

# **Programs of All-Inclusive Care for the Elderly (PACE)**

## **Chapter 4 – Enrollment and Disenrollment**

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*(Rev. 2, Issued: 06-09-11)*

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## **10 - Introduction**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

This chapter discusses eligibility criteria and the enrollment process for the PACE program as provided in 42 CFR § 460.150. The eligibility criterion includes a requirement that a PACE eligible individual meet a specific level of care which is determined by the State Administering Agency and varies from state to state. State enrollment processes are separate from the processes identified below. PACE organizations should consult their State Administering Agency for instruction in State enrollment processes.

### **10.1 - Eligibility for Enrollment**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

### **10.2 - Eligibility Criteria**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

To enroll in a PACE program, an individual must meet the following eligibility requirements listed in the Program Agreement:

- Be 55 years of age or older;
- Be determined by the State Administering Agency to need the level of care required under the State Medicaid plan for coverage of nursing facility services;
- Reside in the PACE organization's service area;
- Be able to live in a community setting at the time of enrollment without jeopardizing his/her health or safety based on criteria set forth in the program agreement;
- Meet any additional program-specific eligibility conditions imposed under its respective PACE Program Agreement;

A PACE participant may not be concurrently enrolled in any other Medicare Advantage, Medicare Prescription Drug, or Medicaid prepayment plan, or optional benefit, such as a 1915c Home and Community Based Services waiver or the Medicare Hospice benefit.

A potential participant is not required to be a Medicare beneficiary or Medicaid recipient. A PACE enrollee may be, but is not required to be, any or all of the following: (1) entitled to Medicare Part A; (2) enrolled under Medicare Part B; (3) eligible for Medicaid.

PACE enrollees who become entitled to Medicare Part A and/or enrolled in Medicare Part B on a retroactive basis will be eligible for Medicare Part D beginning the month in which the individual received notification of the retroactive Medicare entitlement

decision, resulting in some cases in which the individual's Medicare Part A and Part B dates will precede the Part D date. For instance, an individual has Medicaid coverage throughout 2009. In May 2009, the individual is notified that s/he is entitled to Medicare Part A and/or B retroactive to November, 2008. The last day of eligibility for Medicaid prescription drug coverage is April 30, 2009; the first day of Part D eligibility is May 1, 2009.

[42 CFR §§ 460.150, 423.30(a)(3)]

### **10.3 - End Stage Renal Disease (ESRD)**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

Individuals with End Stage Renal Disease (ESRD) are among the most frail and complex persons to care for.

In January 2005, a risk-adjusted capitation model was implemented exclusively for ESRD. The ESRD CMS-HCC (Health Condition Code) model accounts for the additional costs of providing ESRD patients with the costly and highly specialized care needed. This model is exclusively for ESRD patients and has three categories of ESRD acuity: those that are on dialysis; that that have kidney or kidney and pancreas transplant(s); and those that have had kidney grafts.

The PACE care delivery model is well-suited to meeting the needs of this population and it is not appropriate to deny enrollment to these individuals solely based on their ESRD status.

[71 FR 71310 (Dec. 8, 2006)]

### **10.4 - Hospice**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

Since comprehensive care is provided to PACE participants, those participants who need end-of-life care will receive the appropriate medical, pharmaceutical, and psychosocial services through the PACE organization. If a participant specifically wants to elect the hospice benefit from a certified hospice organization, the participant must voluntarily disenroll from the PACE program. The PACE organization will work with the State Administering Agency and CMS to facilitate the election of the hospice benefit and will work with the elected hospice organization to coordinate the transition of care.

[42 CFR § 460.154(i)]

## **20 - Discrimination against Beneficiaries Prohibited**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

The PACE organization must not discriminate against any participant in the delivery of required PACE services based on race, ethnicity, national origin, religion, sex, age,

mental or physical disability, sexual orientation or source of payment. Each PACE organization must agree to meet all applicable requirements under Federal, State and local laws and regulations including provisions of the Civil Rights Act, the Age Discrimination Act and the Americans with Disabilities Act. These requirements include, but are not limited to, all requirements contained in the regulations implementing those Acts.

