# QIO - Program of All Inclusive Care for the Elderly (PACE)

## Purpose:

QIO Services will complete initial and continued stay level of care (LOC) reviews for PACE. QIO Services also performs tasks associated with CMS-mandated onsite reviews and quality oversight of the PACE centers, as directed by Policy.

## Identification of Roles:

Review assistant (RA) – provides program support.

Review coordinator (RC) – performs LOC review referring to Medicaid medical director (MMD) when appropriate, as well as providing education and quality oversight to PACE staff in collaboration with the Policy program manager to ensure program is complying with Code of Federal Regulations and Iowa Administrative Code rules.

Manager – oversees review processes, tracks performance standards, produces reports, and conducts internal quality control for review decisions.

MMD – provides LOC determinations and reviews for medical appropriateness of care.

## Performance Standards:

- Complete 95% of LOC determination for admissions within 2 business days of receipt of complete information; complete 100% within 5 business days.
- Complete 95% of continued stay reviews (CSRs) within 5 business days of receipt of complete information; complete 100% within 10 business days.
- Complete quality oversight audits at least annually as directed by DHHS Policy.

## Path of Business Procedure:

**Step 1:** Refer to MED-LTC LOC operational procedure for the LOC certification process. Admission and annual CSR LOC approval is required in order for the person to be eligible for the PACE program.

**Step 2:** Conduct announced and unannounced onsite audits of PACE staff and participants, as well as State readiness reviews, technical assistance, follow up on corrective action plan (CAP), investigate complaints, and complete onsite quality of care reviews and compliance as directed by DHHS Policy.

**Step 3:** RC monitors the PACE inbox (PACE@dhs.state.ia.us) at least daily for correspondence from the PACE organizations, forwarding emails to the PACE team as indicated and responding to the emails promptly.

**Step 4:** RC reviews exception to policy (ETP) requests for a PACE provider to complete the initial LOC review when the participant does not have a personal physician available. RC emails approval or denial to the PACE enrollment coordinator within 2 business days.

**Step 5:** RC monitors the CMS Health Plan Management System (HPMS) portal for any PACE marketing submissions that need approval. PACE marketing items submitted will be reviewed by the PACE and the Iowa Medicaid Communication teams, then approved or denied via the HPMS portal following the PACE marketing guidelines provided by CMS.

**Step 6:** RC assists in reviewing requests for disenrollment from the PACE program and provides Policy an overview of the findings. At the time of a participant's disenrollment, RC monitors the disenrollment form completed by the PACE organization (see Attachment 2) to determine if the disenrollment is voluntary or involuntary. If voluntary, RC assists Policy to validate this information. If involuntary, RC assists Policy to ensure the disenrollment is warranted, participant needs are met, and safety is maintained. If disenrollment is due to death of the participant, RC reviews for concerns and identifies if there is a need to complete a targeted review.

**Step 7:** RC is responsible to coordinate, collect agenda topics, scribe, and email meeting minutes for monthly and quarterly meetings with PACE organizations and Policy. Additional phone conferences are held as needed to ensure participant transfers to other PACE organizations or other placements are completed seamlessly and that the participant's rights are maintained.

## Forms/Reports:

Form 470-4490 PACE Program Level of Care Assessment

Form 470-5030 PACE Disenrollment

## RFP Reference:

1.3.1.5.A

## Interfaces:

IoWANS, OnBase, MQUIDS

## Attachments:

Attachment 1: PACE Addendum – Annual Level of Care Review or Admission Review with Expected Services

**PACE Addendum**
**Annual Level of Care Review or**
**Admission Review with Expected Services**

**Date:**
**Participant Name:** **SID:**

| **ADLS** | Frequency | Cues/Setup | Assist of 1 | Assist of 2 | Total Dependence | Family Provides |
|---|---|---|---|---|---|---|
| Bathing | | | | | | |
| Dressing | | | | | | |
| Grooming | | | | | | |
| Toileting | | | | | | |
| Mobility | | | | | | |

**Narrative:**

| **Other Services** | Yes | No | Frequency |
|---|---|---|---|
| Medication Set up | | | |
| Laundry | | | |
| Housekeeping | | | |
| Meals | | | |
| Shopping | | | |
| Transportation | | | |
| Attend PACE center | | | |

