12 VAC 30-10-1000. General provider appeals. These provisions shall apply to all provider types for informal and formal administrative appeals.

12 VAC 30-20-500 (Attachment 7.5) describes the process, procedures, and time frames for all provider informal and formal administrative appeals.

CERTIFIED:

Date	Dennis G. Smith, Director Dept. of Medical Assistance Services

PART I. DEFINITIONS AND GENERAL PROVISIONS

12 VAC 30-20-500. Definitions.

The following words, when used in these regulations, shall have the following meanings:

"Day" means a calendar day unless otherwise stated.

"DMAS" means the Virginia Department of Medical Assistance Services or its agents or contractors.

"Hearing officer" means an individual selected by the Executive Secretary of the Supreme Court of Virginia to conduct the formal appeal in an impartial manner pursuant to Va. Code §§ 9-6.14:12 and 32.1-325.1 and these regulations.

"Informal appeals agent" means a DMAS employee who conducts the informal appeal in an impartial manner pursuant to Va. Code §§ 9-6.14:11 and 32.1-325.1 and these regulations.

"Provider" means an individual or entity that has a contract with DMAS to provide covered services and that is not operated by the Commonwealth of Virginia.

12 VAC 30-20-510. Reserved.

12 VAC 30-20-520. General Provisions.

A. These regulations shall govern all DMAS informal and formal provider appeals and shall supersede any other provider appeals regulations.

B. A provider may appeal any DMAS action that is subject to appeal under the Virginia Administrative Process Act (Chapter 1.1:11 of Title 9 of the Code of Virginia), including DMAS' interpretation and application of payment methodologies. A provider may not appeal the actual payment methodologies.

C. DMAS shall mail all items to the last known address of the provider. It is presumed that DMAS mails items on the date noted on the item. It is presumed that providers receive items mailed to their last known address within 3 days after DMAS mails the item.

D. Whenever DMAS or a provider is required to file a document, the document shall be considered filed when it is date stamped by the DMAS Appeals Division in Richmond, Virginia.

E. Whenever the last day specified for the filing of any document or the performance of any other act falls on a day on which DMAS is officially closed, the time period shall be extended to the next day on which DMAS is officially open.

F. Conferences and hearings shall be conducted at DMAS' main office in Richmond, Virginia, or at such other place as agreed to by the parties.

G. Whenever DMAS or a provider is required to attend a conference or hearing, failure by one of the parties to attend the conference or hearing shall result in dismissal of the appeal in favor of the other party.

H. DMAS 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 DMAS' position is not substantially justified, unless special circumstances would make an award

unjust. In order to substantially prevail on the merits of the appeal, the provider must be successful on more than 50% of the dollar amount involved in the issues identified in the provider's notice of appeal.

12 VAC 30-20-530. Reserved.

PART II. INFORMAL APPEALS

12 VAC 30-20-540. Informal appeals.

A. Providers appealing a DMAS decision shall file a written notice of informal appeal with the DMAS Appeals Division within 30 days of the provider's receipt of the decision. Providers appealing adjustments to a cost report shall file a written notice of informal appeal with the DMAS Appeals Division within 90 days of the provider's receipt of the notice of program reimbursement. The notice of informal appeal shall identify the issues being appealed. Failure to file a written notice of informal appeal within 30 days of receipt of the decision or within 90 days of receipt of the notice of program reimbursement shall result in dismissal of the appeal.

B. DMAS shall file a written case summary with the DMAS Appeals Division within 30 days of the filing of the provider's notice of informal appeal. DMAS shall mail a complete copy of the case summary to the provider on the same day that the case summary is filed with the DMAS Appeals Division. The case summary shall address each adjustment, patient, service date, or other disputed matter and shall state DMAS' position for each adjustment, patient, service date, or other disputed matter. The case summary shall contain the factual basis for each adjustment, patient, service date, or other disputed matter and any other information, authority, or documentation DMAS relied upon in taking its

action or making its decision. Failure to file a written case summary with the Appeals Division in the detail specified within 30 days of the filing of the provider's notice of informal appeal shall result in dismissal in favor of the provider on those issues not addressed in the detail specified.

