

**CHAPTER 411  
DIVISION 45**

**PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)**

**411-045-0000 Purpose**

*(Adopted 1/1/2001)*

(1) The Program of All-inclusive Care for the Elderly (PACE) is a permanent provider type under Medicare that allows states the option to pay for PACE services under Medicaid. The PACE program is capitated by both Medicare and Medicaid to provide all medical and long-term care services.

(2) The intent of these rules is to implement the PACE Program as administered by the Department of Human Services and to address the responsibilities of the Department as the state administering agency under 42 CFR 460, which includes additional obligations of coordination with HCFA in the administration of the Medicare aspects of the PACE Program. The Department will regularly consult with HCFA in conducting related responsibilities and in the implementation of the PACE Program through the submission of appropriate state plan amendments and the PACE program agreement.

Stat. Authority: ORS 410.090

Stats. Implemented: ORS 410.070

**411-045-0010 Definitions**

*(Adopted 1/1/2001)*

(1) Administrative Hearing -- A hearing related to a denial, reduction, or termination of benefits that is held when requested by the PACE Participant or his/her Representative. A hearing may also be held when requested by a PACE Participant who believes a claim for services was not acted upon with reasonable promptness or believes the payor took an action erroneously.

(2) Advance Directive -- A form that allows a person to have another person make health care decisions when he/she cannot make the decision and tells a doctor that the person may not want certain life sustaining measure if he/she is near death.

(3) Alternate Care Settings-- Include, but are not limited to Residential Care Facilities, Assisted Living Facilities, Adult Foster Homes, and Nursing Care Facilities.

(4) Americans with Disabilities Act (ADA)-- Federal law promoting the civil rights of persons with disabilities. The ADA requires that reasonable accommodations be made in employment, service delivery, and facility accessibility.

(5) Ancillary Services --Those medical services which are Medically Appropriate to support a Covered Service under the PACE benefit package. A list of ancillary services and limitations is specified in OMAP's Ancillary Services Criteria Guide.

(6) Area Agency on Aging (AAA)-- An established public agency within a planning and service area designated under Section 305 of the Older American's Act that has responsibility for local administration of Division programs. AAAs contract with the Division to perform specific activities in relation to PACE programs including processing of applications for Medicaid and determining the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services.

(7) Assessment - The determination of a Participant's need for Covered Services. It involves the collection and evaluation of data by each of the members of the Interdisciplinary Team pertinent to the Participant's health history and current problem(s) obtained through interview, observation, and record review. The Assessment concludes with one of the following:(1)documentation of a diagnosis providing the clinical basis for a written Care Plan; or (2) a written statement that the Participant is not in need of Covered Services for a particular condition.

(8) Automated Information System (AIS) – A computer system that provides information on the current eligibility status for Participants under the Medical Assistance Program.

(9) Care Plan - An individualized, written plan that addresses all relevant aspects of a Participant's health and socialization needs that is developed by the Interdisciplinary Team with the Participant and/or Participant's Representative involvement. It is based on the findings of the Participant's Assessments and defines specific service and treatment goals and objectives; proposed interventions; and the measurable outcomes to be achieved. It is reviewed at least every four months or as indicated by a change in the Participant's condition.

(10) Clinical Record -- The Clinical Record includes, but is not limited to, the medical, social services, dental, and mental health records of a PACE Participant. These records include the Interdisciplinary Team's records, hospital records, and Complaint and Disenrollment records that may reside in the PACE Programs administrative offices.

(11) Comfort Care - The provision of medical services or items that give comfort and/or pain relief to a Participant who has a Terminal Illness. Comfort care includes the combination of medical and related services designed to make it possible for a Participant with Terminal Illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness. Comfort Care includes but is not limited to care provided through the PACE Program, pain medication, palliative services, and hospice care including those services directed toward ameliorating symptoms of pain or loss of bodily function or to prevent additional pain or disability. These guarantees are provided pursuant to 45 CFR, Chapter XIII, 1340.15. Where applicable Comfort Care is provided consistent with Section 4751 OBRA 1990 - Patient Self-Determination Act and ORS 127 relating to health care decisions as amended by the Sixty-Seventh Oregon Legislative Assembly, 1993. Comfort Care does not include diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness and intended to prolong life.

(12) Complaint -- A PACE Participant's or the Participant's Representative's clear expression of dissatisfaction with the PACE Program that addresses issues that are part of the PACE Programs contractual responsibility. The expression may be in whatever form of communication or language that is used by the Participant or the Participant's Representative but must state the reason for the dissatisfaction.

(13) Community Standard -- Typical expectations for access to the health care delivery system in the PACE Participants community of residence. Except where the Community Standard is less than sufficient to ensure quality of care, The Department requires that the health care delivery system available to PACE Participants take into consideration the Community Standard and be adequate to meet the needs of PACE Participants.

(14) Covered Services -- Those diagnoses, treatments, and services listed in OAR 410-141-0520. In addition, all services that would be covered by Medicare must be covered even if they fall below the currently funded line for the Oregon Health Plan. Covered services must also include those services listed in 42 CFR Sections 460.92 and 460.94.

(15) Dentally Appropriate -- Services that are required for prevention, diagnosis or treatment of a dental condition and that are:

(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of the PACE participant or a provider of the service;

(d) The most cost effective of the alternative levels of dental services that can be safely provided to an PACE Participant.

(16) Dental Emergency Services -- Dental services provided for severe pain, bleeding, unusual swelling of the face or gums, or an avulsed tooth.

(17) Department of Human Services (DHS) - The Department comprises seven divisions and two major program offices: Adult and Family Services Division; State Office for Services to Children and Families; Health Division; Mental Health and Developmental Disability Services Division; Senior and Disabled Services Division; Vocational Rehabilitation Division; and the Office of the Director, that includes the Office of Medical Assistance Programs and the Office of Alcohol and Drug Abuse Programs.

(18) Department -- For the purposes of this rule, Department will indicate those DHS Divisions and Offices that contract with the PACE Program: Senior and Disabled Services Division, Mental Health and Developmental Disability Services Division and the Office of Medical Assistance Programs.

(19) Disenrollment -- The act of discharging a PACE Participant from a PACE Program. After the effective date of Disenrollment a PACE Participant is no longer authorized to obtain Covered Services from the PACE Program.

(20) Division -- Senior and Disabled Services Division. The designated State Unit on Aging (SUA) required by the Older Americans Act.

(21) Emergency Services -- The health care and services provided for diagnosis and treatment of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

(22) Enrollment -- A process by which individuals are determined to be eligible for the PACE Program. A PACE Participant's Enrollment with a PACE Program indicates that the PACE Participant must obtain from, or be referred by, the PACE Program for all Covered Services.

(23) Health Care Financing Administration (HCFA) -- The federal agency under the Department of Health and Human Services that is responsible for approving the PACE Program and joining the state in signing an agreement with the PACE Program once it has been approved as a provider under 42 CFR Part 460.

(24) Health Management Unit (HMU) -The OMAP unit responsible for adjustments to Enrollments and retroactive Disenrollments.

(25) Interdisciplinary Team (IDT) – PACE staff and/or PACE subcontractors with current and appropriate licensure, certification, or accreditation who are responsible for assessment and development of the PACE Participant's

Care Plan. These professionals may conduct assessments of PACE Participants and provide services to PACE Participants within their scope of practice, state licensure or certification. These persons include at least one representative from each of the following groups:

(a) Medical Doctor, Osteopathic Physician, Nurse Practitioner, or Physician's Assistant; and

(b) Registered Nurse or a Licensed Practical Nurse supervised by an RN; and a Social Worker with a Masters degree or a Social Worker with a Bachelor degree who is supervised by a Masters level Social Worker ; and

(c) Occupational Therapist or a Certified Occupational Therapy Assistant supervised by an Occupational Therapist; and

(d) Recreational Therapist or an Activity Coordinator with two years experience; and

(e) Physical Therapist or a Physical Therapy Assistant supervised by a Physical Therapist; and

(f) Dietician and Pharmacist as indicated; and

(g) In addition to the persons listed above in paragraphs 21(a) through (g), the IDT must include the PACE Center Manager, the Home Care Coordinator, Personal Care Attendant and the Driver or Transportation Coordinator.

(26) Medicaid -- A federal and state funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by the Department of Human Services.

(27) Medically Appropriate -- Services and medical supplies required for prevention, diagnosis or treatment of a health condition that encompasses physical or mental conditions, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of a PACE Participant or a provider of the service or medical supplies; and;

(d) The most cost effective of the alternative levels of Medical services or medical supplies that can be safely provided to a PACE Participant in the PACE Program's judgment.

(28) Medicare --The federal health insurance program for the aged and disabled administered by the Health Care Financing Administration under Title XVIII of the Social Security Act.

(29) Mental Health and Developmental Disability Services Division (MHDDSD) -- The Department of Human Services agency responsible for the administration of the state's mental health and developmental disability services.

(30) Non-Covered Services -- Services or items the PACE Program is not responsible for providing or paying for.

(31) Non-Participating Provider -- A provider who does not have a contractual relationship with the PACE Program, i.e., is not on their panel of providers.

(32) Office of Medical Assistance Programs (OMAP) -- The Office of the Department of Human Services responsible for coordinating Medical Assistance Programs. OMAP writes and administers the state Medicaid rules for medical services, contracts with providers, maintains records of Participant eligibility and processes and pays OMAP providers and contractors such as PACE.