**Narrative:**

| **Therapies** | Frequency | Goals of therapy |
|---|---|---|
| PT | | |
| OT | | |
| ST | | |

**Narrative:**

| **Living situation** | Alone | Family | ALF | NF |
|---|---|---|---|---|

**Narrative:**

| **Other** | Yes | No |
|---|---|---|
| Family involved? | | |
| Recent or upcoming surgery? | | |
| History of skin breakdown? | | |
| Does participant drive? | | |
| Uses oxygen or nebulizer? | | |
| Colostomy or stoma present? | | |
| History of self-neglect? | | |
| Chronic diagnoses not controlled? | | |

**Narrative:**

**Signature and title or person preparing form:**

## Instructions for PACE Program Level of Care Addendum Reviews

This form was developed in order for the PACE staff to provide clarifying information determined to be most frequently requested by the physician reviewers when considering annual level of care reviews and possible presence of deemed eligibility criteria for ongoing PACE services.

**Participant Name:** The PACE participant's first name and last name.

**Social Security or State ID #:** The member's social security number or state identification number as applicable.

**Date:** The date the form is completed (MM/DD/YYYY).

**ADLs Section** -for each topic listed, indicate under **Frequency** the number of times per week the participant requires assistance with bathing, dressing, grooming, toileting and mobility. Next select by inserting an "X" in the column which applies to the type of assistance required, such as:
**Cues and setup:** help only to gather supplies within easy reach or reminders to the participant to completely perform the task, select appropriate, clean clothing, etc.,
**Assist of 1:** assistance of one person required to complete the task,
**Assist of 2:** assistance of 2 persons always required in order to complete the task,
**Total dependence:** fully relies upon others to do this task, or
**Family provides:** a family member provides this care
**Narrative optional:** can be utilized to further explain any ADL care needs required in bathing, dressing, grooming, toileting, and mobility.

**Other Services Section**- this section allows the provider to give additional information and "Yes" or "No" responses along with the frequency of the need for assistance regarding: medication set up, laundry, housekeeping, meals, shopping, transportation, and attendance at the PACE center. A narrative field is again provided for additional clarification if needed.

**Therapies** this section allows the provider to identify the type, frequency, and goals for physical, occupational and speech therapies if any are provided. A narrative field is again provided for additional clarification if needed.

**Living situation** this section allows the provider to identify where the participant resides such as: alone, with family, in assisted living facility (ALF), or nursing facility (NF). A narrative field is again provided for additional clarification if needed.

**Other:** this category has been added in order to assist the review coordinator to determine if there are potential factors which may allow the member to continue to qualify for PACE under the deemed eligibility rule. Simple yes or no responses must be given to each of the questions regarding: family involvement with participant's care, recent or upcoming surgery expected, history of skin breakdown, does the participant drive, do they use oxygen or a nebulizer, do they have a colostomy or other stoma, do they have a history of self-neglect, do they have a history of a chronic diagnosis which is not well controlled such as diabetes or congestive heart failure.

**Signature and title of the person preparing the form:** the person preparing the form should sign it and provide their title. It is not required this be the attending physician.

## Attachment 2: PACE Physician Request for Level of Care

**IME PACE PROGRAM**
**PACE PHYSICIAN REQUEST FOR LEVEL OF CARE**

| FROM INFORMATION | | | |
|---|---|---|---|
| Name | Phone Number | Date of Request | |
| PACE Organization | Email Address | | |
| Address | City | State | Zip Code |

| INFORMATION REGARDING APPLICANT | | |
|---|---|---|
| Name: | Social Security or State ID Number | Birth Date: |

**The PACE Physician Request**

*Include the following in your request:*

- *Name of the community physician, the practice name and the location.*
- *Identify:*
  - *The dates of community physician contact (A minimum of 2 contacts over a 5- working day period)*
  - *The means of contact (telephone, email or fax) and the documentation (tel. notes, email sent or fax)*
  - *To whom the contact was made*
- *The description of the basis for the PACE physician request*

**Effective Date for Request:**