REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

EXCEPTIONS TO NURSING FACILITY REIMBURSEMENT STUDY

(SB 1249)

TO THE CHAIRMAN OF THE SENATE COMMITTEE ON EDUCATION AND HEALTH

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Patrick W. Finnerty

Preface

Senate Bill 1249 and House Bill 2276, which were introduced during the 2001 General Assembly Session, addressed concerns regarding the need for more timely reimbursement of extraordinary expenses encountered by nursing facilities. The bills were not identical but addressed similar reimbursement issues. SB 1249 addressed the issues of (i) extraordinary cost increases faced by nursing facilities because of the shortage of nurses, and (ii) reimbursement of nursing facilities which increase their bed capacity.

Neither SB 1249 nor HB 2276 was passed by the General Assembly. SB 1249 was left in the Senate Committee on Education and Health. The Senate Committee approved a motion that the issues included in SB 1249 be included in the 2001 study plan for the Joint Commission on Health Care (JCHC). HB 2276 was reported by the House Committee on Health, Welfare and Institutions but was subsequently tabled by the Committee on Appropriations.

Based on our research and analysis during this review, we concluded the following:

- Virginia's Medicaid methodology historically has not adequately reimbursed nursing facilities. A 2000 report by the Joint Legislative Audit and Review Commission reported that in 1997, Medicaid reimbursement was only paying for approximately 92 percent of the cost of caring for a patient.
- Changes have been made in the Medicaid reimbursement methodology in order to provide more adequate compensation of nursing facilities. Additional funding was appropriated for Medicaid reimbursement for nursing facilities beginning in FY 2000, first to fund increases in salaries for direct care providers and later to fund changes in the Medicaid methodology. The average per diem rate is expected to be $89.81 for 2001 (in 1999, the average per diem rate was $78.12).
- Nursing facilities often pay significant but unreimbursed cost increases while waiting for an updated per diem rate. Nursing facilities receive an initial "calculated" per diem rate that is based on their previous year's rate which is then inflated for one year's costs. Any significant cost increases experienced in the previous year will not be addressed until after the cost reports for that year have been submitted and approved by DMAS.

- DMAS was not able to readily provide information regarding the total amount of the payments that nursing facilities received as compared with the total amount that had to be paid back. DMAS staff indicated that total payments to facilities are typically substantially higher than total collections from facilities. The time it takes to receive reimbursement for actual costs can be very difficult for nursing facilities if they are experiencing financial pressures. The American Health Care Association reported that 26 or 9.9 percent of nursing facilities in Virginia filed for bankruptcy protection in 1999 and 2000.
- DMAS staff indicated that they would not support amending the Medicaid reimbursement methodology as recommended in SB 1249 or HB 2276. DMAS staff specifically object to bill provisions that would allow nursing facilities to receive payments that might be in excess of what they are entitled to receive. DMAS prefers to continue its nursing facility work group to resolve reimbursement issues.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 17 and 18. Public comments were solicited on the draft report. A summary of the public comments is attached at Appendix B.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Virginia Department of Medical Assistance Services, Blue Ridge Nursing Home, the Virginia Association of Nonprofit Homes for the Aging, the Virginia Health Care Association, the Virginia Hospital and Healthcare Association, and the other agencies and individuals who provided input and information during this study.

Patrick W. Finnerty
Executive Director

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TABLE OF CONTENTS

I.
Authority for the Study

Senate Bill (SB) 1249 and House Bill (HB) 2276 of the 2001 General Assembly Session addressed concerns regarding the need for more timely reimbursement of extraordinary expenses encountered by nursing facilities. The bills were not identical but addressed similar reimbursement issues.

SB 1249 was left in the Senate Committee on Education and Health. The Senate Committee approved a motion that the issues included in SB 1249 be included in the 2001 study plan for the Joint Commission on Health Care (JCHC). The letter from the chairman of the Senate Committee on Education and Health states:

> SB 1249 "addressed issues concerning increases in the direct patient care payment rate because of extraordinary circumstances beyond the control of the nursing home, such as a shortage of nurses that requires the hiring of contract nurses and, thus, higher personnel costs, and the effects of a patient-bed expansion on the calculation of a nursing home's prospective payment rate. Although the Committee discussed Virginia Medicaid's nursing facility reimbursement and financial challenges faced by nursing facilities, the bill was tabled due to the more than $10 million per year fiscal impact statement and because of concerns about imposing changes in the payment methodology without appropriate and cautious evaluation. The motion on SB 1249 included a request that the Joint Commission on Health Care direct its Long-Term Care Subcommittee to evaluate the issues presented by SB 1249."

A copy of this letter is included in Appendix A.

HB 2276 would require the Board of Medical Assistance Services to "include a provision to revise the payment methodology for nursing facility reimbursement that addresses the nursing personnel shortages in rural nursing facilities." HB 2276 was reported by the House Committee on Health, Welfare and Institutions but was subsequently tabled by the House Committee on Appropriations.

SB 1249 and HB 2276 are included in Appendix B.

Organization of Report

The report is presented in four major sections. This section discussed the authority for the study. Section II presents background information on Virginia's Medicaid reimbursement methodology for nursing facilities. Section III discusses the possible need to implement a process in which extraordinary expenses could be considered for timely reimbursement. Section IV provides a series of policy options the Joint Commission on Health Care may wish to consider in addressing the issues raised in this study.

II.
Background

Virginia's Medicaid Reimbursement Methodology Historically Has Not Adequately Reimbursed Nursing Facilities for the Costs of Providing Care

A report completed by the Joint Legislative Audit and Review Commission (JLARC) in 2000 found that Virginia's Medicaid reimbursement for nursing facilities did not adequately reimburse for the cost of providing care. The report, *Virginia's Medicaid Reimbursement to Nursing Facilities*, found that nursing facilities in 1994 were reimbursed for approximately 97 percent of the cost of caring for a Medicaid patient. By 1997, however, the adequacy of that reimbursement had "dropped to 92 percent" of cost. The JLARC report indicated that after adjusting Virginia's 1998 Medicaid rate to make it as comparable as possible to the rates paid by other states, Virginia had the 38th lowest reimbursement rate. This low rate was exacerbated by the fact that Virginia was "ranked number one in the country for having the heaviest care nursing facility patients." (This ranking was made by the American Health Care Association based on information collected in 1998 by the U. S. Department of Health and Human Resources.)

Virginia's Medicaid Reimbursement Methodology Consists of Three Cost Components

Virginia's Medicaid reimbursement includes three cost components: direct care costs, indirect care costs, and capital costs. As noted in the JLARC report, direct care costs include "nursing salaries and benefits, supplies, medical director salaries, pharmacy, consultant fees, oxygen, nutrient/tube feedings, and ancillaries (such as physical, occupational, and respiratory therapies)." Indirect care costs include supportive costs such as food services, laundry, housekeeping, maintenance, staff training, quality assurance, and administrative costs. This study will focus primarily on direct care costs.

Nursing facilities are prospectively paid according to the lower of either their calculated "actual" costs or the payment ceilings set by the Department of Medical Assistance Services (DMAS) which administers the

Medicaid program for Virginia. Payment ceilings are established by DMAS based on median nursing facility costs for the facility's assigned "peer group." At the time of the JLARC report, payment ceilings were based on 1989 cost reports that had been adjusted for inflation over the nine-year period. The JLARC report recommended that frequent recalculation of ceilings be instituted as noted in the following excerpt.

> "The use of inflation only over the last nine years ignores the fact that costs may have increased due to changes in the type of resident served by each facility. The purpose of frequent recalculation is to determine whether facilities are in danger of failing to meet the residents' care needs or are in excess of costs incurred by economic and efficient facilities."

