SERVICE ACCESS AND AUTHORIZATION

How to Access Services

The Program of All-Inclusive Care for the Elderly (PACE) applicant/representative must call the PACE organization located in his/her geographical area or the toll-free telephone number to the Office of Aging and Adult Services (OAAS) designated contract agency and request a Louisiana Level of Care Eligibility Tool (LOCET) to be completed. The telephone LOCET is a level of care pre-enrollment screening tool that is completed by the OAAS designated contracted agency.

Authorization Process

The PACE authorization process includes the following intake process as specified in 42 CFR 460.152(a):

- The PACE staff must explain to the potential recipient and his/her representative or caregiver the following information:
    - PACE organization, using a copy of the PACE Enrollment Agreement specifically references the elements of the agreement;
    - The requirement that the PACE organization would be the recipient's sole service provider and clarification that the PACE organization guarantees access to services, but not a specific provider;
    - A list of the employees of the PACE organization who furnish care and the most current list of contracted health care providers under 42 CFR 460.70(c);
    - Monthly premiums, if any;
    - Any Medicaid spenddown obligations; and
    - Post-eligibility treatment of income.

- The potential recipient must sign a release to allow PACE the organization to obtain his/her medical and financial information and eligibility status for Medicare and Medicaid.

- PACE staff must assess the potential recipient to ensure that he/she can be cared for appropriately in a community setting and meets all requirements for PACE eligibility. The criteria used to determine if the individual's health and safety would be jeopardized by living in the community setting must be specified in the program agreement in accordance with 42 CFR 460.150 (c) (2).

  When an enrollment is denied, because the PACE applicant's health or safety would be jeopardized by living in the community setting, the PACE organization must meet the following requirements as specified by 42 CFR 460.152(b):

  - Notify the individual in writing of the reason for enrollment denial;

  - Refer the individual to alternative services as appropriate;

  - Maintain supporting documentation of the denial;

  - Make the documentation available for review;

  - Notify Centers for Medicare and Medicaid Services (CMS) and OAAS through the reporting of the Data Elements in monitoring in CMS' Health Plan Management System (HPMS) and make documentation available for review; and

  - The PACE organization must submit proposed denial of enrollment determinations of applicants for health and safety reasons for review prior to notifying applicants of such adverse decisions. OAAS RO must review denials of PACE enrollment eligibility in a timely manner.

As required by 42 CFR 460.154, each applicant enrolling in PACE must accept the PACE organization and its provider network as the sole provider of services. This requirement must be included in the PACE Enrollment Agreement. The applicant or his/her designated representative must sign and date an enrollment agreement that contains, at a minimum, the following:

- Mission and philosophy;

- Eligibility criteria;
- Enrollment and disenrollment procedures;
- Recipient rights and responsibilities;
- Benefits and coverage;
- Multidisciplinary care team;
- Consumer advisory committee;
- Contract providers;
- Emergency and urgent care;
- Out-of-service-area coverage;
- Prescription drug coverage; and
- Grievance and appeals procedures.

As specified in 42 CFR 460.156, the PACE organization must give a recipient, upon signing the PACE Enrollment Agreement, the following:

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

The PACE interdisciplinary team (IDT) must conduct an initial in-person comprehensive assessment of each recipient. The information obtained through the recipient assessment is the basis for the Plan of Care developed by the IDT. The assessment must be as comprehensive as possible in order to capture all of the information necessary for the IDT to develop a Plan of Care that will adequately address all of the recipient's functional, psychosocial and health care needs. The assessment process begins before enrollment, when the PACE organization evaluates whether a potential PACE recipient can be cared for appropriately in the program. The comprehensive assessment is often accomplished by the effective date of enrollment, but shall never be delayed more than a few days beyond that date.

The PACE applicant must receive a face-to-face Minimum Data Set-Home Care (MDS-HC) assessment prior to enrollment to verify that the applicant continues to meet the required nursing facility level of care criteria for enrollment in PACE. The MDS-HC must be completed by OAAS trained and certified PACE staff. If the initial MDS-HC assessment determined the applicant does not meet nursing facility level of care the PACE organization must notify the OAAS RO to request review of all enrollment data, including the MDS-HC. The OAAS RO will ensure the accuracy of the enrollment data and make the final determination regarding nursing facility level of care. OAAS RO shall be responsible for assuring that all avenues of eligibility have been explored prior to determining that an individual does not meet the required nursing facility level of care. OAAS RO shall notify the PACE organization of the final determination.

When an enrollment is denied the PACE organization must notify CMS and the SAA through the Data Elements in Health Plan Management System (HPMS).

When a PACE applicant request transition from a waiver program to the PACE program the OAAS trained and certified PACE staff will complete a hard copy of the initial MDS-HC assessment. The OAAS RO will be notified of the completed MDS-HC assessment. The OAAS RO will enter the hard copy MDS-HC assessment into the OAAS database. The OAAS RO will send the PACE organization a computer generated copy of the MDS-HC and notify the PACE organization of the MDS-HC results.

Once medical and functional eligibility and program requirements have been established as being met the PACE organization must submit all enrollment data to the OAAS Regional Office (RO). The Louisiana Department of Health and Hospitals Medicaid Program Notice of Medical Certification (Form 142) is generated and submitted to the Parish Medicaid Office by the OAAS RO. The issuance of this by OAAS RO ensures that the PACE recipient has met medical and functional eligibility for PACE. The Parish Medicaid Office must determine financial eligibility. The PACE applicant is not officially enrolled until the PACE organization receives the Form 18P from the Parish Medicaid Office. The issuance of Form18P ensures that the PACE recipient is financially eligible.

The recipient's effective date of enrollment is on the first day of the calendar month following the date the PACE organization receives the recipient's signed PACE Enrollment Agreement as specified in 42 CFR 460.158. The recipient is enrolled for the next year unless the recipient either decides to voluntarily disenroll or is involuntarily disenrolled or in death in accordance with 42 CFR 460.160(a).

Changing Providers

The recipient may request voluntary disenrollment for the purpose of reinstatement into other Medicare and Medicaid programs for which the recipient is eligible as specified in 42 CFR 460.168.

The PACE organization must take the following actions to assist the recipient:

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

- Work with CMS and OAAS to reinstate the recipient in other Medicaid programs for which the recipient is eligible.

No disenrollment will become effective until the recipient is appropriately reinstated into other Medicare and Medicaid programs for which the recipient is eligible and alternative services are arranged. The recipient must continue to use PACE organization services and remain liable for any premiums until the date of enrollment is terminated.