COMMONWEALTH of VIRGINIA

Office of the Attorney General

900 East Main Street
Richmond, Virginia 23219
804-786-2071
FAX 804-786-1991
Virginia Relay Services
800-828-1120

Mark R. Herring
Attorney General

MEMORANDUM

TO: **EMILY MCCLELLAN**
Regulatory Supervisor
Virginia Department of Medical Assistance Services

FROM: **USHA KODURU** uk
Assistant Attorney General

DATE: **June 28, 2016**

SUBJECT: **Exempt final regulation to amend the PACE regulation**

I have reviewed the attached exempt final regulation to remove the requirement that the Program for All Inclusive Care for the Elderly ("PACE") program be licensed as Adult Day Care Centers. You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to amend the regulation and if the regulation comports with state and federal law.

Based on my review and pursuant to the HB 435 passed by the 2016 Session of the Virginia General Assembly, the Director of DMAS, acting on behalf of the Board of Medical Assistance Services, in accordance with Virginia Code §§ 32.1-324 and 325, has the authority to amend these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act ("APA") and has not exceeded that authority. It is my view that the amendment of these regulations is exempt from the procedures of Article 2 of the APA pursuant to Va. Code § 2.2-4006(A)(4)(a).

If you have any questions about this matter, please contact me at 786-4074.

cc: Kim F. Piner, Esquire

Attachment

Final Text

Action:
PACE and Licensure of Adult Day Care Centers
Stage: Final
5/26/16 1:51 PM

12VAC30-50-335. General PACE plan requirements.

A. DMAS, the state agency responsible for administering Virginia's Medicaid program, shall only enter into PACE plan contracts with approved PACE plan providers. The PACE provider must have an agreement with CMS and DMAS for the operation of a PACE program. The agreement must include:

1. Designation of the program's service area;

2. The program's commitment to meet all applicable federal, state, and local requirements;

3. The effective date and term of the agreement;

4. The description of the organizational structure;

5. Participant bill of rights;

6. Description of grievance and appeals processes;

7. Policies on eligibility, enrollment, and disenrollment;

8. Description of services available;

9. Description of quality management and performance improvement program;

10. A statement of levels of performance required on standard quality measures;

11. CMS and DMAS data requirements;

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

13. Procedures for program termination; and

14. A statement to hold harmless CMS, the state, and PACE participants if the PACE organization does not pay for services performed by the provider in accordance with the contract.

B. A PACE plan feasibility study shall be performed before DMAS enters into any PACE plan contract. DMAS shall contract only with those entities it determines to have the ability and resources to effectively operate a PACE plan. A feasibility plan shall only be submitted in response to a Request for Applications published by DMAS.

C. PACE plans shall offer a voluntary comprehensive alternative to enrollees who would otherwise be placed in a nursing facility. PACE plan services shall be comprehensive and offered as an alternative to nursing facility admission.

D. All Medicaid-enrolled PACE participants shall continue to meet the nonfinancial and financial Medicaid eligibility criteria established by federal law and these regulations. This requirement shall not apply to Medicare only or private pay PACE participants.

E. Each PACE provider shall operate a PACE site that is in continuous compliance with all state licensure requirements for that site.

~~F. Each PACE provider shall offer core PACE services as described in 12VAC30-50-345 B through a coordination site that is licensed as an ADHC by DSS.~~

~~G.~~ F. Each PACE provider shall ensure that services are provided by health care providers and institutions that are in continuous compliance with state licensure and certification requirements.

~~H.~~ G. Each PACE plan shall meet the requirements of §§ 32.1-330.2 and 32.1-330.3 of the Code of Virginia and 42 CFR Part 460.

~~I.~~ H. All PACE providers must meet the general requirements and conditions for participation pursuant to the required contracts by DMAS and CMS. All providers must sign the appropriate participation agreement. All providers must adhere to the conditions of participation outlined in the participation agreement and application to provide PACE services, DMAS regulations, policies and procedures, and CMS requirements pursuant to 42 CFR Part 460.

~~J.~~ I. Requests for participation as a PACE provider will be screened by DMAS to determine whether the provider applicant meets these basic requirements for participation and demonstrates the abilities to perform, at a minimum, the following activities:

1. Immediately notify DMAS, in writing, of any change in the information that the provider previously submitted to DMAS.

2. Assure freedom of choice to individuals in seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid Program at the time the service or services are performed.

