

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXIII. All Inclusive Care for the Elderly

Chapter 1. General Provisions

§101. Purpose and Scope

A. The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing implements the Program of All Inclusive Care for the Elderly (PACE) in accordance with federal regulations at 42 CFR 460 et seq., as published in the *Federal Register* on November 24, 1999 and amended on October 2, 2002, and as may be amended in the future. These regulations set forth:

1. the requirements that an entity must meet to be approved as a PACE organization that operates a PACE program under Medicare and Medicaid;
2. how individuals may qualify to enroll in a PACE program;
3. how Medicare and Medicaid payments will be made for PACE services;
4. provisions for federal and state monitoring of PACE programs; and
5. procedures for sanctions and terminations.

B. The purpose of the Program of All Inclusive Care for the Elderly is to provide prepaid, capitated, comprehensive health care services designed to meet the following objectives:

1. enhance the quality of life and autonomy for frail, older adults;
2. maximize dignity of, and respect for, older adults;
3. enable frail, older adults to live in the community as long as medically and socially feasible; and
4. preserve and support the older adult's family unit.

C. This Part XXIII sets forth the election of state options under the federal regulations and additional requirements established by the state for the efficient operation of the program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:244 (February 2004).

§103. Organization Application and Evaluation

A. A PACE organization shall be licensed as an adult day health care (ADHC) facility. The Department of Health and Hospitals (DHH) shall grant appropriate waivers of ADHC licensing requirements in instances where ADHC licensing

regulations conflict with PACE requirements when such waivers are determined to have no adverse effect on participant health and safety and quality of life.

B. A PACE organization shall not be required to be licensed as a health maintenance organization under the Louisiana regulations for risk based entities.

C. A PACE organization must be a non-profit entity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:245 (February 2004).

§105. Administrative Requirements

A. A PACE organization must have a fiscally sound operation, as demonstrated by:

1. total assets greater than total unsubordinated liabilities;
2. sufficient cash flow and adequate liquidity to meet obligations as they become due;
3. a net operating surplus or a financial plan for solvency that is satisfactory to the Center for Medicaid and Medicare Services (CMS) and the Department of Health and Hospitals.

B. A PACE organization shall operate under the control of an identifiable governing body such as a board of directors, which must include at least one community representative. The following advisory committees shall also be established to advise the board of directors:

1. Consumer Advisory Committee;
2. Ethics Committee;
3. Restraint Committee;
4. other committees as required by CMS and/or DHH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:245 (February 2004).

Chapter 3. Services

§301. Medicare and Medicaid Coordination

A. If a Medicare beneficiary or Medicaid recipient chooses to enroll in a PACE program:

1. the participant, while enrolled in a PACE program, must receive Medicare and Medicaid benefits solely through the PACE organization; and

2. Medicare and Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, co-payments, coinsurance, or other cost-sharing do not apply.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:245 (February 2004).

§303. Services Provided

A. The PACE benefit package for all participants, regardless of the source of payment, must include:

1. all Medicaid-covered services, as specified in the state's approved Medicaid plan;

2. interdisciplinary assessment and treatment planning;

3. primary care, including physician and nursing services;

4. social work services;

5. restorative therapies, including:

a. physical therapy;

b. occupational therapy; and

c. speech-language pathology services;

6. personal care and supportive services;

7. nutrition counseling;

8. recreational therapy;

9. transportation;

10. meals;

11. medical specialty services including, but not limited to:

a. anesthesiology;

b. audiology;

c. cardiology;

d. dentistry;

e. dermatology;

f. gastroenterology;

g. gynecology;

h. internal medicine;

i. nephrology;

j. neurosurgery;

k. oncology;

l. ophthalmology;

m. oral surgery;

n. orthopedic surgery;

o. otorhinolaryngology;

p. plastic surgery;

q. pharmacy consulting services;

r. podiatry;

s. psychiatry;

t. pulmonary disease;

u. radiology;

v. rheumatology;

w. general surgery;

x. thoracic and vascular surgery; and

y. urology;

12. laboratory tests, x-rays and other diagnostic procedures;

13. drugs and biologicals;

