Programs of All-Inclusive Care for the Elderly (PACE) and Case Management Agency (CMA) Handbook

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Background

Colorado Revised Statutes (C.R.S.) require the Department of Health Care Policy & Financing (HCPF) to work with Case Management Agencies (CMA) to develop and implement a coordinated plan to provide education about the **P**rogram of **A**ll-Inclusive **C**are for the **E**lderly (PACE). The statutes also require that PACE organizations provide on-going training to CMA case managers in counties where a PACE program operates and that CMA case managers discuss the option and potential benefits of participating in the PACE program with all individuals eligible for long-term care.

See the Resources Section of this Handbook for the specific C.R.S. references.

Purpose

The purpose of the PACE and CMA Handbook is to provide PACE organizations with uniform training material to train CMAs and to provide CMAs with a uniform reference material when discussing the PACE program with individuals who are eligible for long-term care.

Definitions

Case Management Agency (CMA) means a public or private not-for-profit or for-profit organization with the State of Colorado to provide case management services and activities.

Long-term services and supports (LTSS) program means any of the following: publicly funded programs:

- Home and Community-Based Services (HCBS) Waivers:
    - Brain Injury (HCBS-BI) waiver
    - Children with Life-Limiting Illness (HCBS-CLLI) waiver
    - Community Mental Health Supports (HCBS-CMHS) waiver
    - Complementary and Integrative Health (HCBS-CIH) waiver (formerly Spinal Cord Injury (HCBS-SCI) waiver)
    - Elderly, Blind and Disabled (HCBS-EBD) waiver
- Medicaid Nursing Facility Care
- Programs for All-Inclusive Care for the Elderly (PACE) (where applicable),
- Hospital Back-up (HBU)
- Adult Long-Term Home Health (LTHH)

PACE stands for Programs of All-inclusive Care for the Elderly.

PACE Center is a facility which includes a primary care clinic, and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining, and which serves as the focal point for coordination and provision of most PACE services.

PACE organization means an entity that has in effect a PACE program agreement to operate a PACE program under this part.

PACE program means a program of all-inclusive care for the elderly that is operated by an approved PACE organization and that provides comprehensive healthcare services to PACE enrollees in accordance with a PACE program agreement.

PACE program agreement means an agreement between a PACE organization, Centers for Medicare & Medicaid Services (CMS), and the State Administering Agency for the operation of a PACE program.

Participant refers to an individual who is enrolled in a PACE program.

Professional Medical Information Page (PMIP) means the medical information form signed by a licensed medical professional used to certify level of care.

Reassessment means a periodic comprehensive reevaluation with the individual receiving services, appropriate collaterals, chosen by the individual, and case manager, to re-determine the individual's level of functioning, service needs, available resources and potential funding resources. [Conducted by the CMA]

State administering agency (SAA) means the State agency responsible for administering the PACE program agreement. HCPF is the SAA in Colorado.

Case Management Agency Overview

A. Current System (as of March 2023): Single entry point agencies, community centered boards, and private case management agencies currently provide case management for individuals enrolled in Colorado's HCBS waiver programs. Each agency provides case management for different waiver programs. Individuals who are seeking or receiving LTSS often qualify for multiple programs and end up navigating between systems that are siloed by program.

B. Future System: case management redesign is intended to simplify access and remove silos so individuals will be able to more easily navigate and find the right programs and services that work for them. It will require one case management agency to provide case management services for all waiver programs (and PACE programs) in each defined service area.

PACE Overview

A. A PACE organization provides pre-paid, capitated, comprehensive health care services designed to meet the following objectives:
    1. Enhance the quality of life and autonomy for older adults who meet nursing facility level of care.
    2. Maximize the dignity of, and respect for, older adults.
    3. Enable older adults to live in the community for as long as medically and socially feasible.
    4. Preserve and support the older adult's family unit.

B. Each PACE organization must sign a PACE Program Agreement with the Centers for Medicare & Medicaid Services (CMS) and HCPF.

