

Programs of All-Inclusive Care for the Elderly (PACE)

Chapter 4 – Enrollment and Disenrollment

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10 - Introduction

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

This chapter discusses eligibility criteria and the enrollment process for the PACE program as provided in 42 CFR § 460.150. The eligibility criteria include a requirement that a PACE eligible individual meet a specific level of care which is determined by the State Administering Agency (*SAA*) and varies from state to state. State enrollment processes are separate from the processes identified below. PACE organizations should consult their *SAA* for instruction in State enrollment processes.

10.1 - Eligibility for Enrollment in PACE

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

To enroll in a PACE program, an individual must meet the following eligibility requirements listed in the Program Agreement:

- Be 55 years of age or older;
- Be determined by the *SAA* to need the level of care required under the Medicaid *State* plan for coverage of nursing facility services;
- Reside in the PACE organization's service area;
- Be able to live in a community setting at the time of enrollment without jeopardizing *their* health or safety based on criteria set forth in the program agreement *that are developed by the SAA; and*
- Meet any additional program-specific eligibility conditions *approved by CMS and* imposed under its respective PACE Program Agreement.

A PACE participant may not be concurrently enrolled in any other Medicare Advantage, Medicare Prescription Drug, or Medicaid prepayment plan, or optional benefit, such as a 1915(c) Home and Community Based Services waiver or the Medicare Hospice benefit.

A potential participant is not required to be a Medicare beneficiary or Medicaid recipient. A PACE enrollee may be, but is not required to be, any or all of the following: (1) entitled to Medicare Part A; (2) enrolled under Medicare Part B; (3) eligible for Medicaid.

PACE enrollees who become entitled to Medicare Part A and/or enrolled in Medicare Part B on a retroactive basis will be eligible for Medicare Part D beginning the month in which the individual received notification of the retroactive Medicare entitlement decision, resulting in some cases in which the individual's Medicare Part A and Part B dates will precede the Part D date. *[42 CFR §§ 460.150, 423.30(a)(3)]*

Example: An individual has Medicaid coverage throughout 2023. In May 2023, the individual is notified that s/he is entitled to Medicare Part A and/or B retroactive to November, 2022. The last day of eligibility for Medicaid prescription drug coverage is April 30, 2023; the first day of Part D eligibility is May 1, 2023.

10.2 - Hospice

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

Since comprehensive care is provided to PACE participants, those participants who need end-of-life care will receive the appropriate medical, pharmaceutical, and psychosocial services through the PACE organization. If a participant specifically wants to elect the hospice benefit from a certified hospice organization, the participant must voluntarily disenroll from the PACE program. The PACE organization will work with the *SAA* and CMS to facilitate the election of the hospice benefit and will work with the elected hospice organization to coordinate the transition of care.

[42 CFR § 460.154(i)]

20 - Discrimination against Beneficiaries Prohibited

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The PACE organization must not discriminate against any participant in the delivery of required PACE services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation or source of payment. Each PACE organization must agree to meet all applicable requirements under Federal, State and local laws and regulations including provisions of the Civil Rights Act, the Age Discrimination Act and the Americans with Disabilities Act. These requirements include, but are not limited to, all requirements contained in the regulations implementing those Acts.

[42 CFR §§ 460.32(a)(2), 460.98(b)(3)]

30 - Enrollment

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

30.1 - Eligibility Determination

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

Intake is an intensive process during which PACE staff members make one or more visits to a potential participant's place of residence and the potential participant may make one or more visits to the PACE center. At a minimum, the intake process must include the following activities:

- The PACE staff must explain to the potential participant and *their* representative or caregiver the following information:
 - The PACE program, using a copy of the enrollment agreement, specifically references the elements of the agreement, including, but not limited to, 42 CFR §§ 460.154(e), (i) through (m), and (r);
 - The requirement that the PACE organization would be the participant's sole service provider and clarification that the PACE organization guarantees access to services, but not to a specific provider;

- A list of the employees of the PACE organization who furnish care and the most current list of contracted health care providers;
- Monthly premiums, if any;
- Any Medicaid spenddown obligations;
- Post-eligibility treatment of income;
- The potential participant must sign a release to allow the PACE organization to obtain *their* medical and financial information and eligibility status for Medicare and Medicaid;
- The *SAA* must assess the potential participant, including any individual who is not eligible for Medicaid, to ensure that *they* need the level of care required under the State Medicaid plan for coverage of nursing facility services.

