

## SUBCHAPTER E—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

### PART 460—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

#### Subpart A—Basis, Scope, and Definitions

Sec.

- 460.2 Basis.
- 460.4 Scope and purpose.
- 460.6 Definitions.

#### Subpart B—PACE Organization Application and Waiver Process

- 460.10 Purpose.
- 460.12 Application requirements.
- 460.14 [Reserved]
- 460.16 [Reserved]
- 460.18 CMS evaluation of applications.
- 460.20 Notice of CMS determination.
- 460.22 Service area designation.
- 460.24 Limit on number of PACE program agreements.
- 460.26 Submission and evaluation of waiver requests.
- 460.28 Notice of CMS determination on waiver requests.

#### Subpart C—PACE Program Agreement

- 460.30 Program agreement requirement.
- 460.32 Content and terms of PACE program agreement.
- 460.34 Duration of PACE program agreement.

#### Subpart D—Sanctions, Enforcement Actions, and Termination

- 460.40 Violations for which CMS may impose sanctions.
- 460.42 Suspension of enrollment or payment by CMS.
- 460.46 Civil money penalties.
- 460.48 Additional actions by CMS or the State.
- 460.50 Termination of PACE program agreement.
- 460.52 Transitional care during termination.
- 460.54 Termination procedures.

#### Subpart E—PACE Administrative Requirements

- 460.60 PACE organizational structure.
- 460.62 Governing body.
- 460.64 Personnel qualifications.
- 460.66 Training.
- 460.68 Program integrity.
- 460.70 Contracted services.
- 460.71 Oversight of direct participant care.

- 460.72 Physical environment.
- 460.74 Infection control.
- 460.76 Transportation services.
- 460.78 Dietary services.
- 460.80 Fiscal soundness.
- 460.82 Marketing.

#### Subpart F—PACE Services

- 460.90 PACE benefits under Medicare and Medicaid.
- 460.92 Required services.
- 460.94 Required services for Medicare participants.
- 460.96 Excluded services.
- 460.98 Service delivery.
- 460.100 Emergency care.
- 460.102 Interdisciplinary team.
- 460.104 Participant assessment.
- 460.106 Plan of care.

#### Subpart G—Participant Rights

- 460.110 Bill of rights.
- 460.112 Specific rights to which a participant is entitled.
- 460.114 Restraints.
- 460.116 Explanation of rights.
- 460.118 Violation of rights.
- 460.120 Grievance process.
- 460.122 PACE organization's appeals process.
- 460.124 Additional appeal rights under Medicare or Medicaid.

#### Subpart H—Quality Assessment and Performance Improvement

- 460.130 General rule.
- 460.132 Quality assessment and performance improvement plan.
- 460.134 Minimum requirements for quality assessment and performance improvement program.
- 460.136 Internal quality assessment and performance improvement activities.
- 460.138 Committees with community input.
- 460.140 Additional quality assessment activities.

#### Subpart I—Participant Enrollment and Disenrollment

- 460.150 Eligibility to enroll in a PACE program.
- 460.152 Enrollment process.
- 460.154 Enrollment agreement.
- 460.156 Other enrollment procedures.
- 460.158 Effective date of enrollment.
- 460.160 Continuation of enrollment.
- 460.162 Voluntary disenrollment.
- 460.164 Involuntary disenrollment.

## Centers for Medicare & Medicaid Services, HHS

## § 460.6

- 460.166 Effective date of disenrollment.
- 460.168 Reinstatement in other Medicare and Medicaid programs.
- 460.170 Reinstatement in PACE.
- 460.172 Documentation of disenrollment.

### Subpart J—Payment

- 460.180 Medicare payment to PACE organizations.
- 460.182 Medicaid payment.
- 460.184 Post-eligibility treatment of income.
- 460.186 PACE premiums.

### Subpart K—Federal/State Monitoring

- 460.190 Monitoring during trial period.
- 460.192 Ongoing monitoring after trial period.
- 460.194 Corrective action.
- 460.196 Disclosure of review results.

### Subpart L—Data Collection, Record Maintenance, and Reporting

- 460.200 Maintenance of records and reporting of data.
- 460.202 Participant health outcomes data.
- 460.204 Financial recordkeeping and reporting requirements.
- 460.208 Financial statements.
- 460.210 Medical records.

AUTHORITY: Secs. 1102, 1871, 1894(f), and 1934(f) of the Social Security Act (42 U.S.C. 1302, 1395, 1395eee(f), and 1396u-4(f)).

SOURCE: 64 FR 66279, Nov. 24, 1999, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 460 appear at 67 FR 61504, Oct. 1, 2002.

### Subpart A—Basis, Scope, and Definitions

#### § 460.2 Basis.

This part implements sections 1894, 1905(a), and 1934 of the Act, which authorize the following:

- (a) Medicare payments to, and coverage of benefits under, PACE.
- (b) The establishment of PACE as a State option under Medicaid to provide for Medicaid payments to, and coverage of benefits under, PACE.

#### § 460.4 Scope and purpose.

(a) *General.* This part sets forth the following:

- (1) The requirements that an entity must meet to be approved as a PACE organization that operates a PACE program under Medicare and Medicaid.

(2) How individuals may qualify to enroll in a PACE program.

(3) How Medicare and Medicaid payments will be made for PACE services.

(4) Provisions for Federal and State monitoring of PACE programs.

(5) Procedures for sanctions and terminations.

(b) *Program purpose.* PACE provides pre-paid, capitated, comprehensive health care services designed to meet the following objectives:

(1) Enhance the quality of life and autonomy for frail, older adults.

(2) Maximize dignity of, and respect for, older adults.

(3) Enable frail, older adults to live in the community as long as medically and socially feasible.

(4) Preserve and support the older adult's family unit.

#### § 460.6 Definitions.

As used in this part, unless the context indicates otherwise, the following definitions apply:

*Contract year* means the term of a PACE program agreement, which is a calendar year, except that a PACE organization's initial contract year may be from 12 to 23 months, as determined by CMS.

*Medicare beneficiary* means an individual who is entitled to Medicare Part A benefits or enrolled under Medicare Part B, or both.

*Medicaid participant* means an individual determined eligible for Medicaid who is enrolled in a PACE program.

*Medicare participant* means a Medicare beneficiary who is enrolled in a PACE program.

*PACE* stands for programs of all-inclusive care for the elderly.

*PACE center* is a facility which includes a primary care clinic, and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining, and which serves as the focal point for coordination and provision of most PACE services.

*PACE organization* means an entity that has in effect a PACE program agreement to operate a PACE program under this part.

*PACE program* means a program of all-inclusive care for the elderly that is

## § 460.10

operated by an approved PACE organization and that provides comprehensive healthcare services to PACE enrollees in accordance with a PACE program agreement.

*PACE program agreement* means an agreement between a PACE organization, CMS, and the State administering agency for the operation of a PACE program.

*Participant* means an individual who is enrolled in a PACE program.

*Services* includes both items and services.

*State administering agency* means the State agency responsible for administering the PACE program agreement.

*Trial period* means the first 3 contract years in which a PACE organization operates under a PACE program agreement, including any contract year during which the entity operated under a PACE demonstration waiver program.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71334, Dec. 8, 2006]

### Subpart B—PACE Organization Application and Waiver Process

#### § 460.10 Purpose.

This subpart sets forth the application requirements for an entity that seeks approval from CMS as a PACE organization and the process by which a PACE organization may request waiver of certain regulatory requirements. The purpose of the waivers is to provide for reasonable flexibility in adapting the PACE model to the needs of particular organizations (such as those in rural areas).

[67 FR 61504, Oct. 1, 2002]

#### § 460.12 Application requirements.

(a) *General.* (1) An individual authorized to act for the entity must submit to CMS a complete application that describes how the entity meets all requirements in this part.

(2) CMS accepts applications from entities that seek approval as PACE organizations beginning on February 22, 2000 except for the following:

(i) Beginning on November 24, 1999, CMS accepts applications from entities that meet the requirements for priority consideration in processing of applications.

## 42 CFR Ch. IV (10–1–13 Edition)

(ii) Beginning on January 10, 2000, CMS accepts applications from entities that meet the requirements for special consideration in processing applications.

(b) *State assurance.* An entity's application must be accompanied by an assurance from the State administering agency of the State in which the program is located indicating that the State—

(1) Considers the entity to be qualified to be a PACE organization; and

(2) Is willing to enter into a PACE program agreement with the entity.

[64 FR 66279, Nov. 24, 1999, as amended at 67 FR 61505, Oct. 1, 2002; 71 FR 71334, Dec. 8, 2006]

#### § 460.14 [Reserved]

#### § 460.16 [Reserved]

#### § 460.18 CMS evaluation of applications.

CMS evaluates an application for approval as a PACE organization on the basis of the following information:

(a) Information contained in the application.

(b) Information obtained through on-site visits conducted by CMS or the State administering agency.

(c) Information obtained by the State administering agency.

#### § 460.20 Notice of CMS determination.

(a) *Time limit for notification of determination.* Within 90 days after an entity submits a complete application to CMS, CMS takes one of the following actions:

(1) Approves the application.

(2) Denies the application and notifies the entity in writing of the basis for the denial and the process for requesting reconsideration of the denial.

(3) Requests additional information needed to make a final determination.

(b) *Additional information requested.* If CMS requests from an entity additional information needed to make a final determination, within 90 days after CMS receives all requested information from the entity, CMS takes one of the following actions:

(1) Approves the application.

(2) Denies the application and notifies the entity in writing of the basis

for the denial and the process for requesting reconsideration of the denial.

(c) *Deemed approval.* An application is deemed approved if CMS fails to act on the application within 90 days after one of the following dates:

(1) The date the application is submitted by the organization.

(2) The date CMS receives all requested additional information.

(d) *Date of submission.* For purposes of the 90-day time limit described in this section, the date that an application is submitted to CMS is the date on which the application is delivered to the address designated by CMS.

#### § 460.22 Service area designation.

(a) An entity must state in its application the service area it proposes for its program.

(b) CMS, in consultation with the State administering agency, may exclude from designation an area that is already covered under another PACE program agreement to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

#### § 460.24 Limit on number of PACE program agreements.

(a) *Numerical limit.* Except as specified in paragraph (b) of this section, CMS does not permit the number of PACE organizations with which agreements are in effect under this part or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, to exceed the following:

(1) As of August 5, 1997—40.

(2) As of each succeeding August 5, the numerical limit for the preceding year plus 20, without regard to the actual number of agreements in effect on a previous anniversary date. (For example, the limit is 60 on August 5, 1998 and 80 on August 5, 1999.)

(b) *Exception.* The numerical limit does not apply to a private, for-profit PACE organization that meets the following conditions:

(1) Is operating under a demonstration project waiver under section 1894(h) and 1934(h) of the Act.

(2) Was operating under a waiver and subsequently qualifies for PACE organization status in accordance with sec-

tions 1894(a)(3)(B)(ii) and 1934(a)(3)(B)(ii) of the Act.

#### § 460.26 Submission and evaluation of waiver requests.

(a)(1) A PACE organization must submit its waiver request through the State administering agency for initial review. The State administering agency forwards waiver requests to CMS along with any concerns or conditions regarding the waiver.

(2) Entities submitting an application to become a PACE organization may submit a waiver request. The entity must submit its waiver request through the State administering agency for initial review. The State administering agency forwards the waiver requests to CMS along with any concerns or conditions regarding the waiver. The waiver request is submitted as a document separate from the application but may be submitted in conjunction with and at the same time as the application.

(b) CMS evaluates a waiver request from a PACE organization on the basis of the following information:

(1) The adequacy of the description and rationale for the waiver provided by the PACE organization or PACE applicant, including any additional information requested by CMS.

(2) Information obtained by CMS and the State administering agency in on-site reviews and monitoring of the PACE organization.

(c) Requirements related to the following principles may not be waived:

(1) A focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(2) The delivery of comprehensive, integrated acute and long-term care services.

(3) An interdisciplinary team approach to care management and service delivery.

