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

PROVIDER MANUAL

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South Carolina Department of Health and Human Services

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OVERVIEW

PROGRAM SUMMARY

The Program of All-Inclusive Care for the Elderly (PACE) is an optional service under the Medicaid State plan. PACE is a capitated, managed care program, with objectives to:

- Enhance the quality of life and autonomy for frail, older adults.
- Enable frail elderly individuals to live independently in the community, rather than be institutionalized, as long as medically and socially feasible.
- Maximize the dignity and respect for older adults; and
- Preserve and support the older adult's family unit.

To meet program requirements, a PACE participant must:

- Be at least 55 years of age or older.
- Live in the approved PACE provider service area.
- Be certified by the state to need nursing facility level of care.
- At the time of enrollment, be able to live in the community with PACE support without jeopardizing health and safety.
- Eligibility to enroll in a PACE program is not restricted to an individual who is either a Medicare beneficiary or Medicaid beneficiary. A potential PACE enrollee may be, but is not required to be, any or all of the following:
  - Entitled to Medicare Part A
  - Enrolled under Medicare Part B
  - Eligible for Medicaid

The PACE organization must provide comprehensive health care services based on his or her individual needs with the goal of enabling individuals to continue living independently in the community. PACE must coordinate and provide all needed preventative, primary health, acute and long-term care services. The PACE organization must establish and implement a written Plan of Care to furnish care that meets the needs of each participant in all care settings 24 hours a day, every day of the year. The PACE program includes all Medicare and Medicaid covered services and other services determined by the PACE interdisciplinary team (IDT) necessary to maintain or restore the PACE participant's independence to remain in their homes or communities. The PACE participant must receive all their services through the PACE organization. PACE providers assume full financial risk for the participant's care without limits on amount, duration, or scope of services. PACE is responsible for all care costs, even if it exceeds the monthly capitated payment, they receive each month from Medicare and/or Medicaid.

Background Information: PACE model of care is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. In the early 1970s a non-profit corporation, On Lok Senior Health Services, was formed to create a community-based system of care that consisted of a comprehensive system of care combining housing and all necessary medical and social services was outlined. The model was tested through Centers for Medicare and Medicaid Services (CMS), then Health Care Financing Administration, demonstration projects that began in the mid-1980s. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized. The Balanced Budget Act of 1997 (BBA) established PACE model as a permanently recognized provider type under both the Medicare and Medicaid programs and mandated that the quality of care be monitored. This enabled states to provide PACE services to Medicaid beneficiaries as a Medicaid State plan option. In 2003 South Carolina included PACE as an optional benefit for Medicaid beneficiaries.

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PURPOSE

The PACE program intends to serve primarily a population that is currently being served in the Medicare and Medicaid fee-for-service system or Managed Care Plans in South Carolina. The purpose of the program is to serve this population in a more efficient, effective manner by the coordination of the service delivery system with an emphasis on the use of community-based services focusing on preventative aspects of care that will delay or reduce the unnecessary use of institutional care (hospital and nursing home).

The South Carolina Department of Health and Human Services (SCDHHS) implements the PACE program in accordance with the federal regulations in Title 42 Part 460 of the Code of Federal Regulations (CFR). SCDHHS based the oversight of PACE Programs operating in the state on the CMS Code of Federal Regulations and on the Adult Care Licensure Requirements issues by the South Carolina Department of Health and Environmental Control (SCDHEC).

The services offered under the PACE program are provided by a Medicaid enrolled agency that has a valid Adult Day Health Care (ADHC) license issued by the SCDHEC in accordance with the State of South Carolina licensing requirements for ADHC. PACE Programs operating in the State of South Carolina are not required to be licensed by the Department of Insurance. This decision was based on the successful completion of the South Carolina replication of the On Lok Long-Term Care Demonstration Model that operated from 1990 until permanent provider status was authorized by the BBA in 1997 and the issuing of federal regulations in 1999 under the Department of Health and Human Services 42 CFR Parts 460, 462, 466, 473, and 476. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-E/part-460.

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SCOPE

This Policy applies to operational PACE Programs and Providers who may be interested in developing a PACE Program in South Carolina. It also addresses operational issues for SCDHHS who serves as the State Administrating Agency for PACE in South Carolina.

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POLICY STATEMENT

The following policies and procedures provide guidance to PACE Programs in accordance with all Federal regulations applicable to PACE Programs and all operational policies and procedures of the SCDHHS and Medicaid requirements. It is not the intent of the state policies to duplicate those outlined in the Federal regulations but rather provide state specific guidance to PACE Programs operating in South Carolina. Please refer to https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019036.

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PROCEDURES

SERVICES

Services: The PACE organization is required to coordinate the entire array of services for their participants with chronic care needs while allowing elders to maintain independence in the home and/or community for as long as possible.

Service Definitions: The PACE service package must include all Medicare and Medicaid covered services including any optional State Plan services, in addition to other services determined necessary by the PACE IDT to improve and maintain the participant's overall health status and services as specified in 42 Code of Federal Regulations (CFR) 460.98(c).