Nursing facility reimbursement is also adjusted according to occupancy rate requirements set by DMAS. The purpose of setting occupancy rates is to encourage nursing facilities to maintain efficient operations by having a high occupancy rate. (Occupancy rates are determined by dividing the facility's average daily census by its licensed bed allotment). At the time of the JLARC report, Virginia had relatively high occupancy rate requirements of 95 percent for facilities with more than 30 beds and 85 percent for the five facilities that had 30 or fewer beds. The occupancy rate was applied to the three cost components of direct care, indirect care, and capital costs in adjusting a facility's Medicaid reimbursement rate.

Significant Changes Continue to Be Made in Virginia's Medicaid Methodology

The resolution which required the JLARC study of Medicaid reimbursement of nursing facility reimbursement specifically asked that "adequacy of reimbursement levels for providing quality care, [and] options for simplifying the nursing facility reimbursement process" be considered.

The JLARC report proposed a number of changes to the reimbursement methodology in order to provide more adequate compensation to nursing facilities. DMAS, in consultation with a work group including industry representatives, has made significant changes in the Medicaid reimbursement methodology including:

- eliminating the occupancy requirement for direct care costs,
- reducing the occupancy requirement for indirect care and capital costs from 95 percent to 90 percent,
- increasing direct care cost ceilings (ceilings above which nursing facility costs are not compensated) from 106 percent to 112 percent of the statewide median,
- increasing indirect care ceilings from 100 percent to 106.9 percent of the statewide median,
- recalculating (or "rebasing") payment ceilings every two years, and
- phasing in (over the next ten years) a new capital cost methodology based on fair rental value.

One of the primary ways in which the reimbursement methodology is being simplified involves developing one payment system for all facilities. As noted in the JLARC report:

> "A certain amount of complexity is inherent in a Medicaid reimbursement methodology. Some complexity is necessary, for example, in order to determine what constitutes a reasonable, efficient, and equitable level of payment to meet the needs of Medicaid residents in the facilities.....[T]he goal of achieving greater simplicity in the reimbursement process should be promoted by DMAS' efforts to develop one payment methodology which includes specialized care residents, and eliminates some of the more routine aspects of cost settlement."

DMAS continues to work with the nursing facility industry regarding specialized care payments and in adopting the federal case mix system known as RUGS-III. The RUGS system is a more complex system of measuring patient acuity than Virginia has now. The RUGS system will allow patients to be classified in one of 43 different acuity categories. The patient-acuity system that Virginia uses now includes only three classifications. It is expected that adoption of the RUGS system will allow for a more accurate representation of the diversity of patient care needs and the services that are provided to care for those needs. The new system is expected to be implemented effective January 1, 2002. DMAS is currently tracking and reporting to nursing facilities what their reimbursement would be under the RUGS system as compared with the

reimbursement they are currently receiving. The adoption of the RUGS system is expected to change how funding is distributed among nursing facilities as opposed to increasing or decreasing the total amount of funding that is provided for nursing facilities.

Additional Funding Has Been Appropriated in the Last Three Years to Support Nursing Facility Reimbursement

The General Assembly has appropriated additional funding to address nurse staffing problems and to implement changes in the Medicaid reimbursement methodology for nursing facilities. Additional funding of $21.7 million in state and federal funding was appropriated for FY 2000 to allow for direct care salary increases to address the difficulty that nursing facilities were facing recruiting and retaining nurses. The funding was designed to provide for wage increases (of $1.00 per hour on average) for CNAs. This funding was added to the "base" funding for nursing facilities beginning in fiscal year 2001 in the form of a $3.47 per diem increase in the Medicaid rates. Total (state and federal) funding of an additional $28 million for each year of the 2000-2002 biennium was appropriated to fund the changes being made in Virginia's Medicaid reimbursement methodology. (It should be noted that JLARC estimated that total annual funding increases of $1.7 million to $31.8 million would be needed depending on the number of proposed changes the General Assembly decided to address. The nursing facility industry estimated the cost of making all JLARC-proposed changes to be $78.8 million in state and federal funding. Moreover, the JLARC report stated the since "the staff review focused on the reimbursement methodology and its relationship to quality of care, some of the funding items identified by the nursing facilities are not captured by the study and may need to be considered as issues that are separate from this report." The nursing facility industry estimated total annual funding of $25.8 million would be needed to fund the additional services which included federal and state quality initiatives, specialized care, and therapy costs that were no longer paid by Medicare.)

The funding increases that have been made to date are expected to increase the average Medicaid reimbursement rate for nursing facilities by 26 percent from $78.12 per day in 1999 to a projected rate of $98.81 per day in 2001. DMAS is in the process of recalculating payment ceilings that will be effective in 2002. Additional funding may be needed if the new payment ceilings continue to be set at 112 percent of median facility costs.

III.
Consideration of the Need for Reimbursement Exceptions

Nursing Facilities Often Pay Significant but Unreimbursed Cost Increases While Waiting to Receive an Updated Per Diem Rate

As noted previously, nursing facilities are prospectively paid according to a per diem rate based on "actual" costs in the previous year or payment ceilings whichever is the lower amount. The current payment ceilings became effective in 2000 and were based on 1998 cost reports. Figure 1 illustrates the timeframes involved in determining nursing facility reimbursement rates for 2001. As shown, nursing facilities receive an initial "calculated" per diem rate that is based on their 2000 rate which is then inflated for one year's costs. Since the 2000 rate is actually based on 1999 cost data, any significant cost increases that were experienced in 2000 will not be factored into the calculated per diem rate. In fact, these cost increases will not be addressed until after the facilities' 2000 cost reports have been submitted to and approved by DMAS. At that point, DMAS will "settle" the difference between the calculated per diem rates and what the actual prospective per diem rates would have been if those rates had been known and adopted at the first of the fiscal year.

The delay in determining actual per diem rates is exacerbated by the fact that 70 percent of nursing facilities have chosen to have a fiscal year of January 1 through December 31. Cost settlement will not be completed until November for many of these facilities because of the volume of reports that are submitted at one time to DMAS. This delay in cost settlement is significant since the majority of nursing facilities receive payment from DMAS because their calculated per diem rate turned out to be lower than their actual rate. DMAS was not able to readily provide information regarding the total amount of the payments that nursing facilities received as compared with the total amount that nursing facilities had to pay back in direct care cash adjustments in 2000. However, DMAS staff indicated that total payments to facilities were substantially higher than total collections from facilities.

Figure 1

DMAS Timeframes Related to Nursing Facility Reimbursement for 2001

Nursing facilities initially receive a calculated per diem rate for 2001 based on their 2000 per diem rate plus an inflation factor. (The 2000 per diem rate is based on 1999 cost data.) The actual per diem rate for 2001 will not be determined until nursing facility cost reports for 2000 have been submitted to DMAS which will analyze the costs for appropriateness. ➡	The majority of nursing facilities have chosen to submit their 2000 cost reports to DMAS by May 31, 2001. DMAS has 180 days after receipt of the cost reports to determine whether retroactive payment to or collection from each of the nursing facilities is needed based on the difference between the calculated per diem rate that was paid and the actual per diem rate that has been established. This process is known as "cost settlement." ➡	Following cost settlement, DMAS will reimburse the nursing facilities for the remainder of 2001, based on their newly-established actual per diem rates.

Source: JCHC staff analysis of information provided by the Department of Medical Assistance Services.

The delay in receiving reimbursement that appropriately reflects actual costs can be very difficult for nursing facilities to sustain if they are experiencing serious financial pressures. The American Health Care Association reported that 26 or 9. 9 percent of nursing facilities in Virginia filed for bankruptcy protection in 1999 and 2000, while nationwide 10.9 percent of nursing facilities filed for bankruptcy protection.