[42 CFR §§ 460.32(a)(2), 460.98(b)(3)]

## **30 - Enrollment**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

### **30.1 - Eligibility Determination**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

Intake is an intensive process during which PACE staff members make one or more visits to a potential participant's place of residence and the potential participant may make one or more visits to the PACE center. At a minimum, the intake process must include the following activities:

- The PACE staff must explain to the potential participant and his or her representative or caregiver the following information:
  - o The PACE program, using a copy of the enrollment agreement, specifically references the elements of the agreement, including but not limited to 42 CFR §§ 460.154(e), (i) through (m), and (r);
  - o The requirement that the PACE organization would be the participant's sole service provider and clarification that the PACE organization guarantees access to services, but not to a specific provider;
  - o A list of the employees of the PACE organization who furnish care and the most current list of contracted health care providers;
  - o Monthly premiums, if any;
  - o Any Medicaid spenddown obligations;
  - o Post-eligibility treatment of income;
- The potential participant must sign a release to allow the PACE organization to obtain his or her medical and financial information and eligibility status for Medicare and Medicaid;
- The State Administering Agency must assess the potential participant, including any individual who is not eligible for Medicaid, to ensure that he or

she needs the level of care required under the State Medicaid plan for coverage of nursing facility services.

The PACE staff must assess the potential participant to ensure that he or she can be cared for appropriately in a community setting and that he or she meets all requirements for PACE eligibility. This involves an assessment of the individual's care support network as well as the individual's health condition to determine whether or not his or her health or safety would be jeopardized by living in a community setting. The criterion for determining if an individual is able to live safely in the community is established, and must be approved, by the State. If it is determined that the prospective PACE enrollee's health or safety would be jeopardized by remaining in a community setting, the PACE organization should deny enrollment. Refer to [Chapter 8](#) of the PACE Manual for the IDT Assessment requirements.

[42 CFR §§ 460.70, 460.152(a); 71 FR 71309 (Dec. 8, 2006)]

### **30.2 - Denial of Enrollment**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

When an enrollment is denied because his or her health or safety would be jeopardized by living in a community setting, the PACE organization is required to complete the following steps:

- Notify the individual in writing of the reason for enrollment denial and their appeal rights;
- Refer the individual to alternative services as appropriate;
- Maintain supporting documentation of the reason for the denial; and,
- Notify CMS and the State Administering Agency and make the documentation available for review. Notification to CMS can be accomplished through reporting the Data Elements for monitoring in HPMS.

[42 CFR § 460.152(b)]

### **30.3 - Enrollment of Individuals Pending Medicare or Medicaid Eligibility**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

Eligibility to enroll in a PACE program is not restricted to an individual who is either a Medicare beneficiary or Medicaid recipient. During the enrollment process the applicant must sign a release to allow the PACE organization to obtain his or her medical and financial information and eligibility status for Medicare and Medicaid. The PACE organization is required to include any Medicaid spenddown obligations in the enrollment agreement. CMS requires that that information regarding post eligibility

treatment of income is also included in the enrollment agreement. As an additional participant protection, PACE organizations are required to review post-eligibility treatment of income with prospective enrollees as determined and calculated by the state.

[42 CFR § 460.152(a)(2) and (g)]

### **30.4 - Initial IDT Assessment**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

An initial comprehensive assessment is performed by the Interdisciplinary Team (IDT) on each participant independent of any pre-enrollment screening by the IDT. This assessment must be completed promptly following enrollment. The eight IDT members who conduct the initial assessment in person are the primary care physician, registered nurse, master's level social worker, dietitian, physical therapist, occupational therapist, recreational therapist or activities coordinator, and home care coordinator. The IDT may identify other healthcare specialists that are required to conduct additional assessments outside the IDT members' expertise or scope of practice. On completion of the assessments, the IDT promptly consolidates the discipline-specific assessments into a single plan of care for each participant through discussion in team meetings and consensus of the entire IDT. In developing the plan of care, female participants 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.