Service Limitations: The PACE organization becomes the sole service provider for Medicaid participants who enroll in a PACE organization. PACE participants must use the PACE organization's physician and provider network for all health services. PACE provides an IDT, consisting of professional and paraprofessional staff, employed, or contracted, to comprehensively assess each individual to determine necessary services for PACE participants. Any service that is not authorized by the IDT is not a covered service unless it is an emergency service. All contracted Providers either providing care directly by employment or under contract must meet applicable federal and state guidelines. Excluded services are in accordance with 42 CFR 460.96.

SERVICE DELIVERY

The PACE program agreement must define its service area. This service area must be approved by both CMS and SCDHHS who also must approve any change in the designated service area as required by 42 CFR 460.32(a)(1). CMS, in consultation with SCDHHS, may exclude from the designation an area that is already covered under another PACE program agreement to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program. The CMS and SCDHHS approved South Carolina PACE service areas are designated by county and or zip code.

The PACE organization must establish and implement a written Plan of Care that meets the needs of each participant in all care settings 24 hours a day, every day of the year as specified in 42 CFR 460.98. These services must be furnished in at least the PACE center, home, inpatient facilities, and other referral service settings that the participant may need. This does not change an individual's PACE enrollment status or the capitation rate. The PACE organization shall be responsible for payment of the cost of the care in any setting.

A PACE participant may need temporary or permanent placement in another health care setting and enter a nursing facility that has a contract with the PACE organization. The PACE organization must establish and implement a written Plan of Care to furnish care that meets the needs of the participant in the nursing facility. There must be coordination of care between the PACE organization and the nursing facility, during the participant's placement in the nursing facility. A Level I Pre-Admission Screening and Resident Review (PASRR) is required before a PACE participant is transferred to a nursing facility. The PACE physician shall complete the Level I PASRR. It must be documented on the front page of the PASRR form that a PACE participant is entering the nursing facility. If the Level I PASRR indicates mental illness or developmental disability the case will be referred to the Level II authority for final determination. A South Carolina Level of Care Eligibility form is not required when a PACE participant enters a nursing facility. When a PACE Participant has been placed in a skilled nursing facility for permanent placement, Participants are considered to be private pay patients.

ELIGIBILITY FOR ENROLLMENT

Eligibility criteria under 42 Code of Federal Regulations (CFR) 460.150, requires an individual meet all of the following criteria to enroll in a PACE program:

- Must be at least 55 years of age or older.
- Live in the approved geographic area of the PACE organization (designated by county or zip code).
- An individual must be financially eligible under either Medicare/Medicaid, Medicaid only, Medicare only with private pay of Medicaid premium, Private pay only, or veterans under the VA-PACE Partnership. Please refer to the Medicaid Policy and Procedures Manual (http://www1.scdhhs.gov/mppm/) for information related to Medicaid Financial eligibility.
- Meet nursing facility level of care requirements.
- At the time of enrollment, the Participant must be able to reside safely in a community setting with PACE support.

The PACE organization must complete an assessment of all potential PACE participants to establish eligibility and ensure that the level of care for nursing home coverage under the state plan is met. The PACE organization's IDT must use both professional and clinical judgement to determine if a potential PACE Participant can safely reside in the community. Considerations for the determination include, but are not limited to:

- Comprehensive evaluation of the potential Participant
- Environmental assessment

- Assessment of natural and informal supports (i.e. family and friends)
- Current and potential medical needs

During the screening process, a comprehensive assessment of the applicant is obtained using the current approved standardized instrument. The South Carolina Nursing Home level of care criteria are applied to determine whether an individual is eligible for skilled or intermediate care. The criteria describe the minimum services and functional deficits necessary to qualify for Medicaid-sponsored long-term care. The criteria are listed under two headings, skilled and intermediate. An individual is determined to be at a skilled or intermediate level of care upon meeting the criteria. Because no set of criteria can adequately describe all the possible circumstances, a knowledge of an individual's particular situation is essential in applying these criteria.

The SCDHHS Community Long Term Care (CLTC) reviews the initial assessment of all potential PACE participants, as well as annual re-certifications, to ensure that the level of care for nursing home coverage under the state plan is met. Upon verification of all enrollment criteria by the PACE Program, an enrollment form specifying that the required enrollment criteria (42 CFR 460.150) have been met is submitted to SCDHHS/CLTC for review and processing and entry into Medicaid Management Information System (MMIS)/Participant Special Programs (RSP).

If the participant no longer meets nursing home level of care, he or she may be deemed to continue to be eligible for the PACE program until the next annual re-evaluation, if, in the absence of continued coverage under this program, the participant reasonably would be expected to meet the nursing facility level of care requirement within the next 6 months. The SCDHHS/CLTC, in consultation with the PACE organization, will make a determination of continued eligibility based on a review of the participant’s medical record and plan of care.

