



VALIR PACE

PROVIDER MANUAL

Oklahoma

2026

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Using This Provider Manual

This Provider Manual is meant to assist you in working with our participants within the framework of Valir PACE’s policies and procedures. Familiarizing yourself with and adhering to the

procedures outlined in this manual is required by our agreement and partnership, and will help ensure a mutually beneficial, productive relationship in caring for our participants. The information provided in this manual is intended to be informative and to assist Providers in navigating the various aspects of participation with the Valir PACE program.

Unless otherwise specified in the Provider Agreement, the information contained in this manual is not binding upon Valir PACE and is subject to change. Valir PACE will make reasonable efforts to notify Providers of changes to the content of this manual. This manual may be updated at any time and is subject to change. In the event of an inconsistency between information contained in this manual and the Provider Agreement between you or your facility and Valir PACE, the Agreement shall govern.

In the event of a material change to the Provider Manual, Valir PACE will make all reasonable efforts to notify you in advance of such changes through email, provider newsletters, and other mailings. In such cases, the most recently published information shall supersede all previous information and be considered the current directive. The manual is not intended to be a complete statement of all Valir PACE's policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications.

General Information

Who is Valir PACE?

Valir PACE is a Program of All-Inclusive Care for the Elderly in Oklahoma working to assist our most vulnerable senior to live their full potential. Valir PACE's mission is to help our aging community thrive with independence and quality of life in the comfort of their own home. We pride ourselves on working with underserved communities. Its leadership team includes exemplary PACE operators and seasoned healthcare innovators that share top-tier expertise in senior care and a passion for helping seniors reach their full potential.

PACE is a national program sponsored by the Federal government through Medicare and the State governments through Medicaid. The goal is to maximize the participant's autonomy and ability to reside in their community while receiving quality care at a lower cost relative to the Medicare, Medicaid and private-pay traditional payment systems. To be eligible to enroll as a Valir PACE participant, an individual must be:

- **55 years of age or older**
- **Eligible for Medicaid or have Medicare and be willing to pay privately**
- **Able to live safely in the community with the services provided by the PACE program**
- **A resident of the Valir PACE service area (map below).**

<https://www.ecfr.gov/current/title-42/section-460.150>

Valir PACE, OKC	721 NW 6 th Street Oklahoma City, Oklahoma 73102	73003,73007,73008,73010,73012,73013,73020,73025,73034,73045, 73049,73066,73083,73084, 73101 through 73152 73154 through 73157 73159,73762,73163,13764,73167,73169,73172,73173,73178,73179, 73184,73185,73190,73194, 73195,73196,13798,73026,73051,73068,73069,73071,73082,73153, 73760,73165,73170,73189,73036,73064,73078,73090,73099,73065, 7308,73093,73004,73089
Valir PACE Shawnee		74801, 74804, 74820, 74824 through 74834, 74836, 74837, 74839, 74840, 74842, 74843, 74844 74845, 74848, 74849, 74850, 74851, 74852, 74854, 74855, 74857, 74859, 74860, 74864, 74867, 74868, 74869, 74871, 74872, 74873, 74875, 74880,74881, 74883, 74884

The PACE model of care is built around an interdisciplinary team (IDT) approach, which includes diverse perspectives working together on behalf of each participant. The IDT consists of the following representatives: (1) Primary care provider. (2) Registered nurses; (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; The members of the IDT meet regularly to comprehensively support the needs of each participant through biannual assessments and care planning. When a participant is enrolled in Valir PACE, their insurance transitions to Valir PACE for coverage of all care and services. Services are available 24 hours a day, 7 days a week, and 365 days a year. Many services such as meals, recreational therapy, physical therapy, and Adult Day Center (ADC) can be provided in the Valir PACE center. Services that are not provided at the centers will be provided in the home or by our network of contracted providers, such as you, in consultation with our IDT. The PACE program provides, at a minimum, all Medicare and Medicaid benefits to its participants at no cost and, based on the discretion and clinical judgment of the IDT, offers additional services when deemed necessary to meet each participant's needs. Core benefits include:

- Medical Care Community-Based Services
- Physician Care
- Nursing
- Prescription Medications
- Dentistry
- Rehabilitation Therapies
- Physical Therapy
- Occupational Therapy
- Speech Therapy

Medical Care	PACE Services
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<ul style="list-style-type: none"> • Physician Care • Nursing • Prescription Medications • Dentistry • Optometry • Audiology • Podiatry • All Medical Specialties • Labs, X-Ray • Dialysis • Hospital Care • Emergency and Urgent Care • Short-term Rehab and Long-Term Care 	<p>Rehabilitation Therapies</p> <ul style="list-style-type: none"> • Physical Therapy • Occupational Therapy • Speech Pathology <p>Engagement Programs</p> <ul style="list-style-type: none"> • Social Events • Cultural Events and Games • Cognitive Activities • Group exercise and other activities <p>Nutrition</p> <ul style="list-style-type: none"> • Meal (Day Center) • Meals on Wheels • Nutrition Counseling <p>Transportation</p> <ul style="list-style-type: none"> • Rides to and from the Valir PACE Center • Appointment Transportation <p>Social Services</p> <ul style="list-style-type: none"> • Medicaid and Medicare Benefit Support • Counseling and psychological services • Support for participants and caregivers. • Connections to community resources <p>In-Home Services</p> <ul style="list-style-type: none"> • Home Health • Safety Assessment and Equipment • Personal Care and Support • Core Services (meal preparation, light housekeeping, laundry)
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Participant Scheduling and Transportation