[42 CFR § 460.104(a) and (b)]

### **30.5 - Enrollment Agreement**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

The PACE-eligible prospective enrollee (or legal representative) must agree to several enrollment conditions including, but not limited to: having the PACE organization and its provider network as the sole provider of services; giving signed consent for the PACE organization to obtain medical and financial information to verify eligibility; and, agreeing to any applicable monthly premiums or Medicaid spenddown obligations. If the prospective PACE enrollee meets the eligibility requirements and signs the PACE enrollment agreement, the effective date of enrollment in the PACE program is on the first day of the calendar month following the date the PACE organization receives the participant's signed enrollment agreement. The PACE organization must submit a timely and accurate enrollment transaction to complete the enrollment in CMS systems. The enrollment agreement must, at a minimum, contain the following information:

- Applicant's name, sex, and date of birth;
- Medicare beneficiary status (Part A, Part B, or both) and number, if applicable;

- Medicaid recipient status and number, if applicable;
- Information on other health insurance, if applicable;
- Conditions for enrollment and disenrollment in PACE;
- Description of participant premiums, if any, and procedures for payment of premiums;
- Notification that a Medicaid participant and a participant who is eligible for both Medicare and Medicaid are not liable for any premiums, but may be liable for any applicable spenddown liability and any amounts due under the post-eligibility treatment of income process;
- Notification that a Medicare participant may not enroll or disenroll at a Social Security office;
- Notification that enrollment in PACE results in disenrollment from any other Medicare or Medicaid prepayment plan or optional benefit. Electing enrollment in any other Medicare or Medicaid prepayment plan or optional benefit, including the hospice benefit or Medicare Part D plan, after enrolling as a PACE participant, is considered a voluntary disenrollment from PACE;
- Information on the consequences of subsequent enrollment in other optional Medicare or Medicaid programs following disenrollment from PACE (i.e., conditions that might apply when enrolling in another managed care plan);
- Description of PACE services available, including all Medicare and Medicaid covered services, and how services are obtained from the PACE organization;
- Description of the procedures for obtaining emergency and urgently needed out-of-network services;
- The participant Bill of Rights;
- Information on the process for grievances and appeals and Medicare/Medicaid phone numbers for use in appeals;
- Notification of a participant's obligation to inform the PACE organization of a move or lengthy absence from the organization's service area;
- An acknowledgment by the applicant or representative that he or she understands the requirement that the PACE organization must be the applicant's sole service provider;

- A statement that the PACE organization has an agreement with CMS and the State Administering Agency that is subject to renewal on a periodic basis and, if the agreement is not renewed, the program will be terminated;
- The applicant's authorization for disclosure and exchange of personal information between CMS, its agents, the State Administering Agency, and the PACE organization;
- The effective date of enrollment;
- The signature of the applicant or his or her designated representative and the date.

After the participant signs the enrollment agreement, the PACE organization must give the participant the following:

- A copy of the enrollment agreement;
- A PACE membership card;
- Emergency information to be posted in his or her home identifying the individual as a PACE participant and explaining how to access emergency services;
- Stickers for the participant's Medicare and Medicaid cards, as applicable, which indicate that he or she is a PACE participant and which include the phone number of the PACE organization.

If there are changes in the enrollment agreement information at any time during the participant's enrollment, the PACE organization must meet the following requirements:

- Give an updated copy of the information to the participant;
- Explain the changes to the participant and his or her representative or caregiver in a manner they understand.

[42 CFR §§ 460.152(a)(1) and (2), 460.154, 460.156, 460.158]

## **40 - Disenrollments**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

There are only three reasons a participant can be disenrolled from a PACE program:

- Death;

- Voluntary disenrollment, (which would include enrollment by a participant into another Medicare Plan); or,
- Involuntary disenrollment by the PACE organization due to cause.