14. prosthetics, orthotics, durable medical equipment, corrective vision devices, such as:

a. eyeglasses and lenses;

b. hearing aids;

c. dentures; and

d. repair and maintenance of these items;

15. acute inpatient care, including:

a. ambulance;

b. emergency room care and treatment room services;

c. semi-private room and board;

d. general medical and nursing services;

e. medical surgical/intensive care/coronary care unit;

f. laboratory tests, x-rays and other diagnostic procedures;

g. drugs and biological;

h. blood and blood derivatives;

i. surgical care, including the use of anesthesia;

j. use of oxygen;

k. physical, occupational, respiratory therapies, and speech-language pathology services; and

l. social services;

16. nursing facility care including:

a. semi-private room and board;

- b. physician and skilled nursing services;
- c. custodial care;
- d. personal care and assistance;
- e. drugs and biologicals;
- f. physical, occupational, recreational therapies, and speech-language pathology, if necessary;
- g. social services; and
- h. medical supplies and appliances;

17. other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:245 (February 2004).

§305. Excluded Services

A. Services excluded from coverage are:

1. any service that is not authorized by the interdisciplinary team, even if it is a required service, unless it is an emergency service;

2. private room and private duty nursing services in an inpatient facility, (unless medically necessary), and nonmedical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the interdisciplinary team as part of the participant's plan of care);

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 mastectomy;

4. experimental medical, surgical or other health procedures;

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

- a. in accordance with 42 CFR 424.122-424.124; or
- b. as permitted under the state's approved Medicaid plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:246 (February 2004).

§307. Conditions of Service

A. A PACE organization must establish and implement a written plan to furnish care that meets the needs of each participant in all care settings 24 hours a day, every day of the year.

B. The PACE organization must furnish comprehensive medical, health, and social services that integrate acute and long-term care.

C. These services must be furnished in at least the PACE center, the home, and inpatient facilities.

D. The PACE organization may not discriminate against any participant in the delivery of required PACE services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or source of payment.

E. The frequency of a participant's attendance at a center is determined by the interdisciplinary team, based on the needs and preferences of each participant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:246 (February 2004).

Chapter 5. Recipient Enrollment

§501. Eligibility

A. In order to be eligible for services from a PACE site an applicant must:

- 1. be 55 years of age or older;
- 2. be determined by the state administering agency to need the level of care required under the state Medicaid plan for coverage of nursing facility services;
- 3. reside in the service area of the PACE organization; and

4. at the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety.

B. Eligibility to enroll in a PACE program is not restricted to an individual who is either a Medicare beneficiary or Medicaid recipient. A potential PACE enrollee may be, but is not required to be, any or all of the following:

1. entitled to Medicare Part A;
2. enrolled under Medicare Part B; or
3. eligible for Medicaid.

C. Persons shall be considered to have met the criteria for determining that an individual is able to live in a community setting without jeopardizing his or her health or safety when the answer to all of the following questions is determined to be in the affirmative.

1. Does the individual or caregiver have a desire to remain in the community?

2. If the individual is not able to live safely alone, is there a primary caregiver at home, or a willingness to use another caregiver or provider to meet the individual's needs?

3. Can the caregiver maintain a safe physical environment in the home?

4. Are hygiene, nutrition, medical care, and support systems adequate?

5. If behavioral problems exist, can they be managed to prevent risk to self or others?

6. Can a plan of care be developed to meet the individual's needs?

D. A PACE organization shall assess the potential participant to ensure that he or she can be cared for appropriately in a community setting and that he or she meets all requirements for PACE eligibility.

E. Reevaluation of Eligibility

1. DHH shall annually reevaluate whether the participant continues to meet level of care for nursing facility services. DHH 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 or the degree of impairment of functional capacity.

2. DHH may determine that a PACE participant who no longer meets the state Medicaid nursing facility level of care requirements may be deemed to continue to be eligible for the PACE program until the next annual reevaluation, if, in the absence of continued coverage under this program, the participant reasonably would be expected to meet the nursing facility level of care requirement within the next six months.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:247 (February 2004), LR 33:850 (May 2007).

