



Program of All-inclusive Care for the Elderly (PACE) Information for Local Offices

Eligibility
Systems set up
Collaboration with the PACE organization

Version: May 8, 2026

Definitions

A service area is defined by zip codes and approved by Centers for Medicare and Medicaid Services (CMS) for the PACE organization to provide services in those areas. The zip codes are chosen using specific criteria established by CMS standards of accessible care.

In Oregon, living in the community means an individual can live safely outside of a nursing facility (NF), such as in their own home, or in an adult foster home (AFH), an assisted living facility (ALF) or memory care, or in an RCF.

Individual – a person not yet receiving Medicaid and long-term services and supports from Oregon Department of Human Services (ODHS) or PACE.

Consumer – a current recipient of long-term services and supports and Medicaid through ODHS but not enrolled in PACE.

Participant – a person enrolled in PACE and may or may not receive Medicaid benefits and long-term services and supports through ODHS.

PACE model

PACE is a care model that combines all medical services, long-term care services, and social services into one program. The uniqueness of PACE is the program can provide supports and services to participants that cannot be provided through Aging and People with Disabilities (APD).

- * Medicare and Medicaid funds cover all medically necessary services.
- * There are no co-pays or deductibles.
- * Medicare only recipients pay a monthly premium for the long-term care and drug benefits.
- * Recipients, who are not Medicare or Medicaid eligible, can still enroll, but need to pay privately for PACE services.



PACE model continued

PACE is considered a program option for long-term services and supports. Oregon has offered this program in limited areas of the state since 1990.

The State of Oregon supports the expansion of the PACE services and PACE providers statewide.

PACE services are currently offered in all of Multnomah and Clatsop counties and in parts of Washington, Tillamook and Clackamas counties. And now in Lane County.

Future PACE service areas, managed by different PACE organizations, include Benton, Crook, Deschutes, Jackson, Josephine, Linn, Marion, and Polk counties.



PACE eligibility

The PACE participant is:

- 55 years old or older
- Living in a PACE service area
- Able to reside safely in the community
- Assessed at Nursing Facility Level of Care (SPL 1-13)
- Willing to receive all Medicaid and Medicare services, including Long Term Services and Supports (LTSS), from the PACE organization and its contracted providers
- Willing to pay privately if not receiving Medicaid benefits



Local office responsibility

Discussion topics

- Local office responsibility
- Screening and referrals
- Assessments and reassessments, PACE courtesy assessments
- Risk assessments, Special Needs, other services, Modified Adjust Gross Income (MAGI) and PACE
- In-home care (IHC), community-based care (CBC), nursing facility (NF)
- Room and Board and Personal Incidental Funds (PIF)
- Liability for PACE cases
- Enrollment and disenrollment
- PACE deeming (aka continued eligibility) and EWE
- Hearings, grievances and appeals



Local office responsibility continued

PACE enrollment cannot happen unless the individual meets all PACE eligibility criteria which requires an assessment with an outcome of SPL 1 -13. Individuals who are interested in PACE enrollment but do not want Medicaid benefits or Medicare Savings Plan (MSP) benefits do not require a Medicaid application, only a four Activities of Daily Living (ADL) assessment. These individuals usually choose to pay for PACE services privately. Most PACE participants are dually eligible for Medicare and Medicaid, so a full assessment is required, along with a completed Medicaid application. Please keep in mind that individuals applying for OPI-M, SPPC services and Healthier Oregon Program (HOP) are not eligible to enroll in PACE unless they choose to pay privately for PACE services and withdraw their application for either program.



Screening and referrals for PACE enrollment

When serving individuals or consumers in a PACE service area, local office staff may refer them to the PACE organization (PO) if they are interested in PACE. Some consumers already receiving LTSS may be referred to the PO if they have high care needs and are interested in enrolling in PACE. Some examples of individuals or consumers that may benefit from PACE services include cognitive impairments that require interventions and wrap around services; coordination and transportation due multiple specialists and/or doctor appointments; the need for assistance when natural supports are not available; needed supports and therapies that cannot be provided by LTSS; the need for coordination of care that cannot be provided by natural supports or by the individual/consumer.