(33) Oregon Health Plan (OHP) --The Medicaid demonstration project that expands Medicaid eligibility. The Oregon Health Plan relies substantially upon a prioritization of health services and managed care to achieve the

policy objectives of access, cost containment, efficacy and cost effectiveness in the allocation of health resources.

(34) PACE-- The Program of all Inclusive Care for the Elderly (PACE) is a permanent provider type under Medicare that allows states the option to pay for PACE services under Medicaid. The PACE program is capitated by both Medicare and Medicaid to provide all medical and long-term care services.

(35) PACE Participant -- An individual who meets the SDSA criteria for nursing facility care and is enrolled in the PACE Program. These individuals would be eligible under the following categories:

(a) AB/AD (Assistance to Blind and Disabled) with Medicare-- Individuals with concurrent Medicare eligibility with income under current Medicaid eligibility rules.

(b) AB/AD without Medicare-- Individuals without Medicare with income under current Medicaid eligibility rules.

(c) OAA (Old Age Assistance) with Medicare--Individuals with concurrent Medicare Part A or Medicare Parts A & B eligibility with income under current Medicaid eligibility rules.

(d) OAA with Medicare Part B Only--Individuals with concurrent Medicare Part B only income under current Medicaid eligibility rules.

(e) OAA without Medicare --Individuals without Medicare with income under current Medicaid eligibility rules

(f) Private---Individuals with or without Medicare with incomes over current Medicaid eligibility

(36) Participating Provider -- An individual, facility, corporate entity, or other organization that supplies medical, dental, or mental health services or items who have agreed to provide those services or items and to bill in accordance with a signed agreement with a PACE Program.

(37) Preventive Services-- -- Those services as defined under Expanded Definition of Preventive Services in OAR 410-141-0480 and OAR 410-141-0520.

(38) Primary Care Provider (PCP) -- A practitioner who has responsibility for supervising and coordinating initial and primary care within his/her scope of practice for PACE Participants. Primary Care Providers initiate referrals for care outside their scope of practice which may include consultations and specialist care, and assure the continuity of Medically or Dentally Appropriate care.

(39) Program of All Inclusive Care for the Elderly (PACE) -- A managed care entity that contracts with the Department and Medicare on a prepaid, capitated basis to supply medical, dental, mental health, social services, transportation and long-term care services to persons age 55 and older in accordance with a signed agreement with the Department and Medicare.

(40) Quality Improvement -- Quality improvement is the effort to improve the level of performance of a key process or processes in health and long term care. A quality improvement program measures the level of current performance of the processes, finds ways to improve the performance and implements new and better methods for the processes. Quality Improvement includes the goals of quality assurance, quality control, quality planning and quality management in health care. Quality of care is the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and is consistent with current professional knowledge.

(41) Representative -- A person who can assist the PACE Participant in making administrative related decisions such as, but not limited to, completing Enrollment application, filing Complaints, and requesting Disenrollment. A Representative may be, in the following order of priority, a person who is designated as the PACE Participant's health care representative, a court-appointed guardian, a spouse, or other family member as designated by the PACE Participant, the Individual Service Plan Team (for developmentally disabled clients), a SDSD/AAA case manager or other DHS designee. This definition does not apply to health care decisions unless the Representative has legal authority to make such decisions.

(42) Senior and Disabled Services Division (SDSD) --A Division of DHS responsible for nursing facility and home and community based care waived services for eligible elderly and disabled individuals, maximizing their ability to function as independently as possible. SDSD includes local Division units and the AAAs who have contracted to perform specific functions of the licensing and enrollment process.

(43) Service Area -- The geographic area defined by Federal Information Processing Standards (FIPS) codes, or other criteria determined by the Department, in which the PACE Program has agreed to provide services under the Oregon PACE Program Regulations and the Federal PACE Regulations 42 CFR Part 460. This geographic area is defined in the PACE contract with the Department.

(44) Triage -- Evaluations conducted to determine whether or not an emergency condition exists, and to direct the OMAP Member to the most appropriate setting for Medically Appropriate care.

(45) Urgent Care Services -- Covered Services required to prevent a serious deterioration of a PACE Participant's health that results from an unforeseen illness or an injury and for dental services necessary to treat such conditions as lost fillings or crowns. Services that can be foreseen by the individual are not considered Urgent Services.

(46) Valid Claim-- An invoice received by the PHP for payment of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the service or from a third party, and

(b) Has been received within the time limitations prescribed in these Rules; and

(c) A "valid claim" is synonymous with the federal definition of a "clean claim" as defined in 42 CFR 447.45(b)

(47) Valid Pre-Authorization -- A request, received by the Pace Program for approval of covered health care services provided by a Non-Participating Provider to an eligible client, which can be processed without obtaining additional information from the provider of the service or from a third party.

Stat. Authority: ORS 410.090  
Stats. Implemented: ORS 410.070

#### **411-045-0020 Program Administration**

*(Adopted 1/1/2001)*

- (1) A PACE Program must be, or be a distinct part of, one of the following:
  - (a) an entity of a city, county, state, or tribal government; or
  - (b) a private, not-for-profit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code or 1986; or
  - (c) a PACE for-profit demonstration program that has been approved by HCFA
- (2) The PACE Program's Service Area must be approved by both the Department and HCFA.
- (3) The PACE Program must employ a program director who is responsible for oversight and administration of the program.
- (4) The PACE Program must employ a medical director who is responsible for the delivery of Participant care as well as the performance of the Quality Improvement program.
- (5) The PACE Program must notify the Division in writing 90 days before changes in organizational structure, including ownership, take effect. Such changes must be approved in advance by the Department.
- (6) A PACE Program must have an identifiable governing body (e.g. a board of directors) with full legal authority and responsibility for the following:
  - (a) governance and operation;
  - (b) development of policies consistent with the mission;

- (c) management and provision of all services;
- (d) establishment of personnel;
- (e) fiscal operations; and
- (f) quality improvement program.

(7) A PACE Program must provide training to maintain and improve the skills and knowledge of staff members in each of the PACE positions.

(8) PACE Programs are responsible for payment of all Covered Services. Such services should be billed directly to the PACE Program. PACE Programs may require providers to obtain pre-authorization to deliver Covered Services other than Emergency Services.

(9) Payment by the PACE Program to providers for Covered Services is a matter between the PACE Program and the provider, except as follows:

(a) Pre-Authorizations:

(A) PACE Programs must have written procedures for processing valid pre-authorization requests received from any provider.

(B) Authorizations for prescription drugs must be completed and the pharmacy notified within 24 hours. If an authorization for a prescription cannot be completed within the 24 hours, the PACE Program must provide for the dispensing of at least a 72-hour supply if the medical need for the drug is immediate. The PACE Program shall notify providers of such determination within 2 working days of receipt of the request;

(C) PACE Programs will notify PACE Participants of a denial of an authorization request within five working days from the final determination using the Division approved client notice format;

(b) Claims Payment;

(A) PACE Programs must have written procedures for processing claims submitted for payment from any source.

(B) PACE Programs shall pay or deny at least 90% of Valid Claims within 45 calendar days of receipt and at least 99% of Valid Claims within 60 calendar days of receipt. PACE Programs shall make an initial determination on 99% of all claims submitted within 60 calendar days of receipt;

(C) PACE Programs shall provide written notification of determinations when such determinations result in a denial of payment for services, for which the PACE Participant may be financially responsible. Such notice shall be provided to the PACE Participant and the treating provider within fourteen (14) calendar days of the final determination. The notice to the Participant shall be a Division- approved notice format and shall include information on the PACE Program's internal appeals process, and the Notice of Hearing Rights (OMAP 3030) shall be attached. The notice to the provider shall include the reason for the denial.

(c) PACE Programs are responsible for payment of Medicare coinsurances and deductibles up to the Medicare or PACE Program's allowable for Covered Services the PACE Participant receives for authorized referral care, and for Urgent or Emergency Services the PACE Participant receives from Non-Participating Providers

(d) PACE Programs will pay transportation, meals and lodging costs for the PACE Participant and any required attendant for out-of-state services (as defined in OMAP General Rules) that the PACE Program has arranged and authorized when those services are available within the state, unless otherwise approved by the Department;

(e) PACE Programs will be responsible for payment of Covered Services provided by a Non-Participating Provider that were not pre-authorized if the following conditions exist:

(A) It can be verified that the Participating Provider ordered or directed the Covered Services to be delivered by a Non-Participating Provider and;

(B) The Covered Service was delivered in good faith without the pre-authorization and;

(C) It was a Covered Service that would have been pre-authorized with a Participating Provider if the PACE Program's referral protocols had been followed;

(D) The PACE Programs will be responsible for payment to Non-Participating Providers according to the PACE Program's reimbursement policies.

(10) Under a PACE program agreement and 42 CFR 460.180, HCFA makes a prospective monthly payment to the PACE organization of a capitation rate for each Medicare participant. Consistent with the requirements of 42 CFR 460.180, PACE Programs are responsible for payment up to the PACE contracted rates for covered services the PACE Participant receives for authorized referral care, and for urgent or emergency services received from non-contracted providers.

