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

200.100 Program Description 9-1-26

A. The Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive health and social services program that helps older adults, who need nursing home level of care, remain in their homes and communities. It is a joint Medicare/Medicaid program that provides and coordinates primary, acute, and long-term care for qualifying beneficiaries who are fifty-five (55) years of age or older. PACE relies on an interdisciplinary team approach to care management and comprehensive service delivery.

1. Social and medical services are provided primarily in a PACE center but are supplemented by in-home and referral services as needed by the PACE Organization (see section 202.000).
2. Pursuant to Arkansas Code Annotated §20-10-801 (14) a licensed, certified PACE Program is exempted from any additional or separate home healthcare licensing requirements.
3. Pursuant to 42 CFR Part 460, PACE providers must be in compliance with all federal regulations.

B. PACE is designed to meet the following aims:

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.
4. Preserve and support the older adult's family unit.

C. PACE provides pre-paid, capitated, comprehensive health care services The PACE assumes full financial risk. The PACE program must provide all the authorized care and services covered by Medicare and Medicaid, as well as additional medically-necessary care and services for program participants, as per 42 CFR §460.92.

D. PACE is a State option under Arkansas Medicaid and is operated by the Division of Aging, Adult, and Behavioral Health Services (DAABHS).

Further programmatic information and guidelines for PACE are outlined by the Centers for Medicare and Medicaid Services (CMS) in their Programs of All-Inclusive Care for the Elderly (PACE) Manual online.

200.200 PACE Terms and Definitions 9-1-26

Contract Year	The term of a PACE Program Agreement between the PACE Organization, DAABHS, and CMS, which is a calendar year that ends on December 31. A PACE Organization's initial contract year may last anywhere from 19 to 30 months as determined by CMS, but will end on December 31st.

PACE Center	A facility which includes a primary care 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	A provider that has a PACE Program Agreement in effect to operate a PACE program in the state.
PACE Program Agreement	An agreement between a PACE Organization, DAABHS, and CMS for the operation of a PACE program.
PACE Service Area	The designated area (zip-code specific) where a PACE Organization is permitted to provide services. This should not overlap with another PACE Organization.
Participant	A beneficiary who is enrolled in a PACE program.

201.000 PACE Applicant Requirements 9-1-26

A. A PACE Organization is a not-for-profit, for-profit, or public entity that is primarily engaged in providing PACE services. The following characteristics must also apply to a PACE organization:

1. Have a governing body, or a designated person functioning as a governing body, that includes participant representation;
2. Be able to provide the complete PACE service package regardless of frequency or duration of services;
3. Have a physical site and staff to provide primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals;
4. Have a defined service area;
5. Have safeguards against conflict of interest;
6. Have demonstrated fiscal soundness;
7. Have a formal Participant Bill of Rights; and
8. Have a process to address grievances and appeals.

B. A provider must meet all of the following participation requirements to qualify as a PACE Organization that operates a PACE program under Arkansas Medicaid:

1. Submit a Notice of Intent to Apply (NOIA) PACE form to the Division of Aging and Adult Services as a letter of intention to establish or expand a PACE Program;
2. Obtain an Adult Day Health Care facility license;
   a. Adhere to all regulations established for the licensure of Adult Day Health Care (ADHC) facilities in Arkansas, overseen by the Division of Provider Services & Quality Assurance (DPSQA).
   b. Refer to 'Rules and Regulations for Adult Day Health Care Providers' for more information. Guidance is subject to periodic revisions as warranted.
3. Submit a PACE Provider Application and be approved by both Arkansas' Division of Aging and Adult Services and the Centers for Medicare and Medicaid Services (CMS), as per 42 CFR §460.18;
   a. A PACE provider's past performance will be considered when determining approval or denial of new or expansion applications.
   b. Submitting a completed PACE provider application to DAABHS after submitting

it to CMS, or failing to submit it to DAABHS altogether, may result in the denial or delay of the application's approval.

c. A PACE Provider Application is also required for a pre-existing PACE Organization that seeks to expand its service area or add a new PACE Center (42 CFR 460.12(d)).

4. Execute a PACE Program Agreement, which acts as a three-party contract governing provider operations signed by the PACE provider, Division of Aging and Adult Services, and CMS; and

5. Complete the Medicaid provider participation and enrollment requirements contained within Section 140.000 of this Medicaid manual.

C. A provider may request a waiver of certain regulatory requirements along with their PACE Provider Application. The purpose of the waiver is to provide for reasonable flexibility in adapting the PACE model to the needs of particular organizations (such as those in rural areas).

1. A provider should follow guidelines set forth in 42 CFR 460.26 for submission and evaluation of waiver requests.

Note: Click here for more information on the PACE Provider Application.

Note: Click here for more information on the PACE Program Agreement.

201.200 Violations, Sanctions, Civil Money Penalties, Suspension, and Termination 9-1-26

A. CMS may impose any of the sanctions as specified in 42 CFR 460.40 if CMS determines that a PACE organization commits programmatic violations.

B. CMS may suspend Medicare payment to the PACE organization and may deny payment to the State for medical assistance for services furnished under the PACE program agreement for one or more program violations as specified in 42 CFR 460.42.

C. CMS may impose civil money penalties up to the maximum amounts specified by federal law as specified in 42 CFR 460.46.

D. CMS in consultation with DAABHS, may take one or more of the following actions as specified in 42. CFR 460.48:

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.

201.300 State Monitoring Activities for PACE Organizations 9-1-26

A. DPSQA, or its vendor, conducts independent site visits annually, or as needed, in addition to CMS site visits, to compliance with regulations, state and federal laws.

B. DPSQA, or its vendor, is responsible for conducting an exit conference with the PACE Organization to discuss any review findings, provide technical assistance in developing corrective action plans, and to assist the PACE Organization in their efforts to implement the required corrections.

C. The PACE Organization must be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an Adult Day Health Care. CMS can conduct an audit at any point after the first year of the trial period. At the

conclusion of the Three-year trial period, CMS in cooperation with DAABHS, continues to conduct reviews, as appropriate, of the PACE Organization considering the quality-of-service provision by the PACE Organization and compliance with all state and federal requirements.

D. The PACE Organization is required to disclose to current PACE participants and potential PACE participants information specific to the PACE Organization's performance and contract compliance deficiencies, in a manner specified by CMS (42 CFR §460.198).

E DPSQA, or its vendor, upon annual inspection will review the following, in addition to ensuring a PACE provider is meeting the requirements of an Adult Day Health provider:

1. The PACE organization's physical environment to ensure a safe, sanitary, functional, accessible, and comfortable environment;
2. Suitable space and equipment to provide primary medical care and suitable space for treatment, restorative therapies, therapeutic recreation, socialization, dining and personal care;
3. Suitable meeting space for personnel to conduct team meetings and for participant's caregivers, and visitors;
4. Spaces which provide participant privacy and dignity during the delivery of services;
5. Proof that there are life safety code inspections from the fire marshal, Department of Health, and other required state agency inspections;
6. The PACE organization must provide evidence of a federal Clinical Laboratory Improvement Amendment (CLIA) exemption if the center is performing waived laboratory services on site or in the home, e.g., glucose meter testing, urine testing, fecal occult blood testing, blood testing, cholesterol screening or hemoglobin or hematocrit testing;
7. In addition, the PACE organization must meet all applicable Federal, State, and local laws and regulations, which include the Americans with Disabilities Act and Section 504 of the Rehabilitation Act;
8. A PACE organization must perform the manufacturer's recommended maintenance on all equipment as indicated in the manufacturer's written recommendations. This maintenance may be performed by PACE staff or contracted entities and in compliance with the contract;
9. The PACE organization is required to have trained personnel, drugs, and emergency equipment immediately available at every PACE center at all times to adequately support participants until Emergency Medical Services (EMS) responds to the PACE center;
10. Each PACE center is required to have at least one staff member who has been trained in cardio-pulmonary resuscitation (CPR) and will be on site during the hours that participants are in attendance;
11. The PACE organization must have a written plan and procedure for handling emergency situations that may arise including, but not limited to, cardiac arrest, choking and seizure activity in accordance with 42 CFR 460.100;
12. PACE center must have a documented plan to obtain Emergency Medical Services from sources outside the PACE center when needed. At least annually, a PACE organization must test, evaluate, and document the effectiveness of its emergency and disaster plans to ensure and maintain appropriate responses to the situations and needs that may arise from both medical and nonmedical emergencies;
13. The minimum emergency equipment that must be on the premises and immediately available includes: portable oxygen, airways, suction, and emergency drugs;

14. A PACE center must meet the applicable provisions of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association that apply to the type of setting in which the center is located;

15. A PACE provider must have an Emergency Preparedness Plan and an Infection Control Plan.

201.400 Emergency Preparedness 9-1-26

In accordance with 42 CFR 460.84, the PACE organization must establish and maintain an emergency preparedness program that meets the federal requirements.

The PACE organization must establish, implement, and maintain documented procedures to manage medical and non-medical emergencies and disasters that are likely to threaten the health and safety of participants, staff, or the public. The Disaster Plan must address the organization's arrangements for emergency food, nutritional supplements, and potable water supplies.

201.500 Infection Control 9-1-26

The PACE organization must, as specified in 42 CFR 460.74, establish, implement, and maintain a documented infection control plan that ensures a safe and sanitary environment and prevents and controls the transmission of disease and infection.

A. An infection control plan must include, but is not limited to:

1. procedures to identify, investigate, control, and prevent infections in every PACE center and in each participant's place of residence;

2. procedures to record any incidents of infection; and

3. procedures to analyze the incidents of infection, to identify trends and develop corrective actions related to the reduction of future incidents.

PACE organizations are required to follow accepted policies and standard procedures with respect to infection control, including, at the least, the standard precautions developed by the Center for Disease Control and Prevention (CDC).

PACE organizations are expected to establish written policies and procedures for the investigation, control, and prevention of infections including:

B. An OSHA Exposure Control Plan which includes the Universal Precautions and Bloodborne Pathogen exposure procedures for staff;

1. Vaccinating participants and staff against diseases of particular concern for the PACE participant and the center's geographic location, e.g., influenza and pneumonia;

2. Initial and ongoing health screening and vaccinations for staff and participants in accordance with OSHA regulations (staff) and CDC guidelines for tuberculosis, Hepatitis B and other communicable diseases;

3. Written plans and procedures for the investigation, evaluation, resolution, and reporting of all incidences of staff and participant infection;

4. Written plans and procedures for maintaining records of staff and participant infections to include post-exposure evaluation, training records, and participant and staff surveillance reports. Written plans and procedures for reporting required communicable diseases to the appropriate state and local officials;

5. Plans and procedures for staff providing direct care to patients with infection(s);

6. Provision of adequate facilities and supplies necessary for infection control to include:

a. Hand washing facilities and supplies;

b. Laundry facilities and supplies;

c. Isolation facilities and supplies;

7. Written plans and procedures for addressing how laundry will be handled. If the service is contracted out, written agreements to comply with the requirements;

8. Written plans and procedures for the ongoing monitoring of the contractual agreement provisions for laundry and waste disposal;

9. Written plans and procedures for the appropriate handling and disposal of all waste products including blood and urine specimens for outside lab tests and other biohazardous wastes.

C. DPSQA, or its vendor, is responsible for conducting an exit conference with the PACE Organization to discuss any review findings, provide technical assistance in developing corrective action plans, and to assist the PACE Organization in their efforts to implement the required corrections.

D. The PACE Organization must be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an Adult Day Health Care. CMS can conduct an audit at any point after the first year of the trial period. At the conclusion of the Three-year trial period, CMS in cooperation with DAABHS, continues to conduct reviews, as appropriate, of the PACE Organization considering the quality-of-service provision by the PACE Organization and compliance with all state and federal requirements.

E. The PACE Organization is required to disclose to current PACE participants and potential PACE participants information specific to the PACE Organization's performance and contract compliance deficiencies, in a manner specified by CMS (42 CFR §460.198).

201.600 Office of Medicaid Inspector General 9-1-26

A. A PACE Organization must have a formal process in place to gather information and must be able to respond in writing to a request from CMS or DAABHS for information regarding:

1. Persons with criminal convictions.

2. A PACE Organization must not employ individuals or contract with organizations or individuals:

a. Who have been excluded from participation in the Medicare or Medicaid programs;

b. Who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, other health insurance or health care programs, or social service programs under title XX of the Social Security Act; or

c. In any capacity where an individual's contact with participants would pose a potential risk because the individual has been convicted of physical, sexual, drug, or alcohol abuse.