(4) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(5) The assumption by the provider of full financial risk.

[67 FR 61505, Oct. 1, 2002; 67 FR 63966, Oct. 16, 2002; 71 FR 71334, Dec. 8, 2006]

**§ 460.28**

**42 CFR Ch. IV (10–1–13 Edition)**

**§ 460.28 Notice of CMS determination on waiver requests.**

(a) *Time limit for notification of determination.* Within 90 days after receipt of a waiver request, CMS takes one of the following actions:

(1) Approves the request.

(2) Denies the request and notifies the PACE organization or PACE applicant in writing of the basis of the denial.

(b) *Date of receipt.* For purposes of the 90-day time limit described in this section, the date that a waiver request is received by CMS from the State administering agency is the date on which the request is delivered to the address designated by CMS.

(c) *Waiver approval.* (1) A waiver request is deemed approved if CMS fails to act on the request within 90 days after the date the waiver request is received by CMS.

(2) CMS may withdraw approval of a waiver for good cause.

[67 FR 61505, Oct. 1, 2002, as amended at 71 FR 71334, Dec. 8, 2006]

**Subpart C—PACE Program Agreement**

**§ 460.30 Program agreement requirement.**

(a) A PACE organization must have an agreement with CMS and the State administering agency for the operation of a PACE program by the PACE organization under Medicare and Medicaid.

(b) The agreement must be signed by an authorized official of CMS, the PACE organization and the State administering agency.

(c) CMS may only sign program agreements with PACE organizations that are located in States with approved State plan amendments electing PACE as an optional benefit under their Medicaid State plan.

[64 FR 66279, Nov. 24, 1999, as amended at 67 FR 61505, Oct. 1, 2002]

**§ 460.32 Content and terms of PACE program agreement.**

(a) *Required content.* A PACE program agreement must include the following information:

(1) A designation of the service area of the organization's program. The

area may be identified by county, zip code, street boundaries, census tract, block, or tribal jurisdictional area, as applicable. CMS and the State administering agency must approve any change in the designated service area.

(2) The organization's commitment to meet all applicable requirements under Federal, State, and local laws and regulations, including provisions of the Civil Rights Act, the Age Discrimination Act, and the Americans With Disabilities Act.

(3) The effective date and term of the agreement.

(4) A description of the organizational structure of the PACE organization and information on administrative contacts, including the following:

(i) Name and phone number of the program director.

(ii) Name of all governing body members.

(iii) Name and phone number of a contact person for the governing body.

(5) A participant bill of rights approved by CMS and an assurance that the rights and protections will be provided.

(6) A description of the process for handling participant grievances and appeals.

(7) A statement of the organization's policies on eligibility, enrollment, voluntary disenrollment, and involuntary disenrollment.

(8) A description of services available to participants.

(9) A description of the organization's quality assessment and performance improvement program.

(10) A statement of the levels of performance required by CMS on standard quality measures.

(11) A statement of the data and information required by CMS and the State administering agency to be collected on participant care.

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

(13) A description of procedures that the organization will follow if the PACE program agreement is terminated.

(b) *Optional content.* (1) An agreement may provide additional requirements

for individuals to qualify as PACE program eligible individuals, in accordance with §460.150(b)(4).

(2) An agreement may contain any additional terms and conditions agreed to by the parties if the terms and conditions are consistent with sections 1894 and 1934 of the Act and regulations in this part.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71334, Dec. 8, 2006]

**§ 460.34 Duration of PACE program agreement.**

An agreement is effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate.

**Subpart D—Sanctions, Enforcement Actions, and Termination**

**§ 460.40 Violations for which CMS may impose sanctions.**

In addition to other remedies authorized by law, CMS may impose any of the sanctions specified in §§460.42 and 460.46 if CMS determines that a PACE organization commits any of the following violations:

(a) Fails substantially to provide to a participant medically necessary items and services that are covered PACE services, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the participant.

(b) Involuntarily disenrolls a participant in violation of §460.164.

(c) Discriminates in enrollment or disenrollment among Medicare beneficiaries or Medicaid beneficiaries, or both, who are eligible to enroll in a PACE program, on the basis of an individual's health status or need for health care services.

(d) Engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment, except as permitted by §460.150, by Medicare beneficiaries or Medicaid beneficiaries whose medical condition or history indicates a need for substantial future medical services.

(e) Imposes charges on participants enrolled under Medicare or Medicaid for premiums in excess of the premiums permitted.

(f) Misrepresents or falsifies information that is furnished—

(1) To CMS or the State under this part; or

(2) To an individual or any other entity under this part.

(g) Prohibits or otherwise restricts a covered health care professional from advising a participant who is a patient of the professional about the participant's health status, medical care, or treatment for the participant's condition or disease, regardless of whether the PACE program provides benefits for that care or treatment, if the professional is acting within his or her lawful scope of practice.

(h) Operates a physician incentive plan that does not meet the requirements of section 1876(i)(8) of the Act.

(i) Employs or contracts with any individual who is excluded from participation in Medicare or Medicaid under section 1128 or section 1128A of the Act (or with any entity that employs or contracts with that individual) for the provision of health care, utilization review, medical social work, or administrative services.

**§ 460.42 Suspension of enrollment or payment by CMS.**

(a) *Enrollment.* If a PACE organization commits one or more violations specified in §460.40, CMS may suspend enrollment of Medicare beneficiaries after the date CMS notifies the organization of the violation.

(b) *Payment.* If a PACE organization commits one or more violations specified in §460.40, for individuals enrolled after the date CMS notifies the PACE organization of the violation, CMS may take the following actions:

(1) Suspend Medicare payment to the PACE organization.

(2) Deny payment to the State for medical assistance for services furnished under the PACE program agreement.

(c) *Term of suspension.* A suspension or denial of payment remains in effect until CMS is satisfied that the following conditions are met:

(1) The PACE organization has corrected the cause of the violation.

(2) The violation is not likely to recur.

## § 460.46

## 42 CFR Ch. IV (10–1–13 Edition)

### § 460.46 Civil money penalties.

(a) CMS may impose civil money penalties up to the following maximum amounts:

(1) For each violation regarding enrollment or disenrollment specified in § 460.40 (c) or (d), \$100,000 plus \$15,000 for each individual not enrolled as a result of the PACE organization's discrimination in enrollment or disenrollment or practice that would deny or discourage enrollment.

(2) For each violation regarding excessive premiums specified in § 460.40(e), \$25,000 plus double the excess amount above the permitted premium charged a participant by the PACE organization. (The excess amount charged is deducted from the penalty and returned to the participant).

(3) For each misrepresentation or falsification of information, specified in § 460.40(f)(1), \$100,000.

(4) For any other violation specified in § 460.40, \$25,000.

(b) The provisions of section 1128A of the Act (other than subsections (a) and (b)) apply to a civil money penalty under this section in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

### § 460.48 Additional actions by CMS or the State.

After consultation with the State administering agency, if CMS determines that the PACE organization is not in substantial compliance with requirements in this part, CMS or the State administering agency may take one or more of the following actions:

(a) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

(b) Withhold some or all payments under the PACE program agreement until the organization corrects the deficiency.

(c) Terminate the PACE program agreement.

### § 460.50 Termination of PACE program agreement.

(a) *Termination of agreement by CMS or State.* CMS or a State administering agency may terminate at any time a PACE program agreement for cause, including, but not limited to the cir-

cumstances in paragraphs (b) or (c) of this section.

(b) *Termination due to uncorrected deficiencies.* CMS or the State administering agency may terminate a PACE program agreement if CMS or the State administering agency determines that both of the following circumstances exist:

(1) Either—

(i) There are significant deficiencies in the quality of care furnished to participants; or

(ii) The PACE organization failed to comply substantially with conditions for a PACE program or PACE organization under this part, or with terms of its PACE program agreement.

(2) Within 30 days of the date of the receipt of written notice of a determination made under paragraph (b)(1) of this section, the PACE organization failed to develop and successfully initiate a plan to correct the deficiencies, or failed to continue implementation of the plan of correction.

(c) *Termination due to health and safety risk.* CMS or a State administering agency may terminate a PACE program agreement if CMS or the State administering agency determines that the PACE organization cannot ensure the health and safety of its participants. This determination may result from the identification of deficiencies that CMS or the State administering agency determines cannot be corrected.

(d) *Termination of agreement by PACE organization.* A PACE organization may terminate an agreement after timely notice to CMS, the State administering agency, and participants, as follows:

(1) To CMS and the State administering agency, 90 days before termination.

(2) To participants, 60 days before termination.

### § 460.52 Transitional care during termination.

(a) The PACE organization must develop a detailed written plan for phase-down in the event of termination, which describes how the organization plans to take the following actions:

(1) Inform participants, the community, CMS and the State administering

agency in writing about termination and transition procedures.

(2) Assist participants to obtain reinstatement of conventional Medicare and Medicaid benefits.

(3) Transition participants' care to other providers.

(4) Terminate marketing and enrollment activities.

(b) An entity whose PACE program agreement is in the process of being terminated must provide assistance to each participant in obtaining necessary transitional care through appropriate referrals and making the participant's medical records available to new providers.

#### § 460.54 Termination procedures.

(a) Except as provided in paragraph (b) of this section, if CMS terminates an agreement with a PACE organization, it furnishes the PACE organization with the following:

(1) A reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of CMS's determination that cause exists for termination.

(2) Reasonable notice and opportunity for hearing (including the right to appeal an initial determination) before terminating the agreement.

(b) CMS may terminate an agreement without invoking the procedures described in paragraph (a) of this section if CMS determines that a delay in termination, resulting from compliance with these procedures before termination, would pose an imminent and serious risk to the health of participants enrolled with the organization.

### Subpart E—PACE Administrative Requirements

#### § 460.60 PACE organizational structure.

(a) A PACE organization must be, or be a distinct part of, one of the following:

(1) An entity of city, county, State, or Tribal government.

(2) A private not-for-profit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986. The entity may be a corporation, a subsidiary of a larger

corporation, or a department of a corporation.

(b) *Program director.* The organization must employ, or contract with in accordance with § 460.70, a program director who is responsible for oversight and administration of the entity.

(c) *Medical director.* The organization must employ, or contract with in accordance with § 460.70, a medical director who is responsible for the delivery of participant care, for clinical outcomes, and for the implementation, as well as oversight, of the quality assessment and performance improvement program.

(d) *Organizational chart.* (1) The PACE organization must have a current organizational chart showing officials in the PACE organization and relationships to any other organizational entities.

(2) The chart for a corporate entity must indicate the PACE organization's relationship to the corporate board and to any parent, affiliate, or subsidiary corporate entities.

(3) A PACE organization planning a change in organizational structure must notify CMS and the State administering agency, in writing, at least 14 days before the change takes effect.

[64 FR 66279, Nov. 24, 1999, as amended at 67 FR 61505, Oct. 1, 2002; 71 FR 71334, Dec. 8, 2006]

#### § 460.62 Governing body.

(a) *Governing body.* A PACE organization must be operating under the control of an identifiable governing body (for example, a board of directors) or a designated person functioning as a governing body with full legal authority and responsibility for the following:

(1) Governance and operation of the organization.

(2) Development of policies consistent with the mission.

(3) Management and provision of all services, including the management of contractors.

(4) Establishment of personnel policies that address adequate notice of termination by employees or contractors with direct patient care responsibilities.

(5) Fiscal operations.

(6) Development of policies on participant health and safety, including a



**§ 460.64**

**42 CFR Ch. IV (10–1–13 Edition)**

comprehensive, systemic operational plan to ensure the health and safety of participants.

(7) Quality assessment and performance improvement program.

(b) *Participant advisory committee.* (1) A PACE organization must establish a participant advisory committee to provide advice to the governing body on matters of concern to participants. Participants and representatives of participants must constitute a majority of the membership of this committee.

(2) The participant advisory committee must provide the liaison to the governing body with meeting minutes that include participant issues.

