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HOUSE BILL NO. 2567

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Education and Health on February 18, 1999)

(Patron Prior to Substitute—Delegate Christian)

A BILL to amend and reenact §§ 11-45, 32.1-325, 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 §§ 11-45, 32.1-325, 32.1-325.1, and 32.1-325.1:1 of the Code of Virginia are amended and reenacted as follows:

§ 11-45. Exceptions to requirement for competitive procurement.

A. Any public body may enter into contracts without competition for the purchase of goods or services (i) which are performed or produced by persons, or in schools or workshops, under the supervision of the Virginia Department for the Visually Handicapped; or (ii) which are performed or produced by nonprofit sheltered workshops or other nonprofit organizations which offer transitional or supported employment services serving the handicapped.

B. Any public body may enter into contracts without competition for (i) legal services, provided that the pertinent provisions of Chapter 11 (§ 2.1-117 et seq.) of Title 2.1 remain applicable; or (ii) expert witnesses and other services associated with litigation or regulatory proceedings.

C. Any public body may extend the term of an existing contract for services to allow completion of any work undertaken but not completed during the original term of the contract.

D. An industrial development authority may enter into contracts without competition with respect to any item of cost of "authority facilities" or "facilities" as defined in § 15.2-4902.

E. The Department of Alcoholic Beverage Control may procure alcoholic beverages without competitive sealed bidding or competitive negotiation.

F. Any public body administering public assistance programs as defined in § 63.1-87, the fuel assistance program, community services boards as defined in § 37.1-1, or any public body purchasing services under the Comprehensive Services Act for At-Risk Youth and Families (§ 2.1-745 et seq.) may procure goods or personal services for direct use by the recipients of such programs without competitive sealed bidding or competitive negotiations if the procurement is made for an individual recipient. Contracts for the bulk procurement of goods or services for the use of recipients shall not be exempted from the requirements of § 11-41.

G. Any public body may enter into contracts without competitive sealed bidding or competitive negotiation for insurance if purchased through an association of which it is a member if the association was formed and is maintained for the purpose of promoting the interest and welfare of and developing close relationships with similar public bodies, provided such association has procured the insurance by use of competitive principles and provided that the public body has made a determination in advance after reasonable notice to the public and set forth in writing that competitive sealed bidding and competitive negotiation are not fiscally advantageous to the public. The writing shall document the basis for this determination.

H. The Department of Health may enter into contracts with laboratories providing cytology and related services without competitive sealed bidding or competitive negotiation if competitive sealed bidding and competitive negotiations are not fiscally advantageous to the public to provide quality control as prescribed in writing by the Commissioner of Health.

I. The Director of the Department of Medical Assistance Services may enter into contracts without competitive sealed bidding or competitive negotiation for special services provided for eligible recipients pursuant to § 32.1-325 ~~E~~ *H*, provided that the Director has made a determination in advance after reasonable notice to the public and set forth in writing that competitive sealed bidding or competitive negotiation for such services is not fiscally advantageous to the public, or would constitute an imminent threat to the health or welfare of such recipients. The writing shall document the basis for this determination.

J. The Virginia Code Commission may enter into contracts without competitive sealed bidding or competitive negotiation when procuring the services of a publisher, pursuant to §§ 9-77.7 and 9-77.8, to publish the Code of Virginia or the Virginia Administrative Code.

K. (Effective until July 1, 1999) The State Health Commissioner may enter into agreements or contracts without competitive sealed bidding or competitive negotiation for the compilation, storage, analysis, evaluation, and publication of certain data submitted by health care providers and for the development of a methodology to measure the efficiency and productivity of health care providers pursuant to Chapter 7.2 (§ 32.1-276.2 et seq.) of Title 32.1, if the Commissioner has made a

determination in advance, after reasonable notice to the public and set forth in writing, that competitive sealed bidding or competitive negotiation for such services is not fiscally advantageous to the public. The writing shall document the basis for this determination. Such agreements and contracts shall be based on competitive principles.

L. A community development authority formed pursuant to Article 6 (§ 15.2-5152 et seq.) of Chapter 51 of Title 15.2, with members selected pursuant to such article, may enter into contracts without competition with respect to the exercise of any of its powers permitted by § 15.2-5158; however, this exception shall not apply in cases where any public funds other than special assessments and incremental real property taxes levied pursuant to § 15.2-5158 are used as payment for such contract.