C. The informal appeals agent shall conduct the conference within 90 days from the filing of the notice of informal appeal. If DMAS and the provider and the informal appeals agent agree, the conference may be conducted by way of written submissions. If the conference is conducted by way of written submissions, the informal appeals agent shall specify the time within which the provider may file written submissions, not to exceed 90 days from the filing of the notice of informal appeal. Only written submissions filed within the time specified by the informal appeals agent shall be considered.

D. The conference may be recorded for the convenience of the informal appeals agent. Since the conference is not an adversarial or evidentiary proceeding, recordings shall not be made part of the administrative record and shall not be made available to anyone other than the informal appeals agent.

E. Upon completion of the conference, the informal appeals agent shall specify the time within which the provider may file additional documentation or information, if any, not to exceed 30 days. Only documentation or information filed within the time specified by the informal appeals agent shall be considered.

F. The informal appeal decision shall be issued within 180 days of receipt of the notice of informal appeal.

12 VAC 30-20-550. Reserved.

PART III. FORMAL APPEALS

12 VAC 30-20-560. Formal appeals.

A. Any provider appealing a DMAS informal appeal decision shall file a written notice of formal appeal with the DMAS Appeals Division within 30 days of the provider's receipt of the informal appeal decision. The notice of formal appeal shall identify the issues being appealed. Failure to file a written notice of formal appeal within 30 days of receipt of the informal appeal decision shall result in dismissal of the appeal.

B. DMAS and the provider shall exchange and file with the hearing officer all documentary evidence on which DMAS or the provider relies within 21 days of the filing of the notice of formal appeal. Only documents filed within 21 days of the filing of the notice of formal appeal shall be considered. DMAS and the provider shall file any objections to the admissibility of documentary evidence within seven days of the filing of the documentary evidence. Only objections filed within seven days of the filing of the documentary evidence shall be considered. The hearing officer shall rule on any objections within seven days of the filing of the objections.

C. The hearing officer shall conduct the hearing within 45 days from the filing of the notice of formal appeal.

D. Hearings shall be transcribed by a court reporter retained by DMAS.

E. Upon completion of the hearing, DMAS and the provider shall have 30 days to exchange and file with the hearing officer an opening brief. Only opening briefs filed within 30 days after the hearing shall be considered. DMAS and the provider shall have 10 days to exchange and file with the hearing officer a reply brief after the opening brief has been filed. Only reply briefs filed within 10 days after the opening brief has been filed shall be considered.

F. The hearing officer shall submit a recommended decision to the DMAS Director with a copy to the provider within 120 days of receipt of the formal appeal request. If the hearing officer does not submit a recommended decision within 120 days, then DMAS shall give written notice to the hearing officer and the Executive Secretary of the Supreme Court that a recommended decision is due.

G. Upon receipt of the hearing officer's recommended decision, the DMAS Director shall notify DMAS and the provider in writing that any written exceptions to the hearing officer's recommended decision shall be filed within 30 days of receipt of the DMAS Director's letter. Only exceptions filed within 30 days of receipt of the DMAS Director's letter shall be considered. The DMAS Director shall issue the final agency case decision within 60 days of receipt of the hearing officer's recommended decision.

12 VAC 30-20-561 through 12 VAC 30-20-599. Reserved.

CERTIFIED:

_____ _____

Date

Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-70-140. ~~Right to appeal and initial agency decision.~~ REPEALED.

~~A. Right to appeal. Any hospital seeking to appeal its prospective payment rate for operating costs related to inpatient care or other allowable costs shall submit a written request to the Department of Medical Assistance Services within 30 days of the date of the letter notifying the hospital of its prospective rate unless permitted to do otherwise under 12VAC30-70-144 E. The written request for appeal must contain the information specified in subsection B of this section. The department shall respond to the hospital's request for additional reimbursement within 30 days or after receipt of any additional documentation requested by the department, whichever is later. Such agency response shall be considered the initial agency determination.~~

~~B. Required information. Any request to appeal the prospective payment rate must specify: (i) the nature of the adjustment sought; (ii) the amount of the adjustment sought; and (iii) current and prospective cost containment efforts, if appropriate.~~