(11) Under the PACE program agreement and 42 CFR 460.182, the Department makes a prospective monthly payment to the PACE organization of a capitation rate for each Medicaid participant. The PACE Program must accept the capitation payment as payment in full for Medicaid participants and may not bill, charge, collect or receive any other form of payment from the Department or from or on behalf of the participant, except as follows:

(a) Payment with respect to the applicable spend-down liability and any amounts due under the post-eligibility treatment of income;

(b) Medicare payment received from HCFA or from other payors, in accordance with section (10) of this rule; or

(c) Adjustments related to enrollment and disenrollment of Participants in the PACE program; and

(d) Fee for service payments by the Department or Medicare prior to the Participant being capitated.

(12) A PACE Program must meet the requirements stated in 42CFR Part 460, Programs of All Inclusive Care for the Elderly (PACE) except where these rules are at variance.

Stat. Authority: ORS 410.090

Stats. Implemented: ORS 410.070

### **411-045-0030 Financial Solvency**

*(Adopted 1/1/2001)*

(1) PACE Programs shall assume the risk for providing Capitated Services under their contracts with the Department. PACE Programs shall maintain sound financial management procedures, maintain protections against insolvency, and generate periodic financial reports for submission to the Division as applicable:

(a) PACE Programs shall comply with solvency requirements specified in contracts with the Department, as applicable. Solvency requirements of PACE Programs must include the following components:

(A) Maintenance of restricted reserve funds with balances equal to amounts specified in contracts with the Department;

(B) Protection against catastrophic and unexpected expenses related to Capitated Services for PACE Programs. The method of protection may include the purchase of stop loss coverage, reinsurance, self insurance or any other alternative determined acceptable by the Department, as applicable. Self-insurance must be determined appropriate by the Department;

(C) Maintenance of professional liability coverage of not less than \$1,000,000 per person per incident and not less than \$1,000,000 in the aggregate either through binder issued by an insurance carrier or by self insurance with proof of same,

except to the extent that the Oregon Tort Claims Act, ORS 30.260 to 30.300 is applicable;

(2) The PACE Program must be able to satisfy the fiscal soundness requirements in 42 CFR Sec. 460.80. If the amount required in the federal PACE regulations exceeds the sum of the restricted reserve and net worth requirement, the difference may be a combination of insolvency insurance, reinsurance, letters of credit, or excess net worth.

Stat. Authority: ORS 410.090

Stats. Implemented: ORS 410.070

#### **411-045-0040 PACE Marketing and Informational Requirements**

*(Adopted 1/1/2001)*

(1) The PACE Program may inform the general public of its program through appropriate informational activities and media. The PACE Program must ensure that prohibited marketing activities as defined in 42 CFR 460.82 are not conducted by its employees or its agents.

(a) PACE Programs will ensure that all staff who have contact with potential PACE Participants are fully informed of PACE Program policies, including Enrollment, Disenrollment and Complaint policies and the provision of language and sign language interpreter services including providers who have bilingual capacity.

(2) PACE Programs will develop informational materials for potential PACE Participants in accordance with the following standards:

(a) PACE Programs will provide informational materials sufficient for eligible PACE Participants to make an informed decision about applying for Enrollment. Information on Participating Providers must be made available from the Program, upon request to potential enrollees, and must include enrollment requirements, benefits and services, locations of PACE Centers, and choice of Centers and PCPs, list of specialists, fees and other charges.

(b) PACE Programs will produce printed informational materials, which at a minimum will include the Marketing brochures, Participant

Handbook, Enrollment Agreement, Disenrollment forms, and denial of services notices. These informational materials will be culturally sensitive and in the primary language of each substantial population (35 households) of non-English speaking PACE applicants and Participants and in alternate forms for all vision impaired PACE applicants and Participants. Alternate forms may include, but are not limited to, audio tapes, close-captioned videos, large type and braille.

(c) No written information will be provided to potential PACE Participants that has not been approved by the Department. Approval or denial will be granted within 30 days of receipt by the Division. No response in 30 days constitutes approval. Any written communication by the PACE Program or its subcontractors and providers that is intended solely for PACE Participants and pertains to requirements to receive care at service sites or benefits must be approved by the Department prior to distribution;

(d) PACE Programs will provide written notice to affected PACE Participants of any significant changes in program or service sites that impacts the PACE Participants' ability to access care or services from PACE providers. Such notice will be provided to PACE Participants or their Representatives at least 14 calendar days prior to the effective date of that change, or as soon as possible if the provider has not given the PACE Program sufficient notification to meet the 14 days notice requirement. The Department will review and approve such materials within two working days of receipt by the Division.

### (3) Participant Handbook Materials:

(a) The Participant Handbook will be made available as described above and will be distributed within 14 calendar days of the PACE Participant's effective date of coverage with the PACE Program;

(b) At a minimum the information in the Participant Handbook will contain the following elements:

(A) Location(s) and office hours of the PACE Program;

- (B) Telephone number(s) to call for more information and telephone numbers relating to information listed below;
- (C) Choice and use of PCPs and policies on changing PCPs;
- (D) How to access Urgent Care Services and advice;
- (E) How and when to use Emergency Services including ambulance;
- (F) Information on the Complaint process, including confidentiality and requesting an Administrative Hearing;
- (G) How to access interpreter services including sign interpreters;
- (H) PACE Participant rights and responsibilities;
- (I) PACE Participant's possible responsibility for charges including Medicare deductibles and coinsurances if he/she goes outside of the PACE Program for non-emergent care, obtain Non-Covered Services or services not authorized by the Interdisciplinary Team (IDT).
- (J) A clear statement that level of care decisions (i.e., whether or not a Participant needs continuing nursing home care or may be discharge to a community based facility), are determined by the Participant's Interdisciplinary Team. The Participant does not have the choice of remaining at a particular level of care unless the level of care warrants such and is approved by the Interdisciplinary Team.
- (K) Information on the availability of Social Services and assistance in placement in community based housing and facilities;
- (L) How to obtain specialty care, mental health and chemical dependency services;

(M) Information on Advance Directives and Physician Order for Life Sustaining Treatment (POLST);

(N) How to obtain copies of the Participant's records (and that the Participant may be charged a reasonable copying fee);

(O) How to obtain non-emergent ambulance services and other medical transportation to appointments, as appropriate;

(P) Explanation of Covered and Non-Covered Services;

(Q) How to obtain prescriptions

(R) Confidentiality Policy.

(c) The Participant Handbook will be reviewed by the PACE Program for accuracy at least yearly and updated with new or corrected information as needed to reflect the PACE Program's internal changes and regulatory changes. If changes impact the PACE Participants ability to use services or benefits, the updated materials will be distributed to all PACE Participants after approval by the Department.

(4) PACE Programs will offer orientation to the PACE Program to new Participants in person within 30 days of Enrollment.

Stat. Authority: ORS 410.090

Stats. Implemented: ORS 410.070

#### **411-045-0050 Enrollment**

*(Adopted 1/1/2001)*

(1) Eligibility: To be eligible to Enroll in a PACE Program a person must:

(a) Reside in the PACE Program's approved Service Area upon Enrollment; and

(b) Be at least 55 years old; and

(c) Be able to be maintained in a community based setting with the assistance of the PACE Program at the time of Enrollment without jeopardizing his/her health or others health or safety; and

(d) Be determined by the local SDS/AAA agency to need the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services in accordance with OAR 411-015-0000 through OAR 411-015-0100 Service Priority, Current Limitations and Eligibility for Nursing Facility or Community Based Care Services; and

(e) Be Medicaid eligible or be willing to pay private fees; and

(f) Be willing to abide by the provision that requires enrollees to receive all health and long term care services exclusively from the PACE Program and its contracted or referred providers.

## (2) Enrollment/Screening and Intake

(a) SDS/AAA staff will process the application for Medicaid services and determine the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services. SDS/AAA staff will follow appropriate PACE enrollment protocols as outlined in the SDS/AAA Policy Manuals.

(b) SDS/AAA staff will conduct initial screening and intake, including providing assistance in completing the application and obtaining relevant information.

(c) The Department will provide for the calculation of any applicable spenddown liability and for post-eligibility treatment of income for Medicaid participants in the same manner as the Department treats spenddown liability and post-eligibility income for individuals receiving services under the home and community based care waiver (OAR 461-160-0620).

(d) The SDS/AAA staff will forward intake information of potential enrollees to the PACE Program, which will assess the applicant's enrollment in the PACE Program in accordance with these rules and the requirements of 42 CFR 460.152. Potential enrollees may be denied enrollment by the PACE Program if it determines the client

would not be able to be maintained in a community based setting without jeopardizing his/her or others health or safety.

(e) If the potential enrollee or his/her Representative is in disagreement with the PACE Program's decision not to enroll the person, he/she may file an informal appeal with the Division.

(f) All letters to applicants regarding denial of enrollment by the PACE Program must include the reason for the denial and the applicants appeal rights. This letter along with documentation of pertinent information related to the decision must be forwarded to the Division for review.

Stat. Authority: ORS 410.090  
Stats. Implemented: ORS 410.070

**411-045-0060 Disenrollment**  
(Adopted 1/1/2001)

(1) PACE Participant Requests for Disenrollment:

(a) All PACE Participant initiated requests for Disenrollment from PACE Programs must be initiated by the PACE Participant, or his/her Representative.

(b) An applicant may request Disenrollment if he/she has surgery scheduled at the time the PACE Enrollment is effective and the provider is not on the PACE Program's provider panel and the Participant wishes to have the services performed by that provider;

(c) PACE Participant/or Representative requests for Disenrollment will be effective at the end of the month following the date of request for Disenrollment except in the case of (b) above .

