

12VAC30-50-320. Program of All-Inclusive Care for the Elderly (PACE).

The Commonwealth of Virginia has ~~not~~ entered into ~~any~~ a valid program agreement or agreements with a PACE provider or providers and the Secretary of the U.S. Department of Health and Human Services.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Service

12VAC30-120-61. Definitions.

For purposes of this part and all contracts establishing the Program of All Inclusive Care for the Elderly (PACE) ~~PACE~~ plans, the following definitions shall apply:

~~"Adult day health care center or ADHC" 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 Mental Health, Mental Retardation, and Substance Abuse Services Board 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.~~ DMAS-enrolled provider that offers a community-based day program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those elderly and disabled individuals at risk of placement in a nursing facility. The ADHC must be licensed by the Virginia Department of Social Services as an ADHC.

"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.

“Centers for Medicare and Medicaid Services or CMS” means the unit of the U.S.

Department of Health and Human Services that administers the Medicare and Medicaid programs.

“CFR” means the federal Code of Federal Regulation.

"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.

"Direct marketing" means either (i) conducting directly or indirectly door-to-door, telephonic or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts or special opportunities to eligible individuals or family/caregivers as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual or family/caregiver for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's or family/caregiver's use of the providers' services.

"Enrollee" means a ~~Medicaid-eligible~~ 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 [§32.1-330.3](#) of the Code of Virginia, 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~~ Preadmission screening" means the process to: (i) evaluate the ~~medical~~ functional, nursing, and social ~~needs~~ supports of individuals referred for preadmission screening, (ii) ~~analyze what specific services the individuals need,~~ assist individuals in determining what specific services individuals' need, (iii) evaluate whether a service or a combination of existing community-based services are available to meet the individuals' needs, and (iv) ~~authorize Medicaid-funded~~ refer individuals to the appropriate provider for Medicaid-funded nursing facility or home and 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~~ the entity ~~contracting~~ contracted with the Department of Medical Assistance Services to perform nursing facility preadmission 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~~ DMAS that is responsible for performing preadmission screening pursuant to §32.1-330 of the Code of Virginia.

"PACE" means a Program of All-Inclusive Care for the Elderly. PACE services are designed to enhance the quality of life and autonomy for frail, older adults, maximize dignity of, and respect for, older adults, enable frail older adults to live in the community as long as medically and socially feasible, and preserve and support the older adult's family unit.

"PACE plan" means a comprehensive acute and long-term care prepaid health plan, pursuant to §32.1-330.3 of the Code of Virginia, 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 §32.1-330.3 of the Code of Virginia, under which an entity assumes full financial risk for operation of a comprehensive acute and long-term care prepaid health plan with capitated payments for services provided to Medicaid enrollees being made by ~~the Department of Medical Assistance Services~~ DMAS. 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~~ DMAS and CMS.

"PACE plan feasibility study" means a study performed by a research entity approved by ~~the Department of Medical Assistance Services~~ DMAS 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.

"Plan of care" means the written plan developed by the provider related solely to the specific services required by the individual to ensure optimal health and safety while receiving services from the provider.

"Primary care provider" or "PCP" means the ~~primary care provider~~ individual responsible for the coordination of medical care provided to an enrollee under a PACE plan.

"State Plan for Medical Assistance" or "the Plan" means the Commonwealth's legal document approved by CMS identifying containing the covered groups, covered services and their limitations, and provider ~~payment~~ reimbursement methodologies as provided for under Title XIX of the Social Security Act.

~~"These regulations" means 12VAC30-120-61 through 12VAC30-120-68.~~

~~"Transitional Advisory Group" means the group established by the Board of Medical Assistance Services pursuant to §[32.1-330.3](#) of the Code of Virginia. 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" or (UAI)" "UAI" means the standardized, multidimensional questionnaire used to that assess assesses an individual's social, physical, health, 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.~~

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Service

12VAC30-120-62. 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. The PACE contractor and provider must have an agreement with CMS and DMAS for the operation of a PACE program. The agreement must include:

1. Designation of the program's service area;
2. The program's commitment to meet all applicable federal, state, and local requirements;
3. The effective date and term of the agreement;
4. The description of the organizational structure;
5. Participant bill of rights;
6. Description of grievance and appeals processes;
7. Policies on eligibility, enrollment, and disenrollment;
8. Description of services available;
9. Description of quality management and performance improvement program;
10. Statement of levels of performance required on standard quality measures;
11. CMS and DMAS data requirements;
12. Medicare and Medicaid capitation rates;
13. Procedures for program termination; and
14. Hold harmless CMS, the State, and PACE participants if the PACE organization does not pay for services performed by the contractor in accordance with the contract.

