DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

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

FINAL

ORDER

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

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to update the Division of Social Services Manual (DSSM) to add policy regarding the eligibility requirements for participation in the *Program of All Inclusive Care for the Elderly (PACE)*. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the August 2012 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by August 31, 2012 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

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.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

The Governor's Advisory Council for Exceptional Citizens (GACEC), the State Council for Persons with Disabilities (SCPD) and Saint Francis Healthcare offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

GACEC and SCPD

First, the key eligibility standards are compiled in §5. There is some "tension" between §5 and §9 in the context of nursing home residency. The CMS document indicates that 7% of PACE enrollees live in nursing homes. Section 9 recites as follows:

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 a nursing facility.

The PACE individual is not required to contribute to the cost of their care while in a nursing facility.

Thus, the CMS guidance and §9.0 suggest that residents of nursing homes may be eligible for the program. However, §5 requires, as a matter of eligibility for enrollment, that the applicant "(b)e living in the community." GACEC and SCPD infer that an individual must be in the community upon initial enrollment but that "continued eligibility" is not affected by post-enrollment nursing home residency. It would be helpful if DMMA clarified this aspect of eligibility.

Agency Response*: The Councils' inference that an individual must be in the community upon initial eligibility for PACE is correct. It has been clarified in the regulations that admission to a nursing facility that happens post-PACE enrollment will not have a negative impact on the individual's continued eligibility, as follows:*

5. To be **[initially]** 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.
9. Nursing facility services are part of the PACE benefit package.

[Nursing facility admission that occur post-PACE enrollment will not have a negative impact on the individual's continued eligibility.]

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.

Second, §10 b. contains the following justification for involuntary termination from the program:

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;...;

This section would literally authorize termination for recurrent "minor/inconsequential" non-compliance with "minor/inconsequential" impact on health and welfare. Providers have a financial incentive to terminate eligibility of "expensive" individuals and it would be preferable to deter involuntary termination in the absence of significant non-compliance. There is also no requirement that the non-compliance be "willful" rather than inadvertent. For example, an elderly individual's plan may contemplate self-administration of medications. Due to memory deficits, the individual may periodically forget to take medications which affect the individual's welfare. Under a literal reading of the regulatory standard, the individual could be terminated from the program based on consistent non-compliance impacting health. Consider the following substitute:

Has decision making capacity and is willfully and consistently non-compliant with material components of the individual's plan of care and enrollment agreement which may significantly impact the participant's health and welfare in the community;...

Agency Response*: DMMA thanks the Councils for their comment. The reasons listed for involuntary enrollment are in accordance with federal regulations (42 CFR §460.164). There is no change to the regulation as a result of this comment.*

Third, §10.b. contains the following additional justification for involuntary termination from the program:

Engages in disruptive, threatening or non-compliant behavior which jeopardizes his or her safety or the safety of

others;...

Individuals with Alzheimer's, dementia, Tourette's or TBI may exhibit such behavior as a symptom of disability. Terminating their eligibility for symptoms of disability would violate §504 and the ADA. CMS requires programs to provide accommodations to participants with disabilities, not "dump" them. Cf. attached CMS Medicaid Director Guidance (July 29, 1998) and CMS Medicaid Director Guidance (May 10, 2010). See also attached October 11, 1985 HHS OCR LOF to Delaware DHSS which held the following regulation violated §504:

57.809 Mental Illness

A. Patients who are, or become, mentally ill and who may be harmful to themselves or others, shall not be admitted or retained in a nursing home.

OCR commented as follows:

Conditions such as Alzheimer's Disease may be considered a mental impairment under the definition of handicapping condition; however the presence of this condition and its manifestations may in no way render one ineligible for the receipt of services normally provided....It is our preliminary determination, based on the preceding discussion, that Section 57.809 as written violates Section 504 of the Rehabilitation Act and its implementing regulation 45 CFR Section 84.4 and Section 84.52(a)(1).

Rather than authorizing termination from the program, enrollees manifesting such behavior due to disability should be considered for specialized treatment. See, e.g., 16 DE Admin Code 3225, §§5.5, 5.12 and 7.0; and 16 DE Admin Code 3201, §5.6. Consider the following substitute:

Has decision making capacity and willfully engages in disruptive, threatening or non-compliant behavior which is not symptomatic of disability and which jeopardizes his or her safety or the safety of others;...

