PACE Program Agreement

AGREEMENT No. **H0247**

An Agreement Between

The Secretary of the Department of Health and Human Services, who has delegated authority to the Administrator of the Centers for Medicare & Medicaid Services, hereinafter referred to as CMS, and State of Oregon, the State Administering Agency, hereinafter referred to as SAA, and AllCare PACE LLC hereinafter referred to as the PACE Organization.

The Secretary, in finding the PACE Organization to be an eligible organization by the Administrator of CMS and Oregon Department of Human Services, agrees to the following with the PACE Organization for the purposes of enacting sections 1894 and 1934 of the Social Security Act:

ARTICLE I
TERM OF AGREEMENT
§460.32(a)(3); **§460.34**

This Agreement is effective for the contract year beginning March 1, 2021 through December 31, 2022 and may be extended for subsequent contract years in the absence of a notice by a party (CMS, SAA, or the PACE Organization) to terminate the agreement. This agreement supersedes any previous understanding, agreement, arrangement or contract with respect to the provision of and/or the payment for PACE services. This Agreement is subject to termination as contained in Article IV.

The PACE Organization agrees to comply with all regulations or other terms and conditions as CMS or the SAA may find necessary and appropriate from time to time for the administration of the PACE program.

ARTICLE II
GENERAL CONDITIONS

A**.** Governing Body **§460.32(a)(4)**; **§460.60**; **§460.62**

1) The name and telephone number of the PACE Organization's program director and the names of all members of the governing body, and the name and phone number of a governing body member who will serve as a liaison between the governing body and CMS and the SAA is contained in **Appendix A.**

2) Any changes in names or telephone numbers shall be reported to CMS and to the SAA prior to the effective date of the change(s).

3) **The Governing Body is responsible for ensuring the PACE Organization's compliance with quality improvement requirements.**

B**.** PACE Structure **§460.32(a)(4); §460.60**

1) A description of the organizational structure of the PACE Organization, including the

relationship to, at a minimum, the governing body, program director, medical director, and to any parent, affiliate or subsidiary entity is shown in **Appendix B.**

2) A PACE Organization planning a change in organizational structure, other than a Change of Ownership (CHOW), shall notify CMS and the SAA, in writing, at least 14 days before the change takes effect.

3) A PACE Organization planning a CHOW must notify CMS CMS and the SAA, in writing, at least 60 days before the change takes effect.

C**.** Service Area and PACE Site(s) **§460.32(a)(1)**

1) The PACE Organization shall furnish PACE services only to participants who live within the designated service area, approved by the SAA and CMS (except as provided in §460.70(b)(2)), which is identified by zip code, county, perimeter street boundaries, census tract, block, or tribal jurisdictional area (as applicable).

2) The PACE Organization shall identify the sites at which it will perform PACE services. Any changes in the designated service area and/or the site(s) identified in this agreement must be approved by CMS and the SAA prior to effecting such changes. The designated service area and site(s) are included in **Appendix C.**

D**.** Participant Bill of Rights **§460.32(a)(5); §460.110 and §460.112**

The PACE Organization shall make available to all enrollees a list and explanation of the rights to which they are entitled. The PACE Organization shall assure that those rights and protections are provided. The participant Bill of Rights that will be used to satisfy this requirement is included in **Appendix D.**

E. Services **§460.32(a)(8); §460.92 and §460.94**

The PACE Organization agrees to make available comprehensive health care services that include, at a minimum, all services required by 42 CFR **§**460.92 and 42 CFR **§**460.94.

F. Eligibility, Enrollment and Disenrollment **§460.32(a)(7) and §460.32(b)(1); §460.150 §460.160(b)(3)(ii); §460.162; §460.164**

1) The PACE Organization shall consider for enrollment and enroll only those persons who: are 55 years or older, are determined by the SAA to need the level of care required under the State Medicaid plan for coverage of nursing facility services, are able to live in a community setting without jeopardizing their health or safety, and reside in the organization's approved designated service area.

2) The PACE Organization's eligibility and enrollment policies, including the criteria used to determine if persons are able to live in a community setting without jeopardizing their health or safety, is contained in **Appendix E.**

3) The SAA, in consultation with the PACE Organization, makes a determination of continued

eligibility based on a review of the participant's medical record and plan of care. The criteria used to make the determination of continued eligibility are contained in **Appendix E.**

4) The PACE Organization may establish other enrollment criteria in addition to that found in Article II F(1) of this Agreement that support decisions to not enroll persons because of certain circumstances. This criteria, however, shall not modify the criteria in Article II F(1) above. All additional enrollment criteria, if any, are specified in **Appendix F.**

5) The PACE Organization agrees that any participant, for any reason, may voluntarily disenroll and**,** upon doing so, is not liable for any additional or penalty payments. The voluntary disenrollment policy is contained in **Appendix G.**

6) The PACE Organization may not involuntarily disenroll a participant except for specific causes. The PACE Organization's involuntary disenrollment policy is located in **Appendix H.**

G. Grievance and Appeals **§460.32(a)(6); §460.122; §460.124**

1) All participants are afforded the right to grieve a PACE Organization's medical and non-medical decisions. They also have the right to appeal the PACE Organization's refusal to provide a particular care-related service or its decision not to pay for a service received by a PACE participant. Internal grievance and appeal procedures for participants are contained in **Appendix I.**

2) PACE participants will be informed, in writing, of his or her appeal rights under Medicare or Medicaid managed care, or both. PACE participants will be assisted in choosing which to pursue if both are applicable. The additional appeal rights procedures under Medicare or Medicaid are contained in **Appendix J.**

H. Quality Improvement **§460.32(a)(9), (a)(10), (a)(11); §460.63; §460.130, §460.134(c), §460.136; §460.202(b)**

1) A description of the PACE Organization's quality assessment and performance improvement program is contained in **Appendix K.**

2) The PACE Organization shall meet or exceed minimum levels of performance on standardized quality measures as established by CMS and the SAA. The minimum level of performance is: The organization will achieve an immunization rate for both influenza and pneumococcal vaccinations of 80% for the participant population that is appropriate. (Rate will exclude those participants who have had prior immunization or the vaccine is medically contraindicated).

3) The PACE Organization shall adopt and implement effective compliance oversight requirements that include the implementation of procedures and a system for promptly responding to, investigating, and correcting compliance issues as they are raised.

4) The PACE Organization shall furnish data and information on participant care activities, as established by CMS and the SAA. These data are contained in **Appendix L.**

I. Maintenance of Records and Reporting of Data **§460.70; §460.200, §460.210; §460.204**

1) The PACE Organization shall collect data, maintain records and submit reports as required by CMS and the SAA. The PACE Organization shall allow CMS and the SAA access to data and records including, but not limited to, participant health outcomes data, financial books and records, medical records, personnel records, any aspect of services furnished, reconciliation of participants, benefit liabilities and determination of Medicare and Medicaid amounts payable**.**

2) The PACE Organization agrees to require that all related entities, contractors or subcontractors agree that the SAA, the U.S. Department of Health and Human Services, CMS, or their designee(s) have the right to inspect, evaluate and audit any pertinent contracts, books, documents, papers, and records of any related entity contractor(s) or subcontractor(s) involving transactions related to this Agreement.

ARTICLE III
PAYMENT
§460.32(a)(12)

For each enrolled participant who is Medicare and/or Medicaid eligible, the PACE Organization will be paid a prospective, monthly capitation amount.

A. For Participants Eligible for Medicare **§460.180**

1) Separate rates are established for Part A and Part B. For a participant entitled to Part A benefits and enrolled under Part B, both the Part A and Part B rates are paid. For a participant who is entitled to Part A benefits but not enrolled under Part B, only the Part A rate is paid. For a participant enrolled under Part B but not entitled to Part A benefits, only the Part B rate is paid.

2) The Medicare payment amount is described in **Appendix M.**

B. For Participants Eligible for Medicaid **§460.182**

1) The monthly capitated Medicaid payment amount is negotiated between the PACE Organization and the SAA. This payment amount or the methodology used to calculate the amount, is specified in **Appendix M.**

2) The SAA shall describe the enrollment/disenrollment reconciliation procedures, to adjust for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants claimed in that month. The reconciliation method is contained in **Appendix N.**

ARTICLE IV
TERMINATION OF THE AGREEMENT
§460.32(a)(13) §460.50, §460.52, §460.54

A. CMS or the SAA may terminate this Agreement at any time for cause, including, but not limited to: uncorrected deficiencies in the quality of care furnished to participants, the PACE Organization's failure to comply substantially with the conditions for a PACE program, or non-compliance with the terms of this Agreement.

B. The PACE organization may terminate this agreement after timely notice to CMS, the SAA and the participants. Notifications shall be made as follows: 90 days before termination to CMS and the SAA and 60 days before termination to the participants.

C. The PACE Organization's detailed written plan for phase-down, in the event of termination, is included in **Appendix O.**

ARTICLE V
REQUIREMENTS OF LAWS AND REGULATION
§460.32(a)(2)

The PACE Organization agrees to comply with all applicable Federal, State, and local laws and regulations, including, but not limited to:

A. Sections 1894 and 1934 of the Social Security Act as implemented by regulations at 42 CFR Part 460;

B. Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR Part 84;

C. The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91;

D. The Americans with Disabilities Act; and

E. Other laws applicable to the receipt of Federal funds.

ARTICLE VI

CHANGES TO THE PROGRAM AGREEMENT

The Parties agree that CMS has the authority to incorporate any additional terms agreed upon by all parties or revise any terms of this agreement and its accompanying appendices that:

A. Are subject to periodic readjustment;

B. Are outmoded as a result of an organizational change made by the PACE Organization;

C. Are outmoded as a result of a contractual modification, initiated by a Party; or

D. Is required by a change in applicable Federal, State, or local laws and regulations.

CMS shall provide the PACE Organization and the SAA with a written notification of any revisions made to the program agreement and/or its appendices, along with the revised program agreement pages. Upon notification, the parties shall notify CMS, in writing, of any disagreement with the terms of the revision(s). Absent written notification to CMS that a party disagrees with the terms contained in CMS's notification, revisions shall become effective thirty (30) days after the date of the initial notification to the parties.

ARTICLE VII
STATE ADMINISTERING AGENCY REQUIREMENTS

Compliance and State Monitoring of the PACE Program:

A. The SAA further assures that its responsibilities under section 1934 of the Social Security Act will be met. All relevant provisions are included in the contract with the PACE entities, either as contractor or SAA responsibility. Both scheduled and unscheduled on-site reviews will be conducted by SAA staff.

   1) Readiness Review: The SAA will perform a Readiness Review of the applicant entity that assures the entity has fully developed its policies and procedures, obtained commitments from key staff, developed its solvency plan and has a facility that meets State and Federal requirements at the time of the application, in accordance with Section 460.12(b)(1).

   2) Monitoring During Trial Period: During the trial period, the SAA, in cooperation with CMS, will conduct comprehensive reviews of a PACE organization to ensure compliance with State and Federal requirements.

   3) At the conclusion of the trial period, the SAA, in cooperation with CMS, will continue to conduct reviews of a PACE organization, as appropriate, taking into account the quality of care furnished and the organization's compliance with State and Federal requirements.

   4) Annual Monitoring: The SAA assures that at least annually it will reevaluate whether a participant meets the level of care required under the State Medicaid plan for coverage of nursing facility services. The SAA understands that this determination may be waived if there is no reasonable expectation of improvement or significant change in the participant's conditions because of the severity of a chronic condition or the degree of impairment of functional capacity. The SAA assures that it will make reviews conducted in accordance with Sections 460.190 and 460.192 available to the public upon request.

   5) Monitoring of Corrective Action Plans: The SAA assures it will monitor the effectiveness of corrective actions required to be taken by the PACE organization.

B. Enrollment and Disenrollment:

   1) A description of the SAA's enrollment process, to include the criteria for deemed continued eligibility for PACE, in accordance with Section 460.160 (b)(3), is contained in **Appendix P**.

   2) A description of the SAA's process for overseeing the PACE Organization's administration of the criteria for determining if a potential PACE enrollee is safe to live in the community is contained in **Appendix Q**.

   3) A description of the information to be provided by the SAA to enrollees, to include information on how beneficiaries access the State's Fair Hearings process, is contained in **Appendix R**.

   4) A description of the SAA's disenrollment process is contained in **Appendix S**.

5) The SAA assures that before an involuntary disenrollment is effective, it will review and determine in a timely manner that the PACE organization has adequately documented grounds for disenrollment.

6) In the event a PACE participant disenrolls or is disenrolled from a PACE program, the SAA will work with the PACE organization to assure the participant has access to care during the transitional period.

7) The SAA assures it will facilitate reinstatement in other Medicaid/Medicare programs after a participant disenrolls.

8) The SAA assures that the State PACE requirements and State procedures will specify the process for how the PACE organization must submit participant information to the SAA.

C. Marketing:

1) The SAA assures that a process is in place to review PACE marketing materials in compliance with Section 460.82(b)(ii).

2) Decisions that require joint CMS/SAA Authority

3) Waivers: The SAA will determine whether regulatory waiver requests submitted by PACE organizations will be considered by CMS and will consult with CMS on those requests. Approved waiver requests are described in **Appendix T**.

4) Service Area Designations: The SAA will consult with CMS on changes proposed by the PACE organization related to service area designation.

5) Organizational Structure: The SAA will consult with CMS on changes proposed by the PACE organization related to organizational structure.

6) Sanctions and Terminations: The SAA will consult with CMS on termination and sanctions of the PACE organization.

D. State Licensure Requirements:

The SAA assures that Life Safety Code requirements are met for facilities in which the PACE organization furnishes services to PACE participants in accordance with Section 460.72(b), unless CMS determines that a fire and safety code imposed by State law adequately protects participants and staff.

AGREEMENT No. H0247

In witness whereof, the parties hereby execute this agreement.

For the PACE Organization

Douglas Flow , CEO

Printed Name & Title

Douglas Flow 06-16-2020

_Signature Date

_1701 NE 7th St Grants Pass, OR 97526

Address**For the State**

Michael McCormick, Interim APD Director

Printed Name & Title

06/16/2020

Signature Date

500 Summer St NE Salem, OR 97301

Address

For the Centers for Medicare & Medicaid Services

Kathryn A. Coleman, Director, Medicare Drug and Health Plan Contract Administration Group
Printed Name & Title

Signature Date

7500 Security Blvd, Mail Stop C4-21-26, Baltimore, Maryland 21244
Address

APPENDIX A: NAMES AND CONTACT LIST

1. Name of Program Director: Douglas Flow, CEO *
Telephone Number: 541-471-4106
E-mail address: doug.flow@allcarehealth.com

2. Name of Governing Body/Board of Director contact person: Thomas Eagan, DO Chair
Telephone Number: 541-295-5615

3. Governing Body/Board of Directors:

2020 Board of Directors

Officers

- Thomas Eagan, DO Chair OB/GYN
- Tori Rumrey, CFNP Family Nurse Practitioner
- Susan Seereiter Secretary/Treasurer Business Advocate/ City of Grants Pass
- *Katherine Johnston, MD Pediatrician
- Mark Jones, MD General Surgeon
- Lisa Callahan, CPNP Pediatric Nurse Practitioner
- Mark Simchuk, DPM Podiatrist
- Richard Williams, MD Family Practitioner
- James Van Horne, MD Orthopedic Surgeon
- Vincent Lucido Retired Insurance Executive
- Brian Mateja, DO

Directors

- Jessica Durrant Director of Teaching/Learning/Federal Programs – Three Rivers School District
- Karin Callahan Executive Director Josephine Community Library, Inc.
- Charles (Chuck) Rund President, Charlton Research Group

*Serves as PACE Participant Representative/ serve as a member of the Participant Advisory Council

APPENDIX B: ORGANIZATIONAL STRUCTURE

1. Legal Entity and Organizational Structure

AllCare PACE, LLC was incorporated on July 18, 2018 as a domestic Single-Member Limited Liability Corporation (LLC) owned by AllCare Health, Inc. AllCare Health, Inc. is the holding company for the AllCare Health family of businesses. There are seven businesses within the AllCare Health, Inc. family of businesses:

1. AllCare CCO, Inc.- a Medicaid, Coordinated Care Organization
2. AllCare Health Plan, Inc.- a company which sponsors five Medicare Advantage (MA) health plans
3. AllCare eHealth Services, LLC
4. AllCare Independent Physician Association, Inc.
5. AllCare Development, LLC
6. AllCare Management Services, LLC
7. AllCare PACE, LLC

Each of these seven businesses are organized within four general business types: (1) Payer Contract; (2) Provider Services; (3) Company Assets; and (4) Direct Service Provider.

A detailed AllCare Health, Inc. organizational chart was provided by AllCare PACE in the Request for Additional Information and is provided in Organizational Tables #1-3 in this summary.

An updated organizational chart for AllCare PACE, LLC is found in Table #3 in this summary. Please refer to the updated organizational chart for further information.

Each of these businesses are and their relationship to AllCare Health, Inc. are outlined in the following summary organizational chart:

AllCare Health, Inc. is a physician-led organization headquartered in Grants Pass, Oregon and was originally founded in 1994 as Mid Rogue Independent Practice Association, Inc. AllCare Health offers a wide range of quality health plans and services designed to meet the needs of Oregon's diverse communities, while controlling costs for both patients and taxpayers. It is completely locally owned and operated by staff who reside in Southern Oregon. The team of integrated network of healthcare providers are fully committed to improving physician-led, member-focused healthcare for the more than 50,000 current AllCare Health members. With the foundational ideas of Care, Coverage, and Compassion, AllCare Health works to change the experience and quality of health care for its members.

The AllCare Health family of businesses is governed by a 14-member Board of Governors (BOG) comprised of nine physician/shareholders and five community representatives.

Board members can serve up to two, three-year terms and are responsible for the financial health of the company, regulatory compliance, clinical quality, and credentialing.

AllCare Health, Inc. is a privately-owned Oregon Benefit Company, certified by the B Lab as a Certified B Corporation. A summary of the AllCare Health organizational structure can be found in Organizational Table #1 in this summary.

AllCare CCO is a Coordinated Care Organization (CCO). CCOs are a type of managed care organization that contracts with the Oregon Health Authority (OHA). OHA pays CCOs a set amount of money each month to give members the healthcare services they need. AllCare CCO is part of the AllCare Health family of companies and 100% wholly-owned by AllCare Health, Inc. AllCare CCO contracts with healthcare providers who manage care for the Oregon Health Plan (OHP) in Jackson, Josephine, and Curry counties and Glendale and Azalea in Douglas County, Oregon.