The PACE staff must assess the potential participant to ensure that *they* can be cared for appropriately in a community setting and that *they* meet all requirements for PACE eligibility. This involves an assessment of the individual's care support network as well as the individual's health condition to determine whether or not *their* health or safety would be jeopardized by living in a community setting. The *criteria the PACE organization uses to determine whether* an individual is able to live safely in the community *are* established, and must be approved, by the State. If it is determined that the prospective PACE *participant's* health or safety would be jeopardized by remaining in a community setting, the PACE organization *must* deny enrollment. *The State will provide oversight of the PACE organization's administration of the criteria, and of any associated enrollment denials based on the application of the criteria.* Refer to Chapter 8 of the PACE Manual for the IDT Assessment requirements.

[42 CFR § 460.152(a); 71 FR 71309 (Dec. 8, 2006)]

30.2 - Denial of Enrollment

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

When an enrollment is denied because *the potential participant's* health or safety would be jeopardized by living in a community setting, the PACE organization is required to complete the following steps:

- Notify the individual in writing of the reason for enrollment denial;
- Refer the individual to alternative services, as appropriate;
- Maintain supporting documentation of the reason for the denial; and,
- Notify CMS and the *SAA in the form and manner specified by CMS* and make the documentation available for review.

[42 CFR § 460.152(b)]

30.3 - Enrollment of Individuals Pending Medicare or Medicaid Eligibility

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

Eligibility to enroll in a PACE program is not restricted to an individual who is either a Medicare beneficiary or Medicaid recipient. During the enrollment process the applicant must sign a release to allow the PACE organization to obtain *their* medical and financial information and eligibility status for Medicare and Medicaid. The PACE organization is required to include any Medicaid spenddown obligations in the enrollment agreement. CMS requires that information regarding post eligibility treatment of income is also included in the enrollment agreement. As an additional participant protection, PACE organizations are required to review post-eligibility treatment of income with prospective enrollees as determined and calculated by the state.

[42 CFR §§ *460.150(d)*, 460.152(a)(2) and *460.154(g)*]

30.4 - Initial IDT Assessment

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

An initial comprehensive assessment is performed by the Interdisciplinary Team (IDT) on each participant independent of any pre-enrollment screening by the IDT. This assessment must be completed promptly following enrollment. The eight IDT members who conduct the initial assessment in person are the primary care *provider*, registered nurse, master's level social worker, dietitian, physical therapist, occupational therapist, recreational therapist or activities coordinator, and home care coordinator. The IDT may identify other healthcare specialists that are required to conduct additional assessments outside the IDT members' expertise or scope of practice. *Within 30 days of the date of enrollment, the interdisciplinary team must* consolidate the discipline-specific assessments into a single plan of care for each participant through discussion in team meetings and consensus of the entire IDT. In developing the plan of care, female participants must be informed that they are entitled to choose a qualified specialist for women's health services from the PACE organization's network to furnish routine or preventive women's health services.

[42 CFR § 460.104(a) and (b)]

30.5 - Enrollment Agreement

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

The PACE-eligible prospective enrollee (or legal representative) must agree to several enrollment conditions including, but not limited to, having the PACE organization and its provider network as the sole provider of services, giving signed consent for the PACE organization to obtain medical and financial information to verify eligibility, and agreeing to any applicable monthly premiums or Medicaid spenddown obligations. If the prospective PACE enrollee meets the eligibility requirements and signs the PACE enrollment agreement, the effective date of enrollment in the PACE program is on the first day of the calendar month following the date the PACE organization receives the participant's signed enrollment agreement. The PACE organization must submit a timely and accurate enrollment transaction to complete the enrollment in CMS systems. The enrollment agreement must, at a minimum, contain the following information:

- Applicant's name, sex, and date of birth;

- Medicare beneficiary status (Part A, Part B, or both) and number, if applicable;
- Medicaid recipient status and number, if applicable;
- Information on other health insurance, if applicable;
- Conditions for enrollment and disenrollment in PACE;
- Description of participant premiums, if any, and procedures for payment of premiums;
- Notification that a Medicaid participant and a participant who is eligible for both Medicare and Medicaid are not liable for any premiums, but may be liable for any applicable spenddown liability and any amounts due under the post-eligibility treatment of income process;
- Notification that a Medicare participant may not enroll or disenroll at a Social Security office;
- Notification that enrollment in PACE results in disenrollment from any other Medicare or Medicaid prepayment plan or optional benefit. Electing enrollment in any other Medicare or Medicaid prepayment plan or optional benefit, including the hospice benefit or Medicare Part D plan, after enrolling as a PACE participant, is considered a voluntary disenrollment from PACE;
- *Notification that when a Medicaid-only or a private pay PACE participant becomes eligible for Medicare, they will be disenrolled from PACE if they elect to obtain Medicare coverage other than from their PACE organization;*
- Information on the consequences of subsequent enrollment in other optional Medicare or Medicaid programs following disenrollment from PACE (i.e., conditions that might apply when enrolling in another managed care plan);
- Description of PACE services available, including all Medicare and Medicaid covered services, and how services are obtained from the PACE organization;
- Description of the procedures for obtaining emergency and urgently needed out-of-network services;
- The participant Bill of Rights (*CMS Participant Rights template can be found at [PACE Participants Rights \(cms.gov\)](https://www.cms.gov/medicare/medicare-eligibility/part-d/medicare-part-d-eligibility-requirements)*);
- Information on the process for grievances and appeals and Medicare/Medicaid phone numbers for use in appeals;
- Notification of a participant's obligation to inform the PACE organization of a move or lengthy absence from the organization's service area;

