DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PARTS C & D OVERSIGHT AND ENFORCEMENT GROUP

April 11, 2025

Mr. Michael Czermak
Chief Administrative Officer
Beacon Care Ventures dba BoldAge PACE
1075 Stephenson Avenue, Suite B
Oceanport, NJ 07757

Re: Notice of Imposition of Civil Money Penalty of Programs of All-Inclusive Care for the Elderly (PACE) contract number: H9323

Dear Mr. Czermak:

Pursuant to 42 C.F.R. §§ 460.40(b), 460.46(a)(4), and 460.50(b)(1)(ii) and 45 C.F.R. § 102.3, the Centers for Medicare & Medicaid Services (CMS) is providing notice that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **$47,596** for PACE contract number H9323.

CMS has concluded that Beacon Care Ventures dba BoldAge PACE (BoldAge) failed substantially to comply with the conditions of the PACE program or the terms of its PACE program agreement.

Background

CMS conducted an audit of BoldAge's operations from July 22, 2024, through August 02, 2024, in order to assess its overall compliance with federal PACE regulations at 42 C.F.R. Part 460. In a final audit report issued on January 6,2025, CMS reported that BoldAge failed to comply with PACE regulations related to PACE services and record maintenance in violation of 42 C.F.R. Part 460, Subparts F and L, respectively. Auditors found that BoldAge did not provide all approved services and did not track, document, and monitor the provision of services across all care settings.

Violations of the PACE program requirements include:

- Failure to provide care that meets the needs of each participant across all care settings, 24 hours a day, every day of the year;
- Failure to ensure accessible and adequate services to meet the needs of participants;
- Failure to document, track, and monitor the provision of services across all care settings; and

- Failure to document the reason(s) for not approving or providing services recommended by employees or contractors, including specialists.

As a result, CMS is imposing a CMP for BoldAge's failures.

PACE Program Requirements

The PACE program provides comprehensive medical and social services to certain frail, elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. PACE programs are designed to provide a range of integrated preventative, acute care, and long-term care services to manage the often complex medical, functional, and social needs of the frail elderly. Health care services provided by PACE organizations are designed to meet the following objectives:

- Enhance the quality of life and autonomy for frail, older adults;
- Maximize dignity of, and respect for, older adults;
- Enable frail, older adults to live in the community as long as medically and socially feasible; and
- Preserve and support the older adult's family unit.

PACE Required Services

(Sections 1894(b)(1)(A), (B), and (D) and 1934(b)(1)(A), (B), and (D) of the Act; 42 C.F.R. §§ 460.70(a), 460.90(b), 460.92, and 460.98(a))

A PACE organization must provide all items and services that are covered or specified under the PACE statute and regulations, including all Medicare- and Medicaid-covered items and services, and other services determined necessary by the interdisciplinary team (IDT) to improve and maintain the participant's overall health status. Participants must have access to necessary covered items and services 24 hours per day, every day of the year. In implementing that requirement, a PACE organization must establish and implement a written plan to furnish care that meets the needs of each participant in all care settings.

While a participant is enrolled in the PACE organization, he or she must receive Medicare and Medicaid benefits solely through the PACE organization. If the PACE organization cannot provide those items and services directly, it must specify them and arrange for the delivery of those items and services through a contractor. A PACE organization must have a written contract with each outside organization, agency, or individual that furnishes administrative or care-related services not furnished directly by the PACE organization, except for emergency services.

Interdisciplinary Team, Plan of Care, Primary Care Provider, and Service Delivery

(Sections 1894(f)(2)(B)(iii) and 1934(f)(2)(B)(iii) of the Act; 42 C.F.R. §§ 460.98, 460.102, 460.104, 460.106, and 460.210(b)(4) and (5))

PACE organizations are required to establish an IDT, composed of members filling specific roles at each PACE center, to comprehensively assess and meet the individual needs of each participant. The IDT is responsible for conducting initial assessments and periodic reassessments

of participants, developing and executing a plan of care, and coordinating 24-hour care delivery. The IDT must continuously monitor the participant's health and psychosocial status, as well as the effectiveness of the plan of care, through the provision of services, informal observation, input from participants or caregivers, and communications among members of the IDT and other providers in implementing the plan of care for a participant.

Each IDT member is responsible for the following:

- Regularly informing the IDT of the medical, functional, and psychosocial condition of each participant:
- Remaining alert to pertinent input from any individual with direct knowledge of or contact with the participant; and
- Documenting changes in a participant's condition in the participant's medical record consistent with policies established by the medical director.

The PACE organization must document, track, and monitor the provision of services across all care settings in order to ensure the IDT remains alert to the participant's medical, physical, emotional, and social needs regardless of whether services are formally incorporated into the participant's plan of care. In addition, the PACE organization must ensure that participants receive any services authorized or approved by the IDT in a manner that meets the participants' needs.

One of the required members of the IDT is the participant's primary care provider (PCP). PCPs are responsible for managing a participant's medical situations and overseeing a participant's use of medical specialists and inpatient care. In order for the PCP (and IDT) to accomplish this, the participant's medical record must include all recommendations for services made by employees or contractors of the PACE organization, including specialists. If a service recommended by an employee or contractor of the PACE organization, including a specialist, is not approved or provided, the medical record must include the reason(s) for not approving or providing that service.

In order for PACE organizations to ensure that services are accessible and adequate to meet the needs of participants, PACE organizations must be sufficiently managed, staffed, and equipped to provide the necessary care. Delays in receiving necessary services can result in adverse outcomes for participants.