[42 CFR § 460.160(a)]

#### **40.1 - Documentation of Disenrollment**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

A PACE organization must meet the following requirements:

- Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments;
- Make documentation available for review by CMS and the State Administering Agency;
- Use the information on voluntary disenrollments in the PACE organization's internal Quality Assessment and Performance Improvement (QAPI) program.

[42 CFR § 460.172]

#### **40.2 - Disenrollment Process**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

The PACE organization must take the following actions upon voluntary or involuntary disenrollment or death of a participant:

- Complete the disenrollment as expeditiously as allowed under Medicare and Medicaid;
- Coordinate the disenrollment date between Medicare and Medicaid as applicable;
- Give reasonable advance notice to the participant about disenrollment;
- Submit the disenrollment transaction to CMS systems in a timely and accurate manner.

The PACE organization must continue to provide all needed services, and the PACE participant must continue to use the PACE organization's services and pay any premiums, until the date the enrollment is actually terminated. The disenrollment date will be coordinated between Medicare and Medicaid for a participant who is dually eligible. No disenrollment will become effective until the participant is appropriately reinstated into other Medicare and Medicaid programs and alternative services are arranged.

[42 CFR §§ 460.166(a) and (b)]

### **40.3 - Voluntary Disenrollment**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

Enrollment in the PACE program continues until the participant's death regardless of changes in health status unless the participant voluntarily disenrolls or the PACE organization involuntarily disenrolls the participant for strictly defined reasons. A PACE participant may voluntarily disenroll from the program without cause at any time [42 CFR § 460.160 and 42 CFR § 460.162]. The disenrollment date will be coordinated between Medicare and Medicaid for a participant who is dually eligible. No disenrollment will become effective until the participant is appropriately reinstated into other Medicare and Medicaid programs and alternative services are arranged.

[42 CFR §§ 460.162, 460.166]

### **40.4 - Involuntary Disenrollment**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

The PACE organization may involuntarily disenroll a participant only for any of the following reasons:

- **Failure to Pay:** Any participant who fails to pay, or make satisfactory arrangements to pay any premiums due, to the PACE organization after a thirty-day grace period;
- **Disruptive or Threatening Behavior:** A participant engages in disruptive or threatening behavior. Such behavior is defined as the following:
  - o Behavior that jeopardizes the participant's own health or safety, or the safety of others; or
  - o Consistent refusal to comply with an individual plan of care or the terms of the PACE enrollment agreement by a participant with decision-making capacity. Note that a PACE organization may not involuntarily disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior related to an existing mental or physical condition unless the participant's behavior is jeopardizing his or her health or safety or that of others. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments;
- **Relocation Outside of the Service Area:** The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days without PACE organization concurrence;

- Non-renewal or Termination of Program Agreement: The PACE organization's program agreement with CMS and the State Administering Agency is not renewed or terminated;
- Inability to Provide Services: The PACE organization is unable to offer healthcare services due to the loss of state licenses or contracts with outside providers;
- Ineligibility: It is determined that the participant no longer meets the State Medicaid nursing facility level of care requirements and is not deemed eligible, the participant must be disenrolled.

Before an involuntary disenrollment is effective, the State Administering Agency must review it and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment. Once it has been deemed appropriate to involuntarily disenroll the participant, the PACE organization must follow the disenrollment process as defined in 42 CFR § 460.166 and discussed in [40.2](#) of this manual.

**NOTE:** A PACE organization may have a waiver allowing for involuntary disenrollment for additional reasons such as, disruptive or threatening behavior by a family member or failure of Medicaid participants to pay share of cost.

[42 CFR §§ 460.164(a), (b), (d), and (e); 71 FR 71315 (Dec. 8, 2006)]

#### **40.5 - Additional Written Evidence of Involuntary Disenrollment for Disruptive or Threatening Behavior**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

In addition to the documentation of disenrollment discussed in [40.1](#), if a PACE organization proposed to involuntarily disenroll a participant who is disruptive or threatening, the PACE organization must document the following information in the participant's medical records:

- The reasons for proposing to disenroll the participant; and
- All efforts to remedy the situation.

