

CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

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PROVIDER ENROLLMENT

A participating provider is a person or organization who has a current, signed participation agreement with DMAS.

Effective April 4, 2022 all newly enrolling providers seeking to participate with Medicaid managed care or fee-for-service (FFS) must be screened and enrolled with DMAS.

DMAS's online provider enrollment process may be accessed through the Provider Enrollment link located on the DMAS Medicaid Enterprise System (MES) Provider Resources site at <https://vamedicaid.dmas.virginia.gov/provider>.

1. As a part of the enrollment process, providers must complete a Participation Agreement applicable to their provider type. In the case of a group practice, hospital, or other agency or institution, the authorized agent of the provider institution must sign the agreement. For group practice, hospital, or other agency or institution, DMAS must receive prior written ratification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists.

2. A National Provider Identifier (NPI) number must be obtained from the National Plan and Provider Enumeration System (NPPES) and provided with the enrollment application. An enrolled provider's NPI is used by MES to manage provider information across functions. For example, this number must be used on all claims submitted to DMAS.

Provider NPIs may be disclosed to other Covered Healthcare Entities pursuant to Centers for Medicaid and Medicare Services (CMS) regulations requiring the disclosure of NPIs as a part of HIPAA-compliant standard transactions. (Please reference the Healthcare Information Portability and Accountability Act (HIPAA) of 1996.)

3. Providers must have an active license from the relevant state licensing authority and provide proof of licensure during the enrollment process.

4. The provider must be successfully screened according to the requirements detailed in the next section (titled "Provider Screening Requirements").

5. Providers may be denied enrollment for any of the following reasons:

- failing to submit any of the requested information;
- conviction of a felony;
- conviction of health care fraud;
- if there are past licensure actions or actions related to privileges, enrollments, educational tenure, board certifications, authorizations, participation in health care programs, malpractice actions, liability actions, or other actions or information indicating that the individual may pose a risk to the health, safety or welfare of Medicaid members.

6. Providers who are located in another state but within 50 miles of the Virginia border may be permitted to enroll if all other qualifications are met, but are required to submit claim documentation to DMAS during the enrollment process.

7. Providers will be notified of the enrollment decision by email notice or letter mailed to the address entered into the provider enrollment portal. For denied applications, information about filing an appeal is included in the notice or letter.

8. The enrollment effective date will begin the 1st day of the month in which the application is received, unless a retroactive effective date is approved for documented extenuating circumstances.

If you have any questions regarding the enrollment process, please email Provider Enrollment Services at VAMedicaidProviderEnrollment@gainwelltechnologies.com or phone toll free 1-888-829-5373 or local 1-804-270-5105.

PARTICIPATION IN MANAGED CARE AND FEE FOR SERVICE (FFS)

Any provider of services must be enrolled with DMAS prior to billing for services rendered to eligible individuals, including individuals enrolled in either FFS or Medicaid managed care.

Most individuals who are eligible for Medicaid or Family Access to Medical Insurance Security (FAMIS) benefits are enrolled with one of the Department of Medical Assistance Services' (DMAS') contracted Managed Care Organizations (MCOs) and receive services from the MCO's network of providers. All participating providers must confirm the individual's MCO enrollment status prior to rendering services. The MCO may require a referral, service authorization or other action prior to the start of services. All providers are responsible for adhering to state and federal requirements, their MCO provider contract(s) (as applicable), and the applicable DMAS provider manual. For providers to participate with one of DMAS' contracted MCOs, they must also become a participating provider in the MCO's network.

Please visit the DMAS website at <https://vamedicaid.dmas.virginia.gov/provider> for more information on participation with the Medicaid FFS and managed care programs

Carved-Out Services

Regardless of an individual's MCO enrollment, some services are "carved-out" of the managed care program and are paid directly by DMAS using FFS methodology. Providers must follow the FFS rules in these instances.

Individuals who receive services under one of the three 1915(c) Developmental Disabilities Home and Community-Based Services (HCBS) Waivers, including the Building Independence, Community Living, and Family and Individual Supports Waivers,

are enrolled in managed care for their non-waiver services (e.g., acute, behavioral health, pharmacy, and non-waiver transportation services). The individual's waiver services benefits are carved-out and managed directly by DMAS.

PROVIDER SCREENING REQUIREMENTS

The 21st Century Cures Act (Cures Act) 114 P.P.255 requires all states to screen Medicaid providers, both those in Medicaid fee-for-service (FFS) and managed care organizations (MCOs) upon enrollment. An abbreviated screening is also performed on a monthly basis for any provider who participates with the Virginia Medicaid Program. The full screening is conducted at the time of revalidation, and providers are required to revalidate at least every 5 years.