3. Direct or indirect interest in contracts. No member of the PACE Organization's governing body or any immediate family member may have a direct or indirect interest in any contract that supplies any administrative or care-related service or materials to the PACE Organization.

202.000 PACE Administrative Requirements 9-1-26

A. In addition to participation requirements listed in Section 201.000, a PACE Organization must adhere to all PACE Administrative Requirements as outlined in 42 CFR Part 460 Subpart E, including:

1. PACE Organizational Structure;
2. PACE governing body and participant advisory committee;
3. Compliance oversight requirements;
4. Program integrity;
5. Physical environment;
6. Infection control;
7. Fiscal soundness; and
8. Emergency Preparedness.

202.100 Interdisciplinary Team **9-1-26**

A. The PACE Organization must establish an Interdisciplinary Team (IDT), composed of members that are qualified to fill the roles described below, at each PACE Center to comprehensively assess and meet the individual needs of each participant (42 CFR 460.102):

1. Primary Care Provider;
2. Registered Nurse;
3. Master's-level social worker;
4. Physical therapist;
5. Occupational therapist;
6. Recreational therapist or activity coordinator;
7. Dietitian;
8. Home Care Coordinator;
9. Personal Care Aide or their representative;
10. Driver or their representative; and
11. PACE Center Manager.

B. The PACE Organization must assign each participant to an Interdisciplinary Team (IDT) functioning at the PACE Center that the participant attends.

1. The IDT is responsible for:
   a. Assessing the needs of each PACE participant;
   b. Developing a Plan of Care;
   c. Providing and coordinating care that meets the needs of each participant across all care settings, twenty-four (24) hours a day, every day of the year (42 CFR 460.98);
   d. Monitoring the participant's Plan of Care and making updates as needed; and
   e. Reviewing and determining the necessity of recommended services from a hospital, emergency department, or urgent care provider, within forty-eight (48) hours of the participant's discharge, to determine if the service will appropriately meet the participant's social, emotional, physical, and medical needs.

202.200 Participant Rights **9-1-26**

A. A PACE Organization must have a written participant bill of rights designed to protect and promote the rights of each participant. Those rights include, at a minimum, the rights specified below (42 CFR 460.112):

1. Respect and nondiscrimination;
2. Right to treatment;
3. Information disclosure, including but not limited to:
   a. Right to have all treatment options explained in a culturally competent manner.
   b. Right to receive information regarding palliative, comfort, or end-of-life care services.
4. Choice of providers;
5. Participation in treatment decisions, including, but not limited to:
   a. Right to receive all care and services needed to improve or maintain the participant's health condition and attain the highest practicable physical, emotional, and social well-being.
   b. Right to access emergency health care services when and where the need arises without prior authorization by the PACE interdisciplinary team.
6. Confidentiality of health information; and
7. Complaints, requests, and appeals.

B. The PACE Organization must inform a participant or their representative, upon enrollment, in writing, of their rights and responsibilities, and all rules and regulations governing participation. It is required to:

1. Have the participant's rights written and displayed in English in a prominent place in the PACE Center; and
2. Have the participant's rights available in other principal languages of the community in which the PACE organization is located, as determined by the state.

C. The PACE organization must protect and provide for the exercise of the participant's rights, including:

1. Have established documented procedures to respond to and rectify a violation of a participant's rights; and
2. Comply with requirements through the CMS complaints tracking module, address and resolve complaints received by CMS against the PACE organization within the required timeframes (42 CFR 460.119).

D. Grievance Processes- Each PACE Organization must have formal written procedures to promptly identify, document, investigate, and resolve all medical and non-medical grievances in accordance with the requirements (42 CFR §460.120).

1. A grievance is a complaint, either oral or written, expressing dissatisfaction with service delivery or the quality of care furnished, regardless of whether remedial action is requested. Grievances may be between participants and the PACE Organization or any other entity or individual through which the PACE Organization provides services to the participant. All grievances must be remediated.
2. Medicare recipients have the right to file a written complaint with the quality improvement organization (QIO) with regard to Medicare covered services.

202.300 Restraints **9-1-26**

The PACE organization must limit use of restraints to the least restrictive and most effective method available. The term restraint includes either a physical restraint or a chemical restraint (42 CFR 460.114).

A. A physical restraint is any manual method or physical or mechanical device, materials, or equipment attached or adjacent to the participant's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

B. A chemical restraint is a medication used to control behavior or to restrict the participant's freedom of movement and is not a standard treatment for the participant's medical or psychiatric condition.

C. If the interdisciplinary team determines that a restraint is needed to ensure the participant's physical safety or the safety of others, the use must meet the following conditions:

1. Be imposed for a defined, limited period of time, based upon the assessed needs of the participant.
2. Be imposed in accordance with safe and appropriate restraining techniques.
3. Be imposed only when other less restrictive measures have been found to be ineffective to protect the participant or others from harm.
4. Be removed or ended at the earliest possible time.
5. The condition of the restrained participant must be continually assessed, monitored, and reevaluated.

202.400 Marketing 9-1-26

A. PACE Organizations that publicize their programs must include in their public marketing materials:

1. An adequate description of the enrollment and disenrollment policies and requirements;
2. PACE enrollment procedures;
3. Description of benefits and services;
4. Premiums;
5. Information on the restriction of services; Materials must state clearly that PACE participants may be liable for the costs of out-of-PACE program agreement services; and
6. Other information necessary for prospective participants to make an informed decision about enrollment.

B. Marketing information must be free of material inaccuracies, misleading information, or misrepresentations.

C. Marketing information must be furnished in English and any other principal languages of the community in which the PACE Organization is located, as determined by the State. This includes Braille, when necessary.

D. Marketing materials must be approved by CMS and DAABHS before distribution by the PACE Organization, including any revised or updated materials. Materials will be given a 45-day review period. If not disapproved within the review period, the organization can distribute it.

E. More details about marketing regulations can be found in 42 CFR 460.82.

203.000 PACE STAFF PARTICIPATION REQUIREMENTS

203.100 PACE Staff Participation Requirements 9-1-26

A. A provider must meet the following requirements to serve as a PACE Organization's staff (employee or contractor):

1. Be legally authorized (active license, registration, or certification in good standing) to practice in Arkansas and only act within the scope of his or her licensed authority.

   a. See specific Certification or Licensure Manual for specific provider types.

2. Successfully pass the background and registry checks and searches required by Ark. Code Ann. §§ 20-33-213 and 20-38-101 et seq.

203.200 Qualifications of PACE Staff with Direct Participant Contact 9-1-26

A. Each member of the PACE Organization's staff (employee or contractor) that has direct contact with participants must meet all the following conditions (42 CFR 460.64):

1. Have one (1) year of experience working with a frail or elderly population or, if the individual has less than one (1) year of experience, must receive appropriate training from the PACE Organization on working with a frail or elderly population.

2. Meet a standardized set of competencies, as described in Section 202.201 for the specific position description established by the PACE Organization, before working independently.

3. Have all immunizations up to date before engaging in direct participant contact.

4. Be medically cleared of communicable disease, and specifically determined free of active Tuberculosis, prior to providing direct care.

   a. Staff must be cleared for communicable diseases based on a physical examination performed by a licensed physician, nurse practitioner, or physician assistant.

   b. A PACE Organization may alternatively choose to perform an individual risk assessment for symptoms and exposure (must meet requirements specified in 42 CFR 460.64(a)(5)(iii)) to determine when a physical exam would be required for staff. Results of risk assessment must be reviewed by RN, physician, nurse practitioner, or physician assistant.

5. PACE Center staff must follow additional staffing regulations outlined in 'Rules and Regulations for Adult Day Health Care Providers,' the licensure manual for Adult Day Health Care (ADHC) facilities in Arkansas. Guidance is subject to periodic revisions as warranted.

203.300 Training for PACE Staff with Direct Participant Contact 9-1-26

A. A PACE Organization must ensure all its employees and contracted staff providing direct care to participants demonstrate the skills necessary for performance of their position (42 CFR §460.71).

1. The PACE Organization must provide all staff with an orientation that includes, at a minimum, the organization's mission, philosophy, policies on participant rights, emergency plan, ethics, the PACE Program, and any policies related to the job duties.

2. The provider must develop a competency evaluation program that identifies those skills, knowledge, and abilities that must be demonstrated by direct participant care staff.

   a. Training shall be appropriate to job function and shall include but is not limited

to the ADHC's licensure manual for training.

3. The competency program must be evidenced as completed before performing participant care and on an on-going basis by qualified professionals.

4. Certification of the satisfactory completion of the competency program must be in the personnel files of all staff.

210.000 PROGRAM ELIGIBILITY

210.100 Scope 9-1-26

Arkansas Medicaid will pay qualified PACE Organizations a fixed monthly payment per enrolled Medicaid participant for comprehensive services delivered to those who meet the PACE eligibility requirements of this Medicaid manual. Medicaid payment is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

210.200 Program Participant Eligibility Requirements 9-1-26

A. Participation in PACE is available to individuals fifty-five (55) years of age and older who live in a PACE Service Area, meet nursing home level of care as determined by Division of Aging and Adult Services, can live safely in a community setting without risking health or safety, and agree to forgo their usual sources of care to receive all services through the PACE Organization.

1. Additional eligibility requirements include:

   a. Having proof of residency in the State of Arkansas;

   b. Being a US citizen or legal alien;

   c. Having proof of a valid Social Security Number;

   d. Meeting Intermediate I-S, I-A, II-B, or III-C nursing facility level of care; and

   e. Meeting one of the following medical criteria, as assessed by a DHS Registered Nurse:

      i. Unable to perform at least one (1) of the three (3) activities of daily living (ADLs) of transferring or locomotion, eating, or toileting without extensive assistance or total dependence upon another person;

      ii. Unable to perform at least two (2) of the three (3) activities of daily living (ADLs) of transferring or locomotion, eating, or toileting without limited assistance from another person;

      iii. Primary or secondary diagnosis of Alzheimer's disease or related dementia and cognitively impaired so as to require substantial supervision from another individual; or

      iv. Diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and if left untreated, would be life threatening.

Note: Individuals diagnosed with serious mental illness (SMI) or an intellectual disability are not eligible for PACE unless their medical needs are unrelated to their SMI/DD diagnosis and they meet the other qualifying criteria.

2. Medicare beneficiaries meeting the above requirements agree to participate in PACE by paying monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or any other type of Medicare or Medicaid cost-sharing.

3. Individuals not eligible for Medicaid or Medicare who meet the above requirements agree to participate in PACE by paying private premiums.

210.300 Evaluation Referral 9-1-26

A. A beneficiary may be initially referred to PACE by a PACE Organization or DHS Registered Nurse, however an outside referral is not required to apply.

B. Beneficiaries apply for PACE through their local Division of County Operations (DCO) office for a determination of financial eligibility.

C. The local DCO office will refer the beneficiary for an independent assessment, determination of financial eligibility notwithstanding.

210.400 Independent Assessment and Level of Care Determination 9-1-26

A. For individuals new to PACE, the individual must receive an Independent Assessment via the Arkansas Independent Assessment (ARIA) instrument, administered by a DHS-appointed Independent Assessment Contractor. The ARIA determines the individual's functional needs eligibility.

1. The Division of County Operations (DCO) registered nurse determines the potential enrollee's nursing facility level of care via the DHS-704 based on the results of the Independent Assessment.

2. The DCO registered nurse notifies the PACE Organization when all requirements have been met.

B. For renewing PACE participants, a Division of Aging and Adult Services registered nurse completes an annual evaluation (Medical Needs Assessment Form DMS-703) to evaluate the potential enrollee's nursing facility level of care.

1. To be eligible for PACE, beneficiaries must have a Medical Needs Assessment indicating they require Intermediate I-S, I-A, II-B, or III-C nursing facility level of care.

2. The Division of Aging and Adult Services' registered nurse must certify that an assessment has been completed and that it is safe for the participant to live in the community.

3. The Division of Aging and Adult Services' registered nurse notifies the local Division of County Operations (DCO) office and the PACE Organization when all requirements have been met.

210.500 Enrollment with PACE Organization 9-1-26

A. If the potential participant meets the eligibility requirements and wants to pursue enrollment with the PACE Organization, they must sign an enrollment agreement with the PACE Organization that serves their Service Area. For more details on the contents of the enrollment agreement, see 42 CFR 460.154.

1. Enrollment in PACE results in disenrollment from any other Medicare or Medicaid prepayment plan or optional benefit. See 42 CFR 460.154(i).

2. The PACE Organization is required to complete its own intensive assessment that includes a minimum of one (1) home visit for enrollment.

