
PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
MA-2275 – PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
ISSUED 02-01-08 – CHANGE NO. 07-08

I. BACKGROUND

Program of All-Inclusive Care for the Elderly (PACE) is a federal program administered by the Centers for Medicare and Medicaid Services (CMS). House Bill 1414 of the 2004-2005 Session of the North Carolina General Assembly mandated the development of PACE programs. The State of North Carolina has received approval from CMS to amend the state plan to include PACE as a state plan option.

II. INTRODUCTION

The Program of All-Inclusive Care for the Elderly (PACE) is a managed care program that 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.

A. PACE Organization

1. The PACE program is regulated through a three-party agreement among Centers for Medicare and Medicaid Services (CMS), North Carolina Department of Health and Human Services through the Division of Medical Assistance, and the PACE organization.
2. The PACE organization administers the PACE program and is responsible for enrolling individuals into the PACE program.

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3. The PACE program allows North Carolina to use Medicaid funds to provide home and community based services to Medicaid recipients who require institutional care (placement in a nursing facility), but for whom care can be provided cost-effectively and safely in the community with PACE services. Institutional care for PACE is defined as SNF level.
4. A PACE organization is required to provide a specified set of services that includes:
 - Interdisciplinary team case management;
 - Adult day health program;
 - Skilled nursing care;
 - Primary care physician services;
 - Specialized therapies;
 - Personal care services;
 - Nutrition counseling;
 - Meals;
 - Transportation, and
 - Prescriptions.
5. If at any time, PACE determines an individual can no longer be cared for in the home, the PACE organization may place the PACE recipient in another health care setting for a short period of time, or if necessary, it can be a permanent placement. Temporary and/or permanent placement in another health care setting such as a nursing facility does not change an individual's PACE enrollment status or capitation rate. The PACE organization is responsible for payment of cost of care.

B. PACE Program Enrollment Requirements

1. An individual must be living in the approved geographic area of the PACE organization;
2. Be at least 55 years old or older;
3. Be determined by the PACE organization to be able to be cared for safely in the community;
4. Meet the State's eligibility criteria for nursing home level of care.

C. PACE Program Enrollment Process

1. Applications for PACE enrollment are initiated and processed by the PACE organization. Once PACE approves enrollment, the applicant must sign a Participant Enrollment Agreement. PACE enrollment is always the first day of the month following the month the Participant Enrollment Agreement is signed and received by the PACE organization.

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2. Once enrolled for PACE, the recipient is enrolled for the next year unless he terminates enrollment. PACE recipients are re-assessed annually by the PACE organization.

3. “Lock-In” Provision

"Lock-in" means once enrolled in PACE, health care services will be provided through the PACE organization. Services will be approved by the members of the PACE Multidisciplinary Team. If a PACE recipient receives medical services that have not been approved by the PACE Multidisciplinary Team, the recipient may be personally responsible for paying the cost of those services. If a PACE recipient receives medical services from a non-PACE medical provider without prior authorization (with the exception of Emergency Services), the recipient may be liable for the full cost of those services.

4. When an individual enrolls in PACE, he is ineligible for any other Medicare plans or any other Medicaid services, programs/categories, or optional benefits, except for MQB. Refer to XI. Below.

D. Medicaid Eligibility for PACE

1. The county must determine Medicaid eligibility for individuals requesting PACE services following the rules and regulations for Aged, Blind and Disabled Medicaid, including the need for a FL-2.
2. DMA makes a prospective capitated monthly payment to the PACE organization for each eligible Medicaid participant. The county must determine Medicaid eligibility for individuals requesting PACE services.
3. Because of the exclusively frail population served by PACE and the immediate need for PACE services, it is imperative that Medicaid applications and requests for PACE services be expedited. Eligibility must be entered by the pull date or the 11th workday from the end of the month for SSI cases in order for the PACE capitated payment to begin the next calendar month. Failure to enter PACE information by these EIS dates will result in denied payments to the PACE organization. PACE organizations are aware that application processing times can be reduced dramatically by assisting the county in obtaining financial and other eligibility information. Communication between the DSS and the PACE organization is crucial to attain priority processing of Medicaid eligibility for PACE services.

