



State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

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Governor

JENNIFER VELEZ
Commissioner

JOHN R. GUHL
Director

MEDICAID COMMUNICATION NO. 09- 18

DATE: November 6, 2009

TO: County Welfare Agency Directors
ISS Area Supervisors

SUBJECT: Programs of All-inclusive Care for the Elderly (PACE) Enrollment and Eligibility

BACKGROUND: PACE has become nationally recognized as a capitated provider under Medicaid and Medicare which is governed by regulations established through the Centers for Medicare and Medicaid Services (CMS). The PACE providers are responsible for evaluating and servicing the enrollees with an all-inclusive direct care plan (no "fee for service") where PACE acts as the insurer, this process is operationally similar to managed care health maintenance organization (HMO) plans. Medicaid financial eligibility will be evaluated utilizing the regulations and procedures for "institutional" applicants, the institutional Medicaid income standard and the resource assessment that entails the lookback period as well as any applicable resource transfer penalties.

This Medicaid Communication provides information and direction regarding the enrollment of individuals in PACE and the Medicaid eligibility process for those applicants.

PACE is not a waiver and the enrollment process differs from enrollment in other Department of Health and Senior Services (DHSS) long-term care or home and community-based waiver (HCBW) programs in New Jersey. Applicants apply directly to the PACE organization for PACE enrollment and the PACE organization must conduct all clinical assessments specified in the CMS PACE regulations as part of the PACE enrollment process. The PACE organization will coordinate the financial eligibility for Medicaid with the applicant's County Welfare Agency (CWA) or the Social Security Administration (SSA) for active SSI (Supplemental Security Income) beneficiaries who are receiving SSI only income (not a combination of SSI supplementing other income such as SSDI, RSDI, Veteran's Benefits, pension, etc.).

While a PACE applicant does not need to be eligible for Medicare or Medicaid to enroll in PACE, approximately 95% of those enrolled in PACE nationally are either dually eligible or eligible for Medicaid only. Medicaid financial eligibility is determined by the CWAs utilizing the regulations applicable to those seeking "institutional" or long term care services. Additionally, the CWAs would be notified when PACE participants disenroll so that the eligibility or

ineligibility can be re-evaluated to determine if the person would be eligible for New Jersey Care...Special Medicaid Programs (non-institutional level and standards) or other programs such as home and community-based waivers. Managed Care (HMO) disenrollments and re-enrollments must be coordinated with Managed Care staff at the Division of Medical Assistance and Health Services (DMAHS) because PACE enrollees cannot be enrolled in Managed Care (HMO). If PACE enrollees disenroll from PACE and they had a HMO prior to PACE then coordination must be completed to ensure continuity of care with the selected providers.

Attached to this communication are instructions prepared by the DHSS and DMAHS, which further explain the PACE enrollment and eligibility procedures. Sample forms are also attached.

Should you have any PACE program questions, please contact Dorothy Ginsberg, PACE Administrator, at 609-633-8603. If your agency staff have need for eligibility policy clarifications, please have the supervisory administrators contact their DMAHS Policy Field Representatives at 609-588-2556.

Sincerely,



John R. Guhl
Director

JRG:E
Attachments

c: Jennifer Velez, Commissioner
Department of Human Services

William Ditto, Executive Director
Division of Disability Services

Kevin Martone, Deputy Commissioner
Department of Human Services

Jeanette Page-Hawkins, Director
Division of Family Development

Kenneth W. Ritchey, Assistant Commissioner
Division of Developmental Disabilities

Kimberly S. Ricketts, Commissioner
Department of Children and Families

Heather Howard, J.D., Commissioner
Kathleen M. Mason, Assistant Commissioner
Patricia Polansky, Assistant Commissioner
Department of Health and Senior Services

**ENROLLMENT AND ELIGIBILITY FOR
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)**

PACE organizations must conduct all assessments as specified in the Centers for Medicare and Medicaid Services (CMS) PACE regulations. Therefore, prospective PACE participants will apply directly to the PACE provider organization (PO). At the time of application the PO will determine if the applicant meets all the following enrollment requirements. The applicant must:

- Be 55 years of age or older
- Live in the authorized service area of the PACE organization
- Live safely in the community at the time of enrollment with PACE services
- Meet New Jersey's criteria for nursing facility level of care (NF LOC)

PACE organizations in New Jersey will conduct enrollments as follows:

1. All PACE applicants must apply directly to the PACE organization (PO).
2. If the applicant does not have Medicaid, but may be financially eligible, the individual is referred to the County Welfare Agency (CWA). The PO may assist the applicant or family by gathering required information to support the application for Medicaid.
3. If an applicant presents a Medicaid card when applying for PACE, the PO will first verify the Medicaid number in the MEVS/REVS system. If the individual is enrolled in a managed care program, the PO will work with designated DMAHS managed care staff in the State Medicaid office to coordinate disenrollment for the applicant prior to enrolling in PACE.
4. The PO will then refer the recipient to the CWA to verify eligibility for Institutional Medicaid. The only exception is for individuals whose only income is SSI.
5. The Department of Health & Senior Services (DHSS) does not require a PA-4 for PACE applicants.
6. When the Medicaid application has been financially approved for institutional Medicaid, the notification of financial eligibility, CP-2 (referral form) is sent by the CWA to the regional Office of Community Choice Options (OCCO). The OCCO Regional Office will notify the PACE provider organization of the financial eligibility.
7. Using the state's approved assessment tool, the PO will conduct the pre-admission screening (PAS) for nursing facility level of care (NF LOC) to evaluate the person's clinical appropriateness for enrollment. This will take place during the time the Medicaid application, or verification of eligibility for those already with some form of Medicaid, is under review by the CWA.
8. The PO will submit the PAS to the OCCO Regional Office for review and await an authorization or non-authorization of NF LOC.
 - a. If within 30 days prior to the enrollee's application or referral to PACE, OCCO completed a PAS, a new PAS will be waived.
9. The OCCO Regional Office will conduct the review of the assessment for LOC and within five (5) business days of receiving the assessment, notify the PO of the authorization, or non-authorization of NF LOC.
10. OCCO will submit a list of all PACE authorizations each week to the CWA PACE liaison.
11. If the LOC is not authorized, an OCCO Community Choice Counselor will be assigned to schedule and conduct a new PAS within fourteen (14) days.
12. OCCO will notify the PO of the outcome of the second PAS.
13. If the applicant meets LOC and all other criteria established under CMS regulations, the PO may enroll the applicant.
14. If the applicant is awaiting approval of a Medicaid eligibility application, and cannot or does not want to pay privately, enrollment will occur when the CP-2 notification has been received by OCCO and the PO has been notified of eligibility.
15. Enrollment Process:
 - a. After the PO receives all needed financial and clinical eligibility approvals, the applicant will sign the enrollment agreement.
 - b. The PO will generate and submit a CP-5 (DHSS' program enrollment form) to OCCO with the date of enrollment.
 - c. Enrollment will always begin on the first of the month following signing of the enrollment agreement.
16. Upon receipt of the CP-5, OCCO will enter the PACE provider number on the 067 capitation screen which is in the sub menu of the Medicaid Eligibility system.

PACE DISENROLLMENT PROCESS

Requirement

A PACE participant may voluntarily disenroll from the program without cause at any time.

Policy

A PACE participant may disenroll at their request at any time or may voluntarily disenroll if after Level of Care (LOC) reassessment the individual no longer meets the New Jersey standard for nursing facility LOC or for any other reason no longer meets PACE eligibility requirements.

Procedure

1. The PACE Organization (PO) will receive the request from the participant in a written or verbal form and will initiate disenrollment procedures upon request.
2. The PO will complete the following forms:
 - a. CP-18 (Client Withdrawal Form)
 - b. CP-23 (Notice of Program Disenrollment)
 - c. PO's Disenrollment Form(DHSS forms can be accessed through the following website: <http://web.doh.state.nj.us/apps2/forms>)
3. The PO will request the participant complete and sign the PO's Disenrollment Form or assist the participant in completing the form, or complete the form based on information given by the participant. The participant has the right to refuse to sign the form.
4. The PO will complete the CP-18 and request the participant's signature. The participant has the right to refuse to sign the form.
5. The PO will attach the completed CP-23 to the CP-18 and the PO's Disenrollment Form and submit all three forms to DHSS within 48 hours after notification by the participant.
6. The PO will also submit a copy of the CP-23 directly to the CWA to the designated PACE liaison. The CWA must financially re-evaluate continued eligibility or ineligibility because eligibility was granted based upon PACE enrollment utilizing Nursing Facility (NF) /LTC income levels. Therefore unless the disenrolled PACE member meets financial criteria of community Medicaid (such as New Jersey Care) or enters a NF or LTC services with a Home & Community-based Waiver program they are no longer eligible and require termination.
7. The PO will assist the participant in completing forms, provide options counseling and referrals, facilitate enrollment in other programs or services, and aid in reenrollment in traditional or managed care Medicare and/or Medicaid.
8. The disenrollment must be coordinated between the PACE organization and DHSS so that there is no lapse in the participant's Medicare and/or Medicaid coverage or needed services.
9. Upon notification by the PO, DHSS will disenroll the participant on the last day of the month that coordination of services and insurance is accomplished.

