DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

August 28, 2017

Ellen Garcia
Chief Executive Officer
Providence Health & Services - Oregon
4531 SE Belmont, Suite 100
Portland, Oregon 97215

Dear Ms. Garcia:

I am pleased to inform you that the request to replace the existing Beaverton Programs of All-Inclusive Care for the Elderly (PACE) center affiliated with Providence Health & Services - Oregon, d.b.a. Providence ElderPlace - Portland, under Program Agreement H3809, has been approved. This decision is based on a determination that the transition plan provided to the Centers for Medicare & Medicaid Services (CMS), along with applicable supporting documentation, is adequate and addresses our requirements.

Enclosed is a copy of the complete, amended Program Agreement for Providence Health & Services-Oregon, d.b.a. Providence ElderPlace- Portland (H3809). Appendix C of the Program Agreement has been amended to reflect the new address of the Beaverton PACE Center located at 18650 NW Cornell Road, Suite 215, Hillsboro, Oregon 97124. No changes have been made to other appendices within this agreement, which was last updated in June 2017.

CMS is prepared to waive the required 30-day waiting period before the change to Appendix C is effective, located in Article VI of the Program Agreement. This would make the change to Appendix C effective immediately. Please note that, per the Health Plan Management System (HPMS) memorandum, dated January 6, 2017, CMS staff will update the Basic Contract Management module in HPMS to reflect the replacement center address.

If you have any questions about this letter, please contact your Regional Office Account Manager, Gertie Jones, at 206-615-3652, or via email at Gertie.Jones@cms.hhs.gov.

Sincerely,

Kathryn A. Coleman
Director

cc: Cindy Noordijk, Providence
Health & Services - Oregon
Cindy Susee, Oregon DHS
Gertie Jones, CMS Regional Office

PACE Program Agreement
AGREEMENT No. H3809
(Amended as of August 28, 2017)

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 and Medicaid Services, hereinafter referred to as CMS, and Oregon Department of Human Services, hereinafter referred to as SAA, and Providence Health & Services - Oregon, d.b.a., Providence ElderPlace - Portland, 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 the Secretary of the SAA, 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 November I, 2003 through December 31, 2004 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 general instructions 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); §460.62; §460.60**

1) The name and telephone number of the PACE Organization's Executive 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).

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 shall notify 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)(l)**

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)(S); §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 **AppendixD.**

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)(l); §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; are Medicaid eligible or willing to pay private pay fees; and are willing to abide by the provision that requires enrollees to receive all health and long term care services exclusively from the PACE program and our contracted or referred providers.

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(l) 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(l) 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 Assessment and Performance Improvement **§460.32(a)(9); §460.32(a)(10); §460.32 (a)(ll); §460.130; §460.134(c); §460.136; §460. 140; §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 refused or the vaccines are medically contraindicated).

3) 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. Data Collection and Reporting Requirements **§460.200(a)(b)(c); §460.204; §460.70**

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 specified 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 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 paiiicipants 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: To CMS and the SAA, 90 days before termination. To the participants, 60 days before termination.

C. The PACE Organization's detailed written plan for phase-down, in the event of termination, is included in **Appendix 0.**

ARTICLE V

REQUIREMENTS OF LAWS AND REGULATIONS
460.32(a)(2)

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

1) Sections 1894 and 1934 of the Social Security Act as implemented by regulations at 42 CPR Part 460;
2) Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CPR Part 84;
3) The Age Discrimination Act of 1975 as implemented by regulations at 45 CPR Part 91;
4) The Americans with Disabilities Act; and
5) 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:

1) Are subject to periodic readjustment;

2) Are outmoded as a result of an organizational change made by the PACE Organization;

3) Are outmoded as a result of a contractual modification, initiated by a Party; or

4) 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

The SAA further assures that its responsibilities of 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.

A. 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 ineets State and Federal requirements at the time of the application, in accordance with Section 460.12(b)(l).

B. 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.

   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.

C. 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.

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

Enrollment and Disenrollment

A. 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.**

B. 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.**

C. 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.**

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

E. 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.

F. 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.

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

H. 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.

Marketing

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

Decisions that require joint CMS/SAA Authority

A. 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.**

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

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

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

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.

PROGRAM AGREEMENT APPENDICES

APPENDIX A: NAMES AND CONTACT LIST

I. Name of Executive Director: Ellen Garcia
Telephone Number: 503-215-3612

2. Program Director: Cynthia Noordijk
Telephone Number: 503-215-4124

3. Name of Governing body/Board of Director Contact: Ellen Garcia
Telephone Number: 503-215-3612

4. Governing body/Board of Directors:

Board of Directors Providence St. Joseph Health

Richard Blair - Board Chair
Dave Olsen - Board Vice Chair
DickP Allen
Isiaah Crawford, PhD
Lucille Dean, SP
Sr. Diane Hejna, CSJ, RN
Michael Holcomb
Sr. Phyllis Hughes, RSM, Dr.PH
Fr. Thomas Kopfensteiner, PhD
Sallye Liner, MSN, RN
Mary Lyons, PhD
Walter Noce, Jr
Carolina Reyes, MD
Phoebe Yang
Rod Hochman, MD - President & CEO Voting Ex-Officio

APPENDIX B: ORGANIZATIONAL STRUCTURE

Providence St. Joseph Health consists of 50 hospitals, 829 physician clinics, senior services, supportive housing and many other health and educational services, the health system and its partners employ more than 100,000 caregivers (employees) serving communities across seven states -Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. With system offices based in Renton, Wash. and Irvine, Calif., Providence St. Joseph Health is the parent organization of Providence Health & Services and St. Joseph Health.

Providence ElderPlace - Portland (PEP) is an operating entity within the corporate umbrella of Providence Health & Services. (PHS) PEP is in the Oregon Region, operating within the Portland Service Area (PSA) and Home and Community Services (HCS) organization structure.

The PEP executive director reports to the Home and Community Services chief executive who reports to the Providence Medical Group and Clinical Services chief executive, Oregon Region. The HCS chief executive is a member of the Leadership Team for Oregon Region. The PEP Leadership Team provides leadership in operational decisions of the program.

The Oregon Community Ministry Board has delegated authority from the Providence Health and Services Board of Directors to approve the ElderPlace Oregon Quality Plan. The Oregon community Ministry Board monitors the ElderPlace Oregon Quality Plan via annual reports submitted to the Quality Committee of the Oregon Community Ministry Board.

The ElderPlace Oregon Quality Council provides oversight for the QAPI program and reviews quarterly status updates of the annual QAPI plan and approves them for submission to the Quality Committee of the Ministry Board. ElderPlace Oregon Quality Management engages with Quality Management and Leadership staff at North Coast as appropriate related to joint projects or care situations.

APPENDIX C: SERVICE AREA AND PACE SITE(S)
Providence ElderPlace Portland H3809
(Amended August 28, 2017)

1. Identify all counties in the service area.

Multnomah County - Full
Washington County - Partial
Clatsop County - Partial
Tillamook County - Partial
Clackamas County - Partial

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

Washin2ton	
97231	97123
97003	97124
97005	97140
9700(	97223
97007	97224
97008	97225
97062	97229
97078	a portion of97116 (south ofHig_i!_way 6)
97113	

Clackamas		
97206	97035	97036
97219	97034	97027
97222	97268	97068
97086	97269	97062
97015	97267	97045

Clatstop	
97121	97138
97146	97145
97103	97102
97110	

Tillamook
97131
97130
97147

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

Providence ElderPlace -Portland in Laurelhurst
4540 NE Glisan St.
Portland, Oregon 97213

Providence ElderPlace -Portland in Glendoveer
13007 NE Glisan St.
Portland, Oregon 97230

Providence ElderPlace -Portland in Cully
5119 NE 57th St.
Portland, Oregon 97218

Providence ElderPlace -Portland in Gresham
17727 E. Burnside
Portland, Oregon 97233

Providence ElderPlace -Portland at Marie Smith Center
4616 N. Albina
Portland, Oregon 97217

Providence ElderPlace - Portland in Irvington Village
420 NE Mason St.
Portland, Oregon 97211

Providence ElderPlace - Portland North Coast
1150 North Roosevelt Drive
Suite 104
Seaside, Oregon 97138

Providence ElderPlace - Portland Milwaukie
10330 SE 32nd Avenue, Suite 110
Milwaukie, Oregon 97222

Providence ElderPlace - Portland Beaverton
18650 NW Cornell Road, Suite 215
Hillsboro, Oregon 97124

APPENDIX D: PARTICPANT BILL OF RIGHTS

Providence ElderPlace
Participant Bill of Rights

I. Respect and Non-discrimination. Each participant has the right to considerate, respectful care from all ElderPlace employees and contractors at all times and under all circumstances. Each participant has the right not to be discriminated against in the delivery of required services based on race, ethnicity, national origin, religion, sex, sexual orientation, age, mental or physical disability, or source of payment. Specifically, each participant has the right to the following:

A. To receive comprehensive health care in a safe and clean environment and in an accessible manner.

B. To be treated with dignity and respect, be afforded privacy and confidentiality in all aspects of care, and be provided humane care.

C. Not to be required to perform services for the ElderPlace organization.

D. To have reasonable access to a telephone.

E. To be free from harm, including physical or mental abuse, neglect, corporal punishment, involuntary seclusion, excessive medication, and any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the participant's medical symptoms.

F. To be encouraged and assisted to exercise rights as a participant, including the Medicare and Medicaid appeals processes, as well as civil and other legal rights.

G. To be encouraged and assisted to recommend changes in policies and services to ElderPlace staff.

H. To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines

2. Information Disclosure. Each ElderPlace participant has the right to receive accurate, easily understood information and to receive assistance in making informed health care decisions. Specifically, each participant has the following rights:

A. To be fully informed in writing of the services available from the ElderPlace organization, including identification of all services that are delivered through contracts, rather than furnished directly by the ElderPlace organization at the following times:

(l) Before enrollment.
(2) At enrollment.
(3) When there is a change in benefits or services.

B. To have the enrollment agreement fully explained in a manner understood by the participant.

C. To have qualified interpreter services for medical, dental, mental health, home health or after-hour emergency calls, to interpret for participants with hearing impairment or in the primary language of non-English speaking participants.

D. To examine, upon reasonable request, to be assisted to examine the results of the most recent review of the ElderPlace organization conducted by CMS or the State administering agency and any plan or correction in effect.

3. Choice of Providers. Each participant has the right to a choice of health care providers, within the ElderPlace organization's network, that is sufficient to ensure access to appropriate high-quality health care. Specifically, each participant the right to the following:

   A. To choose his or her primary care physician and specialists from within the ElderPlace network.

   B. To request that a qualified specialist for women's health services furnish routine or preventive women's health services.

   C. To disenroll from the program at any time.

4. Access to Urgent and Emergency Services. Each participant has the right to access urgent and emergency health care services when and where the need arises without prior authorization by the ElderPlace interdisciplinary team.