ENROLLMENT DENIAL

The SCDHHS/CLTC reviews the assessment of all potential PACE participants to ensure that the level of care for nursing home coverage under the state plan is met and that they meet all requirements for PACE eligibility. In addition, during the application/enrollment process, PACE staff must complete a comprehensive evaluation of the potential enrollee to include an evaluation of the potential enrollee’s medical, functional and psychosocial needs, and assess potential enrollees to ensure that the applicant can be cared for appropriately in the community setting. The PACE organization’s IDT must use both professional and clinical judgement to determine if a potential PACE enrollee can safely reside in the community.

The criteria to be utilized by PACE organizations in making this determination is outlined below. If any of the following conditions exist, a prospective participant may be considered inappropriate for enrollment in PACE by the PACE organization.

- Based on an assessment of the individual's mental and physical condition and functional capabilities, the individual is reasonably considered to be unsafe to be left alone, with or without a Personal Emergency Response System, and the individual lacks the support of a caregiver who is capable and willing to provide adequate care to ensure health, safety, and welfare of the individual during those hours when the PACE organization services are not being provided.

- An environmental assessment to determine if the residence is reasonably considered to be habitable, determines that the potential enrollee's place of residence is not reasonably considered to be habitable, and that any concerns that may have been identified cannot be addressed in a plan of care.

- The potential enrollee's place of residence or residential environment is unsafe to the extent that is would reasonably be expected to endanger the health and safety of the individual, the individual's caregiver or the PACE organization staff if services were to be provided there; or

- The potential enrollee's behavior is disruptive, threatening or otherwise harmful (i.e., suicidal or self-injurious) to the extent that it would be reasonably expected to endanger the health and safety of the individual, the individual's caregiver, other PACE enrollees, or the PACE organizations staff.

- An assessment determines that the potential enrollee is unable to be safely transported into and out of the home.

Should the PACE provider determine they cannot ensure appropriate care in the community, notice will be given in writing of the reason for denial, to include rights to appeal, to the individual, the State and CMS. In each case, SCDHHS designee will review the documentation submitted and may request additional information or further review.

The PACE organization must seek approval from the State Administering Agency (SAA) on any decisions to deny enrollment of a potential applicant. As a part of this process, the PACE organization must demonstrate to the SAA its efforts to work with the family to resolve any issues or concerns where appropriate.

INFORMATION TO BE PROVIDED TO PARTICIPANTS

At the time of the initial visit by and during the assessment and enrollment process, the PACE Program will provide potential PACE participants sufficient information for eligible participants to make an informed decision about applying for enrollment. The Participant Handbook will include, but is not limited to:

- Locations and office hours

- Contact information

- Accessing services
- Notice of action
- Information on grievance and appeal process and how to access the State's Fair hearing process
- Confidentiality
- Patient rights and responsibilities
- Interpreter services
- How to obtain prescriptions

CONTINUED ELIGIBILITY IN PACE

In accordance with 42 CFR 460.160(b) (2), SC DHHS may determine that a PACE participant, who no longer meets the State Medicaid nursing facility level of care requirements, may be deemed to continue to be eligible for the PACE program until the next annual reevaluation. The PACE organization may request "deemed continued eligibility" based on the following criteria:

- The participant no longer meets the nursing facility level of care criteria but would reasonably be expected to become eligible within six months in the absence of continued coverage under the program.
- The participant's medical record and plan of care support deemed continued eligibility.

The PACE organization must submit the request to the SCDHHS Designee within five business days of notification of a PACE participant not having met nursing facility level of care. The PACE IDT must submit a brief justification summary and supporting documentation from the participant's medical record/Plan of Care that supports the request for Deemed Continued Eligibility.

Supporting documentation includes any information that, in the absence of PACE services, the participant would reasonably be expected to experience a decline in functional abilities or health to a degree that he/she would meet nursing facility level of care criteria within six months.

Examples of supporting documentation include, but are not limited to:

- Diagnosis of a chronic, and/or disabling condition.
- Physician and/or nursing progress notes documenting the treatment and impact of same on chronic, and/or disabling condition(s).

- Physician's Orders and a list of services currently provided to the participant (e.g. physical therapy, occupational therapy, dietary management, blood pressure checks, etc.).
- Frequency of medical appointments and/or frequency of medical treatments/interventions that point to unstable medical condition that must be treated, and or monitored to avoid complications.

SCDHHS Designee shall review all documentation and respond within 10 business days upon the receipt of the request and all supporting documentation. SCDHHS Designee may request an onsite visit to meet with the participant, conduct its own level of care assessment and/or request additional information. The PACE organization must submit the requested information no later than 5 business days from the date of receipt of SCDHHS request for the additional information. If SCDHHS does not receive the requested information within the five business days, SCDHHS Designee shall proceed with the denial process.

EFFECTIVE DATE OF ENROLLMENT

The participant's effective date of enrollment is on the first day of the calendar month following the date the PACE organization receives the participant's signed PACE Enrollment Agreement as specified in 42 CFR 460.158. The participant is enrolled for the next year unless the participant either decides to voluntarily disenroll or is involuntarily disenrolled or dies in accordance with 42 CFR 460.160(a).

