STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE SERVICES (12 VAC 30-50-320)

The State of Virginia has entered into valid program agreements with a PACE provider(s) and the Secretary of the Department of Health and Human Services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. XX The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

The special home and community based waiver group under 42 CFR 435.217. Individuals who would be eligible for Medicaid if they were in an institution who have been determined to need home and community based services and who are covered under PACE. In addition, the state shall apply institutional eligibility rules to the following groups: Low income families with children as described in Section 1931 of the Act; Aged, Blind or Disabled who are eligible under 42 CFR 435.121; Optional Categorically Needy Aged or Disabled who have income at 80% of FPL, and the Medically Needy.

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. ____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. XX The State 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. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1. ___ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

(a). Sec. 435.726–States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1.____The following standard included under the State plan (check one):

(a) _____SSI
(b) _____Medically Needy
(c) _____The special income level for the institutionalized
(d) _____Percent of the Federal Poverty Level: _____%
(e) _____Other
(specify):_____

2._____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

3._____The following formula is used to determine the needs allowance:

_____

_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1.____ SSI Standard
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5 ____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

6.____ The amount is determined using the following formula:

_____

_____

7.____ Not applicable (N/A)

(C.) Family (check one):

1.____ AFDC need standard

2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.

5.____ The amount is determined using the following formula:

_____

_____

6.____ Other

7.____ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. XX 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
   (A.) Individual (check one)
   1.___The following standard included under the State plan (check one):
   (a) _____SSI
   (b) _____Medically Needy
   (c) _____The special income level for the institutionalized
   (d) _____Percent of the Federal Poverty Level: _____%
   (e) XX Other (specify): 165% of SSI
2.___The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
3___The following formula is used to determine the needs allowance:

_____
_____

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B.) Spouse only (check one):
1._____The following standard under 42 CFR 435.121:
_____
2._____The Medically needy income standard
_____
3.___The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

4 .____The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5._____The amount is determined using the following formula:
_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

6. XX Not applicable (N/A)

(C.) Family (check one):
1. ____AFDC need standard
2. XX Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

4. ____The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5. ____The amount is determined using the following formula:

6. ____ Other
7. ____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. XX State uses the post-eligibility rules of Section 1924 of 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.

(a.) Allowances for the needs of the:
1. Individual (check one)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

(A). __ The following standard included under the State plan (check one):

1. ___ SSI
2. __Medically Needy
3. __ The special income level for the institutionalized
4. __percent of the Federal Poverty Level: _____ %
5. XX_Other (specify): 165% of SSI

(B). The following dollar amount: $_ ---,,-

__

Note: lf this amount changes, this item will be revised.

(C)__ The following formula is used to determine the needs allowance:

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

II. Rates and Payments

A. The State assures CMS that the capitated rates will be less than the cost to the agency of providing State plan approved services to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the amount the state would have otherwise paid for a comparable population.

I. XX Rates are set at a percent of the amount that would otherwise been paid for a comparable population.

2. Experience-based (contractor's/State's cost experience or encounter date)(please describe)

3 Adjusted Community Rate (please describe)

4 Other(please describe)

The methodology develops an amount that would otherwise have been paid under the state plan (AWOP). The AWOP is developed using base period encounter data adjusted for comparable populations and services to those covered by the PACE program, specifically individuals over the age of 55 historically receiving services in an institutional setting (nursing home) or enrolled in a home and community based services (HCBS) waiver. The historical data, which is not more than three years old, is adjusted to reflect legislative modifications of payment arrangements between the data period and the contract period as well as benefit or eligibility changes occurring prior to the beginning of the contract period. The base period data is also updated to reflect expected increases in utilization and cost for the contract period covered by the rates referred to as prospective medical trend. An allowance for administrative costs is added to the AWOPs along with a provision for underwriting gain, consistent with actuarial assumptions for comparable administrative costs and underwriting gain included in capitation rates for MLTSS plans or state administrative costs for comparable FFS individuals. The final capitation rates are determined as a percentage discount (savings factor) off of the AWOP.

Rates vary by geographic region, and the state calculates two separate rates within each region: one for dual eligible participants and a rate for Medicaid-only participants.

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

C. The State will submit all capitated rates to the CMS Regional Office for prior approval, and will include the name, organizational affiliate of any actuary used, and attestation/description of the capitation rates.

Ill. Enrollment and Disenrollment

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

12VAC30- 50-330. Definitions.

For purposes of this part and all contracts establishing the Program of All-Inclusive Care for the Elderly (PACE) programs, as defined in 42 CFR Part 460, the following definitions shall apply:

"Adult day health care center" or "ADHC" means a 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 provider for all 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.

"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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

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

"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.

"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 42 CFR 460.6, operating on a capitated payment basis through which the 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 DMAS. The parties to a PACE plan contract are the entities operating the PACE plan, DMAS and CMS.

"PACE plan feasibility study" means a study performed by a research entity approved by DMAS to determine a potential PACE plan provider's ability and resources or lack thereof to effectively operate a PACE plan. All study costs are the responsibility of the potential 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

"PACE site" means the location, which includes a primary care center, where the 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.

"Preadmission screening" means the process to: (i) evaluate the functional, nursing, and social supports of individuals referred for preadmission screenings; (ii) 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 individual's needs; (iv) 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.

"Preadmission screening team" means the entity contracted with DMAS that is responsible for performing preadmission screening pursuant to §32.1-330 of the Code of Virginia.

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

"Provider" means the individual or other entity registered, licensed, or certified, or both, as appropriate, and enrolled by DMAS to render services to Medicaid recipients eligible for services.

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

"Virginia Uniform Assessment Instrument" or "UAI" means the standardized, multidimensional questionnaire that assesses an individual's social, physical and mental health, and functional abilities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

12VAC30- 50-335. 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 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

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 Medicaid-enrolled PACE participants shall continue to meet the nonfinancial 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.

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

F. [Removed]

G. Each PACE 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, Part 460.

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, Part 460.

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:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

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. 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., 12VAC30-20-90, 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

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. Prior to the beginning of employment, 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

M. Reporting suspected abuse or neglect. Pursuant to §§63.2-1606 of the Code of Virginia, if a participating provider entity suspects that an adult is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately to DSS 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.

12VAC30- 50-340. 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 the following nonfinancial criteria shall be eligible to enroll in PACE plans approved by DMAS:

1. Individuals who are age 55 or older and who at the time of enrollment are able to live in a community setting without jeopardizing his or her safety.

2. Individuals who require nursing facility level of care as determined by a Nursing Home Preadmission Screening Team through a Nursing Home Preadmission Screening performed using the UAI;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

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 program agreement;

6. 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 shall be 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 Preadmission Screening team.

12VAC30- 50-345. PACE enrollee rights.

A. PACE providers' 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:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

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

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

B. PACE providers shall notify enrollees of the full scope of services available under a PACE plan, as described in 42 CFR 460.92. 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. Dental services;

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

15. Interdisciplinary case management services;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

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 nonmedical 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.

D. 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.

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

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

G. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

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

I. 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.

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

K. PACE providers shall maintain the confidentiality of enrollees and the services provided to them.

12VAC30- 50-350. 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 provider. In the event an enrollee fails to choose a PCP, one shall be assigned by the provider.

B. 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.).

C. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

12VAC30- 50-355. 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 providers.

B. At the point of PACE plan contract agreement, DMAS shall modify 12VAC30-50-320 accordingly and submit it to 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.

12VAC30- 50-360. PACE sanctions.

A. DMAS shall apply sanctions to providers 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 provider;

2. Withholding all or part of the PACE 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.