C. HCPF, often in cooperation with CMS, conducts reviews of a PACE organization's operations.

D. PACE organizations operate in the following Colorado counties/service areas:

PACE Organization	Service Area (For the exact zip codes, contact the PACE organization)
HopeWest PACE	Mesa
InnovAge Colorado PACE	Adams, Arapahoe, Broomfield, Denver, Jefferson, Larimer, Pueblo, Weld
Rocky Mountain PACE	El Paso
Senior CommUnity Care PACE	Delta, Montrose
TRU PACE	Adams, Boulder, Jefferson, Weld (southwest)

PACE Eligibility Criteria

To be eligible to enroll in PACE, an individual must meet the following requirements:

1. Be 55 years of age or older.
2. Meet nursing facility level of care.
3. Live in the service area of a PACE organization.
4. Meet any additional program specific eligibility conditions imposed under the PACE program agreement. **Note**: Additional eligibility conditions are rare.

5. Be able to live in a community setting without jeopardizing his or her health or safety, at the time of enrollment.

PACE Services

A. The PACE benefit package for all participants, regardless of the source of payment, must include the following:
    1. All Medicare-covered services.
    2. All Health First Colorado-covered services, as specified in the Colorado Medicaid State Plan.
    3. Other services determined necessary by the interdisciplinary team (IDT) to improve and maintain the overall health of the participant that Medicare and Health First Colorado do not cover.

B. There are no benefit limitations or conditions as to amount, duration or scope of services and there are no deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare and Health First Colorado for services determined necessary by the IDT.

    Note: Participants are liable for any applicable premium due to the PACE organization, Health First Colorado spend down liability, or any amount due under the post-eligibility treatment of income process.

C. The participant, while enrolled in a PACE program, must receive Medicare and Health First Colorado benefits solely through the PACE organization, including contractors of the PACE organization.

    Note: Participants may be fully and personally liable for the costs of unauthorized or out-of-PACE program agreement services.

D. PACE services include, but are not limited to:
    - Adult Day Services
    - Behavioral and Mental Health Services
    - Dental Services
    - Durable Medical Equipment
    - Emergency and Hospital Care
    - End of Life Care
    - Home Care Services
    - Laboratory/X-Ray Services
    - Meals
    - Nutritional Counseling
    - Occupational Therapy
    - Optometry
    - Personal Care and Supportive Services
    - Physical Therapy
    - Prescription Drugs
    - Preventive Care
    - Primary Care (including nursing services)
    - Recreational Therapy
    - Respite
    - Social Services
    - Social Work Counseling
    - Specialists
    - Transportation

Note: PACE participants will get Medicare Part D-covered drugs and all other necessary medication from the PACE program. PACE participants do not need to join a separate Medicare Part D prescription drug plan. Joining a separate drug plan is considered a voluntary disenrollment from PACE.

PACE Interdisciplinary Team

A. The interdisciplinary team (IDT) is a group of healthcare and social service professionals who comprehensively assess and meet the individual needs of each participant across all care settings, up to and including residential and rehabilitation settings (e.g., acute and subacute facilities, assisted living residences, skilled nursing facilities, etc.).

B. IDT responsibilities include but are not limited to the following:
    1. The initial assessment, periodic reassessments, plan of care, and coordination of 24-hour care delivery across all care settings.
    2. Regularly informing other IDT members of the medical, functional, and psychosocial condition of each participant.
    3. Remaining alert to pertinent input from any individual with direct knowledge of or contact with the participant.
    4. The implementation, coordination and monitoring of the participant's plan of care, whether the services are furnished by PACE employees or contractors.

C. IDT members must include:
    1. Primary care provider
    2. Registered nurse
    3. Master's level social worker
    4. Physical therapist
    5. Occupational therapist
    6. Recreational therapist or activity coordinator
    7. Dietitian
    8. PACE center manager
    9. Home care coordinator
    10. Personal care attendant or his or her representative
    11. Driver or his or her representative

    Note: The list includes the required IDT members in accordance with Federal regulations. At the recommendation of the interdisciplinary team, other professional disciplines (for example, speech-language pathology, dentistry, or audiology) may be included.

PACE Payment and Financial Risk

A. A PACE organization receives a prospective, monthly capitation payment for each Medicare and Health First Colorado participant.

   Note: Participants may also pay privately.

B. A PACE organization combines these funds into a common pool from which they pay participant expenses.

C. The capitated payment ensures a participant receives service for the entire month - even if a participant is serving a Health First Colorado period of ineligibility.

   Note: A PACE organization may submit an involuntary disenrollment request to HCPF if after a 30-day grace period, the participant fails to pay or make satisfactory arrangements to pay any premium due the PACE organization or 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.

