LEGISLATIVE REPORT

S.L. 2014-100, Section 12H.34. (b)

State of North Carolina
Department of Health and Human Services
Division of Medical Assistance

January 1, 2015

FINAL REPORT

INTRODUCTION

Per Session Law 2014-100, Section 12H.34, the General Assembly requires two reports on the Program of All-Inclusive Care for the Elderly (PACE). This is the second of the two reports that the Department of Health and Human Services, Division of Medical Assistance (DMA), will provide to the Joint Legislative Oversight Committee on Health and Human Services.

> **SECTION 12H.34.(a)** *By October 1, 2014, the Department of Health and Human Services, Division of Medical Assistance, shall report to the Joint Legislative Oversight Committee on Health and Human Services with the following information on the Program of All-Inclusive Care for the Elderly (PACE):*
>
> *(1) The number of individuals being served in each of the PACE service areas.*
> *(2) A description of the program enrollment criteria and enrollment process.*
> *(3) Detailed figures showing how funding for the program has been spent during the past two fiscal years.*
> *(4) The per member per month cost of serving individuals through the PACE program compared to the cost of serving individuals in a nursing home.*
> *(5) An estimate of how many PACE participants would enter a nursing home if they were not enrolled with the PACE program.*

> **SECTION 12H.34.(b)** By January 1, 2015, *the Department of Health and Human Services, Division of Medical Assistance, shall submit an additional report to the Joint Legislative Oversight Committee on Health and Human Services with the following information on the Program of All-Inclusive Care for the Elderly (PACE):*
>
> *(1) An update on all of the information required by subsection (a) of this section.*
> *(2) A comparison of North Carolina's PACE program to PACE programs in other states.*
> *(3) Recommendations for how to make the program sustainable*.

PROGRAM BACKGROUND

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated managed care program for frail and elderly beneficiaries enrolled in Medicaid or in both Medicaid and Medicare. As a capitated payment program, PACE funds a comprehensive service delivery system that integrates both Medicare and Medicaid financing for beneficiaries enrolled in both programs. Monthly capitation fees from the two sources are combined by a PACE organization into a common pool from which all health care expenses are paid. PACE organizations assume full financial risk for the costs of all medical care for their clients, including: nursing home (NH), long-term care services, inpatient hospital, outpatient hospital, physician services, laboratory and radiology services, pharmacy, transportation, durable medical equipment (DME), and hospice services.[1] Because PACE organizations assume full risk for patient care at a fixed monthly cost, the cost to the State per beneficiary does not change during the year in response to changes in participants' health status or service settings (e.g., communities, nursing homes, or hospitals) as long as the beneficiary remains enrolled in the PACE program.

[1] See Exhibit B for the complete list of beneficiary services.

CURRENT ENROLLMENT

As of December 2014, 1,178 Medicaid beneficiaries were enrolled in PACE organizations throughout North Carolina. The table below shows current PACE enrollment by organization and operational dates of each organization. There are ten operational PACE organizations serving eleven sites.[2] Staywell PACE Organization in Asheboro is the newest, having opened on December 1, 2014. CarePartners in Asheville has completed its State readiness review and will begin operating in March 2015.

PACE Enrollment by Organization: December 2014

PACE Organization	Operational Date	Current Enrollment
LIFE Saint Joseph of the Pines (Fayetteville)	April 2011	223
Pace@Home (Hickory)	January 2012	92
Carolina SeniorCare (Lexington)	October 2012	139
Senior Community Care of North Carolina, Inc.	September 2013	89
Piedmont Health Senior Care (Burlington and Pittsboro)	November 2008	184
Elderhaus (Wilmington)	February 2008	122
PACE of Triad (Greensboro)	July 2011	155
Senior Total Life Care (Gastonia)	January 2014	82
PACE of Southern Piedmont (Charlotte)	July 2013	90
Staywell SeniorCare (Asheboro)	Dec 2014	2
Asheville CarePartners (Asheville)[3]	March 2015	N/A
TOTAL		1178