(c) *Participant representation on the governing body.* (1) A PACE organization must ensure participant representation on issues related to participant care. This shall be achieved by having a participant representative on the governing body.

(2) The participant representative is a liaison of the participant advisory committee to the PACE organization governing body.

(3) *Duty of the participant representative.* The participant representative must present issues from the participant advisory committee to the governing body.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71334, Dec. 8, 2006]

**§ 460.64 Personnel qualifications for staff with direct participant contact.**

(a) *General qualification requirements.* Each member of the PACE organization's staff that has direct participant contact, (employee or contractor) must meet the following conditions:

(1) Be legally authorized (for example, currently licensed, registered or certified if applicable) to practice in the State in which he or she performs the function or action;

(2) Only act within the scope of his or her authority to practice;

(3) Have 1 year of experience with a frail or elderly population;

(4) Meet a standardized set of competencies for the specific position description established by the PACE organization and approved by CMS before working independently.

(5) Be medically cleared for communicable diseases and have all immunizations up-to-date before engaging in direct participant contact.

(b) *Federally-defined qualifications for physician.* In addition to the qualification specified in paragraph (a) of this section, a physician must meet the qualifications and conditions in § 410.20 of this chapter.

[71 FR 71334, Dec. 8, 2006]

**§ 460.66 Training.**

(a) The PACE organization must provide training to maintain and improve the skills and knowledge of each staff member with respect to the individual's specific duties that results in his or her continued ability to demonstrate the skills necessary for the performance of the position.

(b) The PACE organization must develop a training program for each personal care attendant to establish the individual's competency in furnishing personal care services and specialized skills associated with specific care needs of individual participants.

(c) Personal care attendants must exhibit competency before performing personal care services independently.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71335, Dec. 8, 2006]

**§ 460.68 Program integrity.**

(a) *Persons with criminal convictions.* A PACE organization must not employ individuals or contract with organizations or individuals—

(1) Who have been excluded from participation in the Medicare or Medicaid programs;

(2) Who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, other health insurance or health care programs, or social service programs under title XX of the Act; or

(3) In any capacity where an individual's contact with participants would pose a potential risk because the individual has been convicted of physical, sexual, drug, or alcohol abuse.

(b) *Direct or indirect interest in contracts.* The PACE organization shall identify members of its governing body or any immediate family member having a direct or indirect interest in any

contract that supplies any administrative or care-related service or materials to the PACE organization.

(1) PACE organizations must develop policies and procedures for handling any direct or indirect conflict of interest by a member of the governing body or by the member's immediate family.

(2) In the event of a direct or indirect conflict of interest by a member of the PACE organization's governing body or his or her immediate family member, the board member must—

(i) Fully disclose the exact nature of the conflict to the board of directors and have the disclosure documented; and

(ii) Recuse himself or herself from discussing, negotiating, or voting on any issue or contract that could result in an inappropriate conflict.

(c) *Disclosure and recusal requirements.* A PACE organization must have a formal process in place to gather information related to paragraphs (a) and (b) of this section and must be able to respond in writing to a request for information from CMS within a reasonable amount of time.

[64 FR 66279, Nov. 24, 1999, as amended at 67 FR 61505, Oct. 1, 2002; 71 FR 71335, Dec. 8, 2006]

#### § 460.70 Contracted services.

(a) *General rule.* The PACE organization must have a written contract with each outside organization, agency, or individual that furnishes administrative or care-related services not furnished directly by the PACE organization except for emergency services as described in § 460.100.

(b) *Contract requirements.* A contract between a PACE organization and a contractor must meet the following requirements:

(1) The PACE organization must contract only with an entity that meets all applicable Federal and State requirements, including, but not limited to, the following:

(i) An institutional contractor, such as a hospital or skilled nursing facility, must meet Medicare or Medicaid participation requirements.

(ii) A practitioner or supplier must meet Medicare or Medicaid requirements applicable to the services it furnishes.

(iii) A contractor must comply with the requirements of this part with respect to service delivery, participant rights, and quality assessment and performance improvement activities.

(2) A contractor must be accessible to participants, located either within or near the PACE organization's service area.

(3) A PACE organization must designate an official liaison to coordinate activities between contractors and the organization.

(c) *List of contractors.* A current list of contractors must be on file at the PACE center and a copy must be provided to anyone upon request.

(d) *Content of contract.* Each contract must be in writing and include the following information:

(1) Name of contractor.

(2) Services furnished (including work schedule if appropriate).

(3) Payment rate and method.

(4) Terms of the contract, including beginning and ending dates, methods of extension, renegotiation, and termination.

(5) Contractor agreement to do the following:

(i) Furnish only those services authorized by the PACE interdisciplinary team.

(ii) Accept payment from the PACE organization as payment in full, and not bill participants, CMS, the State administering agency, or private insurers.

(iii) Hold harmless CMS, the State, and PACE participants if the PACE organization does not pay for services performed by the contractor in accordance with the contract.

(iv) Not assign the contract or delegate duties under the contract unless it obtains prior written approval from the PACE organization.

(v) Submit reports required by the PACE organization.

(vi) Agree to perform all the duties related to its position as specified in this part.

(vii) Participate in interdisciplinary team meeting as required.

(viii) Agree to be accountable to the PACE organization.

## § 460.71

(ix) Cooperate with the competency evaluation program and direct participant care requirements specified in § 460.71.

(e) *Contracting with another entity to furnish PACE Center services.* (1) A PACE organization may only contract for PACE Center services if it is fiscally sound as defined in § 460.80(a) of this part and has demonstrated competence with the PACE model as evidenced by successful monitoring by CMS and the State administering agency.

(2) The PACE organization retains responsibility for all participants and may only contract for the PACE Center services identified in § 460.98(d).

[64 FR 66279, Nov. 24, 1999, as amended at 67 FR 61505, Oct. 1, 2002; 71 FR 71335, Dec. 8, 2006]

### § 460.71 Oversight of direct participant care.

(a) The PACE organization must ensure that all employees and contracted staff furnishing care directly to participants demonstrate the skills necessary for performance of their position.

(1) The PACE organization must provide each employee and all contracted staff with an orientation. The orientation must include at a minimum the organization's mission, philosophy, policies on participant rights, emergency plan, ethics, the PACE benefit, and any policies related to the job duties of specific staff.

(2) The PACE organization must develop a competency evaluation program that identifies those skills, knowledge, and abilities that must be demonstrated by direct participant care staff (employees and contractors).

(3) The competency program must be evidenced as completed before performing participant care and on an ongoing basis by qualified professionals.

(4) The PACE organization must designate a staff member to oversee these activities for employees and work with the PACE contractor liaison to ensure compliance by contracted staff.

(b) The PACE organization must develop a program to ensure that all staff furnishing direct participant care services meet the following requirements:

## 42 CFR Ch. IV (10–1–13 Edition)

(1) Comply with any State or Federal requirements for direct patient care staff in their respective settings.

(2) Comply with the requirements of § 460.68(a) regarding persons with criminal convictions.

(3) Have verified current certifications or licenses for their respective positions.

(4) Are free of communicable diseases and are up to date with immunizations before performing direct patient care.

(5) Have been oriented to the PACE program.

(6) Agree to abide by the philosophy, practices, and protocols of the PACE organization.

[67 FR 61505, Oct. 1, 2002, as amended at 71 FR 71335, Dec. 8, 2006]

### § 460.72 Physical environment.

(a) *Space and equipment*—(1) *Safe design.* A PACE center must meet the following requirements:

(i) Be designed, constructed, equipped, and maintained to provide for the physical safety of participants, personnel, and visitors.

(ii) Ensure a safe, sanitary, functional, accessible, and comfortable environment for the delivery of services that protects the dignity and privacy of the participant.

(2) *Primary care clinic.* The PACE center must include sufficient suitable space and equipment to provide primary medical care and suitable space for team meetings, treatment, therapeutic recreation, restorative therapies, socialization, personal care, and dining.

(3) *Equipment maintenance.* (i) A PACE organization must establish, implement, and maintain a written plan to ensure that all equipment is maintained in accordance with the manufacturer's recommendations.

(ii) A PACE organization must perform the manufacturer's recommended maintenance on all equipment as indicated in the organization's written plan.

(b) *Fire safety*—(1) *General rule.* Except as otherwise provided in this section—

(i) A PACE center must meet the applicable provisions of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association

that apply to the type of setting in which the center is located. The Director of the Office of the Federal Register has approved the NFPA 101<sup>®</sup> 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:

[http://www.archives.gov/federal\\_register/](http://www.archives.gov/federal_register/)

[code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the FEDERAL REGISTER to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to PACE centers.

(2) *Exceptions.* (i) The Life Safety Code provisions do not apply in a State in which CMS determines that a fire and safety code imposed by State law adequately protects participants and staff.

(ii) CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the Pace center, but only if the waiver does not adversely affect the health and safety of the participants and staff.

(3) Beginning March 13, 2006, a PACE center must be in compliance with Chapter 9.2.9, Emergency Lighting.

(4) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to PACE centers.

(5) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a PACE center may install alcohol-based hand rub dispensers in its facility if—

(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;

(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

(iii) The dispensers are installed in a manner that adequately protects against inappropriate access;

(iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00-1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00-1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269; and

(v) The dispensers are maintained in accordance with dispenser manufacturer guidelines.

(c) *Emergency and disaster preparedness*—(1) *Procedures.* The PACE organization must establish, implement, and maintain documented procedures to manage medical and nonmedical emergencies and disasters that are likely to threaten the health or safety of the participants, staff, or the public.

(2) *Emergencies defined.* Emergencies include, but are not limited, to the following:

(i) Fire.

(ii) Equipment, water, or power failure.

(iii) Care-related emergencies.

(iv) Natural disasters likely to occur in the organization's geographic area. (An organization is not required to develop emergency plans for natural disasters that typically do not affect its geographic location.)

(3) *Emergency training.* A PACE organization must provide appropriate training and periodic orientation to all staff (employees and contractors) and participants to ensure that staff demonstrate a knowledge of emergency

## § 460.74

procedures, including informing participants what to do, where to go, and whom to contact in case of an emergency.

(4) *Availability of emergency equipment.* Emergency equipment, including easily portable oxygen, airways, suction, and emergency drugs, along with staff who know how to use the equipment, must be on the premises of every center at all times and be immediately available. The organization must have a documented plan to obtain emergency medical assistance from sources outside the center when needed.

(5) *Annual test of emergency and disaster plan.* At least annually, a PACE organization must actually test, evaluate, and document the effectiveness of its emergency and disaster plans.

[64 FR 66279, Nov. 24, 1999, as amended at 68 FR 1386, Jan. 10, 2003; 69 FR 49266, Aug. 11, 2004; 70 FR 15238, Mar. 25, 2005; 71 FR 55340, Sept. 22, 2006; 71 FR 71335, Dec. 8, 2006]

## § 460.74 Infection control.

(a) *Standard procedures.* The PACE organization must follow accepted policies and standard procedures with respect to infection control, including at least the standard precautions developed by the Centers for Disease Control and Prevention.

(b) *Infection control plan.* The PACE organization must establish, implement, and maintain a documented infection control plan that meets the following requirements:

(1) Ensures a safe and sanitary environment.

(2) Prevents and controls the transmission of disease and infection.

(c) *Contents of infection control plan.* The infection control plan must include, but is not limited to, the following:

(1) Procedures to identify, investigate, control, and prevent infections in every Pace center and in each participant's place of residence.

(2) Procedures to record any incidents of infection.

(3) Procedures to analyze the incidents of infection to identify trends and develop corrective actions related to the reduction of future incidents.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71334, Dec. 8, 2006]

## 42 CFR Ch. IV (10–1–13 Edition)

## § 460.76 Transportation services.

(a) *Safety, accessibility, and equipment.* A PACE organization's transportation services must be safe, accessible, and equipped to meet the needs of the participant population.

(b) *Maintenance of vehicles.* (1) If the PACE organization owns, rents, or leases transportation vehicles, it must maintain these vehicles in accordance with the manufacturer's recommendations.