~~C. Nonappealable issues. The following issues will not be subject to appeal: (i) the organization of participating hospitals into peer groups according to location and bed size and the use of bed size and the urban/rural distinction as a generally adequate proxy for case mix and wage variations between hospitals in determining reimbursement for inpatient care; (ii) the use of Medicaid and applicable Medicare Principles of Reimbursement to determine reimbursement of costs other than operating costs relating to the provision of inpatient care; (iii) the calculation of the initial group ceilings on allowable operating costs for inpatient care as of July 1, 1982; (iv) the use of the inflation factor identified in the State Plan as the prospective escalator; and (v) durational limitations set forth in the State Plan (the "twenty-one day rule").~~

~~D. The rate which may be appealed shall include costs which are for a single cost reporting period only.~~

~~E. The hospital shall bear the burden of proof throughout the administrative process.~~

CERTIFIED:

_____ _____

Date Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-70-141. ~~Administrative appeal of adverse initial agency determination~~. REPEALED.

~~A. The administrative appeal of an adverse initial agency determination shall be made in accordance with the Virginia Administrative Process Act, §9-6.14:11 through §9-6.14:14 of the Code of Virginia, as set forth below.~~

~~B. The informal proceeding:~~

~~1. The hospital shall submit a written request to appeal an adverse initial agency determination in accordance with §9-6.14:11 of the Code of Virginia within 15 days of the date of the letter transmitting the initial agency determination.~~

~~2. The request for an informal conference in accordance with §9-6.14:11 of the Code of Virginia shall include the following information:~~

~~a. the adverse agency action appealed from;~~

~~b. a detailed description of the factual data, argument or information the hospital will rely on to challenge the adverse agency decision.~~

~~3. The agency shall afford the hospital an opportunity for an informal conference in accordance with §9-6.14:11 of the Code of Virginia.~~

~~4. The Director of the Appeals Division of the Department of Medical Assistance Services, or a designee, shall preside over the informal conference. As hearing officer, the director, or the designee, may request such additional documentation or information from the hospital or agency staff as may be necessary in order to render an opinion.~~

~~5. After the informal conference, the Director of the Appeals Division, having considered the criteria for relief set forth in 12VAC30-70-143 and 12VAC30-70-144, shall take any of the following actions:~~

~~a. Notify the provider that its request for relief is denied setting forth the reasons for such denial;~~

~~b. Notify the provider that its appeal has merit and advise it of the agency action which will be taken; or~~

~~c. Notify the provider that its request for relief will be granted in part and denied in part, setting forth the reasons for the denial in part and the agency action which will be taken to grant relief in part.~~

~~6. The decision of the informal hearing officer shall be rendered within 90 days of the conclusion of the informal conference.~~

CERTIFIED:

_____ _____

Date Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-70-142. ~~The formal administrative hearing: procedures~~. REPEALED.

~~A. The hospital shall submit its written request for a formal administrative hearing under §9-6.14:12 of the Code of Virginia within 15 days of the date of the letter transmitting the adverse informal agency decision.~~

~~B. At least 21 days prior to the date scheduled for the formal hearing, the hospital shall provide the agency with:~~

~~1. Identification of the adverse agency action appealed from, and~~

~~2. A summary of the factual data, argument and proof the provider will rely on in connection with its case.~~

~~C. The agency shall afford the provider an opportunity for a formal administrative hearing within 45 days of the receipt of the request.~~

~~D. The Director of the Department of Medical Assistance Services, or his designee, shall preside over the hearing. Where a designee presides, he shall make recommended findings and a recommended decision to the director. In such instance, the provider shall have an opportunity to file exceptions to the proposed findings and conclusions. In no case shall the designee presiding over the formal administrative hearing be the same individual who presided over the informal appeal.~~

~~E. The Director of the Department of Medical Assistance Services shall make the final administrative decision in each case.~~

~~F. The decision of the agency shall be rendered within 60 days of the conclusion of the administrative hearing.~~

CERTIFIED:

_____ _____

Date

Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-70-143. ~~The formal administrative hearing: necessary demonstration of proof.~~ REPEALED.

