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TO: PACE Organizations

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SUBJECT: Retroactive Enrollment/Disenrollment Implementation Guidance for PACE Organizations

The purpose of this document is to provide guidance to PACE organizations on the Medicare retroactive member enrollment and disenrollment process.

Originally created as a demonstration, the Program for All-Inclusive Care for the Elderly (PACE) combines the health care services provided by Medicare and Medicaid in a community setting, while concurrently meeting social and custodial needs of frail beneficiaries. Since the expiration of the demonstration, the program has steadily grown to more than 15,500 members across 70 provider sites. Due to the growth of the program it has become essential that formal guidance as it relates to the enrollment and disenrollment process of PACE participants be communicated.

Enrollment and Disenrollment in the PACE Program

To enroll in a PACE program, an individual must meet the following eligibility requirements: (see 42 CFR §460.150 listed in the program agreement [§460.150(c)(2)])

- Be 55 years of age or older [§460.150(b)(1)]
- 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 [§460.150(b)(2)]
- Reside in the PACE organization's service area [§460.150(b)(3)]
- Be able to live in a community setting at the time of enrollment without jeopardizing his/her health or safety [§460.150(c)(1-2)]
- Meet any additional program-specific eligibility conditions imposed under its respective PACE program agreement [§460.150(b)(4)]
- Not be concurrently enrolled in any other Medicare or Medicaid prepayment plan or optional benefit (such as a 1915c) HCBS waiver or the Medicare Hospice benefit)

The PACE-eligible enrollee (or legal representative) must also agree to several enrollment conditions, including 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 spend-down obligations [§460.152(c)(1-2)]. If the prospective PACE enrollee

meets the eligibility requirements and signs the PACE enrollment agreement listing the terms of enrollment [see §460.154(a-t)], 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 [§460.158]. The PACE organization must submit a timely and accurate enrollment transaction to complete the enrollment in CMS systems.

If the PACE organization determines that the prospective PACE enrollee's health or safety would be jeopardized by living in a community setting and denies the enrollment, the organization must take the following steps as required under §460.152(b)(1-4):

- Notify the individual in writing of the reason for enrollment denial
- Refer the individual to alternative services as appropriate
- Maintain supporting documentation of the reason for the denial
- Notify CMS and the State Administering Agency (SAA) and provide the denial documentation for review if requested

Retroactive Enrollment for Medicare Payment

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 (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. Please 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 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: www.reedassociates.org to submit retroactive requests for consideration.

NOTE: In very limited circumstances, a PACE organization may be directed by CMS via a regional office account manager (or designee) to submit a retroactive enrollment or disenrollment request to resolve a complaint. In those situations, the PACE organization must provide the following two (2) items as documentation to CMS (or its designee):

- A screen print from the Complaint Tracking Module (CTM) or other documentation showing the CMS Regional Office (RO) decision and direction to the *CMS Retroactive Processing Contractor*; and
- A copy of the enrollment or disenrollment request, if one is available. Occasionally, due to the nature of casework, this item may not be available. When that occurs, the PACE organization should submit a complete description and statement of explanation for the missing documentation.

Voluntary Disenrollment

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

- Death;
- Voluntary disenrollment; or
- Involuntary disenrollment by the PACE organization due to cause.

A PACE participant may voluntarily disenroll from the program **without cause at any time** (§460.160, 460.162). However, due to the time needed to coordinate payment termination between Medicare and Medicaid, the disenrollment may not be effective until 1) the end of the month in which the disenrollment is requested, or 2) the following month if the disenrollment is requested near the end of a month.

Involuntary Disenrollment

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

- 1) **Failure to Pay:** The participant fails to pay, or make satisfactory arrangements to pay, any premium due to the PACE organization after a 30-day grace period [§460.164(a)(1)];
- 2) **Disruptive or Threatening Behavior:** The participant engages in disruptive or threatening behavior [§460.164(a)(2)] as exhibited by
 - a) behavior that jeopardizes the participant's own health or safety, or the safety of others;
 - b) consistent refusal to comply with an individual plan of care or the terms of the PACE agreement by a participant with decision-making capacity. Note that a PACE organization may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior directly related to an existing mental or physical condition. Refusal to comply is defined as repeated noncompliance with medical advice and repeated failure to keep appointments;
- 3) **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 [§460.164(a)(3)];

- 4) **Non-renewal or Termination of Program Agreement:** The PACE organization's program agreement with CMS and the state administering agency (SAA) is not renewed or terminated [§460.164(a)(5)];
- 5) **Inability to Provide Services:** The PACE organization is unable to offer healthcare services due to the loss of state licenses or contracts with essential outside providers [§460.164(a)(6)];
- 6) **Nursing Home Level of Care Ineligibility:** The participant is determined to no longer meet the State Medicaid nursing facility level of care requirements and is not deemed eligible [§460.164(a)(4)],
 - a) **Annual Recertification:** At least annually and using the eligibility criteria specified in the program agreement, the SAA must reevaluate whether a participant needs the level of care required under the state Medicaid plan for coverage of nursing facility services through a review of the participant's medical record or plan of care [§460.160(b)(1, 3)]. The state may waive the annual recertification if it determines there is no reasonable expectation of improvement or significant change in the participant's condition or the degree of impairment of functional capacity (NOTE: State authorized waiver of annual recertification must be documented in the medical record.).
 - b) **Deeming:** The SAA 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 the SAA determines the participant would be expected to meet the nursing facility level of care requirement in the next six (6) months [§460.160(b)(2)].

The PACE organization must have written evidence in the form of medical record documentation that the PACE organization proposes to involuntarily disenroll the participant [§460.172(a-c)]. This documentation must include a detailed explanation of the reasons for the action and the efforts made to remedy the situation. It must be reviewed by the SAA to verify the adequate documentation before the disenrollment is effective [§460.164(e)].

Disenrollment Process

The PACE organization must take the following actions when a participant voluntarily, or is involuntarily, disenrolled [§460.166(a-b)]:

- 1) Complete the disenrollment as expediently as allowed under Medicare and Medicaid
- 2) Coordinate the disenrollment date between Medicare and Medicaid as applicable
- 3) Give reasonable advance notice to the participant
- 4) 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.

Retroactive Disenrollment

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 PACE service area, a contract violation, or other limited exceptional conditions established by CMS (e.g., fraudulent enrollment or misleading marketing practices).

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 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: www.reedassociates.org to submit retroactive requests for