

§ 460.166

(5) The PACE program agreement with CMS and the State administering agency is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of State licenses or contracts with outside providers.

(b) *Disruptive or threatening behavior.* For purposes of this section, a participant who engages in disruptive or threatening behavior refers to a participant who exhibits either of the following:

(1) A participant whose behavior jeopardizes his or her health or safety, or the safety of others; or

(2) A participant with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.

(c) *Documentation of disruptive or threatening behavior.* If a PACE organization proposes to disenroll a participant who is disruptive or threatening, the organization must document the following information in the participant's medical record:

(1) The reasons for proposing to disenroll the participant.

(2) All efforts to remedy the situation.

(d) *Noncompliant behavior.* (1) A PACE organization may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior jeopardizes his or her health or safety, or the safety of others.

(2) For purposes of this section, noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

(e) *State administering agency review and final determination.* Before an involuntary disenrollment is effective, the State administering agency must review it and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.

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§ 460.166 Effective date of disenrollment.

(a) In disenrolling a participant, the PACE organization must take the following actions:

(1) Use the most expedient process allowed under Medicare and Medicaid procedures, as set forth in the PACE program agreement.

(2) Coordinate the disenrollment date between Medicare and Medicaid (for a participant who is eligible for both Medicare and Medicaid).

(3) Give reasonable advance notice to the participant.

(b) Until the date enrollment is terminated, the following requirements must be met:

(1) PACE participants must continue to use PACE organization services and remain liable for any premiums.

(2) The PACE organization must continue to furnish all needed services.

§ 460.168 Reinstatement in other Medicare and Medicaid programs.

To facilitate a participant's reinstatement in other Medicare and Medicaid programs after disenrollment, the PACE organization must do the following:

(a) Make appropriate referrals and ensure medical records are made available to new providers in a timely manner.

(b) Work with CMS and the State administering agency to reinstate the participant in other Medicare and Medicaid programs for which the participant is eligible.

§ 460.170 Reinstatement in PACE.

(a) A previously disenrolled participant may be reinstated in a PACE program.

(b) If the reason for disenrollment is failure to pay the premium and the participant pays the premium before the effective date of disenrollment, the participant is reinstated in the PACE program with no break in coverage.

§ 460.172 Documentation of disenrollment.

A PACE organization must meet the following requirements:

(a) Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments.

(b) Make documentation available for review by CMS and the State administering agency.

(c) Use the information on voluntary disenrollments in the PACE organization's internal quality assessment and performance improvement program.

Subpart J—Payment

§ 460.180 Medicare payment to PACE organizations.

(a) *Principle of payment.* Under a PACE program agreement, CMS makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicare participant in a payment area based on the rate it pays to a Medicare Advantage organization.

(b) *Determination of rate.* (1) The PACE program agreement specifies the methodology used to calculate the monthly capitation amount applicable to a PACE organization.

(2) Except as specified in paragraph (b)(4) of this section, the monthly capitation amount is based on the Part A and Part B payment rates established for purposes of payment to Medicare Advantage organizations. As used in this section, "Medicare Advantage rates" means the Part A and Part B rates calculated by CMS for making payment to Medicare Advantage organizations under section 1853(c) of the Act.

(3) CMS will adjust the monthly capitation payment amount derived under paragraph (b)(2) of this section based on a risk adjustment that reflects the individual's health status. CMS will ensure that payments take into account the comparative frailty of PACE enrollees relative to the general Medicare population.

(4) For Medicare participants who require ESRD services, the monthly capitation amount is based on the Medicare Advantage ESRD risk adjustment model.

(5) CMS may adjust the monthly capitation amount to take into account other factors CMS determines to be appropriate.

(6) The monthly capitation payment is a fixed amount, regardless of changes in the participant's health status.

(7) The monthly capitation payment amount is an all-inclusive payment for Medicare benefits provided to participants. A PACE organization must not seek any additional payment from Medicare. The only additional payment that a PACE organization may collect from, or on behalf of, a Medicare participant for PACE services is the following:

(i) Any applicable premium amount specified in § 460.186.

(ii) Any charge permitted under paragraph (d) of this section when Medicare is not the primary payer.

(iii) Any payment from the State, as specified in § 460.182, for a participant who is eligible for both Medicare and Medicaid.

(iv) Payment with respect to any applicable spenddown liability under §§ 435.121 and 435.831 of this chapter and any amount due under the post-eligibility treatment of income process under § 460.184 for a participant who is eligible for both Medicare and Medicaid.

(8) CMS computes the Medicare monthly capitation payment amount under a PACE program agreement so that the total payment level for all participants is less than the projected payment under Medicare for a comparable population not enrolled under a PACE program.

(c) *Adjustments to payments.* If the actual number of Medicare participants differs from the estimated number of participants on which the amount of the prospective monthly payment was based, CMS adjusts subsequent monthly payments to account for the difference.

(d) *Application of Medicare secondary payer provisions—*(1) *Basic rule.* CMS does not pay for services to the extent that Medicare is not the primary payer under part 411 of this chapter.

(2) *Responsibilities of the PACE organization.* The PACE organization must do the following:

(i) Identify payers that are primary to Medicare under part 411 of this chapter.

(ii) Determine the amounts payable by those payers.

(iii) Coordinate benefits to Medicare participants with the benefits of the primary payers.