(2) PACE Program requests for Disenrollment:

(a) Causes for Disenrollment:

(A) The Department may disenroll PACE Participants for the following causes when requested by the PACE Program subject to ADA requirements and approval by the Department.

(i) Participant's behavior is disruptive, unruly, or abusive to the point that his/her enrollment seriously impairs the providers ability to furnish services to either the Participant or other Participants; the Participant commits or threatens an act of physical violence directed at PACE staff, other patients, property, or other providers; Participant commits fraudulent or illegal acts such as: permitting use of his/her medical ID card by others, altering a prescription, theft or other criminal acts committed in any providers or PACE Programs premises. The PACE Program will report any illegal acts to law enforcement authorities or to the Medicaid Fraud Unit as appropriate.

(ii) The Participant fails to complete and submit consents, releases, or assignments and other documents reasonably requested by the PACE Program in order to obtain or assure payment by Medicare, Medicaid, or other third party payors.

(iii) The PACE Participant moves out of the PACE Program's Service Area, and that move was not facilitated by the PACE Program.

(B) Other Reasons for the PACE Program's Requests for administrative Disenrollment include the following:

(i) If a PACE Participant is enrolled in the PACE Program on the same day the Participant is admitted to the hospital, the PACE Program will be responsible for said hospitalization. If the Participant is enrolled after the first day of the inpatient stay, the Participant will be Disenrolled, and the date of Enrollment will be the next available Enrollment date following discharge from inpatient hospital services.

(ii) The Participant is admitted to a state psychiatric institution.

(b) PACE Participants will not be disenrolled solely for the following reasons:

- (A) Because of a physical or mental disability;
- (B) Because of an adverse change in the Participant's health;
- (C) Because of the Participant's utilization of services, either excessive or lack thereof;
- (D) Because the Participant requests a hearing;
- (E) Because the Participant exercises his/her option to make decisions regarding his/her medical care with which the PACE Program disagrees;

(c) Requests by the PACE Program for Disenrollment of specific PACE Participants will be submitted in writing to the Division for approval. The PACE Program must document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made. The following is the minimal documentation and process the Division will request:

- (A) Documentation in the PACE Participant's Clinical Record at the time the problem is identified.
- (B) Documentation regarding how the problem was addressed in the Care Plan. The PACE Program will inform the Participant or his/her Representative that if the behavior persists it may result in Disenrollment;
- (C) A written request to disenroll the Participant to the Division, with a copy to the Participant's SDS/AAA caseworker. Documentation with the request will include the reason the PACE Program is requesting disenrollment; a summary of the PACE Program's efforts to resolve the problem and other options attempted before requesting disenrollment;

(D) If the Participant is Disabled, the following documentation will also be submitted as applicable:

(i) A written assessment of the relationship of the behavior to the disability including: current medical knowledge or best available objective evidence to determine the nature, duration and severity of the risk to the health or safety of others; the probability that potential injury to others will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk to others;

(ii) An Interdisciplinary Team review that includes a mental health professional or behavioral specialist to assess the behavior, its history, and previous history of efforts to manage behavior;

(iii) If warranted, a clinical assessment that the behavior will not respond to reasonable clinical or social interventions;

(iv) Documentation in the Care Plan of any accommodations that have been attempted;

(v) Any additional information or assessments requested by the Division.

(d) Disenrollment Requests will be reviewed according to the following process:

(A) The request will be evaluated by a team of Department representatives who may request additional information from the SDS/AAA casemanager, or other agencies as needed;

(B) The Department representatives will review the request and notify the PACE Program of the decision within ten working days of receipt. Written decisions, including reasons for denials, will be sent to the PACE Program within 15 working days from receipt of request;

(C) If the request is approved, the Disenrollment date is the end of the month after the date of approval. The PACE Program must send the Participant a letter within 14 days after the request was approved, with a copy to the Participant's DHS caseworker and OMAP's Health Management Unit (HMU). The letter must give the Disenrollment date, the reason for Disenrollment, and the notice of Participant's right to an Administrative Hearing.

(e) If a request for Disenrollment is approved, the PACE Program will be responsible for facilitating a PACE Participant's Enrollment into other programs by:

(A) Making appropriate referrals, ensuring Clinical Records are made available to new providers within 10 days of Disenrollment to ensure Participants needs are met without interruption of care or services;

(B) Working with HCFA and the Department to reinstate the Participant in other Medicare and Medicaid programs for which they are eligible.

(f) If a Participant requests a hearing, the Participant will continue to be Disenrolled until a hearing decision reversing that Disenrollment has been mailed to the Participant and the PACE Program;

(A) If a Disenrollment date is determined from the Administrative Hearing, the Division sends a letter to the Participant with a copy to the Participant's SDSD/AAA casemanager and the PACE Program. The letter will inform the Participant of the reason for the Disenrollment decision.

(3) Department Initiated Disenrollments:

(a) The Department may initiate and disenroll PACE Participants as follows:

(A) If a Medicaid-only PACE Participant moves out of the PACE Program's Service Area(s), the effective date of Disenrollment

will be the date specified by the Department and the Department will recoup the balance of that month's capitation payment. If the Participant has Medicare, the effective date of Disenrollment will be the first of the month following the move out of the Service Area;. If the Participant has neither Medicare or Medicaid, the date of Disenrollment will be the date specified by the Department.

(B) If the PACE Participant is no longer eligible under the PACE eligibility criteria, the effective date of Disenrollment will be the date specified by the Department;

(C) If the PACE Participant dies, the effective date of Disenrollment will be the end of the month following the date of death, and the Department will recoup any capitation payments made to PACE Program after the end of the month;

(4) If the Disenrollment is generated by the Department under subsection (3)(a)(A) or subsection (3)(a)(B) of this rule, the Department will inform the Participant of the Disenrollment decision in writing, including the right to request an Administrative Hearing. If a Participant requests a hearing, the Participant will continue to be disenrolled until a hearing decision reversing that Disenrollment has been mailed to the Participant. .

Stat. Authority: ORS 410.090

Stats. Implemented: ORS 410.070

#### **411-045-0070 Access to Care**

*(Adopted 1/1/2001)*

(1) PACE Programs will develop written policies and procedures for communicating with, and providing care to PACE Participants who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or where there is no telephone:

(a) Such policies and procedures will address the provision of qualified interpreter services by phone or in person in the PACE Center, PACE administrative offices, and Participant's residence.

(2) PACE Programs will provide or ensure the provision of qualified interpreter services for covered medical, mental health or dental care visits, including home health visits and after hours emergency calls, to interpret for persons with hearing impairment or in the primary language of non-English speaking PACE Participants.

(a) Interpreters must be linguistically appropriate and be capable of communicating in English and the primary language of the PACE Participant and be able to translate clinical information effectively. Interpreter services must be sufficient for the provider to be able to understand the PACE Participant's complaint; to make a diagnosis; respond to a Participant's questions and concerns; and to communicate instructions to the PACE Participant;

(b) Interpreters must be culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect of those on the medical care of the PACE Participant;

(3) PACE Programs must have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act (ADA) of 1990 in providing access to Covered Services for all PACE Participants and must arrange for services to be provided by Non-Participating referral providers when necessary:

(a) The policies and procedures must include the assurance of appropriate physical access to obtain Covered Services for all PACE Participants including, but not limited to the following:

(A) Street level access or accessible ramp into facility;

(B) Wheelchair access to lavatory;

(C) Wheelchair access to examination room; and,

(D) Doors with levered hardware or other special adaptations for wheelchair access.

(b) PACE Programs must ensure that providers, their facilities and personnel are prepared to meet the special needs of PACE Participants who require accommodations because of a disability. PACE Programs must monitor providers for compliance with ADA and take corrective action, when necessary. .

Stat. Authority: ORS 410.090  
Stats. Implemented: ORS 410.070

**411-045-0080 Provision of Services**  
*(Adopted 1/1/2001)*

(1) PACE Services

(a) PACE Covered Services for all Participants must be the same regardless of the source of payment. They must include all OHP Covered Services specified in OAR 410-141-0480 and Medicare Covered Services. In addition the Covered Services must include the following:

- (A) Interdisciplinary assessment and treatment planning;
- (B) Case management and social work services;
- (C) Personal care and supportive services;
- (D) Nutritional counseling;
- (E) Recreational therapy;
- (F) Meals and nutritional supplement as appropriate;
- (G) Community based long term care including nursing facility care as appropriate; and
- (H) Other services determined necessary by the Interdisciplinary Team to improve or maintain the PACE Participants overall health and functioning or to provide pain management and Comfort Care.

(b) The following are Non-Covered Services under PACE:

(A) Any service that is not authorized by the Interdisciplinary Team, even if it is a Covered Service, unless it is an Emergency Service;

(B) Any service listed in OAR 410-0141-0500, Excluded Services and Limitations, described in OAR 410-0120-1200, or in the individual OMAP Provider Guides;

(C) Any service that is excluded under the Oregon Health Plan unless it is a Covered Service under 42 CFR 460.92 or Medicare;

(D) Excluded services listed in 42 CFR 460.96

(E) Services furnished outside of the United States except as permitted under 42CFR 424.124 through 424.124 and under Oregon's approved Medicaid plan.

(c) The PACE Program must operate at least one PACE Center either in or contiguous to its defined Service Area, with sufficient capacity to allow routine attendance by PACE Participants. The frequency of attendance at a Center is determined by the Interdisciplinary Team based on the needs and preferences of each Participant.

