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 Part 440, Subpart A, or, for EPSDT services, §1905(r) and 42 CFR Part 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 (12VAC30-50-320, 12VAC30- 50-321, 12VAC 30-50-325, and 12VAC 30-50-328).

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

_____ _____

Date

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

12VAC30-50-20. Services provided to the categorically needy without limitation.

The following services as described in Part III (12VAC30-50-100 et seq.) of this chapter are provided to the categorically needy without limitation:

1. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

2. Services for individuals age 65 or over in institutions for mental diseases: inpatient hospital services; skilled nursing facility services; and services in an intermediate care facility.

3. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with §1902(a)(31)(A) of the Act, to be in need of such care, including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

4. Hospice care (in accordance with §1905(o) of the Act).

5. Any other medical care and any type of remedial care recognized under state law, specified by the Secretary: care and services provided in religious nonmedical health care institutions; nursing facility services for patients under 21 years of age; emergency hospital services.

6. Private health insurance premiums, coinsurance and deductibles when cost effective (pursuant to P.L. 101-508 §4402).

7. Program of All-Inclusive Care for the Elderly (PACE) services are provided for eligible individuals as an optional State Plan service for categorically needy individuals without limitation.

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

_____ _____

Date

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

12VAC30-50-60. Services provided to all medically needy groups without limitations.

Services as described in Part III (12VAC30-50-100 et seq.) of this chapter are provided to all medically needy groups without limitations.

1. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

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

3. Reserved.

4. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with §1905(a)(4)(A) of the Act to be in need of such care.

5. Hospice care (in accordance with §1905(o) of the Act).

6. Any other medical care or any other type of remedial care recognized under state law, specified by the secretary, including: care and services provided in religious nonmedical health care institutions; skilled nursing facility services for patients under 21 years of age; and emergency hospital services.

7. Private health insurance premiums, coinsurance and deductibles when cost effective (pursuant to P.L. 101-508 §4402).

8. Program of All-Inclusive Care for the Elderly (PACE) services are provided for eligible individuals as an optional State Plan service for medically needy individuals without limitation.

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

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

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

12VAC30-50-321. Eligibility for PACE enrollees.

A. The Commonwealth determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. The post-eligibility treatment of income rules specified below are the same as those that apply to the Commonwealth's approved Home and Community Based Services waivers.

B. Regular Post Eligibility. As a 209(b) state, the Commonwealth is using more restrictive eligibility requirements than those for Supplemental Security Income (SSI). The Commonwealth is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

1. 42 CFR 435.735: States using more restrictive requirements than SSI.

(a) Allowances for the needs of the individual shall be 165% of SSI.

(b) Allowance for the needs of the spouse shall not apply.

(c) Allowance for the needs of the family shall be the medically needy income standard.

2. Medical and remedial care expenses shall be as specified in 42 CFR 435.735.

C. Spousal Post Eligibility. The Commonwealth uses the post-eligibility rules of Section 1924 of the Social Security Act (the Act) (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan. Allowances for the needs of the individual shall be 165% of SSI.

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

_____ _____

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

12VAC 30-50-325. Rates and Payments.

A. The Commonwealth assures that the capitated rates will be equal to or less than the cost to the Agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Rates are set at a percent of fee-for-service costs.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner.

C. The Commonwealth will submit all capitated rates to the Centers for Medicare and Medicaid Services (CMS) Regional Office for prior approval.

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

_____ _____

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

12VAC30-50-328. PACE Enrollment and Disenrollment.

A. The Commonwealth assures that there is a process in place to provide for dissemination of PACE enrollment and disenrollment data. The Commonwealth assures that it has developed and will implement procedures for the enrollment and disenrollment of PACE participants via the Virginia Medicaid management information system, including procedures for any adjustment to account for the difference between the estimated number of PACE participants on which the prospective monthly payment was based and the actual number of PACE participants in that month.

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~~ programs, as defined in 42CFR460, 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 Adult Day Care Center (ADC) as defined in 22VAC40-60-10.