D. A PACE organization assumes full financial risk for participant care.

E. The amount that a PACE organization can charge a participant as a monthly premium depends on the participant's eligibility under Medicare and Health First Colorado, as follows:

   1. **Medicare Parts A and B.** For a participant who is entitled to Medicare Part A, enrolled under Medicare Part B, but not eligible for Health First Colorado, the premium equals the Health First Colorado capitation amount.
   2. **Medicare Part A only.** For a participant who is entitled to Medicare Part A, not enrolled under Medicare Part B, and not eligible for Health First Colorado, the premium equals the Health First Colorado capitation amount plus the Medicare Part B capitation rate.
   3. **Medicare Part B only.** For a participant who is enrolled only under Medicare Part B and not eligible for Health First Colorado, the premium equals the Health First Colorado capitation amount plus the Medicare Part A capitation rate.
   4. **Health First Colorado, with or without Medicare.** A PACE organization may not charge a premium to a participant who is eligible for both Medicare and Health First Colorado, or who is only eligible for Health First Colorado.

   Note: The term “premiums” as used in this section does not include spenddown liability under 42 CFR §435.121 and 42 CFR §435.831, or post-eligibility

treatment of income under 42 CFR §460.184. A participant's "share of cost" responsibility under Health First Colorado is not considered a premium.

PACE and Adult HCBS Waivers Differences

Differences between the PACE program and the adult HCBS waivers include but are not limited to:

Topic	HCBS Waiver	PACE
Benefit Type	Waiver. Section 1915(c) of the Social Security Act permits States to offer, under a waiver of statutory requirements, an array of Home and Community Based Services (HCBS) that an individual needs to avoid institutionalization.	State Plan. Section 1934 of the Social Security Act permits States to elect to provide the PACE program under the Medicaid State Plan as an alternative to institutional care.
Case Management	CMA case managers are responsible for the case management of HCBS waiver members. Staff are available within contract and rule requirements for CMAs.	PACE IDTs are responsible for the case management of PACE participants. Staff are responsible for the coordination of 24-hour care delivery, including an on-call provider.
Continued Stay Review (CSR)	CMAs conduct CSRs at a minimum every 12 months, and unscheduled CSRs as needed for the purpose of reviewing and re-establishing eligibility for all HCBS waiver programs, in accordance with all applicable statutes, regulations and federal waiver provisions.	CMAs conduct an initial assessment and one CSR for PACE participants. After the initial assessment and one CSR, PACE participants are no longer reassessed by the CMA. CMAs will waive the annual recertification requirement for PACE participants if the participant continues to meet nursing facility level of care or if the participant has a diagnosis specified in the PACE Program Agreement at the time of the CSR.

Topic	HCBS Waiver	PACE
Eligibility	An individual must meet the level of care (functional eligibility) and target group criteria for the specific HCBS waiver. An individual must be financially eligible for Long-Term Care Medicaid.	An individual must meet nursing facility level of care and PACE program eligibility criteria. An individual is **not** required to be financially eligible for Health First Colorado.
Enrollment Effective Date	An individual's start date of eligibility for HCBS-EBD services (the waiver serving the most similar target group to PACE) shall not precede the date that all of the requirements in 10 CCR 2505-10 8.485.60 have been met. The first date for which HCBS-EBD services can be reimbursed shall be the later of any of the following: A. Financial: The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to 10 CCR 2505-10 8.100. B. Level of Care: This date is determined by the official Utilization Review Contractor's (URC) stamp and the URC-assigned start date on the LTSS Assessment. C. Receiving Services: This date shall be determined by the date on which the client signs either a case plan form, or a preliminary	If a potential participant meets eligibility requirements, his or her enrollment in the PACE program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

Topic	HCBS Waiver	PACE
	case plan (intake) form, as prescribed by the state, agreeing to accept services. D. Institutional Status: HCBS-EBD eligibility cannot precede the date of discharge from the hospital or nursing facility.	
Disenrollment Effective Date	An individual's disenrollment is effective when the member's appeal period has been completed or at the time they request voluntary disenrollment. Individuals seeking or receiving services shall be denied or discontinued from services under publicly funded programs served by the CMA system if they are determined ineligible for any of the following reasons: 1. The individual is found to be financially ineligible for LTSS programs. 2. The individual does not meet the functional eligibility threshold for LTSS Programs or nursing facility admissions. 3. The individual does not meet the target group criteria as specified by the HCBS Program. 4. The individual has not received waiver services for one month.	1. **Voluntary** - A PACE participant has the right to voluntarily disenroll from the PACE program at any time for any reason. A participant's voluntary disenrollment is effective on the first day of the month following the date the PACE organization receives the participant's notice of voluntary disenrollment. **Note:** Enrollment in any other Medicare or Medicaid prepayment plan or optional benefit, including the hospice benefit, after enrolling as a PACE participant is considered a voluntary disenrollment from PACE. 2. **Involuntary** - HCPF must approve a participant's involuntary disenrollment. A participant's involuntary disenrollment occurs after HCPF determines that the PACE organization has documented acceptable

