DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

November 9, 2000

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Balanced Budget Act of 1997 (BBA) and is a follow-up to our State Medicaid Director letter of March 23, 1998. The purpose of this letter is to provide additional information on section 1934 of the Social Security Act (enacted in section 4802 of the BBA), which establishes the Program of All-Inclusive Care for the Elderly (PACE) as a Medicaid State plan option. PACE serves the frail elderly in the home and community, and features a comprehensive delivery system including acute and long-term care services and integrated Medicaid and Medicare financing. Enclosure 1 provides more information about PACE.

In our letter of March 23, 1998, we provided a suggested preprint and supplemental pages for States to express their intention to elect PACE as an option in the State plan, pending further guidance from the Health Care Financing Administration (HCFA). It is important to note that submitting the State plan amendment electing to cover the PACE option merely indicates the State's intent and does not obligate the State to enter into a program agreement with the Secretary and a PACE organization to provide PACE services. Enclosure 2 provides general information about completing the eligibility portions of the State plan amendment. To satisfy the remaining State plan amendment requirements for PACE, we have provided Enclosures 3 and 4 as suggested preprint text pages, and Enclosures 5, 6, and 7 as suggested preprint attachments and supplements.

The Application Process

The BBA incorporates the PACE model of care as a benefit of the Medicare program and enables States to provide PACE services to Medicaid beneficiaries as a State option. To provide this new Medicaid benefit, States must elect to cover PACE services as a State plan option and collaborate with potential PACE organizations to submit the PACE provider application. Upon completion and approval of these documents, a three-party program agreement is entered into.

This program agreement is the contract between the PACE organization, the State, and the Federal government, and is the mechanism for the State to receive matching funds for PACE services.

Amending the State Plan

States that have already elected to provide PACE services through a previous State plan amendment should provide any additional information requested in the attached suggested preprint either prior to, concurrent with, or subsequent to the PACE organization submitting an application for permanent provider status. The requirement to complete the new preprinted materials also applies to States with PACE sites currently operating under demonstration authority. Further, each time a State enters into a program agreement with an additional PACE organization, the State plan must be amended to include information about the new PACE organization. As the preprint is only a suggested format in which to submit State plan amendments, it may need to be customized to reflect the status of PACE programs in each State. The State plan amendment must be approved before HCFA can enter into a PACE program agreement.

States wishing to provide PACE services through the State plan, without having providers ready to become operational, should use the suggested preprint forms transmitted in the March 23, 1998, State Medicaid Directors letter.

Submitting the PACE Provider Application

Provider organizations should be instructed to work with their State Administering Agency to complete the provider application. The State will send the completed application from the PACE organization directly to HCFA s Central Office and appropriate Regional Office. The provider application may be submitted either simultaneously with the State plan amendment to elect PACE, or subsequent to the State plan amendment.

As part of the provider application process, the State will certify that the information contained in the application is accurate, that the State is willing to enter into a program agreement with the organization, and that the State will provide to the appropriate HCFA Regional Office any documentation used in determining Medicaid PACE reimbursement rates. Enclosure 8 provides the addresses for State use in submitting the provider application.

The suggested format for both the State plan preprint and the provider application may be downloaded from the PACE homepage on the Internet at www.hcfa.gov/medicaid/pace/pacehmpg.htm.

The State plan amendment and the provider application should be submitted to the Associate Regional Administrator in the appropriate HCFA Regional Office's Division of Medicaid and State Operations.

If you have any questions about electing the PACE State option, please contact Melissa Harris of my staff at (410) 786-3397.

Sincerely,

/s/

Timothy M. Westmoreland
Director

Enclosures

cc:
All HCFA Regional Administrators

All HCFA Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Administration

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors' Association

Enclosure 1

PACE Program Summary

Program History

The Program of All-Inclusive Care for the Elderly (PACE) is a new benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The program is modeled on the system of acute and long term care services developed by On Lok Senior Health Services in San Francisco, California. The model was tested through Health Care Financing Administration (HCFA) demonstration projects that began in the mid-1980s. The PACE model was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized. Through PACE, organizations are able to deliver all services covered by PACE which participants need rather than only those services reimbursable under the Medicare and Medicaid fee-for-service systems.

The scope of current PACE demonstration sites is small. There are currently 26 PACE demonstration sites. Each site serves an average of 200 enrollees, whose average age is 82. Currently, an additional 36 sites nationwide are considering the feasibility of PACE.