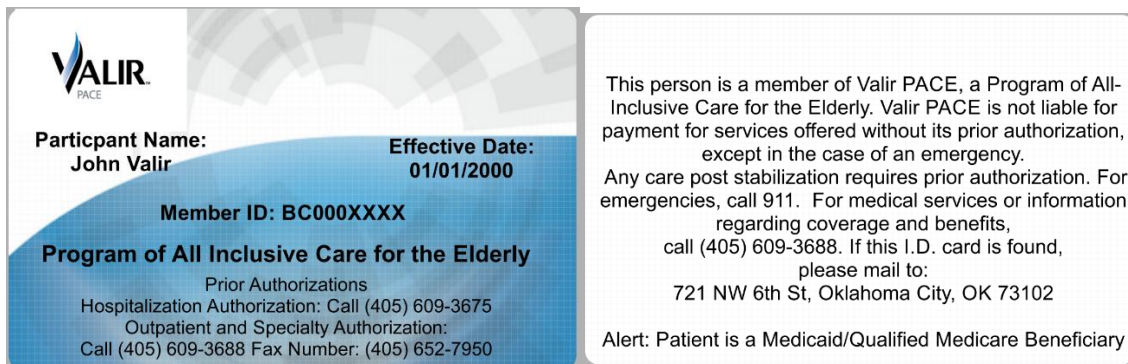
Valir PACE provides transportation to all authorized appointments. The PACE care team will coordinate the transportation with the participant.

Billing and Reimbursement

Eligibility for Payment

Every Valir PACE participant receives an insurance identification card that will detail the participant’s name and identification number. This card identifies them as a Valir PACE participant and should be presented to physicians and other providers when seeking healthcare services. If a Valir PACE participant is requesting service and is unable to present an identification card, please

contact Valir PACE at (405) 609-3688 (Press 2, then Press 1) for outpatient and specialty authorizations and (405) 609-3675 for hospitalization authorizations.



Providers should contact Valir PACE in case emergency care is needed. We have nursing staff available and on-call 24/7 to respond to emergent situations. Regardless of whether a participant has an identification card, providers should verify participant eligibility at the time of service to ensure s/he is enrolled in the Valir PACE program. Failure to do so may affect claims payment. Payment terms are defined within the provider contracts with Valir PACE. The payment for services provided is affected not only by the terms in the contract, but also by the following:

- Participant's eligibility at the time of service
- Whether services provided are covered services
- Whether services provided are medically necessary
- Whether services have authorization if prior approval is required
- Adjustments of payments based on coding edits described below

A Provider who receives reimbursement for services rendered to Valir PACE participants must comply with all federal laws, rules, and regulations applicable to individuals and entities receiving federal funds, including without limitation Title VI of the Civil Rights act of 1964, Age Discrimination Act of 1975, Americans with Disability Act, and Rehabilitation Act of 1973, and the False Claims Act [amend 1986].

Nothing contained in the provider agreement, or this Manual is intended by Valir PACE to be a financial incentive or payment which directly or indirectly acts as an inducement for providers to

limit medically necessary services. Valir PACE applies the CMS site-of-service payment differentials in its fee schedules for CPT codes based on the place of treatment (physician office services versus other places of treatment).

Coding Edits

Valir PACE will process provider claims that are a “clean claim” in accordance with Valir PACE’s normal claims processing procedures and applicable state and/or federal laws, rules and regulations with respect to the timeliness of claims processing. Such claims processing procedures and edits may include, without limitation, automated systems applications which identify, analyze and compare the amounts claimed for payment with the diagnosis codes and which analyze the relationships among the billing codes used to represent the services provided to participants. These automated systems may result in an adjustment of the payment to the Provider for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these automated systems by submitting a timely request for reconsideration to Valir PACE (please see the Provider Claims Reconsideration section of this Manual for more information). A reduction in payment due to claims policies and/or processing procedures is not an indication that the service provided is a noncovered service.

Pass-Through Billing

Valir PACE prohibits pass-through billing. Pass-through billing occurs when the ordering provider requests and bills for a service, but the service is not performed by the ordering provider or those under their direct employment. Provider agrees that services related to pass-through billing will not be eligible for reimbursement from Valir PACE and the provider shall not bill, charge, seek payment or have any recourse against Valir PACE or its participants for any amounts related to the provision of passthrough billing.