The requirement for screening is in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid Program agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers' categorical risk levels are defined as "limited", "moderate", or "high."

Limited Risk Screening Requirements

The following screening requirements apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations and State requirements for the provider or supplier type; (2) Verification that a provider or supplier meets applicable licensure requirements; and (3) Verification that a provider or supplier has not been excluded from providing services in federally funded programs. The verification process includes a review of applicable federal and state databases checks and is completed on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.

Moderate Risk Screening Requirements

In addition to the screening requirements applicable to the limited risk provider category listed above, unannounced pre-and/or post-enrollment site visits apply to moderate risk providers. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submit fingerprints. These requirements apply

to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening.

Application Fees

Institutional providers may be required to pay a federally-required fee at the time of application for enrollment, re-enrollment or reactivation, and when adding new locations. If a provider is required to pay an application fee, it will be outlined in the provider enrollment application and/or revalidation notice.

CMS determines the application fee each year. This fee is not required to be paid to DMAS if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request for CMS approval with their enrollment application. If CMS does not approve the hardship request, then providers have 30 calendar days from the date of the CMS notification to pay the application fee or the application for enrollment will be rejected.

An appeal of a hardship exception determination must may be made to CMS pursuant to 42 CFR 424.514.

Out-of-State Provider Screening

Prior to enrollment in DMAS, providers with a primary servicing address located outside of the Virginia border must have a site visit conducted by either their state’s Medicaid program or by CMS due to their provider risk-level. Pursuant to 42 CFR 455 Subpart E, an application will be pended for proof of this information if it is received by DMAS prior to the completion of the site visit.

Revalidation Requirements

All participating providers are required to revalidate at least every 5 years. Providers are notified in writing of their revalidation due date and of any new or revised provider screening requirements. (Providers will indicate their preferred mode of notification, i.e., email or USPS, at the time of enrollment.) DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements if a provider is enrolled as a Medicare provider at the time of revalidation.

ORDERING, REFERRING, AND PRESCRIBING (ORP) PROVIDERS

42 CFR 455.410(b) states that state Medicaid agencies must require all ordering, or referring, and prescribing physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ORP providers to enroll to meet new program integrity requirements designed to ensure that all orders, prescriptions or referrals for items or services for Medicaid members originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. There is one exception: the provider enrollment requirements do not apply to physicians who order or refer services for a Medicaid member in a risk-based managed care plan.

If a provider does not participate with Virginia Medicaid currently but may order, refer, or prescribe to Medicaid members, they must be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Virginia Medicaid Program must perform the following activities, as well as any other activities specified by DMAS:

- Immediately notify Provider Enrollment Services in writing of any change in the information that the provider previously submitted to DMAS.
- Ensure freedom of choice to individuals who are eligible for medical assistance under the Virginia Medicaid Program (eligible individuals) in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the required service(s) and participating in the Virginia Medicaid Program at the time the service was performed.
- Ensure the eligible individual's freedom to reject medical care and treatment.
- Provide services and supplies to eligible individuals in the same mode of delivery and of the same quality and as provided to the general public.
- Charge DMAS for the provision of services and supplies to eligible individuals in amounts not to exceed the provider's usual and customary charges to the general public.
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill an eligible individual for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from an eligible individual, or any financially responsible

relative or representative of that individual, any amount that exceeds the established Medicaid allowance for the service rendered. A provider may not charge DMAS or an eligible individual for missed or broken appointments.

- Accept assignment of Medicare benefits for eligible individuals.
- Use DMAS-designated billing forms to submit claims.
- Maintain and retain business and professional records sufficient to fully and accurately document fully and accurately the nature, scope, and details of the health care provided. In general, such records must be retained for a period of not less than six years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved.
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
- As requested by DMAS, 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 eligible individuals.
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding eligible individuals. A provider shall disclose information in his or her 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. DMAS shall not disclose medical information to the public.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES

In order to comply with Federal Regulations and Virginia Medicaid Program policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by individuals or entities that have been excluded from participation in any state Medicaid Program or Medicare.

