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MEMORANDUM

TO: BRIAN MCCORMICK
Regulatory Supervisor
Department of Medical Assistance Services

FROM: JENNIFER L. GOBBLE
Assistant Attorney General

DATE: November 8, 2013

SUBJECT: **Fast Track Regulation: ICF/IID Ceiling; Cost Report Submission; Credit Balance Reporting**

I am in receipt of the attached fast-track regulation proposing to amend three aspects of Medicaid reimbursement methodology for nursing facilities.

You asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to promulgate the regulation and if the regulation comports with state and federal law. Based on that review, it is my view that the Director, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code §§ 32.1-324 and 325, has the authority to promulgate this regulation, subject to compliance with the provisions of Article 2 of the Administrative Process Act, and has not exceeded that authority.

This regulatory action will implement necessary updates to Medicaid policies relating to (i) the closure of state operated Intermediate Care Facilities for Individuals with Intellectual Disabilities, (ii) modified procedures for nursing facility reporting and resolution of credit balances, and (iii) a technical correction to an internal citation.

Pursuant to Va. Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, DMAS shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process set out in Article 2 of the Administrative Process Act with the

initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

If you have any questions or need additional information about these regulations, please contact me at 786-4905.

cc: Kim F. Piner
Chief/Senior Assistant Attorney General

Attachment

Proposed Text

Action:
ICF/IID ceiling; cost report submission; credit balance ...
Stage: Fast-Track
9/30/13 12:39 PM [latest]

12VAC30-90-20
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-90-20. Nursing home payment system; generally.

A. Effective July 1, 2001, the payment methodology for nursing facility (NF) reimbursement by the Virginia Department of Medical Assistance Services (DMAS) is set forth in this part.

B. Three separate cost components are used: plant or capital, as appropriate, cost; operating cost; and nurse aide training and competency evaluation program and competency evaluation program (NATCEPs) costs. The rates, which are determined on a facility-by-facility basis, shall be based on annual cost reports filed by each provider.

C. Effective July 1, 2001, in determining the ceiling limitations, there shall be direct patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg Metropolitan Statistical Area (MSA), and in the rest of the state. There shall be indirect patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA MSA, for NFs with less than 61 beds in the rest of the state, and for NFs with more than 60 beds in the rest of the state. The Washington DC-MD-VA MSA and the Richmond-Petersburg MSA shall include those cities and counties as listed and changed from time to time by the Centers for Medicare and Medicaid Services (CMS). A nursing facility located in a jurisdiction which CMS adds to or removes from the Washington DC-MD-VA MSA or the Richmond-Petersburg MSA shall be placed in its new peer group, for purposes of reimbursement, at the beginning of its next fiscal year following the effective date of HCFA's final rule.

D. Nursing facilities operated by the Department of Behavioral Health and Developmental Services [(DBHDS)] and the Department of Veterans Services [(DVS)] shall be exempt from the prospective payment system as defined in Articles 1 (12VAC30-90-29), 3 (12VAC30-90-35 et seq.), 4 (12VAC30-90-40 et seq.), 6 (12VAC30-90-60 et seq.), and 8 (12VAC30-90-80 et seq.) of this subpart. All other sections of this payment system relating to reimbursable cost limitations shall apply. These facilities [operated by DBHDS and DVS] shall continue to be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare principles of reimbursement.

[E.] Reimbursement to Intermediate Care Facilities for [~~the Mentally Retarded~~ Individuals with Intellectual Disabilities ~~(ICF/MR)~~] [(ICF/IID)] shall be [~~reimbursed retrospectively~~ retrospective] on the basis of reasonable costs in accordance with Medicare principles of reimbursement [. ~~but~~ Non-state facilities shall be limited to [a ceiling based on] the highest [as filed] rate paid to [~~a state ICF/MR~~ an ICF/IID] institution [in SFY 2012 and annually adjusted thereafter with the application of the NF inflation factor (as set out in 12 VAC 30-90-41(B) ~~, approved each July 1 by DMAS~~].

[~~E.~~F.] Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate calculations. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see 12VAC30-90-270 through 12VAC30-90-276) and must be identifiable and verifiable by contemporaneous documentation.

All matters of reimbursement which are part of the DMAS reimbursement system shall supersede Medicare principles of reimbursement. Wherever the DMAS reimbursement system conflicts with Medicare principles of reimbursement, the DMAS reimbursement system shall take precedence. Appendices are a part of the DMAS reimbursement system.