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 comprehensive 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~~ Medicaid enrolled PACE participants shall continue to meet the non-financial and financial Medicaid eligibility criteria established by federal law and these regulations. This requirement shall not apply to Medicare only or private pay PACE participants. ~~To the extent federal law or regulations are inconsistent with these regulations, the federal law and regulations shall control.~~

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

F. Each PACE ~~plan~~ contractor shall offer core PACE services as described 12VAC30-120-64(B) through a coordination site that is licensed as an ~~adult day care center~~ ADHC by DSS.

G. Each PACE ~~plan~~ contractor 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 [32.1-330.3](#) of the Code of Virginia and 42 CFR, Subchapter E.

I. All PACE contractors and providers must meet the general requirements and conditions for participation pursuant to the required contracts by DMAS and CMS. All providers must sign the appropriate participation agreement. All providers must adhere to the conditions of participation outlined in the participation agreement and application to provide PACE services, DMAS regulations, policies and procedures, and CMS requirements pursuant to 42 CFR, Subchapter E.

J. Requests for participation as a PACE provider will be screened by DMAS to determine whether the provider applicant meets these basic requirements for participation and demonstrates the abilities to perform, at a minimum, the following activities:

1. Immediately notify DMAS, in writing, of any change in the information that the provider previously submitted to DMAS;

2. Assure freedom of choice to individuals in seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid Program at the time the service or services are performed;

3. Assure the individual's freedom to refuse medical care, treatment, and services;

4. Accept referrals for services only when staff is available to initiate and perform such services on an ongoing basis;

5. Provide services and supplies to individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000 et seq.), which prohibits

discrimination on the grounds of race, color, religion, or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act of 1990, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications;

6. Provide services and supplies to individuals of the same quality and in the same mode of delivery as is provided to the general public;

7. Use only DMAS-designated forms for service documentation. The provider must not alter the DMAS forms in any manner unless approval from DMAS is obtained prior to using the altered forms.

8. Not perform any type of direct marketing activities to Medicaid individuals;

9. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided;

a. In general, such records shall be retained for at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for at least six years after such minor has reached the age of 18 years. However, records for Medicare Part D shall be maintained for 10 years in accordance with 42 CFR 423.505(d).

b. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth.

10. Furnish information on request and in the form requested, to DMAS, the Attorney General of Virginia or his authorized representatives, federal personnel, and the state Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and records shall survive any termination of the provider agreement.

11. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to individuals of Medicaid;

12. Pursuant to 42 CFR 431.300, et seq., 12 VAC 30-20-90, and any other applicable federal or state law, all providers shall hold confidential and use for authorized DMAS purposes only all medical assistance information regarding individuals served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits, or the data is necessary for the functioning of DMAS in conjunction with the cited laws;

13. Change of ownership. When ownership of the provider changes, DMAS shall be notified in writing at least 15 calendar days before the date of change;

14. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their

individual provider participation agreements and in the applicable DMAS provider manual. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies. A provider's noncompliance with DMAS policies and procedures may result in a retraction of Medicaid payment or termination of the provider agreement, or both.

15. Minimum qualifications of staff.

a. All employees must have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of vulnerable adults and children. The criminal record check shall be available for review by DMAS staff who are authorized to review these files. Providers are responsible for complying with the Code of Virginia regarding criminal record checks as it pertains to the licensure and program requirements of their particular practice areas.

b. Staff must meet any certifications, licensure, registration, etc. as required by applicable State law. Staff qualifications must be documented and maintained for review by DMAS or its authorized contractors.

16. At the time of their admission to services, all providers participating in the Medicare and Medicaid programs must provide adult individuals with written information regarding each individual's right to make medical care decisions, including the right to accept or refuse medical treatment and the right to formulate advance directives.