SB 1249 Provides for Changing the Reimbursement Methodology for Nursing Facilities So Increased Payments for Direct Care Costs May Be Expedited

SB 1249 requires the Board of Medical Assistance Services to amend the reimbursement methodology for nursing facilities as defined in the *State Plan for Medical Assistance*. Specifically, the amendment would allow the Director of DMAS "to make exceptions to the payment system...to allow an increase in the direct patient care payment rate for a nursing facility based upon extraordinary circumstances." This would apply to cases in which:

- the nursing facility's costs are above its direct care per diem or applicable ceilings due to "extraordinary circumstances beyond control of the nursing facility's administrator or owner,"
- the higher costs will have a "significant negative effect" on the facility's financial stability, and
- the costs were incurred to allow the facility to remain in compliance with licensure and certification requirements.

To request the increased direct care rate, the nursing facility would file a cost report addendum to show the reasons for and the amount of the increase being requested. Within the addendum, the nursing facility would need to include supporting documentation of the extraordinary circumstances and the negative effect these circumstances have on the facility's financial stability as well as the need for the increase "to assure that the nursing facility operates in substantial compliance with applicable licensure and certification requirements." The bill further requires the Director of DMAS to decide on the request within 30 days. Any approved increase in the direct payment rate would be effective as of the date that the nursing facility filed the request. Any increased payment would be subject to time limits, periodic reporting, and retroactive audit to ensure that only costs that are extraordinary are reimbursed.

The current reimbursement system allows for extraordinary expenses to be considered at the time that the facility's "actual" per diem rate is being determined (based on submitted cost reports). The difference between the "actual" rate and the previously "calculated" per diem rate results in a payment to the nursing facility up to the payment ceiling allowed for the facility. There is no provision for a facility to receive reimbursement if its per diem costs are above its payments ceiling.

A second provision of the bill allows a nursing facility that expands its bed capacity by 60 beds to retain its current prospective rate or to be treated as a new facility. Currently, facilities that increase their bed capacity by at least 50 percent may choose to be treated as a new facility for rate-setting purposes. New facilities are not required to meet occupancy requirements for the first year they operate. While the occupancy requirements have been removed from the direct care cost calculations, there is still a 90 percent occupancy requirement for indirect and capital costs. Thus, facilities that do not maintain 90 percent occupancy or higher will have their reimbursement for indirect and capital costs reduced accordingly. SB 1249 allows a nursing facility that chooses to be treated as a new facility to have its occupancy requirements waived in setting the

first cost reporting rate. The bill provisions indicate that the rate "shall be determined based upon the lower of (i) its anticipated allowable costs as determined for a detailed budget or pro forma cost report prepared by the nursing facility and accepted by the Director or (ii) the appropriate operating ceilings or charges."

HB 2276 Addresses Changing the Reimbursement Methodology for Rural Nursing Facilities Which Have Problems Hiring Nursing Staff

HB 2276 is similar to SB 1249 in its intent, but HB 2276 more narrowly focuses on the problems of rural nursing facilities in hiring nursing staff. Specifically, HB 2276 requires the Board of Medical Assistance Services to amend the *State Plan for Medical Assistance* to "include a provision to revise the payment methodology for nursing facility reimbursement that addresses the nursing personnel shortages in rural nursing facilities." Similar to SB 1249, HB 2276 would allow a nursing facility to submit an amended cost report to request an increase in direct care reimbursement when significantly higher costs were incurred than were reflected in the facility's previous cost reports. HB 2276 would restrict reimbursement increases to rural nursing facilities and to costs incurred because contract staff are used "in order to maintain regular nursing staff levels for direct patient care during a nursing shortage...." In addition, the costs would have to "be demonstrated to have a major impact on the fiscal stability of the rural nursing facility." Again, a decision regarding the reimbursement request would need to be made within 30 days of the amended cost report submission. Moreover, the higher reimbursement rate would need to be "initiated within 30 days of the recalculation of the reimbursement rate."

Nursing Facilities Are Having a Difficult Time Recruiting and Retaining Nursing Staff

One of the serious problems faced by all health care providers is the ability to recruit and retain sufficient nursing staff to provide care. The shortage of nurses, and certified nurse aides (CNAs) in particular, has been documented in numerous studies including studies by JCHC. Nursing facilities like other health care providers have had to increase salaries and/or provide enhanced benefits in order to adequately staff their facilities. Industry representatives indicate that the costs associated with employing direct care staff represents at least 70 percent of total operating

costs for most nursing facilities. If a nursing facility is unable to staff appropriately, quality of resident care is likely to suffer. Nursing facilities are highly regulated and failure to provide quality care can result in costly monetary penalties and ultimately loss of federal certification and/or state licensure.

Nursing facilities employ a variety of approaches to ensure that quality of care does not suffer when staffing shortages occur. Some of the approaches include requiring management staff to assist with direct care tasks, asking staff to work additional hours, and using contract staff to meet nurse staffing needs. Contract staff refer to staff who work for an employment agency and are contracted out on a temporary, as-needed basis. Some advocacy groups believe that because contract staff are used on a temporary basis, they do not provide the type of continuity of care that contributes to high quality care. Moreover, contract nurses are typically unfamiliar with the requirements and routines of the nursing facility which can negatively affect quality of care.

As the current staffing crisis has continued, an increasing number of hospitals, nursing facilities, and other health care providers have retained contract staff. Nevertheless, nursing facility representatives indicated that contract staff are used as little as possible because of their effect on quality of care and the expense involved. Employment agencies often receive as much as $15 to $52 per hour (plus additional expenses if the nurses are "traveling nurses" from another part of the state) depending on the qualifications and the assigned responsibilities of the nurse that is being retained. Industry representatives indicated that most nursing facilities have raised nurse salaries in the last two years in an attempt to recruit and retain staff and avoid having to use contract staff.

Resident Advocacy Groups Would Not Favor Encouraging the Use of Contract Staff

Several resident advocacy groups including the Jefferson Area Board for Aging and TLC 4 Long-Term Care indicated that they did not want anything to be done that would encourage the use of contract staff. As noted previously, they believe quality of care issues arise when temporary staff are used particularly related to continuity of care, and familiarity with the residents and the requirements and routines of the nursing facility. Industry representatives agreed that while contract staff should be used as little as possible, at times such staff need to be used on a temporary basis

due to unexpected staff absences or turnover or difficulty in filling vacancies.

Additional Suggestions Were Made by Industry Representatives to Address Reimbursement Problems

Industry representatives indicated that in addition to the problem of extraordinary costs that are not compensated in a timely manner, there is an underlying problem related to the time delay in having an actual per diem rate adopted for each nursing facility. As noted previously, last year's cost settlement of direct care costs resulted in payments to nursing facilities that exceeded collections from nursing facilities by a considerable amount. Industry representatives cited this difference as evidence that despite recent improvements in the Medicaid methodology, calculated per diem rates do not reflect the costs being borne by nursing facilities.

Industry representatives stated having calculated per diem rates that are too low results in cash-flow problems for nursing facilities. Since nursing facilities do not begin to receive their actual per diem rates until six to 11 months into their fiscal year, facilities are required to either reduce or delay costs, or if possible, receive a loan until the per diem adjustment is made. (The representatives noted that the number of bankruptcies in the industry have made it more difficult for facilities to receive loans.) The representatives added that because staffing represents 70 percent of the cost of operating most nursing facilities, there are a limited number of ways that facilities can significantly reduce costs. Reducing or delaying costs for part of the year also has a negative effect on the facility's per diem rate for the following year. For example, if a facility increases nurse salaries six months into its fiscal year, the cost of that increase will be spread over the entire 12 months. This means that the facility's per diem rate will not reflect the full cost of the salary increases but only half of the additional cost.