- An acknowledgment by the applicant or representative that *they* understand the requirement that the PACE organization must be the applicant’s sole service provider;
- A statement that the PACE organization has an agreement with CMS and the *SAA* that is subject to renewal on a periodic basis and, if the agreement is not renewed, the program will be terminated;
- The applicant’s authorization for disclosure and exchange of personal information between CMS, its agents, the *SAA*, and the PACE organization;
- The effective date of enrollment;
- The signature of the applicant or *their* designated representative and the date. *The applicant signature requirement may be satisfied with either a pen-and-ink or an electronic signature. Electronic signatures have the same legal effect and validity as pen-and-ink signatures. The electronic signature must capture an accurate time and date stamp at the time it is executed by the applicant. A PACE organization utilizing electronic signatures must, at a minimum, comply with the CMS security policies. For more information on the requirements for legally binding electronic signatures, see the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. §7001, and “Use of Electronic Signatures in Federal Organization Transactions” published by the Federal Chief Information Officers (CIO) Council.*

After the participant signs the enrollment agreement, the PACE organization must give the participant the following:

- A copy of the enrollment agreement;
- A PACE membership card *that must indicate the member is a participant of a PACE program and must include the phone number of the PACE organization;*
- Emergency information to be posted in *their* home identifying the individual as a PACE participant and explaining how to access emergency services;

If there are changes in the enrollment agreement information at any time during the participant’s enrollment, the PACE organization must meet the following requirements:

- Give an updated copy of the information to the participant;
- Explain the changes to the participant and *their* representative or caregiver in a manner they understand.

[42 CFR §§ 460.152(a)(1) and (2), 460.154, 460.156, 460.158]

40 – Disenrollments

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

Enrollment in the PACE program continues until the participant's death regardless of changes in health status unless the participant voluntarily disenrolls or the PACE organization involuntarily disenrolls the participant for strictly defined reasons.

[42 CFR § 460.160(a)]

40.1 – Documentation of Disenrollment

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

A PACE organization must meet the following requirements:

- Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments;
- Make documentation available for review by CMS and the *SAA*;
- Use the information on voluntary disenrollments in the PACE organization's internal Quality Improvement (QI) program.

[42 CFR § 460.172]

40.2 - Voluntary Disenrollment

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

A PACE participant may voluntarily disenroll from the program without cause at any time. *The PACE organization must ensure that its employees or contractors do not engage in any practice that would reasonably be expected to have the effect of steering or encouraging disenrollment of participants due to a change in health status.*

A participant's voluntary disenrollment is effective on the first day of the month following the date the PACE organization receives the participant's notice of voluntary disenrollment.

[42 CFR §§ 460.162, 460.166]

40.3 - Involuntary Disenrollment

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

The PACE organization may involuntarily disenroll a participant only for the following reasons:

- *Failure to Pay/Satisfactory Payment Arrangements: After a thirty-day grace period, the participant fails to pay, or make satisfactory arrangements to pay, any premiums due to the PACE organization;*
- *Failure to Pay/Satisfactory Payment Arrangements: After a thirty-day grace period, the participant fails to pay, or make satisfactory arrangements to pay, any applicable*

Medicaid spend down liability or any amount due under the post-eligibility treatment of income process;

- Disruptive or Threatening Behavior: A participant *and/or a participant's caregiver, which includes any family member involved in the participant's care*, engages in disruptive or threatening behavior. Such behavior is defined as the following:
 - Behavior that jeopardizes the participant's own health or safety, or the safety of others; or
 - Consistent refusal to comply with an individual plan of care or the terms of the PACE enrollment agreement by a participant with decision-making capacity. Note that a PACE organization may not involuntarily disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior related to an existing mental or physical condition unless the participant's behavior is jeopardizing *their* health or safety or that of others. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments;
- Relocation Outside of the Service Area: The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days without PACE organization concurrence;
- Non-renewal or Termination of Program Agreement: The PACE organization's program agreement with CMS and the *SAA* is not renewed or *is* terminated;
- Inability to Provide Services: The PACE organization is unable to offer healthcare services due to the loss of state licenses or contracts with outside providers;
- Ineligibility: It is determined that the participant no longer meets the State Medicaid nursing facility level of care requirements and is not deemed eligible.