5. Participation in Treatment Decisions. Each participant has the right to participate fully in all decisions related to his or her treatment. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. Specifically, each participant has the following rights:

   A. To have all treatment options explained in a culturally competent manner and to make health care decisions, including the right to refuse treatment, and be informed of the consequences of the decisions.

   B. To have the ElderPlace organization explain advance directives and to establish them, if the participant so desires.

   C. To be fully informed of his or her health and functional status by the interdisciplinary team.

D. To participate in the development and implementation of the plan of care.

E. To request a reassessment by the interdisciplinary team.

F. To obtain covered preventative and diagnostic services.

G. To be given reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer and of any denials or changes of benefits or services. The ElderPlace organization must document the justification in the participant's medical record.

6. Confidentiality of Health Information. Each participant has the right to communicate with health care providers in confidence and to have the confidentiality of his or her individually identifiable health care information protected. Each participant also has the right to review and copy his or her own medical records and request amendments to those records. Specifically, each participant has the following rights:

   A. To be assured of confidential treatment of all information contained in the health record, including information contained in an automated data bank.

   B. To be assured that his or her written consent will be obtained for the release of information to persons not otherwise authorized under law to receive it.

   C. To provide written consent that limits the degree of information and the persons to whom information may be given.

7. Complaints and Appeals. Each participant has the right to a fair and efficient process for resolving differences with the ElderPlace organization, including a rigorous system for internal review by the organization and an independent system of external review. Specifically, each participant has the following rights:

   A. To be encouraged and assisted to voice complaints to ElderPlace staff and outside representatives (including the State of Oregon Administrative Hearing or the Medicare Administrative Review) of his or her choice, free of any restraint, interference, coercion, discrimination, or reprisal by the ElderPlace staff.

   B. To appeal any treatment decision of the ElderPlace organization, its employees or contractors.

APPENDIX E: ELIGIBILITY AND ENROLLMENT POLICIES AND CONTINUED ELIGIBILITY CRITERIA

Subject: Enrollment Process	**Policy Number:** BPll00.102	
Approval Group: Leadership Team	**Policy Owner:** Marketing & Enrollment Manager	
Signed By: Executive Director Ellen Garcia, 2:A-	ONew [8l Revised D Reviewed	**Date:** 2/22/2017

I. Objective of this Policy:

To describe the intake and enrollment process.

II. Text of this Policy:

1. SCREENING PROCESS:

Purpose: To receive preliminary information regarding potential enrollees sufficient to make initial determination about eligibility of person for the program and/or provide other information and referral. The Information and Referral Specialist (l&R) or Intake and Enrollment Specialist (l&E) will respond to a referral within one working day.

Action	Responsible Staff
A. Receive written or verbal referral information.	I&R or I&E
B. Obtain as much information as possible from referring source and document on Information & Referral (pre-intro) form.	I&R or I&E
C. Evaluate information in relation to Eligibility Criteria: 1) be 55 years or age or older; 2) Meet nursing home level of care as determined by an APD case manager; 3) reside in the service area; and 4) at the time of enrollment must be able to live safely in the community.	I&R or I&E
D. Eligibility determination:	
• If ineligible, explain reason for ineligibility and provide information and referral.	I&RorI&E
• If eligibility is questionable, follow procedure according to policy (see BPI 100.10).	I&E
• If eligible, complete I&R steps in Epic and refer to I&E.	I&R
E. Contact APD case manager to confirm the state's assessment has determined NF level of care.	I&R

F. I&E to continue screening process. I&E

G. Conduct tour of health & social center with potential enrollee and/or significant other(s) as they prefer. I&E

2. INTAKE VISIT:

Purpose: To inform potential enrollee and significant other(s) about aspects of the program to allow them to make an informed decision about enrollment. To gather initial information regarding medical condition and functional levels for the purpose of informing the Interdisciplinary Team (IDT) for care planning purposes. The I&E Specialist will schedule an intake as quickly as the schedules of those involved allow. Interpreter services will be utilized as needed.

Action	Responsible Staff
A. Schedule visit with potential enrollee and significant other(s) at potential enrollee's home or ElderPlace health & social center.	I&E
B. Provide written and verbal information about program. [!) a copy of the enrollment agreement; 2) that ElderPlace would be the sole service provider; 3) clarification that ElderPlace guarantees access to services, but not to a specific Provider; 4) a list of the employees and contracted health care providers; 5) monthly premiums, if any 6) Medicaid spend-down obligations; and 7) post eligibility treatment of income.	I&E
C. Interview potential enrollee and significant other(s) and complete I&E steps in Epic.	I&E
D. Obtain signature(s) from potential enrollee and/or representative on the Authorization for Release of Medical Information form.	I&E
E. Provide enrollee with Advance Directive Booklet and administrative list of employees.	I&E
F. If potential enrollee chooses to enroll, continue as follows.	I&E

3. ENROLLMENT PROCESS:

Purpose: To ensure understanding of ElderPlace and to enroll into the program. Once determined eligible, the potential participant may enroll at anytime. The effective date of enrollment will be the first day of the calendar month following the date the Enrollment Agreement is signed.

Action:	Responsible Staff
A. Review Enrollment Agreement, BiU of Rights, Complaint and Grievance Procedure and any costs associated with enrollment (private pay premium,	

APD pay-in liability, room & board), answering any questions the enrollee and/or significant other(s) may have. l&E

B. Obtain signature(s) from enrollee and/or representative on the following: I&E

(1) Enrollment Agreement
(2) Payment Agreement, if enrollee is Private Pay
(3) Medicare Part D Premium Payment Option Form
(4) Authorized Debit Payment for Premium and Program Housing
(5) Rights and Responsibilities Agreement
(6) **HIP**AA Joint Notice of Privacy Practices
(7) USDA income statement form
(8) Genetic Privacy Notice and Opt Out Statement

C. Give copies of above forms to participant and/or significant other(s). I&E

D. Notify IDT and l&R of client's enrollment via Epic message. l&E

E. Notify referral source and APD case manager of enrollment, including date of capitation. I&E

F. Facilitate transition meeting with primary care team at the site. I&E

G. Complete Post-enrollment steps in Epic and Epas. I&R

H. Provide Enrollee Packet according to policy (see BPI I00.103) Site Admin Ass't

III. Related Policies and References:

BPll00.104: Enrollment Denial
BPI 100.103: Enrollee Packet

IV. Revision History:

Version<	••..)i bate .. · ..... . .A11tb1!r		.. .. MQdification
1.0	3/01/2002	Not Specified	Initial Release
2.0	10/2008	Not Specified	Not Specified
3.0	11/16/2009	Jeannie Frederick	Policy was revised and converted to new policy format.
4.0	7/30/2014	Jeannie Frederick	Revised / updated process.
5.0	10/4/2016	Jeannie Frederick	Revised policy.
6.0	2/22/2017	Jeannie Frederick	Updated language based on feedback from CMS

Subject: Enrollee Packet	**Policy Number:** BPl 100.103	
Approval Group: Leadership Team	**Policy Owner:** Marketing and Enrollment Manager	
Signed By: Ellen Garcia, Executive Director 3/-	ONew Revised D Reviewed	**Date:** 02/22/2017

I. Objective of this Policy:

To identify documents given to participants:

- Upon enrollment
- When transferring to another site or living situation as needed

II. Text of this Policy:

A. Per PACE Regulations Section 30.5 and CFR 460.152:

After the participant signs the enrollment agreement, the PACE organization must give the participant the following:

- A copy of the Enrollment Agreement (Intake and Enrollment provides the handbook);

If there are changes to the Enrollment Agreement after an individual enrolls, ElderPlace will provide an updated coy of the information to the participant and explain the changes, via quarterly participant newsletter.

1. A PHP **membership card** for ElderPlace. PHP will ship the insurance cards to Belmont. The EP Admin Assistant at Belmont will scan into Epic and then interoffice mail the card to the site.

2. Emergency information to be posted in his or her home identifying the individual as a PACE participant and explaining how to access emergency services; including the participant's primary contacts.

3. **Stickers** for the participant's Medicare and Medicaid cards, as applicable, which indicate that he or she is a PACE participant and which include the phone number of the PACE organization.

B. When a participant enrolls in Providence ElderPlace, he or she will be provided with an enrollee packet within the first month of enrollment. Site Administrative Assistant or Clinic Assistant will put the packet together and document "Enrollment packet received" in Epic. The Home Care Coordinator, CCRN or EP Housing RCM, will give the packet to the participant or representative, as appropriate, The packet will include the following:

- 1 through 3 above
- A Welcome Letter explaining the above
- Medication administration letter
- Pharmacy information/ Medication order process
- Incident reporting- provided to the caregiver if the participant lives in a contracted home or facility

- Caring Behaviors - provided to the caregiver if the participant lives in a contracted home or facility
- Medication Information for In-home Participants - provided to the participant if she/he lives in-home
- Contents Page listing the above
- The ElderPlace Diabetes Care Manual and/or the Palliative Care Program booklet will be included/ provided as needed

III. Revision History:

Version	pate	… Author	Modification
1.0	06/25/2002	Not Specified	Initial Release
2.0	10/2008	Not Specified	Not Specified
3.0	11/16/2009	Jeannie Frederick	Policy was revised and converted to new policy format.
5.0	07/2/2013	Jeannie Frederick	Updated Urgent & Emergent Protocol.
6.0	10/30/2014	Jeannie Frederick	Revised process
7.0	04/18/2016	Jeannie Frederick	Revised for new PHP membershio cards
8.0	2/22/2017	Jeannie Frederick	Updated language based on feedback from CMS

Safety Criteria

The following constitute situations or unsafe behaviors that may cause denial of enrollment, if they cannot be remediated. You:

- Have a physician documented condition that meets the criteria for Medicare skilled care and you do not appear to be able to be discharged to the community within the next 30 days.
- Are in need of imminent nursing facility placement.
- Are determined to be appropriate for Enhanced Care Services or placement at Oregon State Hospital.
- Have evidence in your clinical record that you have been repeatedly placed in appropriate care settings and despite medically appropriate treatment, placement has resulted in frequent hospitalizations or failed placements.
- Demonstrate behavior that is physically harmful to yourself or others, including, but not limited to:
    a. Suicidal or self-injurious behaviors
    b. Threatening or assaultive behaviors
- Wish to remain in your own home but require 24-hour care in order to be safely maintained in your home, and you lack the support of a capable and willing caregiver. For any individual who cannot be safely left alone, the individual or the individual's responsible party must demonstrate at the time of application for enrollment that there is a designated adult caregiver who has agreed to provide, and is capable of providing, personal care and other services during those hours when ElderPlace services are not being provided.
- Reside in a home environment that is dangerous to homecare workers or prevents delivery of care.

If after review of the above, there are questions regarding your enrollment in the ElderPlace program, you or your representative or the referring agency may initiate a collaborative care planning process that may include referral to an ElderPlace contracted specialist.

