

§ 460.28

(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]

EFFECTIVE DATE NOTE: At 67 FR 61505, Oct. 1, 2002, § 460.26 was added, effective Oct. 31, 2002.

§ 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 in writing of the basis for 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]

EFFECTIVE DATE NOTE: At 67 FR 61505, Oct. 1, 2002, § 460.28 was added, effective Oct. 31, 2002.

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.

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(b) The agreement must be signed by an authorized official of the PACE organization.

EFFECTIVE DATE NOTE: At 67 FR 61505, Oct. 1, 2002, § 460.30 was amended by revising paragraph (b) and adding paragraph (c), effective Oct. 31, 2002. For the convenience of the user, the revised and added text is set forth as follows:

§ 460.30 Program agreement requirement.

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(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.

§ 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 capitation rates for Medicare and Medicaid.

(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.

§ 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 recipients, 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 recipients 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