DISENROLLMENT PROCESS

When the decision to disenroll has been reached, whether voluntary or involuntary, the PACE organization will develop a discharge plan, make appropriate referrals for care to facilitate continuity of care and will work with SCDHHS designee to facilitate the participant's re-entry into the Medicare and Medicaid fee-for-service or other appropriate Medicare and Medicaid systems.

The disenrollment request will be forwarded to SCDHHS designee for review, processing and termination in the state's MMIS/RSP system.

In the case of involuntary disenrollment, after all efforts by the PACE organization to resolve areas of conflict or jeopardy, the recommendation for involuntary disenrollment and any supporting documentation will be reviewed by the SCDHHS designee. If involuntary disenrollment is approved, a letter advising the participant of disenrollment, including information concerning their rights to the disenrollment through fair hearing, will be sent to the participant by the PACE Program.

The PACE organization must comply with regulatory requirements for the involuntary disenrollment process. Involuntary disenrollment will occur only after all attempts at resolving the issues have been exhausted. The state will continue to review each request for involuntary disenrollment on a case-by-case basis for approval or disapproval. The PACE organization shall document reasons for

the disenrollment and all efforts to resolve the problem. The PACE organization must provide participants with at least a 30 day notice of involuntary disenrollment. During the interim period between notifying the participant of an upcoming disenrollment and the effective date of the disenrollment, the PACE organization must continue to furnish all needed services.

EXTERNAL APPEALS

In compliance with 460.124, PACE participants have additional appeal rights under Medicare or Medicaid for a Dual eligible participant. The PACE program is required to assist a participant in accessing their external appeal rights. A participant may choose to appeal a decision under Medicare or Medicaid but not both. If a participant chooses to appeal under Medicaid, they can access that process by contacting the following:

SCDHHS
Division of Appeals and Hearing
P.O. Box 8206
Columbia, SC 29202-8206
Phone: Toll Free: 1-800-763-9807
Or local: 803-8982600
Fax: 803-255-8206
Online submissions: www.scdhhs.gov/appeals

PROGRAM ADMINISTRATION

Medicaid Rate Setting

The rates paid to the PACE organizations are determined on an annual basis as a percentage of the amount that would have otherwise been paid (AWOP). The AWOP is based on the current Medicaid delivery system costs derived from a comparable population (55 or older) of nursing facility and Home and Community-Based Services (HCBS) eligible. To develop the AWOP, the data from sub-populations (Dually Eligible and Non-Dually Eligible) of nursing facility and HCBS clients, along with historical fee-for-service where applicable, is blended into the final AWOP rate. The rate is then set in accordance information in the State Plan Amendment.

Patient Liability

Under Medicaid regulation, when an individual enters a nursing facility as a permanent Medicaid nursing home resident, a determination of the individual's required contribution towards the cost of care is based on their monthly income and allowable expenses, otherwise known as a "patient liability" (PL) amount. The PL amount is a shared cost between the participant and Medicaid related to nursing facility placement. Patient liability amounts can vary greatly. The PL amount is paid to the PACE provider or contracted nursing facility. The PL paid by the participant will serve to discount the contracted rate paid by PACE to the nursing facility.

SCDHHS has the right to audit the PACE provider's PL documentation. If PL is not paid by the participant, the participant may be involuntarily disenrolled from the PACE program. In accordance with 42 Code of Federal Regulations (CFR) 460.164(a) (1), 460,182, 460.184 and state regulation, a participant may be involuntarily disenrolled if they fail to pay, or to make satisfactory arrangements to pay, any PL due to PACE organization after a 30-day grace period. The PACE organization must make every opportunity available for participants to pay PL and ensure that participants are not involuntarily disenrolled without good cause.

Selection of New PACE Providers

Prior to submission of a PACE application to CMS, an interested provider must be approved by SCDHHS in accordance with CFR 460.12. The State must assure that the applicant is a qualified provider and willing to enter into a 3-way program agreement between CMS, SCDHHS and the PACE provider. In order to determine if the applicant meets the expectation of a qualified provider the following information is requested.

- A formal request that outlines who the potential PACE provider is and what service area is being requested.
- Evidence that they are an organizational entity doing business in South Carolina.
- Market study verifying sufficient PACE eligible to support a viable program.
- An address of the potential PACE Center/business location.
- A business plan reflecting the projections of the first five years of operation.
- Evidence of compliance with the fiscal soundness criteria found in CFR 460.80.
- Other information as may be requested by SCDHHS.

Approval of Applications

Upon approval by SCDHHS of an interested provider wishing to develop a PACE program in the state, the provider must submit a PACE application in accordance with CMS policies and procedures. For SCDHHS to have sufficient time to review and approve specific areas of the PACE application information must be submitted at a minimum of 90-days prior to the quarterly submission dates determined by CMS for PACE provider applications. Unless approved in writing by SCDHHS prior to that date, no applicant can go forward with submission to CMS as an approved PACE Provider. https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.

Contractual Agreements

PACE programs must enter into a 3-way contractual agreement between the PACE Program, CMS, and SCDHHS. The 3-way agreement outlines the responsibilities of each party and may be updated

from time to time. The agreement remains in place with no yearly renewal necessary unless CMS or SCDHHS regulations or requirements are updated or notice by a party to terminate.

