COMMONWEALTH of VIRGINIA

Office of the Governor

John E. Littel
Secretary of Health and Human Resources

February 22, 2023

James G. Scott, Director
Division of Program Operations
Medicaid & CHIP Operations Group
Centers for Medicare and Medicaid Services
601 E. 12th St., Room 355
Kansas City, MO 64106

Dear Mr. Scott:

Attached for your review and approval is amendment 23-002, entitled "Program of All-Inclusive Care for the Elderly" to the Plan for Medical Assistance for the Commonwealth. I request that your office approve this change as quickly as possible.

Sincerely,

John E. Littel

Attachment

cc: Cheryl J. Roberts, Director, Department of Medical Assistance Services

Transmittal Summary

SPA 23-002

I. IDENTIFICATION INFORMATION

Title of Amendment: Program of All-Inclusive Care for the Elderly

II. SYNOPSIS

Basis and Authority: The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements.

Purpose: This SPA will allow DMAS to update sections of the state plan that pertain to the Program of All-Inclusive Care for the Elderly (PACE) to align with the Department's current practices pursuant to the Code of Virginia, state regulations, and federal regulations. Specifically, this SPA will:

- Remove an outdated requirement for licensure by the Virginia Department of Social Services in the definition of adult day health care centers (ADHCs).

- Update the definition of Uniform Assessment Instrument (UAI) and other definitions to accommodate a change from the term "preadmission screening" to "long-term services and supports screening," pursuant to Chapters 304 and 365 of the 2020 Acts of Assembly.

- Update documentation requirements regarding the filing of the UAI to align with state statute, pursuant to Chapters 304 and 365 of the 2020 Acts of Assembly.

- Conform the PACE SPA to federal regulations, including (i) changing the description of the required "quality management and performance" program to be a "quality improvement" program; (ii) allowing either the Medicaid capitation rate or the Medicaid payment rate methodology to be included in program agreement between DMAS and CMS; (iii) requiring PACE providers to retain business and professional records for at least 10 years; (iv) requiring PACE providers planning a change of ownership to notify CMS and the department in writing at least 60 days before the anticipated effective date of the change; and, (v) allowing participants to disenroll from the PACE program at any time and have such disenrollment be effective on the first day of the month following the date the provider organization receives the participant's notice of voluntary disenrollment.

Substance and Analysis: The section of the State Plan that is affected by this amendment is the "Program of All-Inclusive Care for the Elderly" Supplement.

Impact: There are no costs associated with this SPA.

Tribal Notice: Please see attached.

Prior Public Notice: N/A

Public Comments and Agency Analysis: N/A

Tribal Notice – Program of All-Inclusive Care for the Elderly (PACE)

Lee, Meredith (DMAS) <Meredith.Lee@dmas.virginia.gov>

Wed 2/8/2023 4:59 PM

To: TribalOffice@MonacanNation.com <TribalOffice@MonacanNation.com>;Ann Richardson <chiefannerich@aol.com>;Gerald Stewart <jerry.stewart@cit-ed.org>;pamelathompson4@yahoo.com (pamelathompson4@yahoo.com) <pamelathompson4@yahoo.com>;rappahannocktrib@aol.com (rappahannocktrib@aol.com) <rappahannocktrib@aol.com>;Reggie Stewart <regstew007@gmail.com>;Gray, Robert <robert.gray@pamunkey.org>;tribaladmin <tribaladmin@monacannation.com>;Sam Bass (samflyingeagle48@yahoo.com) <samflyingeagle48@yahoo.com>;chiefstephenadkins@gmail.com (chiefstephenadkins@gmail.com) <chiefstephenadkins@gmail.com>;Frank Adams <Board.R1D@DGIF.VIRGINIA.GOV>;bradbybrown@gmail.com (bradbybrown@gmail.com) <bradbybrown@gmail.com>;tabitha.garrett@ihs.gov (tabitha.garrett@ihs.gov) <tabitha.garrett@ihs.gov>;kara.kearns@ihs.gov (kara.kearns@ihs.gov) <kara.kearns@ihs.gov>;Mia Eubank (mia.eubank@ihs.gov) <mia.eubank@ihs.gov>

Dear Tribal Leaders and Indian Health Programs:

Attached is a Tribal Notice letter from Virginia Medicaid Director, Cheryl Roberts, indicating that the Dept. of Medical Assistance Services (DMAS) plans to submit a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services. This SPA will allow DMAS to revise the state plan to update sections that pertain to the Program of All-Inclusive Care for the Elderly (PACE) to align with the Department's current practices pursuant to the Code of Virginia, state regulations, and federal regulations.

If you would like a copy of the SPA documents or proposed text changes, or if you have any questions, please let us know.

Thank you! -- Meredith Lee

Meredith Lee
Division of Policy, Regulation, and Member Engagement
Policy, Regulations, and Manuals Supervisor
Department of Medical Assistance Services
Hours: 6:00 am - 4:30 pm (Monday-Thursday); out of the office on Fridays
meredith.lee@dmas.virginia.gov
(804) 371-0552

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CHERYL J. ROBERTS
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

February 8, 2023

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to Program of All-Inclusive Care for the Elderly.