3. The potential enrollee is required to complete one (1) visit to the PACE Center, unless otherwise approved by CMS.

4. At the time of enrollment, the PACE Organization is required to do the following:

a. Verify whether the participant is dually eligible for Medicare and Medicaid and whether the participant has Medicare Part A, Part B, or both;

b. Remind participants that unless they are dually eligible, they will need to continue to pay their Medicare Part A premium (if not free), Part B premium (if

not eligible for State coverage), and Part D premium, if applicable; and

c. Identify payers that are primary to Medicare, determine the amounts payable by those payers, and coordinate benefits to Medicare participants with the benefits of primary payers.

B. Involuntary Disenrollment

1. Involuntary disenrollments are to be handled pursuant to federal law.

2. Refer to 42 C.F.R. 460.164, 460.166 and 460.172.

210.600 Person-Centered Plan of Care 9-1-26

A. After the individual is enrolled, the PACE Organization's Interdisciplinary Team (IDT) is responsible for individualized assessment, treatment planning, and care delivery. The IDT must meet the following requirements for the Plan of Care:

1. Complete an initial, in-person, comprehensive assessment by the following members promptly following the beneficiary's enrollment:

a. Primary care physician;

b. Registered nurse;

c. Master's-level social worker;

d. Physical therapist;

e. Occupational therapist;

f. Recreational therapist or activity coordinator;

g. Dietitian; and

h. Home care coordinator.

2. Develop, evaluate, and, if necessary, revise the comprehensive Person-Centered Plan of Care for the participant (42 CFR §460.106).

a. The Interdisciplinary Team must complete the initial Plan of Care within thirty (30) calendar days of the participant's date of enrollment.

b. The Interdisciplinary Team must involve the participant and their family members or circle of natural supports in the development of the Plan of Care. The PACE Organization should document beneficiary and/or family approval of the Plan of Care.

c. The Plan of Care must explain different treatment options, provide written information of those options, and obtain written consent prior to initiating any palliative, comfort, or end-of-life care services.

d. At least once every one hundred eighty (180) calendar days from the date the latest Plan of Care was finalized, the Interdisciplinary Team must complete a semi-annual Plan of Care evaluation, and if necessary, revisions to each participant's Plan of Care.

3. For requests from the participant, or their representative or caregiver, to initiate, modify, or continue a service during the development of the initial Person-Centered Plan of Care, the IDT must:

a. Document the request; and

b. Discuss the request during the care planning meeting and either:

i. Approve the requested service and incorporate it into the participant's initial Plan of Care; or

ii. Document the rationale for not approving the service in the initial Plan of Care.

4. Additional in-person Assessments and Treatment Plans corresponding to the overall Person-Centered Plan of Care must be completed, as applicable, by the:
    a. Physical therapist;
    b. Occupational therapist;
    c. Dietitian; and
    d. Home care coordinator.

B. Change of Condition

1. When a change of condition is noted by any provider delivering services to the PACE participant, the Interdisciplinary Team must update the Plan of Care within fourteen (14) days from the actual status change.
2. Re-assessments and Treatment Plan changes are also completed when the PACE participant experiences a change in health or psycho-social condition.

210.700 Service Determination Process **9-1-26**

A. Service Determination Requests (42 CFR 460.121)

1. A Service Determination Request is a request made by a participant, their representative, or their caregiver to initiate a new service, modify an existing service, or continue coverage of a service that a PACE Organization is recommending being discontinued or reduced.
    a. Requests can be made orally or in writing to any employee or contractor of the PACE Organization that provides direct care to a participant, including transportation personnel.
    b. If a request is made prior to completing the development of the initial Person-Centered Plan of Care, it is not considered a Service Determination Request.
2. The PACE organization must bring a Service Determination Request to the Interdisciplinary Team (IDT) as expeditiously as the participant's condition requires, but no later than three (3) calendar days from the time the request is made.
    a. If a member of the IDT is able to approve the Service Determination Request in full at the time the request is made, the PACE Organization:
        i. Must provide oral or written notice of decision to approve a service determination request to the participant, in understandable language. The approval should include the conditions of the approval, including when the participant may expect to receive the approved service.
        ii. Must follow recordkeeping requirements established in Part B below.
        iii. Does not need a full IDT review.
    b. In all other cases, the full IDT must review and discuss each Service Determination Request and decide to approve, deny, or partially deny the request based on that review.
        i. IDT will consider all relevant information when evaluating a request, including, but not limited to, the findings and results of any reassessments.
    c. The IDT may extend the timeframe for review and notification by up to five (5) calendar days if either of the following occur:
        i. The participant or their representative request the extension; or
        ii. The IDT needs additional information from an individual, not directly employed by the PACE Organization, that may change the interdisciplinary team's decision to deny a service.
    d. The participant or their representative must be notified of any extension in

review timeframe either orally or in writing, no later than twenty-four (24) hours after the IDT decides to extend the review timeframe.

e. If the IDT fails to provide the participant with timely notice of the resolution of the request, or does not furnish the services required by the revised Person-Centered Plan of Care, this constitutes an adverse decision. The participant's request must be automatically processed by the PACE organization as an appeal (42 CFR 460.121(l)).

B. Recordkeeping

1. The PACE organization must establish and implement a process to document, track, and maintain records related to all processing requirements for Service Determination Requests received both orally and in writing.

2. These records must be available to the IDT to ensure that all members remain alert to pertinent participant information.

C. Reassessments based on a Service Determination Request

1. If the IDT expects to deny or partially deny a Service Determination Request, the appropriate members of the IDT must conduct an in-person Reassessment before the IDT makes a final decision.

2. IDT members performing the Reassessment evaluate whether the requested service is necessary to meet the participant's medical, physical, emotional, and social needs.

3. The IDT may conduct a Reassessment prior to approving a Service Determination Request, either in-person or through the use of remote technology, if the team determines that a Reassessment is necessary.

210.800 Service Determination Approvals and Denials 9-1-26

A. Notice of decision to approve a Service Determination Request

1. If the interdisciplinary team (IDT) decides to approve a Service Determination Request, it must provide the participant or representative either oral or written notice of the determination.

2. The approval must explain the conditions of the approval in understandable language, including when the participant may expect to receive the approved service.

B. Notice of decision to deny a Service Determination Request (42 CFR 460.121(j))

1. If the IDT decides to deny or partially deny a service, it must provide the participant or representative both oral and written notice of the determination.

2. Notice of any denial must:

a. State the specific reason(s) for the denial, including why the service is not necessary to maintain or improve the participant's overall health status, taking into account the participant's medical, physical, emotional, and social needs, and the results of the Reassessment(s) in understandable language.

b. Inform the participant or representative of his or her right to appeal the decision.

c. Describe the standard and expedited appeals processes, including the right to, and conditions for, obtaining expedited consideration of an appeal of a denial of services.

d. For a Medicaid participant, inform the participant of both of the following:

i. His or her right to continue receiving disputed services during the appeals process until issuance of the final determination.

ii. The conditions for continuing to receive disputed services.

C. Appeals

1. An appeal to a PACE Organization is a participant's action taken with respect to the PACE Organization's noncoverage of, or nonpayment for, a service including denials, reductions, or termination of services. Refer to Appendix R in the PACE Program Agreement.

2. A request to initiate, modify, or continue a service must first be processed as a service determination request under Section 210.700 before the PACE organization can process an appeal under this section.

3. See further details on a PACE Organization's Appeals Process (42 CFR 460.122).

4. Additional appeal rights under Medicare or for those dually eligible for Medicare and Medicaid can be found 42 CFR 460.124.

5. Medicaid Administrative Reconsideration and Appeals:

a. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 Section 1 of this Medicaid Manual.

b. When the State Medicaid Agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section 1 of this Medicaid Manual.

220.000 PROGRAM SERVICES

220.100 Non-covered Services 9-1-26

A. Medicare and Medicaid services delivered solely through the PACE Organization are the only benefits covered while the participant is enrolled in a PACE program (42 CFR 460.90).

B. The following services are excluded from coverage under PACE:

1. Cosmetic surgery;

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

3. Services furnished outside the USA, except as permitted under the state's Medicaid Plan.

220.200 Covered Services 9-1-26

The PACE benefit package for all participants, regardless of the source of payment, must include the following as prescribed by the Interdisciplinary Team (IDT) assessment:

A. All Medicaid-covered services, as specified in the State's approved Medicaid plan.

B. Interdisciplinary assessment and treatment planning.

C. Primary care, including physician and nursing services.

D. Social work services.

E. Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services.

F. Personal care and supportive services.

G. Nutritional counseling.

H. For more detailed policies on meal requirements and sanitary conditions, see 42 CFR 460.78.

I. Recreational therapy.

J. Transportation.

1. For more detailed policies on required safety, accessibility, and equipment; maintenance of vehicles; vehicle communication with PACE center; personnel training; and inclusion in any changes to the person-centered service plan, see 42 CFR 460.76.

K. Meals as required by the interdisciplinary team's plan of care.

L. Medical specialty services including, but not limited to the following:

1. Anesthesiology;
2. Audiology;
3. Cardiology;
4. Dentistry;
5. Dermatology;
6. Gastroenterology;
7. Gynecology;
8. Internal medicine;
9. Nephrology;
10. Neurosurgery;
11. Oncology;
12. Ophthalmology;
13. Oral surgery;
14. Orthopedic surgery;
15. Otorhinolaryngology;
16. Palliative Medicine
17. Plastic surgery;
18. Pharmacy consulting services;
19. Podiatry;
20. Psychiatry;
21. Pulmonary disease;
22. Radiology;
23. Rheumatology;
24. General surgery;
25. Thoracic and vascular surgery; and
26. Urology.

M. Laboratory tests, x-rays, and other diagnostic procedures.

N. Drugs and biologicals.

O. Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items.

P. Acute inpatient care, including the following:

1. Ambulance;
2. Emergency room care and treatment room services;
3. Semi-private room and board;
4. General medical and nursing services;
5. Medical, surgical, intensive care, and the Coronary Care Unit;
6. Laboratory tests, x-rays, and other diagnostic procedures;
7. Drugs and biologicals;
8. Blood and blood derivatives;
9. Surgical care, including the use of anesthesia;
10. Use of oxygen;
11. Physical, occupational, respiratory therapies, and speech language pathology services; and
12. Social services.

Q. Nursing facility care, including the following:

1. Semi-private room and board;
2. Physician and skilled nursing services;
3. Custodial care;
4. Personal care and assistance;
5. Drugs and biologicals;
6. Physical, occupational, recreational therapies, and speech-language pathology, if necessary;
7. Social services; and
8. Medical supplies and appliances.

R. Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

1. Medications must be provided within twenty-four (24) hours of the Primary Care Provider’s order.
2. All services (other than medications) approved by the IDT must be set-up, scheduled, or arranged within seven (7) days of the approval. This does not include routine or preventative services.
3. Notwithstanding, all services and medications are to be provided as expeditiously as the participant’s health requires, so if needed, services must be provided more quickly than the timelines provided for in this section.
4. Contracted Services.

S. The PACE organization must have a written contract with each outside organization, agency, or individual that furnishes administrative or care-related services not furnished directly by the PACE organization, including, at a minimum, the medical specialties listed previously in this Section (as per 42 CFR 460.70).

1. Contracts with medical specialists must be executed prior to enrollment of participants and must be maintained on an ongoing basis to ensure participants receive appropriate and timely access to all medically necessary care and services.

2. A PACE Organization is responsible for making all reasonable and timely attempts to contract with medical specialists. If at any time a PACE Organization is unable to directly contract or maintain a contract with a specific specialty, the PACE Organization must:

   a. Ensure care and services that would otherwise be provided to participants by a contracted specialist are provided and that the participant's needs are met through a different mechanism to include hospitalization; and

   b. Promptly report the contracting issue to CMS and DAABHS, including the attempts made to contract, the reason why the contract was not effectuated, and the PACE Organization's plan to provide access to the necessary services.

3. A PACE Organization is not required to have a contract with a particular medical specialty if the PACE Organization directly employs one (1) or more individuals prior to contracting, who are legally authorized, and, if applicable, board certified in the particular medical specialty.

4 For more information about contract requirements, the mandatory list of contractors that must be kept on file, see 42 CFR 460.70.

TOC Required

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

200.100 Program Description 9-1-26

A. The Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive health and social services program that helps older adults, who need nursing home level of care, remain in their homes and communities. It is a joint Medicare/Medicaid program that provides and coordinates primary, acute, and long-term care for qualifying beneficiaries who are fifty-five (55) years of age or older. PACE relies on an interdisciplinary team approach to care management and comprehensive service delivery.