Description of Non-Compliance

BoldAge substantially failed to comply with the conditions of the PACE program or terms of its PACE program agreement due to two primary reasons: (1) BoldAge failed to provide services that were adequate to meet the needs of its participants; and (2) BoldAge failed to provide services recommended by an employee or contractor, including a specialist, or failed to document the reason for not approving, or providing a recommended service, if applicable..

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addition, BoldAge failed to provide services that were approved by the IDT because it did not effectively document, track, and monitor the provision of services across all care settings. BoldAge did not demonstrate that it provided services as ordered, care planned or approved by the IDT in all of the 15 medical records, in two of the service determination requests, and one grievance sampled. For example:

- In 33 instances, BoldAge did not provide specialist consults that were determined to be necessary.
- In 17 instances, BoldAge failed to ensure ordered diagnostic tests were completed.
- In 6 instances, homecare was not provided as ordered.
- In 5 instances, participants did not receive their durable medical equipment (DME)
- In 7 instances, medications were not provided.
- In 4 instances, labs were not provided.
- In 1 instance, social work services were not provided.

BoldAge failed to provide services recommended by an employee or contractor of the PACE organization, including specialists, or failed to document the reason(s) for not approving, or providing a recommended service, if applicable.

BoldAge did not ensure that all recommendations made by employees and/or contractors, including specialists, were received and documented in the participant medical records. Also, BoldAge did not have an effective process to ensure its IDT either approved and provided recommended services or documented the rationale for not approving recommended services. BoldAge did not demonstrate that the IDT took appropriate action in response to all recommendations in 11 of the 15 medical records sampled. The identified noncompliance involved recommendations from hospital discharges, specialists, and primary care physicians.

Violations of PACE Requirements

CMS has determined that BoldAge violated the following PACE requirements:

1. BoldAge failed to ensure participants received necessary services. As a result, BoldAge failed to (1) provide care that meets the needs of each participant across all care settings, 24 hours a day, every day of the year; and (2) ensure accessible and adequate services to meet the needs of its participants, in violation of 42 C.F.R. § 460.98(a) and (b).

2. BoldAge failed to document, track, and monitor the provision of services across all care settings. As a result, IDT-approved services were not provided to participants, in violation of 42 C.F.R. § 460.98(b)(4).

3. BoldAge failed to document services recommended by an employee or contractor of the PACE organization, including a specialist, and the reason(s) for not approving or providing a recommended service, if applicable. As a result, services were either never provided to the participants or discussed by the IDT to determine if they were necessary, in violation of 42 C.F.R. § 460.210(b)(4) and (5).

Basis for Civil Money Penalty

Pursuant to 42 C.F.R. §§ 460.40(b), 460.46(a)(4), and 460.50(b)(1)(ii), CMS may impose a CMP if CMS determines the organization substantially failed to comply with the conditions of the PACE program or the terms of its PACE program agreement. CMS has determined that BoldAge's violations provide a sufficient basis for the imposition of a CMP as provided in 42 C.F.R. §§ 460.40(b), 460.46(a)(4), and 460.50(b)(1)(ii).

Right to Request a Hearing

BoldAge may request a hearing to appeal CMS's determination in accordance with the procedures outlined in 42 C.F.R. Parts 422 and 423, Subpart T. BoldAge must send a request for a hearing to the Departmental Appeals Board (DAB) office listed below by June 11, 2025.[1] The request for hearing must identify the specific issues and the findings of fact or conclusions of law with which BoldAge disagrees. BoldAge must also specify the basis for each contention that the finding or conclusion of law is incorrect.

The request should be filed through the DAB E-File System (https://dab.efile.hhs.gov) unless the party is not able to file the documents electronically. If a party is unable to use DAB E-File, it must send appeal-related documents to the Civil Remedies Division using a postal or commercial delivery service at the following address:

Civil Remedies Division
Department of Health and Human Services
Departmental Appeals Board
Medicare Appeals Council, MS 6132
330 Independence Ave., S.W.
Cohen Building Room G-644
Washington, D.C. 20201

Please see https://dab.efile.hhs.gov/appeals/to_crd_instructions for additional guidance on filing the appeal.

A copy of the hearing request should also be emailed to CMS at the following address:

Kevin Stansbury
Director
Division of Compliance Enforcement
Centers for Medicare & Medicaid Services
Email: kevin.stansbury@cms.hhs.gov

If BoldAge does not request an appeal in the manner and timeframe described above, the initial determination by CMS to impose a CMP will become final and due on June 12, 2025. BoldAge may choose to have the penalty deducted from its monthly payment or transfer the funds

[1] Pursuant to 42 C.F.R. §§ 422.1020(a)(2) and 423.1020(a)(2), the plan sponsor must file an appeal within 60 calendar days of receiving the CMP notice.

electronically. To notify CMS of your intent to make payment and for instructions on how to make payment, please email the enforcement contact provided in the email notification.

Impact of CMP

Further failures by BoldAge to provide its enrollees with Medicare benefits in accordance with CMS requirements may result in CMS imposing additional remedies available under law, including contract termination, intermediate sanctions, penalties, or other enforcement actions as described in 42 C.F.R. Part 460, Subpart D.

If BoldAge has any questions about this notice, please call or email the enforcement contact provided in the email notification.

Sincerely,

/s/

John A. Scott
Director
Medicare Parts C and D Oversight and Enforcement Group

cc: Kevin Stansbury, CMS/CM/MOEG/DCE
Kathleen Flannery, CMS/CM/MOEG/DPAO
Tamara McCloy, CMS/OPOLE
Annemarie Anderson, CMS/OPOLE
Yvette Banks, CMS/OPOLE
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