PACE Provisions of the BBA

The BBA establishes PACE within the Medicare program and enables States to provide PACE services to Medicaid beneficiaries as a State option. In order to provide this new Medicaid benefit, States must elect to cover PACE services as a State plan option and also enter into a program agreement with the PACE provider and the Secretary of the Department of Health and Human Services (DHHS). PACE providers must operate under both the Medicare and Medicaid programs. The program agreement is the contract between the PACE provider, the State, and the Federal government, and is the mechanism for receiving Federal matching funds for PACE services.

The BBA also limits annual growth of the PACE program. It limits the number of PACE program agreements in the first year after enactment to no more than 40; the limit increases by 20 each year thereafter. The statute further provides for priority processing and special consideration of applications for existing PACE demonstration sites and to those entities that applied to operate a PACE demonstration project on or before May 1, 1997.

Eligibility - Participants must be at least 55 years old, live in the PACE service area, and be certified as eligible for nursing home care by the appropriate State agency. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees.

Services - An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing facility services) which are integrated for a seamless provision of total care. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE service package must include all Medicare and Medicaid covered

services, and other services determined necessary by the multidisciplinary team to improve and maintain the care of the PACE participant.

Payment - PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible Medicare and Medicaid enrollee. Medicare eligible participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

Transition for PACE Demonstration Sites

Currently operating PACE sites have the ability to seek conversion from their current demonstration authority to permanent provider status for up to 2 years (3 years for those sites operating as a demonstration as of the date the law was enacted, at State discretion) after the date of promulgation of the PACE regulations. Therefore, States that currently have PACE demonstration sites do not need to submit a State plan amendment electing the PACE State option to continue to provide services through the demonstration. However, to continue the PACE program at any time the demonstration ceases, a State must elect to provide PACE as a Medicaid State plan option in its State plan, and the PACE demonstration site must submit an application to enter into a program agreement with the State and the Secretary of DHHS as a PACE provider.

The following PACE sites are currently operating under the demonstration authority:

California

On Lok Senior Health Services
Kate O'Malley, Director
1333 Bush Street
San Francisco, CA 94109-5611
(415) 292-8883

Sutter Senior Care
Janet Tedesco, Administrator
1234 U. Street
Sacramento, CA 95818
(916) 446-3100

Center for Elders' Independence
Peter Szutu, Executive Director
1411 East 31st Street, Ward B2
Oakland, CA 94602
(510) 433-1150

AltaMed Health Services
Maria Torres, Senior Vice President
500 Citadel Drive, Suite 400
Los Angeles, CA 90040
(213) 889-7328

Colorado

Total Long Term Care
David Reyes, Executive Director
3202 West Colfax
Denver, CO 80204
(303) 869-4664

Maryland

Hopkins Elder Plus
Johns Hopkins Bayview Medical Center
Karen Armacost, RNC
5505 Hopkins Bayview Circle
Baltimore, MD 21224-2780
(410) 550-0756

Massachusetts
Elder Service Plan
Ann Marie Giovino, Project Director
10 Grove Street
East Boston, MA 02128
(617) 539-5036

Harbor Health Services, Elder Service Plan
Sheila R. Morrison, Vice President
2216 Dorchester Avenue
Dorchester, MA 02124
(617) 296-5100

Elder Service Plan of Mutual Health Care
Charlotte C. Burrage, Admin. Coordinator
1140 Dorchester Avenue
Dorchester, MA 02123
(617) 288-0970

Fallon Community Health Plan
Linda Fitzpatrick
10 Chestnut Street
Worchester, MA 01608
(508) 799-2100

Cambridge Hospital Professional Services
J. Glover Taylor
1531 Cambridge Street
Cambridge, MA 02139
(617) 868-6323

Michigan

Center for Senior Independence
Laura Seriguchi, Executive Director
Henry Ford Hospital
1 Ford Place, 5E
Detroit, MI 48202-3450
(313) 874-7205

Missouri
Alexian Brothers Community Services
Victoria Steward-Alexander, CEO
3900 South Grand Boulevard
St. Louis, MO 63118
(314) 771-5800

New York
Comprehensive Care Management
Susan Aldrich, Senior Vice President
612 Allerton Avenue
Bronx, NY 10467
(718) 519-5925