1. Social and medical services are provided primarily in a PACE center but are supplemented by in-home and referral services as needed by the PACE Organization (see section 202.000).
2. Pursuant to Arkansas Code Annotated §20-10-801 (14) a licensed, certified PACE Program is exempted from any additional or separate home healthcare licensing requirements.
3. Pursuant to 42 CFR Part 460, PACE providers must be in compliance with all federal regulations.

B. PACE is designed to meet the following aims:

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.
4. Preserve and support the older adult's family unit.

C. PACE provides pre-paid, capitated, comprehensive health care services The PACE assumes full financial risk. The PACE program must provide all the authorized care and services covered by Medicare and Medicaid, as well as additional medically-necessary care and services for program participants, as per 42 CFR §460.92.

D. PACE is a State option under Arkansas Medicaid and is operated by the Division of Aging, Adult, and Behavioral Health Services (DAABHS).

Further programmatic information and guidelines for PACE are outlined by the Centers for Medicare and Medicaid Services (CMS) in their Programs of All-Inclusive Care for the Elderly (PACE) Manual online.

200.200 PACE Terms and Definitions 9-1-26

Contract Year	The term of a PACE Program Agreement between the PACE Organization, DAABHS, and CMS, which is a calendar year that ends on December 31. A PACE Organization's initial contract year may last anywhere from 19 to 30 months as determined by CMS, but will end on December 31st.

PACE Center	A facility which includes a primary care 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	A provider that has a PACE Program Agreement in effect to operate a PACE program in the state.
PACE Program Agreement	An agreement between a PACE Organization, DAABHS, and CMS for the operation of a PACE program.
PACE Service Area	The designated area (zip-code specific) where a PACE Organization is permitted to provide services. This should not overlap with another PACE Organization.
Participant	A beneficiary who is enrolled in a PACE program.

201.000 PACE Applicant Requirements 9-1-26

A. A PACE Organization is a not-for-profit, for-profit, or public entity that is primarily engaged in providing PACE services. The following characteristics must also apply to a PACE organization:

1. Have a governing body, or a designated person functioning as a governing body, that includes participant representation;
2. Be able to provide the complete PACE service package regardless of frequency or duration of services;
3. Have a physical site and staff to provide primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals;
4. Have a defined service area;
5. Have safeguards against conflict of interest;
6. Have demonstrated fiscal soundness;
7. Have a formal Participant Bill of Rights; and
8. Have a process to address grievances and appeals.

B. A provider must meet all of the following participation requirements to qualify as a PACE Organization that operates a PACE program under Arkansas Medicaid:

1. Submit a Notice of Intent to Apply (NOIA) PACE form to the Division of Aging and Adult Services as a letter of intention to establish or expand a PACE Program;
2. Obtain an Adult Day Health Care facility license;
   a. Adhere to all regulations established for the licensure of Adult Day Health Care (ADHC) facilities in Arkansas, overseen by the Division of Provider Services & Quality Assurance (DPSQA).
   b. Refer to ‘Rules and Regulations for Adult Day Health Care Providers’ for more information. Guidance is subject to periodic revisions as warranted.
3. Submit a PACE Provider Application and be approved by both Arkansas’ Division of Aging and Adult Services and the Centers for Medicare and Medicaid Services (CMS), as per 42 CFR §460.18;
   a. A PACE provider’s past performance will be considered when determining approval or denial of new or expansion applications.
   b. Submitting a completed PACE provider application to DAABHS after submitting

it to CMS, or failing to submit it to DAABHS altogether, may result in the denial or delay of the application's approval.

c. A PACE Provider Application is also required for a pre-existing PACE Organization that seeks to expand its service area or add a new PACE Center (42 CFR 460.12(d)).

4. Execute a PACE Program Agreement, which acts as a three-party contract governing provider operations signed by the PACE provider, Division of Aging and Adult Services, and CMS; and

5. Complete the Medicaid provider participation and enrollment requirements contained within Section 140.000 of this Medicaid manual.

C. A provider may request a waiver of certain regulatory requirements along with their PACE Provider Application. The purpose of the waiver is to provide for reasonable flexibility in adapting the PACE model to the needs of particular organizations (such as those in rural areas).

1. A provider should follow guidelines set forth in 42 CFR 460.26 for submission and evaluation of waiver requests.

Note: Click here for more information on the PACE Provider Application.

Note: Click here for more information on the PACE Program Agreement.

201.200 Violations, Sanctions, Civil Money Penalties, Suspension, and Termination 9-1-26

A. CMS may impose any of the sanctions as specified in 42 CFR 460.40 if CMS determines that a PACE organization commits programmatic violations.

B. CMS may suspend Medicare payment to the PACE organization and may deny payment to the State for medical assistance for services furnished under the PACE program agreement for one or more program violations as specified in 42 CFR 460.42.

C. CMS may impose civil money penalties up to the maximum amounts specified by federal law as specified in 42 CFR 460.46.

D. CMS in consultation with DAABHS, may take one or more of the following actions as specified in 42. CFR 460.48:

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.

201.300 State Monitoring Activities for PACE Organizations 9-1-26

A. DPSQA, or its vendor, conducts independent site visits annually, or as needed, in addition to CMS site visits, to compliance with regulations, state and federal laws.

B. DPSQA, or its vendor, is responsible for conducting an exit conference with the PACE Organization to discuss any review findings, provide technical assistance in developing corrective action plans, and to assist the PACE Organization in their efforts to implement the required corrections.

C. The PACE Organization must be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an Adult Day Health Care. CMS can conduct an audit at any point after the first year of the trial period. At the

conclusion of the Three-year trial period, CMS in cooperation with DAABHS, continues to conduct reviews, as appropriate, of the PACE Organization considering the quality-of-service provision by the PACE Organization and compliance with all state and federal requirements.

D. The PACE Organization is required to disclose to current PACE participants and potential PACE participants information specific to the PACE Organization's performance and contract compliance deficiencies, in a manner specified by CMS (42 CFR §460.198).

E DPSQA, or its vendor, upon annual inspection will review the following, in addition to ensuring a PACE provider is meeting the requirements of an Adult Day Health provider:

1. The PACE organization's physical environment to ensure a safe, sanitary, functional, accessible, and comfortable environment;
2. Suitable space and equipment to provide primary medical care and suitable space for treatment, restorative therapies, therapeutic recreation, socialization, dining and personal care;
3. Suitable meeting space for personnel to conduct team meetings and for participant's caregivers, and visitors;
4. Spaces which provide participant privacy and dignity during the delivery of services;
5. Proof that there are life safety code inspections from the fire marshal, Department of Health, and other required state agency inspections;
6. The PACE organization must provide evidence of a federal Clinical Laboratory Improvement Amendment (CLIA) exemption if the center is performing waived laboratory services on site or in the home, e.g., glucose meter testing, urine testing, fecal occult blood testing, blood testing, cholesterol screening or hemoglobin or hematocrit testing;
7. In addition, the PACE organization must meet all applicable Federal, State, and local laws and regulations, which include the Americans with Disabilities Act and Section 504 of the Rehabilitation Act;
8. A PACE organization must perform the manufacturer's recommended maintenance on all equipment as indicated in the manufacturer's written recommendations. This maintenance may be performed by PACE staff or contracted entities and in compliance with the contract;
9. The PACE organization is required to have trained personnel, drugs, and emergency equipment immediately available at every PACE center at all times to adequately support participants until Emergency Medical Services (EMS) responds to the PACE center;
10. Each PACE center is required to have at least one staff member who has been trained in cardio-pulmonary resuscitation (CPR) and will be on site during the hours that participants are in attendance;
11. The PACE organization must have a written plan and procedure for handling emergency situations that may arise including, but not limited to, cardiac arrest, choking and seizure activity in accordance with 42 CFR 460.100;
12. PACE center must have a documented plan to obtain Emergency Medical Services from sources outside the PACE center when needed. At least annually, a PACE organization must test, evaluate, and document the effectiveness of its emergency and disaster plans to ensure and maintain appropriate responses to the situations and needs that may arise from both medical and nonmedical emergencies;
13. The minimum emergency equipment that must be on the premises and immediately available includes: portable oxygen, airways, suction, and emergency drugs;

14. A PACE center must meet the applicable provisions of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association that apply to the type of setting in which the center is located;

15. A PACE provider must have an Emergency Preparedness Plan and an Infection Control Plan.

201.400 Emergency Preparedness 9-1-26

In accordance with 42 CFR 460.84, the PACE organization must establish and maintain an emergency preparedness program that meets the federal requirements.

The PACE organization must establish, implement, and maintain documented procedures to manage medical and non-medical emergencies and disasters that are likely to threaten the health and safety of participants, staff, or the public. The Disaster Plan must address the organization's arrangements for emergency food, nutritional supplements, and potable water supplies.

201.500 Infection Control 9-1-26

The PACE organization must, as specified in 42 CFR 460.74, establish, implement, and maintain a documented infection control plan that ensures a safe and sanitary environment and prevents and controls the transmission of disease and infection.

A. An infection control plan must include, but is not limited to:

1. procedures to identify, investigate, control, and prevent infections in every PACE center and in each participant's place of residence;

2. procedures to record any incidents of infection; and

3. procedures to analyze the incidents of infection, to identify trends and develop corrective actions related to the reduction of future incidents.

PACE organizations are required to follow accepted policies and standard procedures with respect to infection control, including, at the least, the standard precautions developed by the Center for Disease Control and Prevention (CDC).

PACE organizations are expected to establish written policies and procedures for the investigation, control, and prevention of infections including:

B. An OSHA Exposure Control Plan which includes the Universal Precautions and Bloodborne Pathogen exposure procedures for staff;

1. Vaccinating participants and staff against diseases of particular concern for the PACE participant and the center's geographic location, e.g., influenza and pneumonia;

2. Initial and ongoing health screening and vaccinations for staff and participants in accordance with OSHA regulations (staff) and CDC guidelines for tuberculosis, Hepatitis B and other communicable diseases;

3. Written plans and procedures for the investigation, evaluation, resolution, and reporting of all incidences of staff and participant infection;

4. Written plans and procedures for maintaining records of staff and participant infections to include post-exposure evaluation, training records, and participant and staff surveillance reports. Written plans and procedures for reporting required communicable diseases to the appropriate state and local officials;

5. Plans and procedures for staff providing direct care to patients with infection(s);

6. Provision of adequate facilities and supplies necessary for infection control to include:

a. Hand washing facilities and supplies;

b. Laundry facilities and supplies;

c. Isolation facilities and supplies;

7. Written plans and procedures for addressing how laundry will be handled. If the service is contracted out, written agreements to comply with the requirements;

8. Written plans and procedures for the ongoing monitoring of the contractual agreement provisions for laundry and waste disposal;

9. Written plans and procedures for the appropriate handling and disposal of all waste products including blood and urine specimens for outside lab tests and other biohazardous wastes.

C. DPSQA, or its vendor, is responsible for conducting an exit conference with the PACE Organization to discuss any review findings, provide technical assistance in developing corrective action plans, and to assist the PACE Organization in their efforts to implement the required corrections.

D. The PACE Organization must be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an Adult Day Health Care. CMS can conduct an audit at any point after the first year of the trial period. At the conclusion of the Three-year trial period, CMS in cooperation with DAABHS, continues to conduct reviews, as appropriate, of the PACE Organization considering the quality-of-service provision by the PACE Organization and compliance with all state and federal requirements.

E. The PACE Organization is required to disclose to current PACE participants and potential PACE participants information specific to the PACE Organization's performance and contract compliance deficiencies, in a manner specified by CMS (42 CFR §460.198).

201.600 Office of Medicaid Inspector General 9-1-26

A. A PACE Organization must have a formal process in place to gather information and must be able to respond in writing to a request from CMS or DAABHS for information regarding:

1. Persons with criminal convictions.

2. A PACE Organization must not employ individuals or contract with organizations or individuals:

a. Who have been excluded from participation in the Medicare or Medicaid programs;

b. Who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, other health insurance or health care programs, or social service programs under title XX of the Social Security Act; or

c. In any capacity where an individual's contact with participants would pose a potential risk because the individual has been convicted of physical, sexual, drug, or alcohol abuse.

3. Direct or indirect interest in contracts. No member of the PACE Organization's governing body or any immediate family member may have a direct or indirect interest in any contract that supplies any administrative or care-related service or materials to the PACE Organization.