[42 CFR § 460.164(c)]

#### **40.6 - Role of State Administering Agency**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

At least annually, the State Administering Agency must re-evaluate whether or not a participant needs the level of care required under the State Medicaid plan for coverage of

nursing facility services by using the eligibility criteria specified in the program agreement and by reviewing the participant's medical record or plan of care.

The State may permanently waive the annual recertification requirement if it determines 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 (**NOTE:** State authorized waiver of annual recertification, which includes the reason for waiving the annual recertification requirement, must be documented in the medical record).

Furthermore, the State Administering Agency may deem a participant who no longer meets the State Medicaid nursing facility level of care requirements to continue to be eligible for the PACE program if, in the absence of continued coverage under the program, the State Administering Agency determines the participant reasonably would be expected to meet the nursing facility level of care requirement in the next six months.

The State Administering Agency must establish the criteria to use in making the determination of "deemed continued eligibility" and the criteria used to make the determination of continued eligibility must be specified in the program agreement. These criteria must be applied in reviewing the participant's medical record and plan of care. The State Administering Agency, in consultation with the PACE organization, may make a determination of deemed continued eligibility based on review of the participant's medical record and plan of care.

Finally, the State Administering Agency is responsible for reviewing medical record documentation and information about the involuntary disenrollment from a PACE organization that plans to involuntarily disenroll a participant. As discussed above, in doing so, the State Administering Agency is required to determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.

[42 CFR § 460.160(b)]

## **50 - Enrollment in other Medicare and Medicaid Programs Following Disenrollment from PACE**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

### **50.1 - General Requirements**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

To facilitate a participant's reinstatement in other Medicare and Medicaid programs after disenrollment, the PACE organization must do the following:

- Make appropriate referrals and ensure medical records are made available to new providers in a timely manner.

- Work with CMS and the State Administering Agency to reinstate the participant in other Medicare and Medicaid programs for which the participant is eligible.

[42 CFR § 460.168; 1894(a)(2)(C) and 1934(a)(2)(C) of the Act]

## **50.2 - Access to MA, PDP and Medigap Coverage Following Disenrollment**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

Individuals who disenroll from PACE have a Special Election Period for 2 months after the effective date of PACE disenrollment to elect an MA plan or a standalone PDP. If the individual decides to return to original Medicare, the individual may purchase a Medigap (Medicare supplemental) policy that is offered in their state within 63 days of the last date of coverage. Under a Guaranteed Issue Period, the issuer of a Medicare Supplemental Policy may not deny or condition the issuance or effectiveness of the policy; may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition, and, may not impose an exclusion of benefits based on a preexisting condition. The agent or insurer may request evidence of the date of disenrollment along with the application for the policy. The effective date of enrollment in the MA plan or standalone PDP would be the first of the month following the plan's receipt of the enrollment request.

[42 CFR § 422.62(b)(4); 71 FR 71246 (Dec. 8, 2006)]

## **50.3 - Enrollment/Disenrollment of Hospitalized Beneficiaries**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

The PACE organization must provide for the prompt transfer of copies of appropriate medical record information between treatment facilities to ensure continuity of care whenever a participant is temporarily or permanently transferred to another facility. Examples of appropriate medical record information include, but are not limited to:

- The reason for the transfer;
- The name and number of the attending physician;
- Participant's demographics;
- Active diagnoses and treatment plan including current medications and activities of daily living status;
- Special dietary considerations, etc.

It is essential that the medical history and plan of care follow the participant. This requirement is intended to ensure communication between providers.

More information regarding medical records documentation can be found in [Chapter 12](#) of this manual.

[71 FR 71326 (Dec. 8, 2006)]

## **60 - Reinstatement in PACE**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

A previously disenrolled participant may be reinstated in the PACE program. If the reason for disenrollment is failure to pay the premium and the participant pays the premium before the effective date of disenrollment, the participant is reinstated in the PACE program with no break in coverage.