Continued Eligibility For PACE

Prior to enrollment and annually thereafter, a Client Assessment and Planning System (CAPS) is completed on the participant to determine level of care and identify service needs. Oregon determines eligibility for nursing home services using the CAPS tool. This electronic, holistic assessment assigns a ranking called a Service Priority Level. Persons at Level I have the most acute, complex needs. Services are provided to persons at different levels based on resources available and their annual assessments. All PACE participants, private and Medicaid, are subjected to these same eligibility standards at the time of intake.

If a PACE participant should score above the current eligibility level determined by the State during their annual reassessment, the local AAA/APD Case Manager, in conjunction with the PACE interdisciplinary team, would 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 without the PACE program, the participant would, within the next six months, deteriorate to the point of eligibility, the participant may be deemed eligible until the next annual re-evaluation.

Enrollment continues until the participant's death regardless of change in health status unless the participant voluntarily disenrolls or is involuntarily disenrolled.

APPENDIX F: ADDITIONAL ENROLLMENT CRITERIA

None

APPENDIX G: VOLUNTARY DISENROLLMENT POLICY

Subject: Participant Voluntary Disenrollment	**Policy Number:** CP6700.103	
Approval Group: Clinical Practices and Quality	**Policy Owner:** Social Work Program Manager	
Signed By: Executive Director Ellen Garcia,	ONew 1:8:J Revised D Reviewed	**Date:** 3/2/2017

I. Objective of this Policy:

This policy provides a standardized process by which voluntary disenrollments are handled within the Providence ElderPlace-Portland (PEP) program. And ElderPlace participant may disenroll from the program without cause at any time. These guidelines would promote timely and effective communication among the interdisciplinary team (IDT) and the disenrolling participant and/or their responsible party. The following procedures will facilitate continuity of care to the greatest extent possible and a smooth transition plan. The site social worker will consult with the Social Work Program Manager at first indication to any disenrollment when:

- Participant is disenrolling due to dissatisfaction with quality or quantity of service
- Participant disenrollment is unexpected and sudden; transition plan has not been developed
- Participant (or participant's surrogate) is choosing to remain in an unauthorized level of care and this is the reason for voluntary disenrollment.

The following procedure would occur after the IDT has exhausted all efforts to resolve any dissatisfaction or complaints prior to the participant's disenrollment decision.

In the case that the participant is choosing to remain in an unauthorized level of care, a clinical consult with the Clinical Practices and Quality group will occur prior to any notice of action regarding non-coverage of the level of care.

Please refer to the Involuntary Disenrollment CP6700.104 prior to any movement toward involuntary disenrollment.

II. Text of this Policy:

Discipline roles and responsibilities are designated as follows:

Social Work

I. Inform the interdisciplinary team of participant's intention to disenroll from program. Timely notification helps to assure comprehensive transition planning and documentation.

2. Facilitate transition planning conference; include Aging and People with Disabilities Services (ADS, APD) case manager, as appropriate.

3. Provide participant (or representative) with the ElderPlace disenrollment from and document into the electronic medical record. Notify Social Work Program Manager of disenrollment.
4. Communicate with contracted care provider regarding participant disenrollment and complete authorization to discontinue payment for housing, as appropriate.
5. If ElderPlace is representative payee, begin paperwork for transition process.
6. Notify Equipment/Supply Coordinator of participant disenrollment and any equipment to be picked up.
7. Collaborate with ADS/APD case manager to transition participant to state system, i.e. enrollment with another health or prescription drug plan, attaining necessary supplies etc. For private pay enrollees, collaborate with participant and/or participant representative for transition planning.
8. Provide disenrolling participant with a review of available health and prescription drug plans available in area.
9. Complete Disenrollment in EPAS.

Reference sites include:

Oregon's Senior Health Insurance Benefits Assistance Program

http://egov.oregon.gov/DCBS/SHIBA/index.shtml

1-800-722-4134

Multnomah County

www.co.mu1tnomah.or.us/ads

Aging & Disability Services Department

(503) 988-3646

Washington County

Aging and People with Disabilities

www.co.washington.or .us/

503-640-3489

Clackamas County

http://www.clackamas .us/

503-650-5622

NorthWest Senior and Disabled Services

2002 Chokeberry Ave, Warrington, Oregon 97146

(503)861-4200 Fax (503) 861-0934

http://www.nwsds.org/locations/clatsop-county/

Medicare

www.Medicare.gov

1-800-MEDICARE

10. Inform about any other alternative resources that may be appropriate.

Interdisciplinary Team

I. Discussion regarding participant's voluntary disenrollment.
2. Identify significant aspects of care for completion prior to disenrollment (i.e. pending lab work).
3. Designate which disciplines need to provide instruction and written educational materials.
4. Develop plan for timely participant/family/other identified parties disenrollment conference.
5. Consider key areas of transition plan, i.e. prescriptions, prescription drug plans, managed care plans, equipment etc. Collaborate with Social Work.

Primary Care Provider

I. Identify and notify clinic navigator of priority medical documentation for transfer to participant's new medical provider (if already selected and participant or POAHC has filed a ROI).
2. Write narrative summarizing participant's current medical treatment plan.
3. Pharmacy order to fill medications supply for interim timeframe, as indicated (maximum 30 days).

Clinic Nurse

I. Ensure dispensing of all medications, supplies and supplementation until disenrollment.
2. Communicate with home health agency that will see participant after disenrollment regarding any skilled tasks to be performed in the home.

Community Care Nurse

I. Communicate to caregiver that any delegation will be rescinded at disenrollment.

Clinic Navigator

1. Write a list of diaried tests and appointments (i.e. annual mammogram due 4/16).
2. Forward recommended copies of documentation to participant's designated new provider, upon receipt of"Authorization of Release oflnformation," signed by participant or legal representative.
3. Close chart and send to archives, when appropriate.

Supply Clerk

I. Compile list ofElderPlace equipment in the participant's living environment.
2. Collaborate with social work for timely end of supply delivery.
3. Document any equipment picked up on the equipment form in the chart.

Health Plan Operations Specialist

I. Notify CMS of participant disenrollment with ElderPlace.
2. Notify Oregon Medical Assistance Program (OMAP) of participant disenrollment with ElderPlace.

Personal Care Aide

I. Identify participant clothing, hearing aid, etc., kept at the center and return to participant.

2. Document in the participant's electronic health record.

III. Revision History:

V rsitin	·· ....·..... /))ate ··. .·	Author	·M· d"fi catuin
1.0	05/01/1998	Not Specified	Initial Release
2.0	10/02/2007	Not Specified	Not Specified
3.0	05/2008	Not Specified	Not Specified
4.0	11/02/2009	Sarah Booth	Policy was revised and converted to new policy format.
5.0	2/27/2012	Sarah Booth	Section II, SW responsibilities #4 revised
6.0	3/6/2012	Sarah Booth	Section I, added Prt may disenroll without cause at any time.
7.0	8/12/2014	Sarah Booth	Minor edits for EPIC, staff titles
8.0	7/8/2015	Sarah Booth	North Coast information added.
9.0	9/15/2016	Sarah Booth	Reviewed; no changes made.
10.0	3/2/2017	Cindy Noordijk	Removed requirement for prt/representative on disenrollment form based on feedback from CMS.

APPENDIX H: INVOLUNTARY DISENROLLMENT POLICY

Subject: Participant Involuntary Disenrollment	**Policy Number:** CP6700.104	
Approval Group: Compliance Committee	**Policy Owner:** Social Work Program Manager	
Signed By: Ellen Garcia, Executive Director	ONew Revised D Reviewed	**Date:** 3/2/2017

I. Objective of this Policy:

Involuntary disenrollment from Providence ElderPlace-Portland (PEP) will occur only when the interdisciplinary team (IDT), including clinicians, and the ADS/APD case manager as appropriate, have exhausted all clinical and social interventions. Consultation with the ElderPlace Clinical Practices and Quality (CPQ) group will occur prior to the Health & Social Center Manager sending a written request for disenrollment to the Senior and People with Disabilities (SPD) PACE Analyst. A CPQ staff member will conduct a participant interview, participant chart review and confer with the IDT regarding their efforts to maintain the participant in the program. The CPQ group will provide the IDT with feedback regarding any clinical, social or legal considerations. The participant will continue to receive all PEP services until the disenrollment date becomes effective.

II. Text of this Policy:'

ElderPlace may consider involuntary disenrollment when cause exits. A participant may be disenrolled for the following reasons:

A. Disruptive or Threatening Behavior: A participant engages in disruptive or threatening behavior. Such behavior is defined as the following:
   - o Behavior that jeopardizes the participant's own health or safety, or the safety of others; or
   - o Consistent refusal to comply with an individual plan of care or the terms of the PACE enrollment agreement by a participant with decision-making capacity. Note that a PACE organization may 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.

B. The participant requires admission to the state psychiatric institution.
   a. Accepted for admission to the Oregon State Hospital
   b. Admitted to an Enhanced Care Unit

** A clinical consultation must occur for A, B & C prior to the Clinical Programs & Compliance Director sending a written request for disenrollment to the Aging and People with Disabilities (APD) PACE Analyst.

C. The participant moves out of the PEP service area or is out of the service area for more than 30 consecutive days. (The PEP IDT may agree to an extended absence due to mitigating circumstances.)

D. Any participant who fails to pay, or make satisfactory arrangements to pay any premiums due, to the PACE organization after a thirty-day grace period.

E. The participant no longer meets the eligibility criteria as determined by ADS/APD case management, and the ADS/APD case manager does not believe that disenrollment will result in deterioration of the participant's condition.

F. The PACE program agreement with CMS and the State of Oregon Senior and People with Disabilities Services and PEP is not renewed or is terminated.

G. Providence Health & Services determines not to continue the PACE program.

H. Providence ElderPlace loses the contracts and or licenses which enable it to offer health care services.

2. The Operations Manager will complete the Request for Clinical Practices and Quality Group Referral Form (see Attachment A) for review of the IDT's efforts to manage participant behavior or mitigate risk to self or others. A CPQ staff member will conduct a participant interview, review participant chart and confer with the IDT regarding their efforts to maintain the participant in the program.

3. The Operations Manager will work with the Clinical Services & Compliance Manager to develop a written request for disenrollment including documentation of the IDT chronology of efforts to manage behavior (when applicable). The Clinical Services & Compliance Manager will submit the request to the Seniors and People with Disabilities (SPD) PACE Coordinator and the Aging and Disability Services (ADS) liaison case manager.

4. The SPD PACE Coordinator and/or representatives will review the request and notify PEP of the decision within ten working days of receipt.

5. Upon approval from the SPD PACE Analyst, the Operations Manager will send the approved Notice of Action (involuntary disenrollment letter). The notice will include the date of disenrollment, reason for disenrollment, and the participant's right to an Administrative Hearing. The ADS case manager and the SPD PACE Coordinator will receive copies of this notice.