(2) If a contractor provides transportation services, the PACE organization must ensure that the vehicles are maintained in accordance with the manufacturer's recommendations.

(c) *Communication with PACE center.* The PACE organization must ensure that transportation vehicles are equipped to communicate with the PACE center.

(d) *Training.* The PACE organization must train all transportation personnel (employees and contractors) in the following:

(1) Managing the special needs of participants.

(2) Handling emergency situations.

(e) *Changes in care plan.* As part of the interdisciplinary team process, PACE organization staff (employees and contractors) must communicate relevant changes in a participant's care plan to transportation personnel.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71334, Dec. 8, 2006]

## § 460.78 Dietary services.

(a) *Meal requirements.* (1) Except as specified in paragraphs (a)(2) or (a)(3) of this section, the PACE organization must ensure, through the assessment and care planning process, that each participant receives nourishing, palatable, well-balanced meals that meet the participant's daily nutritional and special dietary needs. Each meal must meet the following requirements:

(i) Be prepared by methods that conserve nutritive value, flavor, and appearance.

(ii) Be prepared in a form designed to meet individual needs.

(iii) Be prepared and served at the proper temperature.

(2) The PACE organization must provide substitute foods or nutritional

supplements that meet the daily nutritional and special dietary needs of any participant who has any of the following problems:

- (i) Refuses the food served.
- (ii) Cannot tolerate the food served.
- (iii) Does not eat adequately.

(3) The PACE organization must provide nutrition support to meet the daily nutritional needs of a participant, if indicated by his or her medical condition or diagnosis. Nutrition support consists of tube feedings, total parenteral nutrition, or peripheral parenteral nutrition.

(b) *Sanitary conditions.* The PACE organization must do the following:

(1) Procure foods (including nutritional supplements and nutrition support items) from sources approved, or considered satisfactory, by Federal, State, Tribal, or local authorities with jurisdiction over the service area of the organization.

(2) Store, prepare, distribute, and serve foods (including nutritional supplements and nutrition support items) under sanitary conditions.

(3) Dispose of garbage and refuse properly.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71335, Dec. 8, 2006]

#### § 460.80 Fiscal soundness.

(a) *Fiscally sound operation.* A PACE organization must have a fiscally sound operation, as demonstrated by the following:

(1) Total assets greater than total unsubordinated liabilities.

(2) Sufficient cash flow and adequate liquidity to meet obligations as they become due.

(3) A net operating surplus or a financial plan for maintaining solvency that is satisfactory to CMS and the State administering agency.

(b) *Insolvency plan.* The organization must have a documented plan in the event of insolvency, approved by CMS and the State administering agency, which provides for the following:

(1) Continuation of benefits for the duration of the period for which capitation payment has been made.

(2) Continuation of benefits to participants who are confined in a hospital on the date of insolvency until their discharge.

(3) Protection of participants from liability for payment of fees that are the legal obligation of the PACE organization.

(c) *Arrangements to cover expenses.* (1) A PACE organization must demonstrate that it has arrangements to cover expenses in the amount of at least the sum of the following in the event it becomes insolvent:

(i) One month's total capitation revenue to cover expenses the month before insolvency.

(ii) One month's average payment to all contractors, based on the prior quarter's average payment, to cover expenses the month after the date it declares insolvency or ceases operations.

(2) Arrangements to cover expenses may include, but are not limited to, the following:

(i) Insolvency insurance or reinsurance.

(ii) Hold harmless arrangement.

(iii) Letters of credit, guarantees, net worth, restricted State reserves, or State law provisions.

#### § 460.82 Marketing.

(a) *Information that a PACE organization must include in its marketing materials.* (1) A PACE organization must inform the public about its program and give prospective participants the following written information:

(i) An adequate description of the PACE organization's enrollment and disenrollment policies and requirements.

(ii) PACE enrollment procedures.

(iii) Description of benefits and services.

(iv) Premiums.

(v) Other information necessary for prospective participants to make an informed decision about enrollment.

(2) Marketing information must be free of material inaccuracies, misleading information, or misrepresentations.

(b) *Approval of marketing information.*

(1) CMS must approve all marketing information before distribution by the PACE organization, including any revised or updated material.

## § 460.90

(2) CMS reviews initial marketing information as part of an entity's application for approval as a PACE organization, and approval of the application includes approval of marketing information.

(3) Once a PACE organization is under a PACE program agreement, any revisions to existing marketing information and new information are subject to the following:

(i) *Time period for approval.* CMS approves or disapproves marketing information within 45 days after CMS receives the information from the organization.

(ii) *Deemed approval.* Marketing information is deemed approved, and the organization can distribute it, if CMS and the State administering agency do not disapprove the marketing material within the 45-day review period.

(c) *Special language requirements.* A PACE organization must furnish printed marketing materials to prospective and current participants as specified below:

(1) In English and in any other principal languages of the community.

(2) In Braille, if necessary.

(d) *Information on restriction of services.* (1) Marketing materials must inform a potential participant that he or she must receive all needed health care, including primary care and specialist physician services (other than emergency services), from the PACE organization or from an entity authorized by the PACE organization.

(2) All marketing materials must state clearly that PACE participants may be fully and personally liable for the costs of unauthorized or out-of-PACE program agreement services.

(e) *Prohibited marketing practices.* A PACE organization must ensure that its employees or its agents do not use prohibited marketing practices which includes the following:

(1) Discrimination of any kind, except that marketing may be directed to individuals eligible for PACE by reason of their age.

(2) Activities that could mislead or confuse potential participants, or misrepresent the PACE organization, CMS, or the State administering agency.

(3) Gifts or payments to induce enrollment.

## 42 CFR Ch. IV (10–1–13 Edition)

(4) Contracting outreach efforts to individuals or organizations whose sole responsibility involves direct contact with the elderly to solicit enrollment.

(5) Unsolicited door-to-door marketing.

(f) *Marketing Plan.* A PACE organization must establish, implement, and maintain a documented marketing plan with measurable enrollment objectives and a system for tracking its effectiveness.

### Subpart F—PACE Services

#### § 460.90 PACE benefits under Medicare and Medicaid.

If a Medicare beneficiary or Medicaid beneficiary chooses to enroll in a PACE program, the following conditions apply:

(a) Medicare and Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply.

(b) The participant, while enrolled in a PACE program, must receive Medicare and Medicaid benefits solely through the PACE organization.

#### § 460.92 Required services.

The PACE benefit package for all participants, regardless of the source of payment, must include the following:

(a) All Medicare-covered items and services.

(b) All Medicaid-covered items and services, as specified in the State's approved Medicaid plan.

(c) Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

[71 FR 71335, Dec. 8, 2006]

#### § 460.94 Required services for Medicare participants.

(a) Except for Medicare requirements that are waived for the PACE program, as specified in paragraph (b) of this section, the PACE benefit package for Medicare participants must include the following services:

(1) The scope of hospital insurance benefits described in part 409 of this chapter.

(2) The scope of supplemental medical insurance benefits described in part 410 of this chapter.

(b) *Waivers of Medicare coverage requirements.* The following Medicare requirements are waived for purposes of the PACE program and do not apply:

(1) The provisions of subpart F of part 409 of this chapter that limit coverage of institutional services.

(2) The provisions of subparts G and H of part 409 of this chapter, and parts 412 through 414 of this chapter that relate to payment for benefits.

(3) The provisions of subparts D and E of part 409 of this chapter that limit coverage of extended care services or home health services.

(4) The provisions of subpart D of part 409 of this chapter that impose a 3-day prior hospitalization requirement for coverage of extended care services.

(5) Section 411.15(g) and §411.15(k) of this chapter that may prevent payment for PACE program services that are provided to PACE participants.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71335, Dec. 8, 2006]

#### § 460.96 Excluded services.

The following services are excluded from coverage under PACE:

(a) Any service that is not authorized by the interdisciplinary team, even if it is a required service, unless it is an emergency service.

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

(c) Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

(d) Experimental medical, surgical, or other health procedures.

(e) Services furnished outside of the United States, except as follows:

(1) In accordance with §424.122 and §424.124 of this chapter.

(2) As permitted under the State's approved Medicaid plan.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71335, Dec. 8, 2006]

#### § 460.98 Service delivery.

(a) *Plan.* A PACE organization must establish and implement a written plan to furnish care that meets the needs of each participant in all care settings 24 hours a day, every day of the year.

(b) *Provision of services.* (1) The PACE organization must furnish comprehensive medical, health, and social services that integrate acute and long-term care.

(2) These services must be furnished in at least the PACE center, the home, and inpatient facilities.

(3) The PACE organization may not discriminate against any participant in the delivery of required PACE services based on race, ethnicity, national origin, religion, sex, age, sexual orientation, mental or physical disability, or source of payment.

(c) *Minimum services furnished at each PACE center.* At a minimum, the following services must be furnished at each PACE center:

(1) Primary care, including physician and nursing services.

(2) Social services.

(3) Restorative therapies, including physical therapy and occupational therapy.

(4) Personal care and supportive services.

(5) Nutritional counseling.

(6) Recreational therapy.

(7) Meals.

(d) *Pace Center operation.* (1) A PACE organization must operate at least one PACE center either in, or contiguous to, its defined service area with sufficient capacity to allow routine attendance by participants.

(2) A PACE organization must ensure accessible and adequate services to meet the needs of its participants. If necessary, a PACE organization must increase the number of PACE centers, staff, or other PACE services.

(3) If a PACE organization operates more than one center, each Pace center must offer the full range of services and have sufficient staff to meet the needs of participants.



## § 460.100

(e) *Center attendance.* The frequency of a participant's attendance at a center is determined by the interdisciplinary team, based on the needs and preferences of each participant.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71334, 71335, Dec. 8, 2006]

### § 460.100 Emergency care.

(a) *Written plan.* A PACE organization must establish and maintain a written plan to handle emergency care. The plan must ensure that CMS, the State, and PACE participants are held harmless if the PACE organization does not pay for emergency services.

(b) *Emergency care.* Emergency care is appropriate when services are needed immediately because of an injury or sudden illness and the time required to reach the PACE organization or one of its contract providers, would cause risk of permanent damage to the participant's health. Emergency services include inpatient and outpatient services that meet the following requirements:

(1) Are furnished by a qualified emergency services provider, other than the PACE organization or one of its contract providers, either in or out of the PACE organization's service area.

(2) Are needed to evaluate or stabilize an emergency medical condition.

(c) An emergency medical condition means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Serious jeopardy to the health of the participant.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(d) *Explanation to participant.* The organization must ensure that the participant or caregiver, or both, understand when and how to get access to emergency services and that no prior authorization is needed.

(e) *On-call providers.* The plan must provide for the following:

(1) An on-call provider, available 24-hours per day to address participant questions about emergency services

## 42 CFR Ch. IV (10–1–13 Edition)

and respond to requests for authorization of urgently needed out-of-network services and post stabilization care services following emergency services.

(2) Coverage of urgently needed out-of-network and post-stabilization care services when either of the following conditions are met:

(i) The services are preapproved by the PACE organization.

(ii) The services are not preapproved by the PACE organization because the PACE organization did not respond to a request for approval within 1 hour after being contacted or cannot be contacted for approval.

(3) *Definitions.* As used in this section, the following definitions apply:

(i) Post stabilization care means services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. They are not emergency services, which POs are obligated to cover. Rather, they are non-emergency services that the PO should approve before they are provided outside the service area.

(ii) Urgent care means the care provided to a PACE participant who is out of the PACE service area, and who believes their illness or injury is too severe to postpone treatment until they return to the service area, but their life or function is not in severe jeopardy.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71335, Dec. 8, 2006]

### § 460.102 Interdisciplinary team.

(a) *Basic requirement.* A PACE organization must meet the following requirements:

(1) Establish an interdisciplinary team at each Pace center to comprehensively assess and meet the individual needs of each participant.

(2) Assign each participant to an interdisciplinary team functioning at the PACE center that the participant attends.