Industry representatives stated that the calculated per diem rates would only need to be raised once to address the fact that the rates have generally been too low. Representatives maintain that if one adjustment were appropriately made, it would carry forward the next year and no further extraordinary adjustments would be needed. Industry representatives indicate that this change would provide facilities with funding early in the fiscal year when it is needed and reduce the amount of the repayments DMAS would need to make to nursing facilities during

cost settlement later in the year. DMAS staff noted that the risk in this approach relates to paying facilities more than their costs would support. If this were the case, DMAS would be put in the position of collecting funds from nursing facilities that had been paid too much.

The Timeliness of Reimbursement for Nursing Facilities Was Addressed During Discussions to Redesign the Medicaid Reimbursement Methodology

The issue of the timeliness of reimbursement adjustments was addressed during discussions between DMAS and an industry workgroup in redesigning the Medicaid reimbursement methodology. Several alternatives were presented by DMAS that would have allowed facilities to receive an updated per diem earlier in the year.

The first alternative involved spacing the submission of the cost reports over the year rather than to have so many facilities operating on a calendar year. Nursing facilities may choose to have a fiscal year that is different from the calendar year. As noted, approximately 70 percent of facilities have chosen to have the calendar year as their fiscal year. Consequently, most cost reports cannot be reviewed by DMAS quickly because of the volume of reports that are received at one time. DMAS contracts with an accounting firm for the auditing of the cost reports. DMAS indicates that the contractor would have to increase its staffing in order to decrease the time that it currently takes to complete the audits. At this time, the audits must be completed within 180 days.

The second alternative for addressing the timing of reimbursement adjustments that was suggested by DMAS involved using an inflation factor rather than cost reports as the basis for the adjustment in per diem increases. Industry representatives did not favor this alternative because it did not allow for the retroactive cash adjustment that currently occurs during cost settlement. Consequently, if the inflation factor used to increase the per diem rates was too low, there would be no opportunity to adjust the rates based on actual costs incurred and reported by the nursing facilities. As noted previously, cost settlement has resulted in substantially more being paid to nursing facilities as opposed to the amount being collected from nursing facilities.

Department of Medical Assistance Services Staff Would Prefer to Work with Industry Representatives Rather than Change the *State Plan for Medical Assistance*

DMAS staff indicated that they would not support amending the Medicaid reimbursement methodology as recommended in SB 1249 or HB 2276. The changes in the Medicaid reimbursement methodology are the result of two years of deliberation between DMAS and the nursing facility industry in considering the proposals made in the JLARC study. Rather than statutorily requiring the Board of Medical Assistance Services to change the *State Plan for Medical Assistance,* DMAS would prefer to work with industry representatives to address any continuing problems.

DMAS staff specifically object to the provisions of the bills which would allow nursing facilities to receive payments that might be in excess of what they are entitled to receive. This could result from allowing a facility to receive a per diem increase based on extraordinary costs or from allowing a nursing facility to receive reimbursement that exceeds its payment ceiling. DMAS indicated it may be difficult to collect from numerous facilities that have been paid too high a per diem and impossible to collect from facilities that declare bankruptcy. Moreover, allowing a facility to be paid more than its ceiling amount would violate the purpose of payment ceilings which is to encourage cost efficiency. Rebasing payment ceilings every two years should allow for adjustments based on changing costs to be made on a timely basis.

DMAS staff also indicated that allowing facilities to submit amended cost reports throughout the year and requiring adjustments to be made to the per diem rates would be administratively burdensome. The fiscal impact statement for SB 1249 and HB 2276 indicated that the effect of each bill would be to "increase the number of times each year that DMAS must calculate and set rates for a provider, from one time per provider to an undetermined number of times." DMAS expected that two additional staff and that additional work by the contracted accounting firm would be required to address the additional work that would result if the provisions of SB 1249 or HB 2276 were adopted. The fiscal impact statements for both bills estimated the cost of adding two DMAS staff to be $152,964 ($76,482 in state funding) for FY 2002 and $140,024 ($70,012 in state funding) for FY 2003. The cost of the additional accounting firm work was estimated to be $72,000 ($36,000 in state funding) for FY 2002 and $74,160 ($37,080 in state funding) for FY 2003 under SB 1249 and $95,000 ($47,500 in state funding)

for FY 2002 and $97,850 ($48,925 in state funding) for FY 2003 under HB 2276.

The two fiscal impact statements showed more variation in estimating the cost of the changes in direct care payments to nursing facilities. The reason for the significant difference is that HB 2276 restricts the changes to rural nursing facilities which experience extraordinary costs due to using contract nurses while SB 1249 includes no such restrictions on nursing facilities or on extraordinary costs. HB 2276 was estimated to cost nearly $12 million ($5.7 million in state funding) for fiscal years 2002 and 2003. SB 1249 was estimated to cost $40 million ($20 million in state funding) for fiscal years 2002 and 2003.

The fiscal impact statement for SB 1249 also estimated the cost of allowing a nursing facility that was expanding its bed capacity by 60 beds to be treated as a new facility. The impact statement indicated that 11 nursing facilities have 60-bed additions and could potentially benefit from the provisions of the bill. However, nine of the 11 facilities already meet the requirements to be treated as new facilities because they are increasing their bed space by 50 percent or more. For the two remaining facilities, a potential financial impact of $1.6 million ($766,754 in state funding) was estimated for FY 2002 and an impact of $1.6 million ($791, 386 in state funding) was estimated for FY 2003. DMAS staff indicated that they would prefer to work with industry representatives on this issue rather than change the *State Plan for Medical Assistance.*

The Primary Goals Suggested by JLARC for Redesigning the Medicaid Reimbursement Methodology Would Be Appropriate to Consider in Fine-Tuning the Methodology

In considering any additional changes to the reimbursement methodology, it would be appropriate for DMAS and the industry workgroup to consider the primary goals used by JLARC in its 2000 review (Figure 2). As shown, the first goal addresses the need for reimbursement to be adequate to enable nursing facilities to provide quality care. The second goal addresses the need to ensure that nursing facilities are appropriately compensated for the level of care they provide so that residents who need more care (and may require a higher level of staffing) actually receive that care. The third and final goal states that while the "reimbursement system should control costs and ensure efficiency,"

flexibility should be provided to address "unique costs or circumstances beyond the facility's control."

Figure 2

Primary Goals Considered by JLARC in Redesigning Virginia's Medicaid Reimbursement Methodology

(1) The nursing facility reimbursement system should have reimbursement levels that are adequate to provide quality services to all residents.

(2) The nursing facility reimbursement system should encourage nursing facilities to admit heavier care residents by reimbursing them according to the nursing resources required.

(3) The nursing facility reimbursement system should control costs and ensure efficiency, but recognize unique costs or circumstances beyond the facility's control.

Source: JLARC Report, *Virginia's Medicaid Reimbursement to Nursing Facilities*, January 2000.

IV.
Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to pursue with regard to providing timely reimbursement for extraordinary costs encountered by nursing facilities.