~~A. The hospital shall bear the burden of proof in seeking relief from its prospective payment rate.~~

~~B. A hospital seeking additional reimbursement for operating costs relating to the provision of inpatient care shall demonstrate that its operating costs exceed the limitation on operating costs established for its peer group and set forth the reasons for such excess.~~

~~C. In determining whether to award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, the Director of the Department of Medical Assistance Services shall consider the following:~~

~~1. Whether the hospital has demonstrated that its operating costs are generated by factors generally not shared by other hospitals in its peer group. Such factors may include, but are not limited to, the addition of new and necessary services, changes in case mix, extraordinary circumstances beyond the control of the hospital, and improvements imposed by licensing or accrediting standards.~~

~~2. Whether the hospital has taken every reasonable action to contain costs on a hospital-wide basis.~~

~~a. In making such a determination, the director or his designee may require that an appellant hospital provide quantitative data, which may be compared to similar data from other hospitals within that hospital's peer group or from other hospitals deemed by the director to be comparable. In making such comparisons, the director may develop operating or financial ratios which are indicators of performance quality in particular areas of hospital operation. A finding that the data or ratios or both of the appellant hospital fall within a range exhibited by the majority of comparable hospitals may be construed by the director to be evidence that the hospital has taken every reasonable action to contain costs in that particular area. Where applicable, the director may require the hospital to submit to the agency the data it has developed for the Virginia Department of Health (formerly Virginia Health Services Cost Review Council). The director may use other data, standards or operating screens acceptable to him. The appellant hospital shall be afforded an opportunity to rebut ratios, standards or comparisons utilized by the director or his designee in accordance with this section.~~

~~b. Factors to be considered in determining effective cost containment may include the following:~~

~~- Average daily occupancy~~

~~- Average hourly wage~~

~~- FTE's per adjusted occupied bed~~

~~- Nursing salaries per adjusted patient day~~

~~- Average length of stay~~

~~- Average cost per surgical case~~

~~- Cost (salary/nonsalary) per ancillary procedure~~

~~- Average cost (food/nonfood) per meal served~~

~~- Average cost per pound of laundry~~

~~- Cost (salary/nonsalary) per pharmacy prescription~~

~~- Housekeeping cost per square foot~~

~~- Maintenance cost per square foot~~

~~- Medical records cost per admission~~

~~- Current ratio (current assets to current liabilities)~~

~~- Age of receivables~~

~~- Bad debt percentage~~

~~- Inventory turnover~~

~~- Measures of case mix~~

~~c. In addition, the director may consider the presence or absence of the following systems and procedures in determining effective cost containment in the hospital's operation.~~

~~- Flexible budgeting system~~

~~- Case mix management systems~~

~~- Cost accounting systems~~

~~- Materials management system~~

~~- Participation in group purchasing arrangements~~

~~- Productivity management systems~~

~~- Cash management programs and procedures~~

~~- Strategic planning and marketing~~

~~- Medical records systems~~

~~- Utilization/Peer review systems~~

~~d. Nothing in this provision shall be construed to require a hospital to demonstrate every factor set forth above or to preclude a hospital from demonstrating effective cost containment by using other factors.~~

~~The director or his designee may require that an onsite operational review of the hospital be conducted by the department or its designee.~~

~~3. Whether the hospital has demonstrated that the Medicaid prospective payment rate it receives to cover operating costs related to inpatient care is insufficient to provide care and service that conforms to applicable state and federal laws, regulations and quality and safety standards.1~~

~~D. In no event shall the Director of the Department of Medical Assistance Services award additional reimbursement to a hospital for operating costs relating to the provision of inpatient~~

~~care, unless the hospital demonstrates to the satisfaction of the director that the Medicaid rate it receives under the Medicaid prospective payment system is insufficient to ensure Medicaid recipients reasonable access to sufficient inpatient hospital services of adequate quality.2~~

~~In making such demonstration, the hospital shall show that:~~

~~1. The current Medicaid prospective payment rate jeopardizes the long-term financial viability of the hospital. Financial jeopardy is presumed to exist if, by providing care to Medicaid recipients at the current Medicaid rate, the hospital can demonstrate that it is, in the aggregate, incurring a marginal loss.3~~