Expansion of Service Area

Approval of the expansion of a service area for a PACE provider will be in accordance with applicable CMS policies and procedures. Due to the rural nature of the state, SCDHHS will not support duplicative or overlapping service areas for a sufficient number of PACE eligible to be available in a given geographic area. If a service area is already awarded to an existing PACE program, no additional PACE provider may be awarded that service area.

PACE Provider Licensure Requirements

PACE programs are required to apply for and maintain an active Adult Day Care License that complies with SCDHEC. If any additional licensure should be determined to apply to PACE programs, SCDHHS will work collaboratively with existing PACE programs on a process for compliance that does not jeopardize the PACE program's ability to provide care in compliance with CMS Federal regulations applicable to PACE. *If a PACE program wishes to contract with an Alternative Care Setting (ACS) they must first seek approval from SCDHHS and submit requested information prior to submitting to CMS for final approval. An ACS must be a licensed ADHC provider in good standing with SCDHEC.*

The PACE organization must be enrolled in the Medicaid program and hold a Medicaid provider agreement/provider identification number as a PACE provider. PACE is a Medicaid State plan service, not a waiver service. PACE will not be enrolled in the Medicaid program as an ADHC. SCDHHS has determined that PACE programs though fully capitated for all services need not be licensed through the South Carolina Department of Insurance.

PACE Readiness and On-going Review

The State Readiness Review, developed by CMS, is used by the SAA to perform the readiness review of nonoperational PACE organization applicants prior to approval by CMS. The SAA must conduct an assessment of provider readiness prior to operation. The SAA reviews the PACE organizations policies and procedures, the design and construction of the building, emergency preparedness, compliance with Occupational Safety and Health Administration (OSHA), Food and Drug Administration (FDA), state and local laws, and life safety codes.

As required by 42 Code of Federal Regulations (CFR) 460.190, CMS and SAA must conduct comprehensive annual reviews of PACE organizations during the trial period of review, that includes the first three years of operation, to ensure compliance with the PACE regulation. After the initial three-year period, reviews shall be conducted by CMS and State, including an onsite visit in accordance with 42 CFR 460.192. CMS and the SAA report the results of the reviews to the PACE organization, along with any recommendations for changes to the organization's program. The PACE organization must develop and implement a corrective action plan, that will be taken to

correct any identified deficiency. Disclosure of the review results must be available as demonstrated in 42 CFR 460.196.

PROGRAM MONITORING

Program monitoring by SCDHHS will occur on an ongoing basis and will include but not be limited to participation in IDT meetings, onsite review of compliance with federal regulations and SCDHHS operational guidelines, review of medical records, and participant and staff interviews as may be deemed necessary to assure that individuals enrolled in the PACE program are receiving appropriate care and services. Any issues or concerns identified by SCDHHS will require a corrective action plan and may also involve the oversight and review by CMS should concerns found be significant enough to trigger a CMS audit and review.

SCDHHS will participant in any oversight and monitoring activities initiated by CMS as may be required.

NETWORK PROVIDERS

The PACE program must maintain a network of providers sufficient to ensure adequate capacity to provide timely and appropriate access to covered services.

All Network providers including applicable employees of the PACE program must be credentialed and re-credentialed under Medicare and Medicaid as applicable in accordance with CFR 460.70.

DATA SUBMISSION REQUIREMENTS

Upon execution of an enrollment agreement by a PACE participant, an enrollment form is filed electronically with SCDHHS indicating the date enrollment into the PACE organization will be effective and other client specific information. SCDHHS enters program and date specific enrollment information directly into the State's MMIS/RSP file. The MMIS/RSP controls payment for Medicaid special programs, including PACE, for date specific services only. The same process is used for disenrollment from the PACE organization. Payment is participant and date specific. Any enrollment information found to be incorrect or erroneous will generate recoupment through the State's MMIS system.

PACE programs must submit the following form as part of the enrollment process:

- SCDHHS Community Long Term Care form 118 A

The 3-way program agreement and any CMS guidelines outline the federal reporting requirements. SCDHHS in collaboration with the PACE programs will establish reporting requirements that allow the SAA to monitor the quality outcomes and encounter reporting. At this time SCDHHS will work collaboratively with the National PACE Association (NPA) data reporting project to provide this information. SCDHHS reserves the right to request any information from a PACE program as may

be deemed necessary to assure the stewardship of public funds and the care being provided to a vulnerable population is sufficient to safely meet their needs.

FISCAL SOLVENCY OVERSIGHT

Financial performance of the PACE program is essential to assure that participants enrolled have access to all care and services. Fiscal soundness requirements will be closely monitored to assure compliance with CFR 460.80 through audited financial statements in accordance with CMS guidelines. SCDHHS requires quarterly balance sheets be submitted that reflect the financial performance of the PACE program specifically and not that of any applicable parent organization.

Failure to provide the requested financial statements in a timely manner that comply with fiscal soundness regulations as defined in 42 CFR 460.80 may result in penalties or suspension of enrollments.