Referrals for PACE

A referral for PACE can be made at the intake process or for current LTSS consumers at any time and during the intake process. The PACE organization (PO) has a standard referral form to be completed and submitted, to the PO, with a copy of the Assessment Summary (SDS 002N) via email or fax. Typically, the PO will contact the individual/consumer or representative to discuss PACE eligibility and enrollment within one to three business days. The referral forms and processes are available on the CM Tools page under Program of All-inclusive Care for the Elderly (PACE) page in each PO section.

Denial of PACE services by the PO must be reviewed by Central Office prior to sending notice to the consumer or individual.



Assessments

Case managers should follow normal assessment processes and timelines for assessments and reassessments. Timely assessments ensure no gap in services or disenrollment of PACE enrollment in the State systems. When the assessment is completed and Medicaid eligibility is established (if applicable), a copy of the SDS 002N and a copy of the SPAN notice (if applicable) should be sent to the O.

Please note, the Service Plan Agreement (SPA) is not signed by the PO. It should be marked as PACE when the consumer is enrolled in PACE, however, if the consumer receives LTSS in a CBC setting, the CBC provider signs the SPA. If the consumer is receiving in-home care, the SPA is signed by the consumer.



Reassessments

When a reassessment is not updated timely, PACE participants are automatically disenrolled from PACE in the State systems. This means the participant may lose medical benefits and delays may occur in long-term services and supports. Overdue reassessments also cause a delay in payments to the PACE organization that is providing the services to and for participants.



Courtesy assessments

When an individual is not applying for Medicaid but wants to enroll in PACE, a courtesy assessment is required. The PO will make a request to the local office for a CA/PS assessment. The case manager completes a 4 ADL assessment and sends the SDS 002N to the PO. The Client Details section of CA/PS does not need to be completed as the PO will do the service planning for the individual when PACE enrollment begins. The benefit or service plan does not need to be completed since there is no OSIPM (Medicaid) eligibility and benefit established. Individuals do not need to submit a Medicaid application unless they express an interest in receiving Medicaid benefits and/or Medicare Savings Plan (MSP) benefits.



Risk assessment

The risk assessment is not required for PACE participants. The PO conducts its own risk assessment and incorporates it into the service planning with the Interdisciplinary Team (IDT). The risk assessment in Client Details should be addressed as “Risks are assessed and mitigated by the PACE organization”.

In addition, case managers do not need to perform Waiver Case Management Contacts (direct and indirect contacts) for consumers enrolled in PACE.



Special needs

All special needs requests from PACE participants are made to the IDT. If the IDT approves the request, the PO is responsible for obtaining and paying for the item or special need. If the request is denied by the IDT, the participant can utilize the grievance or appeals process through the PO as well as request a State administrative hearing with the help of the case manager. APD is responsible for special needs payments or allowances that are considered supplemental payments to the participant, such as their PIF and room and board.

Consumers in enrolled in PACE are not eligible for K Ancillary items and exception requests through APD, since the PO is responsible for those items.



Other services

The PO is responsible for providing all Medicaid and Medicare services. Some of these services include behavioral support services (BSS), long-term care community nursing services (LTCCN), emergency response systems (ERS), home delivered meals (HDM), K-Plan services, and mental health services. Local office staff should refer PACE participants to the PO to talk to their IDT about additional services they feel they need. APD may be able to assist a PACE participant with Money Management services and Crisis Support services. The case manager may contact the PACE Policy Analyst if there are any questions.



MAGI and PACE

When a MAGI consumer is eligible for long-term services and supports, they may be eligible for PACE if the consumer meets all other PACE eligibility criteria.



