TITLE 8 SOCIAL SERVICES
CHAPTER 280 MEDICAID ELIGIBILITY - PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)
PART 600 BENEFIT DESCRIPTION

8.280.600.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.280.600.1 NMAC - Rp, 8.280.600.1 NMAC, 1/1/2019]

8.280.600.2 SCOPE: The rule applies to the general public.
[8.280.600.2 NMAC - Rp, 8.280.600.2 NMAC, 1/1/2019]

8.280.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Section 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991).
[8.280.600.3 NMAC - Rp, 8.280.600.3 NMAC, 1/1/2019]

8.280.600.4 DURATION: Permanent.
[8.280.600.4 NMAC - Rp, 8.280.600.4 NMAC, 1/1/2019]

8.280.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.280.600.5 NMAC - Rp, 8.280.600.5 NMAC, 1/1/2019]

8.280.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.280.600.6 NMAC - Rp, 8.280.600.6 NMAC, 1/1/2019]

8.280.600.7 DEFINITIONS: [**RESERVED**]

8.280.600.8 [**RESERVED**]

8.280.600.9 BENEFIT DESCRIPTION: An applicant/recipient who is eligible for PACE is eligible for specified services available under the program. See specific program policy sections for covered services.
[8.280.600.9 NMAC - Rp, 8.280.600.9 NMAC, 1/1/2019]

8.280.600.10 BENEFIT DETERMINATION: Application for PACE is made using the HSD 100 application. Applications must be acted upon and notice of approval, denial, or delay sent out within 45 days of the date of application. The applicant/recipient may complete the form himself, or receive help from a relative, friend, guardian, or other designated representative. To avoid a conflict of interest, a PACE provider must not complete the application nor be a designated representative.
[8.280.600.10 NMAC - Rp, 8.280.600.10 NMAC, 1/1/2019]

8.280.600.11 INITIAL BENEFITS: An application for PACE can be approved when all factors of eligibility have been met and the individual is enrolled in the program. The effective date for PACE enrollment is the first day of the calendar month following the signing of the enrollment agreement (if all financial, non-financial, and medical eligibility criteria are met and an approved level of care (LOC) is in place). Applicants determined to be ineligible for PACE are notified of the reason for the denial and provided with an explanation of appeal rights. Applicants determined to be eligible for PACE are notified of the approval.
[8.280.600.11 NMAC - Rp, 8.280.600.11 NMAC, 1/1/2019]

8.280.600.12 ONGOING BENEFITS:

A. A complete redetermination of eligibility must be performed annually by the income support division worker for each open case.

B. Level of care reviews are required to be completed at least annually. Level of care determinations for PACE are made by the utilization review contractor.

[8.280.600.12 NMAC - Rp, 8.280.600.12 NMAC, 1/1/2019]

8.280.600.13 RETROACTIVE BENEFITS: Retroactive coverage is not available in the PACE program.
[8.280.600.13 NMAC - Rp, 8.280.600.13 NMAC, 1/1/2019]

8.280.600.14 CHANGES IN ELIGIBILITY: If the recipient ceases to meet any of the eligibility criteria, the case is closed following provision of advance notice as appropriate. See 8.200.430 NMAC for information about notices and hearing rights.

A. Non-provision of PACE services: To be eligible for PACE, an applicant/recipient must receive PACE services. If PACE services are no longer being provided and are not expected to be provided for at least a full calendar month, the recipient is ineligible for the program and the case must be closed after appropriate notice is provided, unless an exception has been prior authorized by MAD.

B. Admission to an acute care or nursing facility: If a PACE recipient enters an acute care or nursing facility, he still remains eligible. A PACE recipient may be disenrolled from the program either voluntarily or involuntarily. If disenrollment occurs, a new application for institutional care medicaid is not required in the following circumstances: the former PACE recipient is in an acute care or nursing facility; he continues to meet all eligibility criteria for institutional care medicaid; or the periodic review on the PACE case is not due in either the month of disenrollment or the following month.

C. Reporting changes in circumstances: The primary responsibility for reporting changes in the recipient's circumstances rests with the recipient or representative. At the initial eligibility determination and all on-going eligibility redeterminations, the income support division (ISD) must explain the reporting responsibilities requirement to the applicant/recipient or representative and document that such explanation was given. In the event that PACE services should cease, the PACE provider must immediately notify the income support division office by telephone of that fact. The telephone call is to be followed by a written notice to the ISD.

D. Disenrollment: A PACE recipient loses medicaid eligibility under this program when he is either voluntarily or involuntarily disenrolled. The PACE provider must inform the ISD office when disenrollment occurs. A **one time only** reinstatement will be allowed if the individual continues to meet all financial, non-financial and medical eligibility criteria. Reinstatement is subject to availability of positions and redetermination of medicaid eligibility. A PACE recipient may voluntarily disenroll at any time. Involuntary disenrollment occurs when any of the following situations exist:

(1) recipient moves out of PACE service area;

(2) recipient is a person with decision-making capacity who consistently does not comply with the individual plan of care and poses a significant risk to self or others;

(3) recipient experiences a breakdown in the physician or team relationship such that the PACE provider ability to furnish services to either the recipients or other recipients is seriously impaired;

(4) recipient refuses services or is unwilling to meet conditions of participation as they appear in the enrollment agreement;

(5) recipient refuses to provide accurate financial information, provides false information or illegally transfers assets;

(6) recipient is out of the PACE service area for more than one calendar month (unless other arrangements have been made);

(7) recipient is enrolled in PACE that loses its contract or licenses which enables it to cover health care services;

(8) recipient fails to meet the financial or non-financial criteria; or

(9) recipient ceases to meet the level of care at any time.

[8.280.600.14 NMAC - Rp, 8.280.600.14 NMAC, 1/1/2019]

HISTORY OF 8.280.600 NMAC:

History of Repealed Material:
8 NMAC 4.PAC.600, Benefit Description, filed 1-20-98 - Repealed effective 12/1/2006.
8.280.600 NMAC - Benefit Description, filed 11/15/2006 - Repealed effective 1/1/2019.