(d) A PACE Program must ensure accessible and adequate services to meet the needs of its Participants.

(e) The PACE Program must establish an Interdisciplinary Team at each PACE Center to comprehensively assess and develop a written Care Plan to furnish care that meets the needs of each Participant in all care settings 24 hours a day, every day of the year.

(f) Each PACE Center must employ at a minimum a half-time physician and a full-time Center Manager, Registered Nurse and Social Worker with a Masters degree before they may add a Nurse

Practitioner, Physician Assistant, Licensed Practical Nurse or Social Worker with a Bachelor degree.

(g) The Interdisciplinary Team members must have appropriate licensure for their respective disciplines within the state. One year experience in working with the elderly or in caregiving is required with exceptions approved by the Division.

(h) Personal care attendants, who are not Certified Nursing Assistants, must be enrolled in the first available Division approved training program in the Service Area and complete the program within 6 months of hire.

(i) The Interdisciplinary Team is responsible for the initial Assessment, periodic reassessments, Care Plan, and coordination of 24 hour care delivery.

(A) The initial Assessment must be completed within 10 working days following Enrollment.

(B) The Interdisciplinary Team must consolidate their individual assessments into a Care Plan within 10 working days following Enrollment.

(C) The appropriate Interdisciplinary Team members must update the Care Plan within 5 working days following a significant change in the Participant's health status or at the request of the Participant or the Participant's Representative.

(D) The Interdisciplinary Team members actively involved in the Participant's Care Plan must conduct an in-person reassessment and revise the Care Plan with the Participant and/or the Participant's Representative or caregiver at least semiannually, and meet with the members of the Interdisciplinary Team and update the Care Plan as needed. To the extent it is appropriate, the Participant and/or the Participant's Representative or caregiver shall be involved in establishing the Participant's goals.

(E) The Interdisciplinary Team must implement, coordinate and monitor the effectiveness of the Care Plan and, as appropriate, involve the Participant and/or the Participant's Representative in care conferences or family meetings when there are issues or changes in the Care Plan.

(F) The Care Plan must specify the care needed to meet the Participant's medical, physical, emotional and social needs as identified in the individual Assessments. The team must document the Care Plan and any changes made to it in the Participant's Clinical Record.

## (2) Health Care

(a) PACE Programs will have written policies and procedures that ensure the provision of all Medically and Dentally Appropriate Care and Covered Services, including Urgent and Emergency Services, Preventive Services and Ancillary Services included in the PACE Contract with the Department. PACE Programs must communicate these policies and procedures to PACE staff and contracted providers, regularly monitor compliance with these policies and procedures, and take any corrective action necessary to ensure compliance. PACE Programs must document all monitoring and corrective action activities.

(b) The PACE Program must maintain a provider panel sufficient to ensure adequate capacity and expertise to provide timely and appropriate access to Covered Services.

(c) PACE Programs must ensure that all providers providing services to PACE Participants are credentialed upon initial contract with the PACE Program and recertified no less frequently than biennially thereafter. This process must include a review and determination based on the results of the PACE Program's Quality Improvement activities.

(d) The credentialing and recertification process must include review of any information in the National Practitioners Databank; and

(A) A determination, based on the requirements of the discipline or profession, that providers have current licensure in the state in which they practice or appropriate certification; and

(B) Applicable hospital privileges; and

(C) Appropriate malpractice insurance.

(e) The PACE Program may elect to contract for or to delegate responsibility for this process but the PACE Program will retain responsibility for delegated activities, including oversight of the following processes:

(A) PACE Programs must ensure that services are provided within the scope of license or certification of the provider or facility and that providers are appropriately supervised according to their scope of practice;

(B) PACE Programs, or their delegated agent, must maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the National Practitioner Data Bank;

(C) PACE Programs must not refer PACE Participants to or use providers who have been suspended or terminated from the Oregon Medical Assistance Program or excluded as Medicare/Medicaid providers by HCFA or convicted of criminal offenses against Medicare, Medicaid, or Title XX of the Social Security Act or related state law by any lawful Court in this state. PACE Programs must not accept billings for services to PACE Participants provided after the date of such providers suspension or termination or conviction.

(f) PACE Programs must have written procedures that allow for choice of a Primary Care Provider (PCP) for physical health within the PACE Program's PCPs or contracted providers. Information about which PCPs are not accepting new patients will be provided by the PACE Program to potential PACE Participants.

(g) PACE Programs must ensure a newly enrolled PACE Participant receives timely, adequate and appropriate health care services necessary to establish and maintain the health of the PACE Participant. PACE Programs must coordinate services for PACE Participants who require services from agencies providing Non Covered Services. The PCP will arrange, coordinate, and monitor all medical, mental health, and dental care for that PACE Participant on an ongoing basis.

(a) A PACE Program's liability covers the period between the Participant's Enrollment and Disenrollment with the PACE Program, unless the Participant is hospitalized at the time of disenrollment. In such an event, the PACE Program is responsible for the Participant in accordance with its contract with the Department. The PACE Program must have written procedures that describe how it will comply with this obligation.

(h) The PACE Program must identify the training needs of its provider panel and PACE staff and address such needs to improve the ability of the providers and staff to deliver Covered Services within the Pace Program.

### (3) Emergency and Urgent Care Services

(a) PACE Programs must have written policies and procedures and monitoring systems that ensure the provision of appropriate Urgent Care, Emergency, and Triage Services 24-hours a day, 7-days-a-week for all PACE Participants. PACE Programs must communicate these policies and procedures to their staff and contracted providers; regularly monitor compliance with these policies and procedures and take any corrective action necessary to ensure provider compliance. PACE Programs must document all monitoring and corrective action activities.

(b) PACE Programs must have written policies and procedures and monitoring processes to ensure that urgent or emergency calls are responded to appropriately. These policies should address the following elements:

(A) The maintenance of 24- hour telephone coverage (not a recording) either onsite or through call sharing or an answering service, adequate to Triage urgent care and emergency calls from PACE Participants.

(B) The standards for call-back for Emergency or Urgent Care, and routine issues and the provision of interpretive services after office hours. Urgent calls will be returned appropriate to the Participant's condition but in no event more than 30 minutes after receipt. If information is not adequate to determine if the call is urgent, the call will be returned within 60 minutes to fully assess the nature of the call. If information is adequate to determine the call may be emergent in nature, the call must be returned immediately.

(C) Provisions for notifying other providers requesting approval to treat a PACE Participant, including emergency departments.

(D) Provisions to ensure that relevant information is entered into the appropriate Clinical Record of the PACE Participant regardless of who responds to the call or the time of day the call is received. PACE Programs must monitor for compliance with this requirement;

(E) Written procedures and trained staff to communicate with hearing impaired PACE Participants via TDD/TTY or Relay Service, and with limited English proficient APCE Participants;

(F) Telephone coverage at PACE Programs Centers and Administrative offices that will permit access to administrative staff during normal office hours, including lunch hours, and have assigned administrative staff available for emergencies after hours and on weekends; and

(G) Provisions to monitor compliance with the policies and procedures governing 24 hour telephone coverage and on-call PCP and Administrative coverage, take corrective action as needed, and report findings to the PACE Program's Quality Improvement Committee.

(c) If a screening examination in an emergency room leads to a clinical determination by the examining physician that an actual emergency medical condition exists under the prudent layperson standard as defined in Emergency Services, the PACE Program must pay for all services required to stabilize the patient. The PACE Program may not require prior authorization for Emergency Services. The PACE Program may not retroactively deny a claim for an emergency screening examination because the condition, that appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature.

(d) When a PACE Participant's PCP, or other PACE Program representative instructs the PACE Participant or his/her Representative to seek Emergency Services, in or out of the network, the PACE Program is responsible for payment of the screening examination and for other Medically Appropriate services. The PACE Program is responsible for payment of post-stabilization care that was (1) pre-authorized by the PACE Program, or (2) not pre-authorized by the PACE program if the program (or the on-call provider) failed to respond to a request for pre-authorization within one hour of the request being made, or the PACE program or provider on call could not be contacted.

#### (4) Continuity of Care

(a) PACE Programs must develop and maintain a formal referral system consisting of a network of consultation and referral providers, including Alternative Care Settings, for all services covered in their contract with the Department. PACE Programs must ensure that access to and quality of care provided in all referral settings is monitored. Referral services and services received in Alternative Care Settings must be reflected in the PACE Participant's Clinical Record. PACE Programs must establish and follow written Procedures for Participating and Non-participating Providers in the PACE Programs referral system. Procedures will include the maintenance of records within the referral system sufficient to document the flow of referral requests, approvals and denials in the system;

(b) PACE Programs must have written procedures for referrals that ensure adequate prior notice of the referral to referral providers and adequate documentation of the referral in the PACE Participant's Clinical Record. These procedures must include:

(A) Review of information by the referring provider;

(B) Entry of information into the PACE Participant's Clinical Record;

(C) Monitoring of referrals to ensure that information, including information pertaining to ongoing referral appointments, is obtained from the referral providers, reviewed by the referring Practitioner, and entered into the Clinical Record.

(c) PACE Programs must have written procedures to orient and train their staff and the staff in contracted Alternative Care Settings in the appropriate use of the urgent and emergency care systems, and the need to send any documents from Emergency Care to the PACE Program.