(b) *Composition of interdisciplinary team.* The interdisciplinary team must be composed of at least the following members:

(1) Primary care physician.

(2) Registered nurse.

(3) Master's-level social worker.

- (4) Physical therapist.
- (5) Occupational therapist.
- (6) Recreational therapist or activity coordinator.
- (7) Dietitian.
- (8) PACE center manager.
- (9) Home care coordinator.
- (10) Personal care attendant or his or her representative.
- (11) Driver or his or her representative.

(c) *Primary care physician.* (1) Primary medical care must be furnished to a participant by a PACE primary care physician.

(2) Each primary care physician is responsible for the following:

(i) Managing a participant's medical situations.

(ii) Overseeing a participant's use of medical specialists and inpatient care.

(d) *Responsibilities of interdisciplinary team.* (1) The interdisciplinary team is responsible for the initial assessment, periodic reassessments, plan of care, and coordination of 24 hour care delivery.

(2) Each team member is responsible for the following:

(i) Regularly informing the interdisciplinary team of the medical, functional, and psychosocial condition of each participant.

(ii) Remaining alert to pertinent input from other team members, participants, and caregivers.

(iii) Documenting changes of a participant's condition in the participant's medical record consistent with documentation policies established by the medical director.

(3) The members of the interdisciplinary team must serve primarily PACE participants.

(e) *Exchange of information between team members.* The PACE organization must establish, implement, and maintain documented internal procedures governing the exchange of information between team members, contractors, and participants and their caregivers consistent with the requirements for confidentiality in § 460.200(e).

#### § 460.104 Participant assessment.

(a) *Initial comprehensive assessment—*

(1) *Basic requirement.* The interdisciplinary team must conduct an initial comprehensive assessment on each participant. The assessment must be completed promptly following enrollment.

(2) As part of the initial comprehensive assessment, each of the following members of the interdisciplinary team must evaluate the participant in person, at appropriate intervals, and develop a discipline-specific assessment of the participant's health and social status:

- (i) Primary care physician.
- (ii) Registered nurse.
- (iii) Master's-level social worker.
- (iv) Physical therapist.
- (v) Occupational therapist.
- (vi) Recreational therapist or activity coordinator.
- (vii) Dietitian.
- (viii) Home care coordinator.

(3) At the recommendation of individual team members, other professional disciplines (for example, speech-language pathology, dentistry, or audiology) may be included in the comprehensive assessment process.

(4) *Comprehensive assessment criteria.* The comprehensive assessment must include, but is not limited to, the following:

- (i) Physical and cognitive function and ability.
- (ii) Medication use.
- (iii) Participant and caregiver preferences for care.
- (iv) Socialization and availability of family support.
- (v) Current health status and treatment needs.
- (vi) Nutritional status.
- (vii) Home environment, including home access and egress.
- (viii) Participant behavior.
- (ix) Psychosocial status.
- (x) Medical and dental status.
- (xi) Participant language.

(b) *Development of plan of care.* The interdisciplinary team must promptly consolidate discipline-specific assessments into a single plan of care for each participant through discussion in team meetings and consensus of the entire interdisciplinary team. In developing the plan of care, female participants must be informed that they are

[64 FR 66279, Nov. 24, 1999, as amended at 67 FR 61506, Oct. 1, 2002; 71 FR 71334, 71336, Dec. 8, 2006]

entitled to choose a qualified specialist for women's health services from the PACE organization's network to furnish routine or preventive women's health services.

(c) *Periodic reassessment*—(1) *Semi-annual reassessment*. On at least a semi-annual basis, or more often if a participant's condition dictates, the following members of the interdisciplinary team must conduct an in-person reassessment:

- (i) Primary care physician.
- (ii) Registered nurse.
- (iii) Master's-level social worker.
- (iv) Recreational therapist or activity coordinator.
- (v) Other team members actively involved in the development or implementation of the participant's plan of care, for example, home care coordinator, physical therapist, occupational therapist, or dietitian.

(2) *Annual reassessment*. On at least an annual basis, the following members of the interdisciplinary team must conduct an in-person reassessment:

- (i) Physical therapist.
- (ii) Occupational therapist.
- (iii) Dietitian.
- (iv) Home care coordinator.

(d) *Unscheduled reassessments*. In addition to annual and semiannual reassessments, unscheduled reassessments may be required based on the following:

(1) *A change in participant status*. If the health or psychosocial status of a participant changes, the members of the interdisciplinary team, listed in paragraph (a)(2) of this section, must conduct an in-person reassessment.

(2) *At the request of the participant or designated representative*. If a participant (or his or her designated representative) believes that the participant needs to initiate, eliminate, or continue a particular service, the appropriate members of the interdisciplinary team, as identified by the interdisciplinary team, must conduct an in-person reassessment.

(i) The PACE organization must have explicit procedures for timely resolution of requests by a participant or his or her designated representative to initiate, eliminate, or continue a particular service.

(ii) Except as provided in paragraph (d)(2)(iii) of this section, the interdisciplinary team must notify the participant or designated representative of its decision to approve or deny the request from the participant or designated representative as expeditiously as the participant's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request for reassessment.

(iii) The interdisciplinary team may extend the 72-hour timeframe for notifying the participant or designated representative of its decision to approve or deny the request by no more than 5 additional days for either of the following reasons:

(A) The participant or designated representative requests the extension.

(B) The team documents its need for additional information and how the delay is in the interest of the participant.

(iv) The PACE organization must explain any denial of a request to the participant or the participant's designated representative orally and in writing. The PACE organization must provide the specific reasons for the denial in understandable language. The PACE organization is responsible for the following:

(A) Informing the participant or designated representative of his or her right to appeal the decision as specified in § 460.122.

(B) Describing both the standard and expedited appeals processes, including the right to, and conditions for, obtaining expedited consideration of an appeal of a denial of services as specified in § 460.122.

(C) Describing the right to, and conditions for, continuation of appealed services through the period of an appeal as specified in § 460.122(e).

(v) If the interdisciplinary team fails to provide the participant with timely notice of the resolution of the request or does not furnish the services required by the revised plan of care, this failure constitutes an adverse decision, and the participant's request must be automatically processed by the PACE organization as an appeal in accordance with § 460.122.

(e) *Changes to plan of care.* Team members who conduct a reassessment must meet the following requirements:

- (1) Reevaluate the participant's plan of care.
- (2) Discuss any changes in the plan with the interdisciplinary team.
- (3) Obtain approval of the revised plan from the interdisciplinary team and the participant (or designated representative).
- (4) Furnish any services included in the revised plan of care as a result of a reassessment to the participant as expeditiously as the participant's health condition requires.

(f) *Documentation.* Interdisciplinary team members must document all assessment and reassessment information in the participant's medical record.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71336, Dec. 8, 2006]

#### § 460.106 Plan of care.

(a) *Basic requirement.* The interdisciplinary team must promptly develop a comprehensive plan of care for each participant.

(b) *Content of plan of care.* The plan of care must meet the following requirements:

(1) Specify the care needed to meet the participant's medical, physical, emotional, and social needs, as identified in the initial comprehensive assessment.

(2) Identify measurable outcomes to be achieved.

(c) *Implementation of the plan of care.*

(1) The team must implement, coordinate, and monitor the plan of care whether the services are furnished by PACE employees or contractors.

(2) The team must continuously monitor the participant's health and psychosocial status, as well as the effectiveness of the plan of care, through the provision of services, informal observation, input from participants or caregivers, and communications among members of the interdisciplinary team and other providers.

(d) *Evaluation of plan of care.* On at least a semi-annual basis, the interdisciplinary team must reevaluate the plan of care, including defined outcomes, and make changes as necessary.

(e) *Participant and caregiver involvement in plan of care.* The team must develop, review, and reevaluate the plan of care in collaboration with the participant or caregiver, or both, to ensure that there is agreement with the plan of care and that the participant's concerns are addressed.

(f) *Documentation.* The team must document the plan of care, and any changes made to it, in the participant's medical record.

### Subpart G—Participant Rights

#### § 460.110 Bill of rights.

(a) *Written bill of rights.* A PACE organization must have a written participant bill of rights designed to protect and promote the rights of each participant. Those rights include, at a minimum, the ones specified in § 460.112.

(b) *Explanation of rights.* The organization must inform a participant upon enrollment, in writing, of his or her rights and responsibilities, and all rules and regulations governing participation.

(c) *Protection of rights.* The organization must protect and provide for the exercise of the participant's rights.

#### § 460.112 Specific rights to which a participant is entitled.

(a) *Respect and nondiscrimination.* Each participant has the right to considerate, respectful care from all PACE employees and contractors at all times and under all circumstances. Each participant has the right not to be discriminated against in the delivery of required PACE services based on race, ethnicity, national origin, religion, sex, age, sexual orientation, mental or physical disability, or source of payment. Specifically, each participant has the right to the following:

(1) To receive comprehensive health care in a safe and clean environment and in an accessible manner.

(2) To be treated with dignity and respect, be afforded privacy and confidentiality in all aspects of care, and be provided humane care.

(3) Not to be required to perform services for the PACE organization.

(4) To have reasonable access to a telephone.

(5) To be free from harm, including physical or mental abuse, neglect, corporal punishment, involuntary seclusion, excessive medication, and any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the participant's medical symptoms.

(6) To be encouraged and assisted to exercise rights as a participant, including the Medicare and Medicaid appeals processes as well as civil and other legal rights.

(7) To be encouraged and assisted to recommend changes in policies and services to PACE staff.

(b) *Information disclosure.* Each PACE participant has the right to receive accurate, easily understood information and to receive assistance in making informed health care decisions. Specifically, each participant has the following rights:

(1) To be fully informed in writing of the services available from the PACE organization, including identification of all services that are delivered through contracts, rather than furnished directly by the PACE organization at the following times:

(i) Before enrollment.

(ii) At enrollment.

(iii) At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.

(2) To have the enrollment agreement, described in § 460.154, fully explained in a manner understood by the participant.

(3) To examine, or upon reasonable request, to be assisted to examine the results of the most recent review of the PACE organization conducted by CMS or the State administering agency and any plan of correction in effect.

(c) *Choice of providers.* Each participant has the right to a choice of health care providers, within the PACE organization's network, that is sufficient to ensure access to appropriate high-quality health care. Specifically, each participant has the right to the following:

(1) To choose his or her primary care physician and specialists from within the PACE network.

(2) To request that a qualified specialist for women's health services fur-

nish routine or preventive women's health services.

(3) To disenroll from the program at any time.

(d) *Access to emergency services.* Each participant has the right to access emergency health care services when and where the need arises without prior authorization by the PACE interdisciplinary team.

(e) *Participation in treatment decisions.* Each participant has the right to participate fully in all decisions related to his or her treatment. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. Specifically, each participant has the following rights:

(1) To have all treatment options explained in a culturally competent manner and to make health care decisions, including the right to refuse treatment, and be informed of the consequences of the decisions.

(2) To have the PACE organization explain advance directives and to establish them, if the participant so desires, in accordance with §§ 489.100 and 489.102 of this chapter.

(3) To be fully informed of his or her health and functional status by the interdisciplinary team.

(4) To participate in the development and implementation of the plan of care.

(5) To request a reassessment by the interdisciplinary team.

(6) To be given reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer (that is, due to medical reasons or for the participant's welfare, or that of other participants). The PACE organization must document the justification in the participant's medical record.

(f) *Confidentiality of health information.* Each participant has the right to communicate with health care providers in confidence and to have the confidentiality of his or her individually identifiable health care information protected. Each participant also has the right to review and copy his or her own medical records and request amendments to those records. Specifically, each participant has the following rights:

(1) To be assured of confidential treatment of all information contained in the health record, including information contained in an automated data bank.

(2) To be assured that his or her written consent will be obtained for the release of information to persons not otherwise authorized under law to receive it.

(3) To provide written consent that limits the degree of information and the persons to whom information may be given.