Before an involuntary disenrollment is effective, the *SAA* must review it and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment. Once it has been deemed appropriate to involuntarily disenroll the participant, the PACE organization must follow the disenrollment process as defined in 42 CFR §§ 460.164 and 460.166.

The PACE organization must provide the participant at least 30 days advance notice of an involuntary disenrollment. A participant's involuntary disenrollment is effective on the first day of the next month that begins 30 days following the date the PACE organization sends notice of the disenrollment.

***Example:** The PACE organization sends a participant the notice of involuntary disenrollment on April 5th. As 30 days from the issuance of the notice is May 5th, the participant's disenrollment effective date will be June 1st.*

[42 CFR §§ 460.164(a), (b), (d), and (e); 71 FR 71315 (Dec. 8, 2006), *84 FR 25677 (June 3, 2019)*]

The PACE organization must take the following actions upon involuntary disenrollment of a

participant:

- *Complete the disenrollment as expeditiously as allowed under Medicare and Medicaid;*
- *Coordinate the disenrollment date between Medicare and Medicaid as applicable;*
- *Give reasonable advance notice to the participant about disenrollment;*
- *Submit the disenrollment transaction to CMS systems in a timely and accurate manner.*

The PACE organization must continue to provide all needed services, and the PACE participant must continue to use the PACE organization's services and pay any premiums, until the date the enrollment is actually terminated.

[42 CFR §§ 460.164, 460.166; 71 FR 71315 (Dec. 8, 2006)]

40.4 - Additional Written Evidence of Involuntary Disenrollment for Disruptive or Threatening Behavior

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

In addition to the documentation of disenrollment discussed in [40.1](#), if a PACE organization proposes to involuntarily disenroll a participant *based on the participant's or the participant's caregiver's* disruptive or threatening *behavior*, the PACE organization must document the following information in the participant's medical records:

- The reasons for proposing to disenroll the participant; and
- All efforts to remedy the situation.

[42 CFR § 460.164(d)]

40.5- Role of State Administering Agency (SAA)

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

At least annually, the *SAA* must re-evaluate whether or not a participant needs the level of care required under the State Medicaid plan for coverage of nursing facility services *using their state-specific assessment* and by reviewing the participant's medical record or plan of care.

The State may permanently waive the annual recertification requirement if it determines there is no reasonable expectation of improvement or significant change in the participant's condition because of the severity of a chronic condition or the degree of impairment of functional capacity (**NOTE:** State authorized waiver of annual recertification, which includes the reason for waiving the annual recertification requirement, must be documented in the medical record).

Furthermore, the *SAA* may deem a participant who no longer meets the State Medicaid nursing facility level of care requirements to continue to be eligible for the PACE program *until the next annual reevaluation* if, in the absence of continued coverage under the program, the *SAA* determines the participant reasonably would be expected to meet the nursing facility level of care requirement in the next six months.

The *SAA* must establish the criteria to use in making the determination of “deemed continued eligibility” and the criteria used to make the determination of continued eligibility must be specified in the program agreement. These criteria must be applied in reviewing the participant’s medical record and plan of care.

The *SAA*, in consultation with the PACE organization, may make a determination of deemed continued eligibility based on review of the participant’s medical record and plan of care.

Finally, the *SAA* is responsible for reviewing medical record documentation and information from a PACE organization that plans to involuntarily disenroll a participant. As *stated in Section 40.3*, the *SAA* is required to determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.

[42 CFR § 460.160(b), *460.164(f)*]

50 - Enrollment in other Medicare and Medicaid Programs Following Disenrollment from PACE

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

50.1 - General Requirements

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

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

- Make appropriate referrals and ensure medical records are made available to new providers *within 30 days*.
- Work with CMS and the *SAA* to reinstate the participant in other Medicare and Medicaid programs for which the participant is eligible.