(d) If a PACE Participant is hospitalized in an inpatient or outpatient setting, PACE Programs must ensure that:

(A) A notation is made in the PACE Participant's Clinical Record of the reason, date, and expected duration of the hospitalization; and

(B) Upon discharge, a notation is made in the PACE Participant's Clinical Record of the actual duration of the hospitalization and follow-up plans, including appointments for provider visits; and

(C) Pertinent reports from the hospitalization are entered in the PACE Participant's Clinical Record. Such reports must include, as applicable, the reports of consulting practitioner's physical history, psycho-social history, list of medications and dosages, progress notes, and discharge summary.

(e) For PACE Participants living in residential facilities or homes providing ongoing care, the IDT will work with the appropriate staff person identified by the facility to ensure that the PACE Participant has timely and appropriate access to services according to the PACE Participant's Care Plan, and to ensure coordination of care provided by the PACE Program and care provided by the facility or home.

(f) For PACE Participants living in residential facilities or homes providing ongoing care, PACE Programs will provide medications in a manner that is consistent with the appropriate medication dispensing system of the facility, that meets state dispensing laws. PACE Programs must provide emergency prescriptions on a 24-hour basis.

(g) When a PACE Participant's care is being transferred from the PACE Program to the PACE Participant's new health care provider, the PACE Program will make every reasonable effort within the laws governing confidentiality to coordinate transfer of the PACE Participant into the care of the new provider.

(h) If a Primary Care Provider (PCP) terminates the patient/provider relationship, the PACE Program will arrange for the Participant to transfer his/her care to another PCP on the PACE Program's panel who will accept the Participant as his/her patient. All terminations of provider/patient relationships must be according to the PACE Program's policies.

(i) PACE Programs must have written procedures and criteria for health education of PACE Participants and their caregivers. Health education will include: information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. Health education may be provided by PACE staff or other individual(s) or program(s) approved by the PACE Program. PACE Programs will endeavor to provide health education in a culturally sensitive manner to communicate most effectively with individuals from nondominant cultures.

## (5) Long term Care Services

(a) PACE Programs will have written policies and procedures that ensure the provision of all Long Term Care Services included in the PACE Contract with the Department. PACE Programs must communicate these policies and procedures to PACE staff and contracted providers, regularly monitor compliance with these policies and procedures, and take any corrective action necessary to ensure compliance. PACE Programs must document all monitoring and corrective action activities.

(b) The PACE Program must maintain a provider panel (either staff or contracted providers) sufficient to ensure adequate capacity and expertise to provide timely and appropriate access to Covered Long Term Care Services.

(c) The PACE Program must identify the training needs of its provider panel and PACE staff and address such needs to improve the ability of the providers and staff to deliver Covered Long Term Care Services under the PACE Program.

(d) In addition to Medicare Covered Services and the OMAP Covered Services listed in OAR 411-045- 0080 (1)(a), the PACE Program is responsible for providing services either directly or through contracted providers that are licensed pursuant to state law including but not limited to the following:

(A) Comprehensive case management;

(B) In-home services as defined in OAR 411-30-002 through 411-30-090;

(C) Home delivered meals;

(D) Personal care services as defined in OAR 411-034-0000 through OAR 411-034-0090;

(E) Non-medical transportation;

(F) Adult day services as defined in OAR 411-066-0000 through OAR 411-066-0020.

- (G) Residential care facility services;
- (H) Assisted living facility services;
- (I) Adult foster home services; and
- (J) Nursing facility services.

(e) If the PACE Program's facility is not in compliance with the provisions defined in OAR 411-066-0000 through OAR 411-066-0020, they must submit a request to the Administrator of the Division for a variance. This request will be reviewed by the Administrator of the Division or his/her designee, and the representatives from the Department assigned to the PACE Program.

(f) When a PACE Program provides community based or long term care for residents outside of a Participant's own residence it must assure that such facilities meet the state requirements for licensure. If the PACE Program's facilities are not in compliance with the licensure requirements for those facilities, the PACE Program must submit a request to the Division for a variance. .

Stat. Authority: ORS 410.090  
Stats. Implemented: ORS 410.070

### **411-045-0090 Quality Improvement System** *(Adopted 1/1/2001)*

(1) A PACE Program must have a planned, systematic and ongoing process for monitoring, collecting data and evaluating data and using that process for improving the quality and appropriateness of services provided to PACE Participants. This process must include an internal Quality Improvement program based on written policies, standards and procedures that are in accordance with relevant law, accepted medical practice and with accepted professional standards.

(2) A PACE Program must designate a Quality Improvement Coordinator who will develop and coordinate systems to facilitate the work of the Quality Improvement committee. The Quality Improvement Coordinator is generally

responsible for the operations of the Quality Improvement program and must have the management authority to implement changes to the Quality Improvement program within the parameters of the PACE Program. The Quality Improvement Coordinator must be qualified to assess the care of people who are Aged, Blind, or Disabled or must retain consultation from individuals who are so qualified.

(3) The PACE Program must have a written quality assessment and performance improvement plan. The plan must include all items included in the PACE Program's contract with the Department. .

Stat. Authority: ORS 410.090  
Stats. Implemented: ORS 410.070

#### **411-045-0100 Record Keeping** *(Adopted 1/1/2001)*

(1) The PACE Program must have policies and procedures that ensure maintenance of a Clinical Record keeping system that is consistent with state and federal regulations to which the PACE Program is subject.

(2) Access to Clinical Records:

(a) Provider Access to Clinical Records:

(A) PACE Programs will release health service information requested by a provider involved in the care of a PACE Participant within ten working days of receiving a signed release;

(B) PACE Programs will assure that health service providers have access to the applicable contents of a PACE Participant's mental health records when necessary for use in the diagnosis or treatment of the Participant. Such access is permitted under ORS 179.505.

(b) PACE Participant Access to Records: Except as provided in ORS 179.505 (9), the PACE Program will, upon request, provide the Participant access to his/ her own Clinical Record and provide copies

within ten working days of the request. The PACE Program may charge the PACE Participant for reasonable duplication costs;

(c) Third Party Access to Records: Except as otherwise provided in this rule, the PACE Program will upon written consent of the PACE Participant, or his/her legal guardian, provide access to Participant's Clinical Record. The PACE Program may charge for reasonable duplication costs;

(3) Confidentiality: PACE Programs must have written policies and procedures to ensure that Clinical Records related to Participants receiving services are kept confidential in accordance with ORS 179.505 through ORS 179.507, ORS 411.320, ORS 433.045 (3), 42 CFR Part 2, 42 CFR Part 431, Subpart F, 45 CFR 205.50. If the PACE Program is a public body within the meaning of the Oregon public records law, such policies and procedures will ensure that PACE Participant's privacy is maintained in accordance with ORS 192.502 (2), ORS 192.502 (8) (Confidential under Oregon law) and ORS 192.502 (9) (Confidential under Federal law) or other relevant public record exemptions.

(a) The PACE Program staff and their providers must not release or disclose any information concerning a PACE Participant to anyone other than the PACE Participant or the Participant's guardian for any purpose not directly connected with the administration of the Medicare program for Medicare recipients or of Title XIX of the Social Security Act for Medicaid recipients except as directed by the PACE Participant;

(b) Except in an emergency, PACE Program providers must obtain a written consent from the PACE Participant or the legal guardian, or the legal Power of Attorney for Health Care Decisions of the PACE Participant before releasing information. The written consent, e.g., the DHR 2100, will specify the type of information to be released and the recipient of the information, and a copy of the consent form will be placed in the PACE Participants Clinical Record. In an emergency, release of service information will be limited to the extent necessary to meet the emergency information needs and then only to those persons involved in providing emergency medical services to the PACE Participant.

Stat. Authority: ORS 410.090  
Stats. Implemented: ORS 410.070

### **411-045-0110 Participant Rights**

*(Adopted 1/1/2001)*

(1) PACE Programs must have written policies and procedures that ensure PACE Participants have the rights and responsibilities included in this rule. The PACE Organization must inform a Participant upon enrollment, in writing, of his or her rights and responsibilities, and all rules and regulations governing participation.

(2) PACE Programs must communicate these policies and procedures to PACE Staff and Participating Providers.

(3) PACE Programs must monitor compliance with policies and procedures governing PACE Participant rights and responsibilities, take corrective action as needed, and report findings to the PACE Programs Quality Improvement Committee.

(4) PACE Participants must have the following rights:

(a) To be treated with dignity and respect. To be free from abuse and/or neglect;

(b) To be treated by providers the same as other people seeking health and long term care services;

(c) To change primary care providers within the guidelines of the PACE Program;

(d) To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;

(e) To be actively involved in the development of his/her Care Plan;

(f) To be given information about his/her condition and Covered and non-covered Services necessary to allow an informed decision about proposed treatment(s);

- (g) To consent to treatment or refuse services, and be told the consequences of that decision, except for court- ordered services;
- (h) To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;
- (i) To have written materials explained in a manner that is understandable to the PACE Participant;
- (j) To receive necessary and reasonable services to diagnose the presenting condition;
- (k) To receive Covered Services under the PACE Program that meet generally accepted standards of practice and are Medically Appropriate;
- (l) To obtain covered Preventive Services;
- (m) To have access to Urgent and Emergency Services 24 hours a day, 7 days a week as described in OAR 411-045-0080 (3).
- (n) To receive a referral to specialty practitioners for Medically Appropriate Covered Services;
- (o) To have a clinical record maintained which documents conditions, services received, and referrals made;
- (p) To have access to one's own Clinical Record, unless restricted by statute;
- (q) To transfer a copy of one's Clinical Record to another provider;
- (r) To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, chemical dependency or mental health treatment and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 - Patient Self-Determination Act.