202.000 PACE Administrative Requirements 9-1-26

A. In addition to participation requirements listed in Section 201.000, a PACE Organization must adhere to all PACE Administrative Requirements as outlined in 42 CFR Part 460 Subpart E, including:

1. PACE Organizational Structure;
2. PACE governing body and participant advisory committee;
3. Compliance oversight requirements;
4. Program integrity;
5. Physical environment;
6. Infection control;
7. Fiscal soundness; and
8. Emergency Preparedness.

202.100 Interdisciplinary Team 9-1-26

A. The PACE Organization must establish an Interdisciplinary Team (IDT), composed of members that are qualified to fill the roles described below, at each PACE Center to comprehensively assess and meet the individual needs of each participant (42 CFR 460.102):

1. Primary Care Provider;
2. Registered Nurse;
3. Master's-level social worker;
4. Physical therapist;
5. Occupational therapist;
6. Recreational therapist or activity coordinator;
7. Dietitian;
8. Home Care Coordinator;
9. Personal Care Aide or their representative;
10. Driver or their representative; and
11. PACE Center Manager.

B. The PACE Organization must assign each participant to an Interdisciplinary Team (IDT) functioning at the PACE Center that the participant attends.

1. The IDT is responsible for:
   a. Assessing the needs of each PACE participant;
   b. Developing a Plan of Care;
   c. Providing and coordinating care that meets the needs of each participant across all care settings, twenty-four (24) hours a day, every day of the year (42 CFR 460.98);
   d. Monitoring the participant's Plan of Care and making updates as needed; and
   e. Reviewing and determining the necessity of recommended services from a hospital, emergency department, or urgent care provider, within forty-eight (48) hours of the participant's discharge, to determine if the service will appropriately meet the participant's social, emotional, physical, and medical needs.

202.200 Participant Rights 9-1-26

A. A PACE Organization must have a written participant bill of rights designed to protect and promote the rights of each participant. Those rights include, at a minimum, the rights specified below (42 CFR 460.112):

1. Respect and nondiscrimination;
2. Right to treatment;
3. Information disclosure, including but not limited to:
   a. Right to have all treatment options explained in a culturally competent manner.
   b. Right to receive information regarding palliative, comfort, or end-of-life care services.
4. Choice of providers;
5. Participation in treatment decisions, including, but not limited to:
   a. Right to receive all care and services needed to improve or maintain the participant's health condition and attain the highest practicable physical, emotional, and social well-being.
   b. Right to access emergency health care services when and where the need arises without prior authorization by the PACE interdisciplinary team.
6. Confidentiality of health information; and
7. Complaints, requests, and appeals.

B. The PACE Organization must inform a participant or their representative, upon enrollment, in writing, of their rights and responsibilities, and all rules and regulations governing participation. It is required to:

1. Have the participant’s rights written and displayed in English in a prominent place in the PACE Center; and
2. Have the participant’s rights available in other principal languages of the community in which the PACE organization is located, as determined by the state.

C. The PACE organization must protect and provide for the exercise of the participant’s rights, including:

1. Have established documented procedures to respond to and rectify a violation of a participant’s rights; and
2. Comply with requirements through the CMS complaints tracking module, address and resolve complaints received by CMS against the PACE organization within the required timeframes (42 CFR 460.119).

D. Grievance Processes- Each PACE Organization must have formal written procedures to promptly identify, document, investigate, and resolve all medical and non-medical grievances in accordance with the requirements (42 CFR §460.120).

1. A grievance is a complaint, either oral or written, expressing dissatisfaction with service delivery or the quality of care furnished, regardless of whether remedial action is requested. Grievances may be between participants and the PACE Organization or any other entity or individual through which the PACE Organization provides services to the participant. All grievances must be remediated.
2. Medicare recipients have the right to file a written complaint with the quality improvement organization (QIO) with regard to Medicare covered services.

202.300 Restraints 9-1-26

The PACE organization must limit use of restraints to the least restrictive and most effective method available. The term restraint includes either a physical restraint or a chemical restraint (42 CFR 460.114).

A. A physical restraint is any manual method or physical or mechanical device, materials, or equipment attached or adjacent to the participant's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

B. A chemical restraint is a medication used to control behavior or to restrict the participant's freedom of movement and is not a standard treatment for the participant's medical or psychiatric condition.

C. If the interdisciplinary team determines that a restraint is needed to ensure the participant's physical safety or the safety of others, the use must meet the following conditions:

1. Be imposed for a defined, limited period of time, based upon the assessed needs of the participant.
2. Be imposed in accordance with safe and appropriate restraining techniques.
3. Be imposed only when other less restrictive measures have been found to be ineffective to protect the participant or others from harm.
4. Be removed or ended at the earliest possible time.
5. The condition of the restrained participant must be continually assessed, monitored, and reevaluated.

202.400 Marketing 9-1-26

A. PACE Organizations that publicize their programs must include in their public marketing materials:

1. An adequate description of the enrollment and disenrollment policies and requirements;
2. PACE enrollment procedures;
3. Description of benefits and services;
4. Premiums;
5. Information on the restriction of services; Materials must state clearly that PACE participants may be liable for the costs of out-of-PACE program agreement services; and
6. Other information necessary for prospective participants to make an informed decision about enrollment.

B. Marketing information must be free of material inaccuracies, misleading information, or misrepresentations.

C. Marketing information must be furnished in English and any other principal languages of the community in which the PACE Organization is located, as determined by the State. This includes Braille, when necessary.

D. Marketing materials must be approved by CMS and DAABHS before distribution by the PACE Organization, including any revised or updated materials. Materials will be given a 45-day review period. If not disapproved within the review period, the organization can distribute it.

E. More details about marketing regulations can be found in 42 CFR 460.82.

203.000 PACE STAFF PARTICIPATION REQUIREMENTS

203.100 PACE Staff Participation Requirements 9-1-26

A. A provider must meet the following requirements to serve as a PACE Organization's staff (employee or contractor):

1. Be legally authorized (active license, registration, or certification in good standing) to practice in Arkansas and only act within the scope of his or her licensed authority.
   a. See specific Certification or Licensure Manual for specific provider types.
2. Successfully pass the background and registry checks and searches required by Ark. Code Ann. §§ 20-33-213 and 20-38-101 et seq.

203.200 Qualifications of PACE Staff with Direct Participant Contact 9-1-26

A. Each member of the PACE Organization's staff (employee or contractor) that has direct contact with participants must meet all the following conditions (42 CFR 460.64):

1. Have one (1) year of experience working with a frail or elderly population or, if the individual has less than one (1) year of experience, must receive appropriate training from the PACE Organization on working with a frail or elderly population.
2. Meet a standardized set of competencies, as described in Section 202.201 for the specific position description established by the PACE Organization, before working independently.
3. Have all immunizations up to date before engaging in direct participant contact.
4. Be medically cleared of communicable disease, and specifically determined free of active Tuberculosis, prior to providing direct care.
   a. Staff must be cleared for communicable diseases based on a physical examination performed by a licensed physician, nurse practitioner, or physician assistant.
   b. A PACE Organization may alternatively choose to perform an individual risk assessment for symptoms and exposure (must meet requirements specified in 42 CFR 460.64(a)(5)(iii)) to determine when a physical exam would be required for staff. Results of risk assessment must be reviewed by RN, physician, nurse practitioner, or physician assistant.
5. PACE Center staff must follow additional staffing regulations outlined in ‘Rules and Regulations for Adult Day Health Care Providers,’ the licensure manual for Adult Day Health Care (ADHC) facilities in Arkansas. Guidance is subject to periodic revisions as warranted.

203.300 Training for PACE Staff with Direct Participant Contact 9-1-26

A. A PACE Organization must ensure all its employees and contracted staff providing direct care to participants demonstrate the skills necessary for performance of their position (42 CFR §460.71).

1. The PACE Organization must provide all staff with an orientation that includes, at a minimum, the organization’s mission, philosophy, policies on participant rights, emergency plan, ethics, the PACE Program, and any policies related to the job duties.
2. The provider must develop a competency evaluation program that identifies those skills, knowledge, and abilities that must be demonstrated by direct participant care staff.
   a. Training shall be appropriate to job function and shall include but is not limited

to the ADHC's licensure manual for training.

3. The competency program must be evidenced as completed before performing participant care and on an on-going basis by qualified professionals.

4. Certification of the satisfactory completion of the competency program must be in the personnel files of all staff.

210.000 PROGRAM ELIGIBILITY

210.100 Scope 9-1-26

Arkansas Medicaid will pay qualified PACE Organizations a fixed monthly payment per enrolled Medicaid participant for comprehensive services delivered to those who meet the PACE eligibility requirements of this Medicaid manual. Medicaid payment is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

210.200 Program Participant Eligibility Requirements 9-1-26

A. Participation in PACE is available to individuals fifty-five (55) years of age and older who live in a PACE Service Area, meet nursing home level of care as determined by Division of Aging and Adult Services, can live safely in a community setting without risking health or safety, and agree to forgo their usual sources of care to receive all services through the PACE Organization.

1. Additional eligibility requirements include:
   a. Having proof of residency in the State of Arkansas;
   b. Being a US citizen or legal alien;
   c. Having proof of a valid Social Security Number;
   d. Meeting Intermediate I-S, I-A, II-B, or III-C nursing facility level of care; and
   e. Meeting one of the following medical criteria, as assessed by a DHS Registered Nurse:
      i. Unable to perform at least one (1) of the three (3) activities of daily living (ADLs) of transferring or locomotion, eating, or toileting without extensive assistance or total dependence upon another person;
      ii. Unable to perform at least two (2) of the three (3) activities of daily living (ADLs) of transferring or locomotion, eating, or toileting without limited assistance from another person;
      iii. Primary or secondary diagnosis of Alzheimer's disease or related dementia and cognitively impaired so as to require substantial supervision from another individual; or
      iv. Diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and if left untreated, would be life threatening.

Note: Individuals diagnosed with serious mental illness (SMI) or an intellectual disability are not eligible for PACE unless their medical needs are unrelated to their SMI/DD diagnosis and they meet the other qualifying criteria.

2. Medicare beneficiaries meeting the above requirements agree to participate in PACE by paying monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or any other type of Medicare or Medicaid cost-sharing.

3. Individuals not eligible for Medicaid or Medicare who meet the above requirements agree to participate in PACE by paying private premiums.

210.300 Evaluation Referral 9-1-26

A. A beneficiary may be initially referred to PACE by a PACE Organization or DHS Registered Nurse, however an outside referral is not required to apply.

B. Beneficiaries apply for PACE through their local Division of County Operations (DCO) office for a determination of financial eligibility.

C. The local DCO office will refer the beneficiary for an independent assessment, determination of financial eligibility notwithstanding.

210.400 Independent Assessment and Level of Care Determination 9-1-26

A. For individuals new to PACE, the individual must receive an Independent Assessment via the Arkansas Independent Assessment (ARIA) instrument, administered by a DHS-appointed Independent Assessment Contractor. The ARIA determines the individual's functional needs eligibility.

1. The Division of County Operations (DCO) registered nurse determines the potential enrollee's nursing facility level of care via the DHS-704 based on the results of the Independent Assessment.
2. The DCO registered nurse notifies the PACE Organization when all requirements have been met.

B. For renewing PACE participants, a Division of Aging and Adult Services registered nurse completes an annual evaluation (Medical Needs Assessment Form DMS-703) to evaluate the potential enrollee's nursing facility level of care.

1. To be eligible for PACE, beneficiaries must have a Medical Needs Assessment indicating they require Intermediate I-S, I-A, II-B, or III-C nursing facility level of care.
2. The Division of Aging and Adult Services' registered nurse must certify that an assessment has been completed and that it is safe for the participant to live in the community.
3. The Division of Aging and Adult Services' registered nurse notifies the local Division of County Operations (DCO) office and the PACE Organization when all requirements have been met.

210.500 Enrollment with PACE Organization 9-1-26

A. If the potential participant meets the eligibility requirements and wants to pursue enrollment with the PACE Organization, they must sign an enrollment agreement with the PACE Organization that serves their Service Area. For more details on the contents of the enrollment agreement, see 42 CFR 460.154.