Independent Living for Seniors
Kathy McGuire, Administrator
2066 Hudson Avenue
Rochester, NY 14617
(716) 226-9040

Loretto Independent Living Services
Donna M. Hanzel, Executive Director
212 N. Main Street, #15
N. Syracuse, NY 13212
(315) 452-5800

Eddy Senior Care
Gary Kozick, Vice President, Director
504 State Street
Schenectady, NY 12305
(518) 382-3290

Ohio

Concordia Care
Susan Griffin
23763 Euclid Heights Boulevard
Cleveland Heights, OH 44106-2797
(216) 791-3580

Tri Health Senior Link
Brian Tilow
619 Oak Street
Cincinnati, OH 45206
(513) 569-6686

Oregon

Providence Elder Place
Don Keister, Executive Director
4540 N.E. Glisan Street
Portland, OR 97213
(503) 215-3612

South Carolina

Palmetto Senior Care
Judy Baskins, Vice President
Two Richland Medical Park, #405
Columbia, SC 29203
(803) 434-3770

Tennessee

Alexian Brothers Health Systems, Inc.
Viston Taylor
425 Cumberland Street, Suite 100
Chattanooga, TN 37404
(423) 698-0802

Texas

Bienvivir Senior Health Services
Rosemary Castillo, Executive Director
6000 Welch, Suite A2
El Paso, TX 77905-1753
(915) 599-8812

Washington

Providence Elder Place - Seattle
Michael Whitley, Director
P.O. Box 18737
5900 Martin Luther King Junior Way South
Seattle, WA 98118
(206) 320-5324

Wisconsin

Community Care for the Elderly
Kirby Shoaf, Executive Director
5228 W. Fond du Lac Avenue
Milwaukee, WI 53216
(414) 298-8600

Elder Care of Dane County
Karen Musser, Director
2802 International Lane
Madison, WI 53704
(608) 245-3061

Enclosure 2

General Instructions For Eligibility Portion of PACE State Plan Amendment

Eligibility and Post-Eligibility:

Eligibility

Individuals are eligible to be served by PACE if they are eligible under your State plan.

In addition, you have the option of making individuals eligible for PACE who would be eligible if they were residing in a medical institution and who would be eligible under rules specifically designed to apply to individuals living in such institutions. You can elect to determine eligibility for PACE enrollees under any such terms only if your plan already covers institutional groups (e.g., the special income level group described at section 1902(a)(10)(A)(ii)(V) and 42 CFR 435.236) and provided you use the same limits on income and assets.

If you already cover individuals for HCBS waivers who would be eligible if they were in an institution (section 1902(a)(10)(A)(ii)(VI) and 42 CFR 435.217), and if you wish to cover PACE enrollees in the same manner, then you should amend your State plan in Section 2.2A to designate the HCBS group as including PACE enrollees. Alternatively, if you choose to apply institutional eligibility rules only to PACE enrollees, you should amend your State plan in Section 2.2A to cover this group and indicate that this group only applies to PACE enrollees.

Eligibility and Spousal Impoverishment Rules

Spousal impoverishment rules (section 1924 of the Act) were originally designed for use in determining eligibility for medical assistance of institutionalized persons who have a spouse living in the community. If you choose to cover PACE enrollees under institutional eligibility rules, then you have the option to also use the spousal impoverishment rules to determine eligibility of individuals with a spouse. Spousal impoverishment rules do not apply in determining eligibility for those eligible for PACE services under community groups or rules.

Post-Eligibility

Post-eligibility rules determine the amount (if any) that an individual is liable to pay for the cost of PACE services. The amount of the liability is calculated based on the individual's income minus certain amounts as described below. The calculation is made after the individual's eligibility has been established. The individual's liability, in turn, determines Medicaid's share of the cost of PACE services furnished to that individual.

If you cover HCBS recipients who would be eligible if in an institution, then you may (but are not required to) apply the same post-eligibility rules to PACE enrollees who are eligible using institutional rules. (Described below.) If you do not make HCBS recipients eligible using institutional rules and therefore do not use post-eligibility rules for HCBS recipients, you are not permitted to apply post-eligibility rules nor to impose post-eligibility share-of-cost expectations on PACE recipients.

