SERVICE ACCESS AND AUTHORIZATION

Accessing Services

The Program of All-Inclusive Care for the Elderly (PACE) applicant/responsible 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 contractor for Louisiana Options in Long Term Care and request a Louisiana Level of Care Eligibility Tool (LOCET) to be completed. The LOCET is completed over the telephone by this contractor and is a level of care pre-enrollment screening tool. If the LOCET indicates that the applicant meets Nursing Facility Level of Care, the approval information is sent over to the PACE provider in the applicant's geographical location. The PACE provider will then contact the applicant and begin the application process.

The PACE provider must create and maintain a log of all potential enrollees who call requesting information and/or admission into the program. This log must include:

- The initial call with the name and contact information for the potential enrollee;
- All subsequent calls regarding the pre-application process with notes of the reason for the call;
- The final outcome regarding whether the potential enrollee proceeded in the application process, or the potential enrollee was turned down and did not proceed with the application;
- The reason that the applicant was not selected to enroll in PACE, if applicable.

Provider Selection

Authorization Process

Once the applicant is linked to the PACE provider, the PACE intake process begins as follows:

- PACE staff members conduct one (1) or more face-to-face visits at the applicant's place of residence (home);
- The applicant makes one (1) or more face-to-face visits to the PACE center;
- PACE staff must explain the following to the applicant and/or his/her responsible representative:
    - the PACE program,
    - the PACE Enrollment Agreement by reviewing all elements of the agreement,
    - The requirement that the PACE provider would be the beneficiary's sole service provider and clarification that the PACE provider guarantees access to services, but not a specific provider,
    - A list of the employees of the PACE provider who furnish care and the most current list of contracted health care providers,
    - Monthly premiums, if any,
    - Any Medicaid spenddown obligations, and
    - Post-eligibility treatment of income; and
- The applicant must sign a release to allow the PACE provider to obtain his/her medical and financial information and eligibility status for Medicare and Medicaid.

Eligibility Assessment

PACE staff must assess the applicant to ensure that he/she meets all eligibility requirements for PACE and can be cared for appropriately in a community setting. The criteria used to determine whether 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 LAC50.XXIII.501. See the following assessment criteria:

- The PACE interdisciplinary team (IDT) must conduct an initial in-person comprehensive assessment of each applicant. The information obtained through this assessment is used by the IDT to develop the beneficiary's Plan of Care that adequately addresses all of the beneficiary's functional, psychosocial, and health care needs. The assessment process begins before enrollment when the PACE organization evaluates whether a potential PACE beneficiary can be cared for appropriately in the program.

  NOTE: This 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 staff must also complete an interRAI HC face-to-face assessment on the applicant to verify that the applicant continues to meet the nursing facility level of care criteria. This assessment must be completed by a PACE staff member that has been trained and certified by OAAS to conduct these assessments. If the initial interRAI HC assessment determines that the applicant does not meet nursing facility level of care, the PACE organization must notify the OAAS Regional Office (RO) to request review of all enrollment data, including the interRAI 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 assure that all avenues of eligibility are 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.

  NOTE: When a PACE applicant is transitioning from a Medicaid waiver program to the PACE program, the PACE staff member trained and certified by OAAS will complete a hard copy of the initial interRAI HC assessment and will send the completed assessment to OAAS RO. OAAS RO will enter this assessment into the OAAS database and then forward a computer generated copy of this assessment to the PACE provider.

When an enrollment is denied because the PACE applicant's health and safety would be jeopardized by living in the community setting, or the applicant does not meet nursing facility level of care, the provider must:

- Submit the proposed denial with all documentation to OAAS RO within 3 business days of the decision.

NOTE: PACE must send these denials to OAAS RO for review/approval before notifying the applicant. OAAS RO must review these denials and respond back to the PACE provider within 2 business days of receipt of the denial information.

If OAAS RO agrees with the denial, the PACE provider must:

- Notify the individual in writing of the reason for the denial (this notice must also include fair hearing rights);
- Refer the individual to alternative services, as appropriate;
- Maintain supporting documentation for the denial;
- Notify Centers for Medicare and Medicaid Services (CMS) through the reporting of the Data Elements in monitoring into CMS Health Plan Management System (HPMS); and
- Make all applicant documentation available for review.

Once it has been determined that the applicant meets the eligibility requirements for PACE and decides to enroll in PACE, he/she must sign and date the Enrollment Agreement that contains the following (at a minimum):

- Beneficiary's Name;
- Beneficiary's Gender;
- Beneficiary's Date of Birth;
- Medicare Beneficiary Status (Part A, Part B, or both) and Number (if applicable);
- Medicaid Beneficiary Status and Number (if applicable);
- Other Health Insurance Information (if applicable);
- PACE mission and philosophy;