SCDHHS will adopt the Federal Fiscal Reporting requirements for PACE programs operating in the State. The PACE organization must have a fiscally sound operation, as demonstrated by the following:

- Total assets greater than total unsubordinated liabilities.
- Sufficient cash flow and adequate liquidity to meet obligations as they become due.
- A net operating surplus or a financial plan for maintaining solvency that is satisfactory to CMS and the SCDHHS.

New PACE Organization

A PACE organization under the three-year trial period is required to submit quarterly financial statements to CMS and SCDHHS within 45-days from the end of each quarter of the PACE organization’s fiscal year.

After the trial period, if CMS or the SCDHHS determines that an organization’s performance requires more frequent monitoring and oversight due to concerns about fiscal soundness, CMS or the SCDHHS may require a PACE organization to submit monthly or quarterly financial statements, or both. The financial statements shall include a balance sheet, income statement, and a cash flow statement. PACE organizations under a three-year trial period are required to submit annually, an audit report containing the organization’s audited financial statements and related notes along with the auditor's opinion issued by an independent licensed certified public accountant. PACE organizations operating within larger sponsoring entities must also submit their sponsoring entities’ independently prepared audit report.

SCDHHS Fiscal Oversight

As part of the fiscal oversight obligations of the State Administering Agency, SCDHHS requires PACE organizations to submit quarterly unaudited financial statements. Submission will include an attestation noting that information is correct to the best of the knowledge of the PACE organization. In addition, the attestation will include verification of the arrangements to cover expenses that meet the requirements noted below, that have been approved by CMS and SCDHHS as part of the PACE Application process. SCDHHS reserves the right to request evidence that such arrangements are in place.

All PACE programs are required to submit annual audited financial statements. The audit reports are due within 180 days after an organization's fiscal year end. PACE organizations are required to upload a PDF or zip file of their financial statements and annual audit reports to the fiscal soundness module within the Health Plan Management System and to submit this information directly to SCDHHS.

If combined financial statements are provided, they must be prepared to show the financial position of overall related health care delivery system when delivery of care or other services is dependent upon Affiliates. Financial Statements shall be presented in a form that clearly shows the financial position of the PACE organization separately from the combined statements.

The PACE organization shall authorize the independent accountant to allow representatives of SCDHHS, upon written request, to inspect any and all working papers related to the audit report provided.

If the PACE organization cannot file the financial information by the regulatory deadlines shown under 42 CFR § 460.208(a), the PACE organization must contact CMS and SCDHHS before the prescribed due date. Failure to submit on time without notifying CMS places the PACE organization in non-compliance status and could result in the PACE organization receiving a non-compliance letter with the requirement of a corrective action plan to resolve the deficiency.

Arrangements to Cover Expenses

A PACE organization must demonstrate that it has arrangements to cover expenses in the amount of at least the sum of the following in the event it becomes insolvent:

- One month’s total capitation revenue to cover expenses the month before insolvency
- One month’s average payment to all contractors, based on the prior quarter’s average payment, to cover expenses the month after the date it declares insolvency or ceases operation

Arrangements to cover expenses may include, but are not limited to, the following:

- Insolvency insurance or reinsurance

- Hold harmless arrangement
- Letters of credit, guarantees, net worth, restricted State reserves, or State law provisions

The PACE organization will provide SCDHHS with any supporting documentation requested to support the calculation above.

The PACE organization will provide SCDHHS with any supporting documentation requested to verify the quarterly financial statements.

In addition to the above, the PACE organization will:

- Attest that the plan is prepared to increase its risk reserve deposit to accommodate projected increase in enrollment.
  - The PACE organization shall demonstrate financial viability/standards compliant with SCDHHS satisfaction for each of the following elements:
    - Tangible net equity — The PACE organization shall maintain a tangible net equity equal to one month's capitation revenue.
    - Administrative cost — The PACE organization's administrative costs shall not exceed 25% unless otherwise authorized by SCDHHS in writing after submission of appropriate justification by the PACE organization.
    - The PACE organization shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for a sound business operation.
    - The PACE organization conducting day-to-day operations of the program is a subsidiary within a larger parent organization, a separation of entities must be clearly established between the two entities in the PACE organizations operating policies and procedures and its financial record keeping. A separate financial statement must be maintained for the PACE entity, which includes but is not limited to the balance and income statements. The financial reserves requirements specified by SCDHHS must be held in a separate bank account clearly designated as a specific program reserve account. The funds in this account shall not be co-mingled with the reserves of any other program.
    - Working capital and current ratio of one of the following:

- The PACE organization shall demonstrate to SCDHHS that they now meet the financial obligations on a timely basis and have been doing so for at least the proceeding two years, OR
- The PACE organization shall provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve the equivalent working capital ratio of 1:1 if noncurrent assets are considered current.