Claims Submission

Providers are responsible for submitting a clean claim for each participant served for payment consideration. A clean claim is free from errors and contains all of the following: **Participant**

Information:

- Participant full name • Participant ID number • Date of birth

Service Information:

- Date(s) of service (date range or individual days) • Service/HCPCS/Revenue code/Modifier
- Diagnosis code • Number of units (number of days in service period or units of provided service) • Unit Rate/Billed Amount

Provider Information:

- Provider name • Provider address • Provider Tax Identification Number (TIN) • National Provider Identifier (NPI)

All providers are required to bill encounters thirty days (30) after the service date, but no later than one hundred and twenty days (120) after the service date, or as indicated in the provider contract. Appeals for denials are also set at one hundred and twenty days (120) from the denial date.

Electronic Claims

All encounters, when possible, should be submitted electronically. **Our submitter ID is R3463.** Valir PACE accepts electronic claim submissions for professional (837P), institutional (837I) and (837D) dental. Contact your clearinghouse to initiate the process to forward Valir PACE claims to Availity.

Paper Claims

Your paper claims must be submitted on typed, redlined CMS-1500 or UB-04 claim forms and mailed to: Valir PACE Claims Department, 721 NW 6th Street, Oklahoma City, Oklahoma 73012. Please contact PACE ahead of time to discuss your electronic claim status.

Failure to send claims to this address may result in delayed claims processing and/or rejected claims. Please ensure that all your claims are submitted in a timely manner, are complete and all required data elements are present, are correct, and valid for the service date to avoid delays in claims processing or denial of your claims.

Payment of Claims

Valir PACE shall process all clean claims within thirty (30) calendar days of receipt. A clean claim means one which can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is known to be under investigation for fraud or abuse, a claim under review for medical necessity or a claim for which there is no authorization, or the claim that does not match the services authorized via the authorization.

Payment Verification:

Valir PACE must ensure the following before a payment is process to a provider:

- The participant was enrolled in Valir PACE at the time the service was provided.
- The service was delivered to the patient (cancelled services are not eligible for payment); and,
- The provider was compliant with Valir PACE Prior Authorization policies at the time of service.

Claims that are “not clean” may be denied. The provider agrees that in the event of a denial of payment for services rendered to a Valir PACE participant, that the provider shall not bill, charge, seek payment or have any recourse against the participant, Medicare, or Medicaid for such services. Medicare and Medicaid will not be responsible for claims for the participant while they are enrolled as a participant of Valir PACE. All claims for services provided to Valir PACE participants must be submitted to Valir PACE. If you have questions concerning claim status, adjustment or requests for claim review please submit your request via email to pace_claims@valir.com. For questions related to appeals, please submit your request to pace_appeals@valir.com.

Utilization Management and Prior Authorization

Valir PACE requires all healthcare providers to obtain prior authorization for all non-emergent healthcare procedures, treatments, and services. This process ensures that our members receive appropriate and medically necessary care while helping us manage healthcare costs effectively. To initiate a prior authorization request, please contact 405-609-3675 (*Inpatient*), and 405-609-3688 [Press 1, and then Press 2] (*Outpatient and Specialty*) to obtain your initial treatment or admission authorization. Your initial communication of patient condition will be used to determine the authorization. You will also be provided with a letter that will indicate the initial authorization timeline and required steps for subsequent approval and treatment.

Our clinical and medical team will respond to initial authorizations immediately. *Emergency treatment authorizations are not required.* However, if the emergency treatment results in a hospitalization, authorization is required. Inpatient admissions require an initial authorization, 48-hour update, and then a reauthorization every seven days as applicable. In addition, inpatient hospitalizations will require medical record submission for each seven-day continued stay authorization granted. Any service initially ordered by a Valir PACE employed provider is automatically authorized and the authorization number will be provided to you on the order document.

Utilization Review/Management

Medical records submission and concurrent review play a pivotal role in the authorization process for continued medical services or clinical intervention. It is important that your CQI representative and/or case management staff assist in all medical record requests for any clinical or medical intervention and for continued hospital stay authorizations by your organization. The authorizations provided must be indicated on your medical claims for reimbursement. Failure to document your authorization number on claim submission may result in payment denial.

We understand the importance of timely access to healthcare services for our members and appreciate your cooperation in adhering to this guideline. Should you have any questions or require assistance with the prior authorization process, please contact our team:

Hospitalization Authorization: 405-609-3675

Outpatient and Specialty Authorization 405-609-3688 – [Press 2, then Press 1]

E-mail: Priorauth@valir.com

Fax number: 405-652-7950

Urgent and Emergency Care

Valir PACE provides coverage for the treatment of an emergency medical condition, which is defined by CMS as a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: • Placing the health of the individual in serious jeopardy • Serious impairment to bodily functions or • Serious dysfunction of any bodily organ or part Inpatient and outpatient emergency health services are covered both inside and outside of the Valir PACE service area. Prior authorization is not required for emergency care. In the event of an emergency, Valir PACE instructs its participants to seek immediate care, or call 911 for assistance. Valir PACE will not deny payment if a Valir PACE contracted health care Provider instructs a participant to seek emergency services. Enrollment in Valir PACE includes coverage for post-stabilization care, defined as non-emergency services needed to ensure the participant remains stabilized after an emergency. In the post-stabilization period, providers should only provide services authorized by Valir PACE.