The Oregon Health Plan (OHP) is a program that pays healthcare costs for low-income Oregonians. OHP covers doctor visits, prescriptions, hospital stays, dental care, mental health services, help with addiction to tobacco, alcohol and drugs, and free rides to covered healthcare services. The OHP can also provide hearing aids, medical equipment, and home health care. OHP Supplemental is for children through age 20 and pregnant women and covers glasses and additional dental care.

In Calendar Year (CY) 2020, AllCare Health, Inc. is sponsoring five Medicare Advantage (MA) plans:

1. AllCare Advantage Gold (HMO)
2. AllCare Advantage Gold Plus Rx (HMO)
3. AllCare Advantage Focus (HMO)
4. AllCare Advantage Focus Rx (HMO)
5. AllCare Advantage Preferred Rx (HMO)

There are slight variations in premiums, services and coverage access between the plans and further information can be provided upon request. AllCare Health Plan, Inc. is a licensed insurance company in the State of Oregon and is 100% wholly-owned subsidiary of AllCare Health, Inc.

AllCare Independent Physician Association (IPA) is committed to helping doctors and providers deliver better and more cost-effective care to local communities. AllCare IPA helps healthcare providers with the business side of a modern medical practice.

Established in 1994, AllCare Independent Physician Association (IPA) is an independent physician association in Southern Oregon. AllCare IPA was created by a group of local independent physicians in Southern Oregon and represents more than 70 independent

physicians in private practice in Josephine County and Rogue River in Jackson County. The AllCare IPA's mission is to advance the independent practice of medicine in Southern Oregon.

An "independent" physician is in private practice and is not an employee of a hospital, a clinic, or an HMO. Local physicians join AllCare IPA to gain the advantage of group purchasing, recruitment, shared information systems, electronic medical records, and more. The IPA also negotiates commercial, state and federal contracts with insurance companies on behalf of its physicians.

AllCare IPA is committed to providing quality patient care combined with cost-effective healthcare management. The AllCare IPA builds relationships with hospitals, health plans and community agencies to support our mission and to enhance quality healthcare. The IPA provides highly professional management that ensures administrative efficiency and effectiveness while helping physicians improve clinical, operational and financial outcomes with technology and improvement resources. The IPA is not a clinic and does not practice medicine. The AllCare IPA credentials its own providers and negotiates contracts with insurance companies.

AllCare IPA is a 100% wholly-owned subsidiary of AllCare Health, Inc.

Additional information about the AllCare Independent Physician Association can be provided upon request.

provide low-cost access to a fully integrated electronic medical record and practice management systems. This includes services such as:

- Electronic Health Records
- Practice Management
- Billing
- e-Prescriptions
- Training and support

AllCare eHealth Services provides operational and administrative support to AllCare PACE through support with the following functions:

- Electronic Health Records (EHR)
- IT/IS Help Desk
- Medical coding
- EHR training
- IT/IS Field Technicians
- Medical billing

AllCare IPA is a 100% wholly-owned subsidiary of AllCare Health, Inc.

AllCare eHealth Services, LLC will provide functional support to AllCare PACE, LLC. Additional information about AllCare eHealth Services can be provided upon request.

AllCare Development, LLC was established on June 24, 2014. AllCare Development owns the real property and corporate headquarters of AllCare Health, Inc.

AllCare Development is a 100% wholly-owned subsidiary of AllCare Health, Inc.

AllCare Management Services, LLC provides functional support to the AllCare family of businesses. This includes support through the following functions:

- Medical direction/Primary care support
- Information Technology
- HIPAA/Privacy
- Credentialing
- Medical informatics
- Quality Improvement
- Contracting
- Clinical pharmacy
- Human Resources
- Network development
- Brand and creative services
- Finance
- Claims administration
- Compliance
- Marketing and communications

AllCare Management Services, LLC will provide the support outlined in the above table to AllCare PACE, LLC as well. All staff in the AllCare PACE program are employees of AllCare Management Services.
AllCare Management Services has an executed administrative services agreement which outlines the services performed by AllCare Management Services for AllCare PACE, LLC.

AllCare Management Services, LLC is a 100% wholly-owned subsidiary of AllCare Health, Inc.

AllCare PACE, LLC was incorporated on July 18, 2018 as a domestic Single-Member Limited Liability Corporation (LLC) owned by AllCare Health, Inc. An overview of the organizational structure for AllCare PACE, LLC can be found in Organizational Table #3 in this summary.

AllCare PACE, LLC is overseen by the following Board of Governors (BOG):

AllCare PACE, LLC is led by Deneen Silva. Ms. Silva serves as the Executive Director for AllCare PACE, LLC. Her title is Senior Vice President of Population Health and PACE Services.

Ms. Silva reports to the AllCare Health, Inc. Chief Executive Officer, Doug Flow, Ph.D. Mr. Flow reports directly to the AllCare PACE Board of Governors.

John Kolsbun, MD serves as the Medical Director for AllCare PACE, LLC. Dr. Kolsbun reports to the Executive Director, Deneen Silva, in his capacity as Medical Director for AllCare PACE, LLC.

AllCare PACE, LLC is a 100% wholly-owned subsidiary of AllCare Health, Inc. As outlined in Organizational Table # in this summary, AllCare PACE, LLC will receive functional support from AllCare Management Services and AllCare eHealth Services.

APPENDIX C: SERVICE AREA AND PACE SITE(S)
AllCare PACE LLC H0247

1. Identify all counties in the service area.
Jackson County, Oregon – Partial
Josephine County, Oregon - Partial

2. For any partial counties above, identify by county and zip code below.

Jackson

97501
97502
97504
97525
97535
97537

Josephine

97526
97527
97543

3. List the name of and address of all PACE centers in the service area.

AllCare PACE, LLC
2166 Vine Street
Grants Pass OR 97526

APPENDIX D: PARTICIPANT BILL OF RIGHTS

The Program of All-inclusive Care for the Elderly, also called PACE, is a special program that combines your medical and long-term care services in a community setting.

When you join a PACE program, you have certain rights and protections. AllCare PACE must fully explain and provide your rights to you or someone acting on your behalf in a way you can understand. These rights will be explained to you before you join AllCare PACE, at the time you join AllCare PACE and any other time your needs require you to have this information explained to you again so you can make an informed choice about your care.

Participant Bill of Rights

You have the right to be treated with respect.

You have the right to be treated with dignity and respect at all times, to have all of your care kept private, and to get compassionate, considerate care. You have the right:

- To get all of your health care in a safe, clean environment.
- To be free from harm. This includes physical or mental abuse, neglect, physical punishment, being placed by yourself against your will, and any physical or chemical restraint that is used on you for discipline or convenience and not required to treat any medical symptoms. This means you have the right to be free from being restrained or forced to be alone in order to make you behave in a certain way or to punish you or because someone finds it useful.
- To be encouraged to use your rights in the AllCare PACE program.
- To get help, if you need it, to use the Medicare and Medicaid complaint and appeal processes, and help to use your civil and your other legal rights.
- To be encouraged and helped in talking to AllCare PACE staff about changes in policy and services you think should be made.
- To use a telephone while at the AllCare PACE Center.
- To not have to do work or services for the AllCare PACE program.

You have a right to protection against discrimination.

Discrimination is against the law. Every company or agency that works with Medicare and Medicaid must obey the law. They cannot discriminate against you because of your:

- Race / Ethnic Origin
- Religion
- Age
- Sex

- Mental or physical ability
- Sexual Orientation
- Source of payment for your health care (For example, Medicare or Medicaid)

If you think you have been discriminated against for any of these reasons, contact a staff member at the AllCare PACE program to help you resolve your problem.

If you have any questions, you can call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

You have a right to information and assistance.

You have the right to get accurate, easy-to-understand information and to have someone help you make informed health care decisions. You have the right:

- To have someone help you if you have a language or communication barrier so you can understand all information given to you.
- To have the AllCare PACE program interpret the information into your preferred language in a culturally competent manner, if your first language is not English and you can't speak English well enough to understand the information being given to you.
- To get marketing materials and the AllCare PACE rights in English and in any other frequently used language in your community. You can also get these materials in Braille, if necessary.
- To get a written copy of your rights from the AllCare PACE program. The AllCare PACE program must also post these rights in a public place in the AllCare PACE center where it is easy to see them.
- To be fully informed, in writing, of the services offered by the AllCare PACE program. This includes telling you which services are provided by contractors instead of the AllCare PACE staff. You must be given this information before you join, at the time you join, and when you need to make a choice about what services to receive.
- To look at, or get help to look at, the results of the most recent review of the AllCare PACE program. Federal and State agencies review all PACE programs. You also have a right to review how the AllCare PACE program plans to correct any problems that are found at inspection.

You have a right to a choice of providers.

You have the right to choose a health care provider within the AllCare PACE program's network and to get quality health care. Women have the right to get services from a qualified women's health care specialist for routine or preventive women's health care services.

You have a right to access emergency services.

You have the right to get emergency services when and where you need them without the AllCare PACE program's approval. A medical emergency is when you think your health is in serious danger—when every second counts. You may have a bad injury, sudden illness or an

illness quickly getting much worse. You can get emergency care anywhere in the United States.

You have a right to participate in treatment decisions.

You have the right to fully participate in all decisions related to your health care. If you cannot fully participate in your treatment decisions or you want to have someone you trust help you, you have the right to choose that person to act on your behalf. You have the right:

- To have all treatment options explained to you in a language you understand
- To be fully informed of your health status and how well you are doing, and to make health care decisions. You have the right to say "no" to any recommended care or services. This includes the right not to get treatment or take medications. If you choose not to get treatment, you must be told how this will affect your health. You have the right to be told about any risks involved in your care.
- To have the PACE program, help you create an advance directive. An advance directive is a written document that says how you want medical decisions to be made in case you cannot speak for yourself. You should give it to the person who will carry out your instructions and make health care decisions for you.
- To participate in making and carrying out your plan of care. You can ask for your plan of care to be reviewed at any time. You have the right to get second medical opinions.
- To request a reassessment by the AllCare PACE team at any time.
- To be given advance notice, in writing, of any plan to move you to another care setting and the reason you are being moved.

You have a right to have your health information kept private.

You have the right to talk with health care providers in private and to have your personal health care information kept private as protected under State and Federal laws. You also have the right to look at and receive copies of your medical records.

There is a new patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used. This rule will become effective on April 14, 2003. If you have any questions about this privacy rule, call the Office for Civil Rights at 800-368-1019, TTY users should call 1-800-537-7697.

You have a right to file a complaint.

You have a right to complain about the services you receive or that you need and don't receive, the quality of your care, or any other concerns or problems you have with the AllCare PACE program. You have the right to a fair and timely process for resolving concerns with the AllCare PACE program. You have the right:

- To have a full explanation of the complaint process explained to you by AllCare PACE staff or contractors.
- To be encouraged and helped to freely explain your complaints to AllCare PACE staff and outside representatives of your choice. You will not be harmed in any way for telling someone your concerns. This means you will not be punished, threatened, or discriminated against.
- To appeal any treatment decision by the AllCare PACE program, staff, or contractors.

You have a right to leave the program.

If, for any reason, you do not feel that the AllCare PACE program is what you want, you have the right to leave the program at any time. If you do choose to leave the AllCare PACE program, this will be effective the first of the month following the date AllCare PACE receives your request to leave the program.

If you have complaints about your PACE program, think your rights have been violated, or want to talk with someone outside your PACE program about your concerns, call 1-800-MEDICARE or 1-800-633-4227 to get the name and phone number of someone in your State Administering Agency.

APPENDIX E: ENROLLMENT

Include policies and procedures for eligibility and enrollment, including the criteria used to determine if individuals are able to live in a community setting without jeopardizing their health or safety. Note: The policies and procedures for eligibility and enrollment must be developed in accordance with 42 CFR §460.150, §460.152, §460.154, §460.156, §460.158, and §460.160.

EnrollmentPolicy

Title: Enrollment Process AllCare PACE	Policy Number:	
Department:	Effective:	Date(s) Last Revised:
Approved By: (name/title)		
Written By:		
Reference: 42 CFR §§ 460.70, 460.152(a); 71 FR 71309; 42 CFR § 460.180 PACE Manual 30 – Enrollment; 20.3 - Pre-Enrollment		

PURPOSE:

The purpose of this policy is to enroll eligible participants into the AllCare PACE program. All participants will be enrolled into AllCare PACE program in a manner which fully informs them of their participant rights and protections in AllCare PACE and apprises them of the information necessary to make an informed decision regarding enrollment into AllCare PACE. This includes information to the participant and caregivers about the program including how to reach the doctor in a medical emergency, services covered, authorization of services, and effective dates of coverage. In addition, it is the purpose of this policy to establish the idea of shared responsibility between the PACE program, PACE participant, and the participant's caregivers. Participants and caregivers will be informed of their rights and responsibilities while enrolled in the program.

Definitions:

A. AllCare PACE Service Area: PACE service area designated by CMS and Oregon Department of Human Services
B. CFR: Code of Federal Regulation
C. CMS: Centers for Medicare and Medicaid Services
D. DHS: Oregon Department of Human Services
E. Legal Decision Maker: A participant's or potential participant's legal decision maker is a person who has the legal authority to make certain decisions on behalf of a participant or potential participant. A legal decision maker may be a guardian of the person or estate (or both), a person designated power of attorney for health care or a person designated durable power of attorney. A legal decision maker may have legal authority to make certain kinds of decisions, but not other kinds of decisions. A participant may have more than one legal

F. decision maker authorized to make different kinds of decisions. In any provision in which the term "legal decision maker" is used, it applies only to a person who possesses the legal authority relevant to that provision. A person designated by the participant or potential participant as an "authorized representative" under 42 CFR § 435.923 for assisting with Medicaid application and renewal of eligibility is not a legal decision maker.

G. Participant Representative: For the purpose of this policy may include the legal decision maker, legal counsel, relative, friend, provider or another individual with the participant's written permission.

H. Participant: When used in this policy, the term "participant" includes the participant, legal decision maker or other authorized representative which may include a provider acting on behalf of the participant with the participant's written consent.

I. PACE IDT: PACE Interdisciplinary Team as defined in 42 CFR §§ 460.64, 460.102(b) and (d)(3); Section 903 of BIPA.

J. PCP: Participant Centered Plan

K. Service(s): Per CMS PACE Manual and Federal 42 CFR §§ 460.92, 460.98(a) and (b), the PACE benefit package is required to include for all participants, regardless of source of payment, all Medicare covered services, all Medicaid covered services as specified in the State's approved Medicaid plan, and any other services determined necessary by the IDT to meet the participant's needs and which improve or maintain the participant's overall health status.

Attachments:

1. Attachment One: Community Safety Criteria for Enrollment into PACE
2. Attachment Two: State of Oregon Long-Term Care Determination Criteria and Process

POLICY:

AllCare PACE enrolls individual in accordance with federal and applicable state regulations and guidelines. Enrollment into AllCare PACE is voluntary and individuals may choose to voluntarily disenrolls from the program at any time. Enrollment into AllCare PACE is based on eligibility criteria as outlined in the Federal PACE Final Rule and specified in this policy.

PROCEDURE:

A. <u>AllCare PACE Eligibility Requirements</u>: To be eligible to enroll in AllCare PACE, an prospective enrollee must meet the following requirements:
   1. Be 55 years of age or older.
   2. Be determined by the State of Oregon's long-term care determination agency to need the level of care required under the Oregon Medicaid plan for coverage of nursing facility services.
   3. Reside in the AllCare PACE service area.
   4. Meet any additional program specific eligibility conditions imposed under the PACE program agreement.
      a. There are no additional program-specific eligibility conditions in the AllCare PACE program agreement.
   5. At the time of enrollment, a prospective enrollee must be able to live in a community setting without jeopardizing his or her health or safety.
      1. The criteria used to determine if an individual's health or safety would be jeopardized by living in a community setting is determined through the DHS.

2. Attachment One to this policy specifies the health and safety criteria as applied by DHS.

B. AllCare PACE Intake Procedures: Intake is an intensive process during which AllCare PACE staff members make one or more visits to a potential participant's place of residence and the potential participant makes one or more visits to the PACE center. During the AllCare PACE Intake process:
    1. Individuals may contact AllCare PACE to learn more about the program. This will be considered a referral.
    2. The APD/AAA office may make a referral to the AllCare PACE, on behalf of the individual, regarding potential enrollment. AllCare PACE will respond to the referral within one business day and begin the assessment process for the appropriateness of enrollment.
        a. Because screening, referral, and intake are important functions for assisting individuals to obtain services to meet their specific needs, case managers and the PACE organization staff will communicate with each other during the eligibility and enrollment processes to ensure services are provided in a timely manner.
    3. Referrals to AllCare PACE are recorded by Intake Specialist. Referrals must adhere to the CMS PACE marketing guidelines.
    4. The Intake Specialist completes the inquiry form.
    5. The Intake Specialist contacts the potential participant and explains the program and eligibility criteria.
    6. If the potential participant is not interested a referral may be appropriate social services agencies.
    7. If the potential participant is interested in learning more about the AllCare PACE program and with permission of the participant:
        a. The Intake Specialist arranges to meet with the potential participant and any caregiver/family members who are involved in their care.
        b. An outreach visit can be made at the potential participant's home, institution or initially done at the AllCare PACE Center. If the visit is not initially completed at home, a home visit will be made prior to enrollment.
        c. Staff make arrangements with the potential participant to tour the PACE center and meet with AllCare PACE staff.
    8. If the potential participant remains interested in AllCare PACE enrollment, the Intake Specialist will:
        a. Gather basic financial information and explains Medicaid eligibility criteria as well as information which may be necessary for the Medicaid financial application, if applicable. This may include bank statements, verifications of income, insurance records and burial information.
        b. Obtain a Disclosure of Medical Records Release form.
        c. Schedule an Intake assessment for the referred participant with the IDT and determine the means of transportation necessary for this to occur.
            i. Determine Medicare and/of Medicaid benefits or services the potential participant is being served through (e.g., Medicaid HCBS waiver, Medicare HMO, etc.). If the individual is enrolled in a Medicaid HCBS waiver program the Intake worker will contact appropriate case manager with the program through which the client

ii. is receiving services. The intake worker will inform the case manager of the client's interest in AllCare PACE and determine which services they are currently receiving from their agency.

d. Contact any other personal contacts of the individual at the individual's request (e.g. family members, home care providers) necessary to complete assessment process.
e. Request medical records via mail or fax. A Disclosure of Medical Records will be provided along with a cover letter to all medical personnel and institutions identified by referred person.
f. Refer the participant to the appropriate State of Oregon's agencies for the required level of Care Determination. This may need to be completed in the event the individual was not referred by these agencies.
    i. See Attachment Two to this policy for further information.
g. Distribute the Preliminary Intake form(s) to AllCare PACE staff at the staff Intake and Assessment meeting and provide a description of the participant's and their interest in potential enrollment into AllCare PACE.
h. Schedule a PACE enrollment assessment with the requisite PACE IDT staff.
i. Coordinate the tasks necessary to schedule the enrollment assessment (e.g., transportation arrangements, special requests, etc.).
j. Meet the individual and family at the PACE center or designated location for the completion of the IDT enrollment assessment.
k. Introduce the individual and family to AllCare PACE staff.
l. Assist in creating a welcoming environment for the individual and guests the individual may have included in the enrollment assessment.

