
PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

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I. BACKGROUND & INTRODUCTION

Program of All-Inclusive Care for the Elderly (PACE) is a federal program administered by the Centers for Medicare and Medicaid Services (CMS).

PACE is a managed care program that enables individuals **who are 55 years or older and** 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 beneficiary. The PACE program becomes the sole source of services for Medicaid and/or Medicaid/Medicare eligible enrollees.

The PACE organization **receives a capitated payment for each beneficiary and** 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 (DHHS) through the Division of Health Benefits (DHB), and the PACE organization.
2. The PACE organization administers and is responsible for enrolling individuals into the PACE program.
3. The PACE program allows North Carolina to use Medicaid funds to provide home and community-based services to Medicaid **beneficiaries** who require institutional care (placement in a skilled nursing facility [SNF]), but for whom care can be provided cost-effectively and safely in the community. 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
 - Prescriptions
5. If at any time, PACE determines a **beneficiary** can no longer be cared for in the home, the PACE organization may place the PACE **beneficiary** 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.
2. Once enrolled for PACE, the **beneficiary** is enrolled for the next year unless **they** terminate enrollment. PACE **beneficiaries** 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 **Interdisciplinary** Team. If a PACE **beneficiary** receives medical services that have not been approved by the PACE **Interdisciplinary** Team, the **beneficiary** may be personally responsible for paying the cost of those services. If a PACE **beneficiary** receives medical services from a non-PACE medical provider without prior authorization (with the exception of

Emergency Services), the **beneficiary** may be liable for the full cost of those services.

4. When an individual enrolls in PACE, **they are** ineligible for any other Medicare plans or any other Medicaid services, programs, or optional benefits, except for **Medicaid for Qualified Medicare Beneficiaries (MQB)**. Refer to **X** 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. **DHB** makes a prospective capitated monthly payment to the PACE organization for each eligible Medicaid participant. The **local agency** 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 **second to the last workday of the month** in order for the PACE capitated payment to begin the next calendar month. Failure to enter PACE **evidence by the second to the last workday of the month** 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 **local agency** and the PACE organization is crucial to attain priority processing of Medicaid eligibility for PACE services.

II. PACE AND MEDICAID REFERRAL PROCEDURES

The [DHB 5106, PACE/Medicaid Referral](#), 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/**beneficiary** and is valid for one year. **This authorization is limited to information listed on the [DHB-5106, PACE/Medicaid Referral](#), which includes notification of application denial and/or termination of eligibility.**

A. Medicaid **Applicant/Beneficiary (A/B) Requests PACE Services**

When an individual requests PACE enrollment information from the local agency, the individual should be referred to the PACE organization covering the service area where the individual resides. The caseworker should also complete page 1 of the [DHB -5106, PACE/Medicaid Referral](#), and send to the PACE organization.

B. Processing PACE Referrals

When an individual requests enrollment with the PACE organization and indicates a need for financial/medical assistance, the PACE organization will complete page 2 of the [DHB -5106, PACE/Medicaid Referral](#), and submit it to the local agency in the county the individual resides in. 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 local agency.

III. ELIGIBILITY DOCUMENTATION FOR PACE

The local agency must maintain a copy of the PACE enrollment notification, the [DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval](#), including automated notices, and the current FL-2 to document eligibility for PACE participation. Refer to [MA-2420, Notice and Hearings Process](#).

IV. POLICY PRINCIPLES

A. General Policy Rules

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

1. Be enrolled in the PACE program.
2. Be eligible for Medicaid in the Aged, Blind, and Disabled (MAABD) aid program.
3. Be certified by the Division of Health Benefits (DHB) as meeting nursing home level of care (FL-2). Preadmission Screening and Annual Resident Review (PASAAR) requirements are not applicable to PACE. When the a/b is admitted to a SNF, temporarily or long-term, PASAAR is required.
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

1. The appropriate PACE living arrangement evidence must be added to dashboard in NCF, to reflect the individual's living arrangement while enrolled in PACE. See NC FAST Job Aid: PACE
2. The following living arrangements are used for PACE. Benefit History should display one of these codes.