Payments cannot be made for items or services furnished, ordered, or prescribed by an excluded provider or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the payment itself is made to another provider, practitioner, or supplier that is not excluded, but is affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services

reimbursable by the Virginia Medicaid Program may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to meet Federal and Virginia Medicaid program integrity requirements:

- Screen all new and existing employees and contractors to determine whether any of them have been excluded from participation in Medicaid or Medicare. (Go to <https://oig.hhs.gov/exclusions/>)
- Search the Health and Human Services Office of the Inspector General (HHS-OIG) List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs.
- Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS

Attn: Program Integrity/Exclusions 600 E. Broad St, Suite 1300
Richmond, VA 23219

-or-

E-mailed to: providerexclusions@dmass.virginia.gov

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C. §794), provides that no disabled individual shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, all Medicaid providers are responsible for making provisions for disabled individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964

All providers of care and suppliers of services under contract with DMAS must comply with the requirements of Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from

participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the basis of race, color, religion, sex, or national origin.

UTILIZATION OF INSURANCE BENEFITS

Virginia Medicaid is a "payer of last resort" program. Benefits available under Medicaid shall be reduced to the extent that they are available through other federal, State, or local programs; coverage provided under federal or State law; other insurance; or, third-party liability.

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- Title XVIII (Medicare) – The Virginia Medicaid Program will pay the amount of any deductible or coinsurance up to the Medicaid limit for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- Workers' Compensation - No payments shall be made for a patient covered by Workers' Compensation.
- Other Health Insurance - When an eligible individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), the Virginia Medicaid Program requires that these benefits be used first. Supplementation shall be made by the Virginia Medicaid Program when necessary, but the combined total payment from all insurance, shall not exceed the amount payable under Medicaid had there been no other insurance.
- Liability Insurance for Accidental Injuries - DMAS will seek repayment from any settlements or judgments in favor of eligible individuals who receive medical care as the result of the negligence of another. DMAS should be notified promptly if an eligible individual is treated as the result of an accident, DMAS should be notified promptly so action can be initiated to establish a lien as set forth in the Code of Virginia §8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing DMAS.

In the case of an accident in which there is a possibility of third-party liability or if the eligible individual reports a third-party responsibility (other than those cited on his Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward the DMAS-1000 to the attention of the Third-Party Liability Casualty Unit, Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219. The form can also be sent electronically to TPLcasualty@dmas.virginia.gov

DOCUMENTATION REQUIREMENTS

The Virginia Medicaid Program provider participation agreement requires that medical records fully disclose the extent of services provided to all Medicaid members. Medical records must clearly document the medical necessity for covered services. This documentation must be written at the time the service is rendered and the description of the services rendered must be clear. All documentation must be signed (name and title) and dated (month, day, year) on the date of service delivery.

ELECTRONIC SIGNATURES

An electronic signature that meets the following criteria is acceptable for clinical documentation:

- Identifies the individual signing the document by name and title;
- Assures that the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and
- Provides for nonrepudiation; that is, strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

Use of the electronic signatures for clinical documentation purposes shall be deemed to constitute a signature and will have the same effect as a written signature on a document. Providers shall have written policies and procedures in effect regarding use of electronic signatures. In addition to complying with security policies and procedures, providers who use electronic signatures shall sign a statement assuring that they alone will have access to and use the key or computer password. The policies and procedures and statements of exclusive use shall be maintained and available at the provider's location.

Additionally, the use of electronic signatures shall be consistent with the applicable accrediting and licensing authorities and the provider's own internal policies. These requirements for clinical documentation apply only to Medicaid claims, and do not preclude other state or federal requirements.

An original written signature is still required on provider enrollment forms and for medical consents. This clarification does not apply to electronic claims submission or the electronic sharing or transmission of clinical records.

TERMINATION OF PROVIDER PARTICIPATION

The provider participation agreement is time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to DMAS 30 days prior to the effective date. The written notification should be sent to the following address:

DMAS Provider Enrollment Services
PO Box 26803
Richmond, Virginia 23261-6803

DMAS may terminate a provider's participation agreement. DMAS must provide written notification 30 days prior to the termination's effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

Pursuant to §32.1-325 (D) of the Code of Virginia, the DMAS Director of Medical Assistance Services is authorized to:

Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

Appeals of Provider Termination or Enrollment Denial: A provider has the right to appeal in any case in which a Virginia Medicaid Program provider agreement or contract is terminated or denied pursuant to Virginia Code §32.1-325(D). The provider may appeal the decision in accordance with the Administrative Process Act (Code of Virginia §2.2-4000 et seq.) and the Provider Appeals regulations (12 VAC 30-20-500 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division within 15 calendar days of the receipt of the notice of termination or denial.