To	OCCO Regional Office	Date
From (Agency Name/Care Management Site/NF Provider)		
Name of Caseworker/CM/D/C Planner	Title	
Name of Client	Date of Birth	Medicaid No./JACC No.
Client Address	SSN	

FINANCIAL INFORMATION

Check appropriate box, indicating date of financial eligibility determination and monthly gross income:

- Medicaid Application Date: _____
- Categorically Eligible Date: _____ Income Amount: _____
- Institutionally Eligible Date: _____ Income Amount: _____

DISABILITY INFORMATION

FOR WAIVER PROGRAMS:

Check appropriate box, indicating date of disability determination:

- Social Security Date: _____
- Disability Review Section Date: _____

CLIENT INFORMATION

Client and Family interested in:

- Community-Based Waiver Program Specify Program: _____
- JACC GO ADHS PACE
- Medicaid Nursing Home Placement
- PA-4 Sent PA-4 Given Date: _____ To: _____
- Physician Name: _____
- Family Member Name: _____
- Address: _____
- Telephone Number: _____

Previously Enrolled In: _____

Client's Location at this Time:

- Own Home Assisted Living Facility Hospital
- Relative's Home Residential Health Care Facility Nursing Home
- Other (specify): _____
- Date Admitted: _____ Planned Discharge Date: _____ Days _____
- Address: _____
- Telephone Number: _____

Supportive Relative: _____ Relationship to Client: _____

Address: _____

Telephone Number (Work/Home): _____

Name of Client	Medicaid No./JACC No.
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Client is currently eligible for or receiving:

- HIC Medicare Number: _____ Part A Part B Part D
 Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program
 Medicaid Managed Healthcare
 Other Insurance:
 Name: _____
 Policy Number: _____
 Other Governmental Programs (specify): _____
 Community Services (specify): _____

Complete for Programs:

- CCPED JACC CAP AL PACE
 AFC GO ADHS Other (specify): _____

Client/Family have been advised of and clearly understand:

Comments

- | | | | |
|-------------------------------------|------------------------------|-----------------------------|--|
| Overview of Program: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Financial Eligibility: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Medical Eligibility: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Services Available and Limitations: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| No Retroactive Eligibility: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Cost: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

Other Pertinent Information:

(Family members or other significant persons who request to be present at the assessment; psychological/physical disabilities which would make client interviewing difficult; foreign primary language; where the client wants to receive services; client/family expectation of the long-term care programs)

Authorized Signature	Telephone Number	Date
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**New Jersey Department of Health and Senior Services
NOTICE OF PROGRAM ENROLLMENT**

To: _____
CWA/Board of Social Services

Date: _____

From: _____
 Care Manager Office of Community Choice Options (OCCO) Field Office Manager PACE Provider

Address _____

This is to advise you that the individual identified below has been enrolled in the noted Medicaid Waiver Program or PACE. Please prepare and submit the appropriate Medicaid Status File input documents in accordance with related Operational Procedures.

Name:	Medicaid Number:
Address:	Social Security Number:
	Date of Birth:

ENROLLMENT DATE: _____	<input type="checkbox"/> Fast Track
Check One:	
Program of Enrollment	Special Program Code
<input type="checkbox"/> AFC.....	(22)
<input type="checkbox"/> ALP.....	(30)
<input type="checkbox"/> ALR.....	(29)
<input type="checkbox"/> CAP.....	(31)
<input type="checkbox"/> CCPED.....	(08)
<input type="checkbox"/> CPCH.....	(28)
<input type="checkbox"/> GO - Global Options.....	(32)
<input type="checkbox"/> PACE.....	(N/A)
<input type="checkbox"/> Other:	()

Care Management/PACE Site: _____

SPECIAL CONSIDERATIONS FOR OFFICE OF COMMUNITY CHOICE OPTIONS (OCCO)	
Does this client have a Medicaid Managed Health Care (HMO):	<input type="checkbox"/> Yes* <input type="checkbox"/> No
*If so, date of disenrollment from HMO: _____	
Does this client have Supplemental Security Income (SSI):	<input type="checkbox"/> Yes** <input type="checkbox"/> No
*If so, indicate the date that the Special Program Code was entered: <u>n/a</u>	

Please contact me immediately, at _____, if you have any questions regarding this information.

Name of Care Manager, OCCO FOM or PACE Administrator (Print)	Signature
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- c: Office of MIS & Data Management
 Care Management Supervisor
 OCCO Field Office Manager
 AL/AFC Provider
 PACE Provider Organization