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III. PACE AND MEDICAID REFERRAL PROCEDURES

The [DMA-5106](#), PACE/Medicaid Referral ([Figure 1](#)), is used for communication, notification, and documentation between Medicaid and the PACE organization. Page 1 is completed by the county and page 2 is completed by the PACE organization. Page 1 contains an authorization for release of information to Medicaid and page 2 includes an authorization for release of information to PACE. The authorizations for release of information must be signed by the applicant/recipient and is valid for one year.

A. Medicaid A/R Requests PACE Services

Individuals requesting PACE enrollment information should be referred to the PACE organization located in the individual's service area. Also, complete page 1 of the [DMA-5106](#), PACE/Medicaid Referral, and send to the PACE organization.

B. Processing PACE Referrals

The PACE organization will complete page 2 of the [DMA-5106](#), PACE/Medicaid Referral, when an individual requests PACE enrollment and indicates a need for financial/medical assistance. PACE may also assist individuals by completing a Medicaid mail-in application. The date of the application is the date a complete application is received by the county dss.

The PACE organization will also complete page 2 of the [DMA-5106](#), PACE/Medicaid Referral, when an individual has signed the PACE Enrollment Agreement and is enrolled in PACE.

IV. Eligibility Documentation for PACE

File in the case record a copy of the PACE enrollment notification, the [DMA-5002](#), Approval Notice (unless automated notice was used), and the current FL-2 to document eligibility for PACE participation.

V. POLICY PRINCIPLES

A. General Policy Rules

To be authorized for Medicaid coverage of PACE services, the a/r must

1. Be enrolled in the PACE program.

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2. Be eligible for Medicaid in the Aged, Blind, and Disabled (MAABD) aid program/categories.
3. Be certified by the Division of Medical Assistance as meeting nursing home level of care (FL-2). Preadmission Screening and Annual Resident Review (PASAAR) requirements are not applicable to PACE.
4. Be at least 55 years old or older.
5. Be living in the approved geographic area of the PACE organization.

B. Budget Unit

Effective the month the PACE Enrollment Agreement is signed, the budget unit is one. This applies even if a couple is enrolled in PACE.

C. Living Arrangement Codes

1. The following three living arrangement codes must be used for PACE:
 - a. 14 PACE Private Living Arrangement
 - b. 15 PACE Living with SSI Recipient(s)
 - c. 54 PACE Living in Nursing Facility
2. Refer to EIS 4000 – Codes Appendix.

D. Retroactive Eligibility/Eligibility Prior to PACE Enrollment

1. There is retroactive coverage for regular Medicaid services if Medicaid eligibility requirements are met in the retroactive period or before PACE enrollment is effective.
2. There is no retroactive coverage for PACE services. For all months prior to the month PACE is authorized in EIS, the applicant/recipient is budgeted PLA and should be budgeted with all persons who are financially responsible for him.

E. Continuous Period of Institutionalization (CPI)

The CPI begins the first day of the month the applicant/recipient signs the PACE Enrollment Agreement with the PACE organization.

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F. Community Spouse Income Protection (Spouse in PLA)

Community Spouse Income Protection applies to PACE applicants/recipients. Follow policy in [MA-2270](#), Long Term Care Need and Budgeting. Exception: The CPI begins the first day of the month the applicant/recipient signs the PACE Enrollment Agreement with the PACE organization.

G. Dependent Family Member Allowance

Dependent family member allowance applies to PACE applicants/recipients. Follow policy in [MA-2270](#), Long Term Care Need and Budgeting.

H. Reserve

1. The reserve limit is for a b.u. of one in all PACE cases. Refer to [MA-2230](#), Financial Resources, for instructions regarding reserve requirements and procedures.
2. Spousal resource protection applies in PACE. The non-institutionalized spouse is entitled to resource protection. Resource protection begins the first day of the month the PACE Enrollment Agreement is signed. Refer to [MA-2231](#), Community Spouse Resource Protection.

I. Transfer of Assets

Transfer of assets sanctions apply to PACE. Refer to [MA-2240](#), Transfer of Assets, and XI.C. below.

J. Estate Recovery

PACE applicants/recipients are subject to estate recovery.

K. Managed Care

PACE individuals are exempt from Carolina Access enrollment. Use special exempt code 9999906. Refer to procedures in [MA-2425](#), Community Care of North Carolina/Carolina Access.

