)
- Disenrollment from plan (including expedited disenrollment);

- Move out of the service area;
- Changes in or termination of Medicaid eligibility;
- Change from Medicaid to private pay and vice versa. PO makes HCS aware.
- Financial reports changes in cost of care to the PO via award letter.
- Client passes away

PO Responsibilities

- Must maintain services for the enrollee while enrolled, regardless of how much service needs increase or decrease;
- Is responsible for admitting and/or discharging PACE enrollees from the various living environments.
- Must collect participation from the enrollee.
- Will contract providers for all PACE services).
- Must have an internal "exception to rule" policy as it relates to needed services above what CARE assessment indicates. (HCS ETR is N/A for PACE)
- Review current CARE assessment prior to requesting significant change
- Must notify HCS of any:
  - Address changes;
  - Changes in income or resources; *or*
  - Changes in living situations (in-home, residential, nursing facility);

HCS/AAA Field Manager/Supervisor Responsibilities

- Point person for HQ PACE PM as it relates to PACE programs' field-level operations
- Point person for other HQ PACE PMs as needed (ProviderOne, contracts, FLSA, etc.)
- Point person for PO management related to day-to-day operations of PACE programs
- Troubleshoot and address enrollment issues including lapses in enrollment
- Point person to provide assistance to PO (or their subcontractor) navigating ProviderOne as it relates to payment authorizations for individual providers
- Point person for PO intake and management staff related to enrollments and disenrollments
- Point person for work with RCS as needed related to PACE clients in residential settings
- Oversee and receive new enrollments monthly and assign to HCS workers
- Assist HQ PACE PM reconciling payment issues with PO on a monthly basis
- Meet with PO and their subcontractors as needed or requested

CARE Rules & PACE Enrollees

- All CARE minimum standards are applicable to PACE enrollee assessments.

- When determining "status" for PACE enrollee, the PO is considered the HCLA paid provider, not the IP, Homecare Agency, Residential or other provider. The actual providers are not to be considered "informal" supports because they are being paid by the PO.
- On the Support Screen, assign the PO as the paid provider for all applicable "unmet" and "partially met" needs. As well, tasks that would otherwise be assigned to PCP/MD should generally be assigned to PO.
- Potential referrals triggered from the CARE assessment are the responsibility of the HCS/AAA worker prior to enrollment into PACE, including the assessment that determines functional eligibility. Once the client is enrolled, the PO assumes all case management for the client.

The PO may request and be granted view access in CARE for clients enrolled in the contractor's PACE program. The PO should contact the HQ program manager to request access to CARE.

Payment

POs receive a set amount of Medicare and Medicaid funds each month to ensure participant care, whether services are provided in the home, community or in a nursing home setting. This capitated funding arrangement rewards providers who are flexible and creative in providing high quality care and gives them the ability to coordinate care across settings and medical disciplines.

The program also accepts participants who pay privately.

Provider Payments

- The PO contracts & enlists their own providers for all PACE services. This includes homecare agencies, AFH's, AL's and all other covered services.
- The PO is responsible for directly paying all their providers.
- IPs are paid via ProviderOne though the PO is billed back for the costs.
  - The PO inputs IP payment authorizations directly into ProviderOne using their own RU.
  - No other payment authorizations will be visible in CARE for PACE clients.

Disenrollment

Disenrollment is effective the last day of the month.

Voluntarily

- Request disenrollment;
- Are no longer Medicaid eligible; i.e. client is not financially or functionally NFLOC;

Involuntarily

- Move out of the PACE service area or leave for more than 30 days (unless an arrangement has been made or client is receiving referred treatment from the PO); *or*
- Engage in disruptive or threatening behavior and involuntary disenrollment is reviewed and approved by the HCS Headquarters Program Manager; *or*
- Fail to pay or to make satisfactory arrangements to pay any amount due to the provider after a 30-day grace period; *or*
- Are enrolled with a PO that loses its contract and/or license and is no longer able to offer services.

Process

1. The PO must send a written notice to the HQ PACE PM that fully documents that one of or more of the conditions exist to justify involuntary disenrollment.
2. The HQ PACE PM will consult with the regional supervisor regarding any concerns with the disenrollment or timeframes. Once approved/denied the HQ Program Manager will notify the regional supervisor and the PO of approval/denial within 15 days of receipt.

Roles

HCS/AAA Case Manager

1. Send the client a Planned Action Notice (DSHS 14-405), stating effective disenrollment date.
2. Follow procedures for setting up other long-term care program/services and supports, if desired by client. This would include enlisting a new formal/paid caregiver and, if it's an IP, work with CDWA to get IP in place to provide services for the client.
3. Coordinate with HQ and the PO.

