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MEMORANDUM

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

FROM: **JENNIFER L. GOBBLE**
Assistant Attorney General

DATE: **August 26, 2016**

SUBJECT: **Exempt Final Regulations: Provider Screening Requirements**

I have reviewed the attached exempt final regulations that will implement federally mandated changes derived from the Affordable Care Act and federal regulations concerning provider screening requirements.

Based on my review, it is this Office's view that the Director of DMAS, acting on behalf of the Board of Medical Assistance Services, pursuant to Virginia Code § 32.1-324, has the authority to promulgate these regulations and has not exceeded that authority. The amendments to the regulations do not materially differ from the federal requirements.

It is my view that amendment of these regulations is exempt from the procedures of Article 2 of the Administrative Process Act pursuant to Virginia Code § 2.2-4006(A)(4)(c). If you have any questions, please contact me at (804) 786-4905.

cc: Kim F. Piner, Esquire
Senior Assistant Attorney General/Chief

Final Text

Action: Provider Screening Requirements

Stage: Final 5/13/16 9:43 AM

12VAC30-10-520. Required provider agreement.

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

A. For all providers, the requirements of 42 CFR 431.107 and 42 CFR 442, Subparts A and B (if applicable) are met.

B. For providers of NF services, the requirements of 42 CFR 483, Subpart B, and § 1919 of the Act are also met. (*plus additional requirements described below)

C. For providers of ICF/MR services, the requirements of participation in 42 CFR 483, Subpart D are also met.

D. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

E. For each provider receiving funds under the plan, all the requirements for advance directives of Section 1902(w) are met:

1. Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State law (whether statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

2. Providers will furnish the written information described in subdivision E 1 (a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Health maintenance organizations at the time of enrollment of the individual with the organization.

3. 12VAC30-20-240 describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

As a condition of participation in the Virginia Medical Assistance Program all nursing homes must agree that when a patient is discharged to a hospital, the nursing home from which the patient is discharged shall ensure that the patient shall be given an opportunity to be readmitted to the facility at the time of the next available vacancy.

The only acceptable reasons for failure to readmit a specific patient who has been discharged to a hospital shall be the patient is certified for a level of care not provided by the facility, the patient is judged by a physician to be a danger to himself or others, or the patient, who at the time of readmission has an outstanding payment to the nursing home for which he is responsible in accordance with Medicaid regulations.

F. DMAS shall conduct provider screening according to the requirements of 42 CFR 455 Subpart E. DMAS shall terminate or deny enrollment to any provider or individual in accordance with the requirements of 42 CFR 455.416.