9. The completion of the enrollment assessment will occur at the AllCare PACE center or at a location designated by the individual (e.g., the individual's home).
10. The purpose of the IDT enrollment assessment is to ensure the participant does not meet non-eligibility criteria as outlined in this policy and to develop an initial participant Plan of Care should the individual choose to enroll. The interdisciplinary team is responsible for assessing if a potential participant meets non-enrollment criteria.
11. The initial participant Plan of Care will be provided in writing to the individual and explained to the person in person as well in order to ensure understanding.
    a. If the initial enrollment assessment yields clinical information which suggests the individual may not be competent to choose to enroll in AllCare PACE, IDT staff will work to identify and inform family or others who might be involved with the individual of this and refer the individual to appropriate agencies which can facilitate decision-making competency determination further.
    b. The enrollment process will be stopped until decision-making competency has been established.
12. Should the individual meet eligibility requirements and the individual chooses to enroll in AllCare PACE, the Intake Specialist, IDT Social Worker and/or other necessary IDT staff (e.g., primary care provider) will complete the enrollment process as outlined in this policy.

C. <u>AllCare PACE Enrollment Procedures</u>

1. In collaboration with the IDT, the Intake Specialist will coordinate an appropriate date for enrollment into AllCare PACE.
2. The Intake Specialist will meet the prospective enrollee at the PACE center or designated location (e.g., the individual's home)
3. Using a copy of the AllCare PACE enrollment agreement, the Intake Specialist and IDT Social Worker explain to the potential participant and his or her representative or caregiver the following information:
    a. The conditions for enrollment and disenrollment in AllCare PACE.
    b. Explanations that enrollment in AllCare PACE results in disenrollment from any other Medicare or Medicaid pre-payment plan or optional benefit. Electing enrollment in any other Medicare or Medicaid prepayment plan or optional benefit, including the hospice benefit, after enrolling as an AllCare PACE participant is considered a voluntary disenrollment from AllCare PACE.
    c. Information on the consequences of subsequent enrollment in other optional Medicare or Medicaid programs following disenrollment from PACE.
    d. Information describing PACE services available, including all Medicare and Medicaid covered services, and how services are obtained from the AllCare PACE.
    e. Information describing procedures for obtaining emergency and urgently needed out-of-network services.
    f. A description of the participant bill of rights.
    g. Information on the process for grievances and appeals and Medicare/Medicaid phone numbers for use in appeals.
    h. Information describing the participant's obligation to inform the AllCare PACE of a move or lengthy absence from AllCare PACE's service area.
    i. Information describing to the applicant or representative of the requirement that AllCare PACE must be the applicant's sole service provider should the individual enroll.
    j. Information indicating AllCare PACE has an agreement with CMS and the State administering agency that is subject to renewal on a periodic basis and, if the agreement is not renewed, the program will be terminated.
    k. Information indicating the applicant's signature on the enrollment agreement and related materials indicates an authorization for disclosure and exchange of personal information between CMS, its agents, the State administering agency and AllCare PACE.
    l. Information indicating the effective date of enrollment should the individual enroll in AllCare PACE. The date of enrollment in the program is effective on the first day of the calendar month following the date AllCare PACE receives the signed enrollment agreement.

m. The requirement that the AllCare PACE will be the participant's sole service provider and clarification that the AllCare PACE organization guarantees access to services but not to a specific provider.
n. A list of the employees of the PACE organization who furnish care and the most current list of contracted health care providers.
o. Monthly premiums, if any.
p. Medicaid spend-down obligations, if any.
q. Provisions regarding post-eligibility treatment of income:
    i. The potential participant will be required to sign a release to allow AllCare PACE to obtain his or her medical and financial information and eligibility status for Medicare and Medicaid.

4. The following forms will also be completed and explained during the enrollment process:
    a. Consent Form
    b. Enrollment Agreement
    c. Enrollment Request
    d. Holiday list of days the PACE center is closed (given to participant/caregiver)
    e. AllCare PACE Membership Card
    f. Emergency services contact information (magnet and sticker)
    g. Staff list and contact information (given to participant/caregiver)
    h. Provider Manual (given to participant/caregiver)
    i. A copy of the participant's initial Plan of Care which, assuming the participant consents to the Plan of Care, will be signed by the participant upon enrollment.
5. The original Enrollment Agreement and Enrollment Request will be sent to CMS and the State Administering Agency as soon as they are completed. A copy of the Enrollment Request and Enrollment Agreement are to be scanned into the participant chart.
6. The Consent Form will be sent to AllCare PACE medical records.
7. A magnet will be given to the participant that lists the AllCare PACE center phone number and indicates the participant is a member of AllCare PACE. This magnet also includes information on how the participant accesses emergency and urgently necessary services.
8. Each participant will receive an AllCare PACE Membership Card at the time of enrollment. This card indicates the participant is a member of AllCare PACE, includes the Center's phone number and includes information on how the participant accesses emergency and urgently necessary services.
9. The participant's enrollment into AllCare PACE effective on the first day of the calendar month following the date AllCare PACE receives the signed enrollment agreement
10. Enrollment in AllCare PACE continues until the participant's death, regardless of changes in health status, unless either of the following actions occur:
    a. The participant voluntarily disenrolls.
    b. The participant is involuntarily disenrolled per criteria in the AllCare PACE Disenrollment policy.

D. Annual Recertification Requirements.

1. At least annually, the State of Oregon agency for long-term care determination will reevaluate whether a participant needs the level of care required under the Oregon Medicaid plan for coverage of nursing facility services. Further information about this process can be found in Attachment Two to this policy.

The criteria for determining that an individual cannot live safely in the community and thereby may be denied enrollment is as follows:

A. The individual demonstrates imminent danger to self or others.
B. The individual needs imminent nursing facility placement.
C. The individual resides in a home environment that is dangerous to care providers or prevents delivery of care.
D. There is evidence in the individual's clinical record that shows he/she has been repeatedly placed in appropriate care settings and, despite medically appropriate treatment, placement has resulted in frequent hospitalizations or failed placements.
E. At the time of application, the individual is determined to be appropriate for Enhanced Care Services or placement at Oregon State Hospital.
F. At the time of application, the individual has a physician-documented condition that meets the criteria for Medicare skilled care and cannot be discharged safely to the community within the next 30 days.

(a) The individual wishes to remain at home but requires 24-hour care to live safely in the home. If either the PACE organization or the APD/AAA[1] case manager has concerns about the safety of a potential enrollee, a case conference can be convened to review the case with outside consultants, as needed, for further evaluation.

The above criteria is developed jointly by the PACE organization, APD/AAA representatives, and the SAA[2]. The APD PACE Coordinator is involved in all actions related to the denial of enrollment based on the above criteria. Supporting documentation for denials of enrollments must include the reason for the denial and the individual's appeal rights. This letter, along with documentation of pertinent information relating to the decision, is forwarded to the APD PACE Coordinator for review. This provides APD with the opportunity to monitor if the PACE organization is administering the criteria appropriately.

<u>Process for Determining LTC Eligibility and Level of Care (LOC)</u>

Option 1 (new to LTC services): [3]APD/AAA case managers are responsible for completing a Long-Term Care (LTC) assessment using the state system Client Assessment and Planning System (CAPS). If the applicant is found eligible for services (SPL 1-13)[4], case managers discuss all services options, including PACE services, with applicants. The applicant may choose PACE services if he/she resides in a PACE service area and meets other enrollment criteria.

Option 2 (new to LTC services/referral from PACE organization): A referral from the PACE organization is received by the APD/AAA office to complete an LTC assessment; APD/AAA case managers[5] are responsible for completing an LTC assessment using CAPS. (This may also be referred to as a 'courtesy assessment'). The applicant may choose to receive Medicaid services in conjunction with PACE services or choose to receive PACE services privately (Medicare and/or private pay).

Option 3 (current consumer of LTC services): APD/AAA case managers are responsible

for completing an annual LTC assessment using CAPS. If the individual is found eligible for services (SPL 1-13), resides in a PACE service area and meets other enrollment criteria, the individual may choose to receive services through the PACE program.

The APD/AAA office will make a referral to the PACE organization, on behalf of the individual, regarding potential enrollment. The PACE organization will respond to the referral within one business day and begin the assessment process for the appropriateness of enrollment. Because screening, referral, and intake are important functions for assisting individuals to obtain services to meet their specific needs, case managers and the PACE organization staff will communicate with each other during the eligibility and enrollment processes to ensure services are provided in a timely manner.

Once the PACE organization makes an enrollment decision, it will communicate the approval or denial of enrollment to the APD/AAA case manager. Any individual may be enrolled on the first of each month but not retroactively. However, consumers/participants who are new to Medicaid LTC services may be enrolled on a weekly basis (on a Monday).

The APD/AAA case manager will create a benefit plan and service plan in CAPS if the PACE organization approves enrollment and communicates the approval to the case manager. The benefit plan information from CAPS is sent to MMIS to initiate the enrollment and payment to the PACE organization each month. This information also initiates enrollment into the PACE medical plan.

For individuals with income above the OSIP-M (Oregon Supplemental Income Program- Medical) standard, the individual must pay-in each month any income above the OSIP-Mstandard or any income above the PIF (personal incidental funds) amount when enrolled in the PACE program.
If the individual is currently enrolled in a Medicare HMO, a CCO[6], or private health insurance, he/she must be disenrolled from that plan with an effective date prior to PACE enrollment.

- The PACE organization may assist with disenrollment from a Medicare HMO.
- If the individual has a Medigap plan (supplemental insurance), the individual or his/her representative should contact the plan to be disenrolled.

Continued Eligibility for PACE

Prior to enrollment and annually thereafter, an assessment is completed using CAPS which determines the level of care and identifies service needs. The CAPS tool is an electronic, holistic assessment assigns a ranking called a Service Priority Level (SPL). Individuals assessed at SPL 1- 13 are considered in need of services at the nursing facility level of care. Services are provided to individuals at different levels based on resources available and their annual assessment outcomes. All PACE participants, private and Medicaid, are subjected to these same eligibility standards at the time of the assessment.

If a PACE participant is assessed at SPL 14 or higher at the annual reassessment, the local APD/AAA case manager, in conjunction with the PACE interdisciplinary team (IDT), will

review the participant's previous assessments to evaluate the effect of disenrollment on the participant's health status, ADLs, and social functioning. If it is determined that the participant’s health and safety would diminish within six months without PACE services, the participant may be deemed eligible until the next annual re-evaluation.

APPENDIX F: ADDITIONAL ENROLLMENT CRITERIA

Not Applicable

APPENDIX G: VOLUNTARY DISENROLLMENT

Include voluntary disenrollment policies and procedures. Note: This process must be developed in accordance with 42 CFR §460.162, §460.166, §460.168, §460.170, and §460.172.

<table>
<tr><td colspan="2">Title: Voluntary Disenrollment from AllCare PACE</td><td>Policy Number:</td></tr>
<tr><td>Department:</td><td rowspan="4">Effective:</td><td rowspan="4">Date(s) Last Revised:</td></tr>
<tr><td>Approved By: (name/title)</td></tr>
<tr><td>Written By:</td></tr>
<tr><td>Reference: 42 CFR §§ 460.70, 460.152(a); 71 FR 71309; 42 CFR § 460.180 PACE Manual 30 – Enrollment; 20.3 - Pre-Enrollment</td></tr>
</table>

PURPOSE:

AllCare PACE ensures participant's rights to voluntarily disenroll at any time are upheld according to processes which are in accordance with PACE regulations and other administrative requirements.

Definitions:

A. AllCare PACE Service Area: PACE service area designated by CMS and Oregon Department of Human Services
B. CFR: Code of Federal Regulation
C. CMS: Centers for Medicare and Medicaid Services
D. DHS: Oregon Department of Human Services
E. Legal Decision Maker: A participant's or potential participant's legal decision maker is a person who has the legal authority to make certain decisions on behalf of a participant or potential participant. A legal decision maker may be a guardian of the person or estate (or both), a person designated power of attorney for health care or a person designated durable power of attorney. A legal decision maker may have legal authority to make certain kinds of decisions, but not other kinds of decisions. A participant may have more than one legal decision maker authorized to make different kinds of decisions. In any provision in which the term "legal decision maker" is used, it applies only to a person who possesses the legal authority relevant to that provision. A person designated by the participant or potential participant as an "authorized representative" under 42 CFR § 435.923 for assisting with Medicaid application and renewal of eligibility is not a legal decision maker.
F. Participant Representative: For the purpose of this policy may include the legal decision maker, legal counsel, relative, friend, provider or another individual with the

G. participant's written permission.
H. Participant: When used in this policy, the term "participant" includes the participant, legal decision maker or other authorized representative which may include a provider acting on behalf of the participant with the participant's written consent.
I. PACE IDT: PACE Interdisciplinary Team as defined in 42 CFR §§ 460.64, 460.102(b) and (d)(3); Section 903 of BIPA.
J. PCP: Participant Centered Plan
K. Service(s): Per CMS PACE Manual and Federal 42 CFR §§ 460.92, 460.98(a) and (b), the PACE benefit package is required to include for all participants, regardless of source of payment, all Medicare covered services, all Medicaid covered services as specified in the State's approved Medicaid plan, and any other services determined necessary by the IDT to meet the participant's needs and which improve or maintain the participant's overall health status.

POLICY:

Participants may voluntarily disenroll from AllCare PACE without cause at any time. All possible efforts will be made to ensure a seamless transition from AllCare PACE to other providers. At no time will AllCare PACE staff or contractors engage in any practice that would reasonably be expected to have the effect of steering or encouraging disenrollment of PACE participants due to a change in health status.

PROCEDURE:

A. A participant may voluntarily disenroll from the program at any time and without cause. A participant may do so by providing notification to an IDT member.
B. Through its training efforts with staff and contractors, AllCare PACE ensures neither staff nor contractors engage in any practice that would reasonably be expected to have the effect of steering or encouraging disenrollment of PACE participants due to a change in health status.
C. For a "Standard Voluntary Disenrollment" the effective date of termination is on the first day of the next month that begins 30 days after the day AllCare PACE received the participant's notice of voluntary disenrollment.
D. AllCare PACE participants are required to continue using AllCare PACE services and remain liable for any premiums.
E. If, upon request for disenrollment, the PACE IDT finds the participant's condition to be of such serious nature that continued treatment is essential to prevent institutionalization, the participant will be informed in writing by the physician that disenrollment from PACE services may be contrary to a participant's desire to remain in the community. A copy of the letter will be provided to the participant's transitioning primary care provider as part of the medical record. The voluntary disenrollment procedure will continue unless the participant decides otherwise.
F. If the participant is hospitalized on the date the disenrollment is to be effective, the disenrollment must be delayed to the last day of the following month.
G. Throughout the disenrollment from AllCare PACE, AllCare PACE will assist participants to transition to other care providers to facilitate a seamless transition of care and minimize disruption to the individual's care.
    1. AllCare PACE will work with APD/AAA case managers and the participant to

2. ensure a seamless transition to other services once approval of the disenrollment is received from DHS.
3. AllCare PACE IDT and the APD/AAA case manager will convene a transition planning conference for all Medicaid clients disenrolling from PACE services. AllCare PACE may initiate similar conferences with families of private pay participants. The conferences will address the range of transition issues including
    i. Participant notification
    ii. Alternate health plan enrollment
    iii. Acquisition of necessary equipment and supplies
    iv. Arrangements for other long-term care services, if eligible or desired by the participant PACE staff will notify any contracted care providers and CMS of the transition plans.
    v. Referrals for arrangements for new providers of care and services.
    vi. AllCare PACE will ensure all medical records are made available to new providers of care and services within 30 calendar days.
4. Once a safe transition plan has been developed, the APD/AAA case manager will initiate closure of PACE services in the State system on the agreed upon date (the last day of the month, following the 30 day period after the PACE organization has given its notice).
    i. The APD/AAA case manager will set-up new benefit and service plans in CAPS in order to continue services for the participant in a non-PACE setting.
    ii. The APD/AAA case manager will close services in CAPS on the last day of the month following the 30 day period after the PACE organization has given its notice.
5. The AllCare PACE Social Worker will ensure continued Medicare and Medicaid benefits eligibility and work in conjunction with State, County and other human services agencies to evaluate service options available to the participant.
    i. The Social Worker will make referrals for the transition of services to other agencies as appropriate, including a Medicare Part D Drug Coverage Plan, if the participant is eligible for Medicare.
6. The Social Worker will complete and send to the participant a disenrollment notification letter which summarizes effective coverage dates and transition issues.
    i. In the event the participant is transitioning care to an out-of-network skilled nursing facility, the Social Worker will work with the responsible party to coordinate coverage to assure AllCare PACE is not responsible for coverage in an out-of-plan facility. If this is unavoidable, the Social Worker will obtain authorization from the PACE Executive Director for limited coverage.