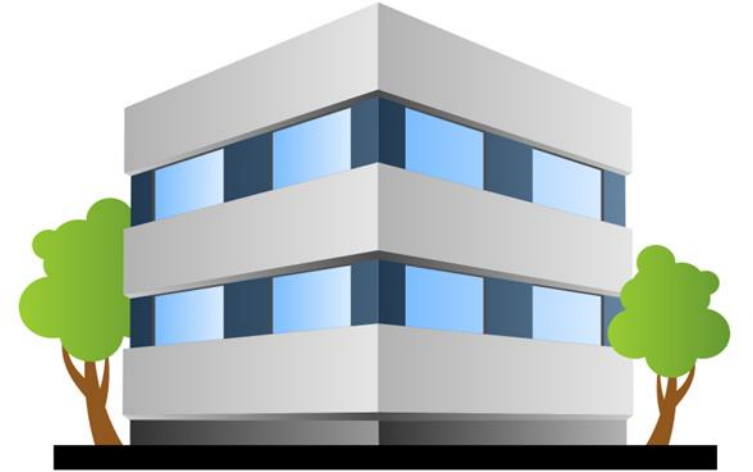
In-home care and PACE

Consumers receiving In-home care (IHC) may be eligible for PACE enrollment if they meet all other eligibility requirements for PACE. When the consumer expresses an interest in PACE enrollment, the referral form is completed and submitted to the PO with a copy of the latest SDS 002N. If the consumer is approved for PACE enrollment, the PO will notify the CM and all other services, such as ERS, BSS, LTCCN, HDM, IHCA, etc., must be closed at the end of the month; the PO is responsible for providing those services during PACE enrollment. In addition, if the consumer is receiving IHC through the Client Employer Program (CEP), the HCW must be notified of the change in services, and all future payment actions should be deleted. All In-home PACE participants are served through an IHCA that is contracted with the PO. IHC participants are not responsible to pay a liability.



CBC and PACE

Consumers receiving CBC may be eligible for PACE enrollment if they meet all other eligibility requirements for PACE. When the consumer expresses an interest in PACE enrollment, the referral form is completed and submitted to the PO with a copy of the latest SDS 002N. If the consumer is approved for PACE enrollment, the PO will notify the CM; all other services, such as ERS, BSS, LTCCN, etc., must be closed at the end of the month as the PO is responsible for providing those services during PACE enrollment. The 512-payment system must be closed at the end of the month since the PO is responsible for paying the CBC provider. The consumer remains responsible for paying room and board and liability to the CBC provider.



PACE and nursing facility

Consumers residing in a nursing facility are not eligible for PACE enrollment since NF placement is not considered living in the community. However, when a PACE participant is placed in a nursing, they will continue PACE enrollment and be served by the PACE organization (PO). When a NF stay is longer than 30 days, or ICF placement, the benefit type and service place in Oregon Access should be changed to PACE Nursing Facility. Do not set up the Plan of Care (POC) and liability line in MMIS. Make sure to narrate the participants change of condition and change in service placement as it is described, or relayed to you, by the PO.



Room and board and PIF

Room and board (R and B) payments are the responsibility of participants or their representatives and are paid directly to the facility. Personal Incidentals Fund (PIF) is the monthly allowance the participant may keep to purchase personal items or services not covered by Medicaid, Medicare, or any other health coverage. If a participant does not have the income to pay the R and B rate or to retain the PIF amount, APD is responsible for making those payments to the participant (PIF) and on behalf of the participant for R and B, if the participant meets eligibility criteria. R and B and PIF are not part of the monthly payment sent to the PACE organization each month.