ENROLLMENT PROCESS

Interested Medicaid beneficiaries or their authorized representatives initiate contact with their local PACE organization and are screened for eligibility. An individual must be financially eligible to receive Medicaid long-term care services and must meet a PACE organization's eligibility criteria imposed under its respective PACE Program Agreement. An eligible beneficiary must meet the minimum criteria set forth in 42 C.F.R. 460.150:

- Be 55 years of age or older;
- Be determined eligible to need the level of care required under the Medicaid State Plan for coverage of nursing facility services;
- Reside in the PACE organization's service area;
- Be able to live in a community setting at the time of enrollment without jeopardizing his or her safety; and
- Meet any additional criteria set forth in the program agreement.

[2] Piedmont Health Senior Care operates in two locations: Burlington and Pittsboro.
[3] Pending CMS final Approval as a PACE Organization

Once deemed minimally eligible, the beneficiary undergoes a comprehensive health assessment by eight of the eleven PACE Interdisciplinary Team (IDT) team members using a discipline-specific, standardized health risk assessment form developed or adopted by the PACE organization. At the conclusion of the assessment, the IDT makes a recommendation for PACE eligibility and submits the Division of Medical Assistance (DMA) Long Term Care (FL-2) form to Computer Sciences Corporation (CSC), DMA's utilization review contractor, for approval and determination of the level of care needed.

The FL-2 form documents the current and recommended levels of care needed based on an individual's medical status and functional ability in activities of daily living (ADLs). It is reviewed by DMA staff for confirmation that eligibility criteria are met. Once DMA confirms eligibility, the PACE organization offers the beneficiary or authorized representative an enrollment agreement. The enrollment agreement contains:

- a participant's demographic data and health insurance status;
- a description of benefits;
- the effective date;
- an explanation of the premiums;
- an emergency care protocol; and
- the participant's rights and responsibilities, including conditions for enrollment and disenrollment.

Once the enrollment agreement is signed by both parties, the PACE organization notifies the local Department of Social Services of the beneficiary's PACE enrollment.

Enrollment in the PACE program is voluntary. PACE enrollees must defer their Medicare Part A, B, and D benefits (if applicable) and the PACE organization becomes their sole health care insurer. A participant's enrollment in PACE is effective on the first day of the calendar month following the date the PACE organization receives a signed enrollment agreement. Enrollment in the PACE program continues until the participant's death unless the participant voluntarily disenrolls or the PACE organization involuntarily disenrolls him or her. Participants may voluntarily disenroll without cause at any time. PACE organizations may involuntarily disenroll participants for reasons allowed under 42 C.F.R. 460.164, including but not limited to disruptive or threatening behavior or no longer needing nursing facility level of care. DMA reviews all disenrollments and determines whether a PACE organization has sufficiently documented the basis for disenrollment.

PACE PROGRAM COSTS AND FUNDING

The table below summarizes total PACE-related expenditures from SFY 2012 to SFY 2015. It also displays the Federal Medical Assistance Percentage (FMAP) or federal matching rate for each fiscal year and State and federal expenditures associated with them.

PACE Medicaid Expenditures ($Millions) by State Fiscal Year (SFY)

	SFY 2012	SFY 2013	SFY 2014	SFY 2015*
State Dollars	$3.61	$5.95	$11.49	$17.53
Federal Dollars	$6.74	$11.28	$22.02	$33.85
FMAP Rate	65.14%	65.45%	65.71%	65.88%
Total Expenditures	**$10.35**	**$17.23**	**$33.50**	**$51.38**

Note: Due to differences between North Carolina State and Federal Fiscal years, the FMAP rates are a weighted average across the months.
**Projected for SFY 2015 based on an average enrollment growth of 9 participants per quarter.*

Total program expenditures in SFY 2014 were $33.5 million and are projected to be $51.4 million in SFY 2015. DMA pays PACE organizations an all-inclusive (capitated) per member per month (PMPM) rate for two distinct groups: 1) Medicaid only beneficiaries; and 2) individuals who are dually eligible for Medicare and Medicaid. DMA contracts with Mercer Government Human Services (Mercer) to develop the capitated payment rates for both groups. The current PMPM rate for a Medicaid only beneficiary is $3,562 and for a dually-eligible beneficiary is $3,310.