7. The Social Worker is to complete the following:
    i. Complete the disenrollment form and submit to the Finance Department, Medical Records and State of Oregon Department of Human Services.
    ii. A copy of this notice scanned in the medical record and the original sent to the Finance Department.
8. The AllCare PACE IDT is notified of the effective date of disenrollment.
9. If attending the PACE Center, the Social Worker will collect all of the participant's personal belongings kept at the center and make arrangements for the items to be returned to the participant. The Social Worker will arrange for pick-up or return of personal emergency response systems equipment (PERS).
10. The Social Worker will remove AllCare PACE sticker from Medicare Card.
11. The Social Worker will facilitate the signing of the release for medical records to be sent to new provider.
12. AllCare PACE Medical Records will:
    i. With written consent as above, prepare copy of medical record for transition into the participant's new system of care. AllCare PACE medical records will be made available to new care and service providers within 30 calendar days.
    ii. The medical record will be closed upon completion of disenrollment process.
13. The Primary Care Provider will write a medical summary to the new Primary Care Provider or make telephone contact to communicate the clinical information necessary for the transfer of care. This will be documented in the medical record.
14. The Executive Director or designee is to complete the following:
    i. All participant letters pertaining to the type of disenrollment occurring, voluntary or involuntary.
    ii. Coordination activities with Quality Improvement to identify reason(s) for disenrollment and follow-up that could prevent similar disenrollments in the future.

H. Reinstatement in AllCare PACE: a previously disenrolled participant may be reinstated in AllCare PACE.
    1. If the reason for disenrollment is failure to pay the premium and the participant pays the premium before the effective date of disenrollment, the participant is reinstated in AllCare PACE with no break in coverage.

I. Voluntary Disenrollment Documentation
    1. AllCare PACE will make all voluntary disenrollment documentation available for review by CMS and the State of Oregon Department of Human Services.

J. Use of Voluntary Disenrollment Information in Quality Improvement

K.

1. AllCare PACE will use applicable information from voluntary disenrollments in its internal quality improvement program.

APPENDIX H: INVOLUNTARY DISENROLLMENT

Describe involuntary disenrollment policies and procedures. Note: This process must be developed in accordance with 42 CFR §460.164, §460.166, §460.168, §460.170, and §460.172.

<table>
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Involuntary Disenrollment from AllCare PACE</td><td colspan="2">Policy Number:</td></tr>
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<tr><td>Signature
Date</td></tr>
<tr><td>Reference: 42 CFR §§ 460.164(a), (b), (d), and (e); 71 FR 71315 (Dec. 8, 2006);
PACE Manual 4 – Enrollment/Disenrollment OAR 411-045-0120</td></tr>
</table>

PURPOSE:

The purpose of the Involuntary Disenrollment policy is to ensure a timely and organized system for the involuntary disenrollment from AllCare PACE and to ensure the participant's rights are upheld throughout this process. Data collected from the involuntary disenrollment process is a fundamental element in AllCare PACE's quality improvement activities.

Definitions:

A. Administrative Hearing: an administrative review by the State through the Oregon Office of Administrative Hearings
B. AGC: Appeals and Grievance Committee
C. APD/AAA: Aging and People with Disabilities/Area Agency on Aging
D. Appeal: An "appeal" is a participant's action taken with respect to AllCare PACE's non-coverage of, or nonpayment for, a service including denials, reductions or termination of services.
E. CAPS: Client Assessment and Planning System
F. CFR: Code of Federal Regulation
G. CMS: Centers for Medicare and Medicaid Services
H. DHS: Oregon Department of Human Services
I. Disruptive or Threatening Behavior: behavior that jeopardizes the participant's health or safety, or the safety of others; or consistent refusal by the participant to comply with an individual plan of care or the terms of the AllCare PACE enrollment agreement by a participant with decision-making capacity.
J. Dual-Eligible: A person who qualifies for Medicare and Medicaid coverage.
K. Legal Decision Maker: A participant's or potential participant's legal decision maker is a person who has the legal authority to make certain decisions on behalf of a participant or potential participant. A legal decision maker may be a guardian of the person or estate (or both), a person designated power of attorney for health care or a person designated durable power of attorney. A legal decision maker may have legal authority to make

L. certain kinds of decisions, but not other kinds of decisions. A participant may have more than one legal decision maker authorized to make different kinds of decisions. In any provision in which the term "legal decision maker" is used, it applies only to a person who possesses the legal authority relevant to that provision. A person designated by the participant or potential participant as an "authorized representative" under 42 CFR § 435.923 for assisting with Medicaid application and renewal of eligibility is not a legal decision maker.

M. PACE IDT: PACE Interdisciplinary Team as defined in 42 CFR §§ 460.64, 460.102(b) and (d)(3); Section 903 of BIPA.

N. Participant: When used in this policy, the term "participant" includes the participant, legal decision maker or other authorized representative which may include a provider acting on behalf of the participant with the participant's written consent.

O. Participant Representative: For the purpose of this policy, a participant representative may include the legal decision maker or legal counsel, relative, friend, provider or another individual with the participant's written permission.

P. PCP: Participant Centered Plan

Q. QAGC: Quality Appeal and Grievance Coordinator

R. Service(s): Per CMS PACE Manual and Federal 42 CFR §§ 460.92, 460.98(a) and (b), the PACE benefit package is required to include for all participants, regardless of source of payment, all Medicare covered services, all Medicaid covered services as specified in the State's approved Medicaid plan, and any other services determined necessary by the IDT to meet the participant's needs and which improve or maintain the participant's overall health status.

S. Service Delivery Request: A service delivery request refers to any instance in which "a participant (or designated representative) believes that a particular service needs to be initiated, continued, or eliminated for the participant." A service request serves as a trigger for a participant reassessment.

T. Verbal Complaint: a statement made either in-person or telephonically by a participant or legal decision-maker

POLICY:

It is the policy of AllCare PACE to adhere to the disenrollment requirements as outlined in the PACE Final Federal Rule and associated PACE regulatory requirements. There are only three reasons a participant can be disenrolled from the AllCare PACE program: (1) Death; (2) Voluntary disenrollment, (which would include enrollment by a participant into another Medicare Plan); or (3) Involuntary disenrollment by AllCare PACE due to cause as outlined in the procedures in this policy. No AllCare PACE participant will be involuntarily disenrolled without prior review and approval of the State of Oregon Department of Human Services.

PROCEDURE:

A. No AllCare PACE participant will be involuntarily disenrolled without prior review and approval of the State of Oregon Department of Human Services.

B. AllCare PACE may seek to involuntarily disenroll a participant only for any of the following reasons:

1. Failure to Pay: The participant, after a 30-day grace period, fails to pay or make satisfactory arrangements to pay any applicable Medicaid spend down liability or any amount due under the post-eligibility treatment of income process, as permitted under §§460.182 and 460.184.
2. Disruptive or Threatening Behavior: A participant engages in disruptive or threatening behavior. Such behavior is defined as the following:
    a. Behavior that jeopardizes the participant's health or safety, or the safety of others.
        i. This behavior has been defined by the State of Oregon Department of Human Services as the participant engaging in behavior which is "disruptive, unruly, or abusive to the point that his/her enrollment seriously impairs the provider's ability to furnish services to the participant or other participants."
    b. Consistent refusal to comply with an individual plan of care or the terms of the AllCare PACE enrollment agreement by a participant with decision-making capacity.
        i. Note: AllCare PACE will not involuntarily disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior related to an existing mental or physical condition unless the participant's behavior is jeopardizing his or her health or safety or that of others. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.
        ii. In circumstances in which AllCare PACE is seeking involuntary disenrollment as the result of Disruptive or Threatening Behavior, the AllCare PACE Medical

            Director will work in consultation with the PACE IDT and review all records related to the circumstances in the involuntary disenrollment.
3. The participant's caregiver engages in disruptive or threatening behavior.
    a. AllCare PACE will only pursue involuntary disenrollment of a participant based on a caregiver's behavior after AllCare PACE has engaged in and documented active and ongoing efforts to resolve the situation.
    b. AllCare PACE cannot involuntarily disenroll a participant based on the caregiver's noncompliance with the participant's plan of care or terms of the PACE enrollment agreement.
4. Relocation Outside of the Service Area: The participant moves out of the AllCare PACE service area or is out of the service area for more than 30 consecutive days without AllCare PACE concurrence.
5. Non-renewal or Termination of Program Agreement: AllCare PACE's program agreement with CMS and the Oregon Health Authority/Department of Human Services is not renewed or is terminated. In this circumstance, the participant must be disenrolled.

6. Inability to Provide Services: AllCare PACE is unable to offer healthcare services due to the loss of state licenses or contracts with outside providers. In this circumstance, the participant must be disenrolled.
7. Ineligibility: It is determined that the participant no longer meets the State of Oregon Medicaid nursing facility level of care requirements and is not deemed eligible. In this circumstance, the participant must be disenrolled.
8. In circumstances in which AllCare PACE is seeking an involuntary disenrollment due to Disruptive or Threatening Behavior, AllCare PACE will document in the medical record:
    a. The reasons for proposing to disenroll the participant.
    b. All efforts taken by AllCare PACE to remedy the situation.
9. Before an involuntary disenrollment is effective, the State of Oregon Department of Human Services must review the involuntary disenrollment and determine in a timely manner that the AllCare PACE has adequately documented acceptable grounds for disenrollment.

C. The IDT will meet with the participant and the family/guardian to attempt to resolve issues prior to considering involuntary disenrollment.
    a. In the event of Disrupting or Threatening Behavior, the IDT will consider service alternatives which may help remedy the situation and will implement these services with the consent of the participant and monitor the outcomes of these interventions. Services which attempt to remedy the situation may be revised as necessary based on outcomes and in efforts to implement an effective set of services which meet the participant's needs.
    b. All efforts to remedy the circumstances surrounding the potential involuntary disenrollment will be documented in the medical record.
    c. The Oregon Department of Human Services will be contacted to consult and assist in resolution of the problem.

D. If no resolution has been reached, the PACE Executive Director will inform the participant and family/decision maker to inform them of the decision to pursue involuntary disenrollment and will provide a written summary of the reason(s) for seeking involuntary disenrollment.

E. In the event AllCare PACE seeks involuntary disenrollment of a participant, the AllCare PACE Executive Director will review all involuntary disenrollment documentation to ensure AllCare PACE's intent in seeking involuntary disenrollment as well as accompanying documentation meets

requirements outlined in this policy and in PACE regulation.

C. Documentation of Involuntary Disenrollment:
    a. AllCare PACE staff will document in the medical record the specific and detailed reasons for the involuntary disenrollment. This includes all discussions with the participant and the participant's representative as well as documentation of evidence provided by the participant and the participant's representative which may refute the grounds for seeking the involuntary disenrollment.

b. All documentation regarding the involuntary disenrollment will be made available for review by CMS and the State of Oregon Department of Human Services.

c. This information will be used in AllCare PACE's internal Quality Improvement activities.

d. The PACE Executive Director or designee completes the following:

i. PACE Request for involuntary disenrollment form.

ii. The PACE Executive Director or designee writes a letter requesting involuntary disenrollment from the Oregon Department of Human Services. The letter will be sent to the Oregon Department of Human Services and will state the reason(s) for requesting the participant's involuntary disenrollment. All documentation supporting this request will be provided as well.

iii. The participant and/or family are notified that a request for involuntary disenrollment is being sent to the Oregon Department of Humanservices.

D. An involuntary disenrollment from AllCare PACE can only occur after AllCare PACE notifies DHS and DHS has reviewed the involuntary disenrollment and determines AllCare PACE has sufficiently documented acceptable grounds for disenrollment.

a. A copy of the notice provided to the participant and/or the representative will be sent to the APD/AAA case manager, the APD PACE Coordinator and CMS Region 10 representative.

E. If the Department of Human Services reviews and approves the involuntary disenrollment request, AllCare PACE will provide written notification of the disenrollment to the participant. This will include information regarding processes the participant may take with the Oregon Department of Human Services to further appeal and/or review the involuntary disenrollment.

F. An involuntary disenrollment is effective on the first day of the next month that begins 30 days after the day AllCare PACE sends notice of the disenrollment to the participant.

G. In the event of an involuntary disenrollment, the following will occur:

a. Until the date the enrollment is terminated, the participant must continue to use AllCare PACE services and remain liable for any premiums. Premiums only apply to non- Medicaid covered participants or participants with neither Medicare nor Medicaid coverage.

b. Until the date the enrollment is terminated, AllCare PACE must continue to furnish all needed services.

H. AllCare PACE will assist participants to transition to other care providers to facilitate a seamless transition of care and minimize disruption to the individual's care.

a. AllCare PACE will work with APD/AAA case managers and the participant to ensure a seamless transition to other services once approval of the disenrollment is received from DHS.

b. AllCare PACE IDT and the APD/AAA case manager will convene a transition planning conference for all Medicaid clients disenrolling from PACE services. AllCare PACE may

   initiate similar conferences with families of private pay participants. The conferences will address the range of transition issues including:

   i. Participant notification
   ii. Alternate health plan enrollment
   iii. Acquisition of necessary equipment and supplies
   iv. Arrangements for other long-term care services, if eligible or desired by the participant PACE staff will notify any contracted care providers and CMS of the transition plans.
   v. Referrals for arrangements for new providers of care and services.
   vi. AllCare PACE will ensure all medical records are made available to new providers of care and services within 30 calendar days.

c. Once a safe transition plan has been developed, the APD/AAA case manager will initiate closure of PACE services in the State system on the agreed upon date (the last day of the month, following the 30 day period after the PACE organization has given its notice).

   i. The APD/AAA case manager will set-up new benefit and service plans in CAPS in order to continue services for the participant in a non-PACE setting.
   ii. The APD/AAA case manager will close services in CAPS on the last day of the month following the 30 day period after the PACE organization has given its notice.

d. The AllCare PACE Social Worker will ensure continued Medicare and Medicaid benefits eligibility and work in conjunction with State, County and other human services agencies to evaluate service options available to the participant.

   i. The Social Worker will make referrals for the transition of services to other agencies as appropriate, including a Medicare Part D Drug Coverage Plan, if the participant is eligible for Medicare.

e. The Social Worker will complete and send to the participant a disenrollment notification letter which summarizes effective coverage dates and transition issues.

   i. In the event the participant is transitioning care to an out-of-network skilled nursing facility, the Social Worker will work with the responsible party to coordinate coverage to assure AllCare PACE is not responsible for coverage in an out-of-plan facility. If this is unavoidable, the Social Worker will obtain authorization from the PACE Executive Director for limited coverage.

f. The Social Worker is to complete the following:

i. Complete the disenrollment form and submit to the Finance Department, Medical Records and State of Oregon Department of Human Services.

ii. A copy of this notice scanned in the medical record and the original sent to the Finance Department.

g. The AllCare PACE IDT is notified of the effective date of disenrollment.

h. If attending the PACE Center, the Social Worker will collect all of the participant's personal belongings kept at the center and make arrangements for the items to be returned to the participant. The Social Worker will arrange for pick-up or return of personal emergency response systems equipment (PERS).

i. The Social Worker will remove AllCare PACE sticker from Medicare Card.

j. The Social Worker will facilitate the signing of the release for medical records to be sent to new provider.

k. AllCare PACE Medical Records will:

i. With written consent as above, prepare copy of medical record for transition into the participant's new system of care. AllCare PACE medical records will be made available to new care and service providers within 30 calendar days.

ii. The medical record will be closed upon completion of disenrollment process.

l. The Primary Care Provider will write a medical summary to the new Primary Care Provider or make telephone contact to communicate the clinical information necessary for the transfer of care. This will be documented in the medical record.

m. The Executive Director or designee is to complete the following:

i. All letters pertaining to the type of disenrollment occurring, voluntary or involuntary.

ii. Documentation of attempts to resolve the issue resulting in the disenrollment.

iii. Document an Administrative Review of the disenrollment, including analysis of reason for disenrollment and follow up that could prevent similar disenrollments in the future.

I. Reinstatement in AllCare PACE: a previously disenrolled participant may be reinstated in AllCare PACE.

a. If the reason for disenrollment is failure to pay the premium and the participant pays the premium before the effective date of disenrollment, the participant is reinstated in AllCare PACE with no break in coverage.

APPENDIX I: INTERNAL GRIEVANCE AND APPEAL PROCEDURES

Include policies and procedures for the grievances process. Note: This process must be developed in accordance with 42 CFR §460.120 and should specify whether the timeframes for responding to grievances are calendar days or business days.)

<table>
<tr><td colspan="2">Title: AllCare PACE Grievance Procedure</td><td colspan="2">Policy Number: GV 01</td></tr>
<tr><td colspan="2">Department:</td><td>Effective:</td><td>Date(s) Last Revised:</td></tr>
<tr><td colspan="2">Signature
Date</td><td colspan="2" rowspan="2"></td></tr>
<tr><td colspan="2">Reference: 42 CFR § 460.120; 71 FR 71300
PACE Manual 10 – Grievances OAR 411-045-0120</td></tr>
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PURPOSE:

The purpose of the Grievance Procedure is to promote a timely and organized system for resolving participant grievances as expeditiously as the situation requires and based on the participant's health status. Data collected from the grievance review and resolution process is a fundamental element in AllCare PACE's quality improvement activities.

Definitions:

A. Administrative Hearing: an administrative review by the State through the Oregon Office of Administrative Hearings
B. AGC: Appeals and Grievance Committee
C. Appeal: An "appeal" is a participant's action taken with respect to AllCare PACE's non-coverage of, or nonpayment for, a service including denials, reductions or termination of services.
D. CFR: Code of Federal Regulation
E. CMS: Centers for Medicare and Medicaid Services
F. DHS: Oregon Department of Human Services
G. Expedited Grievance: a grievance in which the participant, participant's representative or AllCare PACE personnel believe the participant's life, physical or mental health or ability to attain, maintain or regain maximum function are in serious or immediate jeopardy as a result of the dissatisfaction with the delivery, timeliness, appropriateness, access to, and/or setting of a health service, procedure or item or the quality of care furnished.
H. Grievance: Is a written or oral complaint, expressing dissatisfaction with the delivery, timeliness, appropriateness, access to, and/or setting of a health service, procedure or item or the quality of care furnished. A grievance may communicate dissatisfaction regardless of whether any remedial action can be taken.
I. Dual-Eligible: A person who qualifies for Medicare and Medicaid coverage.
J. Legal Decision Maker: A participant's or potential participant's legal decision maker is

K. a person who has the legal authority to make certain decisions on behalf of a participant or potential participant. A legal decision maker may be a guardian of the person or estate (or both), a person designated power of attorney for health care or a person designated durable power of attorney. A legal decision maker may have legal authority to make certain kinds of decisions, but not other kinds of decisions. A participant may have more than one legal decision maker authorized to make different

kinds of decisions. In any provision in which the term "legal decision maker" is used, it applies only to a person who possesses the legal authority relevant to that provision. A person designated by the participant or potential participant as an "authorized representative" under 42 CFR § 435.923 for assisting with Medicaid application and renewal of eligibility is not a legal decision maker.