3. Assure the individual's freedom to refuse medical care, treatment, and services.

4. Accept referrals for services only when qualified staff is available to initiate and perform such services on an ongoing basis.

5. Provide services and supplies to individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000 et seq.), which prohibits discrimination on the grounds of race, color, religion, sexual orientation or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act of 1990, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications.

6. Provide services and supplies to individuals of the same quality and in the same mode of delivery as is provided to the general public.

7. Use only DMAS-designated forms for service documentation. The provider must not alter the DMAS forms in any manner unless approval from DMAS is obtained prior to using the altered forms.

8. Not perform any type of direct marketing activities to Medicaid individuals.

9. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

a. In general, such records shall be retained for at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for at least six years after such minor has reached the age of 18 years. However, records for Medicare Part D shall be maintained for 10 years in accordance with 42 CFR 423.505(d).

b. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review. The location, agent, or trustee shall be within the Commonwealth.

10. Furnish information on request and in the form requested to DMAS, the Attorney General of Virginia or his authorized representatives, federal personnel, and the state Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and records shall survive any termination of the provider agreement.

11. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to individuals of Medicaid.

12. Pursuant to 42 CFR 431.300 et seq., 12VAC30-20-90, and any other applicable federal or state law, all providers shall hold confidential and use for authorized DMAS purposes only all medical assistance information regarding individuals served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits, or the data are necessary for the functioning of DMAS in conjunction with the cited laws.

13. CMS and DMAS shall be notified in writing of any change in the organizational structure of a PACE provider organization at least 14 calendar days before the change takes effect.

14. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider participation agreements and in the applicable DMAS provider manual. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies. A provider's noncompliance with DMAS policies and procedures may result in a retraction of Medicaid payment or termination of the provider agreement, or both.

15. Minimum qualifications of staff.

a. All employees must have a satisfactory work record as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of vulnerable adults and children. Prior to the beginning of employment, a criminal record check shall be conducted for the provider and each employee and made available for review by DMAS staff. Providers are responsible for complying with the Code of Virginia and state regulations regarding criminal record checks and barrier crimes as they pertain to the licensure and program requirements of their employees' particular practice areas.

b. Staff must meet any certifications, licensure, registration, etc., as required by applicable federal and state law. Staff qualifications must be documented and maintained for review by DMAS or its authorized contractors.

16. At the time of their admission to services, all providers participating in the Medicare and Medicaid programs must provide adult individuals with written information regarding each individual's right to make medical care decisions, including the right to accept or refuse medical treatment and the right to formulate advance directives.

~~K.~~ J. Provider's conviction of a felony. The Medicaid provider agreement shall terminate upon conviction of the provider of a felony pursuant to § 32.1-325 of the Code of Virginia. A provider convicted of a felony in Virginia or in any other of the 50 states, the District of Columbia, or the U.S. territories must, within 30 days, notify the Virginia Medicaid Program of this conviction and relinquish the provider agreement. In addition, termination of a provider participation agreement will occur as may be required for federal financial participation.

~~L.~~ K. Ongoing quality management review. DMAS shall be responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies and periodically recertify each provider for participation agreement renewal with DMAS to provide PACE services.

~~M.~~ L. Reporting suspected abuse or neglect. Pursuant to §§ 63.2-1508 through 63.2-1513 and 63.2-1606 of the Code of Virginia, if a participating provider entity suspects that a child or vulnerable adult is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately to DSS and to DMAS. In addition, as mandated reporters for vulnerable adults, participating providers must inform their staff that they are mandated reporters and provide education regarding how to report suspected adult abuse, neglect, or exploitation pursuant to § 63.2-1606 F of the Code of Virginia.

~~N.~~ M. Documentation requirements. The provider must maintain all records of each individual receiving services. All documentation in the individual's record must be completely signed and dated with name of the person providing the service, title, and complete date with month, day, and year. This documentation shall contain, up to and including the last date of service, all of the following:

1. The most recently updated Virginia Uniform Assessment Instrument (UAI), all other assessments and reassessments, plans of care, supporting documentation, and documentation of any inpatient hospital admissions;

2. All correspondence and related communication with the individual and, as appropriate, consultants, providers, DMAS, DSS, or other related parties; and

3. Documentation of the date services were rendered and the amount and type of services rendered.