



## Ohio Administrative Code

### Rule 173-50-03 PACE: application, assessment, enrollment, plan of care, reassessment, and continued enrollment.

Effective: June 1, 2026

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(A) Oversight:

- (1) AGE manages the enrollment for PACE.
- (2) AGE determines if a slot is available in PACE.
- (3) AGE may restrict enrollment based on funding for PACE.
- (4) AGE may increase or decrease the maximum number of PACE slots.

(B) Intake process:

- (1) A person may apply for PACE through either ODM's administrative agency or a PO. The two agencies coordinate intake with AGE.
- (2) The PO is responsible for completing its intake duties under 42 C.F.R. 460.152 and notifying AGE of any applicant and its determination under 42 C.F.R. 460.152(a)(4). The PO may help the applicant apply for medicaid, unless the applicant is already enrolled in medicaid.
- (3) ODM's administrative agency is responsible for determining whether the applicant meets all financial eligibility requirements for medicaid in Chapters 5160:1-1 to 5160:1-6 of the Administrative Code, notifying AGE, the PO, and the applicant (or the applicant's representative) of its determination, and, if the applicant does not meet all financial eligibility requirements, notifying the applicant (or the applicant's authorized representative) of the denial and appeal rights under section 5101.35 of the Revised Code and division 5101:6 of the Administrative Code.
- (4) A PO may enroll an applicant whose coverage status is "medicaid pending" (i.e., in the process of being determined for PACE medicaid eligibility until the issuance of the notice of action) following the eligibility determination:
  - (a) If the applicant is eligible for PACE medicaid, ODM is responsible for paying the applicable monthly premium to the PO beginning on the date the applicant was eligible for PACE medicaid.
  - (b) If the applicant is ineligible for PACE medicaid, or eligible with a share of cost, the PO assumes full financial responsibility for the period of pending PACE medicaid eligibility. If the applicant was already enrolled as a PACE participant, the PO cannot retroactively collect any monthly premium or other amount due under the post eligibility



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treatment of income process (also referred to as share of cost or patient liability).

(c) An applicant who is denied PACE medicaid eligibility may continue to be enrolled in PACE if the applicant is willing to pay the premium that would have been covered by medicaid. The applicant has the option to voluntarily disenroll pursuant to rule 173-50-04 of the Administrative Code if they do not wish to assume payment responsibility for the premium amount.

(d) The PO is responsible for updating the enrollment agreement with the premium amount and patient liability, if applicable, and satisfying the requirements of 42 C.F.R. 460.156(c) before the first payment is due.

(5) AGE is responsible for the level-of-care assessment under 42 C.F.R. 460.152(a)(3) and rule 5160-3-08 of the Administrative Code. AGE, in its discretion, may delegate this responsibility.

(C) Enrollment eligibility:

(1) If AGE determines that an applicant meets all eligibility requirements in rule 173-50-02 of the Administrative Code, then the following apply:

(a) AGE notifies the PO of its determination.

(b) The PO is responsible for notifying the applicant of the opportunity to proceed with the process of enrolling into PACE, providing the applicant with the enrollment agreement under 42 C.F.R. 460.154, and completing the enrollment procedures in 42 C.F.R. 460.156 if the applicant signs the enrollment agreement.

(c) 42 C.F.R. 460.158 determines the effective date of the applicant's enrollment into PACE as the first day of the month following the date the PO receives the signed enrollment agreement.

(2) If AGE determines that an applicant does not meet basic eligibility requirements in rule 173-50-02 of the Administrative Code and 42 C.F.R. 460.150(b)(1) to (b)(3), then the following apply:

(a) AGE notifies the PO of its determination.

(b) AGE notifies the applicant (or the authorized representative) of the determination of ineligibility.



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- (c) If the applicant is ineligible because AGE determines they do not meet the level of care requirement in accordance with rule 5160-3-08 of the Administrative Code, then AGE provides appeal rights under section 5101.35 of the Revised Code and division 5101:6 of the Administrative Code.
- (D) Denial: If the PO determines that an applicant is not able to live safely in the community at the time of enrollment, then the PO shall notify CMS and AGE of its determination; and provide the applicant with written notification of the denial which includes the reason for the denial and information on appeal rights under section 5101.35 of the Revised Code and division 5101:6 of the Administrative Code; and refer the applicant to alternative services as appropriate.
- (E) No available medicaid slot: If a slot is not available in PACE, the PO shall enroll the applicant when a slot becomes available (if the individual continues to meet the eligibility requirements) by one of the following two means:
  - (1) Unified waiting list: If the applicant meets the non-financial eligibility requirements for enrollment into PACE, but a slot in the program is not available, the PO shall place the applicant on the unified waiting list under rule 173-44-04 of the Administrative Code.
  - (2) Home first: If the applicant meets all requirements for the home first component of PACE in section 173.501 of the Revised Code, the PO shall enroll the applicant in PACE before enrolling any applicant from the unified waiting list in PACE.
- (F) Continued eligibility: AGE is responsible for the initial level of care assessment and the annual reassessments under 42 C.F.R.460.152(a)(3) and 460.160. AGE, at its discretion, may delegate this responsibility.
  - (1) Waiver of annual requirement:
    - (a) AGE may permanently waive the annual recertification requirement for a participant if it determines that 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.
    - (b) The PO must retain in the participant's medical record the documentation of the reason for waiving the annual recertification requirement.



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- (2) Deemed eligibility: If AGE determines that a participant no longer meets intermediate or skilled level of care requirements, the participant may be deemed to continue to be eligible for the PACE program until the next annual reevaluation, if, in the absence of continued coverage under this program, the participant reasonably would be expected to meet the nursing facility level of care requirement within the next six months.