6. The IDT will follow the procedure below for reinstatement into other Medicare/Medicaid Programs and sources of care.

   a. The PEPP social worker will facilitate a transition planning conference with ElderPlace staff and the ADS/APD case manager for all Medicaid clients. This transition meeting with be documented in the electronic health record.

   b. PEP social worker will collaborate with ADS/APD case manager to transition client to county senior services case management system (i.e. enrollment with another health plan, attaining necessary equipment and supplies, etc.).
   c. For cases when client will be receiving a notice of case closure from Medicaid, the PEP social worker and ADS/APD case manager will determine appropriate resource for case follow-up and inform client of consequences of losing Medicaid and PEP coverage. ADS/APD case manager will send the client a written "Ten Day Notice of Case Closure", unless client is voluntarily choosing to disenroll from Medicaid.

   d. For private pay enrollees, the ElderPlace social worker will collaborate with the participant and/or participant's representative for transition planning. The transition meeting will include appropriate ElderPlace staff and will be documented in the electronic health record. The social worker will provide information regarding other community resource and signing up with a community primary care provider.

   e. The clinic assistant will ensure that the participant's new provider receives the participant's medical records within ten days of the disenrollment.

   f. ElderPlace Health Play Analyst will notify CMS and Oregon Medical Assistance Program (OMAP) of disenrollment with ElderPlace.

III. Revision History:

Vjlrsioil	Date	A11tbor	Modification
1.0	06/01/2002	Not Specified	Initial Release
2.0	10/2007	Not Specified	Not Specified
3.0	05/2008	Not Specified	Not Specified
4.0	12/01/2009	Sarah Booth	Policy was revised and converted to new policy format.
5.0	9/15/2016	Sarah Booth	APD case manager added.
6.0	3/2/2017	Cindy Noordijk	Revised language for reasons involuntary disenrollment based on CMS feedback.

APPENDIX I: INTERNAL GRIEVANCE AND APPEAL PROCEDURES

Subject: Participant Voice: Grievance Process	**Policy Number:** BPl 700.101	
Approval Group: Leadership Team	**Policy Owner:** Quality, Risk and Informatics Manager	
Signed By: Ellen Garcia, Executive Director	0New Revised D Reviewed	**Date:** 2/22/17

I. Objective of this Policy:

To assure Providence ElderPlace (PEP) participants, their families, and/or their caregivers may file a grievance. All participants are informed and receive written copy of the grievance procedure giving the steps and timeframes for resolving a grievance upon emollment and annually thereafter. Participant dissatisfaction in the form of an oral or written concern or grievance will be processed through the following procedures. Services will continue to be provided throughout all grievance review procedure. All information related to grievances will be treated as confidential. If the participant filing the grievance does not speak English, an interpreter and translation services will be provided to facilitate the grievance process.

II. Text of this Policy:

To describe the procedures by which grievances are resolved:

1. Grievance Procedure:

   Definition: A grievance is an oral or written expression of dissatisfaction related to quality of care or service provided.

   A. Participants, caregivers, families or representatives are encouraged to express their grievances and concerns to any member of the ElderPlace staff. Complete information must be collected so that the appropriate PACE Manager can facilitate a resolution in a timely manner.

      Note: *If the participant/family member/caregiver does not agree to pursuit of the complaint, the staff member receiving the concern should complete the electronic form and check "No" under the question "Participant gives verbal approval to pursue complaint". The PACE Manager will still perform an internal investigation of the issue and will review resolution with the IDT. The PACE Manager will NOT contact the participant/family or send a follow up letter in this case.*

   B. The staff member who receives the grievance fills out the electronic grievance form on the SharePoint. https://teams.providence.org/sites/orelderplace/SitePages/Complaints.aspx

      Once submitted, an e-mail notification will go to the site leadership mailbox. PACE Managers are responsible to coordinate investigations and designate

persons responsible to take corrective action. Grievances that constitute food program-related civil rights complaints (race, color, religion, national origin, age, sexual orientation*, sex, disability, or political affiliation) will be designated as such on the grievance form. PACE Manager will send a copy of grievance to USDA within three working days of complaint. * Please note, a complaint related to sexual orientation is not considered a civil rights complaint by the USDA, so these complaints should be documented but not sent to the USDA.

C. 1 - Investigation follow up will begin within 1-2 working days by making personal contact with the participant/family member/caregiver. The PACE Manager or designee will confirm with the complainant that they would like to pursue a grievance resolution and attain verbal "release of information" to discuss the grievance with involved parties.

2 - The participant may also be informed that a written release of outside medical records may be required to resolve the grievance.

3 - Once the-resolution has been determined, the PACE Manager or designee will contact the participant or their representative to discuss the resolution. The goal will be to have the-resolution take no longer than 30 calendar days, but this timeframe may be extended to assure participant or representative satisfaction with the final plan.

Exception: For situations in which applying the standard grievance process could seriously jeopardize the participant's life, health, or ability to regain maximum function an expedited process will be implemented. Investigations will begin within 24 hours and be completed within 72 hours, unless the participant requests an extension to 14 days or the ElderPlace staff thinks that a delay is in the best interest of the participant (this reason will be documented on the grievance form).

D. Once the resolution has been implemented and finalized with participant or representative agreement, the PACE Manager will send the participant or representative a written summary of the resolution actions taken (see Attachment B - Response to Grievance Letter #1). The completed letter will be saved to the H: drive in the Quality Folder under Grievance Information and the appropriate year and site.

E. The grievance resolution is documented on the Electronic Grievance Form. Once the PACE Manager has sent the final letter, they will submit the completed grievance to ElderPlace administration for tracking and compliance purposes. Additionally, the Grievances and documented resolution are kept on file for quality monitoring and reporting.

F. The Electronic Grievance form will also send notification to the original staff member who submitted the grievance. This notification includes a link to the SharePoint form so staff can be aware of the resolution.

G. If a satisfactory solution to the grievance is not achieved, the PACE Manager or designee will explain the extended grievance process to the complainant. If the complainant wishes to pursue this process, the PACE Manager or designee will inform the Quality and Risk Manager (see below).

Exception: Issues associated with Room and Board are not grievable through State Administrative Hearing. Examples include food related concerns and apartment maintenance issues.

2. Extended Grievance Procedure

Definition: A grievance that has not been resolved to a participant and/or family or caregiver's satisfaction. Any unresolved grievance will be brought to the attention of the ElderPlace Quality and Risk Manager. If the participant and/or family or caregiver wishes to continue the process of resolution, the PACE Manager will mark the electronic grievance as "Dissatisfied and wants further actions" before submitting to administration.

A. A participant/family member/caregiver may wish to continue the internal process to resolve any unsatisfactory grievance decision when all other attempts at resolution have been explored. The appropriate IDT team will be informed by the PACE Manager that an extended process of resolution process has been initiated.

B. The Quality and Risk Manager or designee will contact the participant or their representative and convene an ad hoc committee for grievance review and resolution proposal.

C. When the grievance is resolved, the Quality and Risk Manager will send written communication to the complainant describing the resolution to the problem and the basis for the resolution. If the complainant is not satisfied with the proposed resolution, the Quality and Risk Manager will inform the complainant of his/her Administrative Hearing Rights. The Quality and Risk Manager will notify the appropriate PACE Manager, who will in turn, notify the IDT of the grievance outcome.

Exception: For situations in which applying the standard extended grievance process could seriously jeopardize the participant's life, health, or ability to regain maximum function an expedited process will be implemented. Investigations will begin within 24 hours and be completed within 72 hours.

3. Tracking, Analysis and Reporting

A. PACE Managers will coordinate the regular submission of Grievance Forms to the Quality, Risk and Informatics Manager.

PACE Manager will record any civil rights related grievance on the "USDA Log of Complaints" (located on the H drive:\EP\USDA\Civil Rights Complaint Log).

B. The PACE Manager is responsible for assuring the investigation and resolution fully address the issue raised by the participant or representative and follow-up plans are well documented. The Quality and Risk Manager holds the same responsibility for all extended grievances. All grievances that the participant or family member have chosen to resolve through another process will be documented as any other grievance and submitted at the end of each quarter.

C. The Quality Manager will review all grievances on a quarterly basis for trends or additional areas of improvement at the site or program level. As appropriate, grievance feedback or trends will be reviewed by the Clinical Practices and Quality group and/ or PEPP leadership and may be incorporated into QAPI projects.

D. Designated staff will submit quarterly reports to the appropriate quality committees, State and Federal agencies including a summary of the data.

E. Records of all grievances will be held confidentially and made available as needed for seven years to State, Federal and accrediting bodies on request.

4. Participant Grievances raised during the Participant Council meeting:
   A. The Participant council facilitator will assure that any participant who raises a concern or grievance during the council meeting is offered the Participant Grievance Process.
   B. Individual or collective grievances raised during the meeting should be documented on the Grievance Form.
   C. The PACE Manager will review Participant Council minutes on a monthly basis to assure that any participant grievances were acknowledged and documented.

III. Revision History:

Version	Date	Author	Modification
1.0	02/2000	Not Specified	Initial Release
2.0	06/02/2008	Not Specified	Not Specified
3.0	03/2009	Not Specified	Not Specified
4.0	10/30/2009	Sarah Booth	Policy was revised and converted to new policy format.
5.0	10/15/2012	Kathi Evans	Policy owner changed, approval group name updated. Sentence added to clarify State Administrative Hearing Rights exception.
6.0	10/9/2013	Rebecca Reed	Policy owner changed and clarified communication with IDT and timeline for submitting to administration. Added Attachment A2 Electronic Version of the form.

7.0	05/02/2014	Rebecca Reed	Minor language change for staff roles.
8.0	01/05/2015	Rebecca Reed	Policy revised for new process and follow-up planning.
9.0	09/30/2015	Rebecca Reed	Updated to reflect Electronic Form and processes.
10.0	02/02/2016	Rebecca Reed	Change to USDA rules and change to QM for extended grievances. Updated letter attachment.
11.0	09/23/2016	Rebecca Reed	Minor edits - removed duplication of information for notifications.
12.0	12/15/2016	Rebecca Reed	Added paragraph about internal review process.
13.0	2/22/17	Rebecca Reed	Updated language regarding the resolution process based on feedback from CMS and SAA.

Subject: Participant Appeals Process	**Policy Number:** BP1700.102	
Approval Group: Leadership Team	**Policy Owner:** Clinical Programs and Compliance Director	
Signed By: Ellen Garcia, Executive Director	ONew Revised D Reviewed	**Date:** 02/24/2017

I. Objective of this Policy:

This policy is written to assure Providence ElderPlace (EP) participants; their families and/or representatives may file an appeal in response to Providence ElderPlace:

1. Denial of a request for a new or additional service
2. Reduction or termination of a covered service
3. Nonpayment of a covered service
4. Involuntary disenrollment
5. Medicare Part D related appeals

All participants are informed and receive in writing the appeal procedure upon enrollment, annually thereafter and in situations when a request for a covered service or payment has been denied. If the participant filing an appeal does not speak English, interpreter and translation services will be provided. All appeals and related information will be confidential.
Definition: An appeal is defined as a participant's action taken with respect to any instance where Providence ElderPlace: 1. denies a request for a new or additional service; 2. reduces or terminates a covered service; 3. denies payment of a covered service; 4. involuntarily disenrolls a participant; or 5. denies a request for coverage of a Medicare Part D prescription drug.