12VAC30-90-70
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

Article 7
Cost Reports

12VAC30-90-70. Cost report submission.

A. Cost reports are due not later than 150 days after the provider's fiscal year end. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, it is considered delinquent. The cost report shall be deemed complete for the purpose of cost settlement when DMAS has received all of the following (note that if the audited financial statements required by subdivisions 3 a and 7 b of this subsection are received not later than 120 days after the provider's fiscal year end and all other items listed are received not later than 90 days after the provider's fiscal year end, the cost report shall be considered to have been filed at 90 days):

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. a. The provider's audited financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of cash flows, the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, footnotes to the financial statements, and the management report. Multi-facility providers shall be governed by subdivision 7 of this subsection;

b. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

c. Schedule of investments by type (stock, bond, etc.), amount, and current market value;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule;

6. Schedule of assets as defined in [~~12VAC30-90-37~~ 12VAC30-90-38];

7. Nursing facilities which are part of a chain organization must also file:

a. Home office cost report;

b. Audited consolidated financial statements of the chain organization including the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, the management report and footnotes to the financial statements;

c. The nursing facility's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of cash flows;

d. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

e. Schedule of investments by type (stock, bond, etc.), amount, and current market value; and

8. Such other analytical information or supporting documentation that may be required by DMAS.

B. When cost reports are delinquent, the provider's interim rate shall be reduced to zero. For example, for a September 30 fiscal year end, payments will be reduced starting with the payment on and after March 1.

C. After the overdue cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to DMAS.

12VAC30-90-257
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-90-257. Credit balance reporting.

A. Definitions. The following words and terms when used in this regulation shall have the following meanings unless the context clearly indicates otherwise:

"Claim" means a bill consistent with 12VAC30-20-180 submitted by a provider to the department for services furnished to a recipient.

"Credit balance" means an excess or overpayment made to a provider by Medicaid as a result of patient billings.

[~~"Interest at the maximum rate" means the interest rate specified in § 32.1-312 or § 32.1-313 of the Code of Virginia depending on the facts of the excess payment.~~]

[~~"Negative balance transaction" means the reduction of a payment or payments otherwise due to a provider by amounts or portions of amounts owed the department from previous overpayments to the provider.~~]

[~~"Overpayment" means payments to a provider in excess of the amount that was or is due to the provider.~~]

[~~"Weekly remittance" means periodic (usually weekly) payment to a provider of amounts due to the provider for claims previously submitted by the provider.~~]

[B. Credit balances may occur when a provider's reimbursement for services it provides exceeds the allowable amount or when the reimbursement has been for unallowable costs, resulting in an overpayment. Credit balances also may occur when a provider receives payments from Medicaid or another third party payer for the same services.]

[~~B.~~C] [~~NFs shall be required to report Medicaid credit balances on a quarterly basis no later than 30 calendar days after the close of each quarter.~~] For a credit balance arising on a Medicaid claim within three years of the date paid by the department, the NF shall submit an adjustment claim. [~~If the NF does not want the claim retracted from future DMAS payments, a check in the amount of the credit balance or the adjustment claim or claims shall be submitted with the report.~~] For credit balances arising on claims over three years old, the NF shall submit a check for the balance due and a copy of the original DMAS payment. [~~Interest at the maximum rate allowed shall be assessed for those credit balances (overpayments) that are identified on the quarterly report but not reimbursed with the submission of the quarterly report. Interest will begin to accrue 30 days after the end of the quarter and will continue to accrue until the overpayment has been refunded or adjusted.~~]

[~~C. A penalty shall be imposed for failure to submit the quarterly credit balance report timely as follows:~~

~~1. NFs that have not submitted their Medicaid credit balance data within the required 30 days after the end of a quarter shall be notified in writing by the department. If the required report is not submitted within the next 30 days, there will be a 20% reduction in the Medicaid per diem payment.~~

~~2. If the required report is not submitted within the next 30 days (60 days after the due date), the per diem payments shall be reduced to zero until the report is received.~~

~~3. If the credit balance has not been refunded within 90 days of the end of a quarter, it shall be recovered, with interest, from the due date through the use of a negative balance transaction on the weekly remittance.~~]

[~~4.~~ D.] A periodic audit shall be conducted of the NFs' [~~quarterly submission~~ claimadjustments] of Medicaid credit balance data. NFs shall maintain an audit trail back to the underlying accounts receivable records supporting each [~~quarterly report~~ claim adjusted for credit balances] .