M. Virginia Correctional Enterprises may enter into contracts without competitive sealed bidding or competitive negotiation when procuring materials, supplies, or services for use in and support of its production facilities, provided such procurement is accomplished using procedures which ensure the efficient use of funds as practicable and, at a minimum, shall include obtaining telephone quotations. Such procedures shall require documentation of the basis for awarding contracts under this section.

N. The Virginia Baseball Stadium Authority may enter into agreements or contracts without competitive sealed bidding or competitive negotiation for the operation of any facilities developed under the provisions of Chapter 58 (§ 15.2-5800 et seq.) of Title 15.2, including contracts or agreements with respect to the sale of food, beverages and souvenirs at such facilities.

O. The Department of Health may procure child restraint devices, pursuant to § 46.2-1097, without competitive sealed bidding or competitive negotiation.

P. With the consent of the Governor, the Jamestown-Yorktown Foundation may enter into agreements or contracts with private entities without competitive sealed bidding or competitive negotiation for the promotion of tourism through marketing provided a demonstrable cost savings, as reviewed by the Secretary of Education, can be realized by the Foundation and such agreements or contracts are based on competitive principles.

Q. The Virginia Racing Commission may designate an entity to administer and promote the Virginia Breeders Fund created pursuant to § 59.1-372.

R. The Chesapeake Hospital Authority may enter into contracts without competitive sealed bidding or competitive negotiation in the exercise of any power conferred under Chapter 271, as amended, of the Acts of Assembly of 1966.

S. The Hospital Authority of Norfolk may enter into contracts without competitive sealed bidding or competitive negotiation in the exercise of any power conferred under Chapter 53 (§ 15.2-5300 et seq.) of Title 15.2. The Authority shall not discriminate against any person on the basis of race, color, religion, national origin, sex, pregnancy, childbirth or related medical conditions, age, marital status, or disability in the procurement of goods and services.

§ 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 $2,500 for the individual and an amount not in excess of $2,500 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 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 *leukemia,* lymphoma or breast cancer 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; and

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.

B. In preparing the plan, the Board shall ~~work~~*:*

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.

~~The Board shall also initiate~~*2. Initiate* such cost containment or other measures as are set forth in the appropriations act.

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

~~Before the Board acts on a regulation to be published in the Virginia Register of Regulations~~

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~~pursuant to § 9-6.14:7.1, the Board shall examine~~*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.

~~The Board's regulations shall incorporate~~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.

~~B~~*D.* The Director of Medical Assistance Services is authorized to ~~administer~~*:*

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.

~~C. The Director of Medical Assistance Services is authorized to enter~~*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.

~~The Director may refuse~~*3. Refuse* to enter into or renew an agreement or contract with any provider which has been convicted of a felony.

~~In addition, the Director may refuse~~*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.

~~D~~*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 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.

~~E~~*H.* The Department shall 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.

~~F~~*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 ~~this~~ subsection *I of this section*. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 32.1-325.1. Adverse initial determination of overpayment; appeals of agency determinations.

A. The Director shall make an initial determination as to whether an overpayment has been made to a provider in accordance with the state plan for medical assistance *services,* the provisions of § 9-6.14:11 and applicable federal law. Once a determination of overpayment 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 determination of overpayment. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 from the date the Director's 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. In any case in which an initial determination of overpayment has been reversed in a subsequent agency or judicial proceeding, the provider shall be reimbursed that portion of the payment to which he is entitled plus any applicable interest.

B. An appeal of the Director's initial determination concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) and the state plan for medical assistance *services* provided for in § 32.1-325. Court review of final agency determinations concerning provider reimbursement shall be made *(i)* in accordance with the Administrative Process Act~~. This provision shall apply to all administrative appeals pending as of its effective date in which no agency hearing has been held~~ *or (ii) by filing a de novo action in the appropriate circuit court pursuant to Article 18 (§ 8.01-192 et seq.) of Chapter 3 of Title 8.01. In any de novo civil action in which any person contests any action of the Department, such person shall be entitled to recover from the Department (a) reasonable costs and attorneys fees if such person substantially prevails on the merits of the case and the agency's position is not substantially justified, unless special circumstances would make an award unjust, and (b) interest at the legal rate on any claim against the Department from the date the court finds payment from the Department was justly due. The provisions of clause (ii) of this subsection shall apply to all pending and future administrative appeals*.

§ 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 *services* pursuant to ~~subsection C~~ *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 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 shall be made within the earlier of (i) four years, or (ii) fifteen months after filing of the final cost report 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.

2. That the Board shall promulgate regulations within 280 days of the enactment of this provision to implement the 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 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.