Dear Tribal Leader and Indian Health Programs:

This letter is to notify you that the Department of Medical Assistance Services (DMAS) is planning to amend the Virginia State Plan for Medical Assistance with the Centers for Medicare and Medicaid Services (CMS). Specifically, DMAS is providing you notice about a State Plan Amendment (SPA) that the Agency will file with CMS to update sections that pertain to the Program of All-Inclusive Care for the Elderly (PACE) to align with the Department's current practices pursuant to the Code of Virginia, state regulations, and federal regulations. Specifically, the SPA will:

- Remove an outdated requirement for licensure by the Virginia Department of Social Services in the definition of adult day health care centers (ADHCs).

- Update the definition of Uniform Assessment Instrument (UAI) and other definitions to accommodate a change from the term "preadmission screening" to "long-term services and supports screening," pursuant to Chapters 304 and 365 of the 2020 Acts of Assembly.

- Update documentation requirements regarding the filing of the UAI to align with state statute, pursuant to Chapters 304 and 365 of the 2020 Acts of Assembly.

- Conform the PACE SPA to federal regulations, including (i) changing the description of the required "quality management and performance" program to be a "quality improvement" program; (ii) allowing either the Medicaid capitation rate or the Medicaid payment rate methodology to be included in program agreement between DMAS and CMS; (iii) requiring PACE providers to retain business and professional records for at least 10 years; (iv) requiring PACE providers planning a change of ownership to notify CMS and the department in writing at least 60 days before the anticipated effective date of the change; and, (v) allowing participants to disenroll from the PACE program at any time and have such disenrollment be effective on the first day of the month following the date the provider organization receives the participant's notice of voluntary disenrollment.

The tribal comment period for this SPA is open through March 10, 2023. You may submit your comments directly to Meredith Lee, DMAS Policy, Regulation, and Member Engagement Division, by phone (804) 371-0552, or via email: Meredith.Lee@dmas.virginia.gov. Finally, if you prefer regular mail you may send your comments or questions to:

Virginia Department of Medical Assistance Services
Attn: Meredith Lee
600 East Broad Street
Richmond, VA 23219

Please forward this information to any interested party.

Sincerely,

Cheryl J. Roberts
Director

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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.

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

"Long-term services and supports (LTSS) screening" or "screening" means the face to face process to (i) evaluate the functional, medical or nursing, and social support needs and at-risk status of individuals referred for certain long-term services requiring nursing facility level of care eligibility; (ii) assist individuals in determining what specific services the individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet the individual's needs; and (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facility, PACE plan services, or the Commonwealth Coordinated Care Plus waiver for those individuals who meet nursing facility level of care.

"Long-term services and supports (LTSS) screening team" means the hospital screening team, community-based team (CBT), nursing facility team, or DMAS designee contracted to perform screenings 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 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 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 Program Agreement" 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 PACE enrollees being made by DMAS. The parties to a PACE Program Agreement are the entities operating the PACE plan, DMAS and CMS.

"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.

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

"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 ~~PACE~~ 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.~~ assessment instrument that is completed by the LTSS screening team that assesses an individual's physical health, mental health, and psycho/social and functional abilities to determine if the individual meets the nursing facility level of care.

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12VAC30- 50-335. General PACE plan requirements.

A. DMAS, the state agency responsible for administering Virginia's Medicaid program, shall only enter into PACE Program Agreements 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~~ the organization's quality 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 or Medicaid payment rate methodology and the methodology used to calculate the Medicare capitation rate; and
13. Procedures for program termination;-.

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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~~ Program Agreement. All providers must adhere to the conditions of participation outlined in the ~~participation agreement~~ Program 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:

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a. In general, such records shall be retained for at least ~~six~~ ten years from the last date of ~~service~~ services or as provided by applicable federal and state laws, whichever period is longer. Records of individuals who have disenrolled from PACE shall be kept for ten years after the date of disenrollment. 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. When planning a change of ownership, CMS and DMAS shall be notified in writing at least 60 calendar days before the anticipated effective date of the change pursuant to 42 CFR 460.60 (d).

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 agreements and in the applicable DMAS provider manual. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies.

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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) and all required forms in the LTSS screening packet pursuant to 12VAC30-60-306, 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.

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 health or safety.

2. Individuals who require nursing facility level of care as determined by a ~~Nursing Home Preadmission~~ LTSS Screening Team through a ~~Nursing Home Preadmission Screening~~ long-term services and supports screening performed using the UAI and all required forms in the LTSS screening packet pursuant to 12VAC30-60-306;

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

4. Individuals who meet other criteria specified in a PACE Program Agreement;

5. 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~~ LTSS 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~~:

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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;

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16. Outpatient mental health and ~~mental retardation~~ intellectual disability 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.