L. Medicare Buy-In

Medicaid-eligible PACE recipients eligible for Medicare qualify for Medicare enrollment and buy-in. Follow procedures in [MA-2410](#), Medicare Enrollment and Buy-In.

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M. Medicare Part D

The PACE organization is also the Medicare Part D prescription drug plan provider. PACE recipients will enroll with PACE for Medicare Part D prescription drug plan. Part D enrollment is completed by the PACE organization.

VI. PACE BUDGETING

A. Use long term care budgeting for applicants/recipients enrolled or seeking enrollment in the PACE program beginning the first day of the month the PACE Enrollment Agreement is signed. Follow procedures in [MA-2270](#), Long Term Care Need and Budgeting with the following exceptions:

1. Because PACE individuals are living in the community and have greater needs for shelter, food and clothing, a different maintenance allowance is required. To meet these greater needs, PACE individuals living in their homes are allowed a Personal Needs Allowance (PNA) in the amount of 100% of the Federal Poverty Level (FPL).
2. 1/3 Reduction does not apply to PACE individuals.

B. Determine Whose Income to Count

Follow policy in [MA-2270](#), Long Term Care Need and Budgeting, V.

C. Establish Financial Eligibility

Follow policy in [MA-2270](#), Long Term Care Need and Budgeting, V.

Note: Contact the appropriate PACE organization to obtain the PACE facility private rates used in Step I and Step II. budgeting.

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D. Determine Patient Monthly Liability (PML) - PACE Recipient Residing at Home or Temporarily in a Nursing Facility

If financial eligibility exists, proceed to determine the recipient's share of cost.

1. Temporary placement in a nursing facility by PACE is defined as less than 6 months.
2. Establish Gross Income

Establish gross amounts of all types of income, earned or unearned, that are countable based on policy in [MA-2250, Income](#).

- a. Count actual amount of SSA benefit received if it is reduced to recoup an SSA overpayment.
- b. Count total VA benefit received in excess of the \$90 improved pension, including Aid and Attendance (A&A) and unreimbursed medical expenses (UME), for veterans who reside in a North Carolina State Veterans Nursing Home.
3. Subtract Operational Expenses

Subtract operational expenses from income-producing real/personal property, or from income produced through the operation of a business. (Refer to [MA-2250, Income](#).)
4. Subtract the Special Personal Needs Allowance. Refer to VII. below.

E. Determine Patient Monthly Liability - PACE Recipient Residing in a Nursing Facility Permanently

If financial eligibility exists, proceed to determine the patient's share of cost.

1. Permanent placement in a nursing facility by PACE is defined as 6 months or longer. PACE recipients residing in a nursing facility continue to be enrolled and authorized for PACE services. The PACE organization is responsible for payment to the nursing facility.

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2. Establish Gross Income

Establish gross amounts of all types of income, earned or unearned, that are countable based on policy in [MA-2250, Income](#).

- a. Count actual amount of SSA benefit received if it is reduced to recoup an SSA overpayment.
- b. Count total VA benefit received in excess of the \$90 improved pension, including Aid and Attendance (A&A) and unreimbursed medical expenses (UME), for veterans who reside in a North Carolina State Veterans Nursing Home.

3. Subtract Operational Expenses

Subtract operational expenses produced on income-producing real/personal property, or from income produced through the operation of a business. (Refer to [MA-2250, Income](#).)

4. Subtract Personal Needs Allowance. Refer to VII. below.

VII. ALLOWABLE DEDUCTIONS

A. PACE Recipient– Residing at Home or Temporarily in Another Health Care Setting or a Nursing Facility

Excluding the Special 100% poverty level PNA deduction, the total deduction for all types of personal needs allowances listed below cannot exceed the medically needy maintenance level for an individual (\$242).

1. Special Personal Needs Allowance (SPNA) – amount equal to 100% Poverty Level

- a. PACE individuals living in the community have greater needs for shelter, food, and clothing. In order to meet these needs, PACE recipients receive a special personal needs allowance in the amount of 100% of the Poverty Level. This replaces the \$30 personal needs allowance. For a married PACE couple, each spouse receives a Special Personal Needs allowance in the amount of 100% of the Poverty Level.