§505. Disenrollment

A. A PACE organization shall submit proposed denial of enrollment determinations of applicants for health and safety reasons and all involuntary disenrollments of participants to DHH for review prior to notifying applicants/participants of such adverse decisions. The Department shall review denials of PACE enrollment eligibility and disenrollments in a timely manner.

B. Involuntary Disenrollment

1. A participant may be involuntarily disenrolled for any of the following reasons:

a. a participant fails to pay, or to make satisfactory arrangements to pay, any premium due the PACE organization after a 30-day grace period;

b. the participant engages in disruptive or threatening behavior, as described in Paragraph 2 below;

c. the participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances;

d. the participant is determined to no longer meet the state Medicaid nursing facility level of care requirements and is not deemed eligible;

e. the PACE program agreement with CMS and DHH is not renewed or is terminated;

f. the PACE organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers; or

g. the participant who is permanently placed in a nursing facility fails to pay, or to make satisfactory

arrangements to pay, the amount of patient liability that would be required to be paid by a Medicaid eligible resident of a nursing facility if he/she was not a participant in a PACE organization.

2. The following are behaviors considered disruptive or threatening behavior for purposes of involuntary disenrollment:

a. behavior that jeopardizes his or her health or safety, or the safety of others; or

b. consistent refusal to comply with his or her individual plan of care or the terms of the PACE enrollment agreement by a participant with decision-making capacity, but not if the behavior is related to a mental or physical condition of the participant. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:247 (February 2004), LR 33:850 (May 2007).

Chapter 7. Quality Assessment and Performance Improvement

§701. Organization Responsibilities

A. A PACE organization must develop, implement, maintain, and evaluate an effective, data-driven quality assessment and performance improvement program.

B. The program must reflect the full range of services furnished by the PACE organization.

C. A PACE organization must take actions that result in improvements in its performance in all types of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:248 (February 2004).

§703. Quality Assessment and Performance Improvement Plan

A. A PACE organization must have a written quality assessment and performance improvement plan.

B. The PACE governing body must review the plan annually and revise it, if necessary.

C. At a minimum, the plan must specify how the PACE organization proposes to meet the following requirements:

1. identify areas to improve or maintain the delivery of services and patient care;

2. develop and implement plans of action to improve or maintain quality of care;

3. document and disseminate to PACE staff and contractors the results from the quality assessment and performance improvement activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:248 (February 2004).

§705. Minimum Requirements

A. A PACE organization's quality assessment and performance improvement program must include, but is not limited to, the use of objective measures to demonstrate improved performance with regard to:

1. utilization of PACE services, such as decreased inpatient hospitalizations and emergency room visits;

2. caregiver and participant satisfaction;

3. outcome measures that are derived from data collected during assessments, including data on the following:

a. physiological well being;

b. functional status;

c. cognitive ability;

d. social/behavioral functioning;

e. quality of life of participants;

4. effectiveness and safety of staff-provided and contracted services, including:

a. competency of clinical staff;

b. promptness of service delivery;

c. achievement of treatment goals and measurable outcomes;

5. nonclinical areas, such as grievances and appeals, transportation services, meals, life safety, and environmental issues.

B. Outcome measures must be based on current clinical practice guidelines and professional practice standards applicable to the care of PACE participants.

C. The PACE organization must meet or exceed minimum levels of performance, established by CMS and the state administering agency, on standardized quality measures, such as influenza immunization rates, which are specified in the PACE program agreement.

D. The PACE organization must ensure that all data used for outcome monitoring are accurate and complete.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:248 (February 2004).

§707. Internal Activities

A. A PACE organization must do the following:

1. use a set of outcome measures to identify areas of good or problematic performance;
2. take actions targeted at maintaining or improving care based on outcome measures;
3. incorporate actions resulting in performance improvement into standards of practice for the delivery of care and periodically track performance to ensure that any performance improvements are sustained over time;
4. set priorities for performance improvement, considering prevalence and severity of identified problems, and give priority to improvement activities that affect clinical outcomes;
5. immediately correct any identified problem that directly or potentially threatens the health and safety of a PACE participant.