DMA began developing a new dashboard reporting process for PACE organizations in November 2014 in collaboration with the North Carolina PACE organizations. DMA will continue to fine-tune the data collection instrument that will allow DMA to track and monitor PACE enrollment activities, expenses, revenue and quality indicators on a monthly basis. Local PACE organizations will self-report the data monthly via e-PACE, a web application for care coordination of PACE eligibility, health and safety assessments, and dashboard reporting.

The table below provides an update of DMA's annual expenditures by PACE organization and the projected expenditures for SFY 2015.

Annual DMA Expenditures ($ Millions) by PACE Organization, by State Fiscal Year

PACE Organization	SFY 2012	SFY 2013	SFY 2014	*SFY 2015
LIFE Saint Joseph of the Pines (Fayetteville)	$2.10	$3.11	$2.08▲	$9.26
Pace@Home (Hickory)	$0.15	$1.57	$3.54	$4.43
Carolina SeniorCare (Lexington)	-	$0.81	$4.28	$5.72
Senior Community Care of North Carolina, Inc.	-	-	$2.01	$3.82
Piedmont Health Senior Care (Burlington and Pittsboro)	$4.03	$4.68	$6.73	$7.45
Elderhaus (Wilmington)	$3.00	$4.22	$5.80	$5.97
PACE of Triad (Greensboro)	$1.07	$2.84	$6.26	$6.57
Senior Total Life Care (Gastonia)	-	-	$0.99	$2.89
PACE of Southern Piedmont (Charlotte)	-	-	$1.79	$3.73
Staywell SeniorCare (Asheboro)	-	-	-	$1.01
Asheville CarePartners (Asheville)	-	-	-	$0.54[4]
TOTAL	$10.35	$17.23	$33.50	$51.38

▲ Life St. Joseph of the Pines had payment issues for the 4th quarter of SFY 2014. Payments in FY2014 reflect a shortfall based on payment issues.
* SFY 2015 is projected based on an average enrollment growth of 9 participants per quarter for each PACE organization.

NURSING HOME COSTS IN PACE RATE DEVELOPMENT

To initiate the PACE PMPM rate development process, Mercer develops separate rates based on projected claims expenditures for both institutional (nursing home) and home and community-based services (HCBS) among Medicaid beneficiaries. Providers bill for these services on a fee-for-service (FFS) basis. The claims costs for the two Medicaid service categories are blended using a weighted average relative to the number of beneficiaries using each service category. Mercer then produces a single blended rate for each group.[5]

SFY 2015 Per Member Per Month Calculations

Groups	Community (HCBS)	Institutional (NH)	Blended
Dually-eligible	$ 2,270.09	$ 3,916.52	$ 3,537.84
Medicaid only	$ 3,620.88	$ 5,542.65	$ 4,773.94

Claims costs are then combined with a projected administrative expense to develop the Upper Payment Limit (UPL) of costs. The UPL is an estimated statewide PMPM for equivalent level services in a nursing home and encompasses a comprehensive benefit package, including: nursing home (NH), long-term care services, inpatient hospital, outpatient hospital, physician services, laboratory and x-ray services, pharmacy, transportation, durable medical equipment

[4] Budget based on assumption that Asheville CarePartners begins operation in March 2015.

[5] The State supplied Mercer with historical Medicaid FFS data which Mercer compiled from its data warehouse for January 1, 2010 through December 31, 2012, by date of service. Claims and eligibility data were gathered for both the dually eligible and the Medicaid only populations. Claims and eligibility data for individuals under age 55 were excluded because they would not be eligible for PACE. Additional detail can be found in Exhibit D.

(DME), and hospice services. It represents the expected cost of providing services to individuals if they remain in the FFS environment. A complete list of benefits and services contained in the PACE UPL are included in Exhibit B.