Option I: **Take no action.**

Option II: **Introduce legislation to amend Section 32.1-325 of the Code of Virginia to incorporate the provisions of Senate Bill 1249 as introduced during the 2001 General Assembly Session and provide additional funding to the Department of Medical Assistance Services to fund the changes. (See language in Appendix B.)**

Option III: **Introduce legislation to amend Section 32.1-325 of the Code of Virginia to incorporate the provisions of House Bill 2276 as introduced during the 2001 General Assembly Session and provide additional funding to the Department of Medical Assistance Services to fund the changes. (See language in Appendix B.)**

Option IV: **Introduce a budget amendment (language only) directing the Department of Medical Assistance Services (DMAS) to continue its nursing facility workgroup and to address reimbursement issues raised in this study, including: (i) identifying specific types of extraordinary circumstances, if any, which may warrant additional reimbursement to a nursing facility and the process by which such additional reimbursement would be provided; (ii) reviewing the current process for establishing and utilizing "calculated" per diem rates to determine if changes could be made to make the rates closer to the "actual" rates and balance the financial impact that the use of "calculated" rates has on nursing facilities and DMAS; and (iii) reviewing the current requirement that nursing facilities must increase bed capacity by 50 percent in order to be considered as a new**

facility for reimbursement purposes. The budget amendment language would require DMAS to report its findings and recommendations to the Governor, and the Chairmen of the House Appropriations Committee, the Senate Finance committee, and the Joint Commission on Health Care by October 1, 2002.

Option V: Introduce a budget amendment (language and funding of an amount to be determined later) to provide funding to allow DMAS to reduce the time it has to complete audits of the nursing facility cost reports from 180 days to 60 days.

APPENDIX A

SENATE OF VIRGINIA

WARREN E. BARRY
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FAIRFAX, VIRGINIA 22030-1146

COMMITTEE ASSIGNMENTS
EDUCATION AND HEALTH, CHAIR
COMMERCE AND LABOR
FINANCE
TRANSPORTATION
RULES

April 4, 2001

The Honorable William T. Bolling, Chairman
Joint Commission on Health Care
1001 East Broad Street
Richmond, Virginia 23219

Dear Senator Bolling:

During the 2001 Session of the General Assembly, the Senate Committee on Education and Health considered SB 1249 (Reynolds) relating to the nursing facility payment methodology for Medicaid reimbursement. This bill addressed issues concerning increases in the direct patient care payment rate because of extraordinary circumstances beyond the control of the nursing home, such as a shortage of nurses that requires the hiring of contract nurses and, thus, higher personnel costs, and the effects of a patient-bed expansion on the calculation of a nursing home's prospective payment rate. Although the Committee discussed Virginia Medicaid's nursing facility reimbursement and financial challenges faced by nursing facilities, the bill was tabled due to the more than $10 million per year fiscal impact statement and because of concerns about imposing changes in the payment methodology without appropriate and cautious evaluation. The motion on SB 1249 included a request that the Joint Commission on Health Care direct its Long-Term Care Subcommittee to evaluate the issues presented by SB 1249.

On behalf of the members of the Senate Committee on Education and Health, I am, therefore, respectfully requesting that the Joint Commission on Health Care include this bill and its related issues in its 2001 study plan. The Commission is also requested to inform the Senate Committee on Education and Health of any recommendations or conclusions it may reach on this matter.

Thank you in advance for considering this request.

Sincerely,

Senator Warren E. Barry, Chairman
Senate Committee on Education and Health

cc: Members, Senate Committee on Education and Health
The Honorable R. Roscoe Reynolds

Enclosures

APPENDIX B

014155524

SENATE BILL NO. 1249

Offered January 10, 2001

Prefiled January 10, 2001

A BILL to amend and reenact § 32.1-325, as it is currently effective and as it may become effective, of the Code of Virginia, relating to medical assistance services.

Patron—Reynolds

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325, as it is currently effective and as it may become effective, of the Code of Virginia is amended and reenacted as follows:

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this

subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

8. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

9. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

10. A provision for payment of medical assistance for annual pap smears;

11. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

12. A provision for payment of medical assistance which provides for payment for forty-eight hours of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

13. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within sixty days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

14. A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

15. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

16. A provision, when in compliance with federal law and regulation and approved by the Health Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions; ~~and~~

17. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of twenty-one years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable to the transplant procedure; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient-selection criteria of the specific transplant center where the surgery is proposed to be performed has been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible

terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living.;

18. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

19. A provision revising the payment methodology for nursing facility (NF) reimbursement by the Virginia Department of Medical Assistance Services that sets out an exception procedure allowing the Director of Medical Assistance Services to establish a direct operating cost payment rate for a nursing facility in excess of the payment rate limits or ceilings or both established under the payment system when such nursing facility's allowable direct operating costs exceed such limits or ceilings or both due to extraordinary circumstances beyond the control of the nursing facility's administrator or owner. Such provision shall require a nursing facility to file (i) an addendum to its cost report establishing the bases for and the amount of the increase sought in the direct operating cost payment, (ii) documents establishing that extraordinary circumstances exist that are causing a significant direct operating cost increase that will have a significant negative effect on the financial stability of the nursing facility, and (iii) documents establishing that such direct operating cost increase was and is necessary to incur in order to assure that the nursing facility operates in substantial compliance with applicable licensure and certification requirements. Such provision shall further require the Director to determine, within thirty days of such filing, whether such filing justifies an increase in the direct operating cost payment of the nursing facility and the amount of such increase. Such provision shall also require that any authorized direct operating cost payment increase shall be retroactive to the initial date of the nursing facility's filing for such increase and shall be time limited and subject to periodic reporting and retroactive audit verifying that the payment increase was expended on such extraordinary costs; and

20. A provision revising the payment system for nursing facility reimbursement by the Virginia Department of Medical Assistance Services that allows a nursing facility that expands its bed capacity by sixty beds to retain its prospective rate or to be treated as a new nursing facility for reimbursement purposes. Such provision shall provide that if a nursing facility elects to be treated as a new nursing facility, the occupancy requirement shall be waived for establishing the first cost reporting period interim rate and that the nursing facility's initial payment rate for its first cost reporting period shall be determined based upon the lower of (i) its anticipated allowable costs as determined from a detailed budget or pro forma cost report prepared by the nursing facility and accepted by the Director or (ii) the appropriate operating ceilings or charges.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 9-6.14:7.1, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq., "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may

adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 9-6.14:7.1 et seq.) of Chapter 1.1:1 of Title 9. However, the Board shall, pursuant to the requirements of § 9-6.14:4.1, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and to receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and to enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony.

4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

F. When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of twenty-one who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such

services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subsection I of § 11-45, the provisions of the Virginia Public Procurement Act (§ 11-35 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in

accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of twenty-four months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

9. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

10. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

11. A provision for payment of medical assistance for annual pap smears;

12. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

13. A provision for payment of medical assistance which provides for payment for forty-eight hours of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within sixty days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

17. A provision, when in compliance with federal law and regulation and approved by the Health Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of twenty-one years when (i) there is no effective alternative

medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed has been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living; ~~and~~

19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

20. A provision revising the payment methodology for nursing facility (NF) reimbursement by the Virginia Department of Medical Assistance Services that sets out an exception procedure allowing the Director of Medical Assistance Services to establish a direct operating cost payment rate for a nursing facility in excess of the payment rate limits or ceilings or both established under the payment system when such nursing facility's allowable direct operating costs exceed such limits or ceilings or both due to extraordinary circumstances beyond the control of the nursing facility's administrator or owner. Such provision shall require a nursing facility to file (i) an addendum to its cost report establishing the bases for and the amount of the increase sought in the direct operating cost payment, (ii) documents establishing that extraordinary circumstances exist that are causing a significant direct operating cost increase that will have a significant negative effect on the financial stability of the nursing facility, and (iii) documents establishing that such direct operating cost increase was and is necessary to incur in order to assure that the nursing facility operates in substantial compliance with applicable licensure and certification requirements. Such provision shall further require the Director to determine, within thirty days of such filing, whether such filing justifies an increase in the direct operating cost payment of the nursing facility and the amount of such increase. Such provision shall also require that any authorized direct operating cost payment increase shall be retroactive to the initial date of the nursing facility's filing for such increase and shall be time limited and subject to periodic reporting and retroactive audit verifying that the payment increase was expended on such extraordinary costs; and