CODE	LIVING ARRANGEMENT
<i>14</i>	<i>PACE Private Living Arrangement</i>
<i>15</i>	<i>PACE Private Living with SSI Recipient(s)</i>
<i>54</i>	<i>PACE Living in a Nursing Facility</i>

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 a PACE enrollment agreement is signed the a/b is budgeted using Private Living Arrangement (PLA) rules and should be budgeted with all financially responsible members of the household. Beginning the month the PACE agreement is signed, the budget unit is one. See IV.B, above.

E. Continuous Period of Institutionalization (CPI)

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

F. Community Spouse Income Allowance (Spouse in PLA)

Community Spouse Income Allowance (CSIA) applies to PACE a/b's. Follow policy in [MA-2270, Long-Term Care Need and Budgeting](#).

1. Only one spouse is PACE participant: CSIA policy applies for the community spouse.
2. Both spouses are PACE participants in a private living arrangement: There is no community spouse in this scenario.
3. Both spouses are PACE participants and one is permanently placed in SNF and the other remains at home: CSIA policy applies for the community spouse

G. Dependent Family Member Allowance

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

H. Reserve

1. The reserve limit is for a budget unit of one in all PACE cases beginning with the month PACE enrollment agreement is signed. 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. **When a transfer of assets sanction period is determined for an applicant/beneficiary who is enrolled in the PACE program, evaluate for MQB only. Individuals enrolled in the PACE program are ineligible for all other Medicaid programs, (excluding MQB) during the sanction period.** Refer to [MA-2240, Transfer of Assets](#), and **X.C** . below.

J. Estate Recovery

PACE **a/b's** are subject to estate recovery. See [MA-2285, Estate Recovery](#).

K. Managed Care

PACE beneficiaries are excluded from enrollment in NC Medicaid Managed Care and they are exempt from choosing a primary care provider (PCP). NC FAST will populate the PACE exemption code (9999906) automatically on the beneficiary's Benefit History. See NC FAST Job Aid: Program of All-inclusive Care for the Elderly (PACE).

L. Medicare Buy-In

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

M. Medicare Part D

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

N. Skilled Nursing and Adult Care Homes

When a beneficiary who is enrolled with a PACE Organization enters a skilled nursing facility or an adult care home, PACE is responsible for paying the facility for the beneficiary's cost of care. See X.D, below, for further instructions on how to react to this type of change in circumstance.

Beneficiaries who are receiving Medicaid for PACE are not eligible to receive Special Assistance while enrolled with a PACE Organization.

V. PACE BUDGETING

A. When to begin Long-Term Care (LTC) budgeting

Use Long-Term Care budgeting for **a/b's** enrolled or seeking enrollment in the PACE program beginning the first day of the month following 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 **beneficiaries** 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 **beneficiaries** 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 **beneficiaries**.

B. Determine Whose Income to Count

1. For all months (including retro months for applications) prior to the month a PACE enrollment agreement is signed, budget the **a/b** with all other financially responsible household members, see [MA-2260, Financial Eligibility Regulations-PLA](#).
2. Beginning the month that a PACE enrollment agreement is signed, the **a/b** is budgeted as a Medicaid individual, see [MA-2270, Long-Term Care Need and Budgeting](#).

C. Establish Financial Eligibility

Follow policy in [MA-2270, Long-Term Care Need and Budgeting](#). Contact the appropriate PACE organization to obtain the PACE facility private rates used in Step I and Step II. budgeting.

D. Determine Patient Monthly Liability (PML)

1. PACE **Beneficiary** Residing at Home or Temporarily in a Nursing Facility

If financial eligibility exists, proceed to determine the **a/b's** share of cost.

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

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

- (1) Count actual amount of SSA benefit received if it is reduced to recoup an SSA overpayment.

(2) 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.

c. 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.](#))

d. Subtract the Special Personal Needs Allowance. Refer to **VI.** below.