L. PACE IDT: PACE Interdisciplinary Team as defined in 42 CFR §§ 460.64, 460.102(b) and (d)(3); Section 903 of BIPA.

M. Participant: When used in this policy, the term "participant" includes the participant, legal decision maker or other authorized representative which may include a provider acting on behalf of the participant with the participant's written consent.

N. Participant Representative: For the purpose of this policy, a participant representative may include the legal decision maker or legal counsel, relative, friend, provider or another individual with the participant's written permission.

O. PCP: Participant Centered Plan

P. QAGC: Quality Appeal and Grievance Coordinator

Q. Service(s): Per CMS PACE Manual and Federal 42 CFR §§ 460.92, 460.98(a) and (b), the PACE benefit package is required to include for all participants, regardless of source of payment, all Medicare covered services, all Medicaid covered services as specified in the State's approved Medicaid plan, and any other services determined necessary by the IDT to meet the participant's needs and which improve or maintain the participant's overall health status.

R. Service Delivery Request: A service delivery request refers to any instance in which "a participant (or designated representative) believes that a particular service needs to be initiated, continued, or eliminated for the participant." A service request serves as a trigger for a participant reassessment.

S. Verbal Complaint: a statement made either in-person or telephonically by a participant or legal decision-maker

POLICY:

It is the policy of AllCare PACE to track, trend and resolve grievances in a timely and effective fashion. All personnel (employees and contractors) who have contact with participants will be trained to understand the basic procedures for receiving grievances, documenting grievances and initiating the appropriate process for resolving participant concerns. All participants will be informed of the grievance process- in writing and in person- upon enrollment into the PACE program and at least annually thereafter.

Written or verbal complaints that express dissatisfaction regarding the quality of care, accessibility or accessibility of care or any other complaints related to administrative matters and/or delivery of health care services are considered grievances. AllCare PACE will strive to resolve all grievances as expeditiously as is feasible but no later than 30 calendar days

after the receipt date of the grievance or 72 hours for expedited grievances. Expedited grievances a grievance in which the participant, participant's representative or AllCare PACE personnel believe the participant's life, physical or mental health or ability to attain, maintain or regain maximum function are in serious or immediate jeopardy as a result of the dissatisfaction with the delivery, timeliness, appropriateness,

access to, and/or setting of a health service, procedure or item or the quality of care furnished. Grievance information will be tracked and trended and utilized to modify or institute new policies that improve participant satisfaction and service.

PROCEDURE(S):

A. Participant Rights:

1. Participants have the right to file a verbal or written grievance with AllCare PACE. Participants must file a request for DHS review within 45 calendar days of the date of receipt of AllCare PACE's grievance resolution decision.
2. Participants have the right to file grievances related to the lack of access to culturally appropriate care.
3. Participants have the right to request a DHS/Administrative Hearing if the participant does not agree with the outcome of the AllCare PACE grievance resolution process.
4. Participants have the right to file a verbal or written grievance expressing dissatisfaction with the plan of care for any reason.

B. Notification of Grievance Rights

1. Upon enrollment, annually and upon request, AllCare PACE provides written and in-person information to participants about the grievance processes via the Participant Enrollment Agreement and through the AllCare PACE website. The grievance processes are described in the Enrollment Agreement. A toll-free phone number (1-800-273-0557; TTY 711) is provided as well in the event the participant chooses to file a grievance directly with the Oregon Health Authority.
2. PACE participants have the right to request an Administrative Review if AllCare PACE fails to process a grievance in a timely manner. AllCare PACE will provide participants with written notice of this right.

C. Grievance Resolution Principles

1. All personnel (employees and contractors) who have contact with participants are trained to understand the procedures for receiving and documenting grievances and initiating the appropriate process for resolving participant concerns.
2. AllCare PACE staff or contractors who are notified of any participant concern will work with the participant to seek immediate resolution of the identified concern.
3. AllCare PACE staff will provide assistance to participants in completing AllCare PACE grievance tracking forms in order to adequately capture the nature of the grievance as determined by the participant.
4. AllCare PACE staff will assist participants in working through the grievance resolution process. AllCare PACE will discuss the grievance resolution process with the participant and outline the specific steps in writing for resolution of the

5. participant's grievance. This includes information regarding resolution timeframes and the steps personnel will take to ensure the grievance issue is addressed.
6. AllCare PACE will strive to resolve all grievances as expeditiously as is feasible. All grievances will be resolved within 5 business days unless an extension is needed in order to gather additional information. All grievances will be addressed within 30 calendar days. Expedited grievances will be addressed within 72 hours
7. Participants have the option to remain anonymous during the grievance process. All identified and anonymous grievances will be managed through the AllCare PACE Grievance tracking process.
8. When a participant submits a grievance by phone, in writing or by any other method to AllCare PACE, the QAGC will initiate the grievance process. It is the responsibility of the QAGC to assist participants in submitting grievances and to ensure participants understand the grievance process.
9. AllCare PACE will continue to furnish all services as identified in the participant's plan of care to the participant throughout the grievance resolution process.
10. AllCare PACE will cooperate with advocates chosen by the participant toresolve grievances.
11. AllCare PACE staff will attempt to resolve each grievance through internal review, negotiation or mediation with the participant and will attempt to resolve each grievance at the moment in which the grievance has been identified by the participant. Personnel will work to adequately resolve the identified grievance without a hearing by the Grievance and Appeal Committee unless the participant wants the grievance reviewed by the Grievance and Appeal Committee rather than resolved by AllCare PACE personnel.
12. During the grievance resolution process, interpreter and translation services are available to participants by AllCare PACE, free of charge. TTY users should call the Oregon Relay System at 711.
13. AllCare PACE staff managing participant grievances will thoroughly document AllCare PACE actions taken to resolve the grievance and identify the specific actions take to resolve the grievance.
14. AllCare PACE staff, providers and business associates will adhere to the privacy standards of AllCare PACE and will maintain the confidentiality of all participant grievances.
15. AllCare PACE will neither permit the unauthorized release of participant information nor deny the participant's right to confidentiality during the grievance process.
16. Neither AllCare PACE nor its staff will retaliate in any way against anyone filing a grievance or against anyone providing information regarding a grievance.
17. If a participant does not want to work with AllCare PACE to resolve a grievance, AllCare PACE staff will inform the participant of their right to send the grievance directly to the Oregon Department of Human Services (DHS).
18. When a dual-eligible PACE participant files a grievance, the QAGC will provide guidance regarding the differences between the Medicare and Medicaid grievance processes and suggest which process should be used.

19. AllCare PACE will maintain, aggregate and analyze information on grievance proceedings. This information will be used in AllCare PACE's internal quality improvement program.
20. The grievance identification, review and resolution processes outlined in this policy may result in a grievance not being resolved to the satisfaction of the participant or their representative.

D. Grievance Identification, Review and Resolution Procedures
1. Filing Requirements: A grievance may be filed with AllCare PACE at any time using the AllCare PACE grievance resolution process.
2. Receipt of Grievances: A participant or participant's authorized representative may submit a grievance review request to any AllCare PACE personnel:
    a. In person (verbally or otherwise)
    b. Telephonically
    c. In writing
    d. By postal mail
    e. By email
    f. Through any other method by which the participant or their authorized representative choose to communicate.
3. AllCare PACE personnel receiving a grievance will identify whether the grievance is an expedited grievance. An expedited grievance is a grievance in which the participant, participant's representative or AllCare PACE personnel believe the participant's life, physical or mental health or ability to attain, maintain or regain maximum function are in serious or immediate jeopardy as a result of the dissatisfaction with the delivery, timeliness, appropriateness, access to, and/or setting of a health service, procedure or item or the quality of care furnished.
    a. In the event of an expedited grievance, AllCare personnel will contact the QAGC.
    b. The QAGC will review the nature of the expedited grievance and will organize the necessary personnel to review the issue identified in the grievance. This may include members of the PACE IDT and/or other personnel such as the AllCare PACE Medical Director, Director of Quality and others as necessary.
4. The AllCare PACE personnel receiving a grievance indicate the date and time of receipt on the AllCare PACE grievance resolution tracking form.
5. The initial receipt date and time of the grievance begins the grievance review and resolution timeframe. All grievances will be resolved within 5 business days unless an extension is needed in order to gather additional information. All grievances will be addressed within 30 calendar days. Expedited grievances will be addressed within 72 hours of receipt.
6. AllCare personnel will work the participant or representative to resolve the issue(s) identified in the grievance. This will occur at the point of receipt if the grievance is identified by the participant in person or telephonically.

a. If the grievance is identified through means other than in person or telephonically, AllCare personnel will attempt to contact the participant or representative telephonically or in person in order to verify the nature of the grievance and verify

b. the identity of the person filing the grievance.

7. Grievances may be resolved to the participant's satisfaction at the point of receipt or may require AllCare personnel to investigate the grievance further in order to gather information, interview other personnel, review records or engage in other information gathering activities.
8. The participant may elect to have the grievance reviewed directly by the Appeals and Grievance Committee.
9. If the grievance is resolved at the point of receipt, AllCare personnel will complete the AllCare PACE grievance resolution tracking form and verify with the participant or representative that the grievance has been resolved to their satisfaction.
    a. In the event the grievance has been resolved at the point of receipt, the AllCare personnel receiving the grievance will complete the AllCare PACE grievance resolution tracking form and provide this form to the QAGC.
    b. In the event the grievance resolution requires other parties to the grievance (e.g., other personnel) participate in the resolution, the completion of this form may require the person receiving and resolving the grievance to work with other personnel to complete this form.
10. If the grievance is not resolved within twelve (12) calendar days from the point of receipt, AllCare personnel will complete the AllCare PACE grievance tracking form and will provide the form to the QAGC. Staff will send all related documentation and a description of efforts to resolve the grievance to the QAGC. The QAGC may have an opportunity to resolve the grievance and will attempt to do so.
11. The QAGC will log the grievance into the "EZ Cap" tracking system and sends an acknowledgement letter to the participant within 5 business days of receipt of the grievance. This letter will be provided within 72 hours of receipt of an expedited grievance. The letter includes:
    a. An explanation of the grievance process and timeframes.
    b. A summary description of the issue raised by the participant.
    c. The participant's right to submit further quality of care grievances for investigation.
12. AllCare personnel in coordination with the QAGC will review the issue(s) identified in the grievance and will work to identify potential solutions to the grievance.
13. Potential solutions to the grievance will be presented to the participant and AllCare PACE staff will work to identify a solution which is satisfactory to the participant and in accordance with PACE regulations and other administrative entities.
14. When all efforts to resolve the grievance with the participant have been unsuccessful within fifteen (15) calendar days of receipt, the QAGC will contact the participant and remind the participant of the option to bring the grievance to the Grievance and Appeal Committee. If the participant declines, the Grievance and Appeal Committee will review the grievance in the participant's absence and will issue a letter communicating the resolution. The participant will be provided

15. notification of their right to present evidence supporting the grievance. This evidence can be provided in person (verbally or otherwise), in writing, through supporting documentation or any other method by which the participant chooses to provide evidence supporting the grievance.
16. If the Grievance and Appeal Committee has reviewed the grievance, the QAGC will verbally communicate the resolution to the participant, guardian or legal decision maker or other authorized representative. The QAGC will send the appropriate grievance resolution letter to the participant. This notification will include a summary of the grievance issue, steps taken to remediate the issue and a description of the resolution status.
17. When a grievance has been resolved within thirty (30) calendar days, AllCare PACE will provide written notice of the disposition of the grievance within thirty (30) calendar days of the date the grievance was received. The written notice of the disposition of the grievance must include the results and date of the decision. For decisions not fully in the participant's favor, the notice must also include the right to request a DHS/Administrative Hearing review and describe the process for doing so.
18. If the grievance has not been resolved to the satisfaction of the participant within thirty (30) calendar days, AllCare PACE will record the disposition of the grievance. This disposition status includes a description of the efforts to resolve the grievance, the participant's response to these efforts and describe any additional efforts which will be made by AllCare PACE to resolve the grievance and the timeframes associated with these efforts. A summary of this disposition status will be provided in writing to the participant.
19. For grievances not resolved within thirty (30) calendar days, AllCare PACE will provide a written notice of the grievance disposition and associated updates to the participant within ninety (90) calendar days of the receipt of the grievance.

E. Grievance and Appeal Committee
   1. The governing board has formally delegated the review and resolution of grievances to the Grievance and Appeal Committee.
   2. AllCare PACE's Grievance and Appeal Committee is comprised of:
      a. Individuals who were not involved in any previous level of review or decision making.
      b. Individuals who are not subordinates of an individual who was involved in a previous level of review or decision making..
      c. Individuals who will take into account all comments, documents, records, and other information submitted by the participant or the participant's legal representative without regard to whether such information was submitted or considered in any attempts to resolve the grievance.
      d. Individuals who have agreed to respect the privacy of participants and have received training in maintaining confidentiality.

F. Documentation and Reporting:
   1. AllCare PACE will maintain records of participant grievance.
   2. Each record must be maintained in an accessible manner and is available to CMS

3. and or DHS upon request.
4. Content of Grievance Record

   At a minimum, the record of each grievance must contain all of the following information:

   a. The name of the participant for whom the grievance was filed.
   b. A statement that the issue is a grievance.
   c. A general description of the reason for the grievance.
   d. The date the grievance was received by AllCare PACE.
   e. The date(s) of any formal or informal reviews or meetings.
   f. The date on which the grievance was resolved.
   g. A summary of the decision.
   h. Whether the grievance was heard by the Grievance and Appeal Committee.
      i. If the grievance was heard by the Grievance and Appeal Committee, whether the original decision was overturned or partially overturned or if the committee agreed with AllCare PACE's decision or response to the grievance; and
   i. Whether a disenrollment occurred during the course of the grievance or within fourteen (14) calendar days of receipt of a committee decision, and if so, the reason for the disenrollment.

H. Tracking, Monitoring and Reporting of Grievances:

1. The Quality Improvement Director prepares an aggregated activity report for presentation to the Quality Improvement Committee on a quarterly basis which includes the following metrics:
   - Number of grievances received by types of grievances, including specific categories for quality of care complaints, number of grievances and grievance hearings.
   - Number of grievances per 1,000 participants.
   - Percent of grievances resolved within timeframe standards.
   - Other pertinent information as needed for Quality Improvement Programs.
2. The Quality Improvement Director will oversee the required submission of all grievance information to CMS as defined in the 2018 HPMS PACE Quality Monitoring requirements. These data elements will be revised based on any future changes in CMS PACE Quality Monitoring requirements.
3. The CMS PACE Quality Monitoring data will be used in quality improvement activities as well.

APPENDIX J: ADDITIONAL APPEALS RIGHTS

Include policies and procedures for informing participants of their additional appeals rights under Medicare and/or Medicaid. Note: This process must be developed in accordance with 42 CFR §460.124, and include the process for filing any further appeals.

Title: **Additional Appeals Rights AllCare PACE**	Policy Number:	
Department: **Quality, Appeals & Grievance and Claims**	Effective:	Date(s) Last Revised:
Approved by: (name/title) Cynthia Ackerman, RN, CHC, Chief Quality Officer		
Written By:		
Reference: 42 CFR § 460.122(a), (b), and (i); 71 FR 71301 (Dec. 8, 2006); 42 CFR § 460.122(c), (d), and (e); 42 CFR § 460.122(f), (h), and (g); 42 CFR § 460.124; 71 FR 71303; 71 FR 71303, 71312, and 71317; 42 § CFR 431.200 thru 431.250; 71 FR 71302 and 71304 PACE Manual 20-Appeals, 20.1;20.2; 20.3; 20.4; 20.6		

PURPOSE:

The purpose of this document is to define and implement an appeal process for the additional appeal rights under Medicaid and Medicare for a participant, or authorized representative, of an action or inaction of AllCare PACE that the participant perceives as negatively impacting the participant.

POLICY:

It is the policy of AllCare PACE to respond participant's request to have the right to appeal any action or inaction of AllCare PACE that the participant perceives as negatively impacting the participant. The overall system for dealing with appeals has been developed in cooperation with participants and other stakeholders. It is intentionally designed to offer participants different options for attempting to resolve differences, and to maintain and/or improve quality of care provided to participants through identification and adjudication of actions and non- actions perceived by the participant as negatively impacting the participant.

Definitions:

A. An "appeal" is a request for review of an "action."

B. An "action" is any of the following:

i. The denial of nursing home level of care eligibility as determined by the local

ii. Department/AAA agency to need the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services in accordance with the rules in OAR chapter 411, division 015 (Long-Term Care Service Priorities for Individuals Served)

iii. The denial or limited authorization of a requested service that falls within the benefit package, including the type or level of service.

iv. The reduction, suspension, or termination of a previously authorized service.

v. The denial, in whole or in part, of payment for a service that falls within the benefit package.

vi. The failure to provide services and support items included in the participant's Care Plan in a timely manner.

vii. The failure of AllCare PACE to act within the required timeframes for resolution of grievances or appeals.

viii. The development of a Care Plan that is unacceptable to the participant because any of the following apply:

a) The plan is contrary to a participant's wishes insofar as it requires the participant to live in a place that is unacceptable to the participant.

b) The plan does not provide sufficient care, treatment or support to meet the participant's needs and support the participant's identified outcomes.

c) The plan requires the participant to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the participant.

ix. Notification by AllCare PACE of a decision made in response to a participant's appeal that is entirely or partially adverse to the participant.

An "action" is not:

i. A change in provider;

ii. A change in the rate AllCare PACE pays a provider;

iii. A termination of a service that was authorized for a limited number of units of service or duration of a service; or

iv. An adverse action that is the result of a change in state or federal law; however, a participant does have the right to a State fair hearing in regard to whether he/she is a participant of the group impacted by the change.

PROCEDURE:

I. The Quality Appeal & Grievance Coordinator (AGC) is responsible for the appropriate continuation of services during appeals. The Participant may obtain continuing benefits if she/he requests an AllCare PACE internal appeal, or a State Fair Hearing on or before the date of intended termination, reduction, or suspension.