- PACE eligibility criteria;
- PACE Enrollment and Disenrollment conditions and procedures;
- Beneficiary Rights and Responsibilities;
- Description of PACE Benefits and Coverage and how services are obtained from the PACE provider;
- Description of participant premiums, if any, and procedures for payment of premiums;
- Description of the Interdisciplinary Care Team;
- Consumer advisory committee;
- Contracted providers;
- Description of Procedures for emergency services and urgently needed out-of-network services;
- Description of Out-of-service-area coverage;
- Prescription drug coverage;
- Notification that a Medicaid beneficiary and a beneficiary who is eligible for both Medicare and Medicaid are NOT liable for any premiums but may be liable for any applicable spend down liability and any amounts due under the post-eligibility treatment of income process;
- Notification that a Medicare beneficiary may not enroll or disenroll at a Social Security office;
- Notification that enrollment into the PACE program 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, after enrolling as a PACE participant is considered voluntary disenrollment from PACE. If a Medicaid-only or private pay beneficiary becomes eligible for Medicare after enrollment in PACE, the beneficiary will be disenrolled from PACE if he/she elects to obtain Medicare coverage other than from the beneficiary's PACE provider;

- Information on the consequences of subsequent enrollment in other optional Medicare or Medicaid programs following disenrollment from PACE;
- Notification of a beneficiary's responsibility to inform the PACE provider of a move or lengthy absence from the PACE service area;
- Acknowledgement that beneficiary understands the requirement that the PACE provider must be the sole service provider;
- Statement that the PACE provider has an agreement with CMS and LDH/OAAS that is subject to renewal on a periodic basis, and if the agreement is not renewed, the program will be terminated;
- Beneficiary's authorization for disclosure and exchange of personal information between CMS, its agents, LDH/OAAS, and the PACE provider;
- Grievance and appeals procedures (including Medicare/Medicaid phone numbers to use in an appeal); and
- The Effective Date of PACE Enrollment.

NOTE: The beneficiary's effective date of enrollment is the 1st day of the calendar month following the date on which the PACE provider receives the signed enrollment agreement, as long as Medicaid and OAAS RO have signed off on the beneficiary's documents.

After the beneficiary signs the PACE Enrollment Agreement, the PACE provider gives the beneficiary the following:

- A PACE membership card that indicates that he/she is a PACE beneficiary and includes the phone number of the PACE organization;

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

Once it has been determined that the applicant meets the medical and functional eligibility and program requirements, the PACE provider must submit all enrollment documents to OAAS RO. OAAS RO submits the LDH Medicaid Program Notice of Medical Certification (Form 142) to the Parish Medicaid Office. The Regional Medicaid Office must determine financial eligibility. The PACE applicant is not officially enrolled until the PACE provider receives the Medicaid Decision Letter from the Regional Medicaid Office stating that the applicant meets Medicaid financial eligibility.

The beneficiary is enrolled for the next year, unless the beneficiary:

- Decides to voluntarily disenroll;
- Is involuntarily disenrolled; or
- Passes away.

Voluntary Disenrollment

The beneficiary may request voluntary disenrollment from PACE without cause at any time.

The effective date of voluntary disenrollment is the 1st day of the month following the date on which the PACE provider received the voluntary disenrollment notice.

Involuntary Disenrollment

When the PACE provider is proposing to involuntarily disenroll a beneficiary from the PACE program, they must submit the documentation to OAAS RO for review/approval before PACE proceeds with the disenrollment.

Beneficiaries may be involuntarily disenrolled from the PACE program for the following reasons:

- The beneficiary, after a 30 calendar day grace period, fails to pay or make satisfactory arrangements to pay any premium due to the PACE provider;

- The beneficiary, after a 30 calendar day grace period, fails to pay or make satisfactory arrangements to pay any applicable Medicaid spend down liability or any amount due under the post-eligibility treatment of income process;

- The beneficiary engages in behavior that jeopardizes his/her health and safety or the safety of others;

- The beneficiary with decision-making capacity consistently refuses to comply with his/her individual Plan of Care, medical advice, or the terms outlined in the PACE enrollment agreement or to keep appointments;

  NOTE: The PACE provider must document this behavior in the beneficiary's record along with all efforts to remedy the situation.

  The PACE provider also cannot disenroll a beneficiary on the grounds of non-compliant behavior if the behavior is related to a mental or physical condition of the beneficiary, unless the behavior jeopardizes his/her health and safety and/or the safety of others.

- The beneficiary moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE provider agrees to a longer absence due to extenuating circumstances;

- The beneficiary is determined no longer meets nursing facility level of care and is not deemed eligible;

- The PACE program agreement with CMS and LDH/OAAS is not renewed or is terminated;

- The PACE provider is unable to offer health care services due to the loss of State licenses or contracts with outside providers; and/or

- Permanent placement of the beneficiary in a nursing facility.

Once OAAS RO approves the involuntary disenrollment, the PACE provider must:

- Use the most expedient process allowed under Medicare and Medicaid procedures, as outlined in the PACE program agreement;

- Coordinate the disenrollment date between Medicare and Medicaid (for beneficiaries who are eligible for both Medicare and Medicaid);

- Give appropriate advance notice to the beneficiary;

- Continue to provide all needed services; and

  NOTE: The beneficiary must continue to use the PACE provider's services and he/she is liable for any premiums until the date on which the PACE services are terminated.

- Facilitate the beneficiary's reinstatement into other Medicare and Medicaid programs after disenrollment by:

  - Making appropriate referrals and ensuring that medical records are made available to new providers within 30 calendar days; and

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

The beneficiary's involuntary disenrollment will occur AFTER the PACE provider meets all of the requirements set forth above.

The effective date of involuntary disenrollment is the 1st day of the next month that begins 30 calendar days after the date on which the PACE provider sends the disenrollment notice to the beneficiary.