Mercer calculates a projected administrative expense as a percent of total medical expenses. The projection reflects the State's average administrative costs over the three previous years.[6] For SFY 2015, Mercer recommended increasing the dually-eligible and Medicaid-only administrative expense projections by 6.0 percent.[7]

SFY2015 Upper Payment Limits (UPLs) per PACE Participant, per Month

Groups	PACE PMPM Rate	Blended Claim Costs	Administrative Expenses	UPL
Dually-eligible	$3,562.02	$ 3,537.84	$ 212.27	$ 3,750.11
Medicaid only	$3,310.86	$ 4,773.94	$ 286.44	$ 5,060.38

A patient in a nursing home with a similar diagnosis who is not enrolled in a PACE program would incur a monthly State cost of $3,750 as a dually-eligible beneficiary and $5,060 as a Medicaid-only beneficiary. DMA pays PACE organizations approximately 95 percent of the FFS UPL for dually-eligible enrollees and approximately 65 percent for Medicaid-only enrollees. Working with Mercer, DMA annually reviews PACE rates to determine whether rate adjustments are needed. In February 2015 Mercer will develop a UPL projection for SFY 2016.

Historically, 96 percent of enrollees have been dually-eligible and 4 percent have been Medicaid-only. This is consistent with other states and nationwide enrollee participation rates.

COMPARISON OF NORTH CAROLINA PACE AND OTHER STATES

The table below provides a state-to-state comparison of key PACE components. It summarizes all states within the US Department of Health and Human Services' Region IV that have PACE programs. There are 8 states in Region IV – Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee. Data from Virginia was included given its close proximity.[8]

[6] Mercer based the projected administrative expense on CY 2010 through CY 2013 CMS 64 expenditure reports.
[7] Exhibit D - Mercer CY13 NC PACE UPLs Certification Letter, 1/6/2014.
[8] DMA surveyed representatives of states in Region IV in addition to representatives from the National PACE Association (http://www.npaonline.org).

STATE COMPARISONS

States	Benefit Covered	Statewide Enrollment (as of 1/1/14)	Total Number of PACE Organizations	Rate Setting Methodology
Alabama	Yes	141	1	Formula - Based
Florida	Yes	838	5	Formula - Based
North Carolina*	Yes	1,100	11	Formula - Based
South Carolina	Yes	426	2	Formula - Based
Tennessee	Yes	286	1	Formula - Based
Virginia	Yes	1,111	7	Formula – Based

*NC enrollment totals as of 12/2014

Many states promote PACE as a federally acceptable community-based option to institutional services in relation to the US Supreme Court's *Olmstead* decision that states that individuals with intellectual disabilities have the right to live within the community if such placement is appropriate and preferred by the individual. States also have committed to grow PACE as an alternative, capitated, integrated-care option in Medicaid.

Most officials in other Region IV states support the expansion of PACE organizations. A few state officials (Virginia and Florida) have indicated that they are evaluating steps to better manage the rapid growth. Virginia leaders developed a request for applications process (RFA) to manage the budget growth and limit the expansion of PACE organizations. The state will determine the geography and the number of new programs that will be added prior to issuing the RFA.

Generally, states have adopted one of the following two methodologies to the rate setting process:

1. a *formula-based model* in which a population comparable to PACE is identified and its total costs to Medicaid are calculated (North Carolina); or

2. a *cost-based model* where PACE organizations present a proposal based on the estimated costs of delivering PACE services.

States then negotiate the rate with the PACE organizations. The negotiated rate is subject to review by the state for reasonableness and adherence the upper payment limit. In its review, DMA found that North Carolina's formula-based model is consistent with all of the other states in the region.

