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**State Name:** Virginia

**State Plan Amendment (SPA) #**: 09-01

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

**Region III/Division of Medicaid and Children's Health Operations**

OCT 20 2009

Patrick W. Finnerty, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Dear Mr. Finnerty:

We are pleased to inform you of the approval of Virginia's Medicaid State Plan Amendment (SPA) 09-01. This SPA makes technical changes to Virginia's Program of All Inclusive Care for the Elderly (PACE). This amendment is effective February 5, 2009.

Enclosed are the approved SPA pages and the signed CMS-179 form. If you have any questions, please contact Donna Fischer of my staff at (215) 861-4221.

Sincerely,

/S/

Ted Gallagher
Associate Regional Administrator

Enclosures

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: 09 – 01

2. STATE: Virginia

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: February 5, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 466

7. FEDERAL BUDGET IMPACT
a. FFY 2009 $ 0.0
b. FFY 2010 $ 0.0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A &B, Supplement 6, Page 1 of 1, New Pages: Attachment 3.1-A &B, Supplement 6, Pages 9-22 of 22

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A &B, Supplement 6, Page 1 of 1

10. SUBJECT OF AMENDMENT: Program of All-Inclusive Care for the Elderly (PACE)

11: GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2009
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☑ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL: /S/

13. TYPED NAME: Patrick W. Finnerty

14. TITLE: Director

15. DATE SUBMITTED: 2/20/09

16. RETURN TO

Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulation Coordinator

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: 02/20/2009

18. DATE APPROVED: OCT 20 2009

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL: FEBRUARY 5, 2009

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: TED GALLAGHER

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR, OMCHO

23. REMARKS

FORM CMS-179 (07/92)

*Instructions on Back*

Save

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of VIRGINIA

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

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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.

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PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

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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. 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.

"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 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 enrollees 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.

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PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

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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 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; 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 Program Agreement. 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. Each PACE provider shall offer core PACE services as described in 42 CFR 460.92 through a coordination site that is licensed as an ADHC by DSS.

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 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:

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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 in the PACE Organization's provider network 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.

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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 Medicaid individuals.

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 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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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.

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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), 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 be 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 Screening Team through a Nursing Home Preadmission Screening performed using the UAI;

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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 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 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.

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

**12 VAC 30- 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 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. 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.

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**12VAC30- 50-355. PACE Program Agreement 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. 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 law and regulation, after consultation with CMS.

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.