CHANGE NOTICE FOR MANUAL NO. 07-08, PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

DATE: JANUARY 28, 2008

Manual: **Aged, Blind, and Disabled Medicaid**

Change No: **07-08**

To: **County Directors of Social Services**

Effective: **February 1, 2008**

I. BACKGROUND

Program of All-Inclusive Care for Elderly (PACE) is a federal program administered by the Centers for Medicare and Medicaid Services (CMS). PACE was authorized under the Balanced Budget Act of 1997 (P.L. 105-33), under which:

- Section 4801 authorizes Medicare coverage of PACE services; and
- Section 4802 authorizes the establishment of PACE as a state option under Medicaid.

The State of North Carolina has received approval from the CMS to amend the state plan to include PACE as a state plan option. House Bill 1414 of the 2004-2005 Session of the North Carolina General Assembly mandated the development of PACE programs.

II. INTRODUCTION

The Program of All-Inclusive Care for the Elderly (PACE) is a managed care program that enables elderly individuals who are certified to need nursing facility care to live as independently as possible. PACE providers receive monthly Medicare and/or Medicaid capitation payments for each eligible enrollee. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

A. Description of PACE

The PACE program is a unique managed care benefit for the frail elderly provided by a not-for-profit or public entity. The PACE model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.

B. PACE Provider Activity

The first North Carolina PACE organization to be developed and receive approval by CMS is Elderhaus, Inc. of Wilmington. Individuals residing in New Hanover County and a small portion of Brunswick County are eligible to apply for PACE enrollment with Elderhaus.

C. PACE Enrollment Eligibility

To enroll in PACE, an individual must:

- Be 55 years of age or older;
- Certified by the State to require nursing facility level of care;
- Able to live safely in the community at the time of enrollment; and
- Reside in the service area of the PACE organization.

D. PACE Services

Services provided directly by the PACE provider include, but are not limited to:

- Interdisciplinary team case management;
- Adult day health program;
- Skilled nursing care;
- Primary care physician services;
- Specialized therapies;
- Personal care services;
- Nutrition counseling;
- Meals;
- Transportation; and
- Prescriptions.

III. POLICY PRINCIPLES

A. Non-Financial Rules

1. A PACE participant's eligibility will be determined under rules applying to institutional groups.

2. The effective date PACE budgeting can begin is the first day of the month following the month of PACE enrollment. Medicaid eligibility for a PACE participant ends the last day of the month of disenrollment. There is no retroactive coverage for PACE.

3. The applicant/recipient must:

   a. Meet the state's nursing home level of care criteria (have a completed FL-2, Long Term Care Services prior approval form).

   b. Be age 55 or over.

   c. Live in a PACE service area.

B. Financial Rules

1. The applicant must be financially eligible for Medicaid in the Aged, Blind, and Disabled (MAABD) aid program/categories.

2. Participants with higher income may be required to contribute to their cost of care. The patient monthly liability (pml) must be paid to the PACE organization.

3. Effective the month the a/r is enrolled in the PACE program, the budget unit is one. PACE budgeting begins the month following the month of PACE enrollment. The reserve limit is for a b.u. of one.

4. The Continuous Period of Institutionalization (CPI) begins the month the applicant/recipient signs the PACE Enrollment Agreement with the PACE organization.

5. A special needs allowance of 100% of the poverty level is excluded from participant's income when an individual resides in his home or is in a nursing facility temporarily. If permanent placement in a nursing facility is required, the needs allowance up to $242 may be excluded from income. Note: Due to the fact that the individual no longer resides in his home, the special personal needs allowance of 100% of the poverty level is no longer applicable.

   a. Temporary nursing facility placement is defined as less than six months.

   b. Permanent nursing facility placement is defined as six or more months.

6. Spousal impoverishment protection rules apply.

7. Dependent family member allowance applies.

8. Transfer of assets sanctions apply to PACE. However, when a PACE individual is in penalty status and he remains enrolled in the PACE program, he is ineligible for Medicaid under any program/category.

C. "Lock-In" Provision

PACE recipients receive all medical services through the PACE Center. Individuals authorized for PACE do not receive a monthly Medicaid card because PACE is the sole source of Medicaid services.

D. Part D Provider

Individuals enrolled with PACE do not enroll with a Medicare Prescription Drug Plan (PDP). The PACE organization is also the PDP provider. Medicare Part D enrollment is completed by the PACE organization.

E. Medicare Part B Buy-In

PACE recipients eligible for Medicare qualify for Medicare enrollment and buy-in.

F. Health Insurance

Third party liability requirements and procedures are not applicable for PACE applicants/recipients.

G. Estate Recovery

PACE individuals are subject to estate recovery.

IV. MEDICAID AUTHORIZATION FOR PACE SERVICES

Authorization for PACE services is always effective on the first day of the month and always ends on the last day of the month. There is no retroactive coverage for PACE.

Once an individual is enrolled into the PACE program by the PACE organization and Medicaid under PACE begins, he is ineligible for Medicaid in any aid program/category except as a PACE authorized recipient.