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- b. If necessary, PACE individuals may be temporarily placed in another health care setting or a nursing facility by the PACE organization. No budgeting changes are made during the temporary status and the PML remains unchanged. Temporary placement in another health care setting or a nursing facility is defined as less than six months. When a PACE individual is temporarily placed in a nursing facility, the [DMA-5106](#), PACE/Medicaid Referral, is used as verification of temporary placement.
 - c. The living arrangement code remains unchanged during temporary nursing facility placement. Refer to [EIS-4000](#) – Codes Appendix.
2. Court ordered guardianship fees. Refer to [MA-2270](#), V.C.
 3. Non-discretionary mandatory deductions. Refer to [MA-2270](#), V.C.
 4. Unmet medical needs. Refer to [MA-2270](#), VIII.
 5. Personal needs allowance for work incentive. Refer to [MA-2270](#), VIII.

B. PACE Applicant/Recipient – Permanently Residing in a Nursing Facility

The total deductions for all types of personal needs allowances listed below cannot exceed the PLA medically needy maintenance level for an individual (\$242).

1. Personal Needs Allowance – \$30 for a PACE individual or \$60 for a married PACE couple residing permanently in a nursing facility and who share a room.
 - a. If necessary, PACE individuals may be permanently placed in another health care setting or a nursing facility by the PACE organization. When permanent placement is required, the PACE individual's needs decrease and the 100% Poverty Level special personal needs allowance is adjusted to \$30. Permanent placement in a nursing facility is defined as six months or longer. [DMA-5106](#), PACE/Medicaid Referral, is used as verification of permanent placement and the effective date of permanent placement.
 - b. The living arrangement code must be changed to reflect permanent nursing facility status. Refer to [EIS 4000](#) – Codes Appendix.
2. Court ordered guardianship fees. Refer to [MA-2270](#), V.C.

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3. Non-discretionary mandatory deductions. Refer to [MA-2270](#), V.C.
4. Unmet medical needs. Refer to [MA-2270](#), VIII.
5. Personal needs allowance for work incentive. Refer to [MA-2270](#), VIII.

VIII. MEDICAID AUTHORIZATION FOR PACE SERVICES

A. Medicaid authorization for PACE services is effective the first day of the month:

1. Following the month PACE enrollment is signed and approved by the PACE organization

AND;
2. The DSS determines eligibility and enters this information into EIS by pull date or the 11th workday from the end of the month for SSI recipients. If keyed after pull or the 11th workday from the end of the month for SSI recipients, the authorization for PACE services is effective the next month.

B. Applications – PACE Enrollment Pending

1. All application processing time frames apply unless the individual referred for PACE is already a Medicaid recipient.
2. When Medicaid eligibility is established, regardless of notification of PACE enrollment:
 - a. Do not wait for PACE enrollment notification.
 - b. Authorize Medicaid without PACE designation in EIS, as for any other applicant.
 - c. Send a [DMA-5099](#), Notice of Pending for Deductible, if the applicant has a deductible. Refer to [MA-2304](#), Processing the Application.

C. Applications and Ongoing Cases – PACE Enrollment Complete

1. When PACE enrollment is established for an ongoing case, notification of PACE enrollment is received, and PACE information is keyed into EIS by the pull date or the 11th workday from the end of the month for SSI cases:
 - a. Authorization for PACE is the first day of the month following the month of PACE enrollment.

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(VIII.B.1.)

- b. EXAMPLE: PACE INFORMATION ENTERED BY PULL DATE OR SSI REGULAR RUN:

Joe Jones applied for Medicaid and requested PACE services on June 27th. He also applies for enrollment with the PACE organization on June 27th. Mr. Jones completes his enrollment with the PACE organization on July 7th. The PACE organization sends a referral to the department of social services on July 8th verifying Mr. Jones' PACE enrollment date as July 7th. Joe's Medicaid caseworker establishes Medicaid eligibility and enters PACE information into EIS on July 20th. Medicaid PACE authorization is effective August 1st.
 - c. Retroactive PLA Medicaid must be evaluated for March, April and May. Ongoing PLA Medicaid must be evaluated for June and July. Refer to [MA-2304](#), Processing the Application, and [MA-2370](#), Retroactive Coverage.
 - d. Send the automated [DSS-8108](#), Notice of Benefits or manual [DMA-5002](#), Approval Notice, for approval of PACE.
2. When Medicaid eligibility is established, notification of PACE enrollment is received, and PACE information cannot be entered before pull date or the 11th workday from the end of the month for SSI cases:
 - a. Authorization for PACE will be the first day of the month the month after the month of PACE enrollment.
 - b. EXAMPLE: PACE INFORMATION NOT ENTERED BY PULL DATE OR SSI REGULAR RUN:

Susie Soloman applies for Medicaid and PACE services on June 27th. She also applies with the PACE organization for enrollment on June 27th. Susie completes her enrollment with the PACE organization on July 7th. The PACE organization sends a referral to the department of social services on July 8th verifying Susie's PACE enrollment date as July 7th. Susie's Medicaid caseworker establishes Medicaid eligibility but does not enter PACE information into EIS until July 30th. This means the PACE organization will not be paid for August. Medicaid PACE authorization is effective September 1st.

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- c. Retroactive PLA Medicaid must be evaluated for March, April and May. Ongoing PLA Medicaid must be evaluated for June, July, and August. Refer to [MA-2304](#), Processing the Application, and [MA-2370](#), Retroactive Coverage.
- d. Send the automated [DSS-8108](#), Notice of Benefits or manual [DMA-5002](#), Approval Notice for PACE.

IX. MEDICAID CERTIFICATION AND AUTHORIZATION FOR PACE

A. For an application:

- 1. Certify the case for 6 months,

AND

- 2. Follow the procedures in [MA-2350](#), Certification and Authorization.
- 3. The approval and PACE information are entered following the instructions in [EIS-2251](#), Approving M-AA, M-AB, and M-AD Applications or Reapplications.

B. For an ongoing case, continue in the established c.p.

EXCEPTION: Shorten c.p. if greater than 6 months. The c.p. cannot be longer than 6 months.

X. REDETERMINATION OF ELIGIBILITY/REVIEW

Follow policy in [MA-2320](#), Redetermination of Eligibility.

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XI. CHANGE IN SITUATION

When a change in situation results in an individual's ineligibility for Medicaid authorization for PACE, always explain that disenrollment from PACE is an option and refer them to the PACE organization. PACE applicants/recipients that disenroll from PACE must be evaluated for other Medicaid aid program/categories. PACE applicants/recipients that do not disenroll from PACE are not eligible for any Medicaid services.

A. Voluntarily/Involuntarily Disenrolls from the PACE Program

When notice of voluntary/involuntarily disenrollment, [DMA-5106](#), PACE/Medicaid Referral, is received by the dss from the PACE organization, determine continuing eligibility for PLA Medicaid. Budget the remaining months in the certification period as PLA following procedures in [MA-2260](#), Financial Eligibility Regulations – PLA.

1. If eligible for Medicaid without PACE, remove PACE information in EIS. EIS will automatically end date the PACE authorization. Refer to [EIS 3101](#), Changes to Medicaid Cases. Send an adequate notice and continue as regular Medicaid.
2. If ineligible for Medicaid without PACE, send a timely notice stating that both PACE and Medicaid will terminate. If eligible with a deductible, send a timely notice that the deductible must be met.

B. County Transfers

1. When a PACE a/r moves out of the county and is no longer enrolled with a PACE organization, the IMC must evaluate for PLA Medicaid, and
 - a. If eligible for regular Medicaid, remove PACE information in EIS. Follow procedures in [DMA-2221](#), County Residence and [EIS-3500](#), County Transfers for Active Cases.
 - b. If ineligible for regular Medicaid, terminate the case and send a timely [DSS-8110](#), Your Benefits are Changing.
2. When a PACE a/r moves out of the county (County 1) and enrolls in PACE in another county (County 2), follow county transfer procedures in [MA-2221](#), County Residence and [EIS 3500](#), County Transfers for Active Cases.

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C. Sanction Status

1. Applications

When an individual applies for Medicaid, a transfer of assets sanction period has been determined, and the individual remains enrolled in the PACE program, evaluate for MQB only. Individuals enrolled in the PACE program are ineligible for Medicaid in all other programs/categories, (excluding MBQ) during the sanction period.

a. If eligible for MQB, authorize Medicaid without PACE designation in EIS.

(1) Refer to [MA-2304](#), Processing the Application.