II. Text of this Policy:

PACE Organization Appeals

1. Appeal for denial of a request for a new or additional service
   - A. The participant or representative will be notified of decision to approve or deny a request for service as expeditiously as the participant's condition requires, but no later than 72 hours after the action. The IDT may extend the timeframe to no more than five additional days if the participant or representative requests the extension or the team documents its need for additional information and how the delay is in the interest of the participant. The PACE Manager will mail a written "Notice of Action" and a "Notice of Appeal Rights" (see Attachments A and B) within 24 hours of the action.
   - B. The PACE Manager or ElderPlace administration will assist the participant in choosing and accessing the most appropriate appeal option. The participant has the right to file an appeal either verbally or in writing to:
     - Providence ElderPlace with the PACE Manager or directly to ElderPlace administration; or
     - The local Aging and Disability Service office

- If the participant is not satisfied with the Providence ElderPlace resolution, s/he has the right to file an appeal in writing to Maximus Federal Services, Inc (if a Medicare beneficiary) (see Section III below).

2. Appeal procedure for reduction or termination a covered service:
   A. When an interdisciplinary team (IDT) authorizes a course of treatment or covered service, but subsequently acts to terminate or reduce the course of treatment or covered service, a team representative will discuss this with the participant and the PACE Manager will mail a written "Notice of Action" and a "Notice of Appeal Rights" (see Attachments A and B) to the participant at least ten working days prior to the termination or reduction of the covered service.

   B. The IDT will reinstate services if any one of the following occurs:
      1. IDT will furnish the disputed service as expeditiously as the participant's health condition requires if a determination is made in favor of the participant.
      2. IDT fails to provide the required notice prior to discontinuing services and the participant requests an appeal.
      3. IDT does not send Notice of Action within the ten business days and the participant requests a hearing within ten business days of the postmarked "Notice of Action".

3. Nonpayment of a covered service:
   A. A "Notice of Action" and a "Notice of Appeal Rights" are mailed to participants within 72 hours of an action of non-payment of a covered service.

   B. The participant has the right to appeal the decision for nonpayment of a covered service. The participant or representative may file an appeal either verbally or in writing to Providence ElderPlace with the PACE Manager or directly to ElderPlace Administration; the local Aging and Disability Service office. The PACE Manager or ElderPlace administration will assist the participant in choice of appeal option, and access to the appeal option chosen by the participant.

4. Appeal for involuntary disenrollment:
   A. When EP intends to involuntary disenroll a participant, the participant will receive a thirty calendar day notice within 72 hours of ElderPlace's disenrollment decision.

5. Appeal process and determination:
   If the participant chooses to appeal to ElderPlace, the Clinical Programs and Compliance Director or designee will request that the impartial appeal review group, composed of the ElderPlace Medical Director, community representative and a representative from both the Ethics Committee and Quality Cormnittee review the appeal. The appeal committee will include an appropriately credentialed and impartial 3rd party who was not involved in the original action and who does not have stake in the outcome of the appeal.

ElderPlace will give all parties involved in the appeal appropriate written notification and reasonable opprtunity to present evidence related to the dispute in person as well as in writing. The participant or designated representative may present any issues or evidence related to the appeal in writing prior to appeal and/or at the appeal meeting. The review group will make a determination and respond in writing including the participant's additional appeal rights as expeditiously as the participant's health condition requires, but no later than 30 calendar days after ElderPlace receives the appeal. The ElderPlace Director or designee will assist the participant in choosing which to pursue and forward the appeal.

- When the determination is in favor of participant, ElderPlace will furnish the disputed service as expeditiously as the participant's health condition reqmres.
- When the determination is wholly or partially adverse to a participant, ElderPlace will notify the participant and the State administering agency at the time the decision is made.

6. Expedited Appeals:

A. An appeal will be expedited in situations when a participant feels his or her life, health, or ability to regain or maintain function will be jeopardized without continuation of the denied services. ElderPlace will make a determination on an oral or written expedited appeal as expeditiously as the participant's health condition requires, but no later than 72 hours after receipt of the appeal.

B. The determination of an expedited appeal may be extended up to 14 calendar days for either of the following reasons:

I. The participant requests an extension.

2. ElderPlace justifies to the Department of Human Services the need for additional information and how the delay is in the best interest of the participant.

<u>Medicare Part D Appeals:</u>

If a participant or his/her representative has made a request for coverage or payment of a Medicare Part D drug benefit and the request is denied, the participant or his/her representative has the right to file a Medicare Part D appeal within 60 calendar days after receiving the denial of coverage. There are two types of Medicare Part D appeals that the participant can request: a standard Medicare Part D appeal or an expedited (72 hour) Medicare Part D appeal.

A. Standard Medicare Part D Appeal

If a participant or his/her representative files a standard Medicare Part D appeal, **EP will make a decision on the appeal request within 7 calendar days after receiving the appeal.** The participant or his/her representative may file the appeal in writing or orally. If an oral appeal request is made, EP will document the oral request in writing in the participant's or his/her representative's own words, repeat the request back to the

participant or his/her representative to confirm the accuracy, and place the request into a tracking system. EP will designate someone other than the person involved in making the initial coverage determination to make a determination on the appeal request, this will include an appropriately credentialed and impartial 3rd party who was not involved in the original action and who does not have stake in the outcome of the appeal. ElderPlace will give all parties involved in the appeal appropriate written notification and reasonable opprtunity to present evidence related to the dispute in person as well as in writing.

If the original denial was based on a lack of medical necessity, the appeal review will be performed by a physician with expertise in the field of medicine that is appropriate for the drug benefits at issue. If a determination is made in favor of the appeal, EP will provide immediate coverage of the drug as requested. If a determination is made to uphold the initial decision to deny coverage of or payment of the requested prescription drug, the participant or his/her representative will be notified of his/her right to ask for an independent review ofEP's decision.

- When the determination is in favor of participant, ElderPlace will furnish the disputed service as expeditiously as the participant's health condition requires.
- When the determination is wholly or partially adverse to a participant, ElderPlace will notify the participant and the State administering agency at the time the decision is made.

The participant or his/her representative will have 60 calendar days from the date of receiving the appeal determination to request an independent review from the following entity:

Mail new files and any other mailings to the following address:

MAXIMUS Federal Services
Medicare Managed Care & PACE Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford, NY 14534-1302
Phone: 585-348-3300

B. Expedited (72 hour) Medicare Part D Appeal

If the participant or his/her representative or his/her physician or other prescriber indicates that the participant's life, health, or ability to regain or maintain maximum function could be jeopardized by using the standard Medicare Part D appeals process, EP will apply the expedited Medicare Part D appeals process. If a participant or his/her representative files an expedited Medicare Part D appeal, **EP will make a decision on the appeal request within 72 hours after receiving the appeal.** The participant or his/her representative may file the appeal in writing or orally. If an oral appeal request is made, EP will document the oral request in writing in the participant's or his/her

representative's own words, repeat the request back to the participant or his/her representative to confirm the accuracy, and place the request into a tracking system. EP will designate someone other than the person involved in making the initial coverage determination to make a determination on the appeal request, will include an appropriately credentialed and impartial 3rd party who was not involved in the original action and who does not have stake in the outcome of the appeal.

ElderPlace will give all parties involved in the appeal appropriate written notification and reasonable opprtunity to present evidence related to the dispute in person as well as in writing. If the original denial was based on a lack of medical necessity, the appeal review will be performed by a physician with expertise in the field of medicine that is appropriate for the drug benefits at issue. If a determination is made in favor of the appeal, EP will provide immediate coverage of the drug as requested. If a determination is made to uphold the initial decision to deny coverage of or payment of the requested prescription drug, the participant or his/her representative will be notified of his/her right to ask for an independent review of EP' s decision.

- When the determination is in favor of participant, ElderPlace will furnish the disputed service as expeditiously as the participant's health condition requires.
- When the determination is wholly or partially adverse to a participant, ElderPlace will notify the participant and the State administering agency at the time the decision is made.

The participant or his/her representative will have 60 calendar days from the date of receiving the appeal determination to request an independent review from the following entity: [Note, the participant or his/her representative or physician or other prescriber can request an expedited (72 hour) decision from MAXIMUS].

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 703
Pittsford, NY 14534-1302
Phone: 877-456-5302
Fax: 866-825-9507

III. State and Medicare Contact Information:

Appeals shall be forwarded to the following agencies in accordance with the participant's selection:

State of Oregon Administrative Hearing (Participants enrolled in Medicaid or Medicare):
State Policy Analyst-PACE
Department of Human Services
500 Summer St NEE 02
Salem, OR 97303
Phone: 844-224-7223

Medicare Appeal (non Part D appeal): (Participants enrolled in Medicare only):
MAXIMUS Federal Services
Medicare Managed Care & PACE Reconsideration Project
3750 Monroe Avenue
Suite 702
Pittsford, NY 14534-1302
Phone: 585-348- 3300

Medicare Part D Appeal: (Participants enrolled in Medicare only):
MAXIMUS Federal Services
3750 Monroe Avenue, Suite 703
Pittsford, NY 14534-1302
Phone: 877-456-5302
Fax: 866-825-9507

IV. Tracking, Analysis and Reporting

A. Operations Managers will send a copy of the "Notice of Action" form to the Clinical Services and Compliance Manager.

B. The ElderPlace Director or designee holds responsibility for all internal appeals. All appeals that the participant or family member have chosen to resolve through another process will be documented and submitted the end of each quarter.

C. Designated staff will maintain, aggregate and analyze information on appeal proceedings. Appeals quarterly reports will be submitted to the appropriate quality committee, state and federal agencies including a summary of the data. The Quality Committee will identify any trends and opportunities for quality improvement.

D. Records of all appeals will be held confidentially and made available as needed for seven years to State, Federal and accrediting bodies on request.

V. Related Policies and References

CMS Prescription Drug Benefit Manual, Chapter 18, Part D Enrollee Grievances, Coverage Determinations, and Appeals; Revision 8, 1/1/2010

VI. Revision History:

version	Date	Author	Modification
1.0	10/01/2002	Not Specified	Initial Release
2.0	07/2008	Not Specified	Not Specified
3.0	10/30/2009	Sarah Booth	Policy was revised and converted to new policy format.
4.0	04/29/2010	Rosalie Wachsmuth	Attachment F and the address for Maximus Federal Services were updated.
5.0	11/10/2010	Rosalie Wachsmuth	New section added to address Medicare Part D appeals. Also, the policy owner was changed from the Social Work Program Manager to the Clinical Services and Compliance Manager.
6.0	11/1/2011	Cindy Noordijk	Changed the contact information for the State and ADS. Added timeframes for requesting appeal to reflect Medicare Part C.