Unauthorized services will not be paid for by Valir PACE unless it is an emergency or *Valir PACE fails to respond to an authorization request within one hour of being contacted for urgently needed or post-stabilization services*. Urgently needed services are defined as those conditions which require immediate medical attention due to unexpected illness or injury. Fevers, abdominal pain,

nausea and vomiting and difficulty urinating are some examples of situations requiring urgently needed services. Urgent care services are covered for participants. Providers must notify Valir PACE within 24 hours or the next business day of providing emergency or urgent services to an Valir PACE participant, or if the participant is admitted to a hospital. Participants are encouraged to always carry their Valir PACE identification card and to notify Valir PACE should they need urgent or emergency care.

Provider Responsibilities

The government expects Valir PACE and all our contractors and providers to follow all laws, rules, regulations, and contract requirements and conduct business in an ethical manner.

This means:

- Providers will always act in the best interests of our program participants, including the protection of participants' rights.
- Providers will avoid conflicts of interest. Where potential conflicts exist, providers are expected to disclose the conflict to Valir PACE and work with us to successfully resolve it.
- Providers will treat participants with dignity, respect and fairness. Participants will not be discriminated against based on race, color, religion, gender, sexual orientation, age, disability, or any other protected characteristic.
- Providers will protect the confidentiality of participant information and any confidential information of Valir PACE.
- Providers will obey all laws, rules, regulations, and contract requirements.
- Providers will report any known or suspected instances of unethical or illegal behavior and will not retaliate against any staff participant who in good faith reports any such concern.
- Provider shall submit evidence of initial and annual compliance training upon request from Valir.

Providers are expected to have written policies and procedures that guide staff in complying with regulatory and contractual requirements. Staff should also be trained annually in compliance

and fraud, waste and abuse. Valir PACE may ask for copies of these training records. These documents may be updated at any time and are subject to change. Providers are expected to check the government sanction and exclusion databases monthly to ensure that they, their employees, and their subcontractors are not excluded from participating in government programs. There are companies that provide monitoring service, or you can monitor by going to the government sites (www.sam.gov and <http://exclusions.oig.hhs.gov/>). Providers need to keep documentation of this monthly monitoring activity. Valir PACE may ask for this documentation as proof the monitoring is being performed.

The provider is expected to always understand and adhere to the contract provisions.

- Provider will annually provide compliance and fraud, waste and abuse training for all staff and document training in staff files.

- Validate monthly that employees have not been listed on the Office of Inspector General exclusion list. <http://oig.hhs.gov/fraud/exclusions.asp>. The provider shall immediately notify Valir PACE if they as a provider or any of their employees appear on the exclusion list.

- Valir PACE shall provide a global authorization upon initial referral of a participant to contracted providers. The provider shall render services necessary as it relates to the participant's diagnosis. If additional needs arise outside of the scope of the initial diagnosis, the provider is expected to contact the participant's *Interdisciplinary Care Team (IDT)* to obtain an additional authorization.

- Written notice of any change in the type, scope or location of delivery of services shall be provided to Valir PACE at least ninety (90) days prior to the effective date of the change.

- Provider must only bill for services provided. Submitting claims for services that were not provided – even if authorized – is illegal (fraud).

- Provider shall send written notice to Valir PACE within five (5) days of any legal, governmental or other action initiated against the provider.

- Valir PACE expects providers to demonstrate sensitivity to cultural diversity and to honor participants' beliefs. Providers are expected to foster staff attitudes and interpersonal communication styles that respect participants' cultural backgrounds.

Record Keeping, Record Submission, and Records Inspection

All network providers must maintain and upon request furnish to Valir PACE all information requested by Valir PACE related to the quality and quantity of services provided through their contract. This includes written documentation of care and services provided, including dates of services, time records, invoices, contracts, vouchers or other official documentation evidencing in proper detail the nature and propriety of the services provided. Network providers should submit progress notes to Valir PACE within 72 hours of care delivery and same day if the provider is recommending any changes to a patient's treatment regimen. Provider shall maintain books and records, including participant medical records, pertaining to actions performed pursuant to this contract by the provider in a form consistent with and in compliance with provisions of all applicable state and federal laws. **For PACE-funded services, records must be retained for a minimum of ten (10) years after termination of services as specified in this contract or from the date of completion of any audit, whichever is later.**

Participant Rights

When enrolled in a PACE program, participants have certain rights and protections. The PACE program must fully explain these rights to all participants or someone acting on their behalf in a way that they can understand at the time they join. As a provider, you have the responsibility to respect every participant's rights. The Participant Rights document can be reviewed at <https://www.ecfr.gov/current/title-42/section-460.112>

HIPAA

Based on the services you provide on behalf of Valir PACE you may be provided with protected health information (PHI). This information includes all medical and care-related

services you provide. Under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) you are responsible for keeping this information secure. Information must not be left out where anyone can read it, including paper records and emails, and should be protected against theft. The law also requires you to only share PHI with the participant's consent in all but a limited number of situations. Any loss, theft, misuse, or accidental disclosure of PHI must be reported to Valir PACE's and may also need to be reported to the government under the breach notification requirements.