21. A provision revising the payment system for nursing facility reimbursement by the Virginia Department of Medical Assistance Services that allows a nursing facility that expands its bed capacity by sixty beds to retain its prospective rate or to be treated as a new nursing facility for reimbursement purposes. Such provision shall provide that if a nursing facility elects to be treated as a new nursing facility, the occupancy requirement shall be waived for establishing the first cost reporting period interim rate and that the nursing facility's initial payment rate for its first cost reporting period shall be determined based upon the lower of (i) its anticipated allowable costs as determined from a detailed budget or pro forma cost report prepared by the nursing facility and accepted by the Director or (ii) the appropriate operating ceilings or charges.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 9-6.14:7.1, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact

analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 9-6.14:7.1 et seq.) of Chapter 1.1:1 of Title 9. However, the Board shall, pursuant to the requirements of § 9-6.14:4.1, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony.

4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

F. When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be

permitted by federal law to establish a program of family assistance whereby children over the age of eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of twenty-one who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subsection I of § 11-45, the provisions of the Virginia Public Procurement Act (§ 11-35 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

Official Use By Clerks

Passed By The Senate		**Passed By The House of Delegates**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the Senate Clerk of the House of Delegates

Department of Planning and Budget
2001 Fiscal Impact Statement

1. **Bill Number** SB1249

House of Origin	☒ Introduced	☐ Substitute	☐ Engrossed
Second House	☐ In Committee	☐ Substitute	☐ Enrolled

2. **Patron** Reynolds

3. **Committee** Committee on Education and Health

4. **Title** Medical assistance services

5. **Summary/Purpose:**
This bill requires the Board of Medical Assistance Services to amend the state plan for medical assistance services to include two provisions. The first provision will allow the Director to make exceptions to the payment system for nursing facility reimbursement to allow an increase in the direct patient care payment rate for a nursing facility based upon extraordinary circumstances. The second provision will allow a nursing facility that expands its bed capacity by 60 beds to have the option of retaining its prospective rate or being treated as a new nursing facility without having to comply with the occupancy requirements. The Director will be authorized to make an exception to the payment methodology to allow the reimbursement of allowable direct patient care operating costs in excess of direct patient care operating cost limits and or ceilings or both established under the payment system. This exception can occur when a nursing facility incurs such costs due to extraordinary circumstances beyond the control of the administrator or owner of the nursing facility. However, the nursing facility must demonstrate that the extraordinary costs were caused by factors beyond its control, that these costs have a major negative effect on its fiscal stability, and that the costs are necessary in order to assure compliance with licensure and certification requirements. The nursing facility will have the right to file a cost report addendum and supporting documents to justify an increase in its direct patient care payment rate. The Director is required to act on the request within 30 days and any authorized increase in the direct payment rate will be retroactive to the date of the filing of the request for the increase. The increased payment will be subject to time limits, periodic reporting, and retroactive audit.

6. **Fiscal Impact Estimates are: Preliminary**

6a. Expenditure Impact:

Item 316, Subprogram 47901

Fiscal Year	*Dollars*	*Positions*	*Fund*
2000-01	$0	0.0	GF
2000-01	$0	0.0	NGF
2001-02	$112,482	1.0	GF
2001-02	$112,482	1.0	NGF
2002-03	$107,092	1.0	GF
2002-03	$107,092	1.0	NGF

Item 319, Subprogram 45609

Fiscal Year	*Dollars*	*Positions*	*Fund*
2000-01	$0	0.0	GF
2000-01	$0	0.0	NGF
2001-02	$10,408,304	1.0	GF
2001-02	$11,074,263	1.0	NGF
2002-03	$10,452,836	1.0	GF
2002-03	$11,077,208	1.0	NGF

Total Department of Medical Assistance Services

Fiscal Year	*Dollars*	*Positions*	*Fund*
2000-01	$0	0.0	GF
2000-01	$0	0.0	NGF
2001-02	$10,520,786	0.0	GF
2001-02	$11,186,745	0.0	NGF
2002-03	$10,559,928	0.0	GF
2002-03	$11,184,300	0.0	NGF

6b. Revenue Impact: None

7. **Budget amendment necessary:** Yes, Item 316, Subprogram 47901 and Item 319, Subprogram 45609

8. **Fiscal implications:** The amendment would allow the Director of the Department of Medical Assistance Services (DMAS) to increase a nursing facility's rate if the facility demonstrated extraordinary circumstances beyond its control. Facilities must file a cost report addendum and supporting documents to justify any increases in their direct patient care payment rates. DMAS would have to respond within 30 days of the request. DMAS would require and review periodic reports from the provider to demonstrate continued existence of extraordinary circumstances.

   A second provision of the bill would permit facilities expanding by 60 beds to choose to retain their previous prospective rate or be treated as new facilities. If treated as new facilities, there would be no occupancy requirement in the first year. DMAS believes that this bill would affect all nursing facilities participating in Virginia' Medicaid program.

   Administrative and Support Services

   This bill would increase the number of times each year that DMAS must calculate and set rates for a provider, from one time per provider to an undetermined number of times. DMAS would have to increase staff to respond to these requests from providers. Additionally, the requirement for ongoing monitoring of the "extraordinary circumstances" that form the basis for the rate adjustment would also create the need for an increase in staff to review financial information. DMAS believes that its current level of staffing cannot provide the extra monitoring that would result from this bill. It estimates that it would require two additional Financial and Audit Service Practitioners II at a cost of $152,964 ($76,482 GF) in FY 2002 and $140,024 ($70,012 GF) in FY 2003. The FY 2002 estimate is higher because it reflects fixed costs associated with all new positions amounting to $12,940 ($6,470 GF). In addition, DMAS estimates that it will incur additional expenditures in regard to the cost settlement audits and reviews performed by its contracted CPA firm. These

additional costs amount to $72,000 ($36,000 GF) in FY 2002 and $74,160 ($37,080 GF) in FY 2003. The estimate in FY 2003 assumes a three percent increase for inflation.

Medical Assistance Services (Medicaid)
Based on historical data, DMAS estimates that there are approximately 88 nursing facilities over their direct care ceiling. That means that the facilities' reimbursement for direct care is less than their costs. DMAS believes it is likely that all of these facilities would file a request for increased reimbursement under the "extraordinary circumstances" clause. If all of these facilities were granted an exception to the ceiling and received full reimbursement for their cost, DMAS estimates that the annual cost to the agency would be approximately $19.9 million ($9.6 million GF in FY 2002 and $9.7 million GF in FY 2003).

Furthermore, this bill would allow nursing facilities with additions of 60 beds to be treated as new facilities for rate setting purposes. Present regulations allow this treatment only if the addition results in a 50 percent increase in beds. Of the 11 nursing facilities with 60-bed additions, all but two would be treated as new facilities under the 50 percent rule. DMAS bases this observation on data generated by the reimbursement model developed for calculation of the new rates effective July 1, 2000. In the case of the two nursing facilities, both had costs below their ceilings. In addition, both had occupancy levels at approximately 95 percent. However, DMAS believes that an increase in beds might not permit the two facilities to stay above the 90 percent threshold. DMAS estimates that for both facilities, the combined potential impact would be approximately $1.5 million. Inflating this figure at three percent per year, the estimated FY 2002 impact would be approximately $1.6 million ($766,754 GF) and the FY 2003 impact would be approximately $1.6 million ($791,386 GF).