If you cover such HCBS recipients using institutional rules, and choose to apply HCBS post-eligibility rules to PACE, then the post-eligibility rules for PACE are as follows:

- If an individual's eligibility is not determined under the spousal impoverishment rules, then you must use the regular post-eligibility rules at 435.726 and 435.735 (discussed below).

- For persons who are determined eligible for Medicaid using the spousal impoverishment rules, you have two options concerning post-eligibility rules:

  Option 1: You may use the regular post-eligibility rules under 42 CFR 435.726 and 435.735.

  Option 2: You may use the spousal post-eligibility rules under section 1924 (discussed below), or see instructions in section 3710 of the State Medicaid Manual for more detailed information.

Please note that the option you choose will be determined by how you apply post-eligibility treatment of income rules to individuals whose eligibility is determined under spousal impoverishment rules under your approved HCBS waiver(s). Application of post-eligibility treatment of income rules for PACE enrollees (whether regular post-eligibility or spousal post-eligibility) must be the same as application of those rules under your approved waiver(s).

Similarities and Differences:

Following is a general discussion of the regular and spousal post-eligibility rules. See the State Medicaid Manual instruction sited above and the regulation cited below for specific rules applying to each.

Both sets of post-eligibility rules require you to deduct the same kinds of things from the individuals income in calculating the individuals share of liability for the cost of care. However, there are differences in the amounts of those deductions, and how those deductions are applied.

o Deduct an amount protected for the maintenance needs of the individual.

  - The rules at 42 CFR 435.726 and 435.735 require the State to base this amount on a reasonable assessment of the individuals needs in the community.

  - Section 1924 requires the State to establish a personal needs allowance (PNA) that is, at a minimum, the same as the PNA for persons in institutions, an amount which is at least $30 per month for clothing and incidentals. In addition, for persons in the community, you must protect an additional amount to cover food and shelter expenses.

- o Deduct an additional amount for the maintenance needs of a spouse.
  - The rules at 42 CFR 435.726 and 435.735 allow States to choose the amount based on a reasonable assessment of need, but limit that amount to the highest income standard for cash assistance, or the medically needy standard. If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
  - Section 1924 imposes Federal mandated minimum amounts for the spouse, that depending on individual circumstances, may be higher.
- o Deduct additional amount(s) for other family members living with the individual
  - The rules at 42 CFR 435.726 and 735 allow States to choose the amount based on a reasonable assessment of need, but limit that amount to the highest income standard for cash assistance, or the medically needy standard. The family members must be living in the home. Federal rules do not define family member.
  - Section 1924 requires States to protect up to 1/3 the amount protected for a community spouse, the specific amount, if any, depending on the family members income. Family members include minor or dependent children, dependent parents, or dependent siblings living in the home.
- o Deduct expenses incurred for medical care that are not payable by a third party.
  - This deduction applies under both the regular and spousal post-eligibility rules.

Enclosure 8

The following are the addresses for HCFA Central and Regional Offices. Please submit your application to both the Center for Medicaid and State Operations and the Center for Health Plans and Providers within Central Office, as well as to the appropriate Regional Office simultaneously.

Central Office:

Health Care Financing Administration
Center for Medicaid and State Operations
Mail Stop S2-14-25
7500 Security Boulevard
Baltimore, MD 21244

Health Care Financing Administration
Center for Health Plans and Providers
Mail Stop C4-23-07
7500 Security Boulevard
Baltimore, MD 21244

Regional Offices:

HCFA Region I
JFK Federal Building, Room 2325
Boston, Massachusetts 02203-0003

HCFA Region II
26 Federal Plaza, Room 3811
New York, NY 10278-0063

HCFA Region III
Suite 216, The Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106

HCFA Region IV
Atlanta Federal Center, 4th Floor
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

HCFA Region V
105 W. Adams Street
Chicago, Illinois 60603-6201

HCFA Region VI
1301 Young Street, Room 714
Dallas, Texas 75202

HCFA Region VII
Richard Bolling Federal Building
601 East 12th Street, Room 235
Kansas City, Missouri 64106-2808

HCFA Region VIII
Colorado State Bank Building
1600 Broadway, Suite 700
Denver, Colorado 80202-4367

HCFA Region IX
75 Hawthorne Street, 4th and 5th Floors
San Francisco, CA 94105-3901

HCFA Region X
2201 Sixth Avenue, MS/RX 40
Seattle, WA 98121