(2) Send the [DMA-5106](#), Medicaid/PACE Referral, to notify the PACE organization the recipient is not eligible for payment of PACE services.

b. If ineligible for MQB;

(1) Send a timely notice stating that both PACE and Medicaid will terminate.

(2) Send the [DMA-5106](#), Medicaid/PACE Referral, to notify the PACE organization the recipient is no longer eligible for payment of PACE services.

2. Ongoing

When a transfer of assets sanction is imposed, and the recipient remains enrolled in the PACE program, evaluate for MQB only. Individuals enrolled in PACE are ineligible for Medicaid in all other programs/categories (excluding MQB) during the sanction period.

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- a. If eligible for MQB, remove PACE information in EIS. EIS will automatically end date the PACE authorization. Refer to [EIS 3101](#), Changes to Medicaid Cases.
 - (1) Send an adequate notice stating that PACE will terminate.
 - (2) Send the [DMA-5106](#), Medicaid/PACE Referral, to notify the PACE organization the recipient is no longer eligible for payment of PACE services.
 - b. If ineligible for MQB, terminate the case.
 - (1) Send a manual [DSS-8110](#), Your Benefits are Changing, stating PACE and Medicaid will terminate.
 - (2) Use notification text, ***“Due to asset transfers you are ineligible for Program of All-Inclusive Care for the Elderly (PACE). You are also ineligible for other Medicaid services because you are enrolled in the PACE Program.”***
 - (3) After the timely notice period has expired, send the [DMA-5106](#), Medicaid/PACE Referral, to notify the PACE organization the recipient is no longer eligible for payment of PACE services.
3. SSI Recipients
- a. Remove PACE information from EIS and follow transfer sanction procedures in MA-2240, Transfer of Assets.
 - b. Send an adequate notice stating PACE will terminate.
 - c. Send the [DMA-5106](#), Medicaid/PACE Referral, to notify the PACE organization the recipient is no longer eligible for payment of PACE services.

XII. ELIGIBILITY INFORMATION SYSTEM (EIS)

- A. PACE information entered into EIS controls the PACE beginning and end dates and payment for PACE services. Beginning authorization dates cannot be retroactive. Refer to [EIS 2251](#), Approving M-AA, M-AB, and M-AD Applications or Reapplications.**

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B. Failure to enter PACE information will result in fee for service payments to all the Medicaid providers.

1. Failure to enter PACE information will result in no payment to the PACE organization.
2. Failure to remove PACE data when a PACE recipient disenrolls from PACE may result in payment errors which will be the financial responsibility of the county department of social services (dss).
3. When the entire case is closed, entering the termination code automatically closes PACE authorization.

C. Always enter the appropriate PACE facility code. Refer to [EIS 1063](#), Automated DMA-5016.

D. Enter the appropriate PACE Living Arrangement codes. Refer to [EIS 4000](#), Code Appendix.

E. Always enter Carolina Access exempt number 9999906.

F. Always enter a PML, even if zero.

XIII. PACE recipients are not issued Medicaid Cards. A PACE enrollment card is issued by the PACE organization. If the PACE recipient is enrolled in Medicare, a PACE identification sticker is placed on the Medicare card by the PACE organization.

XIV. XPTR REPORT

A. A monthly report of PACE recipients in XPTR is titled DHRWDB PACE ENROLLED RECIPIENTS. The report is sorted by county and district number.

B. The following information is displayed on the report:

1. PACE recipient name
2. PACE recipient ID number
3. EIS case ID number
4. County name and number
5. District number
6. PACE agency providing services

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XV. AUTOMATED AND MANUAL NOTICES FOR PACE SERVICES

A. Automated and manual notices are used for PACE cases. When using an “other code” (02 and 50) you must key the notice text on page two of the DSS-8125. Refer to [EIS 4000](#) for the appropriate automated text code. Follow all notice requirements in [MA-2420](#), Notices and Hearings Process, including the right to a fair hearing. The a/r has the right to request a hearing if he disagrees with any decision regarding his benefits. Also send the [DMA-5106](#), PACE/Medicaid Referral, to the PACE organization when the PACE organization is not designated as the recipient’s representative.