9. **Specific agency or political subdivisions affected:** DMAS

10. **Technical amendment necessary:** No

11. **Other comments:** Existing regulations require DMAS to establish a prospective operating rate for each provider each year. The prospective rate is based on information reported in the provider's prior year annual cost report. The cost per day from the prior fiscal year is adjusted for one year's inflation. However, a nursing facility's rate is limited based on the direct and indirect care ceiling for the provider peer groups. DMAS reimbursement regulations set ceilings for direct care services at 112 percent of the median cost and indirect care services at 106 percent of the median cost for the facilities within the peer groups. Ceilings are intended to ensure that Medicaid is not obligated to cover a nursing facility's costs if they are significantly above the costs incurred by similar facilities.

    DMAS regulations do not provide for other changes to the prospective rate during the year. If a provider's operating cost is less than the prospective rate, the provider keeps the difference. If the cost exceeds the rate, the provider absorbs the difference. DMAS believes that this bill would retain the prospective methodology so long as there are not circumstances that cause a provider's costs to exceed its prospective rates.

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cc: Secretary of Health and Human Resources

014159708

HOUSE BILL NO. 2276

Offered January 10, 2001

Prefiled January 10, 2001

A BILL to amend and reenact § 32.1-325, as it is currently effective and as it may become effective, of the Code of Virginia, relating to medical assistance services.

Patron—Day

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325, as it is currently effective and as it may become effective, of the Code of Virginia is amended and reenacted as follows:

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this

subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

8. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

9. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

10. A provision for payment of medical assistance for annual pap smears;

11. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

12. A provision for payment of medical assistance which provides for payment for forty-eight hours of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

13. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within sixty days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

14. A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

15. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

16. A provision, when in compliance with federal law and regulation and approved by the Health Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions; ~~and~~

17. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of twenty-one years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable to the transplant procedure; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient-selection criteria of the specific transplant center where the surgery is proposed to be performed has been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible

terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living.;

18. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations; *and*

19. A provision revising the payment methodology for nursing facility (NF) reimbursement by the Virginia Department of Medical Assistance Services that (i) sets out an exception to the uniform expense classification requirement that allowable expenses for operating costs not exceed the limits or ceilings or both established in the payment system when such a rural nursing facility has exceeded the limits or ceilings or both for allowable expenses for operating expenses because, in order to maintain regular nursing staff levels for direct patient care during a nursing shortage, the rural nursing facility has had to hire contract nurses at higher salary rates than the facility's gross salary calculations as submitted in the rural nursing facility's previous annual cost report; (ii) defines the circumstances described in clause (i) as a significant operational change that can be demonstrated to have a major impact on the fiscal stability of the rural nursing facility; (iii) establishes the right of the rural nursing facility to submit, immediately upon incurring the expenses described in clause (i), amendments to its previous annual cost report; (iv) provides for adjustment of the prospectively determined operating cost rate or ceiling for such rural nursing facility regardless of the peer group in which such facility has been placed and for recalculation of the rural nursing facility's reimbursement rate based on such adjustment within thirty days of submission of the amended cost report; and (v) provides for initiation of reimbursement of the rural nursing facility on the basis of the newly recalculated reimbursement rate within thirty days of such recalculation.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 9-6.14:7.1, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq., "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 9-6.14:7.1 et seq.) of Chapter 1.1:1 of Title 9. However, the Board shall, pursuant to the requirements of § 9-6.14:4.1, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments

which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and to receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and to enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony.

4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

F. When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of twenty-one who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subsection I of § 11-45, the provisions of the Virginia Public Procurement Act (§ 11-35 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of twenty-four months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow

transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

9. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

10. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

11. A provision for payment of medical assistance for annual pap smears;

12. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

13. A provision for payment of medical assistance which provides for payment for forty-eight hours of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within sixty days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

17. A provision, when in compliance with federal law and regulation and approved by the Health Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of twenty-one years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed has been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living; ~~and~~

19. A provision for payment of medical assistance for colorectal cancer screening, specifically

screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations; *and*

20. A provision revising the payment methodology for nursing facility (NF) reimbursement by the Virginia Department of Medical Assistance Services that (i) sets out an exception to the uniform expense classification requirement that allowable expenses for operating costs not exceed the limits or ceilings or both established in the payment system when such a rural nursing facility has exceeded the limits or ceilings or both for allowable expenses for operating expenses because, in order to maintain regular nursing staff levels for direct patient care during a nursing shortage, the rural nursing facility has had to hire contract nurses at higher salary rates than the facility's gross salary calculations as submitted in the rural nursing facility's previous annual cost report; (ii) defines the circumstances described in clause (i) as a significant operational change that can be demonstrated to have a major impact on the fiscal stability of the rural nursing facility; (iii) establishes the right of the rural nursing facility to submit, immediately upon incurring the expenses described in clause (i), amendments to its previous annual cost report; (iv) provides for adjustment of the prospectively determined operating cost rate or ceiling for such rural nursing facility regardless of the peer group in which such facility has been placed and for recalculation of the rural nursing facility's reimbursement rate based on such adjustment within thirty days of submission of the amended cost report; and (v) provides for initiation of reimbursement of the rural nursing facility on the basis of the newly recalculated reimbursement rate within thirty days of such recalculation.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 9-6.14:7.1, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 9-6.14:7.1 et seq.) of Chapter 1.1:1 of Title 9. However, the Board shall, pursuant to the requirements of § 9-6.14:4.1, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony.

4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

F. When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of twenty-one who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subsection I of § 11-45, the provisions of the Virginia Public Procurement Act (§ 11-35 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate

Department of Planning and Budget
2001 Fiscal Impact Statement

1. **Bill Number** HB2276

House of Origin	☒ Introduced	☐ Substitute	☐ Engrossed
Second House	☐ In Committee	☐ Substitute	☐ Enrolled

2. **Patron** Day

3. **Committee** Health, Welfare & Institutions

4. **Title** Medical assistance services.

5. **Summary/Purpose:**
This bill requires the Board of Medical Assistance Services to amend the state plan for medical assistance services to include a provision to revise the payment methodology for nursing facility reimbursement that addresses the nursing personnel shortages in rural nursing facilities. The amendment would provide an exception for rural nursing facilities when, during a nursing shortage, these facilities find it necessary to contract nurses. Rural facilities would be entitled to amend the previous year's cost reports to include costs being incurred in the current year. These facilities would receive an adjustment to their reimbursement rates within 60 days from the date they submitted the amended cost reports.

6. **Fiscal Impact Estimates are: Preliminary**

6a. Expenditure Impact:

Item 316, Subprogram 47901

Fiscal Year	*Dollars*	*Positions*	*Fund*
2000-01	$0	0.0	GF
2000-01	$0	0.0	NGF
2001-02	$123,982	1.0	GF
2001-02	$123,982	1.0	NGF
2002-03	$118,937	1.0	GF
2002-03	$118,937	1.0	NGF

Item 319, Subprogram 45609

Fiscal Year	*Dollars*	*Positions*	*Fund*
2000-01	$0	0.0	GF
2000-01	$0	0.0	NGF
2001-02	$2,863,806	0.0	GF
2001-02	$3,047,043	0.0	NGF
2002-03	$2,869,717	0.0	GF
2002-03	$3,041,132	0.0	NGF

Total Department of Medical Assistance Services

Fiscal Year	*Dollars*	*Positions*	*Fund*
2000-01	$0	0.0	GF
2000-01	$0	0.0	NGF
2001-02	$2,987,788	1.0	GF
2001-02	$3,171,025	1.0	NGF
2002-03	$2,988,654	1.0	GF
2002-03	$3,160,069	1.0	NGF

6b. Revenue Impact: None

7. **Budget amendment necessary:** Yes, Item 316, Subprogram 47901 and Item 319, Subprogram 45609

8. **Fiscal implications:** Under existing regulations the Department of Medical Assistance Services (DMAS) establishes a prospective operating rate for each provider each year based on information reported in the provider's prior year annual cost report. The cost per day from the prior fiscal year is adjusted for one year's inflation. However, the regulations do not provide for other changes to the prospective rate during the year. If a provider's operating cost is less than the prospective rate, the provider keeps the difference. If the cost exceeds the rate, the provider absorbs the difference.