~~For purposes of this section, marginal loss is the amount by which total variable costs for each patient day exceed the Medicaid payment rate. In calculating marginal loss, the hospital shall compute variable costs at 60% of total inpatient operating costs and fixed costs at 40% of total inpatient operating costs; however, the director may accept a different ratio of fixed and variable operating costs if a hospital is able to demonstrate that a different ratio is appropriate for its particular institution.~~

~~Financial jeopardy may also exist if the hospital is incurring a marginal gain but can demonstrate that it has unique and compelling Medicaid costs, which if unreimbursed by Medicaid, would clearly jeopardize the hospital's long-term financial viability.~~

~~2. The population served by the hospital seeking additional financial relief has no reasonable access to other inpatient hospitals. Reasonable access exists if most individuals served by the hospital seeking financial relief can receive inpatient hospital care within a 30-minute travel time at a total per diem rate which is less to Department of Medical Assistance Services than the costs which would be incurred by DMAS per patient day were the appellant hospital granted relief.4~~

~~E. In determining whether to award additional reimbursement to a hospital for reimbursable costs which are other than operating costs related to the provision of inpatient care, the director shall consider Medicaid and applicable Medicare rules of reimbursement.~~

~~1See 42 USC §1396a(a)(13)(A). This provision reflects the Commonwealth's concern that she reimburse only those excess operating costs which are incurred because they are needed to provide adequate care. The Commonwealth recognizes that hospitals may choose to provide more than "just adequate" care and, as a consequence, incur higher costs. In this regard, the Commonwealth notes that "Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services... that package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered --not "adequate health care."' Alexander v. Choate,--U.S.--decided January 9, 1985, 53 L.W., 4072, 4075.~~

~~2In Mary Washington Hospital v. Fisher, the court ruled that the Medicaid rate "must be adequate to ensure reasonable access." Mary Washington Hospital v. Fisher, at p. 18. The need to demonstrate that the Medicaid rate is inadequate to ensure recipients reasonable access derives directly from federal law and regulation. In its response to comments on the NPRM published September 30, 1981, HCFA points out Congressional intent regarding the access issue:~~

~~The report on H.R. 3982 states the expectation that payment levels for inpatient services will be adequate to assure that a sufficient number of facilities providing a sufficient level of services actively participate in the Medicaid program to enable all Medicaid beneficiaries to obtain quality inpatient services. This report further states that payments should be set at a level that ensures the active treatment of Medicaid patients in a majority of the hospitals in the state. 46 FR 47970.~~

~~3The Commonwealth believes that Congressional intent is threatened in situations in which a hospital is incrementally harmed for each additional day a Medicaid patient is treated --and therefore has good cause to consider withdrawal from the program --and where no alternative is readily available to the patient, should withdrawal occur. Otherwise, although the rate being paid a hospital may be less than that paid by other payors --indeed, less than average cost per day for all patients --it nonetheless equals or exceeds the variable cost per day, and therefore benefits the hospital by offsetting some amount of fixed costs, which it would incur even if the bed occupied by the Medicaid patient were left empty.~~

~~It should be emphasized that application of this marginal loss or "incremental harm" concept is a device to assess the potential harm to a hospital continuing to treat Medicaid recipients, and not a mechanism for determining the additional payment due to a successful appellant. As discussed below, once a threat to access has been demonstrated, the Commonwealth may participate in the full average costs associated with the circumstances underlying the appeal.~~

~~4With regard to the 30-minute travel standard, this requirement is consistent with general health planning criteria regarding acceptable travel time for hospital care.~~

CERTIFIED:

_____ _____

Date

Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-70-144. ~~Available relief.~~ REPEALED.