1. Enrollment in PACE results in disenrollment from any other Medicare or Medicaid prepayment plan or optional benefit. See 42 CFR 460.154(i).
2. The PACE Organization is required to complete its own intensive assessment that includes a minimum of one (1) home visit for enrollment.
3. The potential enrollee is required to complete one (1) visit to the PACE Center, unless otherwise approved by CMS.
4. At the time of enrollment, the PACE Organization is required to do the following:
    a. Verify whether the participant is dually eligible for Medicare and Medicaid and whether the participant has Medicare Part A, Part B, or both;
    b. Remind participants that unless they are dually eligible, they will need to continue to pay their Medicare Part A premium (if not free), Part B premium (if

not eligible for State coverage), and Part D premium, if applicable; and

c. Identify payers that are primary to Medicare, determine the amounts payable by those payers, and coordinate benefits to Medicare participants with the benefits of primary payers.

B. Involuntary Disenrollment

1. Involuntary disenrollments are to be handled pursuant to federal law.
2. Refer to 42 C.F.R. 460.164, 460.166 and 460.172.

210.600 Person-Centered Plan of Care 9-1-26

A. After the individual is enrolled, the PACE Organization's Interdisciplinary Team (IDT) is responsible for individualized assessment, treatment planning, and care delivery. The IDT must meet the following requirements for the Plan of Care:

1. Complete an initial, in-person, comprehensive assessment by the following members promptly following the beneficiary's enrollment:
   a. Primary care physician;
   b. Registered nurse;
   c. Master's-level social worker;
   d. Physical therapist;
   e. Occupational therapist;
   f. Recreational therapist or activity coordinator;
   g. Dietitian; and
   h. Home care coordinator.
2. Develop, evaluate, and, if necessary, revise the comprehensive Person-Centered Plan of Care for the participant (42 CFR §460.106).
   a. The Interdisciplinary Team must complete the initial Plan of Care within thirty (30) calendar days of the participant's date of enrollment.
   b. The Interdisciplinary Team must involve the participant and their family members or circle of natural supports in the development of the Plan of Care. The PACE Organization should document beneficiary and/or family approval of the Plan of Care.
   c. The Plan of Care must explain different treatment options, provide written information of those options, and obtain written consent prior to initiating any palliative, comfort, or end-of-life care services.
   d. At least once every one hundred eighty (180) calendar days from the date the latest Plan of Care was finalized, the Interdisciplinary Team must complete a semi-annual Plan of Care evaluation, and if necessary, revisions to each participant's Plan of Care.
3. For requests from the participant, or their representative or caregiver, to initiate, modify, or continue a service during the development of the initial Person-Centered Plan of Care, the IDT must:
   a. Document the request; and
   b. Discuss the request during the care planning meeting and either:
      i. Approve the requested service and incorporate it into the participant's initial Plan of Care; or
      ii. Document the rationale for not approving the service in the initial Plan of Care.

4. Additional in-person Assessments and Treatment Plans corresponding to the overall Person-Centered Plan of Care must be completed, as applicable, by the:
    a. Physical therapist;
    b. Occupational therapist;
    c. Dietitian; and
    d. Home care coordinator.

B. Change of Condition

1. When a change of condition is noted by any provider delivering services to the PACE participant, the Interdisciplinary Team must update the Plan of Care within fourteen (14) days from the actual status change.
2. Re-assessments and Treatment Plan changes are also completed when the PACE participant experiences a change in health or psycho-social condition.

210.700 Service Determination Process 9-1-26

A. Service Determination Requests (42 CFR 460.121)

1. A Service Determination Request is a request made by a participant, their representative, or their caregiver to initiate a new service, modify an existing service, or continue coverage of a service that a PACE Organization is recommending being discontinued or reduced.
    a. Requests can be made orally or in writing to any employee or contractor of the PACE Organization that provides direct care to a participant, including transportation personnel.
    b. If a request is made prior to completing the development of the initial Person-Centered Plan of Care, it is not considered a Service Determination Request.
2. The PACE organization must bring a Service Determination Request to the Interdisciplinary Team (IDT) as expeditiously as the participant's condition requires, but no later than three (3) calendar days from the time the request is made.
    a. If a member of the IDT is able to approve the Service Determination Request in full at the time the request is made, the PACE Organization:
        i. Must provide oral or written notice of decision to approve a service determination request to the participant, in understandable language. The approval should include the conditions of the approval, including when the participant may expect to receive the approved service.
        ii. Must follow recordkeeping requirements established in Part B below.
        iii. Does not need a full IDT review.
    b. In all other cases, the full IDT must review and discuss each Service Determination Request and decide to approve, deny, or partially deny the request based on that review.
        i. IDT will consider all relevant information when evaluating a request, including, but not limited to, the findings and results of any reassessments.
    c. The IDT may extend the timeframe for review and notification by up to five (5) calendar days if either of the following occur:
        i. The participant or their representative request the extension; or
        ii. The IDT needs additional information from an individual, not directly employed by the PACE Organization, that may change the interdisciplinary team's decision to deny a service.
    d. The participant or their representative must be notified of any extension in

review timeframe either orally or in writing, no later than twenty-four (24) hours after the IDT decides to extend the review timeframe.

e. If the IDT fails to provide the participant with timely notice of the resolution of the request, or does not furnish the services required by the revised Person-Centered Plan of Care, this constitutes an adverse decision. The participant's request must be automatically processed by the PACE organization as an appeal (42 CFR 460.121(l)).

B. Recordkeeping

1. The PACE organization must establish and implement a process to document, track, and maintain records related to all processing requirements for Service Determination Requests received both orally and in writing.

2. These records must be available to the IDT to ensure that all members remain alert to pertinent participant information.

C. Reassessments based on a Service Determination Request

1. If the IDT expects to deny or partially deny a Service Determination Request, the appropriate members of the IDT must conduct an in-person Reassessment before the IDT makes a final decision.

2. IDT members performing the Reassessment evaluate whether the requested service is necessary to meet the participant's medical, physical, emotional, and social needs.

3. The IDT may conduct a Reassessment prior to approving a Service Determination Request, either in-person or through the use of remote technology, if the team determines that a Reassessment is necessary.

210.800 Service Determination Approvals and Denials 9-1-26

A. Notice of decision to approve a Service Determination Request

1. If the interdisciplinary team (IDT) decides to approve a Service Determination Request, it must provide the participant or representative either oral or written notice of the determination.

2. The approval must explain the conditions of the approval in understandable language, including when the participant may expect to receive the approved service.

B. Notice of decision to deny a Service Determination Request (42 CFR 460.121(j))

1. If the IDT decides to deny or partially deny a service, it must provide the participant or representative both oral and written notice of the determination.

2. Notice of any denial must:

a. State the specific reason(s) for the denial, including why the service is not necessary to maintain or improve the participant's overall health status, taking into account the participant's medical, physical, emotional, and social needs, and the results of the Reassessment(s) in understandable language.

b. Inform the participant or representative of his or her right to appeal the decision.

c. Describe the standard and expedited appeals processes, including the right to, and conditions for, obtaining expedited consideration of an appeal of a denial of services.

d. For a Medicaid participant, inform the participant of both of the following:

i. His or her right to continue receiving disputed services during the appeals process until issuance of the final determination.

ii. The conditions for continuing to receive disputed services.

C. Appeals

1. An appeal to a PACE Organization is a participant's action taken with respect to the PACE Organization's noncoverage of, or nonpayment for, a service including denials, reductions, or termination of services. Refer to Appendix R in the PACE Program Agreement.
2. A request to initiate, modify, or continue a service must first be processed as a service determination request under Section 210.700 before the PACE organization can process an appeal under this section.
3. See further details on a PACE Organization's Appeals Process (42 CFR 460.122).
4. Additional appeal rights under Medicare or for those dually eligible for Medicare and Medicaid can be found 42 CFR 460.124.
5. Medicaid Administrative Reconsideration and Appeals:
   a. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 Section 1 of this Medicaid Manual.
   b. When the State Medicaid Agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section 1 of this Medicaid Manual.

220.000 PROGRAM SERVICES

220.100 Non-covered Services 9-1-26

A. Medicare and Medicaid services delivered solely through the PACE Organization are the only benefits covered while the participant is enrolled in a PACE program (42 CFR 460.90).

B. The following services are excluded from coverage under PACE:

1. Cosmetic surgery;
2. Experimental medical, surgical, or other health procedures; and
3. Services furnished outside the USA, except as permitted under the state's Medicaid Plan.

220.200 Covered Services 9-1-26

The PACE benefit package for all participants, regardless of the source of payment, must include the following as prescribed by the Interdisciplinary Team (IDT) assessment:

A. All Medicaid-covered services, as specified in the State's approved Medicaid plan.

B. Interdisciplinary assessment and treatment planning.

C. Primary care, including physician and nursing services.

D. Social work services.

E. Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services.

F. Personal care and supportive services.

G. Nutritional counseling.

H. For more detailed policies on meal requirements and sanitary conditions, see 42 CFR 460.78.

I. Recreational therapy.

J. Transportation.

1. For more detailed policies on required safety, accessibility, and equipment; maintenance of vehicles; vehicle communication with PACE center; personnel training; and inclusion in any changes to the person-centered service plan, see 42 CFR 460.76.

K. Meals as required by the interdisciplinary team's plan of care.

L. Medical specialty services including, but not limited to the following:

1. Anesthesiology;
2. Audiology;
3. Cardiology;
4. Dentistry;
5. Dermatology;
6. Gastroenterology;
7. Gynecology;
8. Internal medicine;
9. Nephrology;
10. Neurosurgery;
11. Oncology;
12. Ophthalmology;
13. Oral surgery;
14. Orthopedic surgery;
15. Otorhinolaryngology;
16. Palliative Medicine
17. Plastic surgery;
18. Pharmacy consulting services;
19. Podiatry;
20. Psychiatry;
21. Pulmonary disease;
22. Radiology;
23. Rheumatology;
24. General surgery;
25. Thoracic and vascular surgery; and
26. Urology.

M. Laboratory tests, x-rays, and other diagnostic procedures.

N. Drugs and biologicals.

O. Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items.

P. Acute inpatient care, including the following:

1. Ambulance;
2. Emergency room care and treatment room services;
3. Semi-private room and board;
4. General medical and nursing services;
5. Medical, surgical, intensive care, and the Coronary Care Unit;
6. Laboratory tests, x-rays, and other diagnostic procedures;
7. Drugs and biologicals;
8. Blood and blood derivatives;
9. Surgical care, including the use of anesthesia;
10. Use of oxygen;
11. Physical, occupational, respiratory therapies, and speech language pathology services; and
12. Social services.

Q. Nursing facility care, including the following:

1. Semi-private room and board;
2. Physician and skilled nursing services;
3. Custodial care;
4. Personal care and assistance;
5. Drugs and biologicals;
6. Physical, occupational, recreational therapies, and speech-language pathology, if necessary;
7. Social services; and
8. Medical supplies and appliances.

R. Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

1. Medications must be provided within twenty-four (24) hours of the Primary Care Provider’s order.
2. All services (other than medications) approved by the IDT must be set-up, scheduled, or arranged within seven (7) days of the approval. This does not include routine or preventative services.
3. Notwithstanding, all services and medications are to be provided as expeditiously as the participant’s health requires, so if needed, services must be provided more quickly than the timelines provided for in this section.
4. Contracted Services.

S. The PACE organization must have a written contract with each outside organization, agency, or individual that furnishes administrative or care-related services not furnished directly by the PACE organization, including, at a minimum, the medical specialties listed previously in this Section (as per 42 CFR 460.70).

1. Contracts with medical specialists must be executed prior to enrollment of participants and must be maintained on an ongoing basis to ensure participants receive appropriate and timely access to all medically necessary care and services.
2. A PACE Organization is responsible for making all reasonable and timely attempts to contract with medical specialists. If at any time a PACE Organization is unable to directly contract or maintain a contract with a specific specialty, the PACE Organization must:
    a. Ensure care and services that would otherwise be provided to participants by a contracted specialist are provided and that the participant's needs are met through a different mechanism to include hospitalization; and
    b. Promptly report the contracting issue to CMS and DAABHS, including the attempts made to contract, the reason why the contract was not effectuated, and the PACE Organization's plan to provide access to the necessary services.
3. A PACE Organization is not required to have a contract with a particular medical specialty if the PACE Organization directly employs one (1) or more individuals prior to contracting, who are legally authorized, and, if applicable, board certified in the particular medical specialty.

4 For more information about contract requirements, the mandatory list of contractors that must be kept on file, see 42 CFR 460.70.

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

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

201.000 Arkansas Medicaid Participation Requirements for Providers of the Program of All-Inclusive Care for the Elderly (PACE) 4-1-06

The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model that enables individuals who are 55 years of age or older and certified by the state to need nursing facility

care, to live as independently as possible. Through PACE, fragmented health care financing and delivery system comes together to serve the unique needs of the enrolled individual with chronic care needs. The population served by PACE is historically very frail. The PACE organization must provide all needed services to the PACE participant.