2. PACE **Beneficiary** Residing in a Nursing Facility Permanently

If financial eligibility exists, proceed to determine the **a/b's** share of cost.

a. Permanent placement in a nursing facility by PACE is defined as 6 months or longer. PACE **beneficiary** 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 **as long as the beneficiary continues to be enrolled in PACE.**

b. Establish Gross Income

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

(1) Count actual amount of SSA benefit received if it is reduced to recoup an SSA overpayment.

(2) 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.

c. 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.](#))

d. Subtract Personal Needs Allowance. Refer to **VI.** below.

VI. ALLOWABLE DEDUCTIONS

A. PACE **Beneficiary– 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).

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

1. PACE individuals living in the community have greater needs for shelter, food, and clothing. In order to meet these needs, PACE **beneficiaries** 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.
2. 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 [DHB-5106, PACE/Medicaid Referral](#), is used as verification of temporary placement.
3. The living arrangement code remains unchanged during temporary nursing facility placement. Refer to [NC FAST job aid](#): Program of All-inclusive for the Elderly (PACE)
4. Court ordered guardianship fees. Refer to [MA-2270, Long-Term Care Need and Budgeting](#).
5. Non-discretionary mandatory deductions. Refer to [MA-2270, Long-Term Care Need and Budgeting](#).
6. Unmet medical needs. Refer to [MA-2270, Long-Term Care Need and Budgeting](#).
7. Personal needs allowance for work incentive. Refer to [MA-2270, Long-Term Care Need and Budgeting](#).

B. Personal Needs Allowance for PACE Beneficiary – 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).

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.

1. If necessary, PACE **beneficiaries** may be permanently placed in another health care setting or a nursing facility by the PACE organization. When permanent placement is required, the PACE **beneficiary'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. [DHB-5106, PACE/Medicaid Referral](#), is used as verification of permanent placement and the effective date of permanent placement. See IV.F and IV.H, above, evaluate for CSIA and resource protection.

2. The living arrangement **evidence** must be changed to reflect permanent nursing facility status. Refer to [NC FAST job aid: Program of All-Inclusive Care for the Elderly \(PACE\)](#).
3. Court ordered guardianship fees. Refer to [MA-2270, Long-Term Care Need and Budgeting](#).
4. Non-discretionary mandatory deductions. Refer to [MA-2270, Long-Term Care Need and Budgeting](#).
5. Unmet medical needs. Refer to, [MA-2270, Long-Term Care Need and Budgeting](#).
6. Personal needs allowance for work incentive. Refer to [MA-2270, Long-Term Care Need and Budgeting](#).

VII. MEDICAID AUTHORIZATION FOR PACE SERVICES

A. Medicaid Authorization for PACE Services Effective Date

1. **The first day of the month** following the month PACE enrollment **agreement** is signed and approved by the PACE organization

AND

2. The **local agency** determines eligibility and enters **evidence** into **NC FAST** by **the second to the last workday of the month**. If keyed after **the second to the last workday of the month**, 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 **beneficiary**.
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 **NC FAST**, **when all eligibility factors are met**.

OR

- c. Refer to [MA-2300 Application](#) and [MA-2360, Medicaid Deductible](#) when the applicant meets eligibility requirements for Medically Needy (MN).

C. Applications and Ongoing Cases – PACE Enrollment Complete

- 1. When an application is approved, or an ongoing change is processed on or before the second to the last workday of the month:
 - a. Authorization for PACE is the first day of the month following the month of PACE enrollment.

EXAMPLE:

Joe Jones is married and living with his spouse, Mary Jones. Mr. Jones applied for Medicaid and requested PACE services on June 27th. Mrs. Jones did not apply for Medicaid.

Mr. Jones 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 local agency on July 8th verifying Mr. Jones' PACE enrollment date as July 7th.

Joe's caseworker establishes Medicaid eligibility and enters PACE evidence in NC FAST on July 20th. Medicaid PACE authorization is effective August 1st.