Liability payment

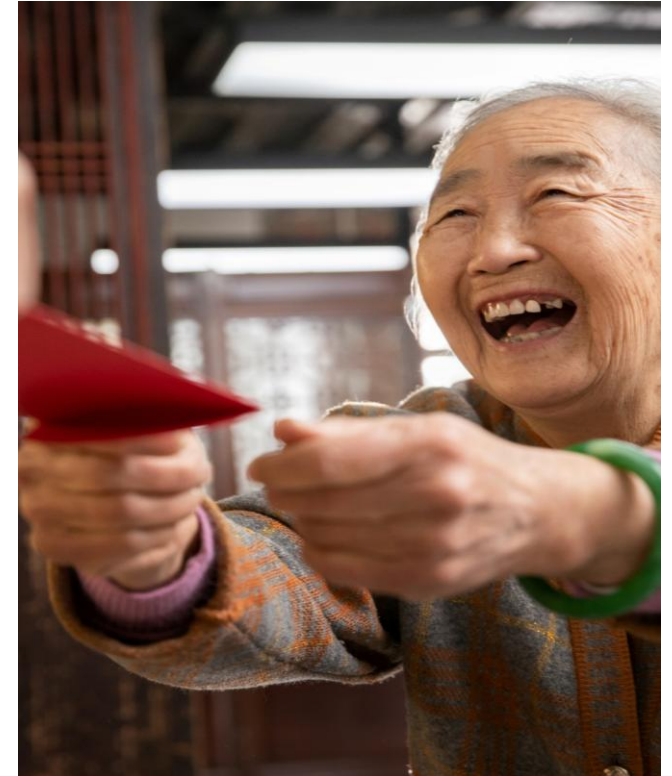
PACE participants who reside in a CBC facility or a NF are responsible for paying a liability payment, when appropriate. Participants receiving PACE services in their home are not required to pay a monthly liability payment.

Liability payments should be made to the LTSS provider. The local office(s), Office of Financial Services (OFS), and the PO will not receipt liability payments on behalf of the PACE participant. If a payment is received, it should be returned to the participant or representative with a note to contact the PO for further instructions. See APD-PT-25-021 for additional information.



PACE enrollment

Once the referral for PACE services is received, the PO Intake Specialists screen for PACE eligibility, provide information to prospective participants, and secure enrollment. Enrollment into PACE usually begins the first day of the month after the PACE enrollment agreement is signed. Diversion/Transition specialists may consult with the PO about enrollment into PACE as part of the discharge plan from the nursing facility into the community. Once notified of the date of enrollment by the PO, case managers should update CA/PS before the end of the month to avoid delays in PACE enrollment. Remember, do not set up a 512 payment; do not set up a POC in MMIS. All other services (i.e., ERS, LTCCN, BSS, IHCA, HDM, etc.) must be ended/closed and HCW timely notices sent since the PO will be responsible for providing those services.

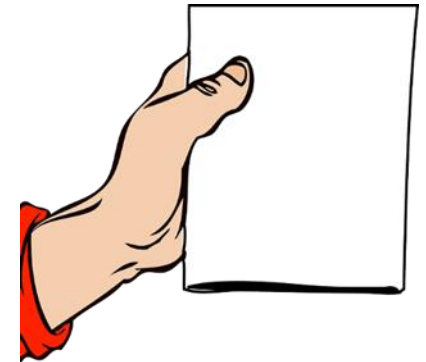


PACE disenrollment

There are two types of PACE disenrollment:

- **Voluntary** disenrollment may be initiated by the participant at any time without cause.
- **Involuntary** disenrollment may occur if (but not limited to):
 - Participant fails to make the pay-in payment; or
 - Engages in disruptive or threatening behavior (must be approved by Central Office); or
 - No longer meets eligibility criteria.

Participants must be given timely notice of disenrollment.

