Programs of All-Inclusive Care for the Elderly (PACE)
Appendix I: Glossary

Table of Contents
(Rev. 2, Issued: 06-09-11)

ACA: Affordable Care Act

ACS - Alternative Care Setting: A physical facility, other than the participant's place of residence, where PACE participants receive any of the required services as defined in 440.98 (c).

Adverse Participant Outcome: A serious, undesirable and unexpected outcome of participant's care or treatment.

Advertising: Advertising materials are primarily intended to attract or appeal to a potential plan enrollee. Advertising materials contain less detail than other marketing materials, and may provide benefit information at a level to entice a potential enrollee to request additional information.

Appeal: An appeal is defined as a participant's action taken with respect to the PACE organization's non-coverage of, or nonpayment for a service, including denials, reductions, or termination of services.

Audit Team: A group of people comprised of CMS, State Administering Agency staff, or their designees who are assigned to perform a PACE Organization audit.

Audit: An external review of a PACE organization's practices and procedures to determine compliance with CMS program requirements.

BBA: Balanced Budget Act of 1997

CDC: Centers for Disease Control & Prevention

CMS - Centers for Medicare & Medicaid Services: The Centers for Medicare & Medicaid Services is federal agency that runs the Medicare program and partners with the States to run the Medicaid program.

CMP: Civil Monetary Penalty

COB: Coordination of Benefits

Contract Year: The term of a PACE Program Agreement, which is a calendar year, except that a PACE organization's initial contract year may be from 12 to 23 months, depending on the effective date of program implementation.

CAP - Corrective Action Plan: A formal written plan submitted by a PACE organization to CMS to rectify/address deficiencies identified as a result of a PACE Audit.

CAR - Corrective Action Required: A term historically used in audit reports requesting a CAP from the PACE organization in response to a deficiency.

Desk Review: Review of information or documentation conducted by CMS and the State Administering Agency that is not performed at the PACE site.

Dual Eligibles: Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

ECRS: Electronic Correspondence Referral System

Emergent Care: Services that are needed immediately because of an injury or sudden illness and the time required to reach the PACE organization or one of its contract providers would cause risk of permanent damage to the participant's health.

Enrollment Materials: Materials used to enroll or disenroll from a plan, or materials used to convey information specific to enrollment and disenrollment issues such as enrollment and disenrollment forms.

ESRD: End Stage Renal Disease

FFS: Fee-for-Service

First Trial Period Audit: First of three on-site yearly audits conducted during the PACE organization's first three years of operation to ensure compliance with the PACE regulations.

Grievance: A complaint, either written or oral, expressing dissatisfaction with the service delivery or the quality of care furnished.

HIPAA - Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191): Legislation passed in 1996 that addresses security and privacy of health data and requires CMS to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employer.

HPMS - Health Plan Management System: Collects data for and manages the following plan enrollment processes for the MA and Part D programs: application

process, bid/benefit package submissions, formulary submissions, marketing material reviews, plan oversight, complaints tracking, survey data, operational data feeds for enrollment and payment, and data support for the Medicare & You Handbook and Medicare website (http://www.medicare.gov). HPMS supports these processes for all private plans participating in the MA and Part D programs.

HOS-M: Health Outcomes Survey- Modified

IDT - Interdisciplinary Team: A group of knowledgeable clinical and non-clinical PACE center staff, employed or contracted, responsible for the holistic needs of the participant who work in an interactive and collaborative manner in order to control the delivery, quality, and continuity of care for each participant.

IME: Indirect Medical Education

IRE: Independent Review Entity

Level II Event: Unusual incidents that have significant impacts on the health and/or safety of a PACE participant, or the PACE Program, in the case of media related events.

Level I Reporting: The submission of the aggregated monitoring data elements via the PACE monitoring module of the Health Plan Management System (HPMS).

Level II Reporting: The reporting of events resulting in significant harm to participants, or negative national or regional notoriety related to the PACE program.

LSC: Life Safety Code

MA-only Plan: A CMS health care managed care offering for Medicare beneficiaries.

MA-PD: Medicare Advantage-Prescription Drug Plan. CMS health care managed care offering for Medicare beneficiaries that includes prescription drug coverage.

Marketing: Information a PACE organization provides to the public about their program and gives to prospective participants in order to steer, or attempt to steer, a potential enrollee towards their plan.

