12VAC30-50-10. Services provided to the categorically needy with limitations.

The following services are provided with limitations as described in 12VAC30-50-100 et seq.:

1. Inpatient hospital services other than those provided in an institution for mental diseases.

2. Outpatient hospital services.

3. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

4. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with §4231 of the State Medicaid Manual (HCFA Pub. 45-4).

5. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

6. Family planning services and supplies for individuals of child-bearing age.

7. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

8. Medical and surgical services furnished by a dentist (in accordance with §1905(a)(5)(B) of the Act).

9. Medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law: podiatrists, optometrists and other practitioners.

10. Home health services: intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area; home health aide services provided by a home health agency; and medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

11. Clinic services.

12. Dental services.

13. Physical therapy and related services, including occupational therapy and services for individuals with speech, hearing, and language disorders (provided by or under supervision of a speech pathologist or audiologist.

14. Prescribed drugs, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

15. Other rehabilitative services, screening services, preventive services.

16. Reserved.

17. Nurse-midwife services.

18. Case management services as defined in, and to the group specified in, 12VAC30-50-95 et seq. (in accordance with §1905(a)(19) or §1915(g) of the Act).

19. Extended services to pregnant women: pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls (see 12VAC30-50-510). (Note: Additional coverage beyond limitations.)

20. Pediatric or family nurse practitioners' service.

21. Any other medical care and any other type of remedial care recognized by state law, specified by the Secretary: transportation.

22. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 6 to Attachment 3.1-A.

CERTIFIED:

May 2, 2000
Date

/s/ Dennis G. Smith
Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-10-140. Amount, duration, and scope of services: Categorically needy.

Medicaid is provided in accordance with the requirements of 42 CFR 440, Subpart B and §1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

Services for the categorically needy are described below and in 12VAC30-50-10 et seq. These services include:

1. Each item or service listed in §1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR 440, Subpart A, or, for EPSDT services, §1905(r) and 42 CFR 411, Subpart B.

2. Nurse-midwife services listed in §1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under state law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

3. Pregnancy-related, including family planning service, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

4. Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women

5. Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of §1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

6. Home health services are provided to individuals entitled to nursing facility services as indicated in 12VAC30-10-220 of this plan.

7. Inpatient services that are being furnished to infants and children described in §1902(l)(1)(B) through (D), or §1905(n)(2) of the Act, on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.

8. Respiratory care services are not provided to ventilator dependent individuals as indicated in 12VAC30-10-300 of this plan.

9. Services are provided to families eligible under §1925 of the Act as indicated in 12VAC30-10-350 of this plan.

10. Home and community care for functionally disabled elderly individuals is not covered.

11. Program of All-Inclusive Care for the Elderly (PACE) services as described and limited in Supplement 6 to Attachment 3.1-A (12 VAC 30-50-30).

12VAC30-50-10 et seq. identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration, and scope of those service, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

CERTIFIED:

May 2, 2000
Date

/s/ Dennis G. Smith
Dennis G. Smith, Director
Dept. of Medical Assistance Services

[PART II.]

12 VAC 30-120-61. **Definitions.**

For purposes of 12 VAC 30-120-61 through 12 VAC 30-120-69 and all contracts establishing PACE plans, the following definitions shall apply:

"Adult day health care center" means a facility licensed by the Department of Social Services, Division of Licensing Programs, to provide partial day supplementary care and protection to adult individuals who reside elsewhere. Facilities or portions of facilities licensed by the State Board of Health or the State Board of Mental Health, Mental Retardation, and Substance Abuse Services and homes or residences of individuals who care solely for persons related by blood or marriage are not adult day health care centers under these regulations.

"Applicant" means an individual seeking enrollment in a PACE plan.

"Capitation rate" means the negotiated monthly per capita amount paid to a PACE contractor for services provided to enrollees.

"Catchment area" means the designated service area for a PACE plan.

"Contractor" means the entity contracting with the Department of Medical Assistance Services to operate a PACE plan.