- b. For applications, evaluate retroactive months for all Medicaid programs. See [MA-2300, Application](#) and [MA-2260, Financial Eligibility Regulations-PLA](#)

EXAMPLE:

Using the scenario in the above example, the caseworker should evaluate Mr. Jones for retroactive Medicaid for the months of March, April, and May. See [MA-2300, Application](#)

- c. Evaluate ongoing months for all Medicaid programs. See section V.C, above for budgeting. Beginning with the month the PACE enrollment agreement is signed, budget the a/b as one.

EXAMPLE:

The caseworker will also evaluate Mr. Jones for the ongoing months of June and July for PLA Medicaid. See [MA-2300, Application](#) and [MA-2260, Financial Eligibility Regulations-PLA](#).

In this scenario, Mr. Jones should be budgeted as a Medicaid Individual with an Ineligible Spouse for March, April, May, and June.

Beginning July 1, Mr. Jones should be budgeted as a Medicaid Individual because the PACE enrollment agreement was signed in July.

- d. Mail [DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval](#), for the approval of PACE.
2. When an application is approved, or an ongoing change is processed AFTER the second to the last workday of the month:
 - a. Authorization for PACE will be the first day of the month after a PACE eligibility decision is accepted and activation is completed in NC FAST.

EXAMPLE:

Susie Solomon is a widow, living alone. She applies for Medicaid and PACE services on June 27th. She also applies with the PACE organization for enrollment on June 27th.

Susie signs her enrollment with the PACE organization on July 7th.

The PACE organization sends a referral to the local agency on July 8th verifying Susie's PACE enrollment date as July 7th.

Susie's caseworker establishes Medicaid eligibility but does not enter PACE evidence into NC FAST until July 31st. This means the PACE organization will not be paid for August. Medicaid PACE authorization is effective September 1st.

- b. For applications, evaluate retroactive months for all Medicaid programs. See [MA-2300, Application](#).

EXAMPLE:

Using the scenario above, retroactive PLA Medicaid must be evaluated for March, April, and May. See [MA-2300, Application](#).

- c. Evaluate ongoing months for all Medicaid programs. See section V.C, above for budgeting. Beginning with the month the PACE enrollment agreement is signed, budget as one.

EXAMPLE:

The caseworker will also evaluate Susie for ongoing PLA Medicaid for June, July, and August. See [MA-2300, Application](#) and [MA-2260, Financial Eligibility Regulations-PLA](#).

In this scenario, Susie is budgeted as a Medicaid Individual for all months because she lives alone. If Susie had a spouse, LTC budgeting would begin July 1 because the PACE enrollment agreement was signed in July.

- d. Mail [DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval](#), for the approval of PACE.

The caseworker should make every effort to process applications and ongoing changes prior to the second to the last workday of the month. When the PACE Product Delivery Case (PDC) is not activated in NC FAST on or before the second to the last workday of the month, the a/b will not be eligible for PACE Medicaid and the PACE organization will not be paid for the next month.

VIII. MEDICAID CERTIFICATION AND AUTHORIZATION FOR PACE

A. For an application

1. Certify the case for 12 months,

AND
2. Follow the procedures in [MA-2350, Certification and Authorization](#).

Refer to [NC FAST job aids](#): Program of All-Inclusive Care for the Elderly (PACE) and Application to Case.

B. For an ongoing case, continue in the established certification period.

IX. REDETERMINATION OF ELIGIBILITY/REVIEW

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

X. 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/beneficiaries that disenroll from PACE must be evaluated for other Medicaid programs. PACE a/b's that do not disenroll from PACE are not eligible for any Medicaid services.

A. Voluntarily/Involuntarily Disenrolls from the PACE Program

A PACE participant may voluntarily disenroll or be involuntarily disenrolled at any time. The disenrollment is effective on the first day of the month after the disenrollment date provided by the PACE Organizations. Disenrollment can occur any day of the month, including the last day of the month and the effective date is the first day of the next month.