Insolvency Plan

The PACE organization must have a documented plan in the event of insolvency, approved by CMS, and the SCDHHS, and implement the Plan which provides for the following:

- Continuation of benefits for the duration of the period for which capitation payment has been made.
- Continuation of benefits to participants who are confined in a hospital on the date of insolvency until their discharge.
- Protection of participants from liability for payment of fees that are the legal obligation of the PACE organization.
- Arrange to cover expenses using risk reserve resources in the amount of at least the sum of one month's total capitation revenue plus one month's average payments to all contractors.

NOTE: The Insolvency plan is included in the 3-way agreement between CMS, SCDHHS and the PACE organization. Any changes to this plan must be submitted as updates to the 3-way agreement.

Change of Ownership

Should a PACE program pursue a change of ownership (CHOW), the process must comply with CMS guidance as defined in the CMS PACE Regulations.

CMS defines a CHOW as:

- The removal, addition, or substitution of a partner, unless the partners expressly agree otherwise as permitted by applicable State law.
- An asset transfer, meaning transfer of title and property to another party.
- The merger of the PACE organization into another entity or the consolidation of the PACE organization with one or more other entities.

SCDHHS must provide an attestation letter that confirms the willingness of Medicaid to enter into a 3-way agreement with the PACE program and CMS to operate a PACE Program. In addition, SCDHHS will play a role in the approval process of a PACE Provider application that must be approved to assure the new owner meets all applicable requirements to be a qualified PACE provider. Information on the CHOW process can be found in CFR 460.60 (d) of the CMS PACE regulations.

PROGRAM TERMINATION

The PACE organization can be terminated for specific reasons and in each case, must comply with CMS and SCDHHS guidelines for program termination.

Termination of the program agreement by CMS or SCDHHS for causes to include but not be limited to:

- If either CMS and/or the SCDHHS determine the program cannot ensure the health and safety of its participants.
- Significant deficiencies in the quality of care furnished to participants, OR
- Failure to comply substantially with conditions for a PACE Program or the Program Agreement.

Process:

If within 30 days of the receipt of written notice of a determination that deficiencies exist and PACE has failed to develop and successfully initiate a corrective action plan or failed to continue the implementation of a plan, CMS or SCDHHS may terminate the PACE program if CMS or SCDHHS determines PACE cannot ensure the health and safety of its participants.

If the PACE program chooses to terminate its contract, adequate notification must be given. PACE participants and network contractors require a 60-day notice, while CMS and SCDHHS require a 90-day notice. Between the time notification is given and the contract is terminated, PACE must provide a full range of health and health-related services to its Participants and ensure Participants a smooth transition back to the traditional Medicare and Medicaid systems.

If the program does not prove to be financially viable, resulting in program termination, the population being served will be redirected to their previous coverage systems of traditional Medicare and Medicaid providers within the community. Various providers would assume responsibility for care, as in the fee-for-service system.

Procedure

With the decision to terminate the Program, the following steps would be taken:

- A date for dissolution of the program and its service capacity will be established.

- All new referrals and enrollments would cease immediately.
- Current participants would be notified in writing of the program's decision to dissolve services and would be assured of 60-days of uninterrupted full-service benefits.
- The input of current community resources would be obtained in planning for the needs of the participants. The services available and the ability of the program to accept the volume of PACE participants requiring services would be determined.
- The IDT would develop a priority list of participants, ranking participants with the most skilled care needs highest and those with lesser needs lower.
- Based on the priority, individual care plans would be developed in conjunction with participant, the participant's family, and the appropriate community resources. Primary assistance in planning would be obtained from the SCDHHS area CLTC office. The CLTC case managers would assume responsibilities for the coordination of care for those persons who were Medicaid eligible after the dissolution of the program. (This step would require an extensive time period. Therefore, dissolution would occur over a 60-to-90-day time period).
- As care plans are completed, participants would be gradually disenrolled until all participants have been integrated into traditional Medicare and Medicaid systems.
- Records would be made available, upon the consent of the participants, to all providers as appropriate. Original records would be stored and maintained as required by State and CMS guidelines.
- All network providers would be provided a written 60-day notice. Based upon program resources, all outstanding debts would be settled upon final dissolution of the program.

Financial obligations and risk will be absorbed by the PACE organization, first using any accumulated reserve funds. All efforts will be made to honor contracts for service providers.

For participants currently residing in a nursing home, PACE will work closely with SCDHHS and CLTC to ensure that each participant meets eligibility requirements for continued nursing home care, including financial and level of care, so that no interruption of service will occur. For all other PACE participants residing in the community at the time of PACE program termination, the PACE IDT will be responsible for developing comprehensive discharge plans to assure that all identified needs of participants continue to be met after PACE program termination. This includes the establishment of a primary care provider willing and able to assume responsibility for care.

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DEFINITIONS

This is a list of acronyms, definitions and terms used in the PACE Manual.