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

"Capitation rate" means the negotiated Medicaid monthly per capita amount paid to a PACE ~~contractor~~ provider 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 Code of Federal Regulations.

~~"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 and as defined in 42CFR460.6, operating on a capitated payment basis through which the ~~contractor~~ PACE provider 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~~ provider's ability and resources or lack thereof to effectively operate a PACE plan. All study costs are the responsibility of the potential ~~contractor~~ PACE provider.

"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, which includes a primary care center, where the ~~contractor~~ PACE provider both operates the PACE plan's adult day health care center and coordinates the provision of core PACE services, including the provision of primary care.

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

"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.~~

"Virginia Uniform Assessment Instrument" or ~~(UAI)"~~ "UAI" means the standardized, multidimensional questionnaire ~~used to~~ that ~~assess~~ assesses an individual's social, 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.~~

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~~ providers. The PACE 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. A statement of levels of performance required on standard quality measures;

11. CMS and DMAS data requirements;

12. The Medicaid capitation rate and the methodology used to calculate the Medicare capitation rate;

13. Procedures for program termination; and

14. A statement to hold harmless CMS, the State, and PACE participants if the PACE organization does not pay for services performed by the provider 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. A feasibility plan shall only be submitted in response to a Request for Applications published by DMAS.

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~~ provider shall operate a PACE site that is in continuous compliance with all state licensure requirements for that site.

F. Each PACE ~~plan~~ provider 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~~ provider 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 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 qualified 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, sexual orientation 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. 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 are necessary for the functioning of DMAS in conjunction with the cited laws.

13. CMS and DMAS shall be notified, in writing, of any change in the organizational structure of a PACE provider organization at least 14 calendar days before the change takes effect.

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. A criminal record check shall be conducted for the provider and each employee and made available for review by DMAS staff. Providers are responsible for complying with the Code of Virginia and state regulations regarding criminal record checks and barrier crimes as they pertain to the licensure and program requirements of their employees' particular practice areas.

b. Staff must meet any certifications, licensure, registration, etc. as required by applicable federal and 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. 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.

N. 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:

1. The most recently updated Virginia Uniform Assessment Instrument (UAI), all other assessments and reassessments, plans of care, supporting documentation, and documentation of any inpatient hospital admissions;

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

3. 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~~ providers 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 provider or under arrangements made by the provider; 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 providers shall notify enrollees of the full scope of services available under a PACE plan, as described in 42CFR460.92. 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~~ 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.

C. Services available under a PACE plan shall not include any of the following:

1. Any service not authorized by the interdisciplinary team, unless such service is an emergency service (i.e., a service provided in the event of a situation of a serious or urgent nature that endangers the health, safety, or welfare of an individual and demands immediate action);

2. 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);

3. Cosmetic surgery except as described in agency guidance documents;

4. Any experimental medical, surgical or other health procedure; and

5. Any other service excluded under 42 CFR 460.96.

~~C.~~D. ~~Contractors~~ PACE providers 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.~~E. ~~Contractors~~ PACE providers shall provide enrollees with access to services authorized by the interdisciplinary team 24 hours per day every day of the year.

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

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

~~H.~~I. ~~Contractors~~ PACE providers 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.~~J. ~~Contractors~~ PACE providers shall fully inform enrollees of the individual ~~contractor's~~ provider's' policies regarding accessing care generally, and in particular, accessing urgent or emergency care both within and without the catchment area.

~~J.~~K. ~~Contractors~~ PACE providers 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~~ provider. In the event an enrollee fails to choose a PCP, one shall be assigned by the ~~contractor~~ provider.

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~~ provider. The ~~contractor~~ provider 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 provider 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~~ providers.

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.

C. Any expansion of PACE programs shall be on a schedule and within an area determined solely at the discretion of DMAS through a Request for Applications (RFA) process. No organization shall begin any new PACE program without going through the RFA process as required by DMAS.

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~~ providers for violations of PACE contract provisions ~~and~~ 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~~ provider;

2. Withholding all or part of the PACE ~~contractor's~~ provider'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