II. AllCare PACE shall continue the Participant's current benefits until the issuance of an appeal decision under the following circumstances:

a. The Participant files an appeal on or before the date of the intended action, or

b. within fifteen (10) calendar days of the date of mailing the written notice;
c. The current level of services was authorized by the interdisciplinary team;
d. AllCare PACE is proposing to suspend, terminate or reduce services currently being provided to the participant
e. The Participant requests the continuation;
f. The appeal includes a specific request that AllCare PACE continue the current level of the service in dispute; and
g. The participant requests continuation with the understanding that he/she may be liable for the costs of the disputed services if the decision is not made in his/her favor.

III. If benefits are continued or reinstated, pending the issuance of an appeal decision, they must be continued until one of the following occurs:

a. The Participant withdraws the appeal.
b. The Participant does not request a State Fair Hearing with continuation of services within ten (10) calendar days from when AllCare PACE mails an adverse decision.
c. A State Fair Hearing decision is made that is adverse to the Participant.
d. The authorization expires or authorization service limits are met.

IV. AllCare PACE will continue to provide the participant with all other required services that are not in dispute as part of the appeal.

3. Available Appeal Processes

I. In addition to the local appeal processes as noted in Sections 5 and 6 below, a participant may request:
a. A state fair hearing.

II. Determination of Appeal Process:

a. The available appeal processes for a PACE participants are determined by whether a participant is eligible for Medicaid or Medicare. If a PACE participant is eligible for both Medicare and Medicaid or is Medicare-only (with a private-pay premium), then the participant will have the two respective appeal options available. The participant has the right to choose which appeal process to follow. If the participant does not choose an appeal process, AllCare PACE staff will utilize the process that is most beneficial to the participant.

III. Summary of Appeals Processes:

a. Medicaid: The participant can appeal to AllCare PACE internal review, and/or the Division of Hearings and Appeals (DHA). A participant may file a fair hearing request with DHA instead of or after using the AllCare PACE appeal process but once the participant files a request for fair hearing with DHA s/he may not file an AllCare PACE internal appeal.

b. Medicare: The participant must appeal to AllCare PACE before appealing to the outside appeals organization, Maximus Center for Health Dispute Resolution (Maximus). For any adverse decisions to the participant, the participant can request a review of the decision with Maximus.
c. Medicaid and Medicare: If the participant is eligible for both Medicare and Medicaid or for Medicare-only (with a private-pay premium), then the participant can appeal using either process summarized above. AllCare PACE staff will assist the participant in choosing which process to pursue.

4. Appeal Notification Procedure

I. When the AllCare PACE interdisciplinary team takes an Action as defined in this policy, the team will provide either a Notice of Action or a Notice of Appeal Rights.

II. A staff person on the interdisciplinary team will notify the Participant of his or her appeal rights in writing using the program-appropriate Notice of Action documents.

III. The Appeal & Grievance Coordinator (AGC) will ensure that all appropriate services are continued and that the appeal is resolved within the appropriate time frames. All appeals will be resolved as expeditiously as the Participant's health condition requires.

IV. The AGC will continue to provide information and assistance as needed for continued appeals and/or reviews outside of AllCare PACE but will not include representing the participant at a DHA fair hearing.
Participants must submit an appeal to AllCare PACE AGC within 45 calendar days of receipt of the notice of action being appealed for Medicaid appeal process and within 60 days for the Medicare appeal process regarding AllCare PACE's notice to suspend, reduce, deny, terminate, or refuse to pay for, services. AllCare PACE will reject appeals submitted more than 45 days for Medicaid appeal process and more than 60 days for Medicare appeal process after the notice.

V. The AGC will provide a written final decision to the participant within 30 calendar days of receipt of the appeal. The written decision will include information on additional appeal steps available if the participant does not agree with the final decision. If not satisfied with AllCare PACE's decision, a Medicare eligible participant must request to have the appeal filed with Maximus for a review of the decision. If the decision on an appeal is wholly or partially adverse to the participant, the Chairperson must notify DHS and CMS at the same time that notification is provided to the Participant. Failure to meet the timeframes in this policy constitutes an adverse decision. No extensions shall be granted for standard PACE appeals.

VI. Participants must submit an appeal to AllCare PACE within 45 calendar days of receipt of the notice of action for Medicaid appeal process and within 60 days for Medicare appeal process of AllCare PACE notice to reduce, deny, terminate, or refuse to pay for, services. AllCare PACE will reject appeals submitted more than 45 calendar days from the receipt of the notice of action for Medicaid appeal process and more than 60 days for Medicare appeal process after the notice.

5. **Appeal Resolution**

I. Services Not Furnished While the Appeal is Pending: If AllCare PACE, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, AllCare PACE must authorize or provide the disputed services promptly, and as expeditiously as the Participant's health condition requires, but no later than the earlier of:

a. The date indicated for effectuation by the fair hearing officer; or
b. Thirty (30) calendar days from the receipt of the decision.

II. Services Furnished While the Appeal is Pending: If AllCare PACE, or the State fair hearing officer reverses a decision to deny authorization of services, and the Participant received the disputed services while the appeal was pending, AllCare PACE must pay for those services.

III. If the current level of service in dispute is requested to continue while the appeal is pending, the participant may be responsible for repaying AllCare PACE for the cost of this level of service being continued if the outcome of the appeal filed with AllCare PACE or DHA is unfavorable to the participant. However, even if the outcome is unfavorable, the participant will not be required to repay the cost of this level of service if it is determined that repaying the cost would impose a significant financial burden on the participant.

IV. AllCare PACE must attempt to resolve issues and concerns without formal hearings or reviews whenever possible. When a participant presents an appeal, the interdisciplinary team and the AGC must attempt to resolve the issue or concern through internal review, negotiation, or mediation, if possible.

6. Withdrawing an Appeal

In order for a Participant to withdraw an appeal, the person who filed the appeal with AllCare PACE must provide a written withdrawal request to AllCare PACE.

7. Appeal Analysis

V. The AGC files all appeals documentation and information to be aggregated and analyzed.

VI. Any and all minutes recorded for an appeal hearing are internal Quality and Risk Department documents, and are considered confidential. Disclosure of the minutes or the information contained in the minutes shall be at the discretion of the Risk Department.

APPENDIX K: QUALITY IMPROVEMENT PROGRAM

(Note: The quality improvement plan must be developed in accordance with 42 CFR §460.132. Service area expansion applicants should provide documentation that reflects their quality improvement program consistent with requirements at 42 CFR §460.134, including requirements in 42 CFR §460.120(f) and 42 CFR §460.122(i).)

PURPOSE

To ensure effective mechanisms for measuring, documenting, evaluating, improving, and maintaining, the quality and appropriateness of the full range of services provided by AllCare PACE to its participants through Quality Improvement (QI) activities and utilization review. The QI plan goals are to: (1) evaluate and improve the quality of services delivered to participants; (2) evaluate and improve the effectiveness and efficiency of services in meeting all participant needs; (3) identify and correct significant unfavorable trends, and; (4) develop, implement and monitor any corrective action plans and to assure that the desired outcomes are achieved and maintained.

POLICY

The AllCare PACE QI plan is developed under the direction and supervision of the Medical Director in conjunction with the Executive Director. The Director of Quality Improvement and the Quality Coordinator are responsible for implementing the QI plan at all AllCare PACE sites. The AllCare PACE QI program is collaborative and interdisciplinary and involves input from staff and IDT members with various levels of experience and knowledge.

PERSONS AFFECTED

All AllCare PACE Departments

RESPONSIBILITIES

Quality Department; Director of Operations

OBJECTIVES:

1. Quality Improvement Activities ensure:
    - participant satisfaction;
    - positive participant outcomes;
    - appropriate/efficient service utilization review; and
    - recommendations for Quality Improvement based presentation and analysis by data
2. Quality Improvement is achieved throug:

- Identifying specific functions, processes and/or outcomes that are areas of high risk,high volume or potential sources of human and/or system error; and
- Measuring these specific functions, processes and/or outcomes and collecting and analyzing

  data to determine the root cause(s) for any incidents, grievances, sentinel events or Level One or Two incidents; problem; and
- Benchmarking AllCare PACE's quality indicators. This data is benchmarked, if benchmark data is available, with other PACE plans locally and nationally through the National PACE Association's DataPACE program;
- Creating and implementing best practices or guidelines when available and applicable to AllCare PACE's population e.g. National PACE Association guidelines

3. Future quality improvement opportunities are identified through the tracking, trending and analysis of data and in response to federal and state mandates. Other mechanisms to identify opportunities for improvement include:

   - Recognition of trends across departments, committees, disciplines and sites.
   - Examination of Level Two incidents.
   - Examination of significant non-Level Two events
   - Response to staff, vendor and participant recommendations
   - Examination of daily operations including individual grievances, appeals,
   - Incidents, infections, falls, wounds, transportation, service delivery issues/failures, and vendor issues

4. Establishing priorities for quality improvement initiatives supports the AllCare PACE mission, vision, and values and is based on the following criteria:

   - Clinical outcomes for participant health
   - Outcomes and issues related to participant safety
   - Consumer satisfaction (participant, physician, payer, community staff and regulatory agencies
   - Programs' ability to provide efficient care and services
   - Relevance to clinical and/or the strategic initiatives of AllCare PACE
   - Likelihood that the initiative will have a positive impact on the program and its participants
   - Ability to provide support and resources to multiple initiatives
   - Ability to achieve required levels of quality on standardized established quality measures

5. The QI Plan consists of short and long term monitoring of clinical practice

6. improvement, quality control of specific areas, and ongoing measurement. The quality improvement methodology allows for the design of new services and redesign of existing services. Leadership and staff receive basic education in quality improvement in orientation and through continuing education. The process of identifying opportunities and setting priorities occurs annually a part of the review of the QI plan and creation of the next year's plan. The management team and AllCare PACE Quality Utilization Management Committee brainstorm about areas for improvement, using the criteria

   listed above and then prioritize the initiatives. In setting priorities, the committee considers issues that have been demonstrated to be high risk or sources of recurrent incidents and/or grievances. The Board of Directors approves the plan initially and annually thereafter. The Board also receives quarterly presentations on quality outcomes, trends and plans for improvement. The Board members review and approve the annual program evaluation.

METHODOLOGY:

AllCare PACE has adopted the Plan, Do, Check, Act (PDCA) model for quality improvement. AllCare PACE will standardize the improvement and/or implement mechanisms for sustaining the improvement with appropriate measurement

The process for collecting data and information to identify areas in need of improvement include:

- Identification of areas in need of weekly review by Medical Director, monthly review by QMC and quarterly evaluation of all incidents and grievances related to both staff and contracted services.
- Infection control surveillance data obtained daily at the morning meeting by QA manager and reviewed bi-weekly or more frequently with the Infection Control Officer and presented monthly at the QMC with quarterly summaries at the Quality Improvement Committee meeting
- Obtaining, completing and updating advance care plans based on monthly audits of all new enrollees and annual evaluations;
- Emergency department visits from clinical information obtained by IDT and claims data nursing home stays including both short and long term stays from IDT and morning meeting information;
- 30 day hospital readmissions from data tracked and trended
- All falls based on incident reports;
- Adequacy and timeliness of transitional care information (both sent and received) by auditing elements of transfer information both sent with

- participant and received with Participant Advisory Committee (PAC) suggestions and concerns by reviewing minutes of PAC meetings;

QUALITY IMPROVEMENT STRUCTURE:

The AllCare PACE quality improvement structure reflects the integration of the QI program with the quality process and the quality oversight process.

The following Committees form the structure the implements the QI plan

I. Quality Improvement Committee

The Quality Improvement Committee, designated by the AllCare PACE Executive Director is responsible

for developing the annual QI Plan, guiding the implementation of plan activities and enabling the staff to become more integrated into the QI processes through education. This committee meets quarterly to review all findings from the activities described below, explore options for action and make recommendations for improvement.

II. Quality Improvement Committee Functions

- Reviews Quality Management reports prepared by Director of Quality Improvement and Quality Improvement Teams. This includes summaries of departmental initiatives and compliance activities.
- Reviews all Network compliance and network provider operational issues. This includes review of findings from audits of contracted service provider and follow-up or corrective action plans.
- Reviews all quality indicators, and results of short and long term monitoring.
- Reviews analysis of all infection control data and reports
- Reviews summary of all grievances and appeals, investigations and corrective action plans. Determines the effectiveness of such actions.
- Reviews incident reports and investigations.
- Makes recommendations for policy and/or procedure changes, as appropriate.
- Reviews all incident/unusual occurrences to identify trends,
- Analyzes problems, explores options for solution and recommends strategies for improvement.
- Monitors progress in achieving recommended follow up.
- As needed, sub-committees for Quality Improvement Teams (QIT) are formed to work on problems requiring expert or special attention.
- Reviews and approves policies and procedures related to care management and recommends these to the Board of Directors
- Meeting minutes will be presented, reviewed and approved;
- The AllCare PACE Medical Director and Director of Quality

- Improvement report quality management activities to the Quality Improvement Committee and subsequently to the AllCare PACE Board of Directors. At the quarterly Quality Improvement Committee meeting, all data- driven QI activities are reported including:
    - Incidents, grievances, infections, and wounds; audits, utilization, quality measures, and trends, root cause analyses of any systemic problems;
    - Quality Improvement Team (QIT) findings, recommendations, corrective action plans, and outcomes.
    - Compliance Updates;
    - Medical record audits and results of any corrective action plans

III. Quality Management Committee:

The Quality Management Committee (QMC) meets monthly to review quality indicators including incidents, grievances, infections, wounds, falls and results of monthly auditing and monitoring activities. These meetings also review recommendations to improve quality, review deaths and disenrollment information, and utilization data.

The QMC includes, but is not limited to:

- Center Manager
- Director of Quality Improvement
- Director of Clinical Services or liaison
- Executive Director
- Marketing Director
- Medical Director, Co-chair
- Infection Control representative (e.g., clinical manager)

AllCare PACE will use CDC criteria for definitions of infectious diseases as they pertain to community acquired, health care institution acquired, and health care related infections. Whenever indicated information regarding infections is gleaned from the CDC website.

The following processes and procedures will be used to track, trend, and analyze infections in AllCare PACE participants to determine any unexplained increases, clusters or outbreaks of infectious diseases so that infection control procedures can be implemented to control and decrease the spread of any infections to other participants, staff, visitors and/or volunteers.

1. Any suspected and documented infections will be considered incidents and incident reports will be completed by whichever staff member reports the suspected or documented infection.

2. At each PACE center morning IDT meeting, a Quality Morning

3. Report Checklist with the following information will be recorded and forwarded to the Director of QA or QA Manager:

   - Emergency department visits;
   - Falls
   - Family Meetings
   - Grievances
   - Appeals
   - Falls, with or without injury
   - Burns
   - Emergency Room Visits
   - Hospitalizations
   - Infections, both treated and resolved
   - All Level 2 incidents
   - New members
   - Participants out of area
   - Psychiatry referrals
   - Respite care
   - Wound care (monitoring)
   - Deaths

This daily attention to infections, as reported on the incident reports and the Quality Morning Report Checklist, will allow the Infection Control representative to determine any clusters or outbreaks of MRSA, VRE, C. diff, influenza, or conjunctivitis, for example that would warrant the immediate implementation of infection control procedures and additional surveillance of participants and staff.

IV. Participant Involvement

Participant and family involvement in QI activities is fostered through the following activities:

- Participation with the interdisciplinary team in decisions regarding the plan of care, and provided services, their amount, duration and scheduling and in evaluating their effectiveness.
- Involvement in the Complaint/Grievance process as applicable to each individual participant.
- Response to Satisfaction Surveys.
- Participation in the Participant Advisory Committee

COMPONENTS OF THE PLAN

The components of the QI Plan consist of:

I. Short-term Monitoring - Concurrent Review

Concurrent Review is the appraisal and observation of participants according to their plan of care by the IDT to determine any change in the participant's physical or mental status. If change has occurred, the review includes an evaluation of the participant with appropriate follow-up. Constant monitoring effectively discloses immediate and potential needs for care plan adjustments.

Daily IDT meeting is an important aspect of concurrent review. Daily meetings allow team participants to discuss changes in participants' conditions and treatment results. Based on the health condition of the participants, the plan of care is reviewed and revised as needed at the daily meeting. The identification of significant changes in participant condition prompts the initiation of additional assessments and care planning which is followed up at subsequent morning meetings.

II. Long-term and ongoing monitoring

Long-term and ongoing monitoring is the process of collecting data in order to determine the stability of processes and functions and to identify changes in those functions which would benefit from improvement. Functions to be monitored may include processes, outcomes, targeted studies, comprehensive quality measures, and dimensions of quality including efficacy, appropriateness, availability, timeliness, continuity, safety, efficiency, and respect and caring. Long term monitoring also includes monitoring those functions required by Oregon State and federal mandates.

The framework for measuring quality is built on an evaluation and outcome recording system which enables AllCare PACE to monitor and track participant response to program interventions by diagnosis and condition in relation to a number of demographic variables including age, gender, location, length of stay, etc. Additional data sources for measuring quality indicators include incident and complaint reports, record reviews and satisfaction surveys.

Quality Improvement Reviews will specifically use objective measures to plan improvement in the following areas:

1. Utilization of Services including:
    - Emergency department visits
    - Hospital Admissions and 30 day readmissions
    - Home Care Aide services
    - Prescription drugs
    - Skilled Nursing Facility Admissions
2. Caregiver and Participant Satisfaction
3. Competency of Staff including:

- Annual competency
- Skills appraisals
- Participation in required in-service training
- Compliance with credentialing and employee health requirements

4. Clinical outcomes derived from IDT assessment process including:

   - Physiological well being
   - Functional status
   - Cognitive ability
   - Social and behavioral functioning
   - Quality of Life of participants

5. Non-clinical outcomes including:

   - Incidents and Accidents
   - Grievances and Appeals
   - Specific non clinical service related measures as indicated (such as transportation, equipment, meals, etc.)

6. Effectiveness of the program services

7. Timeliness of service delivery

8. Coordination of services within the interdisciplinary team

9. Coordination of services with network providers

10. Communication of Patient's Rights

11. Adherence to participant stated care guidelines and/or end of life wishes

12. Achievement of Plan of Care treatment goals and measurable outcomes.

13. Targeted Reviews based on identified needs for improvement, identified standards to be achieved, or as part of cross-program quality comparisons

14. Adherence to infection control guidelines

References to the processes and tools to be used for measurement of the above quality indicators can be found in the Quality Indicator Review Process and Methodology.