Topic	HCBS Waiver	PACE
	5. The individual has two times in a thirty-day consecutive period refused to schedule an appointment for assessment, or monitoring required by these regulations. 6. The individual has failed to keep three scheduled assessment appointments within a thirty-day consecutive period. 7. The CMA does not receive the completed PMIP form, when required. 8. The individual is not eligible to receive HCBS services while a resident of a nursing facility, hospital, or other institution. 9. An individual who is already a recipient of program services enters a hospital for treatment, and hospitalization continues for thirty days or more.	grounds for disenrollment and is effective on the first day of the next month that begins 30 days after the day the organization sends notice of the disenrollment to the participant. The PACE organization must continue to furnish all needed services until the date enrollment is terminated for voluntary and involuntary disenrollments.
Services	HCBS waiver members may receive all Health First Colorado-covered services. Services specified under their enrolled waiver should overlay Health First Colorado covered services. Waiver services should not be duplicative of Health First Colorado covered services.	PACE participants may receive all Medicare and Health First Colorado-covered services as well as other services determined necessary by the IDT to improve and maintain the overall health of the participant that Medicare and Health First Colorado would not otherwise cover (e.g. pest extermination).

Topic	HCBS Waiver	PACE
	HCBS adult waivers do not cover nursing facility or hospital care. Services must be furnished in the home or community. The CMA may be granted a waiver by HCPF to provide direct services.	PACE organizations must provide care that meets the needs of each participant across all care settings, 24 hours a day, every day of the year, including nursing facility, long-term hospital care, and an on-call provider. Services must be furnished in at least the PACE center, the home, and inpatient facilities. PACE IDT members deliver care and services directly unless provided by a contractor.
Terminology	Support Plan - refers to the plan that addresses a member's goals and assessed needs and preferences. CMAs do not develop Support Plans for PACE participants but do require PACE participants to sign the Service Plan Signature Page. Their signature indicates agreement with their choice to receive services from PACE.	Plan of care - refers to the plan developed by IDT members, in collaboration with the participant or caregiver, for each PACE participant based on the initial comprehensive assessment findings and reassessments.

For more information, see the HCBS Adult Waiver and PACE Comparison Chart

PACE and CMA Coordination

A PACE organization must:

A. Ensure a potential PACE participant meets the PACE eligibility requirements, including whether the individual can live safely in the community at the time of enrollment.

B. Refer a potential PACE participant to the CMA for a LTSS assessment.

C. Collaborate with and provide on-going training to CMA case managers in counties that have a PACE program.

D. Work with the CMA during enrollment and disenrollment periods to ensure timely enrollment and disenrollment of PACE participants.

A CMA must:

A. Assess potential and existing PACE participants using the current LTSS Assessment to determine whether the individual is functionally eligible (i.e. requires nursing facility level of care).

B. Discuss the option and potential benefits of participating in the PACE program with all eligible long-term care members.

C. Refer individuals who choose the PACE program to the PACE organization.

D. Work with the PACE organization during enrollment and disenrollment periods to ensure timely enrollment and disenrollment of PACE participants.

For more information, see Appendix A - PACE and CMA Work Flow

Forms

Most of the forms used by CMAs for referral, assessment, enrollment, and disenrollment of PACE participants are found on HCPF's Long-Term Services and Supports Case Management Tools Page.

