

CHAPTER 37-000 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

37-001 INTRODUCTION: This chapter regulates Nebraska's Program of All-Inclusive Care for the Elderly (PACE) provided under Nebraska Medicaid.

37-001.01 Definitions:

Appeal: The process by which a participant may seek and obtain a review and reversal with respect to enrollment denial; involuntary disenrollment; or non-coverage of, or nonpayment for, a service including denials, reductions, or termination of services.

External appeal: The State Administering Agency's or Medicare's formal appeal processes.

Grievance: A complaint, either written or oral, by participants, their family members, and/or representatives expressing dissatisfaction with service delivery or the quality of care furnished.

Internal appeal: A PACE organization's appeal process.

PACE organization: An entity that has a PACE program agreement in effect to operate a PACE program.

PACE program: 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 participants in accordance with a PACE program agreement.

PACE program agreement: An agreement between a PACE organization, CMS, and the State Administering Agency for the operation of a PACE program.

Participant: An individual who is enrolled in a PACE program.

Premium: The monthly amount that a PACE organization charges a participant as determined by the participant's eligibility status for Medicare and Medicaid pursuant to 42 CFR 460.186.

State Administering Agency (SAA): The State agency responsible for administering the PACE program agreement. In Nebraska the SAA is the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care.

37-001.02 Legal Basis: PACE is authorized by Sections 1894 and 1934 of the federal Social Security Act. Federal PACE regulations are located at 42 CFR, Part 460.

37-002 PARTICIPANT ELIGIBILITY

37-002.01 Eligibility Criteria: Participation in PACE is voluntary. PACE eligibility criteria include the following:

1. Be 55 years of age or older;
2. Meet the nursing facility level of care (NF LOC) criteria (See 471 NAC 12);
3. Live in the service area of the PACE organization; and
4. Be able to safely live in a community setting, at the time of enrollment, with PACE services.

37-002.02 Eligibility Determinations: The PACE organization shall be responsible for determining eligibility based on the criteria set forth in section 37-002.01 of this chapter.

37-002.03 Denial of Eligibility: A potential participant shall be denied enrollment if he/she does not meet the eligibility criteria as set forth in section 37-002.01 of this chapter.

37-002.03A Nursing Facility Level of Care Not Met: If a potential participant does not meet NF LOC, the SAA will notify the PACE organization, and the potential participant shall receive a notice of adverse action. Upon receipt of adverse action, potential participants may appeal using the SAA's appeal process (See 465 NAC 2-001.02).

37-002.03B Unsafe: If a potential participant is determined to be unable to safely live in a community setting, the PACE organization shall:

1. Notify the potential participant in writing of the reason for the denial;
2. Refer the potential participant to alternative services, as appropriate;
3. Maintain supporting documentation of the reason for the denial; and
4. Notify CMS and the SAA and make the documentation available for review.

37-002.03B1 Appeal Process: Upon receipt of the PACE organization's written denial based on the inability to safely live in the community, potential participants have the right to appeal using the SAA's appeal process (465 NAC 2-001).

37-002.03C Appeal Process for Medicare-only Beneficiaries: Medicare does not have an appeal process that permits challenges of enrollment denials for Medicare-only beneficiaries within PACE. Medicare-only eligible participants, as well as private pay participants, must use the appeals process provided by the SAA (71 Fed. Reg. 71244, 71303, 71312, 71317 (Dec. 8, 2006)).

37-002.04 Annual Nursing Facility Level of Care Recertification: A PACE participant's NF LOC shall be documented by the PACE organization and recertified by the SAA within 12 months of each previous recertification.

37-002.05 Waiver of Annual Nursing Facility Level of Care Recertification: The annual recertification requirement may be permanently waived by the SAA at the PACE organization's request. The PACE organization shall provide to the SAA the participant's diagnosis, medical record and plan of care for review for waiver and will be notified of the SAA's determination.

37-002.06 Deemed Continued Eligibility: If a participant no longer meets NF LOC at the time of annual recertification, he/she may be allowed to continue eligibility until the next annual recertification upon the request of the PACE organization. The PACE organization shall provide information to the SAA to be reviewed under the following criteria:

1. The participant can reasonably be expected to meet NF LOC eligibility again within six months in the absence of continued coverage under the program; and
2. The participant's medical record and plan of care support continued eligibility.

37-003 PARTICIPANT ENROLLMENT

37-003.01 Participant Enrollment: A PACE organization shall receive direct inquiries from potential participants. The PACE organization shall verify that the potential participant meets all eligibility criteria as set forth in section 37-002 of this chapter.