"DMAS" means the Department of Medical Assistance Services.

"DSS" means the Department of Social Services.

"Enrollee" means a Medicaid eligible individual meeting PACE enrollment criteria and receiving services from a PACE plan.

"HCFA" means the federal Health Care Financing Administration.

"Full disclosure" means fully informing all PACE enrollees at the time of enrollment that, pursuant to Va. Code §32.1-330.3, PACE plan enrollment can only be guaranteed for a 30-day period.

"Imminent risk of nursing facility placement" means that an individual will require nursing facility care within 30 days if a community-based alternative care program, such as a PACE plan, is not available.

"Nursing home preadmission screening" means the process to: (1) evaluate the medical, nursing, and social needs of individuals referred for pre-admission screening, (2) analyze what specific services the individuals' need, (3) evaluate whether a service or a combination of existing community-based services are available to meet the individuals' needs, and (4)

authorize Medicaid funded nursing facility or community-based care for those individuals who meet nursing facility level of care criteria and require that level of care.

"Nursing Home Preadmission Screening Committee/Team" means an entity contracting with the Department of Medical Assistance Services to perform nursing facility pre-admission screenings. For individuals in the community, this entity is a committee comprised of staff from the local departments of health and social services. For individuals in an acute care facility, this entity is a team of nursing and social work staff. Each local committee and acute care team must have a physician member.

"PACE" means a Program of All-Inclusive Care for the Elderly.

"PACE plan" means a comprehensive acute and long-term care prepaid health plan, pursuant to the *Code* § 32.1-330.3, operating on a capitated payment basis through which the contractor assumes full financial risk. PACE plans operate under both Medicare and Medicaid capitation.

"PACE plan contract" means a contract, pursuant to the Code § 32.1-330.3, under which an entity assumes full financial risk for operation of a comprehensive acute and long-term care pre-paid health plan with capitated payments for services provided to Medicaid enrollees being made by the Department of Medical Assistance Services. The parties to a PACE plan contract are the entity operating the PACE plan and both the Department of Medical Assistance Services and the federal Health Care Financing Administration.

“PACE plan feasibility study” means a study performed by a research entity approved by the Department of Medical Assistance Services to determine a potential PACE plan contractor’s ability and resources or lack thereof to effectively operate a PACE plan. All study costs are the responsibility of the potential contractor.

“PACE protocol” means the protocol for the Program of All-Inclusive Care for the Elderly, as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon by the federal Secretary of Health and Human Services and On Lok, Inc.

"PACE site" means the location where the contractor both operates the PACE plan's adult day health care center and coordinates the provision of core PACE services.

“PCP” means the primary care provider responsible for the coordination of medical care provided to an enrollee under a PACE plan.

"State Plan" means the document containing the covered groups, covered services and their limitations, and provider payment methodologies as provided for under Title XIX of the Social Security Act.

“These regulations” means 12 VAC 30-120-61 through 12 VAC 30-120-69.

"Transitional Advisory Group" means the group established by the Board of Medical Assistance Services pursuant to the Va. Code §32.1-330.3. The group is responsible for advising the Department of Medical Assistance Services on issues of PACE plan license requirements, reviewing regulations, and providing ongoing oversight.

"Uniform Assessment Instrument (UAI)" means the standardized, multi-dimensional questionnaire used to assess an individual's physical and mental health and social and functional abilities. Under these regulations, the UAI is used to gather the information needed to determine an individual's long-term care needs and PACE plan service eligibility, for planning the care to be provided, and for monitoring care as it is provided.

12 VAC 30-120-62. General PACE plan requirements.

A. DMAS, the state agency responsible for administering Virginia's Medicaid program, shall only enter into PACE plan contracts with approved PACE plan contractors.

B. A PACE plan feasibility study shall be performed before DMAS enters into any PACE plan contract. DMAS shall contract only with those entities it determines to have the ability and resources to effectively operate a PACE plan.