H. PACE providers shall clearly and fully inform each enrollee of that enrollee's right to disenroll at any time and have such disenrollment be effective the first day of the month following the date the PACE organization receives the enrollee's notice of voluntary disenrollment.

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~~H.~~ I. PACE providers shall make available to enrollees a mechanism whereby disputes relating to enrollment and services can be considered. Both DMAS and CMS must approve mechanisms to resolve disputes over enrollment and service provision. PACE providers shall clearly and fully inform enrollees of their right to disenroll at will.

~~I.~~ 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.

~~J.~~ 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 grievances relating to PACE coverage and services directly with the PACE provider. The provider shall have a DMAS and CMS approved grievance process in place at all times.

~~B.~~ C. Enrollees shall raise grievances pertaining to Medicaid eligibility and PACE plan eligibility directly to DMAS. These grievances shall be considered under DMAS' Client Appeals regulations (12VAC30-110-10 et seq.).

~~C.~~ D. 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. Both DMAS and CMS must approve the grievance process.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0002

2. STATE: VA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
1/1/2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 460

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0
b. FFY 2024 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1A&B, Supplement 6, revised pages 2, 3, 4, 5, 6, 8, 10, 11, 12, 13 and 14

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Same as box #7.

9. SUBJECT OF AMENDMENT
Program of All-Inclusive Care for the Elderly

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED: Secretary of Health and Human Resources

11. SIGNATURE OF STATE AGENCY OFFICIAL
Cheryl Roberts

12. TYPED NAME
Cheryl Roberts

13. TITLE
Director

14. DATE SUBMITTED
02/08/23

15. RETURN TO
Department of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Policy, Regulations, and Manuals Supervisor

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

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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.

"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.

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

"Long-term services and supports (LTSS) screening" or "screening" means the face to face process to (i) evaluate the functional, medical or nursing, and social support needs and at-risk status of individuals referred for certain long-term services requiring nursing facility level of care eligibility; (ii) assist individuals in determining what specific services the individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet the individual's needs; and (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facility, PACE plan services, or the Commonwealth Coordinated Care Plus waiver for those individuals who meet nursing facility level of care.

"Long-term services and supports (LTSS) screening team" means the hospital screening team, community-based team (CBT), nursing facility team, or DMAS designee contracted to perform screenings 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 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 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 Program Agreement" 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 PACE enrollees being made by DMAS. The parties to a PACE Program Agreement are the entities operating the PACE plan, DMAS and CMS.

"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.

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

"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.

"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 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 assessment instrument that is completed by the LTSS screening team that assesses an individual's physical health, mental health, and psycho/social and functional abilities to determine if the individual meets the nursing facility level of care.

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12VAC30- 50-335. General PACE plan requirements.

A. DMAS, the state agency responsible for administering Virginia's Medicaid program, shall only enter into PACE Program Agreements 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 the organization's quality 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 or Medicaid payment rate methodology and the methodology used to calculate the Medicare capitation rate; and
13. Procedures for program termination.-

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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 Program Agreement. All providers must adhere to the conditions of participation outlined in the Program 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:

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a. In general, such records shall be retained for at least ten years from the last date of services or as provided by applicable federal and state laws, whichever period is longer. Records of individuals who have disenrolled from PACE shall be kept for ten years after the date of disenrollment. 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. When planning a change of ownership, CMS and DMAS shall be notified in writing at least 60 calendar days before the anticipated effective date of the change pursuant to 42 CFR 460.60 (d).

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 agreements and in the applicable DMAS provider manual. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies.

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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 Virginia Uniform Assessment Instrument (UAI) and all required forms in the LTSS screening packet pursuant to 12VAC30-60-306, 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.

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 health or safety.

2. Individuals who require nursing facility level of care as determined by a LTSS Screening Team through a long-term services and supports screening performed using the UAI and all required forms in the LTSS screening packet pursuant to 12VAC30-60-306;

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

4. Individuals who meet other criteria specified in a PACE Program Agreement;

5. 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 LTSS Screening team.

12VAC30- 50-345. PACE enrollee rights.

A. PACE 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:

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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:

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;

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16. Outpatient mental health and intellectual disability 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.

H. PACE providers shall clearly and fully inform each enrollee of that enrollee's right to disenroll at any time and have such disenrollment be effective the first day of the month following the date the PACE organization receives the enrollee's notice of voluntary disenrollment.

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I. PACE providers shall make available to enrollees a mechanism whereby disputes relating to enrollment and services can be considered. Both DMAS and CMS must approve mechanisms to resolve disputes over enrollment and service provision. PACE providers shall clearly and fully inform enrollees of their right to disenroll at will.

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 grievances relating to PACE coverage and services directly with the PACE provider. The provider shall have a DMAS and CMS approved grievance process in place at all times.

C. Enrollees shall raise grievances pertaining to Medicaid eligibility and PACE plan eligibility directly to DMAS. These grievances shall be considered under DMAS' Client Appeals regulations (12VAC30-110-10 et seq.).

D. 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. Both DMAS and CMS must approve the grievance process.