(g) *Complaints and appeals.* Each participant has the right to a fair and efficient process for resolving differences with the PACE organization, including a rigorous system for internal review by the organization and an independent system of external review. Specifically, each participant has the following rights:

(1) To be encouraged and assisted to voice complaints to PACE staff and outside representatives of his or her choice, free of any restraint, interference, coercion, discrimination, or reprisal by the PACE staff.

(2) To appeal any treatment decision of the PACE organization, its employees, or contractors through the process described in § 460.122.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71336, Dec. 8, 2006]

#### § 460.114 Restraints.

(a) The PACE organization must limit use of restraints to the least restrictive and most effective method available. The term restraint includes either a physical restraint or a chemical restraint.

(1) A physical restraint is any manual method or physical or mechanical device, materials, or equipment attached or adjacent to the participant's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

(2) A chemical restraint is a medication used to control behavior or to restrict the participant's freedom of movement and is not a standard treatment for the participant's medical or psychiatric condition.

(b) If the interdisciplinary team determines that a restraint is needed to ensure the participant's physical safety

or the safety of others, the use must meet the following conditions:

(1) Be imposed for a defined, limited period of time, based upon the assessed needs of the participant.

(2) Be imposed in accordance with safe and appropriate restraining techniques.

(3) Be imposed only when other less restrictive measures have been found to be ineffective to protect the participant or others from harm.

(4) Be removed or ended at the earliest possible time.

(c) The condition of the restrained participant must be continually assessed, monitored, and reevaluated.

#### § 460.116 Explanation of rights.

(a) *Written policies.* A PACE organization must have written policies and implement procedures to ensure that the participant, his or her representative, if any, and staff understand these rights.

(b) *Explanation of rights.* The PACE organization must fully explain the rights to the participant and his or her representative, if any, at the time of enrollment in a manner understood by the participant.

(c) *Display.* The PACE organization must meet the following requirements:

(1) Write the participant rights in English and in any other principal languages of the community.

(2) Display the participant rights in a prominent place in the PACE center.

#### § 460.118 Violation of rights.

The PACE organization must have established documented procedures to respond to and rectify a violation of a participant's rights.

#### § 460.120 Grievance process.

For purposes of this part, a grievance is a complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished.

(a) *Process to resolve grievances.* A PACE organization must have a formal written process to evaluate and resolve medical and nonmedical grievances by participants, their family members, or representatives.

(b) *Notification to participants.* Upon enrollment, and at least annually

## § 460.122

## 42 CFR Ch. IV (10–1–13 Edition)

thereafter, the PACE organization must give a participant written information on the grievance process.

(c) *Minimum requirements.* At a minimum, the PACE organization's grievance process must include written procedures for the following:

(1) How a participant files a grievance.

(2) Documentation of a participant's grievance.

(3) Response to, and resolution of, grievances in a timely manner.

(4) Maintenance of confidentiality of a participant's grievance.

(d) *Continuing care during grievance process.* The PACE organization must continue to furnish all required services to the participant during the grievance process.

(e) *Explaining the grievance process.* The PACE organization must discuss with and provide to the participant in writing the specific steps, including timeframes for response, that will be taken to resolve the participant's grievance.

(f) *Analyzing grievance information.* The PACE organization must maintain, aggregate, and analyze information on grievance proceedings. This information must be used in the PACE organization's internal quality assessment and performance improvement program.

### § 460.122 PACE organization's appeals process.

For purposes of this section, an appeal is a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for, a service including denials, reductions, or termination of services.

(a) *PACE organization's written appeals process.* The PACE organization must have a formal written appeals process, with specified timeframes for response, to address noncoverage or nonpayment of a service.

(b) *Notification of participants.* Upon enrollment, at least annually thereafter, and whenever the interdisciplinary team denies a request for services or payment, the PACE organization must give a participant written information on the appeals process.

(c) *Minimum requirements.* At a minimum, the PACE organization's ap-

peals process must include written procedures for the following:

(1) Timely preparation and processing of a written denial of coverage or payment as provided in § 460.104(c)(3).

(2) How a participant files an appeal.

(3) Documentation of a participant's appeal.

(4) Appointment of an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal to review the participant's appeal.

(5) Responses to, and resolution of, appeals as expeditiously as the participant's health condition requires, but no later than 30 calendar days after the organization receives an appeal.

(6) Maintenance of confidentiality of appeals.

(d) *Notification.* A PACE organization must give all parties involved in the appeal the following:

(1) Appropriate written notification.

(2) A reasonable opportunity to present evidence related to the dispute, in person, as well as in writing.

(e) *Services furnished during appeals process.* During the appeals process, the PACE organization must meet the following requirements:

(1) For a Medicaid participant, continue to furnish the disputed services until issuance of the final determination if the following conditions are met:

(i) The PACE organization is proposing to terminate or reduce services currently being furnished to the participant.

(ii) The participant requests continuation with the understanding that he or she may be liable for the costs of the contested services if the determination is not made in his or her favor.

(2) Continue to furnish to the participant all other required services, as specified in subpart F of this part.

(f) *Expedited appeals process.* (1) A PACE organization must have an expedited appeals process for situations in which the participant believes that his or her life, health, or ability to regain or maintain maximum function could be seriously jeopardized, absent provision of the service in dispute.

(2) Except as provided in paragraph (f)(3) of this section, the PACE organization must respond to the appeal as expeditiously as the participant's health condition requires, but no later than 72 hours after it receives the appeal.

(3) The PACE organization may extend the 72-hour timeframe by up to 14 calendar days for either of the following reasons:

(i) The participant requests the extension.

(ii) The organization justifies to the State administering agency the need for additional information and how the delay is in the interest of the participant.

(g) Determination in favor of participant. A PACE organization must furnish the disputed service as expeditiously as the participant's health condition requires if a determination is made in favor of the participant on appeal.

(h) Determination adverse to participant. For a determination that is wholly or partially adverse to a participant, at the same time the decision is made, the PACE organization must notify the following:

- (1) CMS.
- (2) The State administering agency.
- (3) The participant.

(i) *Analyzing appeals information.* A PACE organization must maintain, aggregate, and analyze information on appeal proceedings and use this information in the organization's internal quality assessment and performance improvement program.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71336, Dec. 8, 2006]

#### **§ 460.124 Additional appeal rights under Medicare or Medicaid.**

A PACE organization must inform a participant in writing of his or her appeal rights under Medicare or Medicaid managed care, or both, assist the participant in choosing which to pursue if both are applicable, and forward the appeal to the appropriate external entity.

### **Subpart H—Quality Assessment and Performance Improvement**

#### **§ 460.130 General rule.**

(a) A PACE organization must develop, implement, maintain, and evaluate an effective, data-driven quality assessment and performance improvement program.

(b) The program must reflect the full range of services furnished by the PACE organization.

(c) A PACE organization must take actions that result in improvements in its performance in all types of care.

#### **§ 460.132 Quality assessment and performance improvement plan.**

(a) *Basic rule.* A PACE organization must have a written quality assessment and performance improvement plan.

(b) *Annual review.* The PACE governing body must review the plan annually and revise it, if necessary.

(c) *Minimum plan requirements.* At a minimum, the plan must specify how the PACE organization proposes to meet the following requirements:

- (1) Identify areas to improve or maintain the delivery of services and patient care.
- (2) Develop and implement plans of action to improve or maintain quality of care.
- (3) Document and disseminate to PACE staff and contractors the results from the quality assessment and performance improvement activities.

#### **§ 460.134 Minimum requirements for quality assessment and performance improvement program.**

(a) *Minimum program requirements.* A PACE organization's quality assessment and performance improvement program must include, but is not limited to, the use of objective measures to demonstrate improved performance with regard to the following:

- (1) Utilization of PACE services, such as decreased inpatient hospitalizations and emergency room visits.
- (2) Caregiver and participant satisfaction.
- (3) Outcome measures that are derived from data collected during assessments, including data on the following:



**§ 460.136**

- (i) Physiological well being.
  - (ii) Functional status.
  - (iii) Cognitive ability.
  - (iv) Social/behavioral functioning.
  - (v) Quality of life of participants.
- (4) Effectiveness and safety of staff-provided and contracted services, including the following:

- (i) Competency of clinical staff.
  - (ii) Promptness of service delivery.
  - (iii) Achievement of treatment goals and measurable outcomes.
- (5) Nonclinical areas, such as grievances and appeals, transportation services, meals, life safety, and environmental issues.

(b) *Basis for outcome measures.* Outcome measures must be based on current clinical practice guidelines and professional practice standards applicable to the care of PACE participants.

(c) *Minimum levels of performance.* The PACE organization must meet or exceed minimum levels of performance, established by CMS and the State administering agency, on standardized quality measures, such as influenza immunization rates, which are specified in the PACE program agreement.

(d) *Accuracy of data.* The PACE organization must ensure that all data used for outcome monitoring are accurate and complete.

**§ 460.136 Internal quality assessment and performance improvement activities.**

(a) *Quality assessment and performance improvement requirements.* A PACE organization must do the following:

- (1) Use a set of outcome measures to identify areas of good or problematic performance.
- (2) Take actions targeted at maintaining or improving care based on outcome measures.
- (3) Incorporate actions resulting in performance improvement into standards of practice for the delivery of care and periodically track performance to ensure that any performance improvements are sustained over time.
- (4) Set priorities for performance improvement, considering prevalence and severity of identified problems, and give priority to improvement activities that affect clinical outcomes.
- (5) Immediately correct any identified problem that directly or poten-

**42 CFR Ch. IV (10–1–13 Edition)**

tially threatens the health and safety of a PACE participant.

(b) *Quality assessment and performance improvement coordinator.* A PACE organization must designate an individual to coordinate and oversee implementation of quality assessment and performance improvement activities.

(c) *Involvement in quality assessment and performance improvement activities.*

(1) A PACE organization must ensure that all interdisciplinary team members, PACE staff, and contract providers are involved in the development and implementation of quality assessment and performance improvement activities and are aware of the results of these activities.

(2) The quality improvement coordinator must encourage a PACE participant and his or her caregivers to be involved in quality assessment and performance improvement activities, including providing information about their satisfaction with services.

**§ 460.138 Committees with community input.**

A PACE organization must establish one or more committees, with community input, to do the following:

- (a) Evaluate data collected pertaining to quality outcome measures.
- (b) Address the implementation of, and results from, the quality assessment and performance improvement plan.
- (c) Provide input related to ethical decisionmaking, including end-of-life issues and implementation of the Patient Self-Determination Act.

**§ 460.140 Additional quality assessment activities.**

A PACE organization must meet external quality assessment and reporting requirements, as specified by CMS or the State administering agency, in accordance with § 460.202.

**Subpart I—Participant Enrollment and Disenrollment**

**§ 460.150 Eligibility to enroll in a PACE program.**

(a) *General rule.* To enroll in a PACE program, an individual must meet eligibility requirements specified in this section. To continue to be eligible for

PACE, an individual must meet the annual recertification requirements specified in § 460.160.

(b) *Basic eligibility requirements.* To be eligible to enroll in PACE, an individual must meet the following requirements:

(1) Be 55 years of age or older.

(2) Be determined by the State administering agency to need the level of care required under the State Medicaid plan for coverage of nursing facility services, which indicates that the individual's health status is comparable to the health status of individuals who have participated in the PACE demonstration waiver programs.

(3) Reside in the service area of the PACE organization.

(4) Meet any additional program specific eligibility conditions imposed under the PACE program agreement. These additional conditions may not modify the requirements of paragraph (b)(1) through (b)(3) of this section.

(c) *Other eligibility requirements.* (1) At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety.

(2) The criteria used to determine if an individual's health or safety would be jeopardized by living in a community setting must be specified in the program agreement.

(d) *Eligibility under Medicare and Medicaid.* Eligibility to enroll in a PACE program is not restricted to an individual who is either a Medicare beneficiary or Medicaid beneficiary. A potential PACE enrollee may be, but is not required to be, any or all of the following:

(1) Entitled to Medicare Part A.

(2) Enrolled under Medicare Part B.

(3) Eligible for Medicaid.