For more information, see Appendix B - Key Forms for PACE

Resources

A. 42 CFR Part 460 Programs of All-Inclusive Care for the Elderly

B. Colorado Revised Statutes

1. C.R.S. 25.5-5-412 Programs of All-Inclusive Care for the Elderly.
   (6) - The state department, in cooperation with the single entry point agencies established in section 25.5-6-106, shall develop and implement a coordinated plan to provide education about PACE program site operations under this section. The state board shall adopt rules:
   (a) To ensure that case managers and any other appropriate state department staff discuss the option and potential benefits of participating in the PACE program with all eligible long-term care clients. These rules shall require additional and on-going training of the single entry point agency case managers in counties where a PACE program is operating. This training shall be provided by a federally approved PACE provider. In addition, each single entry point agency may designate case managers who have knowledge about the PACE program.

2. C.R.S 25.5-6-106 - Single Entry Point System.
   (2)(c) - The major functions of a single entry point shall include, but need not be limited to, the following:
   (IX.5) Informing eligible persons about the benefits of participating in the program of all-inclusive care for the elderly provided by a PACE organization pursuant to section 25.5-5-412 as an alternative to enrollment in a managed care organization, an organization contracted with the state department pursuant to part 4 of article 5 of this title, or other risk-bearing entity;

C. Colorado Code of Regulations

1. 10 CCR 2505-10 8.300 Medical Assistance - Hospital Services, Long-Term Care Single Entry Point System

2. 10 CCR 2505-10 8.400 Long-Term Care, Nursing Facility Care, Adult Day Care Services

D. Colorado PACE Ombudsman

The Colorado PACE Ombudsman website (as of 8/15/23) says, “The PACE Ombudsman Program provides critical and independent advocacy to help individuals attempting to enroll in PACE, PACE participants, and those who have dis-enrolled in PACE navigate the complex service delivery system within PACE and ensure quality care. PACE Ombudsmen provide assistance to resolve issues related to care, health, safety, and participant rights.”

1. CRS 26-11.5 Colorado Long-Term Care Ombudsman Program

E. Colorado HCBS Adult Waiver and PACE Comparison Chart

APPENDIX A - PACE and CMA Work Flow

This appendix provides a high-level summary of the intake, referral, assessment and continued stay review (CSR) processes between Programs of All-Inclusive Care for the Elderly (PACE) organizations and Case Management Agencies (CMA) agencies concerning potential and existing PACE participants.

Intake - PACE Organization

1. Identifies potential participants through referrals, marketing, and outreach.

2. Initiates the PACE intake process, including visiting a potential participant's place of residence and the potential participant making one or more visits to the PACE center.

3. Determines if a potential participant meets PACE eligibility requirements.

4. Refers potential participants to the CMA for a Long-Term Services and Supports (LTSS) functional assessment.

5. The PACE organization assists the participant to complete the PMIP form as needed.

6. Refers potential participants to the local county Department of Human Services for a Health First Colorado (Medicaid) financial (re)application. PACE organizations may assist potential participants with gathering information but the organization does not determine financial eligibility.

Note: The PACE organization must explain to potential and existing participants that the PACE organization does not determine financial eligibility for Medicaid and that potential and existing participants are ultimately responsible for ensuring timely and accurate submission of the required information.

Intake - Case Management Agency

1. Receives referrals from PACE organizations and other sources.

2. Sends the PMIP to the PACE organization for individuals who choose PACE as their program of care and ensures the PMIP is accurately completed.

3. Based upon information gathered on the intake form, the case manager determines the appropriateness of a referral for an LTSS Assessment and explains the reasons for the decision on the intake form. Individuals are informed of the right to request an assessment if the individual disagrees with the case manager's decision.

4. Conducts the LTSS Assessment within 10 business days (for an individual who is not being discharged from a hospital or a nursing facility).

5. Determines if a potential participant meets functional eligibility requirements (i.e. nursing facility level of care).

6. Discusses the option and potential benefits of participating in the PACE program with all eligible long-term care members as an alternative to other healthcare options per C.R.S. 25.5-6-106(2)(c).

7. Sends the Level of Care Certification to the PACE organization. The assessment is to be completed within the same 10 business days.

8. Sends the Long-Term Care Waiver Program Notice of Action (LTC 803) to the individual or the individual's designated representative in accordance with 10 CCR 2505-10 8.393.3.A.

Enrollment - PACE Organization

1. Explains the contents of the PACE Enrollment Agreement to potential participants.

2. Enrolls individuals who choose the PACE program on the first day of the month following the date the organization receives the signed enrollment agreement.