There are government resources available to assist you to understand your obligations. These include:

- <http://www.hhs.gov/ocr/privacy/index.html>
- <http://www.cms.gov/Regulations-and-Guidance/HIPAA-AdministrativeSimplification/HIPAAGenInfo/index.html>

Please contact our Network Development/Provider Relations if you have questions or concerns about HIPAA. Valir PACE is concerned with protecting participant privacy and is committed to complying with the Health Insurance and Portability Act (HIPAA) privacy regulations. Generally, covered health plans and covered Providers are not required to obtain individual participant consent or authorization for use and disclosure of Protected Health Information (PHI) for treatment, payment and healthcare operations. Activities such as: care coordination, reviewing the competence of health care professionals, billing/claims management, and quality improvement fall into this category.

Individuals should be notified in writing or e-mail if that is their preferred method of contact, and be provided with basic information about the breach, such as:

- When the breach happened, when the event was discovered, and a brief statement about what happened
- What type of PHI was breached
- Things that the individual can do in order "to protect themselves from potential harm resulting from the breach"

- What corrective actions and investigation the covered entity is doing to prevent future breaches and mitigate losses; and contact information for the individual to use in case of any questions.

In addition to disclosure accounting, the individual is also entitled to receive a copy of his or her electronic health record, if they request; this information may be sent to the individual, or another person designated by individual.

Fraud, Waste, and Abuse

Valir PACE operates a comprehensive compliance program that actively investigates allegations of fraud, waste and abuse on the part of providers and participants. Valir PACE is required to report all suspected fraud, waste or abuse (FWA) to Oklahoma Insurance Department (OID) Senior Medicare Patrol (SMP) or Investigations Medicare Drug Integrity Contractor (I-MEDIC).

- **Fraud** – is defined as an intentional deception, false statement or misrepresentation made by an individual with knowledge that the deception could result in unauthorized benefit to that individual or another person. Claims submitted for services not provided are considered fraudulent.
- **Waste** – is defined as failing to control costs or using Medicare or Medicaid funds to pay for services that are not determined to be necessary.
- **Abuse** – is defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business or medical practices. The primary difference between fraud and abuse is “intent”. Poor recordkeeping, lack of understanding of care responsibilities or reporting obligations may result in an investigation into abuse.

The following are some examples of fraudulent, abusive, and unacceptable practices that are prohibited by Valir PACE:

- Submission of false information for the expressed purpose of obtaining greater compensation than that to which the Provider is legally entitled (i.e. up coding or unbundling of charges).
- Billing for services not rendered or billing in advance of care.
- Knowingly demanding or collecting any compensation in addition to claims submitted for covered services (except where permitted by law).
- Ordering or furnishing inappropriate, improper, unnecessary or excessive care services or supplies.
- Failing to maintain or furnish, for audit and investigative purposes, sufficient documentation on the extent of care and services rendered to participants
- Offering or accepting inducements to influence participants to join the plan or to use or avoid using a particular service.
- Submitting bills or accepting payment for care services or supplies rendered by a provider who has been disqualified from participation in the Medicare or Medicaid programs

Providers must comply with federal laws and regulations designed to prevent fraud, waste and abuse, but not limited to, applicable provisions of federal criminal law, the False Claims Act, the Anti-Kickback Statute, and the Health Insurance Portability and Accountability Act administrative simplification rules, applicable state and federal law, including, but not limited to, Title VI of The Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act and all other laws applicable to recipients of federal funds from which payments to Providers under this Agreement are made in whole or in part, and all applicable Medicare laws, regulations, reporting requirements, and CMS instructions. Confirmed cases of fraud and abuse are reported to the appropriate state agency. Providers who suspect fraud, waste and abuse on the part of another Provider or a participant should contact Valir PACE. Remember, you may report anonymously to 1-855-865-3746 or <https://report.syntrio.com/valir> as Valir PACE abides by a

zero-tolerance against non-compliance. All contacts and provided information will be treated confidentially.

Quality Management

Valir PACE strives to deliver outstanding services so participants can achieve their goals and desired outcomes. Delivering quality care is a strategic objective and is driven each year by the Quality Improvement (QP) plan.

- Valir PACE conducts formal QI projects as defined and approved by state and federal agencies. Required projects to meet CMS and DHCS contract requirements.

- Valir PACE strategically selects meaningful projects that will benefit the participants.

- Valir PACE measures and evaluates the quality of the care management activities to improve the participants' experience.

- Conducting Participant Satisfaction Survey.

- Care Management process monitoring.

- Regulatory audit readiness/corrective action planning

- Practice Guidelines and Clinical Pathways

- All-inclusive approach to quality care and provider input to the QI plan.

- Integrate other organizational plans with the organizational QI plan.

Valir PACE encourages its network providers to communicate feedback on how we can continue with our strong tradition of delivering quality care.

Utilization Management and Prior Authorization

Valir PACE maintains a “Right Care, Right Place, Right Time” Program to evaluate medical necessity and manage the quality and cost of health care services delivered to participants. All services are evaluated either prospectively, concurrently, or retrospectively to determine medical necessity based on standard criteria. This program is designed to ensure that:

- Services are medically necessary, consistent with the assigned participant's diagnoses, 20 and are delivered at appropriate levels of care.