#### § 460.152 Enrollment process.

(a) *Intake process.* Intake is an intensive process during which PACE staff members make one or more visits to a potential participant's place of residence and the potential participant makes one or more visits to the PACE center. At a minimum, the intake process must include the following activities:

(1) The PACE staff must explain to the potential participant and his or her

representative or caregiver the following information:

(i) The PACE program, using a copy of the enrollment agreement described in § 460.154, specifically references the elements of the agreement including but not limited to § 460.154(e), (i) through (m), and (r).

(ii) The requirement that the PACE organization would be the participant's sole service provider and clarification that the PACE organization guarantees access to services, but not to a specific provider.

(iii) A list of the employees of the PACE organization who furnish care and the most current list of contracted health care providers under § 460.70(c).

(iv) Monthly premiums, if any.

(v) Any Medicaid spenddown obligations.

(vi) Post-eligibility treatment of income.

(2) The potential participant must sign a release to allow the PACE organization to obtain his or her medical and financial information and eligibility status for Medicare and Medicaid.

(3) The State administering agency must assess the potential participant, including any individual who is not eligible for Medicaid, to ensure that he or she needs the level of care required under the State Medicaid plan for coverage of nursing facility services, which indicates that the individual's health status is comparable to the health status of individuals who have participated in the PACE demonstration waiver programs.

(4) PACE staff must assess the potential participant to ensure that he or she can be cared for appropriately in a community setting and that he or she meets all requirements for PACE eligibility specified in this part.

(b) *Denial of Enrollment.* If a prospective participant is denied enrollment because his or her health or safety would be jeopardized by living in a community setting, the PACE organization must meet the following requirements:

(1) Notify the individual in writing of the reason for the denial.

(2) Refer the individual to alternative services, as appropriate.

## § 460.154

## 42 CFR Ch. IV (10–1–13 Edition)

(3) Maintain supporting documentation of the reason for the denial.

(4) Notify CMS and the State administering agency and make the documentation available for review.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71337, Dec. 8, 2006]

### § 460.154 Enrollment agreement.

If the potential participant meets the eligibility requirements and wants to enroll, he or she must sign an enrollment agreement which contains, at a minimum, the following information:

(a) Applicant's name, sex, and date of birth.

(b) Medicare beneficiary status (Part A, Part B, or both) and number, if applicable.

(c) Medicaid beneficiary status and number, if applicable.

(d) Other health insurance information, if applicable.

(e) Conditions for enrollment and disenrollment in PACE.

(f) Description of participant premiums, if any, and procedures for payment of premiums.

(g) Notification that a Medicaid participant and a participant who is eligible for both Medicare and Medicaid are not liable for any premiums, but may be liable for any applicable spenddown liability under §§ 435.121 and 435.831 of this chapter and any amounts due under the post-eligibility treatment of income process under § 460.184.

(h) Notification that a Medicare participant may not enroll or disenroll at a Social Security office.

(i) Notification that enrollment in PACE results in disenrollment from any other Medicare or Medicaid prepayment plan or optional benefit. Electing enrollment in any other Medicare or Medicaid prepayment plan or optional benefit, including the hospice benefit, after enrolling as a PACE participant is considered a voluntary disenrollment from PACE.

(j) Information on the consequences of subsequent enrollment in other optional Medicare or Medicaid programs following disenrollment from PACE.

(k) Description of PACE services available, including all Medicare and Medicaid covered services, and how services are obtained from the PACE organization.

(l) Description of the procedures for obtaining emergency and urgently needed out-of-network services.

(m) The participant bill of rights.

(n) Information on the process for grievances and appeals and Medicare/Medicaid phone numbers for use in appeals.

(o) Notification of a participant's obligation to inform the PACE organization of a move or lengthy absence from the organization's service area.

(p) An acknowledgment by the applicant or representative that he or she understands the requirement that the PACE organization must be the applicant's sole service provider.

(q) A statement that the PACE organization has an agreement with CMS and the State administering agency that is subject to renewal on a periodic basis and, if the agreement is not renewed, the program will be terminated.

(r) The applicant's authorization for disclosure and exchange of personal information between CMS, its agents, the State administering agency, and the PACE organization.

(s) The effective date of enrollment.

(t) The signature of the applicant or his or her designated representative and the date.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71337, Dec. 8, 2006]

### § 460.156 Other enrollment procedures.

(a) *Items a PACE organization must give a participant upon enrollment.* After the participant signs the enrollment agreement, the PACE organization must give the participant the following:

(1) A copy of the enrollment agreement.

(2) A PACE membership card.

(3) Emergency information to be posted in his or her home identifying the individual as a PACE participant and explaining how to access emergency services.

(4) Stickers for the participant's Medicare and Medicaid cards, as applicable, which indicate that he or she is a PACE participant and include the phone number of the PACE organization.

(b) *Submittal of participant information to CMS and the State.* The PACE organization must submit participant information to CMS and the State administering agency, in accordance with established procedures.

(c) *Changes in enrollment agreement information.* If there are changes in the enrollment agreement information at any time during the participant's enrollment, the PACE organization must meet the following requirements:

(1) Give an updated copy of the information to the participant.

(2) Explain the changes to the participant and his or her representative or caregiver in a manner they understand.

**§ 460.158 Effective date of enrollment.**

A participant's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

**§ 460.160 Continuation of enrollment.**

(a) *Duration of enrollment.* Enrollment continues until the participant's death, regardless of changes in health status, unless either of the following actions occur:

(1) The participant voluntarily disenrolls.

(2) The participant is involuntarily disenrolled, as described in § 460.164.

(b) *Annual recertification requirement.* At least annually, the State administering agency must reevaluate whether a participant needs the level of care required under the State Medicaid plan for coverage of nursing facility services.

(1) *Waiver of annual requirement.* (i) The State administering agency may permanently waive the annual recertification requirement for a participant if it determines that there is no reasonable expectation of improvement or significant change in the participant's condition because of the severity of a chronic condition or the degree of impairment of functional capacity.

(ii) The PACE organization must retain in the participant's medical record the documentation of the reason for waiving the annual recertification requirement.

(2) *Deemed continued eligibility.* If the State administering agency determines

that a PACE participant no longer meets the State Medicaid nursing facility level of care requirements, the participant may be deemed to continue to be eligible for the PACE program until the next annual reevaluation, if, in the absence of continued coverage under this program, the participant reasonably would be expected to meet the nursing facility level of care requirement within the next 6 months.

(3) *Continued eligibility criteria.* (i) The State administering agency, must establish criteria to use in making the determination of "deemed continued eligibility." The State administering agency, in consultation with the PACE organization, makes a determination of deemed continued eligibility based on a review of the participant's medical record and plan of care. These criteria must be applied in reviewing the participant's medical record and plan of care.

(ii) The criteria used to make the determination of continued eligibility must be specified in the program agreement.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71337, Dec. 8, 2006]

**§ 460.162 Voluntary disenrollment.**

A PACE participant may voluntarily disenroll from the program without cause at any time.

**§ 460.164 Involuntary disenrollment.**

(a) *Reasons for involuntary disenrollment.* A participant may be involuntarily disenrolled for any of the following reasons:

(1) The participant fails to pay, or to make satisfactory arrangements to pay, any premium due the PACE organization after a 30-day grace period.

(2) The participant engages in disruptive or threatening behavior, as described in paragraph (b) of this section.

(3) The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(4) The participant is determined to no longer meet the State Medicaid nursing facility level of care requirements and is not deemed eligible.

**§ 460.166**

(5) The PACE program agreement with CMS and the State administering agency is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of State licenses or contracts with outside providers.

(b) *Disruptive or threatening behavior.* For purposes of this section, a participant who engages in disruptive or threatening behavior refers to a participant who exhibits either of the following:

(1) A participant whose behavior jeopardizes his or her health or safety, or the safety of others; or

(2) A participant with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.

(c) *Documentation of disruptive or threatening behavior.* If a PACE organization proposes to disenroll a participant who is disruptive or threatening, the organization must document the following information in the participant's medical record:

(1) The reasons for proposing to disenroll the participant.

(2) All efforts to remedy the situation.

(d) *Noncompliant behavior.* (1) A PACE organization may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior jeopardizes his or her health or safety, or the safety of others.

(2) For purposes of this section, noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

(e) *State administering agency review and final determination.* Before an involuntary disenrollment is effective, the State administering agency must review it and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.

**42 CFR Ch. IV (10-1-13 Edition)**

**§ 460.166 Effective date of disenrollment.**

(a) In disenrolling a participant, the PACE organization must take the following actions:

(1) Use the most expedient process allowed under Medicare and Medicaid procedures, as set forth in the PACE program agreement.

(2) Coordinate the disenrollment date between Medicare and Medicaid (for a participant who is eligible for both Medicare and Medicaid).

(3) Give reasonable advance notice to the participant.

(b) Until the date enrollment is terminated, the following requirements must be met:

(1) PACE participants must continue to use PACE organization services and remain liable for any premiums.

(2) The PACE organization must continue to furnish all needed services.

**§ 460.168 Reinstatement in other Medicare and Medicaid programs.**

To facilitate a participant's reinstatement in other Medicare and Medicaid programs after disenrollment, the PACE organization must do the following:

(a) Make appropriate referrals and ensure medical records are made available to new providers in a timely manner.

(b) Work with CMS and the State administering agency to reinstate the participant in other Medicare and Medicaid programs for which the participant is eligible.

**§ 460.170 Reinstatement in PACE.**

(a) A previously disenrolled participant may be reinstated in a PACE program.

(b) If the reason for disenrollment is failure to pay the premium and the participant pays the premium before the effective date of disenrollment, the participant is reinstated in the PACE program with no break in coverage.

**§ 460.172 Documentation of disenrollment.**

A PACE organization must meet the following requirements:

(a) Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments.

(b) Make documentation available for review by CMS and the State administering agency.

(c) Use the information on voluntary disenrollments in the PACE organization's internal quality assessment and performance improvement program.

### Subpart J—Payment

#### § 460.180 Medicare payment to PACE organizations.

(a) *Principle of payment.* Under a PACE program agreement, CMS makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicare participant in a payment area based on the rate it pays to a Medicare Advantage organization.

(b) *Determination of rate.* (1) The PACE program agreement specifies the methodology used to calculate the monthly capitation amount applicable to a PACE organization.

(2) Except as specified in paragraph (b)(4) of this section, the monthly capitation amount is based on the Part A and Part B payment rates established for purposes of payment to Medicare Advantage organizations. As used in this section, "Medicare Advantage rates" means the Part A and Part B rates calculated by CMS for making payment to Medicare Advantage organizations under section 1853(c) of the Act.

(3) CMS will adjust the monthly capitation payment amount derived under paragraph (b)(2) of this section based on a risk adjustment that reflects the individual's health status. CMS will ensure that payments take into account the comparative frailty of PACE enrollees relative to the general Medicare population.

(4) For Medicare participants who require ESRD services, the monthly capitation amount is based on the Medicare Advantage ESRD risk adjustment model.

(5) CMS may adjust the monthly capitation amount to take into account other factors CMS determines to be appropriate.

(6) The monthly capitation payment is a fixed amount, regardless of changes in the participant's health status.

(7) The monthly capitation payment amount is an all-inclusive payment for Medicare benefits provided to participants. A PACE organization must not seek any additional payment from Medicare. The only additional payment that a PACE organization may collect from, or on behalf of, a Medicare participant for PACE services is the following:

(i) Any applicable premium amount specified in § 460.186.

(ii) Any charge permitted under paragraph (d) of this section when Medicare is not the primary payer.

(iii) Any payment from the State, as specified in § 460.182, for a participant who is eligible for both Medicare and Medicaid.

(iv) Payment with respect to any applicable spenddown liability under §§ 435.121 and 435.831 of this chapter and any amount due under the post-eligibility treatment of income process under § 460.184 for a participant who is eligible for both Medicare and Medicaid.