EVALUATION

A number of multi-disciplinary studies have attempted to determine the return-on-investment (ROI) of PACE and review the impact of PACE organizations on Medicaid beneficiaries' utilization of medical services and nursing home diversion. The most recent review, released by

the US Department of Health and Human Services, reviewed PACE program evaluations done by states – including South Carolina, Texas, and California – on their own programs to evaluate quality and cost-effectiveness of PACE programs, nursing home admissions, and mortality. From the literature review, a number of key findings about the methodological approaches of prior PACE evaluations, as well as on the impact of PACE in reducing nursing home use, hospitalizations, and ability to control spending, materialized. Two conclusions stand out:

1. There are significant challenges in evaluating the impact of PACE, given the characteristics of the program and its beneficiaries. Information about the acuity of beneficiaries at the time of enrollment varies beyond nursing home eligibility, and their risk of institutionalization is variable.

2. Findings from studies included in this review are unlikely to be useful in assessing possible PACE expansion efforts or new care coordination and integration models being proposed for dually eligible beneficiaries.[9]

The report also concluded that PACE programs do not generate cost savings in Medicare and Medicaid nor provide better outcomes. Since the initial publication of the report, the National PACE Association (NPA) has argued that data used to draw this conclusion was flawed. Mathematica has noted that the data within these charts is under review and the validity of the data has been questioned. Mathematica is in the process of correcting the data, which may impact their conclusions.

CONCLUSION

Answering the question "What would have happened to PACE enrollees in the absence of the intervention (PACE)?" is difficult. The challenge in evaluating PACE is due to the structure of the PACE program and from the characteristics of beneficiaries it serves, who self-select into the program. PACE is a Medicare and Medicaid program. Individuals who are nursing home level-of-care certifiable cannot be denied entry into a PACE program. Randomized evaluation of PACE, where eligible beneficiaries are randomly assigned to a PACE plan or to a non-PACE alternative, is impossible. Defining the right care alternatives for PACE enrollees were PACE not an option is also problematic. It is difficult to identify a comparison group of beneficiaries who are similar to PACE enrollees in their pre-enrollment characteristics, not enrolled in PACE, and reside in a health service environment comparable to that for PACE.

Because of these challenges, quantifying the cost-benefit and evaluating PACE organizations in North Carolina's Medicaid program is a difficult task. National studies and other state driven reviews demonstrate conflicting results about the value of PACE. The problems with data in the aforementioned Mathematica study illustrates the difficulty in comparing PACE to FFS programs such as nursing homes and other community-based Medicaid programs.

[9] http://www.mathematica-mpr.com/our-publications-and-findings/publications/evaluating-pace-a-review-of-the-literature

Few states have evaluated their PACE programs well and the results from the states that have studied PACE's impact cannot be applied to North Carolina. North Carolina's nursing homes generally have a higher acuity than other states based on CMS state comparisons. PACE organizations in North Carolina also do not have the scale or history to make the data statistically useful.

Coordinated care in the community provides PACE beneficiaries with an enhanced opportunity to receive social and emotional support, entertainment, and the opportunity to interact with other participants and with PACE staff. Early evaluations of the program consistently suggest that PACE enrollees and their caregivers benefit significantly from having coordinated health care and social services, patient satisfaction, and quality of life compared to non-PACE populations. These impacts, while important, are not easily quantifiable. Health outcomes related to decreasing or delaying nursing home admissions, quality of care, hospital and ambulatory usage, and mortality continue to be the subject of on-going studies.

RECOMMENDATIONS

Despite the difficulties in evaluating PACE, the State has identified the following opportunities for improvement in the Department's administration of the PACE program. These recommendations do not require legislative action for their implementation.

RECOMMENDATION 1: Establish annual enrollment limits to provide budget predictability to the State and local PACE organizations.

The lack of predictable enrollment growth for new participants created a high degree of budget unpredictability for the State. The program's total expenditures have increased by 20 percent since SFY 2012. Effective May 2014, DMA gave PACE organizations SFY 2015 enrollment limits to each PACE organizations based on budget availability. DMA is working with PACE organizations to develop a long-term budget and enrollment process that provides budget predictability and limits enrollment growth.

RECOMMENDATION 2: Complete a strategic plan and a RFA process to target future growth towards underserved areas of the state. Future expansion of PACE will be determined by budget availability, and DHHS will not consider applications for growth or expansion of new or existing PACE organizations through SFY 2016-17.