37-003.02 Duration of Enrollment: Enrollment continues until the PACE participant's death, regardless of changes in health status, unless the participant voluntarily disenrolls or is involuntarily disenrolled by the PACE organization under section 37-006.01 or 37-006.02 of this chapter.

37-004 PACE BENEFITS

37-004.01 Benefits: The PACE benefit package for all participants, regardless of source of payment, shall include the following:

1. All Medicare-covered items and services;
2. All Medicaid-covered items and services as specified in Nebraska's approved Medicaid State Plan; and
3. Other services determined necessary by the PACE organization's interdisciplinary team to improve and maintain the participant's overall health status.

37-004.02 Benefit Conditions: If a Medicare beneficiary or Medicaid recipient chooses to enroll in the PACE program, the following conditions apply:

1. Medicare and Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply (Note: Participants who have been determined to have a Medicaid share of cost remain responsible to meet their share of cost as per 469 NAC 4); and

2. The participant, while enrolled in the PACE program, shall receive all Medicare and Medicaid benefits, as well as other services determined necessary by the PACE organization interdisciplinary team, solely through the PACE organization.

37-004.03 Excluded Benefits: The following services are excluded from coverage under PACE:

1. Any service that is not authorized by the interdisciplinary team.
2. In an inpatient facility, a private room and private duty nursing services, unless medically necessary, as well as non-medical items for personal convenience unless specifically authorized by the interdisciplinary team as part of the participant's plan of care.
3. Cosmetic surgery, not including surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.
4. Experimental medical, surgical, or other health procedures.
5. Services furnished outside of the United States, including the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, except under particular circumstances and as permitted under the Medicaid State Plan.

37-005 PARTICIPANT RIGHTS

37-005.01 Written Explanation: Upon enrollment, a PACE participant shall be informed, in writing, of his/her rights and responsibilities and all rules and regulations governing participation according to 42 CFR 460.110 and 460.112.

37-005.02 Grievance Process: Upon enrollment and at least annually thereafter, the PACE organization supply participants written information about its grievance process. In the event of a grievance, the PACE organization shall:

1. Discuss with and provide to the participant in writing the specific steps, including timeframes for response, that will be taken to resolve the participant's grievance;
2. Continue to furnish all required services to the participant during the grievance process.

37-005.03 Appeal Processes for Non-Coverage or Non-Payment of a Service: The PACE organization shall give enrolled participants written information on available appeal processes upon enrollment, at least annually thereafter, and whenever a participant takes action with respect to the PACE organization's non-coverage or non-payment of a service including denials, reductions, or terminations of services. (See section 37-002.04 of this chapter for appeals of denial of enrollment and section 37-006.04 of this chapter for appeals of involuntary disenrollments.)

37-005.03A Available Appeal Processes:

1. The PACE organization's internal appeal process.
2. The SAA's appeal process (external appeal process).

3. Medicare's appeal process through the Independent Review Entity (IRE) that contracts with CMS (external appeal process).

37-005.03B PACE Organization Internal Appeal Process: Participants shall first access the PACE organization's internal appeal process prior to using the SAA's or Medicare's appeal process for all decisions pertaining to non-coverage of, or non-payment for, a service including denials, reductions, or terminations of services.

37-005.03C PACE Organization Third Party Review: The PACE organization must appoint an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal to review the participant's appeal.

37-005.03C1 Notice of Internal Appeal Outcome: The PACE organization shall notify a participant of the outcome of his/her appeal in writing no later than 30 calendar days after the organization receives the verbal or written appeal, unless the appeal has been expedited as described in section 37-005.03C2 of this chapter.

37-005.03C2 Expedited Appeal Process: A PACE organization shall have an expedited appeal process for situations in which the participant believes that his or her life, health, or ability to regain or maintain maximum function could be seriously jeopardized, absent provision of the services in dispute.

37-005.03C2a Expedited Appeal Notice: The PACE organization must respond in writing to an expedited appeal no later than 72 hours after it receives the appeal.

37-005.03C2b Expedited Appeal Extension: The PACE organization may extend the 72-hour timeframe by up to 14 calendar days for either of the following reasons:

1. The participant requests the extension; or
2. The PACE organization justifies to the SAA the need for additional information and how the delay is in the interest of the participant.

37-005.03C3 Favorable Determination: If a determination is made in favor of the participant on appeal, the PACE organization must furnish the disputed service as expeditiously as the participant's health condition requires.

37-005.03C4 Adverse Determination: For a determination that is wholly or partially adverse to a participant, the PACE organization must notify the participant, the SAA, and CMS.