~~A. Any relief granted under 12VAC30-70-140 through 12VAC30-70-143 shall be for one cost reporting period only.~~

~~B. Relief for hospitals seeking additional reimbursement for operating costs incurred in the provision of inpatient care shall not exceed the difference between:~~

~~1. The cost per allowable Medicaid day arising specifically as a result of circumstances identified in accordance with 12VAC30-70-143 (excluding plant and education costs and return on equity capital); and~~

~~2. The prospective operating costs per diem, identified in the Medicaid Cost Report and calculated by DMAS.5~~

~~5The Commonwealth recognizes that in cases where circumstances warrant relief beyond the existing payment rate, she may share in the cost associated with those circumstances. This is consistent with the existing policy, whereby payment is made on an average per diem basis. The Commonwealth will not reimburse more than her share of fixed costs. Any relief to an appellant hospital will be computed using patient days adjusted for the level of occupancy during the period under appeal. In no case will any additional payments made under this rule reflect lengths of stay which exceed the 21-day limit currently in effect.~~

~~C. Relief for hospitals seeking additional reimbursement for (i) costs considered as "pass-throughs" under the prospective payment system or (ii) costs incurred in providing care to a disproportionate number of Medicaid recipients or (iii) costs incurred in providing extensive neonatal care shall not exceed the difference between the payment made and the actual allowable cost incurred.~~

~~D. Any relief awarded under 12VAC30-70-140 through 12VAC30-70-143 shall be effective from the first day of the cost period for which the challenged rate was set. Cost periods for which relief will be afforded are those which begin on or after January 4, 1985. In no case shall this limitation apply to a hospital which noted an appeal of its prospective payment rate for a cost period prior to January 4, 1985.~~

~~E. All hospitals for which a cost period began on or after January 4, 1985, but prior to the effective date of these regulations, shall be afforded an opportunity to be heard in accordance with these regulations if the request for appeal set forth in 12VAC30-70-140 A is filed within 90 days of the effective date of these regulations.~~

CERTIFIED:

_____ _____

Date

Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-70-145. ~~Catastrophic occurrence~~. REPEALED.

~~A. Nothing in this part shall be construed to prevent a hospital from seeking additional reimbursement for allowable costs incurred as a consequence of a natural or other catastrophe. Such reimbursement will be paid for the cost period in which such costs were incurred and for cost periods beginning on or after July 1, 1982.~~

~~B. In order to receive relief under this section, a hospital shall demonstrate that the catastrophe met the following criteria:~~

~~1. One time occurrence;~~

~~2. Less than 12 months duration;~~

~~3. Could not have been reasonably predicted;~~

~~4. Not of an insurable nature;~~

~~5. Not covered by federal or state disaster relief;~~

~~6. Not a result of malpractice or negligence.~~

~~C. Any relief sought under this section must be calculable and auditable.~~

~~D. The agency shall pay any relief afforded under this section in a lump sum.~~

CERTIFIED:

_____ _____

Date

Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-90-130. ~~Dispute resolution for nonstate operated nursing facilities~~. Repealed.

~~A. NF's have the right to appeal the DMAS's interpretation and application of state and federal Medicaid and applicable Medicare principles of reimbursement in accordance with the Administrative Process Act, §9-6.14:1 et seq. and §32.1-325.1 of the Code of Virginia.~~

~~B. Nonappealable issues are identified below:~~

~~1. The use of state and federal Medicaid and applicable Medicare principles of reimbursement.~~

~~2. The organization of participating NF's into peer groups according to location as a proxy for cost variation across facilities with similar operating characteristics. The use of individual ceilings as a proxy for determining efficient operation within each peer group.~~

~~3. Calculation of the initial peer group ceilings using the most recent cost settled data available to DMAS that reflects NF operating costs inflated to September 30, 1990.~~

~~4. The use of the moving average of the Skilled Nursing Facility market basket of routine service costs, as developed by Data Resources, Incorporated, adjusted for Virginia, as the prospective escalator.~~

~~5. The establishment of separate ceilings for direct operating costs and indirect operating costs.~~

~~6. The use of Service Intensity Indexes to identify the resource needs of given NFs patient mix relative to the needs present in other NFs.~~

~~7. The development of Service Intensity Indexes based on:~~

~~a. Determination of resource indexes for each patient class that measures relative resource cost.~~

~~b. Determination of each NF's average relative resource cost index across all patients.~~

~~c. Standardizing the average relative resource cost indexes of each NF across all NF's.~~

~~8. The use of the DMAS Long Term Care Information System (LTCIS), assessment form (currently DMAS-95), Virginia Center on Aging Study, the State of Maryland Time and Motion Study of the Provision of Nursing Service in Long Term Care Facilities, and the KPMG Peat Marwick Survey of Virginia long-term care NF's nursing wages to determine the patient class system and resource indexes for each patient class.~~

~~9. The establishment of payment rates based on service intensity indexes.~~

CERTIFIED:

_____ _____

Date Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-90-131. ~~Conditions for appeal.~~ Repealed.