Development of a new PACE organization takes 18-36 months from the initiation of a feasibility study conducted by community leaders interested in bringing PACE to their area. Most states manage the growth of PACE organizations by a request for application (RFA) process where interested stakeholders respond. The state determines the geographic location and number of programs to be added prior to issuing the RFA.

A strategic plan should include a proposed geographic configuration to enable access for all Medicaid beneficiaries eligible for the program. DHHS will also evaluate the impact of current provisions that allow PACE programs to have additional enrollees beyond budgeted growth when they are enrolling in PACE upon nursing home discharge.

RECOMMENDATION 3: Require the completion of initial FL-2 by the Primary Care Practitioner of the beneficiary seeking enrollment to the PACE Organization.

Upon receipt of the FL-2, the PACE organization will complete the DMA Service Request Form (SRF) which provides more information than the FL-2 and also helps certify that PACE enrollees are skilled nursing facility eligible. The SRF is currently used to determine eligibility for CAP/DA, a community-based DMA Waiver program for disabled adults, which also requires that enrollees qualify for a nursing facility level of care. DMA has worked with the contractor VieBridge to train PACE organizations on use of the tool.

RECOMMENDATION 4: Require future programs to more thoroughly attest to and document their financial viability prior to approval of expansion plans or submission of an application to develop a new PACE organization.

Concerns exist about the ability of PACE organizations to manage the financial risk associated with capitation. PACE providers can become more financially sustainable by aligning with larger providers as equity partners. With the exception of Elderhaus, all NC PACE organizations are either wholly owned by a larger provider or owned by a combination of larger providers in an equity partnership.

Federal regulation requires PACE organizations to have reserves to cover the sum of one month's total capitation revenue to cover expenses the month before insolvency and one month's average payment to all contractors, based on the prior quarter's average payment, to cover expenses the month after the date it declares insolvency or ceases operations. The state will evaluate if additional requirements are needed.

RECOMMENDATION 5: Execute with PACE organizations a new two-way agreement focusing on quality improvement outside of what is currently required in the existing three-way agreement between DMA, CMS, and the State.

Currently NC utilizes the federally mandated three-way agreement to administer the PACE program between the PACE organization, CMS and the State Administering Agency. It establishes the roles of each entity with respect to monitoring and auditing, and ensures that every PACE organization maintains compliance with State and Federal requirements. Federal regulations permit states to require that PACE organizations provide the State Administering Agency 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 Medicaid amounts payable.

To improve the overall reporting and tracking of PACE organizations in North Carolina, DMA worked with PACE organizations to develop a monthly reporting electronic template. The monthly reporting dashboard was introduced in November 2014.

Mercer also developed a new yearly financial reporting data tool. The yearly financial reporting tool will mimic information currently being provided by the LMEs/MCOs. The combination of the new reporting tool and the monthly dashboard will allow the State to better monitor the financial health of the PACE organizations to ensure financial viability.

RECOMMENDATION 6: Review and adjust current PACE per member per month (PMPM) rates.

Under a PACE Program Agreement, the State Administering Agency makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid participant.

The monthly capitation payment amount is negotiated between the PACE organization and the State Administering Agency, and specified in the PACE Program Agreement. The amount represents the following:

- Is less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program (as measured under the UPL estimate process);
- Takes into account the comparative frailty of PACE participants;
- Is a fixed amount regardless of changes in the participant's health status;
- Can be renegotiated on an annual basis.

The State can adjust Medicaid capitation rates to ensure that savings are generated from Fee-for-Service (FFS) costs.

Exhibit A – PACE Organizations by Service Area

The table below shows the service area of each program by county. 42 U.S. Code § 1395eee (e) (2) (B) gives federal authorities the discretion, with State agency consultation, to prohibit overlap of PACE organization service areas to avoid duplication of services and preserve the area's capacity to serve eligible individuals.