[42 CFR § 460.170]

## **70 - Retroactive Enrollment for Medicare Payment**

*(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

CMS expects that PACE plans will follow the procedures described in the Medicare Advantage & Prescription Drug Plan Communications User Guide (PCUG) to successfully submit accurate enrollment and disenrollment transactions to CMS within the current operating month cycle (<http://www.reedassociates.org/>). A calendar of the cycle for data submission is provided in the PCUG as Appendix C. Following the timely submission of enrollment and disenrollment actions, PACE plans must review the reports and replies provided by CMS to ensure each action has been successfully processed, as well as to obtain other important information that CMS provides via these interchanges. Descriptions and file lay-outs are provided in detail in the PCUG.

However, if an eligible individual has fulfilled all enrollment requirements, but the PACE organization or CMS has been unable to process the enrollment for the required effective date, CMS (or its designee) may process a retroactive enrollment. A retroactive enrollment is an action to enroll a beneficiary into a PACE program for an earlier time period.

The request by a PACE organization for a retroactive enrollment must be made within ninety (90) days of the original effective date of enrollment (first day of the calendar month following the date the PACE organization receives the participant's signed enrollment agreement). When an individual has fulfilled all enrollment requirements, but the PACE organization or CMS has been unable to process the enrollment in a timely manner, the PACE organization must submit to CMS via the CMS retroactive processing contractor (RPC) a copy of the signed completed enrollment agreement. Note that the document must have been signed by the participant (or authorized representative) prior to the requested effective date of coverage in order to effectuate the requested effective coverage date. Continued failure to accurately and timely process enrollment transactions via direct systems interchange with CMS is contrary to operational guidance and will be

considered a compliance issue by CMS. Issues older than 90 days from the original, valid effective date must be reviewed and approved by the CMS regional office account manager prior to submission to the RPC. PACE organizations must follow the standard operating procedure (SOP) in conjunction with these instructions, as provided on the RPC web site at: <http://www.reedassociates.org/> to submit retroactive requests for consideration.

## **80 - Retroactive Disenrollment for Medicare Entitled Participants** *(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)*

If an enrollment was never legally valid or if a valid request for disenrollment was properly made, but not processed or acted on (including system error or plan error), CMS (or its designee) may process a retroactive disenrollment. CMS (or its designee) may also process a retroactive disenrollment if the reason for the disenrollment is related to a permanent move out of the service area.

A retroactive disenrollment can only be submitted to CMS by the PACE organization via submission of the request to the retroactive processing contractor. Requests from a PACE organization must include a copy of the disenrollment request or documentation that substantiates an allowable involuntary disenrollment as well as an explanation as to why the disenrollment was not processed and submitted to CMS correctly. PACE organizations must submit retroactive disenrollment requests to CMS (or its designee) within ninety (90) days of the effective disenrollment date. If CMS approves a request for retroactive disenrollment, the PACE organization must return any premium paid by the participant for any month for which CMS processed a retroactive disenrollment. In addition, CMS will retrieve any capitation payment for the retroactive period.

A retroactive request must be submitted by the PACE organization to CMS (or its designee) in cases in which the PACE organization has not properly processed or acted on the participant's request for disenrollment as required. A disenrollment request would be considered not properly acted on or processed if the effective date is a date other than as required. Continued failure to accurately and timely process enrollment transactions via direct systems interchange with CMS is contrary to operational guidance and will be considered a compliance issue by CMS. Issues older than 90 days from the original, valid effective date must be reviewed and approved by the CMS regional office account manager prior to submission to the RPC. PACE organizations must follow the Standard Operating Procedure (SOP) in conjunction with these instructions, as provided on the RPC web site at: <http://www.reedassociates.org/> to submit retroactive requests for consideration.

[Retroactive Enrollment/Disenrollment Implementation Guidance for PACE Organizations (Dec. 22, 2009)]

## Transmittals Issued for this Chapter

<b>Rev #</b>	<b>Issue Date</b>	<b>Subject</b>	<b>Impl Date</b>	<b>CR#</b>
<a href="#">R2PACE</a>	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

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