37-005.03D External Appeals: If dissatisfied with the outcome of their internal appeal to the PACE organization, participants may appeal as follows:

37-005.03D1 Participants Eligible for Both Medicaid and Medicare: Participants who are eligible for both Medicare and Medicaid have the choice of using either the SAA's or Medicare's appeal process; however, they may only choose one route by which to exercise their external appeal rights. The PACE organization shall assist the participant in choosing which process to pursue if both are applicable, and the PACE organization must forward the appeal to the appropriate external agency.

37-005.03D2 Participant Eligible Only for Medicare: Participants who are only eligible for Medicare shall appeal through the Independent Review Entity (IRE).

37-005.03D3 Participants Eligible Only for Medicaid: Participants who are only eligible for Medicaid shall appeal using the SAA's appeal process.

37-005.03D4 Private Pay Participants: Participants who are private pay shall appeal using the SAA's appeal process.

37-005.03E Services Provided During the Appeals Process: During the appeals process, the PACE organization shall continue to provide non-disputed services to a participant.

37-005.03E1 Medicaid Recipient: For a participant who is a Medicaid recipient, the PACE organization shall continue to provide the disputed service until the final determination is issued if the following conditions are met:

1. The PACE organization is proposing to terminate or reduce a service currently being furnished to the participant; and
2. The participant requests continuation of the provision of services with the understanding that he or she may be liable for the cost of the contested services if the determination is not made in his/her favor.

37-006 PARTICIPANT DISENROLLMENT

Reasons for disenrollment, either voluntary or involuntary, shall be documented by the PACE organization.

37-006.01 Voluntary Disenrollment: A participant may voluntarily disenroll from the program without cause at any time, including if he/she no longer meets NF LOC criteria.

37-006.02 Involuntary Disenrollment: A PACE organization may involuntarily disenroll a participant for any of the following reasons:

1. The participant fails to pay, or make satisfactory arrangements to pay, any premium due the PACE organization after a 30-day grace period.

2. The participant engages in disruptive or threatening behavior. Disruptive or threatening behavior is either of the following:
 - a. Behavior that jeopardizes a participant's health or safety or the safety of others; or
 - b. Consistent refusal to comply with an individual plan of care or the terms of the PACE enrollment agreement while having decision-making capacity.
3. The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.
4. The participant is determined to no longer meet nursing facility level of care and is not deemed eligible under section 37-002.06 of this chapter.
5. The PACE organization's agreement with CMS and the SAA is not renewed or is terminated.
6. The PACE organization is unable to offer required services because of the loss of State licenses or outside provider contracts.

37-006.02A SAA Review and Final Determination: Before an involuntary disenrollment is effective, it shall be reviewed by the SAA and a determination made that acceptable grounds for disenrollment have been documented by the PACE organization.

37-006.02B Reinstatement in PACE: A previously disenrolled PACE participant may re-enroll but shall do so as a new applicant.

A participant scheduled to be disenrolled for failure to pay his/her premium may be reinstated with no break in coverage if payment is made prior to the effective date of disenrollment. If payment is received after the effective date of disenrollment, the participant shall re-enroll as a new applicant.

37-006.03 Transition from PACE: Upon either voluntary or involuntary disenrollment, the PACE organization shall:

1. Facilitate a participant's reinstatement in other Medicare and Medicaid programs for which the participant is eligible;
2. Coordinate the disenrollment date between Medicare and Medicaid for participants who are eligible for both programs;
3. Give reasonable advance notice of the disenrollment date to the participant; and
4. Continue to furnish all needed services as identified in the participant's plan of care until the disenrollment date.

37-006.03A Effective Date: The participant shall be allowed to continue to use PACE organization services and will remain liable for any premiums due until the disenrollment date.

37-006.04 Appeals of Involuntary Disenrollment: Participants who are involuntarily disenrolled may appeal using the SAA's appeal process (465 NAC 2-001).

37-006.04A Appeal Process for Medicare-only Beneficiaries: Medicare does not have an appeals process that permits challenges of disenrollment determinations of Medicare-only beneficiaries within PACE. Medicare-only eligible participants, as well as private pay participants, must use the appeals process provided by the SAA (71 Fed. Reg. 71244, 71303, 71312, 71317 (Dec. 8, 2006)).

37-007 PACE ORGANIZATIONS

37-007.01 Agreement: PACE organizations shall have an agreement with CMS and the SAA for the operation of a PACE program. The agreement specifies the prospective monthly capitated Medicaid payment amount as negotiated by the PACE organization and the SAA. The monthly capitated payment may be renegotiated on an annual basis as pursuant to 42 CFR 460.182.

37-007.02 Licenses or Credentials: PACE organizations must hold appropriate licenses or credentials as required under state licensing laws.

37-007.03 Federal Requirements: In addition to the requirements in this chapter, PACE organizations must also meet all applicable federal requirements, including those set forth in 42 CFR, Part 460.