- Services are provided by Valir PACE contracted Providers and that the utilization review staff is notified immediately to discuss the use of non-contracted Providers based on services that are not available through contracted Providers.

- Hospital admissions and length of stay are justified.
- Services are not over-utilized or under-utilized.
- Continuity and coordination of care is monitored.
- Guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to as appropriate.

Valir PACE utilizes standard criteria, such as InterQual Criteria, National Coverage Decisions, the Medicare Benefit Policy Manual, Local Coverage Determinations and current literature to assess all requests for determination of medical necessity. All criteria are reviewed by the Quality Improvement Committee on an annual basis.

- New technology is evaluated based on Medicare and Medicaid reviews and reviews of studies that determine its application and effectiveness.

- There is coordination of thorough and timely investigations and responses to Provider Appeals (see Provider Appeals section).

All non-emergency services provided to Valir PACE participants, outside the scope of the initial diagnosis, require prior authorization from Valir PACE. With that said, any service ordered by Valir PACE employed providers is automatically authorized and the authorization for services will be faxed or emailed to the provider by Valir PACE. Prior authorization is based upon the clinical documentation that supports medical necessity for the requested item. If you have questions concerning prior authorizations, please contact please contact Valir PACE at (405) 609-3688 (Press 2, then Press 1) for outpatient and specialty authorizations and (405) 609-3675 for hospitalization authorizations

Urgent and Emergency Care

Valir PACE provides coverage for the treatment of an emergency medical condition, which is defined by CMS as *a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:*

- Placing the health of the individual in serious jeopardy
- Serious impairment to bodily functions or
- Serious dysfunction of any bodily organ or part

inpatient and outpatient emergency health services are covered both inside and outside of the Valir PACE service area.

Prior authorization is not required for emergency care. In the event of an emergency, Valir PACE instructs its participants to seek immediate care, or call 911 for assistance. Valir PACE will not deny payment if a Valir PACE contracted health care provider instructs a participant to seek emergency services. Enrollment in Valir PACE includes coverage for post-stabilization care, defined as non-emergency services needed to ensure the participant remains stabilized after an emergency. In the post-stabilization period, providers should only provide services authorized by Valir PACE.

Unauthorized services will not be paid for by Valir PACE unless it is an emergency or for urgently needed or post-stabilization services. Urgently needed services are defined as those conditions which require immediate medical attention due to unexpected illness or injury. Fevers, abdominal pain, nausea and vomiting and difficulty urinating are some examples of situations requiring urgently needed services. Urgent care services are covered for participants. However, providers must notify Valir PACE within 24 hours or the next business day of providing emergency or urgent services to a Valir PACE participant, or if the participant is admitted to a hospital. Participants are also encouraged to always carry their Valir PACE identification card and to also notify Valir PACE should they need urgent or emergency care.

Network Participation

How to Become a Network Provider

If a potential provider is interested in joining the Valir PACE Provider Network, please go to <https://valir.com/pace> to complete the online provider application – if you encounter issues you can also email providersupport@valir.com for assistance. Valir PACE considers requests for contracting based on the following criteria:

- The proposed provider’s mission and vision complement the Valir PACE mission
- The provider is committed to serving participants consistent with the PACE model of care.
- The provider meets applicable licensing and/or certification standards applicable to the services to be provided.
- The provider is willing and able to sign and adhere to all components of a contract with Valir PACE including, but not limited to:
 - Agree to Valir PACE rate.
 - Follow contractual requirements related to authorizations and billing
 - Maintain ongoing communications with Valir PACE staff
 - Meet or exceed quality assurance expectations set by Valir PACE Updating Services or

Providers in Existing Network Provider Organizations If you are a current Valir PACE contracted provider and you are interested in adding services to your existing contract or otherwise amending or terminating that contract, please email us at providersupport@valir.com.

Credentialing

Valir PACE’s credentialing process enables us to contract with qualified health care providers and to meet the requirements of our contracts with the Centers for Medicare & Medicaid Services (CMS) and the Oklahoma Healthcare Authority. The credentialing process ensures that providers are properly educated, trained, and accessible to Valir PACE’s participants. Although Valir PACE delegates some credentialing activities to recognized credentialing programs, Valir PACE always retains the right and the obligation to accept or reject the recommendations of our

credentialing delegates. Valir PACE reviews these credentialing programs on an annual basis. Information acquired through the credentialing and re-credentialing processes is considered confidential, and Valir PACE staff and credentialing delegates who have access to the files are responsible for ensuring the information remains confidential, except as otherwise provided by law.

Valir PACE may deny or restrict participation, terminate participation, or take other action in accordance with the provider's written agreement with Valir PACE and our credentialing policies and procedures.

Initial Credentialing

Each practitioner, facility or ancillary provider must complete a standard application form when applying for initial participation in the Valir PACE Network. This application may be a state-mandated form, or a standard form created by or deemed acceptable by Valir PACE for practitioners, facilities and ancillary practitioners. The Council for Affordable Quality Healthcare ("CAQH"), a universal credentialing data source is utilized. CAQH is building the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals, and practitioners. To learn more about CAQH, visit their web site at www.CAQH.org. The provider participation/application form can be found at <https://valir.com/pace>

PACE will verify those elements related to an applicant's legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred and eighty (180) calendar-day period prior to Valir PACE making its credentialing recommendation or as otherwise required by applicable accreditation standards. During the credentialing process, Valir PACE will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These lists represent minimum verification requirements.