Agency Response*: DMMA thanks the Councils for their comment. The reasons listed for involuntary enrollment are in accordance with federal regulations (42 CFR §460.164). There is no change to the regulation as a result of this comment.*

Fourth, it is unclear if "assisted living" services are part of the PACE benefit package. Compare §9.0. This could be clarified. Assisted living settings are required to be "homelike" (16 DE Reg. 3225, §3.0 (definition of "homelike") and may be less restrictive settings than nursing facilities.

Agency Response*: DMMA thanks the Councils for their comment. Assisted living services may be provided by the PACE organization as part of the individual's Care Plan as determined by the Interdisciplinary Team. There is no change to the regulation as a result of this comment.*

Fifth, the CMS document recites as follows: "If you disagree with the interdisciplinary team about your care plan, you have the right to file an appeal." The DMMA regulation omits any reference to the right to a hearing to contest denial of program eligibility (§5.0); involuntary termination from the program (§10.0); and disagreements about the plan of care. It would be preferable to clarify that 16 DE Admin Code 5000 applies.

Agency Response*: The following clarification will be added:*

[12. Medicaid appeal requirements apply to PACE cases. See DSSM 5000]

Saint Francis Healthcare

We are concerned that the proposed PACE enrollment eligibility standards, those governing Medicaid eligibility for PACE enrollees, set out in DSSM 20775, are proposing a stipulation that will not be budget neutral to the State and will add significant burden to the State, the PACE enrollees, their families and PACE providers. The stipulation of concern, #9 (nine), third line states "PACE individuals are not required to contribute to the cost of their care while in a nursing facility."

The State and PACE enrollees will incur added processing burdens for Medicaid eligibility with some frequency if this stipulation remains in the proposed regulation. PACE enrollees living in a skilled facility with no requirement to contribute to the cost of their care will accumulate funds from their monthly social security and other resources that will potentially increase resources over the allowable $2,000.00 and will disqualify the enrollee from Medicaid. The PACE enrollee permanently living in a nursing facility will be required to spend down as a private pay nursing facility resident and then reapply for Medicaid when resources are reduced to become Medicaid eligible. This cycle will repeat itself, requiring the State as well as the enrollee, to continuously be denied and reenroll, increasing the burden to the frail elderly and the Delaware Medicaid Offices.

This is the result of the recent adoption of the 1115 Waiver, replacing the 1915c Waiver for Home and Community Based Services for the nursing facility eligible population. The 1115 Waiver does not have an accommodation for post eligibility treatment of income, as the 1915c Waiver did and on which the PACE Medicaid State Plan Amendment (SPA) was based. It is our understanding that individuals covered for community based services under the 1115 Waiver by non-PACE providers will convert to the Nursing Home Medicaid Program when long term placement in a nursing home as necessary. The Nursing Home Medicaid program regulation requires individuals to contribute to the cost of nursing facility care, less the personal needs allowance, when permanently placed in a nursing home. However, this does not apply to PACE enrollees under the separate regulations; though no adjustment in the PACE Medicaid SPA has been addressed to date to our knowledge.

We respectfully request consideration of the following issue. PACE enrollees residing permanently in a nursing facility

(permanently as defined by Medicaid State rules) have the same requirement as all other individuals receiving Medicaid state funds as basis for care, to contribute to that care. Therefore we request removal of #9 (nine) third line, "PACE individuals are not required to contribute to the cost of their care while in a nursing facility." as stated above from the proposed regulation.

Saint Francis Healthcare is committed to serving the nursing home eligible population in Delaware who wish to remain safely in the community with the support of PACE services. We anticipate a portion of the individuals served by PACE will age in place for a period of time and ultimately require nursing home placement. It is our goal to work cooperatively with the State of Delaware to provide care as seamlessly as possible for all the individuals we serve in the PACE program.

Agency Response: DMMA appreciates Saint Francis Healthcare's comment. Post eligibility treatment of income is set forth according to the federal regulations (42 CFR §460.164). There is no change to the regulation as a result of this comment.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the August 2012 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to update the Division of Social Services Manual (DSSM) to add policy regarding the eligibility requirements for participation in the *Program of All Inclusive Care for the Elderly (PACE)* is adopted and shall be final effective November 10, 2012.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #12-49
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 **[initially]** 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.

[Nursing facility admission that occurs post-PACE enrollment will not have a negative impact on the individual's continued eligibility.]

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.

[12. Medicaid appeal requirements apply to PACE cases. See DSSM 5000]

16 DE Reg. 532 (11/01/12) (Final)