III. Quality Control – Grievances and Appeals and Incident Monitoring

Administrative staff of AllCare PACE will respond to, investigate and resolve grievances and appeals, and review comments and recommendations from participants, family and visitors in accordance with the Grievances and Appeals policy. Grievances, appeals, and occurrences will be tracked, trended and reported on a monthly basis to the QMC and on a quarterly basis to the Quality

Improvement Committee and Board.

Incidents are defined as any happening which is not consistent with the routine operation of the program or the routine management of a participant's care. Incidents include complications which constitute major or minor injury, unexpected complications that require prolonged care, any treatment for which there is an unexpected outcome, medication and treatment errors, injury or potential injury, or controlled substance loss. Incidents are reported, investigated and resolved per approved administrative procedure.

IV. Abuse Prevention and Reporting

All instances of potential abuse, alleged abuse and actual abuse will be investigated and reported to the appropriate authorities. In addition, all such occurrences will be tracked, trended and reported to the QMC on a monthly basis and the Quality Improvement C Committee on a quarterly basis.

V. Participant Satisfaction

AllCare PACE participant and caregiver satisfaction surveys shall be conducted no less than annually. Findings will be reported to the Quality Improvement Committee and Executive Director detailing major satisfiers and dis-satisfiers and highlighting opportunities for improvement. Findings will be shared with staff and reported to the Board of Directors and used as data sources in quality improvement efforts and activities at all levels.

VI. Record Review Process

The record review process incorporates ongoing reviews of qualitative and quantitative aspects of care (QA and UR) as well as periodic focused reviews of discrete care components such as prevention. In addition, Quality Improvement Project Teams are appointed to study and to improve critical components of care identified on reviews by staff or other QM measures. The AllCare PACE Director of Quality Improvement is responsible for ensuring and monitoring participation in the record review process. In addition to record review team participants, other disciplines (such as nursing home clinical staff, transportation and other specialists) will participate as needed. Reviewers will not be involved in review of care in which they are directly involved. A sample representing 10% of the active census will be reviewed on a quarterly basis. In addition, a sample of the following records will be reviewed periodically at the direction of program management or the AllCare PACE Quality Management Committee:

- Disenrolled participants,
- Nursing home admissions,
- Unplanned hospitalizations
- All cause hospital readmissions

An emphasis will be placed on reviewing potential clinical problems such as participants at high risk of hospitalization or of developing complications from chronic diseases. Focused reviews may also be conducted on specific conditions or diagnoses, high risk, high volume or problem prone services identified through QI/UR data sources and from existing standards of practice. Review content includes qualitative clinical considerations such as effectiveness of the interdisciplinary team process; as well as utilization and process issues that affect quality such as visit and service frequency and duration.

Findings are discussed during review sessions and recommendations are made; findings related to specific cases are referred to the team for immediate follow up. The Medical Director and Director of Clinical Services are responsible for analysis and formulation of an action plan to address problems identified. The plan might include immediate changes such as staffing re-allocation or appointment of a Quality Improvement Team to study the problem in greater depth. All record review findings are tabulated, summarized centrally by AllCare PACE and reported to the Executive Director, the QMC, Quality Improvement Committee, and the Board of Directors. The Executive Director communicates the finding to PACE staff and ensures communication to contractors as appropriate.

VII. Annual Program Evaluation

An annual program evaluation is conducted by the AllCare PACE Director of Quality Improvement, in collaboration with the PACE Medical Director, Director of Clinical Services, Director of Provider Relations and the Quality Improvement Committee.

The evaluation includes:

a. An analysis of administrative and organizational practices;
b. An evaluation of the quality of services provided throughout the period;
c. An evaluation of the extent to which the program meets the needs of the area and the population being served.

The Annual Program Review is presented to the AllCare PACE Executive Director, the Quality Improvement Committee, and Board of Directors for review and approval. The annual program review is shared with staff and contractors in whole or in part, as appropriate, for learning and is disseminated in a variety of ways including but not limited to: staff meetings and in-service training, IDT meetings including daily briefings and I&A meetings, staff newsletters and memorandums.

REFERENCES

Not applicable

REVISION HISTORY

- 12/05/2019: Document created

APPENDIX L: PACE Quality Reporting

Programs of All-Inclusive Care for the Elderly (PACE) quality monitoring and reporting requirements are outlined in Title 42 of The Code of Federal Regulations, §§460.130(d), 460.200(b)(1), 460.200(c) and 460.202. To be in compliance with the above-referenced regulatory requirements, PACE organizations (POs) must report both aggregate and individual PACE quality data to CMS on a quarterly basis. All PACE quality data are reported to CMS using the Health Plan Management System (HPMS). POs are also required to timely report certain unusual incidents to other Federal and State agencies consistent with applicable statutory or regulatory requirements (see 42 CFR §460.136(a)(5)). Specific reporting requirements and timeframes may be found on the respective Federal or State agencies' websites.

PACE Quality Data Types:

PACE Quality Data without Root Cause Analysis (RCA)
PACE Quality Data without Root Cause Analysis (RCA) reporting requirements apply specifically to the aggregate data such as appeals, enrollment data, falls without injury, etc.

PACE Quality Data with RCA
PACE Quality Data with RCA reporting requirements apply specifically to unusual incidents that result in serious adverse participant outcomes, or negative media coverage related to the PACE program. In these instances, the PO must initiate the RCA investigation internally within three working days of identifying the incident. POs are required to document all RCA information in the fields provided in HPMS, as well as indicate what the participant's current status is at the conclusion of the RCA investigation.

Additional information regarding PACE Quality Data reporting requirements is outlined in the PACE Quality Monitoring and Reporting Guidance of April 2018.

APPENDIX M: MEDICARE AND MEDICAID PAYMENT AMOUNTS

CMS makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicare participant in the payment area. Prospective payments are made up of the pre-ACA county rate, unadjusted for Indirect Medical Education (IME), and multiplied by the sum of the individual risk score and the organization frailty score. This payment methodology is described in the PACE program agreement. We have provided a brief description of PACE payment and the differences between PACE payment and payment for other Medicare Advantage plans below.

County Rates

The prospective payment rates for PACE are based on the applicable amount calculated under section 1853(k)(1) of the Act, unadjusted for IME.[1] In rebasing years, this rate is the greater of: 1) the county's FFS rate for the payment year or 2) the prior year's applicable amount increased by the payment year's National Per Capita Medicare Advantage Growth Percentage. In non-rebasing years, this rate is the prior year's applicable amount increased by the payment year's National Per Capita Medicare Advantage Growth Percentage. To determine whether a given year is a rebasing year, and for rules applicable to specific payment years, refer to the applicable Rate Announcement (available online at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html)

Section 1853(k)(4) of the Act requires CMS to phase out indirect medical education (IME) amounts from MA capitation rates. PACE programs are excluded from the IME payment phase out under that section pursuant to section 1894(d)(3).

Effective CY 2006 and subsequent years for MA organizations, CMS makes advance monthly per capita payments for aged and disabled enrollees based on the bidding methodology established by the MMA. *See* section 1854 of the Act. POs are not required to bid; however, CMS also makes advance monthly per capita payments to POs for their enrollees, based on the PACE county benchmark amounts as the capitation rate.

Risk Adjustment

For the final payment rate, the county rate for the PO is multiplied by the individual participant risk score. Risk adjustment allows CMS to pay plans for the risk of the beneficiaries they enroll, instead of an average amount for Medicare beneficiaries. The individual participant risk score for Medicare Advantage and PACE is calculated using a CMS–HCC model (community, long-term institutionalized, End-Stage Renal Disease (ESRD) or new enrollee), which is published in the annual Announcement of Calendar Year Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (Rate Announcement).

Section 1894(d)(2) of the Act requires CMS to take into account the frailty of the PACE population when making payments to POs. Therefore, a frailty factor is added to each individual's risk score for PACE payment. Risk adjustment predicts (or explains) the future

Medicare expenditures of individuals based on diagnoses and demographics. Because risk adjustment may not explain all of the variation in expenditures for frail community populations, the frailty adjustment is used to predict the Medicare expenditures of community populations with functional impairments.

The frailty score added to the beneficiary's risk score is calculated at the contract-level, using the aggregate counts of ADLs among HOS-M survey respondents enrolled in a specific organization who responded to the survey the prior year. More information regarding the HOS-M can be found in section 10.30 in Chapter 10 of the PACE manual chapter, Quality Assessment and Performance Improvement, located online at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pace111c10.pdf

Because the CMS-HCC model adequately predicts the costs of beneficiaries under age 55 or who are among the long-term institutionalized population, frailty adjustments are added to the risk scores for community-based and short-term institutionalized enrollees aged 55 and older. Updated frailty factors are published in the Rate Announcement for the payment year in which they are first used.

Additional Information

For additional, more detailed information about PACE Medicare payment, please see the following documents:

- Payments to Medicare Advantage Organizations, Chapter 8, Medicare Managed Care Manual
- Risk Adjustment, Chapter 7, Medicare Managed Care Manual
- CMS publishes changes to the Medicare Advantage payment methodologies in the Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Advance Notice) in mid-February at http://www.cms.gov/MedicareAdvtgSpecRateStats/ for public comment.

The final payment methodologies are published in the Announcement of Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (Rate Announcement) on the first Monday in April at the same website.

Medicare Part D

In order for POs to continue to meet the statutory requirement of providing prescription drug coverage to their enrollees, and to ensure that they receive adequate payment for the provision of Part D drugs, beginning January 1, 2006, POs began to offer qualified prescription drug coverage to their enrollees who are Part D eligible individuals. The MMA did not impact the manner, in which POs are paid for the provision of outpatient prescription drugs to non-part D eligible PACE participants.

POs are required to annually submit two Part D bids: one for a Plan Benefit Package (PBP) for dually eligible enrollees and one for a PBP for Medicare-only enrollees. The Part D payment to POs comprises several pieces, including the risk adjusted direct subsidy, reinsurance payments, and risk sharing. With a few exceptions, Part D payments are made to POs in the same manner as to MA-PD and standalone PDP plans. The direct subsidy is risk adjusted. Payments for eligible

enrollees of either PBP will include a low-income premium subsidy and a low-income cost-sharing subsidy for basic Part D benefits. Payments for dually eligible enrollees will also include an additional amount to cover nominal cost sharing amounts ("2% capitation"), and an additional premium payment in situations where the PO's basic Part D beneficiary premium is greater than the regional low-income premium subsidy amount.

Description of Rate (ex. Dual Eligible, Medicaid Only)Amount of Rate (LTC + Acute care = Total)

Dual Eligible	$3,956.32
Medicaid Only	$5,825.03

APPENDIX N: STATE ENROLLMENT/DISENROLLMENT RECONCILIATION METHODOLOGY

A description of the State's procedures for the enrollment and disenrollment of participants into the state system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month as required at 42 CFR §460.182(d).

Oregon’s PACE payment is prospective, based on actual numbers that are entered into the state system prior to the participant’s start date or reassessment date. The SAA conducts a monthly reconciliation based on the PACE organization’s enrollment/disenrollment list and the state’s Remittance Advice for the PACE capitation payment. This reconciliation process captures enrollments that may have been missed after the system compute deadline for enrollment, as well as capturing the date of death entered into the system for potential recoupment of a prospective payment. The PO and SAA work collaboratively on this reconciliation process on a monthly basis.

APPENDIX O: TERMINATION

Include a detailed written plan for phase-down in the event of termination consistent with the requirements of 42 CFR §460.50, §460.52.

AllCare PACE Program Insolvency and Program Termination Plan:

Preamble

According to §460.80, Fiscal soundness, AllCare PACE must have a fiscally sound operation, as demonstrated by the following:

(i) Total assets greater than total unsubordinated liabilities.
(ii) Sufficient cash flow and adequate liquidity to meet obligations as they become due.
(iii) A net operating surplus or a financial plan for maintaining solvency that is satisfactory to CMS and the State administering agency.

Insolvency plan: The organization must have a documented plan in the event of insolvency, approved by CMS and the State administering agency, which provides for the following:

(i) Continuation of benefits for the duration of the period for which capitation payment has been made.
(ii) Continuation of benefits to participants who are confined in a hospital on the date of insolvency until their discharge.
(iii) Protection of participants from liability for payment of fees that are the legal obligation of AllCare PACE.

This document outlines AllCare PACE's Insolvency Plan and Program Termination Procedures.

Purpose

AllCare PACE shall ensure continuity of care for enrolled participants through sound financial management systems and practices. Financial management systems shall be sufficient to track, reconcile, report, and project the operational and financial results of the organization, and support informed decision-making. Financial management practices shall ensure the overall financial health of the organization and support the maximization of quality services with the funds expended. AllCare PACE shall also demonstrate the capacity for financial solvency and stability and the ability to assume the level of financial risk required under this contract and ensure continuity of care for enrolled participants.

Financial Arrangements to Cover Expenses

AllCare PACE 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:

A. One month's total capitation revenue to cover expenses the month before insolvency.

B. 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 operations.
C. Arrangements to cover expenses may include, but are not limited to, the following:
    (i) Insolvency insurance or reinsurance.
    (ii) Hold harmless arrangement.
    (iii) Letters of credit, guarantees, net worth, restricted State reserves, or State law provisions

Prohibition on Billing in Insolvency
In the event of AllCare PACE's insolvency, the organization shall not bill participants for any debts of AllCare PACE or for PACE services provided during the member's period of enrollment.

Billing Participants/Hold Harmless
The payments by AllCare PACE and/or any third party payer will be the sole compensation for services rendered under the federal PACE three party agreement. All subcontractors agree not to bill participants and to hold harmless individual participants, the Department and CMS in the event AllCare PACE cannot pay for services that are the legal obligation of AllCare PACE to pay, including, but not limited to, AllCare PACE's insolvency, breach of contract, and provider billing. AllCare PACE and the subcontractor may not bill a member for PACE services.

Sanctions for Violation, Breach, or Non-Performance
Imposition of Sanctions
1. AllCare PACE shall provide all necessary services that AllCare PACE is required to provide, under law or under this contract to any member covered under the contract, and meet the quality standards and performance criteria of this contract. AllCare PACE
2. AllCare PACE shall not act to discriminate among participants on the basis of their health status or need for health care services. This includes, but is not limited to, termination of enrollment or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future PACE services.
3. AllCare PACE shall not misrepresent or falsify information that it furnishes to CMS or to the Department.
4. AllCare PACE shall not misrepresent or falsify information that it furnishes to a member, potential member, or a provider.
5. AllCare PACE shall not violate any of the other requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations;

CMS may impose sanctions if it determines AllCare PACE fails to meet the performance expectations set forth in this document.
1. AllCare PACE fails substantially in furnishing the medically necessary items and services to the participant that are covered by PACE if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the participant;
2. AllCare PACE involuntary disenrolls a participant in violation of 42 CFR § 460.164;

3. AllCare PACE discriminates on the basis of an individual's health status or need for health care services in the enrollment or disenrollment process, among Medicare beneficiaries or Medicaid recipients, or both, who are eligible to enroll in a PACE program;
4. AllCare PACE engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment, except as permitted by 42 CFR § 460.150 (the section of the PACE regulation which describes eligibility criteria and the enrollment process for the PACE program) by Medicare beneficiaries or Medicaid recipients whose medical condition or history indicates a need for substantial future medical services;
5. AllCare PACE imposes premium charges on a participant enrolled under Medicare or Medicaid that is more than the allowable amount;
6. AllCare PACE misrepresents or falsifies information that is furnished to CMS or the State or, to an individual or any other entity under Part 460;
7. AllCare PACE prohibits or restricts a covered healthcare professional, who is acting within their lawful scope of practice, from advising a participant (their patient) about the patient's health status, medical care, or treatment for the participant's condition or disease, regardless of whether the PACE program provides the benefits for that care or treatment;
8. AllCare PACE operates a physician incentive plan that does not meet the requirements of Section 1876(i)(8) of the Act;
9. AllCare PACE employs or contracts with any individual who is excluded from participation in Medicare or Medicaid under Section 1128 or 1128A of the Act (or with any entity that employs or contracts with such an individual) for the provision of health care, utilization review, medical social work, or administrative services.

Suspension of Enrollment or Payment by CMS

CMS may suspend enrollment of Medicare beneficiaries due to the above mentioned violation after the date

CMS notifies the PACE organization of the violation. For individuals enrolled after the date CMS notifies the PACE organization of the violation, CMS may suspend Medicare payment to the PACE organization and deny payment to the State of Federal Financial Participation for medical assistance for services furnished under the PACE program agreement. The State Administering Agency determines if suspension of enrollment should occur with Medicaid recipients. A suspension or denial of payment remains in effect until CMS is satisfied that AllCare PACE has corrected the cause of the violation and the violation is not likely to recur.

There are certain violations for which CMS will impose a civil money penalty (CMP). The penalty is amounts up to the following maximum amounts, depending on the type of violation.

CMP violations include:

- For each violation regarding enrollment or disenrollment specified in 42 CFR § 460.40(c) or (d), $100,000 plus $15,000 for each individual not enrolled as a result of the PACE organization's discrimination in enrollment or disenrollment or practice that would deny or discourage enrollment;

- For each violation regarding excessive premiums specified in 42 CFR § 460.40(e), $25,000 plus double the excess amount above the permitted premium charged a participant by the PACE organization (the excess amount charged is deducted from the penalty and returned to the participant);
- For each misrepresentation or falsification of information as specified in 42 CFR § 460.40(f)(1), $100,000;
- For any other violation specified in 42 CFR § 460.40, $25,000; The provisions of Section 1128A of the Act (other than subsections (a) and (b)) apply to a civil money penalty under this section in the same manner as they apply to a civil money penalty or proceeding under Section 1128A(a).

Additional Actions by CMS or the State

After CMS consults with the State Administering Agency, if CMS determines AllCare PACE is not in substantial compliance with the PACE requirements, CMS or the State Administering Agency can take one or more of the following actions:

- The continuation of the AllCare PACE Program Agreement is contingent on AllCare PACE's timely execution of a corrective action plan (CAP);
- AllCare PACE must correct the deficiency or CMS and/or the State Administering Agency can withhold some or all payments under the PACE agreement;
- Termination of the AllCare PACE Program Agreement.