3. Sends written enrollment data to the CMA monthly (best practice).

Enrollment - Case Management Agency

1. Enters a note in the information management system, documenting the individual selected PACE, including a signed statement of choice from the individual (Service Plan Signature Page).
2. Works with individuals who do not select the PACE program, or who disenroll from PACE, to enroll in another Medicaid program for which the individual is eligible.

Note: The PACE organization and the Case Management Agency are encouraged to communicate verification of participant enrollment.

Continued Eligibility - Case Management Agency

1. Conducts a CSR for the participant after the first year of PACE enrollment. If the person remains eligible, an open end date is entered in the information management system, and notification is sent to the county Department of Human Services and the PACE organization.

2. Waiver for lack of improvement. At the time of the first annual recertification, the participant's physician will document whether the participant continues to meet nursing facility level of care. If the CMA determines that there is no reasonable expectation of improvement or significant change in the participant's condition because of the severity of a chronic condition or the degree of impairment of functional capacity, the CMA will permanently waive the annual recertification requirement and allow continuous eligibility.

3. Waiver by diagnosis. At the time of the first annual recertification, the CMA will permanently waive the annual recertification requirement and allow continuous eligibility if the participant's physician indicates the participant has one or more of the following diagnoses:
    - Cardiomyopathy
    - Dementia
    - Multiple Sclerosis
    - Primary liver cirrhosis
    - Renal failure, on dialysis

    The CMA must document the diagnosis on the summary page of the LTSS Assessment, which indicates there is no reasonable expectation of functional improvement.

Continued Eligibility - PACE Organization

1. The PACE organization must retain documentation of the reason for waiving the annual recertification requirement in the participant's medical record.

Deemed Continued Eligibility - Case Management Agency and PACE Organization

1. Per 42 CFR 460.160(b)(2), at the time of the first annual recertification, if the CMA determines that a PACE participant no longer meets the State Medicaid nursing facility level of care requirements, the participant may be deemed to continue to be eligible for the PACE program until the next annual reevaluation, if, in the absence of continued coverage under this program, the participant reasonably would be expected to meet the nursing facility level of care requirement within the next 6 months.

2. The CMA must issue the Notice of Action to the participant at the time the determination is made.

3. If the PACE organization believes the participant would be expected to meet the nursing facility level of care within the next 6 months, the organization must submit a request for deemed continued eligibility in the form and manner specified by HCPF.

4. HCPF, in consultation with the PACE organization, makes a determination of deemed continued eligibility based on a review of the participant's medical record and plan of care.

5. HCPF will issue a written notification of the decision to the PACE organization and the CMA.

For more information, see 42 CFR 460.160 and the PACE Program Agreement, Appendix P, which is included in this Handbook as Appendix C.

Disenrollment - PACE Organization

1. Notifies the CMA in a timely manner of each participant who will be disenrolled from the PACE program.

2. Works with the CMA to reinstate participants who disenroll from the PACE program in other Medicaid programs for which the participant is eligible.

3. Sends written disenrollment data to the CMA monthly (best practice).

Disenrollment - Case Management Agency

1. Works with PACE participants who disenroll from the PACE program to reinstate them in other Medicaid programs for which the individual is eligible.

Education - PACE Organization

1. Provides education and information about the PACE program to CMA case managers and implements on-going training per C.R.S. 25.5-5-412(6).

APPENDIX B - Key Forms for PACE

This appendix provides a high-level overview of forms relevant to the Case Management Agency (CMA), the PACE Organization (PO), and the PACE Participant, during referrals, assessments, enrollments, and disenrollments.

Referral, Assessment, and Enrollment Forms			
Name of Form	**Case Management Agency (CMA)**	**PACE Organization (PO)**	**PACE Participant**
Adult Services Referral Form (page one of LTSS Assessment	Some but not all CMAs request this form	If requested, the PO completes the form and sends to the CMA	n/a
Professional Medical Information Page (PMIP)	CMA sends PMIP to PO	PO sends completed PMIP to CMA	Signed by the individual's physician*
LTSS Assessment	CMA conducts an assessment using the LTSS Assessment within 10 business days of referral for LTSS	n/a	Individual signs the signature page of the LTSS Assessment
LOC (Level of Care Certification)	CMA completes and sends to PO after conducting assessment	n/a	n/a
Long-Term Care Waiver Program 803 Notice of Action (Notice of Functional Eligibility)	CMA sends to potential participant after conducting functional assessment stating eligibility status with rights to appeal	n/a	n/a
Signed Release of Information form	n/a	n/a	Individual signs form (in collaboration with CMA and PO) to allow PO and CMA to access financial and medical records