C. PACE plans shall offer a voluntary alternative to enrollees who would otherwise be placed in a nursing facility. PACE plan services shall be comprehensive and offered as an alternative to nursing facility admission.

D. All enrollees shall meet the non-financial and financial Medicaid eligibility criteria established by federal law and these regulations. To the extent federal law or regulations are inconsistent with these regulations, the federal law and regulations shall control.

E. Each PACE plan shall operate a PACE site that is in continuous compliance with all state licensure requirements for that site.

F. Each PACE plan shall offer core PACE services through a coordination site that is licensed as an adult day care center by DSS.

G. Each PACE plan shall ensure that services are provided by health care providers and institutions that are in continuous compliance with state licensure and certification requirements.

H. Each PACE plan shall meet the requirements of §§32.1-330.2 and 330.3 of the Code of Virginia.

12 VAC 30-120-63. Criteria for PACE enrollment.

A. Eligibility shall be determined in the manner provided for in the State Plan and these regulations. To the extent these regulations differ from other provisions of the State Plan for purposes of PACE eligibility and enrollment, these regulations shall control.

B. Individuals meeting all of the following non-financial criteria are eligible to enroll in PACE plans approved by DMAS:

1. Individuals who are age 55 or older;

2. Individuals who require nursing facility level of care and are at imminent risk of nursing facility placement as determined by a Nursing Home Pre-Admission Screening Team through a Nursing Home Pre-Admission Screening performed using the UAI;

3. Individuals for whom PACE plan services are medically appropriate and necessary because without the services the individual is at imminent risk of nursing facility placement.

4. Individuals who reside in a PACE plan catchment area;

5. Individuals who meet other criteria specified in a PACE plan contract;

6. Individuals who participate in the Medicaid or Medicare programs as specified in § 32.1-330.3 E of the Code of Virginia; and

7. Individuals who voluntarily enroll in a PACE plan and agree to the terms and conditions of enrollment.

C. To the extent permitted by federal law and regulation, individuals meeting the following financial criteria are eligible to enroll in PACE plans approved by DMAS:

1. Individuals whose income is determined by DMAS under the provision of the State Plan to be equal to or less than 300% of the current Supplemental Security Income payment standard for one person; and

2. Individuals whose resources are determined by DMAS under the provisions of the State Plan to be equal to or less than the current resource allowance established in the State Plan.

D. For purposes of a financial eligibility determination, applicants shall be considered as if they are institutionalized for the purpose of applying institutional deeming rules.

E. DMAS shall not pay for services provided to an applicant by a PACE contractor if such services are provided prior to the PACE plan authorization date set by the Nursing Home Pre-Admission Screening team.

12 VAC 30-120-64. PACE enrollee rights.

A. PACE plan contractors shall ensure that enrollees are fully informed of their rights and responsibilities in accordance with all state and federal requirements. These rights and responsibilities shall include, but not be limited to:

1. The right to be fully informed at the time of enrollment that PACE plan enrollment can only be guaranteed for a 30-day period pursuant to [~~§32.1-330.2~~ §32.1-330.3 F]of the Code of Virginia;

2. The right to receive PACE plan services directly from the contractor or under arrangements made by the contractor; and

3. The right to be fully informed in writing of any action to be taken affecting the receipt of PACE plan services.

B. Contractors shall notify enrollees of the full scope of services available under a PACE plan. The services shall include, but not be limited to,

1. Medical services, including the services of a PCP and other specialists;

2. Transportation services;

3. Outpatient rehabilitation services, including physical, occupational and speech therapy services;

4. Hospital (acute care) services;

5. Nursing facility (long-term care) services;

6. Prescription drugs;

7. Home health services;

8. Laboratory services;

9. Radiology services;

10. Ambulatory surgery services;

11. Respite care services;

12. Personal care services;

13. Hospice services;

14. Adult day health care services, to include social work services;

15. Multi-disciplinary case management services;

16. Outpatient mental health and mental retardation services;

17. Outpatient psychological services;

18. Prosthetics; and

19. Durable medical equipment and other medical supplies.

C. Contractors shall ensure that PACE plan services are at least as accessible to enrollees as they are to other Medicaid eligible individuals residing in the applicable catchment area.