(s) To receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations;

(t) To receive information on how to make a complaint with the PACE Program and receive a response as defined in 411-045-0120;

(u) To request an Administrative Hearing with the Department of Human Services;

(v) To receive interpreter services as defined in OAR 411-045-0070 of the rule;

(w) To have the use of restraints (both physical and chemical) limited to the least restrictive and most effective method available. The use of such restraints must meet the requirements in 42 CFR 460.114; and

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

Stat. Authority: ORS 410.090

Stats. Implemented: ORS 410.070

### **411-045-0120 Complaint Process**

*(Adopted 1/1/2001)*

(1) PACE Programs must have written policies and procedures for the receipt, disposition and documentation of all Complaints from PACE Participants and their Representatives. The PACE Program's written procedures for handling Complaints, must, at a minimum:

(a) Address how the PACE Program will accept, process and respond to all Complaints from PACE Participants or their Representatives, including expedited and additional reviews; and the continuation of care during the compliant review process;

(b) Address the resolution of all Complaints that PACE Participants identify as needing resolution and must describe how Complaints will be resolved or reviewed should the PACE Participant or his/her Representative decline to provide a release of information;

(c) Address how information concerning an PACE Participant's Complaint is kept confidential, with the exception that the Department and the local SDDS/AAA office have the right to this information without a signed release from the PACE Participant;

(d) Describe how the PACE Program informs PACE Participants, both orally and in writing, about the PACE Program's Complaint procedures. Information provided to the Participant must include at least:

(A) Written material describing the Complaint process; and

(B) Assurance in all written, oral, and posted material of PACE Participant confidentiality in the Complaint process; and

(C) Information on alternatives to the PACE Programs Compliant process, including but not limited to the Medicare appeals process, and the state's Administrative Hearing process.

(e) Include a requirement for a Department-approved complaint log to be maintained by the PACE Program.

(f) Addresses how the PACE Program will ensure the availability of a supply of blank Complaint forms (OMAP 3001) in all PACE sites and in the administrative offices.

(2) The PACE Program must assure that a Participant's or his/her Representative's expression of dissatisfaction, or Complaint is recognized and resolved by the PACE Program's staff as follows:

(a) A PACE Participant or the PACE Participant's Representative may relate any incident or concern to a PACE Program staff person by indicating or expressing dissatisfaction or concern. Complaints

may also be termed concerns, problems, or issues by the PACE Participant or the Participant's Representative.

(b) If the PACE Participant or the Participant's Representative indicates dissatisfaction or concern, the PACE Program staff person will advise the PACE Participant or his or her Representative that he or she may make a Complaint using the PACE Program's Complaint process.

(c) Any PACE staff person the Participant makes a Complaint to must either resolve the Complaint and communicate the Complaint and its resolution to the PACE Program staff person designated for receiving Complaints, or direct the PACE Participant to that person;

(d) If the PACE Participant or Participant's Representative's intent is unclear, the PACE Program's designee will determine if the expression of dissatisfaction is a Complaint in need of resolution or if the PACE Participant or the Participant's Representative does not wish a resolution and only wishes to register the Complaint. If the Participant or his/her Representative wishes only to register the Complaint, the Complaint should be logged and reported the same as other Complaints.

(e) If a PACE Participant or the PACE Participant's Representative wishes the Complaint to be resolved, the PACE Program will ask the PACE Participant or his or her Representative to consent verbally to the release of information regarding the Complaint to individuals who are directly involved in the Complaint or to other individuals as needed to resolve the Complaint. Verbal consent must be documented in the Complaint file. A PACE Participant's or his or her Representative's consent to release information related to the Complaint does not constitute consent to release medical information. If the Participant or the Participant's Representative does not give consent, he or she should be advised that the Complaint may not be resolved to their satisfaction.

(f) For situations when the PACE Participant's life, health, or ability to regain maximum functioning is at risk, an expedited Complaint process may be requested by the PACE Participant or his or her Representative, or the PACE Program Staff. In such cases, the

investigation will begin within 24 hours and a determination must be provided to the PACE Participant or his or her Representative within 72 hours unless the PACE Participant requests an extension to 14 days or the PACE Program finds that the delay is in the best interest of the Participant.

(g) Complaints concerning denial of service or service coverage will be handled as Complaints as described in OAR 411-045-0130.

(h) The PACE Program must, within 5 working days from the date the Participant or his/her Representative files the Complaint, either:

(A) Make a decision on the Complaint and proceed according to subsection (2)(i) of this rule; or

(B) Notify the PACE Participant or the PACE Participant's Representative in writing that a delay in the PACE Program's decision of up to 30 calendar days from the date the Complaint was received by the PACE Program necessary to resolve the Complaint. The letter must specify the reasons the additional time is necessary.

(i) Once a decision has been reached, that decision, must be communicated to the PACE Participant or his/her Representative orally or in writing no later than 30 calendar days from the date of receipt of the Complaint:

(A) An oral decision must address each aspect of the Participant's Complaint and explain the reason for the PACE Program's decision. The oral decision must include informing the PACE Participant of his/her rights to an Administrative Hearing;

(B) A written decision must be made if the Complaint was received in writing, or if the Complaint involves a denial of services or service coverage:

(i) The written decision on the Complaint must review each element of the PACE Participant's Complaint and

address each of those concerns specifically, including the reasons for the PACE Program's decision;

(ii) The written decision must have both the Notice of Hearing Rights (OMAP 3030) and the AFS 443, Hearing Request, attached;

(iii) A written decision, that involves denial of service or service coverage, must conform to the requirements for notice in OAR 411-045-0130.

(j) If the PACE Participant does not wish to attempt to resolve the Complaint through the use of the PACE Program's internal Complaint procedure, the staff person will notify the PACE Participant or his or her Representative that he or she has the right to seek resolution through the state's Administrative Hearing process, or if the Participant is a Medicare beneficiary, through the Medicare appeals process. Under no circumstances may the PACE Program discourage a PACE Participant's use of the Administrative Hearing process. The PACE Program may, however, explain to the PACE Participant the potential benefits of using the PACE Program's Complaint procedure.

(k) Hearing requests made without previous use of the PACE Program's Complaint process will be forwarded to the PACE staff person designated to receive Complaints by the SDS/AAA PACE Liaison Case Manager and reviewed as a Complaint or as part of an informal meeting requested by the SDS/AAA Case Manager.

### (3) Additional Review of Complaint

(a) The PACE Program must provide for additional review of a Participant's Complaint, as follows:

(A) If the PACE Participant or his or her Representative indicates dissatisfaction with the decision on the Participant's Complaint, the PACE Program must provide the PACE Participant with the opportunity to request another review pursuant to subsection (3) of this rule, in addition to the notice of hearing rights and hearing request;

(b) The additional review must be offered by the PACE Program in conjunction with the decision on the initial Complaint and will not release the PACE Program from the obligations to notify the Participant or his or her Representative of the Participant's right to an Administrative Hearing and to provide a copy of AFS 443;

(c) The request for additional PACE Program review of the Complaint may be conveyed by the PACE Participant, the PACE Participant's Representative or PACE Programs designee, upon the request of the PACE Participant;

(d) The additional PACE Program review of the Complaint will be reviewed, investigated, considered or heard by either:

(A) The PACE Program's medical or program director; who was not involved in the original action; or

(B) A person or group, such as the Quality Improvement Committee or board of directors, responsible for internal review with the authority to make a final clinical or administrative decision at the PACE Program level.

(e) A written decision, including the reasons for the PACE Program's decision, will be mailed to the PACE Participant or his or her Representative no later than 30 calendar days from the date of receipt of the request for additional PACE Program review of the Complaint, unless:

(A) Further time is needed for the receipt of information requested from or submitted by the PACE Participant and the new time frame is communicated to the Participant in writing;

(B) The PACE Participant fails to provide the requested information within 30 calendar days of the request by the PACE Program, or another mutually agreed upon time frame, the Complaint may be resolved against the PACE Participant;

(f) The PACE Program's decision on the additional review of the PACE Participant's Complaint must have an additional Notice of Hearing Rights (OMAP 3030) attached.

(4) Responsibility for Documentation and Quality Improvement Review of Complaints

(a) The PACE Program's documentation must include, at the minimum:

(A) The log of all Complaints and concerns including Complaints that the Participant chooses either to resolve through another process, or not to have resolved. The log will identify the PACE Participant, the date of the Complaint, the nature of the Complaint, the resolution and the date of resolution or the date of a Complaint where no resolution was requested;

(B) A file of Complaints and records of their review or investigation and resolution, including all written decisions and copies of correspondence with the PACE Participant related to the Complaint will be retained for seven years.

(b) The PACE Programs must have written procedures for the review and analysis of all Complaints received by the PACE Program and the operation of the entire Complaint process. The analysis of Complaints will be forwarded to the Quality Improvement committee as necessary to comply with the Quality Improvement standards.

(c) PACE Programs will monitor the written log, on a monthly basis, for receipt, disposition and documentation of Complaints.

(d) Monitoring of Complaints will include at a minimum a review for completeness, accuracy, timeliness of documentation, and compliance with plan procedures for receipt, disposition, and documentation of Complaints.