Referral, Assessment, and Enrollment Forms			
Name of Form	**Case Management Agency (CMA)**	**PACE Organization (PO)**	**PACE Participant**
Service Plan Signature Page	n/a	Note: The PO is not required to sign the Service Plan Signature Page	Individual signs to indicate that they are in agreement with the information in the Service Plan and agrees to receive services accordingly
PACE Enrollment Agreement	n/a	n/a	If the individual meets eligibility requirements and chooses to enroll, he/she must sign PACE enrollment agreement

* The Medical Provider section of the LTSS Assessment must be completed and signed by a licensed medical professional. For Continued Stay Reviews (CSR), the PMIP signature date must be within 90 days of the Certification Start Date and prior to the Certification End Date. For new enrollees, the PMIP signature date must be prior to and no earlier than six months from the Certification Start Date and no later than 90 days from the LTSS Assessment date.

See HCPF Operational Memo 20-014 for more information.

Disenrollment Forms			
Name of Form	**Case Management Agency (CMA)**	**PACE Organization (PO)**	**PACE Participant**
Adult Services Referral Form (page one of LTSS Assessment)	n/a	PO sends to CMA with notification of disenrollment and requested action (if a PACE participant chooses a HCBS waiver)	n/a
Long-Term Care Waiver Program 803 Notice of Action (Notice of Functional Eligibility), with Appeal Rights	CMA sends a Notice of Action to potential or existing participant after conducting functional assessment stating eligibility status with rights to appeal	n/a	n/a

Disenrollment Forms			
Name of Form	**Case Management Agency (CMA)**	**PACE Organization (PO)**	**PACE Participant**
PACE Disenrollment Report	n/a	PO sends a report to CMA including the date and reason for disenrollment	n/a

APPENDIX C - Continued Eligibility

Note: This information was taken from the PACE Program Agreement, Appendix P, Section B. Certain requirements listed below are the contracted responsibility of the CMA.

1. **Annual recertification requirement.** At least annually, the SAA [CMA] must reevaluate whether a participant needs the level of care required under the State Medicaid plan for coverage of nursing facility services.

2. **Waiver of annual requirement.** The SAA may permanently waive the annual recertification requirement for a participant if it determines that there is no reasonable expectation of improvement or significant change in the participant's condition because of the severity of a chronic condition or the degree of impairment of functional capacity. The PACE organization must retain in the participant's medical record the documentation of the reason for waiving the annual recertification requirement.

3. **Deemed Continued Eligibility.** If the SAA [CMA] determines that a PACE participant no longer meets the State Medicaid nursing facility level of care requirements, the participant may be deemed to continue to be eligible for the PACE program until the next annual reevaluation, if, in the absence of continued coverage under this program, the participant reasonably would be expected to meet the nursing facility level of care requirement within the next six months.

4. **Continued Eligibility Criteria.** The SAA established the following criteria for deemed continued eligibility:

    a. **Waiver by Diagnosis.** At the time of the first annual recertification, the SAA [CMA] will permanently waive the annual recertification requirement and allow continuous eligibility if the participant's physician indicates the participant has at least one of the following diagnoses:
        i. Cardiomyopathy
        ii. Dementia
        iii. Multiple Sclerosis
        iv. Primary liver cirrhosis
        v. Renal failure, on dialysis

The diagnoses indicate there is no reasonable expectation of functional improvement. The SAA [CMA] must document the diagnosis on the summary page of the Universal Long-Term Care Functional Eligibility Assessment Tool, known as the ULTC 100.2, or its replacement.

b. **Waiver for Lack of Improvement.** At the time of the first annual recertification, the participant's physician will document whether the participant continues to meet nursing facility level of care on a form specified by the SAA. If the SAA [CMA] determines that there is no reasonable expectation of improvement or significant change in the participant's condition because of the severity of a chronic condition or the degree of impairment of functional capacity, the SAA will grant a permanent written waiver of the annual recertification requirement. The PACE organization must retain documentation of the reason for waiving the annual recertification requirement in the participant's medical record.

5. The SAA, in consultation with the PACE organization, determines deemed continued eligibility based on a review of the participant's medical records and plan of care. The criteria under section (B)(4) of this appendix must be applied in reviewing the participant's medical record and plan of care.