- Activities of Daily Living (ADL) — Those activities that are required by an individual for continued well-being, health, and safety. This includes basic personal everyday activities as bathing, dressing, transfer, toileting, mobility, and eating.
- Adult Day Health Care (ADHC) — A group program designed to meet the individual needs of functionally-impaired adults which is structured and comprehensive and provides a variety of health, social, and related support services at a licensed day site.
- Alternative Care Setting — An alternative care setting is a physical facility, other than the participant's place of residence, where PACE participants receive any of the required services
- Appeal — The participant's action taken with respect to the PACE organization's non-coverage of, non-payment for a service, including denials, reductions, or termination of services.
- Assessment — The process of gathering and integrating formal and informal information relevant to the development of an individualized Plan of Care.
- Audit — An external review of the PACE organization's practices and procedures to determine compliance with CMS program requirements.
- Audit Team — A group of people comprised of CMS, SAA staff, or other designees who are responsible to perform a PACE organization audit.
- Balanced Budget Act of 1997 (BBA) — Established PACE model as a permanently recognized provider type under both the Medicare and Medicaid programs and mandated that the quality of care be monitored.
- Centers for Medicare and Medicaid Services (CMS) — The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid and Medicare programs.
- Change of Ownership (CHOW) — process by which PACE Programs undergo a change of ownership.

- Code of Federal Regulations (CFR) — A publication by the Federal government containing PACE requirements which organizations must comply with to receive payment under Medicaid/Medicare programs. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-E/part-460

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

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

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

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

- South Carolina Department of Health and Human Services (SCDHHS) —. The state agency responsible for administering the state's Title XIX (Medicaid) Program and other health and related services.

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

- Department of Health and Environmental Control (DHEC) — The state agency responsible for approving the required Adult Day Care license.

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

- Grievance — A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished.

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

- Interdisciplinary Team (IDT) — A group of professionals and paraprofessionals PACE center staff, employed or contracted, involved in assessing the needs of the participant and making recommendations in a team staffing for services or interventions targeted at those needs.
- Licensure — A determination by the SCDHHS that a service provider agency meets the requirements of state law to provide services.
- Medicaid — A federal-state financed medical assistance program that is provided under a State Plan approved under Title XIX of the Social Security Act.
- Medicaid Management Information System (MMIS) — The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible participants.
- Medicare — The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.
- National PACE Association (NPA) — Non-profit membership organization that represents the interests of PACE organizations. These member organizations share the goal of promoting the availability of quality, comprehensive, and cost-effective health care services to frail older adults through the PACE and similar models of care.
- Nursing Facility (NF) — A facility which meets the requirements of sections 1819 or 1919 (a), (b), (c), and (d) of the Social Security Act. A nursing facility provides long term care and placement for those individuals who meet the eligibility requirements.
- PACE Center — The facility which includes an adult day care, a primary clinic, and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining and which serves as the focal point for coordination and provision of most PACE services.
- PACE Organization — The entity that has in effect a PACE program agreement to operate a PACE under this part.
- PACE Program — An optional service under the Medicaid State Plan that is a capitated, managed care program.
- PACE Participant — An individual who is enrolled in the PACE program.
- Patient Liability (PL) — The amount a participant is responsible for paying to a provider of PACE services.

- Plan of Care (POC) — The written documentation that outlines how PACE services are delivered to the participant. A written plan developed by the IDT that is based on assessment results and specifies services to be accessed and coordinated on the participant's behalf. It includes long-range goals, assignment of responsibility, and time frames for completion or review by the IDT.
- Program of All-Inclusive Care for the Elderly (PACE) — a comprehensive and supportive services program designed to assist those 55 or older to remain at home and in the community.
- Participant — An individual who has been certified for medical benefits by the Medicaid Program. A participant certified for Medicaid services may also be referred to as a participant.
- Sanction — Denial of benefits for failure to comply with an eligibility requirement.
- Service Area — The geographically designated (by zip code/parish areas) region where PACE services are provided.
- Services — This includes both items and services.
- State Administering Agency (SAA) — The state agency responsible for administering the PACE program. In South Carolina this is the SCDHHS.
- State Readiness Review (SRR) — The purpose of this review is to determine the organization's readiness to administer the PACE program and enroll and serve participants. Every application must meet all requirements of the SRR prior to enrolling participants.
- Transition — The steps or activities conducted to support the passage of the participant from existing formal or informal services to the appropriate level of services, including disengagement from all services.
- Trial Period — Means a PACE Program that is operated by a PACE provider under a PACE program agreement, the first three years under such an agreement.

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RELATED LEGISLATION AND DOCUMENTS

PACE Federal Regulations: Title 42 Part 460—Programs of All-Inclusive Care for the Elderly (PACE)

CMS PACE Manual: PACE Manual

Medicare benefits: Medicare Beneficiary Benefits Coverage

DHEC Adult Day Care Licensing: https://scdhec.gov/health-regulation/healthcare-facility-licensing-0

Medicaid Policy and Procedure Manual: (http://www1.scdhhs.gov/mppm/).

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APPROVAL AND REVIEW DETAILS

APPROVAL AND REVIEW	DETAILS
Approval Authority	
Advisory Committee to Approval Authority	
Administrator/Owner	
Next Review Date	
APPROVAL AND AMENDMENT HISTORY	**DETAILS**
Original Approval Authority and Date	
Amendment Authority and Date	
Notes/Change Summary	