Providing Beneficiaries Mid-Month Access to Services from PACE Organizations
May 2021

Background

Prospective PACE enrollees are currently required under federal regulations (§460.158) to wait until the first day of the month following the date the PACE organization receives the signed enrollment agreement to enroll in PACE. In many states, if the enrollment agreement is not received and approved by the state agency a minimum number of days prior to the first day of the following month (e.g., 10 -15 days before), the enrollment is further deferred until the first day of the month after. This can result in delays in access to service of up to 45 days.

Given these delays in the effective enrollment date and the often urgent needs of prospective PACE participants and their families, PACE organizations (POs) are seeking ways to work with their states to provide prospective PACE enrollees' access to services while they await their effective PACE enrollment date. Addressing timely access to health care services is needed to make access to care for PACE participants as timely as access to care in a nursing facility. Admission to a nursing facility does not involve the delays imposed by the PACE effective enrollment date process. As a result, older adults may be forced to enter a nursing facility in order to obtain care quickly rather than enroll in PACE, which would enable them to continue living in at home.

While POs may provide services in advance of enrollment without revenue, this is not sustainable for lengthy periods or significant numbers of individuals. Allowing POs to provide care to and receive payment for prospective participants who are waiting for their effective enrollment date would avoid the need for these individuals to seek alternative forms of care (e.g., enrollment in a Medicaid plan, admission to a nursing facility). In some cases, these would be permanent alternatives to PACE. In others, they could be temporary options but would result in the need for individuals to subsequently transition into a PACE program, creating unnecessary confusion and use of administrative and provider resources.

Although NPA has requested that CMS consider a regulatory change that would allow beneficiaries to enroll in PACE mid-month for both Medicare and Medicaid, CMS has not been receptive to this citing administrative system and partial month payment issues. What may be more realistic, at least in the short term, is the potential for POs to work with their states to allow for Medicaid payment for Medicaid beneficiaries prior to their effective date of PACE enrollment.

To assist POs in this endeavor, NPA has explored how this might be possible and important considerations.

CMS Guidance

In the preamble of the 2006 PACE regulation, CMS includes the following language: "A state may choose to pay the PO for services for a participant prior to the effective date of enrollment whether on a fee-for-service or pro-rated capitated basis. However, the participant's effective date of enrollment as a PACE participant is not established until the first of the following month."[1]

While the language does provide some flexibility to states to provide funding to POs, the language does make clear that the individual is not enrolled in PACE until the first of the following month.

CMS shared with NPA that POs can reach out to states regarding available reimbursement options; however, the states would have to use an appropriate authority for any expenditures paid on behalf of an eligible beneficiary prior to PACE enrollment.

Considerations for State Engagement

In consultation with outside counsel, NPA believes that the PACE program agreement between the PO and the state may not be a sufficient authority for this type of payment since the period of time for which payment would be made under such an arrangement would precede PACE enrollment.

Therefore, POs and states wishing to explore how to initiate payment for services prior to prospective PACE participants' effective date of enrollment in PACE will need to identify an alternative payment authority. NPA has researched and assessed possible options for POs to discuss with their states. While NPA has not identified a clear-cut option, there are a few possibilities that POs and their states may want to discuss and explore further.

I. **Fee-for-Service (FFS) Provider** – The 2006 preamble indicates that states could pay POs on a fee-for-service basis. For this alternative to work, it is our understanding that a PO and its state would need to explore whether the PO would qualify as a Medicaid FFS provider or whether the state could somehow deem it as such. Further, processes would need to be developed for the PO to bill and for the state to account for payment for services provided. Ideally, some accommodation could be made for the PO to bill for

[1] The preamble also states, "In an instance where there is a lag time between the signing of the enrollment agreement and its effective date, the PO may choose to provide services to the newly signed enrollee. However, any services provided are not considered ''PACE'' services until the effective date of enrollment. Therefore, services would only be covered to the extent an individual's existing health plan (for example, Medicare fee-for service or Medicaid) provided the coverage. Should the PO choose to provide services outside the individuals existing benefits package prior to the effective date of enrollment in PACE, the PO would be liable for the cost of providing these services."

services in a manner consistent with its processes, e.g., invoice the state a daily rate multiplied by the number of days the prospective PACE participant receives care from the PO with the rate inclusive of PACE center services, home care, etc. It is possible that this may be a more viable option for PACE organizations holding adult day care or home care licensure.

II. **Medicaid managed care authority** – An option may be a state's Medicaid managed care authority, although it is unclear that a PO would meet federal and/or state Medicaid MCO requirements and, if not, what accommodations could be made. Whether or not this alternative is possible would have to be discussed between a PO and its state. For example, if a PO's sponsoring entity qualifies as an MCO, could this authority be extended in some way to allow for payment for services provided by the PO prior to a participant's enrollment in PACE.

III. **Continued Services During Transition** – CMS's Medicaid managed care rule provides that states must have a continuity of care policy to ensure continued access to services during beneficiary transitions from FFS to a managed care plan or from one managed care plan to another when, without continued services, an enrollee would suffer serious detriments to his or her health or a risk of hospitalization or institutionalization. Given that individuals enrolling in PACE meet nursing home level of care, a case could be made that without PACE services an individual could experience serious detriments to his/her health. POs could discuss with states whether payments to POs for services provided to prospective PACE participants transitioning to PACE could be considered under this care transition provision.

Next Steps

NPA encourages POs to continue conversations with their states about ways to improve access to care for PACE participants in advance of their effective date of enrollment in PACE. As discussed above, a challenge in this regard is to identify an appropriate payment authority under which states can pay for services provided by POs prior to enrollment. We expect such payment authority will vary across states. As you work with your states on this issue, we ask that you share your experiences with NPA, so that we can inform POs in other states that may be pursuing this opportunity.