~~An appeal shall not be heard until the following conditions are met:~~

~~1. Where appeals result from desk or field audit adjustments, the provider shall have received a notification of program reimbursement (NPR) in writing from the DMAS.~~

~~2. Any and all moneys due to DMAS shall be paid in full, unless a repayment plan has been agreed to by DMAS.~~

~~3. All first level appeal requests shall be filed in writing with the DMAS within 90 business days following the date of a DMAS notice of program reimbursement that adjustments have been made to a specific cost report.~~

CERTIFIED:

_____ _____

Date

Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-90-132. ~~Appeal procedure.~~ Repealed.

~~A. There shall be two levels of administrative appeal.~~

~~B. Informal appeals shall be decided by the Director of the Appeals Division after an informal fact finding conference is held. The decision of the Director of the Appeals Division shall be sent in writing to the provider within 90 business days following conclusion of the informal fact finding conference.~~

~~C. If the provider disagrees with such initial decision the provider may, at its discretion, file a notice of appeal to the Director of the DMAS. Such notice shall be in writing and filed within 30 business days of the date of the initial decision.~~

~~D. Within 30 business days of the date of such notice of appeal, the director shall appoint a hearing officer to conduct the proceedings, to review the issues and the evidence presented, and to make a written recommendation.~~

~~E. The director shall notify the provider of his final decision within the time frames set for disposition of appeals in this subpart and the Administrative Process Act, §9-6.14:1 et seq. of the Code of Virginia.~~

~~F. The director's final written decision shall conclude the provider's administrative appeal.~~

~~G. Formal hearing procedures, as developed by DMAS, shall control the conduct of the formal administrative proceedings.~~

CERTIFIED:

_____ _____

Date Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-90-133. ~~Appeals time frames~~. Repealed.

~~Appeal time frames noted throughout this section may be extended for the following reasons:~~

~~1. The provider submits a written request prior to the due date requesting an extension for good cause and the DMAS approves the extension.~~

~~2. Delays on the part of the NF documented by the DMAS shall automatically extend DMAS's time frame to the extent of the time delayed.~~

~~3. Extensions of time frames shall be granted to the DMAS for good cause shown.~~

~~4. When appeals for multiple years are submitted by a NF or a chain organization or common owners are coordinating appeals for more than one NF, the time frames shall be reasonably extended for the benefit of the DMAS.~~

~~5. Disputes relating to the time lines established in 12VAC30-90-132 B or to the grant of extensions to the DMAS shall be resolved by application to the Director of the DMAS or his designee.~~

CERTIFIED:

_____ _____

Date Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-90-135. ~~Reimbursement of legal fees associated with appeals having substantial merit.~~ Repealed.

~~A. The Department of Medical Assistance Services shall reimburse a nursing facility for reasonable and necessary legal fees associated with an informal or formal appeal brought pursuant to the Administrative Process Act, only if the nursing facility substantially prevails on the merit of the appeal. The term "substantially prevails" is defined as being successful on more than 50% of the issue as appealed and on more than 50% of the amount under appeal. The reimbursement of legal fees remains subject to the State Plan for Medical Assistance and all existing ceilings. Any legal fees claimed must be supported by adequate, detailed, and verifiable documentation.~~

~~B. Subject to the requirements of subsection A of this section, the reimbursable legal fees will be included in the calculation of total allowable costs in the fiscal year the appeal process is concluded and Medicaid will reimburse the nursing facility for its Medicaid proportionate share.~~

CERTIFIED:

_____ _____

Date

Dennis G. Smith, Director
Dept. of Medical Assistance Services