DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 Del.C. §512)

PROPOSED

PUBLIC NOTICE

DSSM 20775: Program of All Inclusive Care for the Elderly (PACE)

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to establish PACE Program enrollee eligibility requirements.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 by August 31, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The proposed amends the Division of Social Services Manual (DSSM) to set out new rules governing the Medicaid eligibility requirements for Program of All-Inclusive Care for the Elderly (PACE) enrollees.

Statutory Authority

42 CFR Part 460, *Program of All Inclusive Care for the Elderly*

Background

Program of All-Inclusive Care for the Elderly (PACE) is a federal program administered by the Centers for Medicare and Medicaid Services (CMS). PACE, a managed care program, enables elderly individuals who are certified to need nursing facility care to live as independently as possible.

PACE participants receive a comprehensive service package which permits them to live at home while receiving services. This prevents institutionalization. The PACE organization must provide all Medicaid covered services, in addition to other services determined necessary by PACE for the individual beneficiary. The PACE program becomes the sole source of services for Medicaid and/or Medicaid/Medicare eligible enrollees.

The PACE program is a fully capitated managed care benefit. The PACE organization assumes full financial risk for participants' care without limits on amount, duration, or scope of services. CMS establishes and pays the Medicare capitation and each State establishes and pays the Medicaid capitation. When the enrollee receives Medicaid and Medicare, the PACE organization receives a Medicaid capitation payment and a Medicare capitation payment.

The State of Delaware has received approval from the CMS to amend the Medicaid State Plan to include PACE as an optional State plan service.

Summary of Proposal

This rule sets forth methods used to determine participant eligibility for the Program for All-Inclusive Care for the Elderly (PACE). Effective October 1, 2012, new policy is added to the Division of Social Services Manual (DSSM) at DSSM 20775 to provide PACE Program enrollment requirements.

Fiscal Impact Statement

Program of All-Inclusive Care for the Elderly (PACE) is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. Capitated financing allows providers to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems.

PACE providers receive prospective monthly Medicare and Medicaid capitation payments for each eligible enrollee. In order to comply with the upper payment limit requirement at 42 CFR §460.182(b), the PACE capitation rates are established as a fixed percentage, of less than 100 percent, of the respective PACE UPL (Upper Payment Limit) per member per month amounts. PACE providers assume full financial risk for participants' care without limits on amount,

duration, or scope of services. Therefore, PACE expenditures will be no more than what they would have been under the former fee for service payment structure.

The proposed regulation imposes no increase in cost on the General Fund as the PACE program will be budget-neutral.

DMMA PROPOSED REGULATION #12-33
NEW:

LTC POL-20775 PROGRAM OF ALL- INCLUSIVE CARE FOR THE ELDERLY (PACE)

Program of All-Inclusive Care for the Elderly (PACE) is a benefit that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The PACE model was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package permits them to continue living at home, while receiving services rather than be institutionalized. Through PACE, organizations are able to deliver all services covered by PACE which participants need rather than only those services reimbursable under the Medicare and Medicaid fee-for-service systems.

This policy applies to all individuals that elect to receive their long-term care services through the PACE and request Medicaid payment for these services.

1. Participation in PACE is voluntary.
2. A PACE participant's eligibility will be determined under rules applying to institutional groups.
   See DSSM 20000
3. Spousal Impoverishment rules apply if individual is married and spouse continues to reside in the community and does not receive long-term care Medicaid.
   See DSSM 20900
4. Post eligibility treatment of income does not apply to PACE participants.
   Participants will not be required to contribute to the cost of their care received from the PACE Organization.
5. To be eligible for enrollment in PACE the individual must:
   - Be at least 55 years old;
   - Meet the State's eligibility criteria for nursing home level of care;
   - Reside in the PACE approved service area;
   - Be living in the community;
   - Be able to be maintained safely in the community based setting at the time of enrollment with the assistance of the PACE;
   - Not be enrolled in a Medicaid/Medicare managed care program; and
   - Voluntarily agree to enroll in PACE and receive services exclusively through the PACE organization and their subcontractors.
6. The Pre-Admission Screening process will be followed when determining medical eligibility.
   See DSSM 20102
7. An individual's enrollment effective date is the first day of the month following the month the PACE Organization receives the signed enrollment form.
8. There is no retroactive coverage for PACE.
9. Nursing facility services are part of the PACE benefit package.
   The PACE Organization must notify the Division of Medicaid and Medical Assistance (DMMA) eligibility worker of the individual's placement in the nursing facility.
   The PACE individual is not required to contribute to the cost of their care while in a nursing facility.
10. An individual's enrollment continues until the enrollee's death unless either of the following actions occurs:
    a. The enrollee voluntarily disenrolls for any reason.
    b. The enrollee is involuntarily disenrolled for any of the following reasons:
       - No longer meets the nursing facility level of care requirement and there is no indication that the participant is expected to need nursing facility level of care within the next 6 months;
       - Moves out of the PACE service delivery area;
       - Has decision making capacity and is consistently non-compliant with the individual plan of care and enrollment agreement, which may impact the participant's health and welfare in the community;
       - Engages in disruptive, threatening or non-compliant behavior which jeopardizes his or her safety or the safety of others;
       - Is out of the service area for more than 30 consecutive days (unless arrangements have been made in advance with the PACE Organization); or
       - Is enrolled in a PACE Organization that cannot provide the required services due to loss of licensure or contracts with outside providers, and/or the PACE program agreement is not renewed.
11. An individual may be administratively disenrolled if the participant is admitted to a hospital prior to the effective date of PACE enrollment.