APPEALS OF ADVERSE ACTIONS

An appeal is a request for a review of an adverse decision taken by DMAS, a DMAS contractor, or another agency on behalf of DMAS. There are two types of appeals – a provider appeal, which may be filed by a provider or their authorized representative, and a client appeal, which may be filed by an individual or an authorized representative on the individual's behalf. The provider appeals process is described below. The client appeals process is described in Chapter III.

PROVIDER APPEALS

Definitions

Administrative Dismissal –the dismissal of a provider appeal that requires only the issuance of an informal appeal decision with appeal rights but does not require the

submission of a case summary or any further informal appeal proceedings.

Adverse Action – means, for services that have already been rendered, the termination, suspension, or reduction in covered benefits or the denial or retraction, in whole or in part, of payment for a service. An adverse action may also include the denial or termination of enrollment as a DMAS participating provider.

Appeal – means:

1. A request made by an MCO provider (in-network or out-of-network) to review the MCO's reconsideration decision of an adverse action in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a DMAS-enrolled provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq.* and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq.*; or

2. For fee-for-service ("FFS") services, a request made by a provider to review DMAS' adverse action or a DMAS Contractor's reconsideration decision of an adverse action in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq.* and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq.*

Reconsideration – means a provider's reconsideration request of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers. Many adverse actions require a provider to request reconsideration with DMAS or the DMAS Contractor before appealing to the DMAS Appeals Division. Read the denial notice carefully to determine if reconsideration is required, as the reconsideration process is a pre-requisite to filing an appeal with the DMAS Appeals Division. Failure to exhaust a required reconsideration process will result in the appeal to the DMAS Appeals Division being deemed premature.

If the provider chooses to exercise available appeal rights, a request for reconsideration

must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. For EAPG and ClaimCheck actions, the request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division
Department of Medical Assistance Services
600 East Broad Street,
Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal reconsideration rights with an MCO must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO. A reconsideration may also be required by other DMAS contractors before appealing to DMAS.

For services that have been rendered and any applicable reconsideration rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et seq.*

Provider appeals to DMAS must be submitted in writing and within 30 calendar days of the provider's receipt of the DMAS adverse action or final reconsideration decision. There are two case types that have other timeframes to file appeals: (1) provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed within 15 calendar days of the provider's receipt of the DMAS adverse action; and (2) providers appealing adjustments to a cost report are required to file the informal appeal within 90 calendar days of the provider's receipt of the notice of program reimbursement.

The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the adverse action being appealed. To ensure that the appeal is efficiently processed, include: the provider name, national provider identification number (NPI), recipient name(s) and Medicaid ID# *[if applicable]*, date(s) of service *[if applicable]*, claim or service authorization number *[if applicable]*, and the reason for the appeal. Also include a copy of the adverse action and a contact name, phone number, and address for appeal correspondence.

Failure to file a written notice of informal appeal within the prescribed timeframe or that

does not identify the action being appealed will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System (“AIMS”) at <https://www.dmas.virginia.gov/appeals/>. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at <https://www.dmas.virginia.gov/appeals/>. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
 - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
 - Email to appeals@dmas.virginia.gov; or
 - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider’s receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et seq.* and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be

added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee must then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries must be final.

PROVIDER PARTICIPATION REQUIREMENTS – NURSING FACILITY

Nursing Facility

For the purpose of Medicaid, a nursing facility is a licensed institution, public or private, or a part thereof, which provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital is designed to provide, but who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

To become a DMAS provider, a nursing facility must:

Be licensed and certified by VDH as meeting standards required by federal regulations to provide Nursing Facility Services or be identified as a distinct part of another medical institution which is either operated by the state or licensed by the appropriate state authority (e.g., a state institution for individuals with intellectual disabilities);

Enter into a Participation Agreement with DMAS;

Comply with the participation requirements of DMAS; and

Submit acceptable financial data to establish a Medicaid reimbursement rate with DMAS.

Nursing facility care is defined as the provision primarily of resident services such as: help in walking, transferring, bathing, dressing, feeding, preparation of diet, supervision of medications which cannot be safely self-administered, and other types of personal assistance which are usually provided by trained nurses' aides and licensed nurses under the supervision of a professional registered nurse (RN). Nursing facility criteria are defined in Appendix B.

Specialized Care Provider

To participate in Medicaid, a specialized care facility must meet all of the requirements outlined for nursing facility participation and enter into an additional Provider Agreement with DMAS specifically for Specialized Care Services.

Note: Nursing facilities must have a separate contract with DMAS to receive reimbursement for Specialized Care Services.

