

§ 460.104

42 CFR Ch. IV (10–1–00 Edition)

- (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 multidisciplinary team.* (1) The multidisciplinary 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 multidisciplinary 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 in a participant's condition in the participant's medical record.

(3) Except as specified in paragraph (g) of this section, the members of the multidisciplinary 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).

(f) *Organization employees.* Except as specified in paragraph (g) of this section, at least the following members of the multidisciplinary team must be employees of the PACE organization:

- (1) Primary care physician.
- (2) Registered nurse.
- (3) Social worker.

(4) Recreational therapist or activity coordinator.

(5) PACE center manager.

(6) Home care coordinator.

(7) PACE center personal care attendant.

(g) *Waivers.* (1) HCFA and the State administering agency may waive either or both of the following:

(i) The requirement in paragraph (d)(3) of this section that members of the multidisciplinary team must serve primarily PACE participants.

(ii) The requirement in paragraph (f)(1) of this section that the primary care physician must be an employee of the PACE organization.

(2) If an applicant seeking approval as a PACE organization believes a waiver under this paragraph is warranted, it must include a request for the waiver in its application and describe in detail the circumstances supporting the request.

(3) HCFA and the State administering agency may grant a waiver if they determine the following:

(i) There is insufficient availability in the PACE organization's service area of individuals who meet the requirements, or State licensing laws make it inappropriate for the organization to employ physicians.

(ii) The proposed alternative does not adversely affect the availability of care or the quality of care that is furnished to participants.

§ 460.104 Participant assessment.

(a) *Initial comprehensive assessment—*
(1) *Basic requirement.* The multidisciplinary 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 multidisciplinary 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) Social worker.
- (iv) Physical therapist or occupational therapist, or both.

(v) Recreational therapist or activity coordinator.

(vi) Dietitian.

(vii) 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 multidisciplinary 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 multidisciplinary team. In developing the plan of care, female participants must be informed that they are 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 multidisciplinary team must conduct an in-person reassessment:

(i) Primary care physician.

(ii) Registered nurse.

(iii) 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 multidisciplinary team must conduct an in-person reassessment:

(i) Physical therapist or occupational therapist, or both.

(ii) Dietitian.

(iii) Home care coordinator.

(3) *Reassessment based on change in participant status or at the request of the participant or designated representative.*

If the health or psychosocial status of a participant changes or if a participant (or his or her designated representative) believes that the participant needs to initiate, eliminate, or continue a particular service, the members of the multidisciplinary team, listed in paragraph (a)(2) of this section, 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 (c)(3)(iii) of this section, the multidisciplinary 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 multidisciplinary team receives the request for reassessment.

(iii) The multidisciplinary 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

§ 460.106

provide the specific reasons for the denial in understandable language.

(v) If the participant or designated representative is dissatisfied with the decision on the request, 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).

(D) If the multidisciplinary 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.

(d) *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 multidisciplinary team.

(3) Obtain approval of the revised plan from the multidisciplinary 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.

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

§ 460.106 Plan of care.

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

42 CFR Ch. IV (10–1–00 Edition)

(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 multidisciplinary team and other providers.

(d) *Evaluation of plan of care.* On at least a semi-annual basis, the multidisciplinary 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.