7.0	6/7/2012	Cindy Noordijk	ADS and State Accountabilities changed Updated Federal Maximus Operations Department has moved to a new location for Health plans and PACE Organizations.
8.0	9/1/2012	Cindy Noordijk	Updated Notice of Action letters to contact ElderPlace Clinical Services and Compliance Manager if State appeal is requested.
9.0	3/25/2013	Rosalie Wachsmuth	Updated the Medicare Part D appeals contact information.
10.0	03/12/2015	Cindy Noordijk	Updated Attachments B and E.
11.0	08/31/2016	Cindy Noordijk	Updated Policy and Attachments A-E with the new State phone number.
12.0	02/24/2017	Cindy Noordijk	Updated language based on feedback from CMS, specifically around impartial 3rd party, appeal outcomes and clarifving timefrarnes.

APPENDIX J: ADDITIONAL APPEAL RIGHTS UNDER MEDICARE OR MEDICAID

For any determinations that are adverse to the participant, Providence ElderPlace will inform a participant in writing of his or her appeal rights under Medicare or Medicaid, or both, assist the participant in choosing which to pursue if both are applicable, and will forward the appeal to the appropriate entity.

APPENDIX K: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

Providence ElderPlace Oregon
Quality Assessment Performance Improvement Program

Purpose

The purpose of the ElderPlace Quality Assessment Performance Improvement (QAPI) Program is to:

- Ensure that ElderPlace participants receive the highest quality of service and clinical care.
- Uphold the values and ideals of the PACE Philosophy and the Providence ElderPlace and Providence Health System Mission.
- Create a data-driven quality improvement program that seeks to enhance systems and processes.

Goals and Objectives

- To work toward achievement of the Triple Aim: best care experience, improve population health and affordable services.
- To elicit, respect and honor each participant's preferences for care and quality oflife.
- To identify areas in which to improve or maintain the quality of care provided and the establishment of teams to address prioritized areas for improvement.
- To develop, implement and monitor plans of action to improve the quality of care and/ or services when appropriate.
- To document and disseminate the results of QAPI activities.
- To provide a forum and support ethical deliberation for participants, families, staff and contractors.

Methodology

- Use a data-driven, systematic approach to monitor and evaluate processes, services and satisfaction across the ElderPlace care continuum.
- Consolidate improvement initiatives into an annual, written QAPI plan that is evaluated and reported.
- Engage staff, participants, caregivers and contractors in the QAPI program.
- When appropriate, utilize the FOCUS-PDCA approach as a model of performance improvement.

Authority and Oversight

The Oregon Community Ministry Board has delegated authority from the Providence Health and Services Board of Directors to approve the ElderPlace Oregon Quality Plan. The Oregon community Ministry Board monitors the ElderPlace Oregon Quality Plan via annual reports submitted to the Quality Committee of the Oregon Community Ministry Board.

The ElderPlace Oregon Quality Council provides oversight for the QAPI program and reviews quarterly status updates of the annual QAPI plan and approves them for submission to the Quality Committee of the Ministry Board. ElderPlace Oregon Quality Management engages with Quality Management and Leadership staff at North Coast as appropriate related to joint projects or care situations.

The ElderPlace Quality Assessment Performance Improvement (QAPI) Program also reports quarterly data to the State of Oregon and to CMS.

Structure/ Responsibilities

Primary responsibility and authority for the quality of care and services delivered to ElderPlace participants rests with the ElderPlace Leadership Team.

The Clinical Practice and Quality Work Group provides leadership, resources and coordination needed to achieve the goals and objectives of the QAPI Program.

For administrative purposes, the Medical Director and the Quality Manager:

- Facilitate & coordinate the development of annual QAPI initiatives.
- Provide a liaison to the Providence ElderPlace Quality Council.

The Medical Director is responsible for oversight of the medical care and Quality Assurance and Performance Improvement program, which includes oversight of the community-based PCPs and nurse practitioner in the North Coast service area.

Program Contents

The Quality Program has many aspects that contribute to the overall QAPI plan.

Annual Quality Initiatives - These initiatives are set on an annual basis. The program develops 4-6 annual initiatives with quarterly goals and workgroup support.

Grievances - Participant grievances are received by staff on a regular basis. Initial resolution is completed at the site level and submitted to the Quality Program. The Quality Manager reviews all grievances for trends and additional follow-up. The clinical

Practices and Quality Group and Quality Council also review the Quarterly grievance summary.

Participant Council minutes and Quarterly updates - Participant Councils are held monthly at each site. Participant Council minutes are posted at the site. Quarterly summaries of the minutes are shared with the ElderPlace Quality Council, the Home and Community Services Quality Council, and the Community Ministry Board. Each quarter, updates from the Quality Program are shared with the Participant Council for participant feedback.

UOR's - Unusual Occurrence Reports are completed by site staff. Each UOR is reviewed by the Interdisciplinary Team and site leadership. Once reviewed by the site, they are submitted to the Quality Department for further review and HPMS reporting. UOR reports are available to sites and managers for care planning reviews or project improvement.

Satisfaction surveys - Satisfaction surveys are performed to gather input for program improvement. Participant Satisfaction surveys are performed annually. The program also surveys families and caregivers on alternating years to assemble their input as well. Based on the feedback provided in these surveys, the program develops follow-up action plans for service improvement.

Utilization Reviews - Program Utilization will be reviewed monthly to identify opportunities for process improvements or ways to enhance provisions of community based care. Utilization discussions will be held at both the site and program levels.

Level 2 reviews - Participant events that meet the threshold for Level 2 review are reported to the Quality Department by site staff. Level 2 reviews are conducted to determine the root cause of the event and to determine any participant specific or policy/ procedure improvements. These improvement plans are monitored by the Clinical Practices and Quality Group.

Level 1 HPMS data - Level 1 data are gathered and reported quarterly. These data are reviewed as appropriate for trends.

Other Metrics as identified or required by regulation - The QAPI program is designed to identify and address new areas of focus and/ or any change in reporting requirements for PACE organizations. These new areas will be developed and added to the annual QAPI plan or on-going program contents as needed.

APPENDIX L: PACE Quality Reporting

In order to comply with the PACE regulations, §460.140, §460.200(b)(l), §460.200 (c), and §460.202, PACE Organizations (POs) must meet external quality assessment and reporting requirements as specified by CMS and the SAA.

PACE Level I quality data elements are reported to CMS using the Health Plan Management System (HPMS). The PACE organization should refer to HPMS for the current PACE Level I Guidance and PACE User Guide.

PACE Level II reporting requirements apply specifically to unusual incidents that result in serious adverse participant outcomes, or negative media coverage related to the PACE program. The PACE Organization should refer to the PACE Level II Guidance dated July 2015. POs are required to report incidents within 3 working days to https://dmaoportal.lmi.org with a copy to the Regional Office (RO) and the SAA.

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 under section 1853(k)(l) of the Act, unadjusted for IME. The applicable amount is the pre-Affordable Care Act rate, which will be phased-out under the Affordable Care Act for other Medicare Advantage plans. The applicable amount will not be phased out for PACE. In rebasing years, this rate is the greater of: I) 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.

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.

Effective CY 2006 and subsequent years, CMS makes advance monthly per capita payments for aged and disabled enrollees based on the bidding methodology established by the MMA. PACE plans are not required to bid, however.

Risk Adjustment

For the final payment rate, the county rate for the PACE organization 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 the CMS-HCC model (community, long-term institutionalized, End-Stage Renal Disease (ESRD) or new enrollee) published in the Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (Rate Announcement).

A frailty factor is added to each individual's risk score for PACE plan payment. Risk adjustment predicts (or explains) the future Medicare expenditures of individuals based on diagnoses and demographics. But risk adjustment may not explain all of the variation in expenditures for frail community populations. The purpose of frailty adjustment is to predict the Medicare expenditures of community populations with functional impairments that are unexplained by risk adjustment. 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. More information regarding the HOS-M can be found in section 10.3.1.3. Because the CMS-HCC model has been designed to pay appropriately for the long-term institutionalized population, frailty adjustments are added to the risk scores only for community-based and short-term institutionalized enrollees (i.e., the frailty adjustment for long-term institutionalized enrollees is zero). 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 PACE organizations 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 I, 2006, PACE organizations 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 PACE organizations are paid for the provision of outpatient prescription drugs to non-part D eligible PACE participants.

PACE organizations 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 PACE organizations comprises several pieces, including the direct subsidy, reinsurance payments, and risk sharing. 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 PACE plan's basic Part D beneficiary premium is greater than the regional low-income premium subsidy amount.

Medicaid Rates:

Clackamas County:

Aged, Blind and Disabled (ABAD) with Medicare	$3,822.46
ABAD without Medicare	$3,822.46
Old Age Assistance (OAA) with Medicare	$3,822.46
OAA without Medicare	$3,822.46

Multnomah and Washington Counties:

Aged, Blind and Disabled (ABAD) with Medicare	$4,041.56
ABAD without Medicare	$4,041.56
Old Age Assistance (OAA) with Medicare	$4,041.56
OAA without Medicare	$4,041.56

North Coast:

Aged, Blind and Disabled (ABAD) with Medicare	$3,544.72
ABAD without Medicare	$3,544.72
Old Age Assistance (OAA) with Medicare	$3,544.72
OAA without Medicare	$3,544.72

Revised May 16, 2016

APPENDIX 0: TERMINATION PHASE-DOWN PLAN

Subject: Termination of PACE Program Agreement	**Policy Number:** BP0l00.104	
Approval Group: Leadership Team	**Policy Owner:** Executive Director	
Signed By: Ellen Garcia, Executive Director	ONew Revised D Reviewed	**Date:** 1/19/2017

I. Objective of this Policy:

To provide a written plan for phase down of services in the event of termination of the PACE program agreement.

II. Text of this Policy:

The plan initiated by PEP would be as follows:

1. A letter would be sent to the Center for Medicare and Medicaid Services, State of Oregon Department of Human Services, the State Office of Long-term Care Ombudsman, and Multnomah, Washington, Clackamas and Tillamook and Clatsop County Aging and People with Disabilities Services (APO) at least 90 days before the agreed upon closure date in accordance with PACE Regulations.
2. PEP would notify participants, and in cases of participants with diminished capacity, a designated family member, guardian, representative, healthcare power of attorney, etc.), contracted providers and caregivers at least 60 days before the final day of service by PEP. In this letter, PEP would commit to facilitating the transition to (l) a new primary care provider and (2) an alternate insurer.
3. All marketing and enrollment activities would cease immediately. Any potential enrollees would be notified that they would not be able to enroll.
4. PEP staff would be retained at a level sufficient to provide quality care until all participants are disenrolled and integrated into the conventional Medicare and Medicaid systems. PEP staff would be laid off gradually as census decreases.
5. The PEP Compliance Officer will oversee the process for all medical records to be archived for seven years.
6. All service contractors would receive a written sixty (60) day notice. Based upon program resources and the risk-sharing plan, all outstanding debts would be settled upon final dissolution of the program. Services provided by Providence Health & Services (PH&S) would be the last to be resolved, pending availability of funds. Financial obligations and risk would be absorbed by the sponsoring organization, PH&S. Every effort would be made to honor contracts for service providers that are outside the PHS (see BP0I00.110 - Insolvency Plan).
7. The interdisciplinary team (IDT) members would each have roles and responsibilities to assure seamless transition care planning.