B. A PACE organization must designate an individual to coordinate and oversee performance improvement activities.

C. Involvement in Quality Assessment and Performance Improvement Activities

1. A PACE organization must ensure that all interdisciplinary team members, PACE staff, and contract providers are involved in the development and implementation of quality assessment and performance improvement activities and are aware of the results of these activities.

2. The quality improvement coordinator must encourage a PACE participant and his or her caregivers to be involved in quality assessment and performance improvement activities, including providing information about their satisfaction with services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:248 (February 2004).

§711. Committees with Community Input

A. A PACE organization must establish one or more committees with community input to:

1. evaluate data collected pertaining to quality outcome measures;
2. address the implementation of, and results from, the quality assessment and performance improvement plan;
3. provide input related to ethical decision-making, including end-of-life issues and implementation of the Patient Self-Determination Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:249 (February 2004).

Chapter 9. Sanctions**§901. Violations**

A. Sanctions may be imposed against a PACE organization if it commits one of the following violations:

1. fails substantially to provide medically necessary items and services to a participant that are covered PACE services, and that failure has adversely affected (or has substantial likelihood of adversely affecting) the participant;
2. involuntarily disenrolls a participant in violation of Section 460.164;
3. discriminates in the enrollment or disenrollment of Medicare beneficiaries or Medicaid recipients, or both, who are eligible to enroll in a PACE program on the basis of an individual's health status or need for health care services;
4. engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment, except as permitted by Section 460.150, by Medicare beneficiaries or Medicaid recipients whose medical condition or history indicates a need for substantial future medical services;
5. imposes charges on participants enrolled under Medicare or Medicaid for premiums in excess of the premiums permitted;
6. misrepresents or falsifies information that is furnished to:
 - a. CMS or the state under this Part XXIII; or
 - b. an individual or any other entity under this Part XXIII;
7. prohibits or otherwise restricts a covered health care professional from advising a participant who is a patient of the professional about the participant's health status, medical care, or treatment for the participant's condition or disease, regardless of whether the PACE program provides benefits for that care or treatment, if the professional is acting within his or her lawful scope of practice;
8. operates a physician incentive plan that does not meet the requirements of Section 1876(i)(8) of the Social Security Act; or

9. employs or contracts with any individual who is excluded from participation in Medicare or Medicaid under Section 1128 or Section 1128A of the Social Security Act (or with any entity that employs or contracts with that individual) for the provision of health care, utilization review, medical social work, or administrative services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:249 (February 2004).

§903. Imposition of Sanctions by CMS

A. The CMS may impose the following sanctions for violations specified in §901:

1. suspend enrollment of Medicare beneficiaries;
2. suspend Medicare payment to the PACE organization;
3. deny payment to the state for medical assistance for services furnished under the PACE program agreement. The state will suspend payments to the PACE organization when payment of the federal portion of PACE reimbursement is denied;
4. impose civil money penalties as specified in federal regulations.

B. The CMS or the state may determine that the PACE organization is not in substantial compliance with PACE requirements, and may take one or more of the following actions:

1. condition the continuation of the PACE program agreement upon timely execution of a corrective action plan;
2. withhold some or all payments under the PACE program agreement until the organization corrects the deficiency;
3. terminate the PACE program agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:249 (February 2004).

Chapter 11. Appeals

§1101. Participant Rights, Grievances, and Appeals

A. The PACE organization must have a formal written appeals process in accordance with 42 CFR 460.122, with specified timeframes for response, to address noncoverage or nonpayment of a service, and involuntary disenrollment.

B. Additional appeal rights under Medicare or Medicaid are available to the participant if an adverse decision is made in the PACE organization appeal process, or if the participant is involuntarily disenrolled from the PACE program. A PACE organization must inform a participant in

writing of additional appeal rights available under Medicare or Medicaid.

C. Medicaid-eligible participants who appeal through Medicaid shall be heard by the DHH Bureau of Appeals within the timeframes applicable to processing Medicaid appeals except in cases where federal PACE requirements require a more expeditious decision. The PACE organization shall prepare the Summary of Evidence in preparation for the appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:249 (February 2004).