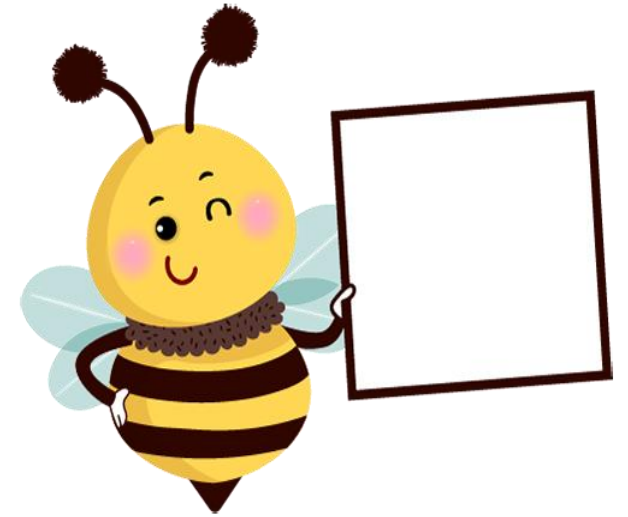


Voluntary disenrollment

When a PACE participant decides to disenroll from PACE services, the case manager should narrate the reason for the voluntary disenrollment.

The CM will set up the comparable APD benefit, to be effective the first of the following month after PACE disenrollment.

Disenrollment takes effect on the last day of the month in which the paperwork for disenrollment was completed.



Involuntary disenrollment

All involuntary disenrollments must be reviewed and approved by Central Office before the PACE organization (PO) can disenroll the participant. The PO is required to provide a 30-day notice whenever they involuntarily disenroll a participant from PACE. In such cases, the end date will be the last day of the following month.

For example, a participant leaves the state on 6/15 and is not expected to return. The PACE organization initiates a 30-day involuntary disenrollment notice on 6/20 stating PACE enrollment will end on 7/31 for failure to reside in a PACE service area.

The PACE organization will provide adequate notice to the case manager to allow for closure of the case or to allow time for alternate placement of the consumer.

The end date of the Benefit and Service plans should match the end date of PACE enrollment.



Involuntary disenrollment Medicaid and service eligibility

A participant can be disenrolled from PACE services if they are no longer eligible for Medicaid and/or no longer SPL 1-13. In this instance, the case manager will notify the PO of the participant's eligibility status and coordinate the end date of PACE enrollment, benefits, and services. A copy of closure and/or reduction notices should be sent to the PO. As stated previously, the PO must provide a 30-day notice for an involuntary disenrollment – benefits, services, and enrollment cannot end mid-month – so the end date will usually be the last day of the following month. See APD-PT-25-005 for additional information.

For example, ineligibility is discovered on April tenth ; the involuntary disenrollment notice will have an end date of May 31, so the benefit and service plans will also have an end date of May 31.



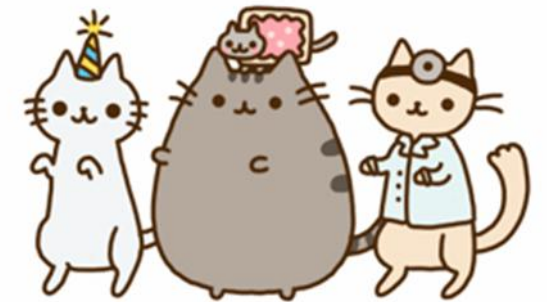
PACE deeming and EWE

CFR §460.160(2)(3) allows a consumer to be “deemed continued eligibility” (also referred to ‘deeming’) if the participant is found to be ineligible for Medicaid funded Long Term Services and Supports (LTSS) as assessed by the State and would have a significant decline in health within 6 months of disenrollment from PACE.

Extended Waiver Eligibility (EWE) criteria are utilized when a consumer receiving LTSS and has been assessed, according to the process outlined in **OAR 411-015-0008**, at Service Priority Level (SPL) 14 – 18. A consumer may be eligible for EWE if they meet the criteria outlined in **OAR 411-015-0030(1)(a-c)**.

See APD-PT-18-038 for more information.

The PACE Deeming guide is located on the CM Tools page under Program of All-inclusive Care for the Elderly, in the Tools section.



PACE deeming and EWE continued

When a PACE participant scores above SPL 14 – 18 at reassessment, the CM will notify the PO of the assessment outcome and provide a copy of the SDS 002N. The PO Interdisciplinary Team (IDT) will determine if PACE deeming will be requested. An extension of the current benefit may be needed during the PACE deeming review process.