PACE Organization Service Areas by County: December 2014

Organization Name	Service Area
1. LIFE St. Joseph of the Pines	Cumberland and Hoke Counties and portions of Harnett, Moore and Robeson Counties
2. PACE @ Home	Catawba County and portions of Lincoln, Caldwell and Alexander Counties (Newton)
3. Carolina SeniorCare	Rowan, Davidson, Davie and Iredell Counties (Lexington)
4. Senior Community Care, Inc.	Durham and Wake Counties and a portion of Granville County
5. Piedmont Health SeniorCare	Alamance, Caswell, Orange, Chatham and portion of Lee Counties (Burlington and Pittsboro)
6. Elderhaus	New Hanover County and portions of Brunswick County (Wilmington)
7. PACE of the Triad	Guilford and Rockingham Counties (Greensboro)
8. Senior Total Life Care	Gaston County and portions of Cleveland and Lincoln Counties (Gastonia)
9. PACE of the Southern Piedmont	Mecklenburg and portion of Cabarrus, Union and Stanley Counties (Charlotte)
10. Staywell SeniorCare	Randolph County and portions of Guilford, Chatham, and Davidson Counties (Asheboro)
11. Asheville CarePartners[i]	Buncombe County and portions of Henderson, McDowell, Haywood Counties (Asheville)

Exhibit B - PACE Service Package

PACE Center

PACE provides a local center which houses a primary care clinic, an adult day health program, areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining that serve as the focal point for coordination and provision of most PACE services.

In-Home Care

PACE includes coverage for additional services to the individual in the home, such as In-Home Personal Care Services and home health care.

Acute, Emergency Care and Long-Term Care Services

The PACE organization arranges, manages, and pays for all care referred to community providers, including hospital services, nursing facility care, emergency room services, physician visits, and ancillary services.

Federal regulations require all PACE organizations to provide a comprehensive array of services that include7 the following:

- All Medicaid-covered services, as specified in the Medicaid State Plan;
- Multidisciplinary assessment and treatment planning;
- Primary care, including physician and nursing services;
- Social work services;
- Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services;
- Personal care and supportive services;
- Nutrition counseling;
- Recreational therapy;
- Transportation;
- Meals;
- Laboratory tests, x-rays, and other diagnostic procedures;
- Drugs and biologicals;
- Prosthetics, orthotics, durable medical equipment, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items;

- Medical specialty services including, but not limited to the following:
  - Digestive Health
    - Gastroenterology
  - Ear, Nose, Throat and Hearing Health
    - Otorhinolaryngology
    - Audiology
  - Eye Health
    - Ophthalmology
  - Foot Health
    - Podiatry
  - Female Health
    - Gynecology
  - Internal Medicine
    - Cardiology
    - Nephrology
    - Oncology
    - Pulmonary Disease
    - Rheumatology
  - Mental Health
    - Psychiatry
  - Oral Health
    - Dentistry
    - Oral Surgery
  - Pharmacy
    - Pharmacy Consulting Services
  - Preventive Health
    - Radiology
  - Skin Health
    - Dermatology
  - Surgery Services
    - Anesthesiology
    - General Surgery
    - Orthopedic Surgery
    - Plastic Surgery
    - Thoracic and Vascular Surgery
  - Urinary and Male Reproductive Health
    - Urology

- Acute inpatient care to include:
  - Ambulance
  - Emergency room care and treatment room services
  - Semi-private room and board
  - General medical and nursing services
  - Medical surgical, intensive care, and coronary care unit
  - Laboratory tests, x-rays, and other diagnostic procedures
  - Drugs and biologicals
  - Blood and blood derivatives
  - Surgical care and anesthesia
  - Oxygen
  - Physical, occupational, respiratory therapies, and speech language pathology services; and
  - Social services
- Nursing facility care to include:
  - Semi-private room and board
  - Physician and skilled nursing services
  - Custodial care
  - Personal care and assistance
  - Drugs and biologicals
  - Physical, occupational, recreational therapies, and speech language pathology, if necessary
  - Social services; and
  - Medical supplies and appliances

Other services determined necessary by the PACE organization Interdisciplinary Team to improve and maintain the participant's overall health status may also be provided.