Social Worker:

A. Facilitate a transition planning conference for each participant, primary representative the APD case manager or other community resource, as appropriate.
B. Complete documentation to stop payment on contracted housing providers by specified dates and collaborate with APD to reassume this financial obligation.
C. Collaborate with APD case manager to transition participant to the appropriate County service delivery system, i.e. enrollment with another health plan, obtaining necessary equipment and supplies, etc., and for private pay enrollees, collaborate with participant and/or participant representative for transition planning.
D. Inform participant and/or representative about any other alternative resources, which may be appropriate, such as district centers, adult day care, etc.
E. Assist participants and or families with re-enrollment in Medicare, Medicaid or other insurers if available. Consent to release information forms will be signed by the participant or the representative.

The Interdisciplinary Team (IDT):

A. Identify significant aspects of care for completion prior to disenrollment of each participant.
B. Designate which disciplines need to provide instruction and written educational materials.
C. Consider key areas of transition plan, i.e. prescriptions, equipment, etc.

Primary Care Provider:

A. Identify priority medical documentation for transfer to the participant's new medical provider, including but not limited to history and physical, problem list, medicine list, advanced care planning documentation, most recent assessment and care plan etc.
B. Write any necessary medication and equipment prescriptions for interim time-frame.

Clinic Nurse:

A. Communicate with the nursing staff who will be assuming future care of the participant, to assure continuity of care.

Community Care RN:

A. Communicate to caregiver that any PEP RN delegation will be rescinded at disenrollment. Coordinate with community housing partner/community resource for another source of delegation service, as appropriate.

Clinic Assistant:

A. Forward recommended copies of documentation to participant's designated new provider upon receipt of"Authorization of Release oflnformation", signed by

participant or legal representative. If no primary care provider is identified, a copy of the documentation will be given to the participant or representative.

D. Collaborate with the rehab staff for timely transition of equipment, if appropriate.

E. Cancel upcoming specialist appointment transportation requests.

Providence ElderPlace - Portland Health Plan Operations Staff:

A. Provide Center for Medicare and Medicaid Services and the State of Oregon Division of Human Services and specific County Aging and People Disabilities Services with a list of participants who will be affected by this termination.

Health and Social Center Staff:

A. Identify and return any of participant's belongings that have been kept at the Health and Social Center.

III. Related Policies and References:

BP0100.110: Insolvency Plan

IV. Revision History:

Version	Qate.	Author	Modification
1.0	01/01/2003	Not Specified	Initial Release
2.0	07/16/2008	Not Specified	Not Specified
3.0	01/22/2009	Not Specified	Not Specified
4.0	10/30/2009	Sarah Booth	Policy was reviewed and converted to new policy format.
5.0	07/15/2016	Sarah Booth	Minor edits.
6.0	01/19/2017	Ellen Garcia	Policy renamed from "Transition During Termination" to "Termination of PACE Program Agreement" and updated. New owner assigned.

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

Due to the current size of the PACE program (Approximately 1,200 participants), literature is being developed at the state level to include PACE as a Medicaid benefit. PACE provides information and literature for all applicants and enrollees per state requirements. APD has a process to review and approve these materials.

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

APPENDIX S: SAA DISENROLLMENT PROCESS

Disenrollments are reviewed by the local AAA/APD Case Managers. Participants are then disenrolled in the State system. Coordination of continued care for the participant is performed between the Case Managers and Social Workers. All requests for involuntary disenrollments, which must including supporting documentation, are reviewed by the APD PACE Coordinator. Specific processes are noted below.

Choice. A participant can choose to voluntarily disenroll from PACE at any time. PACE staff then notify the local AAA/APD Case Manager of the participant's choice. PACE must provide the AAA/APD with documentation stating the reason for disenrollment as well as any health related information necessary to ensure continued eligibility and transition service planning.

Eligibility. Ifa PACE participant loses Medicaid eligibility, the AAA/APD staff will immediately notify the PACE program of the situation. A financial and service assessment will be completed by AAA/APD and a PACE staff person prior to closure of Medicaid eligibility to assist in transition planning. Hearing rights will also be reviewed with the participant. Persons who lose Medicaid eligibility may pay the private fee to PACE and remain enrolled in the program.

Non-payment. On occasion a PACE participant may fail to provide the pay-in required to maintain their long-term care service eligibility. Nonpayment is cause to terminate Medicaid long-term care services although the person may maintain eligibility for other Medicaid programs. Processes outlined in the Standard Operating Procedures documents how PACE and the local AAA/APD office ensure that they work together to determine the reasons for non-payment and the participants' capacity to understand the consequences of termination.

Participant Death. Upon a participant's death PACE notifies the AAA/APD Case Manager so that the AAA/APD office may close the case in a timely manner.

Service Area: If the participant moves out of the PACE service area they will be disenrolled from the PACE Program the first of the following month. The PACE program and the local AAA/APD Case Manager shall work with the participant to address transition issues.

Involuntary Disenrollment : PACE must provide the participant with a 30-day notice of intent to disenroll. This notification must include the reasons and the participant's appeal rights. A copy of the notice provided to the participant and/or their representative will be sent to AAA/APD office, the APD PACE Policy Analyst and Region X CMS. All involuntary disenrollments must be approved by the APD PACE Policy Analyst.

The PACE program will work with the local AAA/APD Case Managers and the participant to assure a smooth transition to other services once approval is received from APD. 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 either the

participant or other participants.

- The participant does not to 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 determined by the local AAA/APD office, and the local office does not believe that disenrollment will result in deterioration of the participant's condition to the point that they will meet eligibility criteria within the next six months.
- The PACE 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 program.
- The PACE program agreement between CMS, the State of Oregon, and PACE is not renewed.
- The local PACE Program determines not to continue to participate in PACE.
- The local PACE Program loses the contracts and/or licenses which enable it to offer health care services.

Disenrollment Transition: PACE and the local AAA/APD case manager will convene a transition planning conference for all Medicaid clients who are disenrolling. The PACE program may, depending on the need, initiate similar conferences with families of private pay participants. The conference will address a range oftransition issues including: client notification, alternate health plan enrollment, acquisition of necessary equipment and supplies and arrangements for long-term care services. PACE staff will notify any contracted care providers and CMS. AAA/APD staff will provide the Office of Medical Assistance (OMAP) staff with the necessary information to complete the disenrollment by compute deadline.

APPENDIX T: REGULATORY WAIVERS
(Amended as of June 13, 2017)

Under the authority of the Benefits Improvement and Protection Act of2000 (BIPA), CMS has granted conditional waivers of the following sections of the PACE regulation:

1. Section 460.102, which permits Nurse Practitioners (NPs) to be involved as part of the Interdisciplinary Team (IDT) along with the eleven required IDT members.
2. Section 460.104, which permits NPs, in collaboration with the Medical Director or Providence ElderPlace's physicians to:
    1) Conduct initial comprehensive assessments.
    2) Conduct periodic reassessments.
    3) Conduct unscheduled reassessments.
    4) Participate in the development of the PACE participant's plan of care and ongoing monitoring of the participant's health status.
3. Section 460.64(a)(3), which requires that each member of the PACE organization's staff (employee or contractor) that has direct participant contact, have one year of experience with a frail or elderly population. This waiver permits the PO to hire drivers who do not have one year of experience working with a frail or elderly population.
4. Section 102(a)(l), which permits 10 Community Based primary care physicians to be part of the IDT at Providence ElderPlace's North Coast PACE Center.
5. Section 460.102(d)(3), which allows Community Based primary care physicians to not primarily serve PACE participants
6. Section 460.104-Participant Assessment
   This waiver permits Philip Boss, under the direct supervision of the MSW at Providence Elder-Place PACE to:
    a) Conduct initial comprehensive assessments.
    b) Conduct periodic reassessments.
    c) Conduct unscheduled reassessments.
    d) Participate in the development of the PACE participant's plan of care and ongoing monitoring of participant's health status.

APPENDIX U: MEDICARE PART D

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and Providence Health & Services - Oregon, d.b.a., Providence ElderP!ace - Portland, 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-l 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.

Article I
Medicare Prescription Drug Benefit

A. The PACE Organization agrees to operate a Medicare Prescription Drug Benefit as described in its application and related materials, including but not limited to al[the attestations contained therein and all supplemental guidance provided by CMS. In addition, the PACE Organization agrees to comply with the provisions of this Appendix, which incorporates in its entirety the Medicare Part D Application for New PACE Organizations. The PACE Organization also agrees to operate in accordance with sections 1860D-1 through 1860D-42 of the Act (with the exception of sections 1860D-22 and 1860D-31), the regulations at 42 CFR §423.1 through 42 CFR §423.910, with the exception of Subparts Q, Rand Sand other sections of 42 CFR Part 423 specifically waived for PACE Organizations (the PACE waivers are attached to this Appendix as Attachment A), the abbreviated application, the PACE regulations at 42 CFR Part 460, as applicable, as well as all other applicable Federal statutes, regulations, and policies. This Appendix is deemed to incorporate any changes that are required by statute to be implemented during the term of this Appendix and any regulations or policies implementing or interpreting such statutory provisions.

B. CMS agrees to perform its obligations to the PACE Organization consistent with the regulations at 42 CFR §423.1 through 42 CFR §423.910, as applicable, sections l 860D-1 through 1860D-42 of the Social Security Act, as applicable, and the abbreviated application, as well as all other applicable Federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 CFR Part 423 that impose new, significant regulatory requirements on the PACE Organization. This provision does not apply to new requirements mandated by statute.

D. This Appendix is in no way intended to supersede or modify 42 CFR, Part 423 or Part

460. Failure to reference a regulatory requirement in this Appendix does not affect the applicability of such requirements to the PACE Organization and CMS.

Article II
Functions to be Performed by the PACE Organization

A. ENROLLMENT

Part D eligible participants enrolled in a PACE plan that offers a Medicare Prescription Drug Plan must receive qualified prescription drug coverage through the PACE Organization's Part D plan pursuant to 42 CFR §423.30(c).