When PACE deeming is being requested, the PO will send the request and supporting documentation to the local office for review. The local office team (may include CM, QA staff, leadership, etc.) will review the request, supporting documentation, assessments, and other documentation from care provider(s) if available, and decide if they agree with the request. If the local office team and the PO cannot agree on the request for PACE deeming, the request and documentation is sent to the PACE Policy Analyst for a final decision.

Extended Waiver Eligibility (EWE) services should be reviewed if PACE Deeming is denied.



Case set-up for PACE deeming

Do not extend the previous assessment for the remainder of the new assessment period. **Do not** create a new benefit plan in Oregon ACCESS (OA). The PACE Policy Analyst will work with the Mainframe Analysts to code SELG with the appropriate information for continued service eligibility.

When PACE Deeming is approved, the CM will:

- Ensure the new assessment is in 'Complete' status
- Narrate the approval for deeming in OA
- Set up a reminder on the case for the reassessment to be completed in 12 months
- Set up a reminder on the case to send a Buckley notice prior to the reassessment
- Send to the State PACE Policy Analyst via email:
 - Participant name
 - Prime number
 - Start and end dates of the benefit



Hearings, grievances and appeals

The participant may request a **State Administrative Hearing** if dissatisfied with the outcome of the grievance and/or appeals processes. The CM will assist the participant with completing the appropriate form(s) and submitting the request to the Office of Administrative Hearings (OAH). The Continuation of Benefits section on the hearing request form should be marked.

During the hearings process, the PACE benefit should remain open/active until the hearing process is completed.

The PO has its own processes when a participant is unsatisfied with the benefits or services they receive from the PO. Those processes are defined below.

Grievance: a complaint, either in writing or verbally, expressing dissatisfaction with the service delivery or the quality of care being provided.

Appeal: a request for review of an 'action' or 'inaction' of service(s) that may be perceived as having a negative impact on the participant's care.



Setting up a PACE case

- Setting up the benefit and service plans – New case
- Steps to convert a case to PACE – Existing case
- MMIS Enrollment



New case – PACE enrollment

CAPS

1. Choose the benefit type: PACE In-Home or PACE Residential or PACE Nursing Facility
 2. The Benefit Plan start date is the PACE enrollment date.
 3. The Benefit Plan end date is the end date of the assessment period.
 4. The Service Plan is either PACE In-Home or PACE Residential or PACE Nursing Facility – dependent on the Benefit Plan choice in step 1.
 5. The Service Plan start and end dates should match the Benefit Plan start and end dates.
 6. Locate the provider using the Provider Search – search by provider name or number. The provider Type should remain “Capitated Provider” since the PACE providers are listed in this category.
 7. Approve the Benefit Plan then the Service Plan.
- Please note:** PACE Nursing Facility is used only for participants currently enrolled in PACE that have been placed in a NF by the PACE organization.

Benefit Eligibility and Service Planning

Assmt Date: 09/03/20 Valid Until: 09/30/21 Pay Date: 10/09/21

Select Assessment
09/03/2020 XIX (Comp) ▼

Assessment Type:
Title XIX

Review Date:
09/30/2021

Status:
Completed

Assessment by:
[REDACTED]

Referrals

IBL Screening

Plan Summary

Model

Benefits					Ben Act
Service Category/Benefit	Begin Date	End Date	Status		
APD-In Home	10/11/2020	04/30/2021	Approved		
PACE - In Home	05/01/2021	09/30/2021	Pending		

Hours Segments						View Dtl
Hours #	Begin Date	End Date	Status	Alwd	Excp	Hrs Act
1	00/00/0000	00/00/0000	N/A	0	0	

Plans For PACE - In Home Benefit (Read Only)

Plan #	Begin Date	End Date	Status	
1	05/01/2021	09/30/2021	Pending	

Services For Plan #1						Pln Act
Row #	Services	Provider Name	Begin Date	End Date	Invalid Entry	
1	PACE - In-Home	TO BE SELECTED	05/01/2021	09/30/2021	<input type="checkbox"/>	

Provider Search Needs Association View/Assign Hours Provider Detail

Existing cases – PACE enrollment

The processes for setting up PACE for an existing case in CAPS:

End the current service benefit on the last day of the month (circled in green) prior to the PACE Benefit begin date. The process for setting up CA/PS is the same as setting up for a new case.

