Program of All-Inclusive Care for the Elderly Plus Act (PACE Plus Act, S.1162)

SECTION 1. SHORT TITLE.

This Act may be cited as the "Program of All-Inclusive Care for the Elderly Plus Act" or the "PACE Plus Act".

SECTION 2. PACE EXPANSION GRANT PROGRAM.

(a) Definitions.

(b) Establishes eligibility and use of funds criteria on a grant program for new or expanding PACE programs in rural or underserved urban areas with an award amount to not exceed $1 million per site for a maximum of 30 awards.

(c) Not later than 60 months after enactment the Secretary shall submit to Congress a report containing the evaluation of the experience of grant recipients.

(d) Establishes eligibility and use of funds criteria on a grant program to States seeking to establish PACE programs with an award amount not to exceed $100,000 per State for a maximum of 20 awards.

SECTION 3. TWO-WAY PACE AGREEMENTS.

(a) Codifies the ability of PACE programs to operate in a State that has not elected PACE as a State Medicaid benefit to serve Medicare-only beneficiaries.

(b,1) For a PACE provider operating in a State that has not elected PACE as a State Medicaid benefit, the Secretary shall administer provisions with which the State would normally oversee.

(b,2) For a PACE provider operating in a State that has not elected PACE as a State Medicaid benefit, the assessment of whether an individual requires the level of care equivalent to that of a nursing facility shall be made by an independent entity based on a level of care assessment tool used by the State.

SECTION 4. ANYTIME ENROLLMENT IN PACE.

(a,1) Ensures a PACE program eligible individual is, under Medicare, eligible to enroll in PACE effective on the date the PACE provider receives the eligible individual's signed enrollment agreement. Clarifies that in the case of a dual eligible beneficiary, anytime enrollment shall only apply if the State in which the individual resides has elected to institute anytime enrollment.

(a,2) Specifies that if a PACE program eligible individual is enrolled in PACE on an effective date that is not the first day of a month, the Medicare capitation amount received by the PACE program shall be prorated.

(b,1) Permits States to elect anytime enrollment under Medicaid and ensures that if a State elects anytime enrollment the eligible individual is able to enroll in PACE effective on the date the PACE provider receives the eligible individual's signed enrollment agreement.

(b,2/3) Specifies that if a State elects anytime enrollment under Medicaid and the PACE program eligible individual is enrolled in PACE on an effective date that is not the first day of the month, the Medicaid capitation amount received by the PACE program shall be prorated.

SECTION 5. IMPROVING ACCESS TO AND AFFORDABILITY OF PACE PROGRAMS FOR MEDICARE BENEFICARIES WHO ARE NOT DUAL ELIGIBLE BENEFICIARIES THROUGH FLEXIBILITY IN RATE SETTING FOR SERVICES NOT COVERED BY MEDICARE.

(a,1) Codifies that in the case of a Medicare-only PACE program eligible individual, the PACE provider may charge the participate a monthly capitation payment for Medicaid long-term services and supports.

(a,2) Outlines that a Medicare-only PACE program participant's monthly capitation payment for Medicaid long-term services and supports shall be determined by the PACE provider based on an assessment and take into account the level of care needs of the participant. The monthly capitation amount may be adjusted not more frequently than once a quarter based on the participant's needs.

(a,3) Clarifies participant protections, including that a provider shall disclose to the PACE program eligible individual the capitation payment amounts that may be charged and the assessment tool that will be used. Also outlines PACE program participants rights to seek review of on their level of care assessment.

SECTION 6. PACE SITE APPROVAL AND EXPANSION.

(a) Establishes that PACE providers may submit new provider and service area expansion applications to the Centers for Medicare and Medicaid services at any time. Clarifies that the PACE provider must have their interdisciplinary team in place at the time the center becomes operational and provide assurances that personnel will commensurate with enrollment to full projected census. All applications are deemed approved within 45 days unless the Secretary denies the application or seeks further clarification.

SECTION 7. PACE PILOT.

(1) Establishes the testing of a national PACE pilot on expanded eligibility for high-need and high-cost populations that are not otherwise eligible to participate in PACE.

(2) Outlines the parameters of such pilot to improve health and reduce cost, including that PACE providers shall receive fixed monthly capitated rates through both Medicare and State Medicaid programs for all services provided and that PACE providers shall partner with non-PACE providers such as Area Agencies on Aging, Centers for Independent Living, local hospitals and non-hospital providers to

effectively reach the targeted population. Further requires PACE providers interested in participating in such pilot to conduct a survey or needs assessment of their service area to determine the most appropriate high-need high-cost population with which to expand eligibility and ensures technical assistance will be available to PACE providers interested in said pilot.

SECTION 8. STATE OPTION TO EXPAND ELIGIBILITY FOR PACE PROGRAM.

(l,1) Provides State Medicaid agencies the option to expand the definition of PACE program eligible individuals beyond those deemed to require a nursing home level of care.

(l,2) Retains existing eligibility requirements of aged 55 years and older and residency within service area of the PACE program. Enables States to extend eligibility to include an individual that is unable to perform at least two (or such higher number as the State may establish) actives of daily living and with an income that does not exceed 150 percent federal poverty.

(l,3) Clarifies that a State is only eligible to participate if they have agreed to offer PACE as a Medicaid benefit.

(l,4) Provides States a 90 percent FMAP to cover such expanded eligibility.

SECTION 9. COORDINATION WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.

(m) Codifies the role of the Federal Coordinated Health Care Office as a point of contact between State Medicaid agencies and the federal government, including staff and offices at CMS for the purposes of implementing and operating PACE programs. The office shall submit a report to Congress on the demographics of populations served under PACE annually.