   DMAS says that it has no way of estimating how many rural facilities will apply for contract nurse reimbursement. However, it feels that it can estimate a potential cost ceiling for this bill. Of the 265 active nursing facilities in the Commonwealth, approximately 116 or 43.77 percent of these facilities are considered rural facilities. DMAS recently had one facility apply for contract cost reimbursement. Based on the data provided by this one facility, the agency calculated an increased cost per patient per day of $2.06 related to contract nursing. Total Medicaid nursing facility days were 6,555,504 as of October 2000. Given this information, DMAS has been able to determine a maximum contracting cost for rural facilities by multiplying .4377 rural facilities by the contracting cost per day by the number of Medicaid days. In other words, .4377 times $2.06 times 6,555,504. The resulting estimate for contract nurses is approximately $5.9 million ($2.9 million GF in both FY 2002 and FY 2003) annually.

   In addition, this bill would increase the number of times each year that DMAS must calculate and set rates for a provider. This increase could vary from once to an indeterminate number of times. Furthermore, the agency would experience an increase in the volume of financial information that it would have to review on a yearly basis. Given the current demands on its staff, DMAS feels that it would be unable to perform these additional tasks satisfactorily. It estimates that it would need two additional Financial and Audit Service Practitioners II (Band 5) at a cost of $152,964 ($76,482 GF) in FY 2002 and $140,024 ($70,012 GF) in FY 2003. The reason that staff costs are higher in the first year versus the second is due to $6,470 per staff member in start-up costs. DMAS also estimates that it will incur additional expenditures with its contracted CPA firm responsible for performing cost settlement audits and reviews. These estimated additional expenditures amount to $95,000 ($47,500 GF) in FY 2002 and $97,850 ($48,925 GF) in FY 2003. The FY 2003 estimate reflects a three percent increase for inflation.

9. **Specific agency or political subdivisions affected:** DMAS
10. **Technical amendment necessary:** No

11. Other comments: None

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Secretary of Health and Human Resources _____ PDF Created 1/22/2001 4:17:39 PM

APPENDIX C

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:
Exceptions to Nursing Facility Reimbursement Study

Organizations/Individuals Submitting Comments

Three organizations submitted comments in response to the exceptions to nursing facility reimbursement study:

- Blue Ridge Nursing Center, Inc.,
- Virginia Health Care Association, and
- Virginia Association of Nonprofit Homes for the Aging.

Policy Options Included in the Exceptions to Nursing Facility Reimbursement Issue Brief

Option I: **Take no action.**

Option II: **Introduce legislation to amend Section 32.1-325 of the *Code of Virginia* to incorporate the provisions of Senate Bill 1249 as introduced during the 2001 General Assembly Session and provide additional funding to the Department of Medical Assistance Services to fund the changes.**

Option III: Introduce legislation to amend Section 32.1-325 of the *Code of Virginia* to incorporate the provisions of House Bill 2276 as introduced during the 2001 General Assembly Session and provide additional funding to the Department of Medical Assistance Services to fund the changes.

Option IV: Introduce a budget amendment (language only) directing the Department of Medical Assistance Services (DMAS) to continue its nursing facility workgroup and to address reimbursement issues raised in this study, including: (i) identifying specific types of extraordinary circumstances, if any, which may warrant additional reimbursement to a nursing facility and the process by which such additional reimbursement would be provided; (ii) reviewing the current process for establishing and utilizing "calculated" per diem rates to determine if changes could be made to make the rates closer to the "actual" rates and balance the financial impact that the use of "calculated" rates has on nursing facilities and DMAS; and (iii) reviewing the current requirement that nursing facilities must increase bed capacity by 50 percent in order to be considered as a new facility for reimbursement purposes. The budget amendment language would require DMAS to report its findings and recommendations to the Governor, and the Chairmen of the House Appropriations Committee, the Senate Finance Committee, and the Joint Commission on Health Care by October 1, 2002.

Option V: Introduce a budget amendment (language and funding of an amount to be determined later) to provide funding to allow DMAS to reduce the time it has to complete audits of the nursing facility cost reports from 160 days to 60 days.

Overall Summary of Comments

Blue Ridge Nursing Center and Virginia Health Care Association commented in support of various actions that would relieve existing financial burdens on nursing facilities. The Virginia Association of Nonprofit Homes for the Aging expressed support for Option IV.

Summary of Individual Comments

Blue Ridge Nursing Center, Inc.

Dorn V. Williams, President, stated that either bill (SB 1249 or HB 2276) can provide relief to nursing homes which might have "extraordinary financial crises at no fault of their own...." Mr. Williams requested that the JCHC introduce legislation during the 2002 Session that would give substantial financial relief in a similar manner to SB 1249 or HB 2276. Mr. Williams noted that "we are operating at considerable losses to our facility and will continue to stretch our management team." Mr. Williams stated that "we can sustain operation at a loss for awhile", but "we know these losses cannot go on forever." Mr. Williams commented that "special circumstances such as the nursing shortage and now drastic increases in insurance rates keep us under critical cash flow restraints." Mr. Williams also pointed out that, under the legislation, any extraordinary reimbursement would be at the discretion of the DMAS director, and that the burden of proof concerning extraordinary circumstances and resulting fiscal impact would be on the provider. Finally, Mr. Williams suggested that the fiscal impact of the legislation "should be significantly less overall" than that estimated by DMAS. According to Mr. Williams, "this legislation would conserve money by saving facilities from bankruptcy and takeover." Mr. Williams does not believe that "DMAS considered the long-term savings when giving their cost estimates – only short term costs."

Virginia Health Care Association

Stephen C. Morrisette, President, said that concerns raised within the proposed legislation are best addressed by working with DMAS to address three specific areas. First, the cost settlement process and related timelines should be reevaluated. Under the current payment system, Mr. Morrisette said that significant increases in cost can go unrecognized in a facility's payment rate for more than two years. Second, a provision

within the Medicaid nursing home payment regulations allowing the DMAS director to approve facility-specific adjustments to interim rates in response to certain conditions should be reestablished. Third, dramatic and significant professional liability insurance premium increases should be carved out of the existing cost reimbursement formula. Under that approach, increased payment could be provided to cover higher premiums on a retroactive, historical-cost basis. According to Mr. Morrisette, this "carve-out" approach could be utilized for a set time period pending the return to normal market conditions for professional liability premium costs.

Virginia Association of Nonprofit Homes for the Aging

Marcia Tetterton, Vice President of Public Policy, specifically expressed support for Option IV regarding the need for more timely reimbursement of extraordinary expenses.

JOINT COMMISSION ON HEALTH CARE

Executive Director

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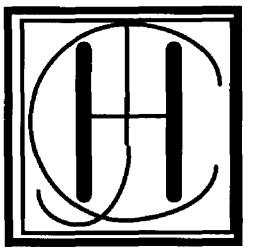

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