Practitioners (Providers)

- National Provider Identification number
- License to practice in the state(s) in which the practitioner will be treating Covered

Individuals

- Current DEA registration (for relevant practitioners)
- Proof of education (evidence of graduation from applicable professional school and completion of residency or other post-graduate training as applicable)

- Malpractice claims history
- Malpractice insurance
- Board certification (for relevant practitioners)
- Clinical and Work history
- Exclusions and sanctions
- Medicare Opt-Out Facility and Ancillary (Health Delivery Organizations)
- Good standing with State and Federal government
- CMS/DHCS Certification (if applicable)
- Certificate of Insurance
- State License

Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or facility and ancillary practitioner's licensure, sanctions, certification, and/or performance information (including, but not limited to, malpractice experience) that may reflect on the practitioner's, facility or ancillary professional's conduct and competence. This information is reviewed to assess whether practitioners, facility and ancillary providers continue to meet Valir PACE's credentialing standards. During the re-credentialing process, Valir PACE will review and verify credentialing data described in the tables under [*Initial Credentialing*] unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements. All applicable practitioners in the network within the scope of Valir PACE's Credentialing Program are

required to be re-credentialed every three (3) years unless otherwise required by contractor state regulations. To support certain credentialing standards between the re-credentialing cycles, Valir PACE performs ongoing monitoring to help ensure continued compliance with credentialing standards by reviewing periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to the following:

- Office of the Inspector General (OIG – LEIE (List of Excluded Individuals/Entities)
- SAMS (System of Award Management)
- National Practitioner Data Base (NPDB).
- Medical Board – (Licensure)
- Board of Nursing – (Licensure)

Valir PACE

Quality Improvement (QI) Plan

Please visit <https://valir.com/pace> to view the Quality Assurance and Performance Improvement Plan.

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Participant Bill of Rights and Responsibilities

When you join a PACE program, you have certain rights and protections. Valir PACE, as your PACE program, must fully explain and provide your rights to you or someone acting on your behalf in a way you can understand at the time you join.

At Valir PACE, we are dedicated to providing you with quality health care services so that you may remain as independent as possible. This includes providing all Medicaid and Medicare-covered items and services, and other services determined to be necessary by the interdisciplinary team across all care settings, 24 hours a day, 7 days a week.

Our staff and contractors seek to affirm the dignity and worth of each participant by assuring the following rights:

You have the right to treatment.

You have the right to treatment that is both appropriate for your health conditions and provided in a timely manner. You have the right:

- To receive all the care and services you need to improve or maintain your overall health condition, and to achieve the best possible physical, emotional, and social well-being.
- To get emergency services when and where you need them without the PACE program's approval. A medical emergency is when you think your health is in serious danger— when every second counts. You may have a bad injury, sudden illness or an illness quickly getting much worse. You can get emergency care anywhere in the United States and you do not need to get permission from Valir PACE prior to seeking emergency services.

You have the right to be treated with respect.

You have the right to be treated with dignity and respect at all times, to have all of your care kept private and confidential, and to get compassionate, considerate care. You have the right:

- To get all of your health care in a safe, clean environment and in an accessible manner.
- To be free from harm. This includes excessive medication, physical or mental abuse, neglect, physical punishment, being placed by yourself against your will, and any physical or chemical restraint that is used on you for discipline or convenience of staff and that you do not need to treat your medical symptoms.
- To be encouraged and helped to use your rights in the PACE program.
- To get help, if you need it, to use the Medicare and Medicaid complaint and appeal processes, and your civil and other legal rights.
- To be encouraged and helped in talking to PACE staff about changes in policy and services you think should be made.
- To use a telephone while at the PACE center.
- To not have to do work or services for the PACE program.
- To have all information about your choices for PACE services and treatment explained to you in a language you understand, and in a way that takes into account and respects your cultural beliefs, values, and customs.

You have a right to protection against discrimination.

Discrimination is against the law. Every company or agency that works with Medicare and Medicaid must obey the law. They cannot discriminate against you because of your:

- Race
- Ethnicity
- National Origin
- Religion
- Age
- Sex
- Mental or physical disability
- Sexual Orientation
- Source of payment for your health care (For example, Medicare or Medicaid)

If you think you have been discriminated against for any of these reasons, contact a staff member at the PACE program to help you resolve your problem.

If you have any questions, you can call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

You have a right to information and assistance.

You have the right to get accurate, easy-to-understand information, to have this information shared with your designated representative, who is the person you choose to act on your behalf, and to have someone help you make informed health care decisions. You have the right:

- To have someone help you if you have a language or communication barrier so you can understand all information given to you.