Specialized Care targets residents who require a higher intensity of nursing care than that which is normally provided in a nursing facility but who do not require the degree of care and treatment that a hospital is designed to provide. Care must be provided by a nursing facility. The resident must have long-term health conditions requiring close medical supervision, 24 hours of licensed nursing care, and specialized services or equipment. Admission requirements are outlined in Chapter IV.

It is intended that the per diem received by the facility for providing Specialized Care Services be all-inclusive for the resident's care with the exception of certain allowable items (e.g., medications) that would be billed by the pharmacy. For example, nursing

facilities may not bill Medicare Part B for the tube-feeding portion of the resident's care for enterally fed residents who are in specialized care beds. In addition, the facility may not bill the co-insurance portion of the tube-feeding claim to Medicaid, as this would constitute a double billing to the Virginia Medicaid Program.

Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IIDs)

For Medicaid purposes, a facility for the IID is a licensed facility, public or private, which provides health and (re)habilitative services for persons who have IID or have "related conditions." 42 CFR 440.150

To participate in Medicaid, an ICF/IID must be certified by VDH as meeting standards required by federal regulations to provide intermediate care for the IID and must comply with the participation requirements of DMAS. The facility may be identified as a distinct part of another medical institution that is operated by the state or licensed by the appropriate state authority.

In addition to meeting the certification and participation requirements, the facility must provide "active treatment" as defined in the 42 CFR 435.1009 and 483.440. "Active treatment" includes each of the following:

Each resident must receive a continuous active treatment program, which includes the aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services directed toward: 1) the acquisition of behaviors necessary for the resident to function with as much self-determination and independence as possible, and 2) the prevention or deceleration of regression or loss of current optimal functional status.

NOTE: Active treatment does not include services to maintain generally independent residents who are able to function with little supervision or in the absence of a continuous active treatment program;

Each resident must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines, or service areas that are relevant to identifying the resident's needs and designing programs to meet those needs; and

Appropriate facility staff must participate in interdisciplinary team meetings. Participation by the resident and his/her parent or guardian is required unless unobtainable or inappropriate.

Assessments required include the following:

Admission decisions must be based on a preliminary evaluation of the resident conducted or updated by the facility or outside sources. This evaluation must include background information as well as currently valid assessments of functional, developmental, behavioral, social, health, and nutritional status;

Within 30 days after admission, the interdisciplinary team must perform accurate assessments or re-assessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into

consideration the resident's age and implications for active treatment at each stage, as applicable;

Within 30 days after admission, the interdisciplinary team must prepare for each resident an individual program plan stating the specific measurable objectives in behavioral terms which are necessary to meet the resident's needs and the planned sequence for dealing with those objectives;

As soon as the interdisciplinary team has formulated a resident's individual program plan, the resident must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. The individual program plan must be reviewed at least by the qualified IID professional and revised as necessary;

At least annually, the comprehensive functional assessment of each resident must be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan must be revised, as appropriate; and

At the time of discharge, the facility must develop a final summary of the resident's development, behavioral, social, health, and nutritional status and, with the consent of the resident, parents (if the resident is a minor), or legal guardian, provide a copy to authorized persons and agencies and provide a post-discharge Plan of Care (POC) that will assist the resident with adjusting to the new living arrangement.

Services for individuals with intellectual disability are defined as a combination of habilitative, rehabilitative, and health services directed toward increasing the functional capacity of the person. The overall objective of programming shall be the attainment of the optimal physical, intellectual, social, and task-learning levels that the person can presently or potentially achieve. Criteria for ICF/IIDs are included in Appendix B.

Out-of-State Nursing Facilities

Generally, non-enrolled, out-of-state nursing facilities are subject to the same policies and program limitations as participating nursing facilities, except that non-enrolled, out-of-state, and non-participating nursing facilities will be reimbursed based upon the average per diem reimbursement to enrolled nursing facilities.

If the specific nursing facility's services required by the resident are available in a Virginia nursing facility within a reasonable distance of the recipient's home, the recipient should not be referred to an out-of-state nursing facility. Out-of-state placements must be approved by DMAS prior to placement. Out-of-state nursing facility providers are subject to the same regulations as in-state nursing facility providers.