201.100 PACE Provider Enrollment Requirements 1-1-19

To ensure quality and continuity of care, all PACE providers approved to receive Medicaid reimbursement for services provided must meet specific qualifications. PACE providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. PACE providers must be certified by the Division of Provider Services and Quality Assurance (DPSQA) as having met all Centers for Medicare and Medicaid Services (CMS) approved provider criteria for the service(s) they wish to enroll to provide.

Certification by the DPSQA does not guarantee enrollment in the Medicaid program.

All providers must maintain their provider files at the Provider Enrollment Unit by submitting current certification, licensure, etc., all DPSQA-issued certification renewals and any other renewals affecting their status as a Medicaid-eligible provider.

Copies of certifications and renewals required by DPSQA must be maintained by DPSQA to avoid loss of provider certification.

B. A PACE provider application must be approved by the Centers for Medicare and Medicaid Services (CMS) and the Division of Aging, Adult and Behavioral Health Services (DAABHS). Failure to submit a PACE provider application to DAABHS at the same time or prior to submitting the application to CMS shall constitute grounds for DAABHS denying or delaying approval of the application.

C. A three-way Provider Agreement must be signed by the DAABHS, CMS, and the provider.

D. The PACE Organization must be licensed by the Arkansas Department of Human Services, DPSQA, as an Adult Day Health Care.

202.000 Staff Requirements (42 CFR §460.64) 4-1-06

Staff members (employees or contractors) of the PACE Organization must meet the following conditions:

A. Be legally authorized, which means currently licensed, certified or registered, if applicable, to practice in the state; and

B. Only act within the scope of his or her authority to practice.

202.100 Staff Training (42 CFR §460.66) 4-1-06

The PACE Organization must provide training to maintain and improve the skills and knowledge of each staff member with respect to the individual's specific duties that results in his or her continued ability to demonstrate the skills necessary for the performance of the position.

202.200 Staff Oversight Responsibility (42 CFR §460.71) 1-1-13

A. The PACE Organization must ensure that all employees and contracted staff providing care directly to participants demonstrate the skills, licensure, and/or certifications necessary for performance of their position.

1. The PACE Organization must provide all staff with an orientation that includes, at a minimum, the organization's mission, philosophy, policies on participant rights, emergency plan, ethics, and the PACE Program and any policies related to the job duties.

2. The provider must develop a competency evaluation program that identifies those skills, knowledge and abilities that must be demonstrated by direct participant care staff.

3. The competency program must be evidenced as completed before performing participant care and on an on-going basis by qualified professionals. Certification of the satisfactory completion of the competency program must be in the personnel files of all staff.

B. The PACE Organization must develop a program to ensure that all staff furnishing direct participant care services:

1. Comply with any state or federal requirements for direct patient care staff in their respective settings;

2. Comply with the requirements of 42 CFR §460.68(a) regarding persons with criminal convictions;

3. Have verified current certifications or licenses for their respective positions;

4. Are free of communicable diseases and are up to date with immunizations before performing direct patient care;

5. Have been oriented to the PACE Program; and

6. Agree to abide by the philosophy, practices and protocols of the PACE Organization.

203.000 Office of Medicaid Inspector General 1-1-16

A PACE Organization must have a formal process in place to gather information and must be able to respond in writing to a request from CMS and/or the State Administering Agency (SAA) for information regarding:

A. Persons with criminal convictions.

B. A PACE Organization must not employ individuals or contract with organizations or individuals:

1. Who have been excluded from participation in the Medicare or Medicaid programs;

2. Who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, other health insurance or health care programs, or social service programs under title XX of the Social Security Act; or

3. In any capacity where an individual's contact with participants would pose a potential risk because the individual has been convicted of physical, sexual, drug or alcohol abuse.

C. Direct or indirect interest in contracts. No member of the PACE Organization's governing body or any immediate family member may have a direct or indirect interest in any contract that supplies any administrative or care-related service or materials to the PACE Organization.

203.100 Infection Control (42 CFR §460.74) 4-1-06

A. The PACE organization must follow accepted policies and standard procedures with respect to infection control, including at least the standard precautions developed by the Centers for Disease Control and Prevention.

The PACE organization must establish, implement, and maintain a documented infection control plan that meets the following requirements:

1. Ensures a safe and sanitary environment

2. Prevents and controls the transmission of disease and infection

B. Contents of infection control plan. The infection control plan must include, but is not limited to, the following:

1. Procedures to identify, investigate, control, and prevent infections in every center and in each participant's place of residence.

2. Procedures to record any incidents of infection.

3. Procedures to analyze the incidents of infection to identify trends and develop corrective actions related to the reduction of future incidents.

203.200 Transportation Services (42 CFR §460.76) 4-1-06

A PACE organization's transportation services must be safe, accessible, and equipped to meet the needs of the participant population.

A. If the PACE organization owns, rents, or leases transportation vehicles, it must maintain these vehicles in accordance with the manufacturer's recommendations.

B. If a contractor provides transportation services, the PACE organization must ensure that the vehicles are maintained in accordance with the manufacturer's recommendations.

C. The PACE organization must ensure that transportation vehicles are equipped to communicate with the PACE center.

D. The PACE organization must train all transportation personnel (employees and contractors) in the following:

1. Managing the special needs of participants.

2. Handling emergency situations.

E. As part of the interdisciplinary team process, PACE organization staff (employees and contractors) must communicate relevant changes in a participant's care plan to transportation personnel.

203.300 Dietary Services (42 CFR §460.78) 4-1-06

Except as specified in paragraphs items B or C of this section, the PACE organization must provide each participant with a nourishing, palatable, well-balanced meal that meets the daily nutritional and special dietary needs of each participant.

A. Each meal must meet the following requirements:

1. Be prepared by methods that conserve nutritive value, flavor, and appearance;

2. Be prepared in a form designed to meet individual needs; and

3. Be prepared and served at the proper temperature.

B. The PACE organization must provide substitute foods or nutritional supplements that meet the daily nutritional and special dietary needs of any participant who has any of the following problems:

1. Refuses the food served;

2. Cannot tolerate the food served; or

3. Does not eat adequately.

C. The PACE organization must provide nutrition support to meet the daily nutritional needs of a participant, if indicated by his or her medical condition or diagnosis. Nutrition support consists of tube feedings, total parenteral nutrition, or peripheral parenteral nutrition.

D. To ensure that conditions are sanitary, the PACE organization must do the following:

1. Procure foods (including nutritional supplements and nutrition support items) from sources approved, or considered satisfactory, by Federal, State, Tribal, or local authorities with jurisdiction over the service area of the organization;

2. Store, prepare, distribute, and serve foods (including nutritional supplements and nutrition support items) under sanitary conditions; and

3. Dispose of garbage and refuse properly.

204.000 Participant Eligibility 4-1-06

The State of Arkansas will utilize essentially the same non-medical and medical eligibility criteria for the PACE participants as that used for determining eligibility for nursing facility services.

An individual who does not meet the non-medical criteria may participate in the PACE Program as private pay if he or she meets the same medical criteria as Medicaid eligibles.

204.100 Non-Medical Criteria 4-1-06

Medicaid eligibility for the PACE Program will be based on the following requirements:

A. Age - 55 or older;

B. Care Need – The participant must require one of the following four levels of nursing facility care: Intermediate I-S, I-A, II-B, and III-C;

C. Citizenship - Must be a citizen of the U.S. or lawfully admitted alien;

D. Residency - Must be a resident of the State of Arkansas and reside in the PACE program service delivery area;

E. Social Security Enumeration required; and

F. Safety of the Participant - Health and safety of the participant will not be jeopardized by living in the community.

204.200 Medical Criteria 1-1-19

PACE participants must meet one of the following criteria:

The individual is unable to perform either of the following:

A. At least one (1) of the three (3) activities of daily living (ADL) of transferring and/or locomotion, eating or toileting without extensive assistance from or total dependence upon another person;

B. At least two (2) of the three (3) activities of daily living (ADL) of transferring and/or locomotion, eating or toileting without limited assistance from another person;

C. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to themselves or others;

D. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life threatening; or,

E. Individuals diagnosed with a serious mental illness or mental retardation are not eligible for the Program of All-Inclusive Care for the Elderly unless they have medical needs unrelated to the diagnosis of mental illness or mental retardation and meet the other qualifying criteria. A diagnosis of severe mental illness or mental retardation must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation when they meet the other qualifying criteria.

205.000 Records PACE Providers Are Required to Keep (42 CFR §460.210)

205.100 Retention of Records 1-1-13

All medical records of PACE participants must be completed promptly, filed and retained for a minimum of six (6) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. The records must be available upon request for audit by an authorized representative of the Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit and representatives of the National Department of Health and Human Services.

205.200 Documentation Requirements (42 CFR §460.210) 1-1-13

All services provided to the PACE participant must be properly documented in the PACE participant's record and signed by the service provider at the time the service is delivered. At a minimum, the medical record must contain appropriate identifying information and documentation of all services furnished including the following:

1. A summary of emergency care and other inpatient or long-term care services
2. Services furnished by employees of the PACE Organization
3. Services furnished by contractors and their reports
4. Interdisciplinary assessments, reassessments, plans of care, treatment and progress notes that include the participant's response to treatment
5. Laboratory, radiological and other test reports
6. Medication records
7. Hospital discharge summaries, if applicable; continuance of follow up care post hospitalization
8. Reports of contact with informal support (for example, caregiver, legal guardian, or next of kin)
9. Enrollment agreement
10. Physician orders
11. Discharge summary and Disenrollment justification, if applicable
12. Advance directives, if applicable
13. A signed release permitting disclosure of personal information
14. Accident and incident reports

205.300 Medicaid Field Audit Review of Records 4-1-06

All documentation must be available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business. No more than thirty (30) days will be allowed after the date on the

recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the 30-day period.

210.000 PROGRAM COVERAGE

211.000 Scope (42 CFR §460.92) 4-1-06

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 per day, every day of the year.

The PACE benefit package for all participants, regardless of the source of payment, must include the following as prescribed by the interdisciplinary team assessment:

A. All Medicaid-covered services, as specified in the State's approved Medicaid plan

B. Interdisciplinary assessment and treatment planning

C. Primary care, including physician and nursing services

D. Social work services

E. Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services

F. Personal care and supportive services

G. Nutritional counseling

H. Recreational therapy

I. Transportation

J. Meals as required by the interdisciplinary team's plan of care

K. Medical specialty services including, but not limited to the following:

1. Anesthesiology,
2. Audiology,
3. Cardiology,
4. Dentistry,
5. Dermatology,
6. Gastroenterology,
7. Gynecology,
8. Internal medicine,
9. Nephrology,
10. Neurosurgery,
11. Oncology,
12. Ophthalmology,
13. Oral surgery,
14. Orthopedic surgery,
15. Otorhinolaryngology,
16. Plastic surgery,

17. Pharmacy consulting services,
18. Podiatry,
19. Psychiatry,
20. Pulmonary disease,
21. Radiology,
22. Rheumatology,
23. General surgery,
24. Thoracic and vascular surgery, and
25. Urology.

L. Laboratory tests, x-rays and other diagnostic procedures

M. Drugs and biologicals

N. Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items.

O. Acute inpatient care, including the following:

1. Ambulance,
2. Emergency room care and treatment room services,
3. Semi-private room and board,
4. General medical and nursing services,
5. Medical surgical/intensive care/coronary care unit,
6. Laboratory tests, x-rays and other diagnostic procedures,
7. Drugs and biologicals,
8. Blood and blood derivatives,
9. Surgical care, including the use of anesthesia,
10. Use of oxygen,
11. Physical, occupational, respiratory therapies, and speech language pathology services, and
12. Social services

P. Nursing facility care

1. Semi-private room and board
2. Physician and skilled nursing services
3. Custodial care
4. Personal care and assistance
5. Drugs and biologicals
6. Physical, occupational, recreational therapies, and speech-language pathology, if necessary
7. Social services
8. Medical supplies and appliances

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

211.100 Emergency Care 4-1-06

A. A PACE Organization must establish and maintain a written plan to handle emergency care. The plan must ensure that CMS, the State, and PACE participants are held harmless if the PACE Organization does not pay for emergency services.

B. Emergency care is appropriate when services are needed immediately because of an injury or sudden illness, and the time required to reach the PACE organization or one of its contract providers would cause risk of permanent damage to the participant's health. Emergency services include inpatient and outpatient services that meet the following requirements:

1. Are furnished by a qualified emergency services provider, other than the PACE organization or one of its contract providers, either in or out of the PACE organization's service area.