Marketing Materials: Materials used to promote the PACE program to enrollees and potential enrollees.

MBD: Medicare Beneficiary Database

Medicare Beneficiary: An individual who is entitled to Medicare Part A benefits or enrolled under Medicare Part B, or both.

MSP: Medicare Secondary Payor

NDM: Network Data Mover

On-site Review: Audit conducted at the PACE organization's site.

PACE: Programs of All-Inclusive Care for the Elderly.

PACE Center: A facility which includes a primary care clinic and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining, and which serves as the focal point for coordination and provision of most PACE services.

PACE Medicaid Participant: An individual determined eligible for Medicaid who is enrolled in a PACE program.

PACE Medicare Participant: A Medicare beneficiary who is enrolled in a PACE program.

PACE Organization: An entity that has in effect a PACE Program Agreement to operate a PACE program.

PACE Participant (or Participant): An individual enrolled in a PACE program.

PACE Program Agreement: An agreement between a PACE organization, CMS, and the State Administering Agency for the operation of a PACE program.

PACE Program: A program operated by an approved PACE organization that provides comprehensive healthcare services to PACE enrollees in accordance with a PACE Program Agreement and the Part 460 regulations.

PACE Trial Period: The first three contract years in which a PACE organization operates under a PACE Program Agreement, including any contract year during which the entity operated under a PACE demonstration or a PACE demonstration waiver program.

PBM - Pharmacy Benefit Manager: An entity contracted with a PACE organization to provide management of the Part D drug benefit. Contracted functions can vary and can range from point of sale claims adjudication to processing Part D appeals.

PBP: Plan Benefit Package

PCA: Personal Care Aide

PCP: Primary Care Physician

PCUG: Medicare Advantage & Prescription Drug Plan Communications User Group

Plan to Plan Reconciliation (P2P): The process by which PACE organizations reconcile prescription drug payments made by the PACE organization for participants enrolled in another plan.

PDE - Prescription Drug Event: Data which details each drug or claim for a drug that a participant receives under the Part D program.

PDP - Prescription Drug Plan: CMS health care offering for Medicare beneficiaries that includes ONLY prescription drug coverage.

Private Pay: The individual does not have Medicare or Medicaid to cover the cost of PACE and must use other resources to pay for participation in the program.

PHI - Protected Health Information: A term which refers to individually identifiable health information, the disclosure of which is restricted by the HIPAA Privacy Rule.

Provider: A commonly used term meant to encompass all health care professionals, except pharmacists, who provide medically necessary health care to enrollees.

QAPI - Quality Assessment and Performance Improvement Plan: A tool for achieving the levels of performance on quality standards and guidelines, data and information required by CMS. This plan is a description of the organization's quality assessment and performance improvement program.

Quality: Quality is how well the health plan keeps its members healthy and treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results.

RDS: Retiree Drug Subsidy

RO: Regional Office

Services: Medical care and items such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital RPCH or SNF facilities.

SAE - Service Area Expansion Application: A request submitted by an existing PACE organization to expand current services into other zip codes, counties, street boundaries, census tracts, blocks, or tribal jurisdictional areas.

Service Area: A geographic area approved by CMS and the State Administering Agency in which a PACE organization may accept members. Each PACE organization must be available to all eligible and appropriate individuals within its' service area(s).

SAA - State Administering Agency: The State agency responsible for administering the PACE Program Agreement.

SMA – State Medicaid Agency

SPA – State Plan Amendment

SRR - State Readiness Review: The purpose of this review is to determine the organization's readiness to administer the PACE program and enroll and serve participants. Every applicant must meet all of the requirements of the SRR prior to enrolling participants.

TAV - Technical Advisory Visit : CMS offers all new PACE organizations a Technical Advisory Visit (TAV) prior to their first regulatory audit. The purpose of the TAV is to ensure that new PACE programs are operating in accordance with the PACE regulations found in 42 CFR Part 460, disclosures in their PACE provider application, and provisions of the three-way program agreement.

TrOOP: True Out-of-Pocket

TBT: TrOOP balance transfer

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R2PACE	06/09/2011	Initial Publication of Manual	06/03/2011	NA
R1_SO	06/03/2011	Initial Publication of Manual - Rescinded and replaced by Transmittal 2	06/03/2011	NA

Back to top of Chapter