PACE Organization

1. Send a monthly electronic disenrollment file by the 15th of the month to HQ PACE PM with a cc to the regional supervisor with the effective dates of participant disenrollments.
2. Coordinate with HCS (field and HQ) and AAA on any disenrollments. Timely notification to HCS/AAA field is critical; HCS/AAA field should be notified at the time PACE becomes aware of a disenrollment to allow time for HCS to implement new plan of care.
3. Determine and communicate safe, ongoing plan of care to HCS/AAA for implementation.
4. Assist client in establishing new PCP.
5. Assist client in signing up for new Medicare Part D plan.

HCS HQ Program Manager

1. Process disenrollments in the ProviderOne payment system.
2. Approve/deny any involuntary disenrollment requests.
3. Coordinate with the field and the PO.

Grievance, Appeals and Hearing Rights

- The PO must report to the HQ PACE PM quarterly regarding all grievance and appeals filed.
- If the PO denies or reduces a previously authorized service, the participant may appeal the denial to the PO.
- If the PO upholds its denial or does not respond timely to a request, the participant may request an administrative hearing.
- The participant must exhaust the appeal process before requesting an admin hearing on a PO determination.

Grievance

The client has the right to file a grievance either verbally or in writing to the PO any time they are dissatisfied with a service, the quality of care received or an interaction with PO staff.

Appeal

The client has the right to appeal any decision made by the PO to reduce, deny or terminate a service or an enrollment. This includes the right to appeal an involuntary disenrollment by the PO. The client should contact the PO to file an appeal.

Administrative Hearing

A client has a right to an administrative hearing only when entitled by the law and when aggrieved by a Department or PO decision or action. Clients have a right to a hearing:

1. For any action taken by the Department and indicated on the Planned Action Notice (PAN) including approval, denial, reduction or termination of services or eligibility.
2. When the department determined a client received more benefit than they were eligible for an overpayment was issued; *and*
3. When they have exhausted the appeal process regarding a PO determination or the PO did not respond timely to the request.

Administrative hearings are coordinated through the admin hearing coordinator for the service area. The department may be a witness.

Per WAC 182-526-0155, an appellant may represent themselves or may be represented by a lawyer, paralegal, relative, friend or any other person of his or her choice. **The appellant cannot be represented by an employee of the Department or the PO.**

RESOURCES

Related WACs & eCFRs

WAC 182-526-0155	HCA & Appellant's Representation
WAC 182-538	Washington State Health Care Authority Managed Care
WAC 182-513-1230	PACE (HCA website)

CFR 42-438	Managed Care
CFR 42-460	PACE

Acronyms

AAA	Area Agency on Aging
ACES	Automated Client Eligibility System
AHC	Apple Health Foster Care
CC	Care Coordinator
CCW	Coordinated Care of Washington
CFC	Community First Choice
CMS	Centers for Medicare and Medicaid Services
COPES	Community Options Program Entry System
DDA	Developmental Disability Administration
DSHS	Department of Social and Health Services
D-SNP	Dual Special Needs Plan
FFS	Fee-for-Service
FIMC	Fully Integrated Managed Care
HAP	Health Action Plan
HCA	Health Care Authority
HCS	Home and Community Services
HH	Health Home
LTSS	Long-Term Services and Supports
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
NFLOC	Nursing Facility Level of Care
PACE	Program for All Inclusive Care for the Elderly
PCCM	Primary Care Case Management
PO	PACE Organization
RSA	Regional Service Area
SSI	Supplemental Security Income
TPL	Third Party Liability

Glossary

Care Coordination	An approach to healthcare in which all of a patient's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the patient and the patient's caregivers and works with the patient to make sure that the patient gets the most appropriate treatment, while ensuring that health care is not duplicated.
Disenrollment	The process by which an enrollee's participation in a managed care program is terminated. Reasons for disenrollment include death, loss of eligibility, or choice not to participate, if applicable.
Fee-For-Service	A service delivery system where health care providers are paid for each service separately (e.g. an office visit, test, or procedure).
Long-Term Services and Supports	A wide variety of services and supports that help people with functional impairments meet their daily needs for assistance in qualified settings and attain the highest level of independence possible. LTSS includes both Home and Community-Based Waiver Services and Medicaid Personal Care Services.
Managed Care	A prepaid, comprehensive system of medical and health care delivery. - *Medical*: Includes preventive, primary, specialty care and ancillary health services - *Integrated***:** Includes Medical services PLUS behavioral health and long term services and supports.
Third Party Liability	Refers to the legal obligation of third parties (e.g., entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a state plan. By law, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state plan.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
8/2/19	Integration Unit	Updated into new template	
5/9/23	Office of Policy and Integration	Split Chapter 22 into three parts: Chapter 22a, 22b, and 22c	

Web Resources

PACE

DSHS – PACE webpage
HCA – PACE webpage