K. Provider's conviction of a felony. The Medicaid provider agreement shall terminate upon conviction of the provider of a felony pursuant to § 32.1-325 of the Code of Virginia. A provider convicted of a felony in Virginia or in any other of the 50 states, the

District of Columbia or, the U.S. territories, must, within 30 days, notify the Virginia Medicaid Program of this conviction and relinquish the provider agreement. In addition, termination of a provider participation agreement will occur as may be required for federal financial participation.

L. Ongoing quality management review. DMAS shall be responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies and periodically recertify each provider for participation agreement renewal with DMAS to provide PACE services.

M. Criminal record checks. Providers are responsible for complying with the Code of Virginia regarding criminal record checks as it pertains to the licensure and program requirements of their particular practice areas. The criminal record check shall be available for review by DMAS staff who are authorized by DMAS to review these files.

N. Reporting suspected abuse or neglect. Pursuant to sections 63.2-1606 and 63.2-1508 through 1513 of the Code of Virginia, if a participating provider entity suspects that a child or vulnerable adult is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately to VDSS and to DMAS. In addition, as mandated reporters for vulnerable adults, participating providers must inform their staff that they are mandated reporters and provide education regarding how to report suspected adult abuse, neglect, or exploitation pursuant to § 63.2-1606(F) of the Code of Virginia.

O. Documentation requirements. The provider must maintain all records of each individual receiving services. All documentation in the individual's record must be completely signed and dated with name of the person providing the service, title, and complete date with month, day, and year. This documentation shall contain, up to and including the last date of service, all of the following:

a. The most recently updated Long-Term Care Uniform Assessment Instrument (UAI), all other assessments and reassessments, plans of care, supporting documentation, and documentation of any inpatient hospital admissions;

b. All correspondence and related communication with the individual, and, as appropriate, consultants, providers, DMAS, DSS, or other related parties; and

c. Documentation of the date services were rendered and the amount and type of services rendered.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Service

12VAC30-120-64. 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 [§32.1-330.3](#) 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~~ PACE 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;

DEPT. OF MEDICAL ASSISTANCE SERVICES

Waivered Services: Program of All Inclusive Care for the Elderly (PACE)

12 VAC 30-120

Page 17 of 22

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~~ Dental services;
14. Adult day health care services, to include social work services;
15. ~~Multidisciplinary~~ Interdisciplinary 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.

20. These services shall not include any of the following:

(a) any service not authorized by the interdisciplinary team, unless such service is an emergency service;

(b) in an inpatient facility, private room and private duty nursing services (unless medically necessary,) and non-medical items for personal convenience such as telephones charges and radio or television rental (unless specifically authorized by the interdisciplinary team as part of the participant's plan of care).

(c) cosmetic surgery except as described in Agency guidance documents; and

(d) any experimental medical, surgical or other health procedure.

(e) any other service excluded under 42 C.F.R. 460.96

C. ~~Contractors~~ PACE 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~~ PACE contractors shall provide enrollees with access to services 24 hours per day every day of the year.

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

F. ~~Contractors~~ PACE 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~~ PACE contractors shall clearly and fully inform enrollees of their right to disenroll at will upon giving 30 days' notice.

H. ~~Contractors~~ PACE 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~~ PACE 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~~ PACE contractors shall maintain the confidentiality of enrollees and the services provided to them.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Service

12VAC30-120-65. 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 PACE 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 (12VAC30-110-10 et seq.).

E. The PACE contractor shall have a grievance process in place including procedures for filing an enrollee's grievance, documenting the grievance, responding to and resolving the grievance in a timely manner, and maintaining confidentiality of the agreement pursuant to 42 CFR 460.120.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Service

12VAC30-120-66. PACE plan contract requirements and standards.

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

B. At the point of PACE plan contract agreement, DMAS shall modify 12VAC30-50-320 accordingly and submit it to ~~the Health Care Financing Administration for approval~~ CMS.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Service

12VAC30-120-68. PACE sanctions.

A. DMAS shall apply sanctions to contractors for violations of PACE contract provisions ~~and~~ or 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 PACE contractor's capitation payments, or retracting all or part of any reimbursement previously paid;
3. Suspension of new enrollment in the PACE plan;
4. Restriction of current enrollment in the PACE plan; and
5. Contract termination.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Service