[42 CFR § 460.168; 1894(a)(2)(C) and 1934(a)(2)(C) of the Act]

50.2 - Access to MA, PDP and Medigap Coverage Following Disenrollment

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

Individuals who disenroll from PACE have a Special Election Period (*SEP*) *to elect an MA plan or a standalone PDP*. *The SEP ends* 2 months after the effective date of PACE disenrollment. If the individual decides to return to original Medicare, the individual may purchase a Medigap (Medicare supplemental) policy that is offered in their state within 63 days of the last date of coverage. Under a Guaranteed Issue Period, the issuer of a Medicare Supplemental Policy may not deny or condition the issuance or effectiveness of the policy, may not discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition, and may not impose an exclusion of benefits based on a preexisting condition. The agent or insurer may request evidence of the date of disenrollment along with the application for the policy. The effective date of enrollment in the MA plan or standalone PDP would be the

first of the month following the plan's receipt of the enrollment request.

[42 CFR §§ 422.62(b)(7); 423.38(c)(14)]

60 - Reinstatement in PACE

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

A previously disenrolled participant may be reinstated in the PACE program. 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.

[42 CFR § 460.170]

70 - Retroactive Enrollment for Medicare Payment

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

CMS expects that PACE plans will follow the procedures described in the Medicare Advantage & Prescription Drug Plan Communications User Guide (PCUG) to successfully submit accurate enrollment and disenrollment transactions to CMS within the current operating month cycle. Following the timely submission of enrollment and disenrollment actions, PACE plans must review the reports and replies provided by CMS to ensure each action has been successfully processed, as well as to obtain other important information that CMS provides via these interchanges. Descriptions and file lay-outs are provided in detail in the PCUG.

However, if an eligible individual has fulfilled all enrollment requirements, but the PACE organization or CMS has been unable to process the enrollment for the required effective date, CMS (or its designee) may process a retroactive enrollment.

The request by a PACE organization for a retroactive enrollment must be made within ninety (90) days of the original effective date of enrollment (first day of the calendar month following the date the PACE organization receives the participant's signed enrollment agreement). When an individual has fulfilled all enrollment requirements, but the PACE organization or CMS has been unable to process the enrollment in a timely manner, the PACE organization must submit to CMS via the CMS retroactive processing contractor (RPC) a copy of the signed completed enrollment agreement. Note that the document must have been signed by the participant (or authorized representative) prior to the requested effective date of coverage in order to effectuate the requested effective coverage date. Continued failure to accurately and timely process enrollment transactions via direct systems interchange with CMS is contrary to operational guidance and will be considered a compliance issue by CMS. Issues older than 90 days from the original, valid effective date must be reviewed and approved by the CMS account manager prior to submission to the RPC. PACE organizations must follow the standard operating procedure (SOP) in conjunction with these instructions, as provided *by* the RPC, to submit retroactive requests for consideration.

80 - Retroactive Disenrollment for Medicare Entitled Participants

(Rev. 3, Issued: 12-05-23; Effective: 12-05-23; Implementation: 12-05-23)

If an enrollment was never legally valid or if a valid request for disenrollment was properly made, but not processed or acted on (including system error or plan error), CMS (or its designee) may process a retroactive disenrollment. CMS (or its designee) may also process a retroactive disenrollment if the reason for the disenrollment is related to a permanent move out of the service area.

A retroactive disenrollment can be submitted to CMS by the PACE organization *only* via submission of the request to the *RPC*. Requests from a PACE organization must include a copy of the disenrollment request or documentation that substantiates an allowable involuntary disenrollment as well as an explanation as to why the disenrollment was not processed and submitted to CMS correctly. PACE organizations must submit retroactive disenrollment requests to CMS (or its designee) within ninety (90) days of the effective disenrollment date. If CMS approves a request for retroactive disenrollment, the PACE organization must return any premium paid by the participant for any month for which CMS processed a retroactive disenrollment. In addition, CMS will retrieve any capitation payment for the retroactive period.

A retroactive request must be submitted by the PACE organization to CMS (or its designee) in cases in which the PACE organization has not properly processed or acted on the participant's request for disenrollment as required. A disenrollment request would be considered not properly acted on or processed if the effective date is a date other than as required. Continued failure to accurately and timely process enrollment transactions via direct systems interchange with CMS is contrary to operational guidance and will be considered a compliance issue by CMS. Issues older than 90 days from the original, valid effective date must be reviewed and approved by the CMS account manager prior to submission to the RPC. PACE organizations must follow the Standard Operating Procedure (SOP) in conjunction with these instructions, as provided *by* the RPC to submit retroactive requests for consideration.

[Retroactive Enrollment/Disenrollment Implementation Guidance for PACE Organizations (Dec. 24, 2009), *Medicare Enrollment for PACE Participants with Prospective or Retroactive Medicare Entitlement (Oct. 19, 2012)*]