(5) Issues involving abuse or neglect shall be reported by PACE to the local SDSD/AAA Protective Services and shall be investigated according to

the setting in which the incident occurred. PACE Program staff are to be considered mandatory reporters under ORS 124.060 and ORS 124.050 (5).

Stat. Authority: ORS 410.090

Stats. Implemented: ORS 410.070

### **411-045-0130 Denial, Reduction, or Termination of Services**

*(Adopted 1/1/2001)*

(1) All denials, reductions, discontinuation or termination of services or service coverage by the PACE Program must be in writing in accordance with Section (3) of this rule. PACE Programs must make available to all PACE Staff and contracted providers information concerning Client Notices, Complaints and hearings processes.

(2) When the PACE Program authorizes a course of treatment or Covered Service, but subsequently acts (as defined in 42 CFR 431.201) to terminate, discontinue, or reduce the course of treatment or a Covered Service, the PACE Program must mail a written notice to the Participant at least ten (10) working days before the date of the termination, reduction, or discontinuation of the Covered Service unless there is documentation that the Participant had previously agreed to the change as part of the course of treatment.

(3) The written Client Notice must be a Division-approved format and is to be used for all denials, reductions, discontinuations or terminations of services and denials of claims payment. The notice must inform the PACE Participant of the following:

(a) Relevant information to include but is not limited to the following: Date of notice, program name, PCP name, Participants name and ID number, Date of Request/Service, Service or Item Requested or provided, Who Requested or Provided the item or service, Effective Date of Action;

(b) Reasons for the action to include the following: treatment is not covered, item requires pre-authorization and it was not pre-authorized, it is not Medically Appropriate, service/item received in an emergency care setting and does not qualify as an Emergency

Service, person was not a Participant at the time of the service or is not a Participant at the time of a requested service, the provider is not on the panel and person did not obtain prior approval.

(c) The PACE Participant's right to file a complaint with the plan and request an Administrative Hearing with the Division including attaching the Notice of Hearing Rights (OMAP 3030) that includes a statement that the PACE Participant may request continuation of benefits until a decision is rendered.

(d) The telephone number to contact for additional information.

(4) The PACE Program will have the following responsibilities in relation to Section (2) of this rule:

(a) The PACE Program must continue services if the PACE Participant or PACE Participant's Representative requests an Administrative Hearing before the effective date of the client notice and requests that services be continued. The service must be continued until whichever of the following occurs first (but in no event should exceed ninety (90) days from the date of the Participant's request for an Administrative Hearing):

(A) The current authorization expires; or

(B) A decision is rendered about the Complaint; or

(C) The Participant is no longer eligible for Medicaid benefits,

(b) The PACE Program must notify the PACE Participant or PACE Participant's Representative in writing that it is continuing the service. The notice must inform the PACE Participant or PACE Participant's Representative that if the hearing is resolved against the PACE Participant, the cost of any services continued after the effective date of the client notice may be recovered from the PACE Participant pursuant to 42 CFR 431.230 (b).

(c) The PACE Program must reinstate services if: (a) the PACE Program takes an action without providing the required notice and the PACE Participant requests a hearing; (b) the PACE Program does

not provide the notice in the time required under Section (2) of this rule and the PACE Participant requests a hearing within 10 days of the mailing of the notice of action; or (c) the post office returns mail directed to the Participant, but the Participant's whereabouts become known during the time the Participant is eligible for services.

(d) The PACE Program must promptly correct the action taken up to the limit of the original authorization, retroactive to the date the action was taken, if the hearing decision is favorable to the PACE Participant, or the Department or the PACE Program decides in the PACE Participant's favor before the hearing even if the PACE Participant has lost eligibility after the date the action was taken.

(5) If a Complaint is made to the PACE Program's staff person designated to receive Complaints that concerns a denial of services or benefits, a termination, reduction or discontinuation of services, as referenced in Section (2) of this rule; authorizations for services or referrals, or a request for claim(s) payment as referenced in 410-0141-0420, the Complaint must be recognized by the PACE Program and answered in writing:

(a) The PACE Program's staff person must notify the PACE Participant or the Participant's Representative in accessible format of the decision that denied, discontinued or reduced the service(s) or coverage within five (5) working days. The decision letter must include at least the elements included in Section (3) of this rule.

(b) A copy of the Notice of Hearing Rights (OMAP 3030) and Administrative Hearing Request (AFS 443) must be attached. .

Stat. Authority: ORS 410.090

Stats. Implemented: ORS 410.070

#### **411-045-0140 Administrative Hearings**

*(Adopted 1/1/2001)*

(1) Individuals who are or were PACE Participants at the time an action is taken are entitled to an Administrative Hearing by the Department regarding the action by the PACE Program to deny services, payment of a claim, or to terminate, discontinue or reduce a course of treatment. PACE

Participants are also entitled to an Administrative Hearing for issues related to their eligibility for PACE benefits, or issues related to enrollment in a PACE Program. Administrative Hearings are governed by the following.

(a) A written hearing request must be received by the SDSD/AAA PACE Liaison Case Manager not later than the 45th day following the date of the Notice of Action or written decision regarding a Complaint.

(b) If the action involves a Notice of Action or decision concerning a Complaint that involves continuation of services, and the PACE Participant or PACE Participant's Representative wishes to have services continued while the hearing issue is being resolved, the PACE Participant or PACE Participant's Representative must request a hearing before the effective date of the intended action or within 10 calendar days after the notice of action or written complaint decision was mailed or given to the PACE Participant or PACE Participant's Representative.

(2) The SDSD/AAA PACE Liaison Case Manager will review the Administrative Hearing Requests, documentation related to the Hearing issue, and computer records to determine whether the claimant or the person for whom the request is being made is or was a PACE Participant at the time the action was taken, whether the hearing request was timely (requested within 45 calendar days of the Notice of Action, or the decision about a complaint) and whether continuation of benefits or services has been requested

(3) The hearing request (AFS 443) must be referred to the Central Hearings Panel and a hearing officer requested. PACE Administrative Hearings are governed by OAR 461-025-300 and the following, except to the extent that Department rules apply.

(4) A final order must be issued or the case otherwise resolved by the Department no later than 90 days following the Division's receipt of the request for hearing. Delay due to a postponement or continuance granted at the PACE Participant or the PACE Participant Representative's request or with the consent of the PACE Participant or the PACE Participant's Representative will not be counted in computing the time limit. The final order is the final decision of the Department.

(5) The PACE Program will immediately transmit to the SDS/AAA PACE Liaison Case Manager any hearing request submitted on behalf of a Participant.

(6) If an Administrative Hearing is requested by a PACE Participant or the Participant's Representative, the PACE Program will cooperate in the hearing process and will make available, as determined necessary by the Division, all persons with relevant information, including the staff person who attempted resolution of the Complaint. The PACE Program will also provide all pertinent files and Clinical Records, as well as the results of the review by the PACE Program of the Complaint in the hearing request and any attempts at resolution by the PACE Program to the Division.

(7) If the PACE Participant or his/ her Representative files a request for an Administrative Hearing, the SDS/AAA PACE Liaison Case Manager will immediately notify the PACE Program. The PACE Program will review the Hearing Request as a Complaint as described below. The SDS/AAA PACE Liaison Case Manager shall evaluate the request, and if warranted, request an informal meeting and will notify the other Departments as appropriate.

(8) A PACE Participant or his/her Representative may request a delay in the Administrative Hearing in writing. This delay will not relieve the PACE Program of resolving the Complaint that was referred to them by the SDS/AAA PACE Liaison Case Manager within 30 days.

(9) PACE Programs will review the Hearing Request, which has not been previously received or reviewed as a complaint, using the PACE Programs Complaint process as follows:

(a) The Complaint will be reviewed immediately and will be resolved, if possible, within 30 days of receipt of the request for hearing in The Division;

(b) The PACE Program's decision must be in writing and will be provided to the SDS/AAA PACE Liaison Case Manager, and to the PACE Participant or his/her Representative;

(c) If the Complaint is not resolved within 30 days, or the Participant or his or her Representative does not accept resolution proposed by

the PACE Program on the hearing request, the PACE Program will provide the SDDS/AAA PACE Liaison Case Manager with all pertinent material and documentation within 30 days from the date of the transmittal of the request for hearing from the Division. Complaints are defined in OAR 410-141-0000, Definitions.

(10) If the PACE Participant or his or her Representative chooses to use the PACE Program's Complaint procedure as well as the Administrative Hearing process, the PACE Program will ensure that the Complaint procedure is completed within 30 days of receipt of the Complaint, and the records sent to by the 30th day.

(11) If a PACE Participant or the PACE Participant's Representative feels the Participant's medical or dental problem cannot wait for the normal PACE Program review process, including the PACE Program's final resolution he or she may request an expedited hearing. The PACE Program will inform PACE Participants of the Participants' rights to request an expedited hearing and provide Participants with a copy of AFS Form 443 and Notice of Hearing Rights.

(12) Expedited hearings are requested using AFS Form 443.

(13) The PACE Program will submit relevant documentation to OMAP's Medical Director within, as nearly as possible, 2 working days for a decision as to the necessity of an expedited Administrative Hearing. OMAP's Medical Director must decide within, as nearly as possible, 2 working days from date of request, if that PACE Participant is entitled to an expedited hearing. .

Stat. Authority: ORS 410.090

Stats. Implemented: ORS 410.070