2. Are needed to evaluate or stabilize an emergency medical condition.

C. An emergency medical condition means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Serious jeopardy to the health of the participant.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

D. The organization must ensure that the participant or caregiver, or both, understand when and how to get access to emergency services.

E. The plan must provide for the following:

1. An on-call provider, available 24-hours per day to address participant questions about emergency services and respond to requests for authorization of urgently needed out-of-network services and post stabilization care services following emergency services.

2. Coverage of urgently needed out-of-network and post-stabilization care services when either of the following conditions are met:

a. The services are pre-approved by the PACE organization.

b. The services are not pre-approved by the PACE organization because the PACE organization did not respond to a request for approval within 1 hour after being contacted or cannot be contacted for approval.

211.200 Exclusions 4-1-06

The following services are excluded from coverage under PACE:

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

B. In an inpatient facility, private room and private duty nursing services (unless medically necessary), and non-medical 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);

C. 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;

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

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

1. In accordance with §424.122 through 4424.124 of 42 CFR.

2. As permitted under the State's approved Medicaid plan.

212.000 Participant Enrollment/Disenrollment 4-1-06

To enroll in the PACE program, an individual must meet the requirements specified in Sections 204.000 through 204.200.

212.100 PACE Enrollment 1-1-19

Participant enrollment into the PACE Program is voluntary. Prospective PACE beneficiaries may apply for PACE services through their local Department of Human Services (DHS) county offices. Applicants may apply by referral from the PACE provider, by referral from a DHS RN, or without a referral from any source. Regardless of the origin of the inquiry, the prospective participant must meet the medical and financial eligibility criteria.

If the prospective PACE beneficiary makes the initial inquiry with the PACE provider or the DHS-Registered Nurse (RN), the provider or RN will instruct the applicant to make application at the local DHS county office for a determination of financial eligibility. The local DHS county office will make the proper referral to the DHS RN for the medical assessment.

The Office of Long Term Care, Division of Provider Services and Quality Assurance, of the Department of Human Services must determine, based on the functional assessment conducted by the Independent Assessment Contractor, that the potential enrollee meets the requirements for nursing facility care prior to enrollment. The DHS RN must certify that an assessment has been completed and that it is safe for the participant to live in the community. The DHS RN will notify the local DHS county office and the Provider Organization (PO) that all requirements have been met.

The PACE provider must explain to the potential enrollee that enrollment in PACE results in disenrollment in any other Medicare or Medicaid plan and the provider is required to complete an intensive assessment that includes a minimum of one home visit and one visit by the potential enrollee to the PACE center unless otherwise approved by CMS.

212.200 Disenrollment 1-1-19

Participants may voluntarily disenroll from the PACE program at any time for any reason.

Participants may be involuntarily disenrolled due to:

A. Participant's failure to pay if he or she has a payment responsibility

B. Participant's disruptive or threatening behavior

C. Participant moves out of the PACE service delivery area

D. Participant no longer meets the nursing facility level of care requirement

E. The PACE program agreement with the Centers for Medicare and Medicaid Services (CMS) and the state is not renewed

F. The PACE organization cannot provide the required services due to loss of licensure or contracts with outside providers

To involuntarily disenroll a participant, the PACE Organization must obtain the prior review and approval of the Department of Human Services. The request to disenroll a participant and documentation to support the request must be sent to the DHS-RN. The DHS- RN will review the request and corresponding documentation and will make a recommendation to the DHS- RN Supervisor and DHS PACE Program Manager regarding whether the PACE Organization should proceed with the involuntary disenrollment. The DHS-RN Supervisor, in consultation with PACE Program management will make a final determination regarding the appropriateness of the involuntary disenrollment and will notify the PACE Organization and the DHS-RN.

The PACE Organization may request an administrative reconsideration pursuant to Section 190.003. A request for administrative reconsideration must be directed to the Division of Aging, Adult and Behavioral Health Services.

215.000 Interdisciplinary Teams 1-1-19

The PACE interdisciplinary team must meet regularly as indicated in the Provider Agreement between the PO, CMS, and the Division of Aging, Adult and Behavioral Health Services to provide overall assessment of care needs and subsequent management, supervision and provision of care for eligible individuals.

215.100 Composition of the PACE Interdisciplinary Team (42 CFR §460.102) 1-1-13

The PACE interdisciplinary team must be composed of at least the following members:

A. Primary care physician (PCP)

B. Registered nurse (RN)

C. Master Social worker (MSW)

D. Physical therapist (PT)

E. Occupational therapist (OT)

F. Recreational therapist (RT)/activity coordinator

G. Dietician

H. PACE center manager

I. Home care coordinator

J. Personal care attendant/aide

K. Transportation staff/driver

215.200 Assessment/Treatment Plan 1-1-19

An interdisciplinary team is responsible for assessment, treatment planning and care delivery after the Independent Assessment Contractor has completed an initial assessment using the ARIA assessment instrument to determine the individual's functional needs and eligibility for nursing facility level of care. The team must meet the following assessment requirements:

A. An initial in-person comprehensive assessment must be completed promptly following enrollment by the:

1. Primary care physician,

2. Registered nurse,
3. Master's-level social worker,
4. Physical therapist,
5. Occupational therapist,
6. Recreational therapist or activity coordinator,
7. Dietitian and
8. Home care coordinator.

B. At least semi-annually, an in-person assessment and treatment plan must be completed by the:

1. Primary care physician,
2. Registered nurse,
3. Master's-level social worker and
4. Recreational therapist/activity coordinator.

C. Annually, an in-person assessment and treatment plan must be completed by the:

1. Physical therapist,
2. Occupational therapist
3. Dietitian and
4. Home care coordinator.

PACE organizations consolidate discipline specific plans into a single plan of care semi-annually through discussion and consensus of the interdisciplinary team. The consolidated plan is then discussed and finalized with the PACE participant and/or his or her significant others.

Reassessments and treatment plan changes are completed when the health or psychosocial situation of the participant changes.

215.300 PACE Participant Appeal Process 6-1-25

When an adverse decision is received, the PACE participant may appeal. The appeal request must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

220.000 Quality Assurance and Monitoring Activities 1-1-13

The Department of Human Services will conduct site visits annually during the trial period in conjunction with CMS or as needed to review the quality of service provision by the PACE Organization. The annual site visit review will include a clinical and administrative component and a review of compliance with life safety codes. The annual on-site review will include but not be limited to a review of the PACE Organization's compliance with requirements in 42 CFR § 460, or its successor, in the following compliance areas:

1. Administrative,
2. PACE Services,
3. Participant Rights,
4. Quality Assessment and Performance Improvement,
5. Participant Enrollment and Disenrollment,
6. Payment,

7. Federal and State Monitoring,
8. Data Collection,
9. Record Maintenance and
10. Reporting, which includes a review of the marketing materials, financial reports, samples of documentation of proper licensure for PACE Organization staff, current contract arrangements to ensure the PACE Organization has the capability to provide all federally and state required services, and other items as deemed necessary to ensure compliance with state and federal requirements.

At the conclusion of the trial period, CMS, in cooperation with the State administering agency, continues to conduct reviews of a PACE organization, as appropriate, taking into account the quality of care furnished and the organization's compliance with all of the requirements.

DHS will be responsible for conducting an exit conference with the PACE Organization to discuss any review findings, provide technical assistance in developing corrective action plans and to assist the PACE Organization in their efforts to implement the required corrections.

220.100 Monitoring by the Division of Provider Services and Quality Assurance 1-1-19

Due to the requirement that PACE Organizations be licensed as Arkansas Adult Day Health Care Centers, the Division of Provider Services and Quality Assurance will be conducting monitoring and oversight of the PACE Center operations.

220.200 Reserved 1-1-13

220.300 Monitoring by RN Supervisor 1-1-13

The DHS RN Supervisor attends the PACE organization's weekly Interdisciplinary Team Meetings (IDT). The DHS RN Supervisor contributes to the IDT meetings as necessary to ensure the health, welfare and safety needs of the beneficiaries are met.

220.400 Monitoring by the Centers for Medicare and Medicaid Services (CMS) and the State Administering Agency (SAA) 1-1-19

In compliance with federal requirements, each PACE Organization will enter required information for nine (9) key indicators into the Health Plan Management System (HPMS), or any successor data elements or data system on a quarterly basis. Both CMS and the State Administering Agency (SAA) will use the data entered into HPMS or its successor system to monitor the ongoing operations of the PACE Organization and identify potential problems or unusual events that may be the first indication of problems in patient care, site operations or financial solvency. These reviews will also be used to determine if further onsite monitoring will be necessary.

A. The nine (9) key indicators are as follows:

1. Routine Pneumococcal Immunizations
2. Grievances & Appeals
3. Enrollments
4. Disenrollments
5. Prospective Enrollees
6. Unscheduled Hospitalizations
7. Emergency (Unscheduled) Care

8. Unusual Incidents for participants and the PACE site (such as falls, attempted suicides, staff criminal records, infectious diseases, food poisoning, participant injury, Medication errors, lawsuits, any type of restraint use, etc.)

9. Participant Deaths

221.000 Electronic Signatures 10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

230.000 PRIOR AUTHORIZATION 4-1-06

Prior authorization of specific services does not apply to the PACE Program.

240.000 REIMBURSEMENT

241.000 Method of Reimbursement 1-1-16

PACE services are financed primarily through Medicaid and Medicare capitated payments. Providers must provide all needed services for PACE participants with the monthly capitated funds.

The PACE rates are based on the Upper Payment Limit (UPL) methodology. The historical fee-for-service population data is extracted for claims and eligibility for PACE eligible populations for more than one fiscal period. Data for participant aged, blind and disabled aid categories for those 55 or greater is used in the UPL and rate calculations. The level of care codes are limited to nursing facility level of care eligible or the ARChoices waiver level of care.

The base rates are calculated using calendar year base data. The base year data is trended forward using the historical claims and eligibility information extracted for the fee-for-service population. The recent trend rates are compared to linear regression model trend rates to determine comparability, and to determine if any adjustments are necessary. The trend rates for future periods are expected to be consistent with the most recent cost data available.

The UPL amounts are reduced by a percentage amount to establish the PACE capitation rate. The percentage (%) amount will be based on the anticipated reductions in health care service costs due to the implementation of the managed care PACE program. Reductions in costs are anticipated to be realized through a reduction in nursing facility and in-patient hospital costs. The UPL will be reset and recalculated every two years.

Participants may be private pay if they choose the service, but do not meet the requirements for Medicaid eligibility.

242.000 Rate Appeal Process 5-1-08

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

~~If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel, established by the Director of the Division of Medical Services, which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.~~

~~The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.~~

State of Arkansas
95th General Assembly
Regular Session, 2025

A Bill

SENATE BILL 180

By: Senator D. Sullivan
By: Representative Ladyman

For An Act To Be Entitled

AN ACT TO EXEMPT PROVIDERS IN THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY FROM THE LICENSING REQUIREMENTS FOR HOME HEALTHCARE SERVICES; AND FOR OTHER PURPOSES.

Subtitle

TO EXEMPT PROVIDERS IN THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY FROM THE LICENSING REQUIREMENTS FOR HOME HEALTHCARE SERVICES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. DO NOT CODIFY. Legislative findings and intent.

(a) The General Assembly finds that:

(1) Providers in the Program of All-Inclusive Care for the Elderly are required to provide all-inclusive care for patients;

(2) All-inclusive care is often provided in homes;

(3) The agreements between the Centers for Medicare & Medicaid Services, the providers in the Program of All-Inclusive Care for the Elderly in this state, and the Department of Human Services provide that home healthcare services shall be provided by providers in the Program of All-Inclusive Care for the Elderly as part of their licensure; and

(4) However, providers in the Program of All-Inclusive Care for the Elderly are not home healthcare service providers.

(b) It is the intent of the General Assembly to exempt or except providers in the Program of All-Inclusive Care for the Elderly from the

licensing requirements under § 20-10-801 et seq., for home healthcare services.

SECTION 2. Arkansas Code § 20-10-802, concerning the exceptions from home healthcare services licensing requirements, is amended to add an additional subdivision to read as follows:

(13) A licensed, certified Program of All-Inclusive Care for the Elderly provider in good standing under the administration of the Arkansas Medicaid Program and providing services to enrolled Program of All-Inclusive Care for the Elderly participants as part of the participants' documented individual care plans within the Program of All-Inclusive Care for the Elderly.

APPROVED: 2/25/25