D. Contractors shall provide enrollees with access to services 24 hours per day every day of the year.

E. Contractors shall provide enrollees with all information necessary to facilitate easy access to services.

F. Contractors shall provide enrollees with identification documents approved by DMAS. PACE plan identification documents shall give notice to others of enrollees' coverage under PACE plans.

G. Contractors shall clearly and fully inform enrollees of their right to disenroll at will upon giving 30 days notice.

H. Contractors shall make available to enrollees a mechanism whereby disputes relating to enrollment and services can be considered. This mechanism shall be one that is approved by DMAS.

I. Contractors shall fully inform enrollees of the individual contractors' policies regarding accessing care generally, and in particular, accessing urgent or emergency care both within and without the catchment area.

J. Contractors shall maintain the confidentiality of enrollees and the services provided to them.

12 VAC 30-120-65. PACE enrollee responsibilities.

A. Enrollees shall access services through an assigned PCP. Enrollees shall be given the opportunity to choose a PCP affiliated with the applicable PACE plan. In the event an enrollee fails to choose a PCP, one shall be assigned by the contractor.

B. Enrollees shall be responsible for co-payments, if any.

C. Enrollees shall raise complaints relating to PACE plan coverage and services directly with the contractor. The contractor shall have a DMAS approved enrollee complaint process in place at all times.

D. Enrollees shall raise complaints pertaining to Medicaid eligibility and PACE plan eligibility directly to DMAS. These complaints shall be considered under DMAS' Client Appeals Regulations (12 VAC 30-110-10 et seq.).

12 VAC 30-120-66. PACE plan contract requirements and standards.

[A. Pursuant to 42 CFR Part 460 and § 32.1-330.3 of the Code, DMAS shall establish contract requirements and standards for PACE plan contractors.]

[B. At the point of Pace plan contract agreement, DMAS shall modify 12 VAC 30-50-320 accordingly and submit it to the Health Care Financing Administration for approval.]

~~[A. DMAS shall, as determined necessary, establish minimum contract requirements and standards for PACE plan contractors.~~

~~[B. PACE plan contracts shall be governed and construed in accordance with Title 32.1 of the Code of Virginia~~].

12 VAC 30-120-67. PACE catastrophic coverage limitation.

A. DMAS shall limit contractors' liability for Medicaid covered services required by individual enrollees when the need for services arises from a catastrophic occurrence or disease.

B. If during a single state fiscal year period (July 1 through June 30), an enrollee receives medically necessary PACE plan services necessitated by a catastrophic occurrence or disease and the cost of those services, calculated using DMAS' applicable provider payment schedules, exceeds the catastrophic coverage limitation established in the PACE plan contract for the Medicaid capitated portion of the payments, DMAS shall compensate the contractor for Medicaid covered services provided beyond the limitation amount.

C. When this provision is invoked, DMAS shall compensate the contractor for Medicaid covered services at the rates established under the applicable Medicaid provider payment schedules.

12 VAC 30-120-68. PACE sanctions.

A. DMAS shall apply sanctions to contractors for violations of PACE contract provisions and federal or state law and regulation.

B. Permissible state sanctions shall include, but need not be limited to, the following:

1. A written warning to the contractor;

2. Withholding all or part of the contractor's capitation payments;

3. Suspension of new enrollment in the PACE plan;

4. Restriction of current enrollment in the PACE plan; and

5. Contract termination.

12 VAC 30-120-69. [~~The preceding regulations shall only be effective upon federal approval, with the concomitant guarantee of federal matching funds, of the Commonwealth's submitted amendment to the State Plan for Medical Assistance.~~ Repealed.]

CERTIFIED:

May 2, 2000
Date

/s/ Dennis G. Smith
Dennis G. Smith, Director
Dept. of Medical Assistance Services