RESPONSIBLE PARTY REQUIREMENTS

Any nursing facility certified by Medicaid or Medicare shall not require a third-party guarantee of payment to the facility as a condition of admission or of expedited admission

to, or continued stay in, the facility. This does not prevent a facility from requiring an individual, with legal access to a resident's income or resources available to pay for care in the facility, to sign a contract without incurring personal financial liability, except for breach of the duty to provide payment from the resident's income or resources for such care. The resident's income or resources shall include any amount deemed to be income or resources of the resident for purposes of Medicaid eligibility and any resources transferred by the resident to a third party if the transfer disqualifies the resident from Medicaid coverage for Nursing Facility Services.

A nursing facility may require financial guarantees from a third party as a condition of admission or continued stay of a Medicaid recipient only if:

The agreement is limited to non-covered services; and

The agreement does not apply to covered services or prior time periods when the recipient is determined to be retroactively Medicaid-eligible.

PRECONDITIONS FOR ADMISSION OR CONTINUED STAY IN MEDICAL FACILITIES

The right of Medicaid recipients to receive Medical Facility Services is based upon medical necessity and a determination of eligibility by the local DSS offices in Virginia. Additional requirements, such as prior status as a private-paying resident, a pre-admission deposit, gifts, donations, or other considerations, may not be established by a participating provider as a precondition for admission or as a requirement for continued stay in a facility.

Federal regulations (42 CFR 447.15) provide that participation will be limited to providers of service who accept as payment in full the amounts paid in accordance with the fee structure. Section 4 of Public Law 95-142 (The Medicare-Medicaid Antifraud and Abuse Amendments of 1977, subsection (d) of 42 USC § 1320a-7b), quoted below, provides that certain actions by facilities constitute a criminal act:

Whoever knowingly and willfully (1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State (or, in the case of services provided to an individual enrolled with a Medicaid managed care organization under subchapter XIX of this chapter under a contract under section 1396b(m) of this title or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or (2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or (B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and, upon conviction thereof, shall be fined not more than \$100,000 or imprisoned for not more than 10 years, or both.

Medicaid policies regarding preconditions for admission or continued stay address three specific situations:

The patient is Medicaid-eligible at the time of admission. – If a patient is admitted to a Medicaid-enrolled facility, there can be no precondition for admission requiring any period of private pay or a deposit from the resident or any other party.

Medicaid eligibility is pending at the time of admission. – Medicaid long-term care providers cannot collect more than the Medicaid rate from a Medicaid recipient. When Medicaid eligibility is determined, it is most often made retroactive to a time prior to the date that the eligibility decision is made. Federal statutory and regulatory requirements mandate that the nursing facility accept Medicaid payment as payment in full when a person's Medicaid eligibility begins. Thus, nursing facilities are required to refund any excess payment received from a resident or family member for the period of time that the Medicaid eligibility was pending and the resident is determined eligible for Medicaid.

A private pay resident applies for Medicaid and becomes eligible after admission. – An enrolled provider may not require discharge of the resident or continue to require a period of private pay subsequent to the initial eligibility date for residents in Medicaid-certified units. The Virginia Medicaid Program must be billed for all covered services delivered by a provider beginning with the date of eligibility in such cases (42 CFR 483.10(e)(11) and § 32.1-138 of the Code of Virginia, 1950 as amended).

NOTE: Nothing in this section is to be construed as altering DMAS policy concerning nursing facility pre-admission screening (see Chapter VI of this manual).

PRE-ADMISSION SCREENING OF INDIVIDUALS WITH MENTAL ILLNESS AND/OR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

As a condition of Medicaid participation, all individuals who apply for nursing facility admission must be screened for conditions of mental illness, individuals with intellectual disabilities, or a related condition, to determine if Medicaid-eligible applicants meet the criteria for nursing facility placement. It is the responsibility of the nursing facility to ensure that the applicable requirements are met. Refer to Appendix C for specific policies and procedures regarding these requirements.

CERTAIN CONTRACT PROVISIONS PROHIBITED

Section 32.1-138.2 of the Code of Virginia requires:

No contract or agreement for nursing facility care shall contain any provisions which restrict or limit the ability of a resident to apply for and receive Medicaid or which require a specified period of residency prior to applying for Medicaid. The resident may be required to notify the facility when an application for Medicaid has been made. No contract or agreement may require a deposit or other prepayment from Medicaid recipients. No contract or agreement shall contain provisions authorizing the facility to refuse to accept retroactive Medicaid benefits.

VALUE-BASED PURCHASING (VBP) PROGRAMS

In a continued effort to support improved quality of care for Medicaid recipients in Virginia, DMAS has established Value-Based Purchasing programs to support providers in quality improvement efforts. Please refer to Appendix H: Value-Based Purchasing (VBP) Programs for specific program information.