

State Roles and Responsibilities Related to PACE Eligibility



Cindy Proper

Carrie Smith, MBA

*Division of Health Homes, PACE and
Coordination of Benefits (COB)/Third
Party Liability (TPL), Disabled and
Elderly Health Programs Group, CMS*

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Basic Eligibility Requirements

460.150(b)

- 55 years of age or older
- Determined by the state administering agency (state) to need the level of care required under the state Medicaid plan for coverage of nursing facility services
- Reside in the service area of the PACE organization (PO)

Nursing Facility Level of Care Eligibility Requirement

- The process for determining level of care varies operationally across states, but ultimately it is the state's responsibility
 - Some states delegate part of the determination process to the PO
- The state determines level of care for all PACE applicants, not just those that are eligible for or are applying for Medicaid

Other Eligibility Requirements

460.150(c)

At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety

Note: The criteria used to determine if an individual's health or safety would be jeopardized by living in a community setting is developed by the state and must be specified in the program agreement

Determination of Living Safely in a Community Setting

- POs are required to use the state's established criteria when determining whether an applicant is able to live safely in the community
- The determination should be made based on the IDT's assessment of prospective participants
 - POs should have policies and procedures that identify the team members that will assess and determine a prospective participant's ability to live safely in the community

Determination of Living Safely in a Community Setting (cont.)

- The only reason a PO can deny enrollment of a prospective participant that meets the basic eligibility requirements is if the participant's health or safety would be jeopardized by living in a community setting
 - Failing to meet basic eligibility requirements would make them ineligible

Ineligible vs. Denied

Ineligible for Enrollment (Screen-Out)	Denied Enrollment
Is not age 55 or over	Health or safety would be jeopardized by living in a community setting
Does not meet Nursing Facility Level of Care	
Does not reside in the PACE Service Area	

PO vs. State Role for Determining Safety in the Community

- The state must have a process in place to provide oversight of the PO's administration of these criteria
 - The state must describe their process as part of the PACE application
 - Some states oversee the process by reviewing documentation of individuals denied enrollment retrospectively as part of the audit process
 - A few states require prior review and approval before a PO can deny enrollment to a prospective participant

Denial of Enrollment

- If a prospective participant is denied enrollment because his or her health or safety would be jeopardized by living in a community setting, the PO must notify the individual in writing of the reason
 - The reason for the denial should be specific and
 - Provide referral to alternate services as appropriate

Denial of Enrollment (cont.)

- The PO must maintain supporting documentation of the denial and make it available for review and
- Notify CMS and the state of the reason for the denial

Appeal of Denial of Enrollment

There is often confusion regarding appeals and enrollment denials:

- An enrollment denial should include an avenue for appeal through the PO
- The state is responsible for establishing an external appeal avenue for prospective participants denied enrollment

Note: Since Medicare does not offer an appeal avenue for enrollment denials, the state agency is responsible to offer an external appeal avenue for all applicants (even those that are not Medicaid eligible)

Eligibility under Medicare and Medicaid 460.150(d)

Reminder: Eligibility in PACE is not restricted to an individual who is either a Medicare beneficiary or a Medicaid recipient. An individual may be, but is not required to be:

- Entitled to Medicare Part A
- Enrolled under Medicare Part B
- Eligible for Medicaid

Continuation of Enrollment

460.160 (a)

- PACE enrollment continues until the participant's death, regardless of changes in health status, unless the participant voluntarily disenrolls or is involuntarily disenrolled
- Note: an individual's ability to live safely in the community is not required for continued enrollment

Annual Recertification Requirement

460.160 (b)

- At least annually, the state must reevaluate whether a participant needs the level of care required under the state Medicaid plan for coverage of nursing facility services
- The state, in consultation with the PO, makes a determination of continued eligibility based on a review of the participant's medical record and plan of care

Note: Documentation of the recertification must be retained in the participant's medical record

Annual Recertification Requirement Waiving and Deeming

- The annual recertification requirement is to determine continued eligibility for level of care
- There is often confusion regarding the annual recertification requirement, especially related to the regulatory provisions permitting “waiving” and “deeming”

Waiver of Annual Recertification Requirement

- The state may permanently waive the annual recertification requirement for a participant if it determines that there is no reasonable expectation of improvement or significant change in the participant's condition because of the severity of a chronic condition or the degree of impairment of functional capacity
- Participant's medical record must include documentation of the reason for waiving the annual recertification requirement
- No further annual recertifications are required

Deemed Continued Eligibility

- If the state determines that a PACE participant no longer meets the state's nursing facility level of care requirements, the participant may be deemed to continue to be eligible for PACE until the next annual reevaluation, if:
 - In the absence of continued coverage under the program, the participant reasonably would be expected to meet the nursing facility level of care requirement within the next six months
- The state must establish criteria to use in making the determination of “deemed continued eligibility”
- The criteria must be applied in reviewing the participant's medical record and plan of care

Questions