(8) CMS computes the Medicare monthly capitation payment amount under a PACE program agreement so that the total payment level for all participants is less than the projected payment under Medicare for a comparable population not enrolled under a PACE program.

(c) *Adjustments to payments.* If the actual number of Medicare participants differs from the estimated number of participants on which the amount of the prospective monthly payment was based, CMS adjusts subsequent monthly payments to account for the difference.

(d) *Application of Medicare secondary payer provisions—*(1) *Basic rule.* CMS does not pay for services to the extent that Medicare is not the primary payer under part 411 of this chapter.

(2) *Responsibilities of the PACE organization.* The PACE organization must do the following:

(i) Identify payers that are primary to Medicare under part 411 of this chapter.

(ii) Determine the amounts payable by those payers.

(iii) Coordinate benefits to Medicare participants with the benefits of the primary payers.

**§ 460.182**

**42 CFR Ch. IV (10–1–13 Edition)**

(3) *Charges to other entities.* The PACE organization may charge other individuals or entities for PACE services covered under Medicare for which Medicare is not the primary payer, as specified in paragraphs (d)(4) and (5) of this section.

(4) *Charge to other insurers or the participant.* If a Medicare participant receives from a PACE organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the PACE organization may charge any of the following:

(i) The insurance carrier, the employer, or any other entity that is liable for payment for the services under part 411 of this chapter.

(ii) The Medicare participant, to the extent that he or she has been paid by the carrier, employer, or other entity.

(5) *Charge to group health plan (GHP) or large group health plan (LGHP).* If Medicare is not the primary payer for services that a PACE organization furnished to a Medicare participant who is covered under a GHP or LGHP, the organization may charge the following:

(i) GHP or LGHP for those services.

(ii) Medicare participant to the extent that he or she has been paid by the GHP or LGHP for those services.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71337, Dec. 8, 2006]

**§ 460.182 Medicaid payment.**

(a) Under a PACE program agreement, the State administering agency makes a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid participant.

(b) The monthly capitation payment amount is negotiated between the PACE organization and the State administering agency, and specified in the PACE program agreement. The amount represents the following:

(1) Is less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program.

(2) Takes into account the comparative frailty of PACE participants.

(3) Is a fixed amount regardless of changes in the participant's health status.

(4) Can be renegotiated on an annual basis.

(c) The PACE organization must accept the capitation payment amount as payment in full for Medicaid participants and may not bill, charge, collect, or receive any other form of payment from the State administering agency or from, or on behalf of, the participant, except as follows:

(1) Payment with respect to any applicable spenddown liability under §§ 435.121 and 435.831 of this chapter and any amounts due under the post-eligibility treatment of income process under § 460.184.

(2) Medicare payment received from CMS or from other payers, in accordance with § 460.180(d).

(d) State procedures for the enrollment and disenrollment of participants in the State's 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, are included in the PACE program agreement.

**§ 460.184 Post-eligibility treatment of income.**

(a) A State may provide for post-eligibility treatment of income for Medicaid participants in the same manner as a State treats post-eligibility income for individuals receiving services under a waiver under section 1915(c) of the Act.

(b) Post-eligibility treatment of income is applied as it is under a waiver of section 1915(c) of the Act, as specified in §§ 435.726 and 435.735 of this chapter, and section 1924 of the Act.

**§ 460.186 PACE premiums.**

The amount that a PACE organization can charge a participant as a monthly premium depends on the participant's eligibility under Medicare and Medicaid, as follows:

(a) *Medicare Parts A and B.* For a participant who is entitled to Medicare Part A, enrolled under Medicare Part B, but not eligible for Medicaid, the

premium equals the Medicaid capitation amount.

(b) *Medicare Part A only.* For a participant who is entitled to Medicare Part A, not enrolled under Medicare Part B, and not eligible for Medicaid, the premium equals the Medicaid capitation amount plus the Medicare Part B capitation rate.

(c) *Medicare Part B only.* For a participant who is enrolled only under Medicare Part B and not eligible for Medicaid, the premium equals the Medicaid capitation amount plus the Medicare Part A capitation rate.

(d) *Medicaid, with or without Medicare.* A PACE organization may not charge a premium to a participant who is eligible for both Medicare and Medicaid, or who is only eligible for Medicaid.

### Subpart K—Federal/State Monitoring

#### § 460.190 Monitoring during trial period.

(a) *Trial period review.* During the trial period, CMS, in cooperation with the State administering agency, conducts comprehensive annual reviews of the operations of a PACE organization to ensure compliance with the requirements of this part.

(b) *Scope of review.* The review includes the following:

(1) An onsite visit to the PACE organization, which may include, but is not limited to, the following:

(i) Review of participants' charts.

(ii) Interviews with staff.

(iii) Interviews with participants and caregivers.

(iv) Interviews with contractors.

(v) Observation of program operations, including marketing, participant services, enrollment and disenrollment procedures, grievances, and appeals.

(2) A comprehensive assessment of an organization's fiscal soundness.

(3) A comprehensive assessment of the organization's capacity to furnish all PACE services to all participants.

(4) Any other elements that CMS or the State administering agency find necessary.

#### § 460.192 Ongoing monitoring after trial period.

(a) At the conclusion of the trial period, CMS, in cooperation with the State administering agency, continues to conduct reviews of a PACE organization, as appropriate, taking into account the quality of care furnished and the organization's compliance with all of the requirements of this part.

(b) Reviews include an on-site visit at least every 2 years.

#### § 460.194 Corrective action.

(a) A PACE organization must take action to correct deficiencies identified during reviews.

(b) CMS or the State administering agency monitors the effectiveness of corrective actions.

(c) Failure to correct deficiencies may result in sanctions or termination, as specified in subpart D of this part.

#### § 460.196 Disclosure of review results.

(a) CMS and the State administering agency promptly report the results of reviews under §§ 460.190 and 460.192 to the PACE organization, along with any recommendations for changes to the organization's program.

(b) CMS and the State administering agency make the results of reviews available to the public upon request.

(c) The PACE organization must post a notice of the availability of the results of the most recent review and any plans of correction or responses related to the most recent review.

(d) The PACE organization must make the review results available for examination in a place readily accessible to participants.

### Subpart L—Data Collection, Record Maintenance, and Reporting

#### § 460.200 Maintenance of records and reporting of data.

(a) *General rule.* A PACE organization must collect data, maintain records, and submit reports as required by CMS and the State administering agency.

(b) *Access to data and records.* A PACE organization must allow CMS and the State administering agency access to



## § 460.202

data and records including, but not limited to, the following:

- (1) Participant health outcomes data.
- (2) Financial books and records.
- (3) Medical records.
- (4) Personnel records.

(c) *Reporting.* A PACE organization must submit to CMS and the State administering agency all reports that CMS and the State administering agency require to monitor the operation, cost, quality, and effectiveness of the program and establish payment rates.

(d) *Safeguarding data and records.* A PACE organization must establish written policies and implement procedures to safeguard all data, books, and records against loss, destruction, unauthorized use, or inappropriate alteration.

(e) *Confidentiality of health information.* A PACE organization must establish written policies and implement procedures to do the following:

(1) Safeguard the privacy of any information that identifies a particular participant. Information from, or copies of, records may be released only to authorized individuals. Original medical records are released only in accordance with Federal or State laws, court orders, or subpoenas.

(2) Maintain complete records and relevant information in an accurate and timely manner.

(3) Grant each participant timely access, upon request, to review and copy his or her own medical records and to request amendments to those records.

(4) Abide by all Federal and State laws regarding confidentiality and disclosure for mental health records, medical records, and other participant health information.

(f) *Retention of records.* (1) A PACE organization must retain records for the longest of the following periods:

(i) The period of time specified in State law.

(ii) Six years from the last entry date.

(iii) For medical records of disenrolled participants, 6 years after the date of disenrollment.

(2) If litigation, a claim, a financial management review, or an audit arising from the operation of the PACE program is started before the expiration of the retention period, specified

## 42 CFR Ch. IV (10–1–13 Edition)

in paragraph (f)(1) of this section, the PACE organization must retain the records until the completion of the litigation, or resolution of the claims or audit findings.

### § 460.202 Participant health outcomes data.

(a) A PACE organization must establish and maintain a health information system that collects, analyzes, integrates, and reports data necessary to measure the organization's performance, including outcomes of care furnished to participants.

(b) A PACE organization must furnish data and information pertaining to its provision of participant care in the manner, and at the time intervals, specified by CMS and the State administering agency. The items collected are specified in the PACE program agreement.

### § 460.204 Financial recordkeeping and reporting requirements.

(a) *Accurate reports.* A PACE organization must provide CMS and the State administering agency with accurate financial reports that are—

(1) Prepared using an accrual basis of accounting; and

(2) Verifiable by qualified auditors.

(b) *Accrual accounting.* A PACE organization must maintain an accrual accounting recordkeeping system that does the following:

(1) Accurately documents all financial transactions.

(2) Provides an audit trail to source documents.

(3) Generates financial statements.

(c) *Accepted reporting practices.* Except as specified under Medicare principles of reimbursement, as defined in part 413 of this chapter, a PACE organization must follow standardized definitions, accounting, statistical, and reporting practices that are widely accepted in the health care industry.

(d) *Audit or inspection.* A PACE organization must permit CMS and the State administering agency to audit or inspect any books and records of original entry that pertain to the following:

(1) Any aspect of services furnished.

(2) Reconciliation of participants' benefit liabilities.

(3) Determination of Medicare and Medicaid amounts payable.

**§ 460.208 Financial statements.**

(a) *General rule.* (1) Not later than 180 days after the organization's fiscal year ends, a PACE organization must submit a certified financial statement that includes appropriate footnotes.

(2) The financial statement must be certified by an independent certified public accountant.

(b) *Contents.* At a minimum, the certified financial statement must consist of the following:

(1) A certification statement.

(2) A balance sheet.

(3) A statement of revenues and expenses.

(4) A source and use of funds statement.

(c) *Quarterly financial statement*—(1) *During trial period.* A PACE organization must submit a quarterly financial statement throughout the trial period within 45 days after the last day of each quarter of the PACE organization's fiscal year.

(2) *After trial period.* If CMS or the State administering agency determines that an organization's performance requires more frequent monitoring and oversight due to concerns about fiscal soundness, CMS or the State administering agency may require a PACE organization to submit monthly or quarterly financial statements, or both.

**§ 460.210 Medical records.**

(a) *Maintenance of medical records.* (1) A PACE organization must maintain a single, comprehensive medical record for each participant, in accordance with accepted professional standards.

(2) The medical record for each participant must meet the following requirements:

(i) Be complete.

(ii) Accurately documented.

(iii) Readily accessible.

(iv) Systematically organized.

(v) Available to all staff.

(vi) Maintained and housed at the PACE center where the participant receives services.

(b) *Content of medical records.* At a minimum, the medical record must contain the following:

(1) Appropriate identifying information.

(2) Documentation of all services furnished, including the following:

(i) A summary of emergency care and other inpatient or long-term care services.

(ii) Services furnished by employees of the PACE center.

(iii) Services furnished by contractors and their reports.

(3) Interdisciplinary assessments, reassessments, plans of care, treatment, and progress notes that include the participant's response to treatment.

(4) Laboratory, radiological and other test reports.

(5) Medication records.

(6) Hospital discharge summaries, if applicable.

(7) Reports of contact with informal support (for example, caregiver, legal guardian, or next of kin).

(8) Enrollment Agreement.

(9) Physician orders.

(10) Discharge summary and disenrollment justification, if applicable.

(11) Advance directives, if applicable.

(12) A signed release permitting disclosure of personal information.

(c) *Transfer of medical records.* The organization must promptly transfer copies of medical record information between treatment facilities.

(d) *Authentication of medical records.*

(1) All entries must be legible, clear, complete, and appropriately authenticated and dated.

(2) Authentication must include signatures or a secured computer entry by a unique identifier of the primary author who has reviewed and approved the entry.

[64 FR 66279, Nov. 24, 1999, as amended at 71 FR 71337, Dec. 8, 2006]