441—88.86 (249A) Access to PACE services. An enrollee's access to PACE services is governed by a comprehensive plan of care developed for each enrollee by an interdisciplinary team based on a comprehensive assessment of the enrollee's health and social status.

88.86(1) *Interdisciplinary team.* A PACE organization shall establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each enrollee.

a. Team composition. The members of the interdisciplinary team must primarily serve PACE enrollees. At a minimum, the interdisciplinary team shall be composed of the following members:

(1) Primary care physician.
(2) Registered nurse.
(3) Master's-level social worker.
(4) Physical therapist.
(5) Occupational therapist.
(6) Recreational therapist or activity coordinator.
(7) Dietitian.
(8) PACE center manager.
(9) Home care coordinator.
(10) Personal care attendant or attendant's representative.
(11) Driver or driver's representative.

b. Team responsibilities. Each enrollee shall be assigned to an interdisciplinary team functioning at the PACE center that the enrollee attends. The interdisciplinary team is responsible for the initial assessment, periodic reassessments, plan of care, and coordination of 24-hour care delivery for each assigned enrollee. Each interdisciplinary team member is responsible for the following:

(1) Regularly informing the team of the medical, functional, and psychosocial condition of each enrollee.
(2) Remaining alert to pertinent input from other team members, enrollees, and caregivers.
(3) Documenting changes in an enrollee's condition in the enrollee's medical record, consistent with documentation policies established by the medical director.

c. Exchange of information. The PACE organization must establish, implement, and maintain documented internal procedures governing the exchange of information between team members, contractors, and enrollees and their caregivers consistent with the federal requirements for confidentiality in 42 CFR Section 460.200(e) as amended to November 24, 1999.

88.86(2) *Initial assessment.* The interdisciplinary team must conduct an initial comprehensive assessment of each enrollee promptly following enrollment.

a. Each of the following members of the interdisciplinary team must evaluate the enrollee, at appropriate intervals, and develop a discipline-specific assessment of the enrollee's health and social status:

(1) Primary care physician.
(2) Registered nurse.
(3) Master's-level social worker.
(4) Physical therapist.
(5) Occupational therapist.
(6) Recreational therapist or activity coordinator.
(7) Dietitian.
(8) Home care coordinator.

b. At the recommendation of interdisciplinary team members, other professional disciplines (such as speech-language pathology, dentistry, or audiology) may be included in the comprehensive assessment process.

c. The assessment of each enrollee must include, but not be limited to, assessment of the following:

(1) Physical and cognitive function and ability.
(2) Medication use.
(3) Enrollee and caregiver preferences for care.
(4) Socialization and availability of family support.
(5) Current health status and treatment needs.
(6) Nutritional status.
(7) Home environment, including home access and egress.
(8) Enrollee behavior.
(9) Psychosocial status.
(10) Medical and dental status.
(11) Enrollee language.

88.86(3) *Plan of care.* The interdisciplinary team must promptly consolidate discipline-specific assessments into a single plan of care for each enrollee through discussion in team meetings and consensus of the entire team.

a. Development. The interdisciplinary team must develop, review, and reevaluate the plan of care in collaboration with the enrollee or caregiver, or both, to ensure that there is agreement with the plan of care and that the enrollee's concerns are addressed. In developing the plan of care, female enrollees must be informed that they are entitled to choose a qualified specialist for women's health services from the PACE organization's network to furnish routine or preventive women's health services.

b. Content. The plan of care must:

(1) Specify the care needed to meet the enrollee's medical, physical, emotional, and social needs, as identified in the initial comprehensive assessment.
(2) Identify measurable outcomes to be achieved.

c. Documentation. The interdisciplinary team shall document in the enrollee's medical record the plan of care and any changes made to the plan of care.

d. Implementation. The interdisciplinary team shall:

(1) Implement, coordinate, and monitor the plan of care, whether the services are furnished by PACE employees or contractors; and
(2) Continuously monitor the enrollee's health and psychosocial status, as well as the effectiveness of the plan of care, through the provision of services, informal observation, input from enrollees and caregivers, and communications among team members and other providers.

e. Evaluation. On at least a semiannual basis, the interdisciplinary team shall reevaluate the plan of care, including defined outcomes, and make changes as necessary.