The PACE Organization will provide the disenrollment date on the [DHB-5106, PACE/Medicaid Referral](#). The caseworker should take the following action:

1. End date the PACE evidence in NC FAST with the last day of the disenrollment month which will make the disenrollment effective the first day of the **next** month.
2. A [DHB-8020, Medicaid Eligibility Corrections Form](#), may be required to be submitted to the DHB DSS Support Unit, if the action is taken too late to end PACE eligibility for the month of disenrollment. See [NC FAST Job Aid: DHB Queue for Claims](#).
3. Redetermine eligibility using PLA budgeting. Refer to [MA 2260, Financial Eligibility Regulations – PLA](#).
 - a. Individual remains **eligible** for Medicaid without PACE:

Send an adequate [DSS-8110, Notice of Modification, Termination, or Continuation](#), stating the PACE eligibility end date and the Medicaid benefits will continue.
 - b. Individual **ineligible** for Medicaid without PACE:

Send a timely [DSS-8110, Notice of Modification, Termination, or Continuation](#), stating the PACE end date and the Medicaid end date. Follow notice requirements found in [MA-2420 Notice and Hearings Process](#). Evaluate for all other Medicaid programs prior to termination.

B. County Transfers

1. When a PACE a/b moves out of the county and is no longer enrolled with a PACE organization, the **caseworker** must evaluate for PLA Medicaid, and
 - a. If a/b continues to be eligible for Medicaid in another program, remove PACE evidence in NC FAST. Follow procedures in [MA-2221, County Residence](#) and [NC FAST job aid: Completing a County Transfer](#).
 - b. If a/b is ineligible for Medicaid, terminate the case and send a timely [DSS-8110, Notice of Modification, Termination, or Continuation](#).
2. When a PACE a/b 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 [NC FAST job aid: Completing a County Transfer](#). When changing PACE enrollment to a different PACE Organization, there may be a break in PACE Medicaid and the a/b must be evaluated for PLA Medicaid.
3. When a PACE a/b moves out of the county (county1) and remains enrolled in the same PACE Organization in a new county (county 2), follow county

transfer procedures in [MA-2221, County Residence](#) and see [NC FAST job aid](#): Completing a County Transfer. When the a/b remains enrolled in the same PACE Organization, there will be no break in PACE Medicaid.

C. Sanction Status

1. Applications

When an individual applies for Medicaid, and 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 **all other** Medicaid **programs**, (excluding **MQB**) during the sanction period.

a. If eligible for MQB, authorize Medicaid without PACE designation in NC **FAST**.

(1) Refer to [MA-2300, Application](#).

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

b. If ineligible for MQB

(1) **Deny the application. NC FAST will send a [DSS-8109, Notice of Benefits Denied or Withdrawn](#). Refer to [MA-2300, Application](#) and [MA-2240, Transfer of Assets](#). Deny the application.**

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

2. Ongoing

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

a. If eligible for MQB, **after** following policy found in [MA-2240, Transfer of Assets](#), allowing the beneficiary opportunity to rebut the transfer/request undue hardship:

(1) **Generate a timely [DSS-8110 Notice of Modification, Termination, or Continuation](#), in NC FAST, to impose the sanction and notify the a/b that their full Medicaid will end. The caseworker should ensure that the correct reason and case outcome are selected. See**

[NC FAST Job Aid: MA/MAGI DSS-8110 Notice of Modification, Termination or Continuation of Public Assistance.](#)

- (2) Follow [NC FAST Job Aid: Sanctions for Transfer of Assets](#) to impose the sanction and continue the MQB case.
- (3) Send the [DHB-5106, Medicaid/PACE Referral](#), to notify the PACE organization the individual is no longer eligible for payment of PACE services.

b. If ineligible for MQB, terminate the case.