Termination of the PACE Program Agreement

CMS or the State Administering Agency may terminate a PACE Program Agreement at any time for cause and a PACE organization may terminate an agreement after appropriate notice to CMS, State Administering Agency and its participants. CMS or the State Administering Agency may terminate a PACE Program Agreement with the PACE organization for cause including, but not limited to, the following:

- There are significant deficiencies in the quality of care furnished to participants or the PACE organization has failed to comply substantially with conditions for a PACE program or PACE organization under the Part 460 regulations or with the terms of its PACE Program Agreement; and, within 30 days of the date of receipt of the written notice regarding the deficiencies, the PACE organization failed to develop and successfully initiate a plan to correct the deficiencies or failed to continue implementation of such a plan, or CMS and the State Administering Agency determined that the deficiencies cannot be corrected; or
- CMS or the State Administering Agency determines that the PACE organization cannot ensure the health and safety of its participants. The determination may result from the identification of deficiencies that CMS or the State Administering Agency determines cannot be corrected.

If the PACE organization initiates the termination, it is required to give CMS and the State Administering Agency 90 days notice and participants 60 days notice before termination in order to provide sufficient time to transition participants to alternative care. If a participant is eligible

for Medicaid, the State should provide assistance in arranging for the alternative care. Neither the State nor CMS considers termination lightly. The primary concern is protecting the health and safety of the participant and all possible ramifications of terminating a program agreement, including the likelihood of participants becoming institutionalized, will be considered before taking such severe action.

Termination Procedures

If CMS terminates an agreement with AllCare PACE, it will provide AllCare PACE with the following: (1) a reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of CMS's determination that cause exists for termination; and (2) reasonable notice and opportunity for a hearing, including the right to appeal an initial determination, before terminating the agreement.

CMS may terminate AllCare PACE's program agreement without invoking any of the above mentioned procedures if CMS determines that a delay in termination, resulting from compliance with these procedures before termination, would pose an imminent and serious risk to the health of participants enrolled with the organization.

In the event the AllCare PACE three party agreement is terminated:

- AllCare PACE will inform participants, CMS and the State Administering Agency in writing about the termination. This will include a description of processes for transitioning care for participants of AllCare PACE to other care and service providers. This will include ensuring participant's medical records are available to new providers.
- AllCare PACE will coordinate with the State Administering Agency to facilitate the reinstatement of Medicare and/or Medicaid benefits to participants based on each participant's qualifications for Medicare and/or Medicaid benefit eligibility requirements.
- AllCare PACE will cease all marketing and enrollment activities upon the initiation of termination procedures.
- AllCare PACE will initiate an assessment of each participant's current medical and social conditions at the time of the initiation of program termination and develop a recommended plan of care for each participant based on this assessment. This recommended plan of care will be used as a basis for identifying the necessary care and services the participant requires through other systems of care following the complete termination of the AllCare PACE program agreement. AllCare PACE in collaboration with the State Administering Agency will work with each participant and their family/caregivers to identify providers of care/services and payer sources outside of AllCare PACE for each service in the individual participant's transitional plan of care. In order to carry-out these transitional care processes, AllCare PACE may hire and train additional staff as necessary to assist in carrying-out the necessary assessment and care planning activities or other functions. All staff will be trained according to standards outlined in 42 CFR §§ 460.64, 460.71(b), 460.76(d) and 460.102(e).

APPENDIX P: STATE ENROLLMENT PROCESS

(Include a description of the state's process for enrollment of participants into the state system in accordance with 42 CFR §460.182(d), as well as the criteria for deemed continued eligibility for PACE in accordance with 42 CFR §460.160(b)(3).)

Process for Determining LTC Eligibility and Level of Care (LOC)

Option 1 (new to LTC services): [1]APD/AAA case managers are responsible for completing a Long-Term Care (LTC) assessment using the state system Client Assessment and Planning System (CAPS). If the applicant is found eligible for services (SPL 1-13)[2], case managers discuss all services options, including PACE services, with applicants. The applicant may choose PACE services if he/she resides in a PACE service area and meets other enrollment criteria.

Option 2 (new to LTC services/referral from PACE organization): A referral from the PACE organization is received by the APD/AAA office to complete an LTC assessment; APD/AAA case managers[3] are responsible for completing an LTC assessment using CAPS. (This may also be referred to as a 'courtesy assessment').
The applicant may choose to receive Medicaid services in conjunction with PACE services or choose to receive PACE services privately (Medicare and/or private pay).

Option 3 (current consumer of LTC services): APD/AAA case managers are responsible for completing an annual LTC assessment using CAPS. If the individual is found eligible for services (SPL 1-13), resides in a PACE service area and meets other enrollment criteria, the individual may choose to receive services through the PACE program.

The APD/AAA office will make a referral to the PACE organization, on behalf of the individual, regarding potential enrollment. The PACE organization will respond to the referral within one business day and begin the assessment process for the appropriateness of enrollment. Because screening, referral, and intake are important functions for assisting individuals to obtain services to meet their specific needs, case managers and the PACE organization staff will communicate with each other during the eligibility and enrollment processes to ensure services are provided in a timely manner.

Once the PACE organization makes an enrollment decision, it will communicate the approval or denial of enrollment to the APD/AAA case manager. Any individual may be enrolled on the first of each month but not retroactively. However, consumers/participants who are new to Medicaid LTC services may be enrolled on a weekly basis (on a Monday).

The APD/AAA case manager will create a benefit plan and service plan in CAPS if the PACE organization approves enrollment and communicates the approval to the case manager. The benefit plan information from CAPS is sent to MMIS to initiate the enrollment and payment to the PACE organization each month. This information also initiates enrollment into the PACE medical plan.

For individuals with income above the OSIP-M (Oregon Supplemental Income Program-

Medical) standard, the individual must pay-in each month any income above the OSIP-M standard or any income above the PIF (personal incidental funds) amount when enrolled in the PACE program.

If the individual is currently enrolled in a Medicare HMO, a CCO[4], or private health insurance, he/she must be disenrolled from that plan with an effective date prior to PACE enrollment.

- The PACE organization may assist with disenrollment from a Medicare HMO.
- If the individual has a Medigap plan (supplemental insurance), the individual or his/her representative should contact the plan to be disenrolled.

Continued Eligibility For PACE

Prior to enrollment and annually thereafter, an assessment is completed using CAPS which determines the level of care and identifies service needs. The CAPS tool is an electronic, holistic assessment assigns a ranking called a Service Priority Level (SPL). Individuals assessed at SPL 1- 13 are considered in need of services at the nursing facility level of care. Services are provided to individuals at different levels based on resources available and their annual assessment outcomes. All PACE participants, private and Medicaid, are subjected to these same eligibility standards at the time of the assessment.

If a PACE participant is assessed at SPL 14 or higher at the annual reassessment, the local APD/AAA case manager, in conjunction with the PACE interdisciplinary team (IDT), will review the participant's previous assessments to evaluate the effect of disenrollment on the participant's health status, ADLs, and social functioning. If it is determined that the participant’s health and safety would diminish within six months without PACE services, the participant may be deemed eligible until the next annual re-evaluation.

APPENDIX Q: SAA OVERSIGHT OF PO ADMINISTRATION OF SAFETY CRITERIA

(Include a description of the state's process to oversee the applicant's administration of the criteria for determining if a potential PACE enrollee is safe to live in the community at the time of enrollment, and any associated enrollment denials based on application of that criteria. Note: The process must be developed in accordance with 42 CFR §460.150(c) and 42 CFR §460.152(b).)

The criteria for determining that an individual cannot live safely in the community and thereby may be denied enrollment is as follows:

a. The individual demonstrates imminent danger to self or others.
b. The individual needs imminent nursing facility placement.
c. The individual resides in a home environment that is dangerous to care providers or prevents delivery of care.
d. There is evidence in the individual's clinical record that shows he/she has been repeatedly placed in appropriate care settings and, despite medically appropriate treatment, placement has resulted in frequent hospitalizations or failed placements.
e. At the time of application, the individual is determined to be appropriate for Enhanced Care Services or placement at Oregon State Hospital.
f. At the time of application, the individual has a physician-documented condition that meets the criteria for Medicare skilled care and cannot be discharged safely to the community within the next 30 days.
g. The individual wishes to remain at home but requires 24-hour care to live safely in the home.

If either the PACE organization or the APD/AAA[1] case manager has concerns about the safety of a potential enrollee, a case conference can be convened to review the case with outside consultants, as needed, for further evaluation.

The above criteria are developed jointly by the PACE organization, APD/AAA representatives, and the SAA[2]. The state has delegated oversight of the criteria for living safely in the community to the APD/AAA case manager, using the CAP[3]S tool, to document the participant's physical abilities, physical inabilities, behaviors, health issues, and cognitive impairments. Based on this information, the APD/AAA case manager can decide if the participant can live in the community safely and possibly benefit from PACE services. The APD PACE Coordinator is involved in all actions related to the denial of enrollment based on the above criteria.

Supporting documentation for denials of enrollments must include the reason for the denial and the individual's appeal rights. This letter, along with documentation of pertinent information relating to the decision, is forwarded to the APD PACE Coordinator for review. This provides APD with the opportunity to monitor if the PACE organization is administering the criteria appropriately.

APPENDIX R: INFORMATION TO BE PROVIDED BY THE SAA TO ENROLLEES

Include a description of any information provided by the State to participants, to include information on how beneficiaries access the State's Fair Hearings process.

At the time of enrollment, all PACE enrollees (including private pay participants) receive materials on their rights, responsibilities, and how to access the State hearing process. The State has chosen to allow private participants access to the State hearing process for both PACE and State actions regarding denials of service and eligibility.

Standard forms and brochures, such as, consumer Rights and Responsibilities for Medicaid, Oregon Voter Registration, 'What to Expect from Your Assessment for Long-term Services and Supports' (brochure), Client Discrimination Complaint information, 'Why Should I care About Elder Abuse' (brochure), a letter explaining the participant's financial responsibility (cost share) for Medicaid benefits and LTC services, and various community resources upon request, are provided to PACE participants at the first meeting or assessment and at each annual reassessment for LTC eligibility.

APPENDIX S: SAA DISENROLLMENT PROCESS

Include a description of the state's process for disenrollment of participants from the state's system in accordance with 42 CFR §460.182(d), as well as the process for prior review of involuntary disenrollments in accordance with 42 CFR §460.164(f).)

APD/AAA[1] case managers must review the reasons for PACE disenrollment. Participants are disenrolled from PACE services in the State system when the case manager enters the last day of services into the State system. The last day of PACE services is on the last day of the month. Coordination of continued care for the participant is performed between the APD/AAA case managers and PACE organization social workers during the transition from PACE services. All requests for involuntary disenrollment, which must include supporting documentation, are reviewed by the APD PACE Coordinator. Specific processes are noted below.

Voluntary Disenrollment

A participant can choose to voluntarily disenroll from PACE services at any time. PACE organization staff notify the APD/AAA case manager of the participant's decision to disenroll. The PACE organization staff must provide the APD/AAA case manager with documentation stating the reason for the disenrollment as well as any health-related information necessary to ensure continued eligibility and transition service planning.

Involuntary Disenrollment

All involuntary disenrollment actions must be reviewed and approved by the SAA[2]. The review process includes reviewing documentation from the PACE organization and from the State case to ensure the reasons for the involuntary disenrollment meet the criteria as set forth in 42 CFR §460.164(e). The SAA representative may discuss the reasons for the involuntary disenrollment with the participant and/or his/her authorized representative to ensure the participant's health and safety are not compromised due to the disenrollment. The PACE organization must provide the participant with a 30- day notice of intent to disenroll from PACE services. This notification must include the reasons for the disenrollment and the participant's appeal rights. A copy of the notice provided to the participant and/or the representative will be sent to the APD/AAA case manager, the APD PACE Coordinator and CMS Region 10 representative. The PACE organization and the APD/AAA case manager will coordinate efforts to transition the participant from PACE services.

Involuntary disenrollment may occur in the following cases and must follow state required procedures.

- The participant's behavior is disruptive, unruly, or abusive to the point that his/her enrollment seriously impairs the provider's ability to furnish services to the participant or other participants.
  The participant does not pay or make satisfactory arrangements to pay the PACE monthly premium after a 30-day grace period.
- The participant no longer meets the nursing home level of care eligibility criteria as assessed by the APD/AAA case manager. The case manager and local office leadership do not believe that disenrollment from PACE

- services will result in deterioration of the participant's condition to the point that he/she will meet eligibility criteria within six months of losing eligibility.
- The participant moves out of the PACE service area or is out of the service area for more than 30 consecutive days and the move or extended absence was not facilitated or approved by the PACE organization.
- The PACE program agreement between CMS, the State of Oregon, and the PACE organization is not renewed.
- The local PACE organization decides not to continue to participate in PACE.
- The local PACE organization loses the contracts and/or licenses which enable it to offer health care services.

Eligibility: If a PACE participant loses Medicaid eligibility or long-term care eligibility, the APD/AAA case manager will notify the PACE organization social worker. A service assessment may be completed by APD/AAA case manager with a PACE staff person present, prior to closure of Medicaid eligibility, to assist in planning the transition from PACE services. Hearing rights will also be reviewed with the participant. Persons who lose Medicaid eligibility may choose to pay the private fee for PACE services and remain enrolled in the program.

Non-payment: On occasion, a PACE participant may fail to provide the pay-in required to maintain long-term care service eligibility. Non-payment is reason to terminate Medicaid long-term care services although the person may maintain eligibility for other Medicaid programs. The APD/AAA case manager and the PACE organization social worker will work together to determine the reasons for non-payment and the participant’s capacity to understand the consequences of termination.

Participant Death: Upon a participant's death, the PACE social worker will notify the APD/AAA case manager so that the case manager may close the case in a timely manner.

Service Area: If the participant moves out of the PACE service area or is out of the service are for more than 30 consecutive days and the move or extended absence was not facilitated or approved by the PACE organization, he/she will be disenrolled from the PACE program at the end of the month, following the 30-day notice of intent to disenroll. The PACE organization and the APD/AAA case manager will work with the participant to address transition issues and continued eligibility for long-term care services.

Disenrollment Transition

The PACE program will work with the APD/AAA case managers and the participant to ensure a smooth transition to other services once approval of the disenrollment is received from SAA. PACE and the APD/AAA case manager will convene a transition planning conference for all Medicaid clients who are disenrolling from PACE services.

The PACE organization may, depending on the need, initiate similar conferences with families of private pay participants. The conferences will address a range of transition issues including:

- Participant notification
- Alternate health plan enrollment
- Acquisition of necessary equipment and supplies
- Arrangements for other long-term care services, if eligible or desired by the participant PACE staff will notify any contracted care providers and CMS of the transition plans.

Once a safe transition plan has been developed, the APD/AAA case manager will initiate closure of PACE services in the State system on the agreed upon date (usually the last day of the month, following the 30 day period after the PACE organization has given its notice) and set up new benefit and service plans in CAPS[3] to continue services for the participant in a non-PACE setting. The APD/AAA case manager will close services on the last day of the month, following 30 day period after the PACE organization has given its notice, in CAPS, whenever the participant has moved out of the service area and the participant has no intention of returning to the PACE service area (includes moving out of state); when the participant loses eligibility for services and is not deemed eligible with PACE; when the participant loses eligibility for Medicaid benefits; when the participant fails to make payments to the State, as required, to maintain Medicaid long-term care services.

APPENDIX T: REGULATORY WAIVERS

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Not applicable

APPENDIX U- MEDICARE PART D

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and ALLCARE PACE LLC., a PACE organization (hereinafter referred to as the PACE Organization) agree that the PACE Organization shall operate a Voluntary Medicare Prescription Drug Plan pursuant to sections 1860D-1 through 1860D-42 (with the exception of sections 1860D-22 and 1860D-31) of the Act.

This agreement is made pursuant to 42 CFR Part 423, Subpart K (to the extent that waivers of those provisions have not been granted pursuant to 42 CFR §423.458(d)) and 42 CFR Part 460, Subpart C, of the PACE regulations.

ATTACHMENT A

PART D WAIVERS

CMS is authorized to grant waivers of Part D program requirements where such a requirement conflicts with or duplicates a PACE requirement, or where granting such a waiver would improve the PACE Organization's coordination of PACE and Part D benefits. The following waivers are in effect for all PACE organizations.

Summary of Medicare Part D Regulatory Requirements Waived for PACE Organizations

Part D Regulation	Regulatory Requirement(s) Description
423.44	Involuntary disenrollment
423.48	Information about Part D
423.104(g)(1)	Access to negotiated prices
423.112	Establishment of PDP service areas
423.120(a)	Access to covered Part D drugs
423.120(c)	Use of standardized technology
423.124	Out-of-network access to covered Part D drugs at out-of-network pharmacies
423.128	Dissemination of Part D plan information
423.132	Public disclosure of pharmaceutical prices for equivalent drugs
423.136	Privacy, confidentiality, and accuracy of enrollee records
423.153(a)-423.153(d)	Drug utilization management, quality assurance, and medication therapy management programs (MTMPs)
423.156	Consumer satisfaction surveys
423.159(c), 423.160(a)	Electronic prescribing
423.162	Quality Improvement organization activities
423.265(b) ***Note: Automatic waiver applies to new or potential organizations that are not operational by the June deadline. Those organizations with effective program agreements must submit a Part D waiver request in the event they are unable to meet the June deadline.***	Part D bid submission deadline
423.401(a)(1)	Licensure
423.420	Solvency standards for non-licensed entities
423.462	Medicare secondary payer procedures
423.464(c)	Coordination of benefits and user fees
423.464(f)(2) and 423.464(f)(4)	Coordination with other prescription drug coverage

Part D Regulation	Regulatory Requirement(s) Description
423.502(b)(1)(i-ii)	Documentation of State licensure or Federal waiver
423.504(b)(2-3), 423.504(b)(4)(i-v) and (vi)(A-E) ***Note: Organizations are required to abide by 423.504(b)(4)(vi)(F-H), 423.504(b)(5), 423.504(c)-(e)***	Conditions necessary to contract as a Part D plan sponsor
423.505(a-c) and 423.505(e-i) ***Note: Organizations are required to abide by 423.505(d and j)***	Contract provisions
423.505(k)(6) ***Note: Organizations are required to abide by 423.505(k)(1-5)***	Certification for purposes of price compare
423.506(a)-(b) ***Note: Organizations are required to abide by 423.506(c)-(e)***	Effective date and term of contract
423.512 – 423.514	Contracting terms
423.551-423.552	Change of ownership or leasing of facilities during term of contract
423.560-423.638	Grievances, coverage determinations, and appeals
423.2262	Approval of marketing materials and enrollment forms
N/A	A PDP sponsor is required to be a nongovernmental entity