Keying PACE information into EIS correctly and by EIS processing dates is extremely important. Failure to enter the correct information or failure to enter the information timely will result in no payment to the PACE organization or erroneous payment to the PACE organization.

V. MEDICAID AND PACE COMMUNICATION AND REFERRALS

A. Individuals requesting PACE services must be referred to the PACE organization to apply for enrollment into the program.

B. The PACE organization will refer PACE applicants to the department of social services when financial assistance is requested or needed.

C. Although application processing times apply to PACE, the State encourages the Medicaid PACE authorization process be expedited. Communication between the department of social services and the PACE organization is crucial in order to coordinate beginning and end dates for PACE authorization in Medicaid.

D. A referral form, DMA-5106, Medicaid/PACE Referral (MA-2275, Figure 1), has been developed to be used as a communication, notification, and documentation tool between the agencies. DMA-5106, Page 1, is completed by the county. DMA-5106, Page 2, is completed by the PACE organization.

VI. APPEAL AND HEARING PROCESS

A. PACE Internal Appeal

When a service is denied or not paid, PACE individuals may request a PACE internal appeal with the PACE organization. If after the PACE internal appeal process the individual is not satisfied, then a Medicaid appeal may be requested. An individual enrolled in PACE may request a Medicaid hearing through the PACE organization or by contacting the county dss.

B. Medicaid Appeal

Medicaid appeal requirements apply to PACE cases just as with any other Medicaid case.

C. PACE Appeal Referral

PACE Referral, Request for a Medicaid Hearing form (MA-2275, Figure 2), is a suggested notification form to be used by the PACE organization. PACE staff will assist PACE enrollees in the hearing and appeal request process and forward requests to the Department of Social Services.

VII. EIS POLICY AND PROCEDURES

Although the EIS Manual policy is not updated at this time, the Eligibility Manual policy provides references and links to the EIS policy for use in the future. EIS policy will be incorporated into the EIS manual in the near future. Until that time, use EIS Administrative Letter 02-08 as guidance. The EIS Administrative Letter will be issued in early February.

VIII. PACE APPLICATION REPORT

Because the PACE organization enrolls very frail individuals in immediate need of services, close monitoring of the Medicaid application processing steps will be done by the Division of Medicaid (DMA). It should be noted that delays caused by lag time in the effective dates of Medicaid eligibility could cause significant financial hardship for the PACE organization.

Figure 3, PACE Application Report, must be completed for all individuals that request PACE services. The form should be completed at the time of an individual's disposition and faxed to the Division of Medical Assistance (DMA), Medicaid Eligibility Unit. The fax number is (919) 715-0801.

IX. OTHER CHANGES

MA-2230, Financial Resources has been revised to provide additional instructions for the annuity evaluation process for applications and redeterminations. A copy of the annuity, the a/r's name, Medicaid ID number, case number, and a short explanation identifying the annuity as a resource or asset must be sent to TPR.

X. EFFECTIVE DATE AND IMPLEMENTATION

This policy is effective February 1, 2008. This policy applies to any applications taken on or after this date in the approved PACE service area.

XI. MAINTENANCE OF MANUAL

A. Insert:	**New Manual Section MA-2275, Program of All-Inclusive Care for the Elderly (PACE), Figure 1, Figure 2, and Figure 3.**
B. Remove:	**MA-200, Definitions, pages 19 – 20.**
C. Insert:	**MA-200, Definitions, pages 19 – 20.**
D. Remove:	**MA-2230, Financial Resources, pages 17 – 18, and 95 - 96.**

E.	**Insert:**	**MA-2230, Financial Resources, pages 17 – 18, and 95 - 96.**
F.	**Remove:**	**MA-2240, Transfer of Assets, pages 1 – 56, Figure 2, and Figure 3.**
G.	**Insert:**	**MA-2240, Transfer of Assets, pages 1 - 56, Figure 2, and Figure 3.**
H.	**Remove:**	**MA-2241, Transition Policy for In-Home Health Services & Supplies, pages 1 – 2.**
I.	**Insert:**	**MA-2241, Transition Policy for In-Home Health Services & Supplies, pages 1 – 2.**
J.	**Remove:**	**MA-2250, Income, pages 1 – 2.**
K.	**Insert:**	**MA-2250, Income, pages 1 – 2.**
L.	**Remove:**	**MA-2301, Conducting a Face-to-Face Interview, pages 5, 6, 9, 10 and Figure 5.**
M.	**Insert:**	**MA-2301, Conducting a Face-to-Face Interview, pages 5, 6, 9, 10 and Figure 5.**

If you have any questions regarding this information, please contact your Medicaid Program Representative. For any issues that are not able to be handled through that venue, Mrs. Angela Floyd, Assistant Director for Recipient and Provider Services, will be your point of contact and can be reached at (919) 855-4000.

Dr. William W. Lawrence, Jr., M.D.
Acting Director

[This material was written by Charlotte Gibbons, Policy Consultant, Medicaid Eligibility Unit.]