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SENATE BILL NO. 1247

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Health, Welfare and Institutions on February 10, 2005)

(Patron Prior to Substitute—Senator Bolling)

A BILL to amend and reenact §§ 32.1-125.3, 32.1-325.1 and 32.1-325.1:1 of the Code of Virginia, relating to medical assistance services.

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-125.3, 32.1-325.1 and 32.1-325.1:1 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-125.3. Bed capacity and licensure in hospitals designated as critical access hospitals; rural hospital designation.

A. Any medical care facility licensed as a hospital pursuant to this article that (i) has been certified, as provided in § 32.1-122.07, as a critical access hospital by the Commissioner of Health in compliance with the certification regulations promulgated by the Health Care Financing Administration pursuant to Title XVIII of the Social Security Act, as amended, and (ii) has, as a result of the critical access certification, been required to reduce its licensed bed capacity to conform to the critical access certification requirement shall, upon termination of its critical access hospital certification, be licensed to operate at the licensed bed capacity in existence prior to the critical access hospital certification without being required to apply for and obtain a certificate of public need for such bed capacity in accordance with Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title.

B. Any hospital that was designated a rural hospital or designated to be located in a rural area pursuant to state or federal law or regulation prior to October 1, 2004, shall be designated a rural hospital or designated to be located in a rural area for purposes of state law.

§ 32.1-325.1. Appeals of agency determinations.

A. The Director shall ~~make an initial determination as to whether an overpayment has been made to a provider~~*issue an informal fact-finding conference decision concerning provider reimbursement* in accordance with the state plan for medical assistance, the provisions of § 2.2-4019 and applicable federal law. The ~~initial determination~~*informal fact-finding conference decision* shall be issued within 180 days of the receipt of the appeal request. If the agency does not render a decision within 180 days, the decision is deemed to be in favor of the provider.

B. An appeal of the Director's ~~initial determination~~*informal fact-finding conference decision* concerning provider reimbursement shall be heard in accordance with § 2.2-4020 of the Administrative Process Act (§ 2.2-4020 et seq.) and the state plan for medical assistance provided for in § 32.1-325. The hearing officer appointed pursuant to § 2.2-4024 shall conduct the appeal and submit a recommended decision to the Director within 120 days of the agency's receipt of the appeal request. The Director shall consider the parties' exceptions and issue the final agency case decision within ~~sixty~~ *60* days of receipt of the hearing officer's recommended decision. If the Director does not render a final agency case decision within ~~sixty~~ *60* days of the receipt of the hearing officer's recommended decision, the decision is deemed to be in favor of the provider. The Director shall adopt the hearing officer's recommended decision unless to do so would be an error of law or Department policy. Any final agency case decision in which the Director rejects a hearing officer's recommended decision shall state with particularity the basis for rejection. Prior to a final agency case decision issued in accordance with § 2.2-4023, the Director may not undertake recovery of any overpayment amount paid to the provider through offset or other means. Once a final ~~determination of overpayment~~*agency case decision* has been made, the Director shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the ~~initial~~*informal fact-finding conference decision* or the final ~~determination of overpayment~~*agency case decision*. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 from the date the Director's *agency case decision* ~~determination~~ becomes final. Nothing in § 32.1-313 shall be construed to require interest payments on any portion of overpayment other than the unpaid balance referenced herein.

C. The burden of proof in informal and formal administrative appeals is on the provider. The agency shall reimburse a provider for reasonable and necessary attorneys' fees and costs associated with an informal or formal administrative appeal if the provider substantially prevails on the merits of the appeal and the agency's position is not substantially justified, unless special circumstances would make an award unjust. In any case in which a provider has recovered attorneys' fees and costs associated with an informal or formal administrative appeal, the provider shall not be entitled to recover those same attorneys' fees and costs in a subsequent judicial proceeding.

D. Court review of final agency determinations concerning provider reimbursement shall be made in

accordance with the Administrative Process Act (§ 2.2-4000 et seq.). In any case in which a final determination of overpayment has been reversed in a subsequent judicial proceeding, the provider shall be reimbursed that portion of the payment to which he is entitled plus any applicable interest, within thirty days of the subsequent judicial order.

§ 32.1-325.1:1. Definitions; recovery of overpayment for medical assistance services.

A. For the purposes of this section, the following definitions shall apply:

"Agreement" means any contract executed for the delivery of services to recipients of medical assistance pursuant to subdivision D 2 of § 32.1-325.

"Successor in interest" means any person as defined in § 1-13.19 having stockholders, directors, officers, or partners in common with a health care provider for which an agreement has been terminated.

"Termination" means (i) the cessation of operations by a provider, (ii) the sale or transfer of the provider, (iii) the reorganization or restructuring of the health care provider, or (iv) the termination of an agreement by either party.

B. The Director of Medical Assistance Services shall collect by any means available to him at law any amount owed to the Commonwealth because of overpayment for medical assistance services. Upon ~~making an initial determination~~*identifying* that an overpayment has been made to the provider ~~pursuant to § 32.1-325.1,~~ the Director shall notify the provider of the amount of the overpayment. Such ~~initial determination~~*notification of overpayment* shall be ~~made~~*issued* within the earlier of (i) four years *after payment of the claim or other payment request*, or (ii) *four years after filing by the provider of the complete cost report as defined in the Department of Medical Assistance Services' regulations, or (iii)* ~~fifteen~~ *15* months after filing *by the provider* of the final *complete* cost report *as defined in the Department of Medical Assistance Services' regulations* ~~by the provider~~ subsequent to sale of the facility or termination of the provider. The provider shall make arrangements satisfactory to the Director to repay the amount due. If the provider fails or refuses to make arrangements satisfactory to the Director for such repayment or fails or refuses to repay the Commonwealth for the amount due for overpayment in a timely manner, the Director may devise a schedule for reducing the Medicaid reimbursement due to any successor in interest.

C. In any case in which the Director is unable to recover the amount due for overpayment pursuant to subsection B, he shall not enter into another agreement with the responsible provider or any person who is the transferee, assignee, or successor in interest to such provider unless (i) he receives satisfactory assurances of repayment of all amounts due or (ii) the agreement with the provider is necessary in order to ensure that Medicaid recipients have access to the covered services rendered by the provider.

Further, to the extent consistent with federal and state law, the Director shall not enter into any agreement with a provider having any stockholder possessing a material financial interest, partner, director, officer, or owner in common with a provider which has terminated a previous agreement for participation in the medical assistance services program without making satisfactory arrangements to repay all outstanding Medicaid overpayment.

D. The provisions of this section shall not apply to successors in interest with respect to transfer of a medical care facility pursuant to contracts entered into before February 1, 1990.