Additional information to consider:

- **Close the 512:** end date should be the last day of the month prior to PACE enrollment.

Example: close the 512 on 4/30/2026; start the PACE benefit and service plans on 5/01/2026

- If the participant is moving, ensure ONE and MMIS have the correct residence address as the **FIPS codes must match the PACE Service Area.**
- **End other services and any MMIS provider authorizations:** end date should be the last day of the month prior to PACE enrollment. It is important to prorate any authorizations for HCW or IHCA authorizations, if needed. Send necessary notices.

MMIS enrollment

Once CA/PS is approved, the information is sent to MMIS and should show up the next day. This information will automatically enroll the participant into the PACE medical benefit package. Enrollment into the PACE medical benefit package ensures payment to the PACE organization and the correct enrollment for Medicaid benefits. Make sure ONE and MMIS have the correct residence address as the **FIPS codes must match the PACE Service Area** otherwise enrollment into the PACE medical benefit in MMIS will not occur and the PACE organization will not be paid.

Active	Active
Benefit Plan	CRN 07/01/2013 - 12/31/2299 ▼
Medicare Coverage	A & B & D
TBQ Record	APPLIED
Managed Care	PACE 05/01/2020 - 12/31/2299 ▼
TPL	No
Lockin	
Level of Care	PACE 05/01/2020 - 09/30/2020 ▼
Patient Liability	CC 05/01/2020 - 12/31/2299 ▼
Medicare Buy-in	B

Collaboration and communication

PACE is a partnership, not just between participants and the program, but also with the APD/AAA Offices, the PO and the State of Oregon. Effective and frequent communication between local office staff and the PO will ensure the PACE participant's health, social, and care needs are being met. Local office staff are strongly encouraged to continue communications with PACE participants. Collaboration and communication are the keys to achieving the goals of enhancing the quality of life for the Oregonians we serve.



Resources

Centers for Medicare and Medicaid Services – PACE

www.cms.gov/medicare/medicaid-coordination/about/pace

National PACE Association

www.npaonline.org/

PACE CFR 460 Title 42 → Chapter IV → Subchapter E → Part 460

www.ecfr.gov/current/title-42/chapter-IV/subchapter-E/part-460

CM Tools page

www.oregon.gov/odhs/providers-partners/seniors-disabilities/Pages/other.aspx

State PACE Brochure Form DE 2658

sharedsystems.dhsoha.state.or.us/forms/

Key Resources



PACE organization contacts

PacificSource PACE (Lane County)

458-544-0400

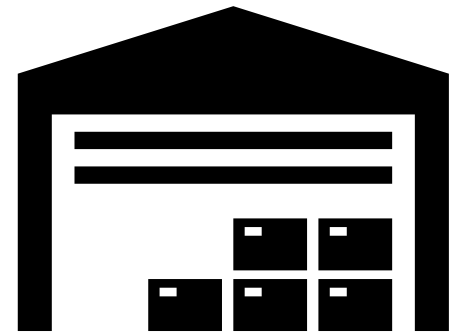
pace@pacificsource.com

Providence PACE - Oregon Intake Specialists

503-215-6556 (metro service areas)

503-717-7150 (North Coast service area)

paceorinfo@providence.org



State contacts

Lisa Bouchell, PACE Policy Analyst, APD

lisa.bouchell@odhs.oregon.gov

Cindy Susee, PACE Financial Analyst, APD

cynthia.susee@odhs.oregon.gov

PACE email: apd.pace@odhsoha.oregon.gov

PACE Information - Oregon Toll-free: 1-844-224-7223



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Human Services