- To have the PACE program interpret the information into your preferred language in a culturally competent manner, if your first language is not English and you can't speak English well enough to understand the information being given to you.
- To get marketing materials and PACE participant rights in English and in any other frequently used language in your community. You can also get these materials in Braille, if necessary.
- To have the enrollment agreement fully explained to you in a manner understood by you.
- To get a written copy of your rights from the PACE program. The PACE program must also post these rights in a public place in the PACE center where it is easy to see them.
- To be fully informed, in writing, of the services offered by the PACE program. This includes telling you which services are provided by contractors instead of the PACE staff. You must be given this information before you join, at the time you join, and when you need to make a choice about what services to receive.
- To be provided with a copy of individuals who provide care-related services not provided directly by Valir PACE upon request.
- To look at, or get help to look at, the results of the most recent review of your PACE program. Federal and State agencies review all PACE programs. You also have a right to review how the PACE program plans to correct any problems that are found at inspection.

Before Valir PACE starts providing palliative care, comfort care, and end-of-life care services, you have the right to have information about these services fully explained to you. This includes your right to be given, in writing, a complete description of these services and how they are different from the care you have been receiving, and whether these services are in addition to, or instead of, your current services. The information must also explain, in detail, how your current services will be affected if you choose to begin palliative care, comfort care, or end-of-life services.

Specifically, it must explain any impact to:

- Physician services, including specialist services.
- Hospital services
- Long-term care services
- Nursing services
- Social services
- Dietary services
- Transportation
- Home care
- Therapy, including physical, occupational, and speech therapy
- Behavioral health
- Diagnostic testing, including imaging and laboratory services
- Medications
- Preventative healthcare services
- PACE center attendance

You have the right to change your mind and take back your consent to receive palliative care, comfort care, or end-of-life care services at any time and for any reason by letting Valir PACE know either verbally or in writing.

You have a right to a choice of providers.

You have the right to choose a health care provider, including your primary care provider and specialists, from within the PACE program's network and to get quality health care. Women have the right to get services from a qualified women's health care specialist for routine or preventive women's health care services.

You have the right to have reasonable and timely access to specialists as indicated by your health condition.

You also have the right to receive care across all care settings, up to and including placement in a long-term care facility when Valir PACE can no longer maintain you safely in the community.

You have a right to participate in treatment decisions.

You have the right to fully participate in all decisions related to your health care. If you cannot fully participate in your treatment decisions or you want to have someone you trust help you, you have the right to choose that person to act on your behalf as your designated representative.

You have the right:

- To be fully informed of your health status and how well you are doing, to make health care decisions, and to have all treatment options fully explained to you. This includes the right not to get treatment or take medications. If you choose not to get treatment, you must be told how this may affect your physical and mental health.
- To fully understand Valir PACE's palliative care, comfort care, and end-of-life care services. Before Valir PACE can start providing you with palliative care, comfort care, and end-of-life care services, the PACE program must explain all of your treatment options, give you written information about these options, and get written consent from you or your designated representative.
- To have the PACE program help you create an advance directive, if you choose. An advance directive is a written document that says how you want medical decisions to be made in case you cannot speak for yourself. You should give it to the person who will carry out your instructions and make health care decisions for you.

- To participate in making and carrying out your plan of care. You can ask for your plan of care to be reviewed at any time.
- To be given advance notice, in writing, of any plan to move you to another treatment setting and the reason you are being moved.

You have a right to have your health information kept private.

- You have the right to talk with health care providers in private and to have your personal health care information kept private and confidential, including health data that is collected and kept electronically, as protected under State and Federal laws.
- You have the right to look at and receive copies of your medical records and request amendments.
- You have the right to be assured that your written consent will be obtained for the release of information to persons not otherwise authorized under law to receive it.
- You have the right to provide written consent that limits the degree of information and the persons to whom information may be given.

There is a patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used. If you have any questions about this privacy rule, call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800- 537-7697.

You have a right to make a complaint.

You have a right to complain about the services you receive or that you need and don't receive, the quality of your care, or any other concerns or problems you have with your PACE program. You have the right to a fair and timely process for resolving concerns with your PACE program. You have the right:

- To a full explanation of the complaint process.
- To be encouraged and helped to freely explain your complaints to PACE staff and outside representatives of your choice. You must not be harmed in any way for telling someone your concerns. This includes being punished, threatened, or discriminated against.
- **To contact 1-800-Medicare for information and assistance, including to make a complaint related to the quality of care or the delivery of a service.**

You have the right to request additional services or file an appeal.

You have the right to request services from Valir PACE, its employees, or contractors, that you believe are necessary. You have the right to a comprehensive and timely process for determining whether those services should be provided.

You also have the right to appeal any denial of a service or treatment decision by the PACE program, staff, or contractors.

You have a right to leave the program.

If, for any reason, you do not feel that the PACE program is what you want, you have the right to leave the program at any time and have such disenrollment be effective the first day of the month following the date Valir PACE receives your notice of voluntary disenrollment.

Additional Help:

If you have complaints about your PACE program, think your rights have been violated, or want to talk with someone outside your PACE program about your concerns, call 1-800-MEDICARE (1-800-633-4227) to get the name and phone number of someone in your State Administering Agency (Oklahoma Health Care Authority).