88.86(4) *Reassessment.*

a. Semiannual reassessment. On at least a semiannual basis, or more often if an enrollee's condition dictates, the following interdisciplinary team members must conduct an in-person reassessment:

(1) Primary care physician.
(2) Registered nurse.
(3) Master's-level social worker.
(4) Recreational therapist or activity coordinator.
(5) Other interdisciplinary team members actively involved in the development or implementation of the enrollee's plan of care, such as the home care coordinator, physical therapist, occupational therapist, or dietitian.

b. Annual reassessment. On at least an annual basis, the following interdisciplinary team members must conduct an in-person reassessment:

(1) Physical therapist.
(2) Occupational therapist.
(3) Dietitian.
(4) Home care coordinator.

c. Unscheduled reassessments. In addition to annual and semiannual reassessments, unscheduled reassessments may be required based on the following:

(1) A change in enrollee status. If the health or psychosocial status of an enrollee changes, the interdisciplinary team members listed in paragraph 88.86(2)*"a"* must conduct an in-person reassessment.

(2) A request by the enrollee or designated representative. If an enrollee (or the enrollee's designated representative) believes that the enrollee needs to initiate, eliminate, or continue a particular service, the appropriate interdisciplinary team members, as identified by the interdisciplinary team, must conduct an in-person reassessment.

d. Changes to plan of care. Interdisciplinary team members who conduct a reassessment must:

(1) Reevaluate the enrollee's plan of care.
(2) Discuss any changes in the plan of care with the interdisciplinary team.
(3) Obtain approval of the revised plan of care from the interdisciplinary team and the enrollee or the enrollee's designated representative.
(4) Document all assessment and reassessment information in the enrollee's medical record.
(5) Furnish to the enrollee any services included in the revised plan of care as a result of a reassessment as expeditiously as the enrollee's health condition requires.

88.86(5) *Procedures for resolving enrollee request to change the plan of care.* The PACE organization must have explicit procedures for timely resolution of a request by an enrollee or an enrollee's designated representative to initiate, eliminate, or continue a particular service.

a. Except as provided in paragraph *"b"* of this subrule, the interdisciplinary team must notify the enrollee or the enrollee's designated representative of its decision to approve or deny the request from the enrollee or the designated representative as expeditiously as the enrollee's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request.

b. The interdisciplinary team may extend the 72-hour period for notifying the enrollee or the designated representative of its decision to approve or deny the request by no more than five additional days if:

(1) The enrollee or designated representative requests the extension; or
(2) The interdisciplinary team documents its need for additional information and how the delay is in the interest of the enrollee.

c. The PACE organization must:

(1) Explain to the enrollee or the enrollee's designated representative orally and in writing any denial of a request to change the plan of care; and
(2) Provide the specific reasons for the denial in understandable language.

d. The PACE organization is responsible for:

(1) Informing the enrollee or the enrollee's designated representative of the enrollee's right to appeal the decision as specified in 42 CFR Section 460.122 as amended to December 8, 2006.

(2) Describing both the standard and expedited appeals processes of the PACE organization, including the right to obtain and conditions for obtaining expedited consideration of an appeal of a denial of services as specified in 42 CFR Section 460.122 as amended to December 8, 2006.

(3) Describing the right to and conditions for continuation of appealed services through the period of an appeal as specified in 42 CFR Section 460.122(e) as amended to December 8, 2006.

e. If the interdisciplinary team fails to provide the enrollee with timely notice of the resolution of the request or fails to furnish the services required by the revised plan of care, this failure constitutes an adverse decision. The enrollee's request must be automatically processed by the PACE organization as an appeal in accordance with 42 CFR Section 460.122 as amended to December 8, 2006.

f. The PACE organization must submit all documentation related to an appeal to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.