B. PRESCRIPTION DRUG BENEFIT

l. The PACE Organization agrees to provide the basic prescription drug coverage as defined under 42 CFR §423.100 to all Part D eligible PACE beneficiaries and, to the extent applicable, supplemental benefits as defined in 42 CFR §423.100 and in accordance with Subpart C of 42 CFR Part 423 to all Part D eligible beneficiaries. The PACE Organization also agrees to provide Part D benefits as described in the PACE Organization's Part D bid(s) approved each year by CMS.

2. The PACE Organization agrees to calculate and collect beneficiary Part D premiums, to the extent applicable, in accordance with 42 CFR §§423.286 and 423.293.

C. DISSEMINATION OF PLAN INFORMATION

I. The PACE Organization agrees to disclose information related to Part D benefits to beneficiaries in the manner specified in the PACE regulations at 42 CFR §460.82.

2. Any PACE Organization that utilizes a Part D formulary agrees to provide notice regarding formulary changes and to educate participants and providers concerning its formulary in accordance with 42 CFR §423.120(b).

3. Approval of marketing materials shall be governed by 42 CFR §460.82 of the PACE regulations.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

I. The PACE Organization will operate quality assurance, cost and utilization management, and medication therapy management as required in 42 CFR §§ 460.102, 460.104, 460.106, and Subpart Hof the PACE regulations to the extent these requirements have relevance to Part **D** and do not exceed the corresponding requirements under 42 **CFR** §§423.153 and 423.162.

2. The PACE Organization will support electronic prescribing in accordance with 42 CFR §423.159.

E. APPEALS AND GRIEVANCES

The PACE Organization agrees that any appeals and grievances regarding Part D issues will be subject to the requirements of 42 CFR §§460.120, 460.122 and 460.124 of the PACE regulations governing grievances and appeals.

F. PAYMENTTOPACEORGANIZATION

The PACE Organization and CMS agree that payment paid for Part D services under this Appendix will be governed by §1894(d) of the Act and the rules in Subpart G of 42 CFR Part 423.

G. **BID** SUBMISSION AND REVIEW

1. If the PACE Organization intends to participate in the Part D Program for the next program year, the PACE Organization agrees to submit the next year's Part **D** bid, including all required information on premiums and benefits, by the applicable due date as provided in Subpart **F** of 42 CFR Part 423, unless a waiver is granted pursuant to 42 CFR §423.265(b), so that CMS and the PACE Organization may conduct negotiations regarding the terms and conditions of the proposed bid and benefit plan renewal.

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. The PACE Organization agrees to comply with the coordination requirements of State Pharmacy Assistance Programs (SPAPs) and, as applicable, agrees to comply with coordination requirements of other plans that provide prescription drug coverage as described in 42 CFR §§423.464(a)-(b),(d)-(e), (f)(l) anc.t(3).

2. The PACE Organization agrees that Medicare Secondary Payer procedures will be governed by 42 CFR §460.180(d) of the PACE regulations.

I. SERVICE AREA AND PHARMACY ACCESS

1. The PACE Organization agrees to provide Part D benefits to Part **D** eligible PACE enrollees in the service area for which it has been approved by CMS to offer PACE benefits.

2. The PACE Organization agrees to ensure adequate access to Part D covered drugs at out-of-network pharmacies in accordance with 42 CFR §§460.90(b), 460.92(q) and 460.100.

3. The PACE Organization agrees to adjudicate prescription drug claims in a timely

and efficient manner in compliance with CMS standards.

J. COMPLIANCE PLAN/PROGRAM INTEGRITY

The PACE Organization agrees that it will develop and implement a compliance plan that applies to its Part D-related operations, consistent with 42 CPR §§423.504(b)(4)(vi)(F)-(H) and 42 CPR §§460.32, 460.60-68, 460.71 and 460.80.

K. LOW-INCOME SUBSIDY

The PACE Organization agrees that it will participate in the administration of subsidies for low-income individuals according to Subpart P of 42 CPR Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

The PACE Organization agrees to afford its enrollees protection from liability for payment of fees related to Part D prescription drug coverage that are the obligation of the PACE Organization in accordance with section 1894(b)(l)(A)(i) of the Act and 42 CPR §§460.70(e)(5) and 460.90(a).

M. RELATIONSHIP WITH RELATED ENTITIES, CONTRACTORS, AND SUBCONTRACTORS

1. The PACE Organization agrees that it maintains ultimate responsibility for adhering to, and otherwise fully complying with, all terms and conditions of this Appendix.

2. The PACE Organization shall ensure that any contracts or agreements with subcontractors or agents performing functions on the PACE Organization's behalf related to the operation of the Part D benefit are in compliance with 42 CPR §460.70 of the PACE regulation.

N. CERTIFICATION OF DATA THAT r:iETERMINE PAYMENT

The PACE Organization shall provide certifications in accordance with 42 CPR §423.S0S(k)(l-5).

Article III
Record Retention and Reporting Requirements

A. MAINTENANCE OF RECORDS

The PACE Organization agrees to maintain records and provide access in accordance with 42 CPR §423.S0S(d) and 42 CPR §§460.200(a)-(e), 460.202, 460.204, 460.208 and 460.210.

B. GENERAL REPORTING REQUIREMENTS

The PACE Organization agrees to submit information to CMS according to 42 CFR 460, Subpart L of the PACE regulations and the "Medicare Part D Reporting Requirements", a document issued by CMS and subject to modification each program year. The Reporting Requirements document specifies the abbreviated list of requirements applicable to PACE organizations.

C. CMS LICENSE FOR USE OF PLAN FORMULARY

If the PACE Organization develops a formulary, then the PACE Organization agrees to submit to CMS its formulary information, including any changes to its formularies, and hereby grants to the Govermnent [and any person or entity who might receive the formulary from the Govermnent,] a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, as applicable.

Article IV
HIPAA Transactions/Privacy/Security

The PACE Organization agrees to comply with the confidentiality and enrollee record accuracy requirements specified in 42 CFR §§460.200(d)-(e) of the PACE regulations.

Article V
Appendix Term and Renewal

A. TERM.OF APPENDIX

This Appendix is effective from the date of CMS' authorized representative's signature through December 31, 2018, and shall be renewable for successive one-year periods thereafter according to 42 CFR §460.34 of the PACE regulations. The PACE Organization shall begin delivering the Medicare prescription drug benefit services upon executing the signed PACE program agreement.

B. QUALIFICATION TO RENEW APPENDIX

1. In accordance with 42 CFR §423.507, the PACE Organization will be determined qualified to renew this Appendix annually only if-
   (a) CMS informs the PACE Organization that it is qualified to renew its Appendix; and
   (b) The PACE Organization has not provided CMS with a notice of intention not to renew in accordance with Article VII of this Appendix.

2. Although the PACE Organization may be determined qualified to renew its Appendix under this Article, if the PACE Organization and CMS cannot reach

agreement on the Part D bid under Subpart F of 42 CFR Part 423, no renewal takes place, and the failure to reach agreement is not subject to the appeals provisions in 42 CFR Part 423, Subpart Nor 42 CFR §460.54.

Article VI
Relationship Between Appendix and PACE Program Agreement

A. In the event that the PACE Organization's Program Agreement is terminated by any party, the provisions of this Appendix shall also terminate. In such an event, the PACE Organization shall provide notice to enrollees and the PACE Organization shall prepare a transitional plan of care as described in the Program Agreement as well as in 42 CFR §460.52 of the PACE regulations.

B. The PACE Organization acknowledges that the termination or nonrenewal of this Appendix by either party may require CMS to terminate or non-renew the PACE Program Agreement in the event that such termination or non-renewal prevents the PACE Organization from meeting the requirements of 42 CFR §§ 460.S0(a) and 460.92, in which case the PACE Organization must provide the notices as specified in Article VI.A. of this Appendix, as well as the notices specified under 42 CFR §460.52. The PACE Organization also acknowledges that the nonrenewal or termination of this Appendix by either party may prevent the PACE Organization from entering into a new Program Agreement with CMS for two years following such Appendix nonrenewal or termination where CMS determines that such non-renewal or termination will prevent the PACE Organization from meeting the requirements of 42 CFR §§460.S0(a) and 460.92.

C. The termination of this Appendix by either party shall not, by itself, relieve the parties from their obligations under the Program Agreement to which this document is an Appendix.

Article VII
Nonrenewal of Appendix

A. NONRENEWAL BY THE PACE ORGANIZATION

1. The PACE Organization may non-renew this Appendix in accordance with 42 CFR §423.507(a).

2. If the PACE Organization non-renews this Appendix under this Article, CMS cannot enter into a Part D Appendix with the organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS.

B. NONRENEWALBYCMS

CMS may non-renew this Appendix under the rules contained in 42 CFR

§423.507(b).

Article VIII
Modification or Termination of Appendix by Written Mutual Consent

This Appendix may be modified or terminated by written mutual consent in accordance with 42 CFR §423.508.

Article IX
Termination of Appendix by CMS

CMS may terminate this Appendix in accordance with 42 CFR 423.509.

Article X
Termination of Appendix by the PACE Organization

A. The PACE Organization may terminate this Appendix in accordance with 42 CFR §423.510.

B. CMS will not enter into a Part D Appendix with any PACE Organization that has terminated its Appendix within the preceding two years unless there are circumstances that warrant special consideration, as determined by CMS

C. If the Appendix is terminated under section A of this Article, the Pace Organization must ensure the timely transfer of any 'ciata and files.

Article XI
Intermediate Sanctions

The PACE Organization shall be subject to sanctions and civil money penalties, consistent with Subpart O of 42 CFR Part 423.

Article XII
Severability

Severability of the Appendix shall be in accordance with 42 CFR §423.504(e).

Article XIII
Miscellaneous

A. DEFINITIONS: Terms not otherwise defined in this Appendix shall have the meaning given such terms at 42 CFR Part 423 or, as applicable, 42 CFR Part 460.

B. ALTERATION TO ORIGINAL APPENDIX TERMS: The PACE Organization agrees that it has not altered in any way the terms of the PACE Part D Appendix. The

PACE Organization agrees that any alterations to the original text of the Appendix made by the PACE Organization shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS: The PACE Organization agrees to include in this Appendix other terms and conditions in accordance with 42 CFR §423.S0SG).

D. CMS APPROVAL TO BEGIN PROVIDING PART D: The PACE Organization agrees that it must complete CMS operational requirements including, but not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the PACE Organization's behalf). To establish and successfully test connectivity, the PACE Organization must 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

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

[illegible]	[illegible]
423.44	Involuntary disenrollment
423.48	Information about Part D
423.104(g)(l)	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.l 53(a)-423. l 53(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)(l)	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(±)(2) and 423.464(±)(4)	Coordination with other prescription drug covera!!e
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(cl-(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 bv 423.505(d and*** il	Contract provisions
423.505(k)(6) ***Note: Organizations are required to abide bv 423.505(k)(l-5)***	Certification for purposes of price compare
423.506(a)-(b) ***Note: Organizations are required to abide bv 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 apoeals
423.2262	Approval of marketing materials and emollment forms
NIA	A PDP sponsor is required to be a nongovernmental entity