B. Approval Notice

Medicaid Applicant/Recipient - PACE Approved

1. A [DMA-5016](#), Notification of Eligibility for Medicaid/Amount and Effective Date of Patient's Liability, is automatically generated and sent to the PACE organization as notification of the pml.
2. The automated [DSS-8108](#), Notice of Benefits, is automatically generated and mailed to the applicant/recipient, or
3. Forward a copy of the manual [DMA-5002](#), Notice of Benefits, to the applicant/recipient and the PACE organization.
4. Notice text states, “PACE/Medicaid application approved.” “_____” is the PACE effective date. \$_____ is your monthly liability. You must pay your liability to the nursing home or the PACE center each month.”

C. Termination/Change

Medicaid Recipient – PACE Terminated

1. The automated [DSS-8110](#), Your Benefits are Changing, is generated and mailed to the recipient when PACE ends (Medicaid terminates, change to MQB, change to deductible, change to another Carolina Access code other than 9999906, change to non-PACE living arrangement code, etc.), or
2. Forward a copy of the manual [DSS-8109](#), Your Benefits are Changing, to the applicant/recipient and the PACE organization.
3. Notice text states “Medicaid authorization for PACE payment ends effective _____.”

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D. Active MAABD Case Transfers with PACE Authorization – Text Code 8K

Example: MAD case transfers to MAA with PACE authorization.

1. The automated [DSS-8108](#), Notice of Benefits, is generated and mailed to the recipient, or
2. Forward a copy of the manual [DMA-5002](#), Notice of Benefits, to the applicant/recipient and the PACE organization.
4. Notice text states “You are eligible for PACE.”

E. Aid/Program Category Transfer to MAABD PACE Authorized – Text Code 8J

Example: MQB case transfer to MAA with PACE authorization.

1. The automated [DSS-8108](#), Notice of Benefits, is generated and mailed to the recipient, or
2. Forward a copy of the manual [DMA-5002](#), Notice of Benefits, to the applicant/recipient and the PACE organization.
4. Notice text states “You are eligible for PACE.”

F. Voluntary/Involuntary Disenrollment

1. Voluntary Disenrollment – Use adequate code 8P
 - a. The automated [DSS-8110](#), Your Benefits are Changing, is generated and mailed to the recipient, or
 - b. Forward a copy of the manual [DSS-8110](#), Your Benefits are Changing, to the applicant/recipient and the PACE organization.
 - c. Notice text states “You have voluntarily disenrolled from the PACE program. Medicaid authorization for the PACE payment ends effective _____.”
2. Involuntary Disenrollment – Use timely Code 3P
 - a. The automated [DSS-8110](#), Your Benefits are Changing, is generated and mailed to the recipient, or

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- b. Forward a copy of the manual, [DSS-8110](#), Your Benefits are Changing, to the applicant/recipient and the PACE organization.
- c. Notice text states “You have been involuntarily disenrolled from the PACE program. Medicaid authorization for the PACE payment ends effective _____.”

XVI. PACE APPLICATION REPORT

PACE application processing activity will be monitored by DMA. On the date of disposition, complete and fax the Pace Application Report ([Figure 3](#)) to (919) 715-0801, Attention: Medicaid Eligibility Unit.

XVII. PACE SERVICES – INTERNAL APPEAL PROCESS

- A. When a service is denied or not paid, PACE staff notifies the PACE recipient both verbally and in writing. This notification will indicate why the service was denied and how to appeal the decision. Requests for appeal will be responded to within 21 days.**
- B. In cases of urgency because the PACE recipient believes not having the service would place his life or ability to function in jeopardy, then the appeal will be responded to within 72 hours by PACE. This expedited decision process is called an Expedited Review.**
- C. Appeal decisions by the PACE organization will be given to individuals in writing.**
- D. If, after the Internal Appeals Process, the PACE recipient is still not satisfied, then an appeal to either Medicare or Medicaid may be requested. PACE staff assistance may include forwarding the PACE individual’s request for an appeal to the department of social services. [MA-2275, Figure 2](#) is a suggested form for the PACE organization to use as a means of communicating appeal requests. The date the form is received by the department of social services is the date of the appeal request.**

XVIII. MEDICAID APPEAL PROCESS

- A. Appeal requirements apply to PACE cases just as with any other Medicaid case.**
- B. Refer to [MA-2420](#), Notice and Hearings Process.**