ADMINISTRATIVE SANCTIONS

Sanctions, Enforcement Actions, and Termination

Centers for Medicare and Medicaid Services (CMS) and the state administering agency (SAA) have the ability to levy sanctions in the form of civil money penalties, a suspension of payments, and termination of the contract for a variety of offenses as they relate to the operation of the Program of All-Inclusive Care for the Elderly (PACE) program. In an exception to the Standards of Payment, any violation of the Adult Day Health Care (ADHC) regulations as otherwise promulgated that would warrant sanctions may be applied only to the ADHC component of PACE.

CMS and the SAA report the results of the reviews to the PACE organization, along with any recommendations for changes to the organization's program. The PACE organization must write a corrective action plan (CAP), a description of the action plan that will be taken to correct the identified deficiency.

The PACE organization must take action to correct deficiencies identified during the reviews as required by 42 Code of Federal Regulations (CFR) 460.194. CMS or SAA monitors the effectiveness of the corrective action. Failure to correct deficiencies may result in sanctions or termination. Disclosure of the review results must be available as demonstrated by 42 CFR 460.196.

CMS may impose any of the sanctions specified in 42 CFR 460.42 and 42 CFR 460.46 if the PACE organization commits any of the following violations:

- Fails substantially to provide a beneficiary medically necessary items and services that are covered PACE services, if the failure adversely affected (or has substantial likelihood of adversely affecting) the beneficiary;

- Involuntarily disenrolls a beneficiary in violation of 42 CFR 460.164;

- Discriminates in enrollment or disenrollment among Medicare beneficiaries or Medicaid beneficiaries, or both, who are eligible to enroll in a PACE program, on a basis of an individual's health status or need for health care services;

- Engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment, except as permitted by 42 CFR 460.150, by Medicare beneficiaries or Medicaid beneficiaries whose medical condition or history indicates a need for substantial future medical services;

- Imposes charges on beneficiaries enrolled under Medicare or Medicaid for premiums in

excess of the premiums permitted;

- Misrepresents or falsifies information that is furnished to CMS or the State under this part or to an individual or any other entity under this part;

- Prohibits or otherwise restricts a covered health care professional from advising a beneficiary who is a patient of the professional about the beneficiary's health status, medical care, or treatment for the beneficiary's condition or disease, regardless of whether the PACE program provided benefits for that care or treatment, if the professional is acting within his or her lawful scope of practice;

- Operates a physician incentive plan that does not meet the requirements of section 1876(i) (8) of the Act; and

- Employs or contracts with any individual who is excluded from the participation in Medicare and Medicaid under section 1128 or section 1128A of the Act (or with any entity that employs or contracts with that individual) for the provision of health care, utilization review, medical social work, or administrative services.