- (1) Send a **timely** [DSS-8110 Notice of Modification, Termination, or Continuation](#),. See [NC FAST Job Aid: MA/MAGI Notice of Modification, Termination or Continuation of Public Assistance.](#)
- (2) After the timely notice period has expired, send the [DHB-5106, Medicaid/PACE Referral](#), to notify the PACE organization the beneficiary is no longer eligible for payment of PACE services.

c. SSI **Beneficiary**

- (1) End date PACE evidence in NC FAST and follow policy in [MA-2240, Transfer of Assets](#).
- (2) Generate a timely [DSS-8110 Notice of Modification, Termination, or Continuation](#), in NC FAST, to impose the sanction and notify the a/b that Medicaid will not pay for PACE services during the sanction period. The caseworker should ensure that the correct reason and case outcome are selected. See [NC FAST Job Aid: MA/MAGI DSS-8110 Notice of Modification, Termination or Continuation of Public Assistance.](#)
- (3) Send the [DHB-5106, Medicaid/PACE Referral](#), to notify the PACE organization the **beneficiary** is no longer eligible for payment of PACE services.

D. Other Changes

1. When a PACE beneficiary enters a skilled nursing facility (SNF) and remains enrolled in the PACE program, the PACE organization is responsible for the beneficiary's cost of care. See section VI.A-B (above) for budgeting instructions.
2. When a PACE beneficiary enters a SNF and disenrolls from the PACE program, the PACE organization is responsible for the beneficiary's cost of care through the month of disenrollment. See section X.A (above) for instructions for voluntary or involuntary disenrollment, including how to make Medicaid Eligibility corrections when needed.

3. When a PACE beneficiary enters an adult care home (ACH), the PACE organization is responsible for the beneficiaries cost of care. Beneficiaries eligible for PACE and enrolled in a PACE program are not eligible for Special Assistance.

XI. AUTOMATED AND MANUAL NOTICES FOR PACE SERVICES

A. Automated and manual notices

1. Follow all notice requirements in [MA-2420, Notices and Hearings Process](#), including the right to a fair hearing. The a/b has the right to request a hearing if they disagree with any decision regarding their benefits.
2. A/B notices should only be forwarded to the a/b and their representative. See [MA-2420, Notices and Hearings Process](#), for more information about representatives. If the PACE Organization is not an authorized representative, only the [DHB-5106, PACE/Medicaid Referral](#), should be shared with the PACE Organization.

B. Approval Notice

Medicaid a/b - PACE Approved (application or ongoing with a change in situation):

1. Forward a copy of the [DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval](#), to the a/b, their authorized representative, and the PACE Organization.
2. A [DHB-5016, Notification of Eligibility for Medicaid/Amount and Effective Date of Patient's Liability](#), should be generated and sent to the PACE organization as notification of the Patient Monthly Liability (PML).

C. Termination/Change

Medicaid Beneficiary – PACE Terminated

1. NC FAST automatically generates the [DSS-8110 Notice of Modification, Termination, or Continuation](#). The caseworker should ensure that the notice is mailed to the beneficiary when PACE ends (Medicaid terminates, change to MQB, change to deductible, selecting a primary care provider – NC Medicaid Direct, change to non-PACE living arrangement, etc.), and
2. Forward a copy of the [DSS-8110 Notice of Modification, Termination, or Continuation](#), to the beneficiary, their authorized representative, and the PACE Organization.

XII. PACE APPLICATION REPORT

PACE application processing activity will be monitored by **DHB**. On the date of disposition, complete and fax the [DHB-5166, Pace Application Report](#), to (919) 224-1070, Attention: Medicaid Eligibility Unit.

XIII. PACE SERVICES – INTERNAL APPEAL PROCESS

A. Appealing a denied PACE service

When a service is denied or not paid, there is an internal PACE appeal that can be requested by the beneficiary. This appeal is not a Medicaid appeal and the process takes place between the PACE Organization and the PACE beneficiary. Caseworkers should refer the beneficiary to the PACE Organization to request this type of appeal.

B. Appealing to Medicare or Medicaid

After the internal PACE appeals process is completed, if the PACE beneficiary is still not satisfied, an appeal to either Medicare or Medicaid may be requested. If the beneficiary is requesting a Medicaid appeal, the PACE Organization should use the [DHB-5165, PACE Referral Request for a Medicaid Hearing](#), as a means of communicating the request to the local agency. The date of the appeal request is the date that the [DHB-5165](#) is received by the local agency.

XIV. 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](#).