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Final Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 30-70-411; 12 VAC 30-70-429; 12 VAC 30-80-20; 12 VAC 30-160-10
VAC Chapter title(s)	Supplemental Payments for Certain Teaching Hospitals Supplemental Payments for Qualifying Private Acute Care Hospitals; Services that are reimbursed on a cost basis; Hospital Assessment
Action title	FFS Supplemental Payments and Hospital Assessment
Date this document prepared	September 17, 2021

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

This regulatory action follows a proposed stage regulation and accomplishes three goals: 1) it authorizes DMAS to levy assessments upon private acute care hospitals operating in Virginia to fund new Medicaid coverage for adults as well as new Medicaid hospital supplemental payments; 2) it establishes new supplemental inpatient and outpatient payments for qualifying private acute care hospitals in Virginia; and 3) it sunsets supplemental payments made to certain private teaching hospitals to avoid overlapping supplemental payments.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

DMAS = Department of Medical Assistance Services

Statement of Final Agency Action

Provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) the name of the agency taking the action; and 3) the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary entitled "FFS Supplemental Payments and Hospital Assessment" and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

September 17, 2021
Date

/signature/
Karen Kimsey, Director
Dept. of Medical Assistance Services

Mandate and Impetus

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding the mandate for this regulatory change, and any other impetus that specifically prompted its initiation. If there are no changes to previously reported information, include a specific statement to that effect.

The Code of Virginia § 32.1 325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

The 2018 and 2019 General Assemblies mandated that DMAS take this action, as discussed more fully in the "Legal Basis" section.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The Code of Virginia § 32.1 325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

The 2018 Appropriation Act, Items 3-5.15 and 5.16 instruct DMAS to levy a provider coverage assessment and a provider payment rate assessment upon private acute care hospitals operating in Virginia beginning on or after October 1, 2018. In addition, the 2018 Appropriation Act, Item 303.XX 6 c states that supplemental payments for certain teaching hospitals shall sunset after the effective date of a statewide supplemental payment for private acute care hospitals authorized in Item 3-5.16.

The 2019 Appropriation Act, Items 3-5.15 and 5.16 carried forward the instructions to DMAS to levy a provider coverage assessment and a provider payment rate assessment upon private acute care hospitals operating in Virginia. In addition, the 2019 Appropriation Act, Item 303.XX 6 c carried forward the instruction to sunset supplemental payments for certain teaching hospitals after the effective date of the statewide supplemental payment for private acute care hospitals authorized in Item 3-5.16.

(The supplemental payments that are sunset in this regulatory package (in accordance with the 2018 and 2019 Appropriations Acts) were authorized by the 2017 Acts of Assembly, Chapter 836, Item 306.RRR.1 which states: "The Department of Medical Assistance Services shall promulgate regulations to make supplemental Medicaid payments to the primary teaching hospitals affiliated with a Liaison Committee on Medical Education (LCME) accredited medical school located in Planning District 23 that is a political subdivision of the Commonwealth and an LCME accredited medical school located in Planning District 5 that has a partnership with a public university." The hospitals described in this Budget Item are Sentara Norfolk General and Carilion Medical Center.)

The 2020, 2021, and 2022 Appropriation Acts, Items 3-5.15 and 5.16 carried forward the instructions to DMAS to levy a provider coverage assessment and a provider payment rate assessment upon private acute care hospitals operating in Virginia.

Emergency regulations and proposed stage regulations were promulgated to implement the General Assembly mandates. The emergency regulations were in effect from October 1, 2018 through September 29, 2020.

The proposed stage was published in the Virginia Register on April 12, 2021, followed by a sixty-day comment period. This final stage action follows the proposed stage.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's intended to solve.

Each of the three items included in this regulatory package is required to fund new Medicaid coverage for adults as well as new Medicaid hospital supplemental payments. The provider coverage assessment will fund the non-federal share of Medicaid coverage for newly-eligible adults while the provider payment rate assessment will fund the non-federal share of an increase in inpatient and outpatient supplemental payments to qualifying private acute care hospitals. The private acute care hospitals required to pay the assessment will benefit from the new coverage as well as new supplemental hospital payments. These regulations establish these new supplemental payments and sunset ones that were previously authorized.

The new Medicaid coverage for adults is essential to protect, the health, safety, and welfare of citizens; to date, it has provided health care coverage to more than 558,000 Virginians who did not have medical insurance (i.e. did not qualify for health insurance subsidies under the Affordable Care Act). The assessments also fund the non-federal share of expansion instead of appropriating general funds. In addition, Medicaid expansion allows Virginia to draw down federal dollars for the expansion population, which avoids increased costs to the state.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

This regulatory action: 1) authorizes DMAS to levy a provider coverage assessment and a payment rate assessment upon private acute care hospitals operating in Virginia; 2) establishes new supplemental inpatient and outpatient payments for qualifying private acute care hospitals in Virginia; and 3) sunsets existing supplemental payments made to certain teaching hospitals to avoid overlapping supplemental payments.

1) Provider Coverage Assessment and Payment Rate Assessment

The provider coverage assessment generates funds that will be used to cover the non-federal share of the full cost of Medicaid coverage for newly eligible individuals, including the administrative costs of collecting the assessment and implementing and operating the coverage for newly eligible adults.

The provider payment rate assessment generates funds that will be used to fund: 1) an increase in inpatient and outpatient rates paid to private acute care hospitals in Virginia up to the private hospital "upper payment limit" and "managed care organization hospital payment gap" and 2) the administrative costs of collecting the assessment and of implementing and operating the associated rate actions.

Separate funds have been established; one for the coverage assessment, and one for the payment rate assessment.

2) New Supplemental Inpatient and Outpatient Payments for Qualifying Private Acute Care Hospitals in Virginia

The 2018 Appropriation Act directs DMAS to provide supplemental inpatient and outpatient hospital payments to qualifying hospitals up to the private hospital upper payment limit for payment to private hospitals. Qualifying hospitals are all private acute care hospitals excluding public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, long stay hospitals, long-term acute care hospitals and critical access hospitals. The total supplemental payment shall be based on the difference between the private hospital inpatient or outpatient upper payment limit (in 42 CFR § 447.272, and 42 CFR 447.321, respectively) as approved by CMS and all other Medicaid payments subject to such limit. DMAS has amended the State Plan to make supplemental payments to all qualifying hospitals and has amended its contracts with managed care organizations to include a directed payment for qualifying hospitals consistent with the State Plan Amendment.

3) Sunsetting Other Supplemental Payments for Private Acute Care Hospitals.

In order to avoid overlapping supplemental payments, supplemental payments made to a limited group of private hospitals were terminated on the date the new payments (in #2, above) were effective.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

Each of the three items included in this regulatory package is required to fund new Medicaid coverage for adults as well as new Medicaid hospital supplemental payments. The primary advantage to the public and the Commonwealth of the new Medicaid coverage for adults is that, to date, it has provided health care coverage to over 558,000 Virginians who did not have medical insurance (i.e. did not qualify for health insurance subsidies under the Affordable Care Act).

The assessments fund the non-federal share of expansion instead of appropriating general funds. In addition, Medicaid expansion allows Virginia to draw down federal dollars for the expansion population, which generates savings for the state.

Requirements More Restrictive than Federal

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any requirement of the regulatory change which is more restrictive than applicable federal requirements. If there are no changes to previously reported information, include a specific statement to that effect.

There are no requirements in this regulation that are more restrictive than federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any other state agencies, localities, or other entities that are particularly affected by the regulatory change. If there are no changes to previously reported information, include a specific statement to that effect.

There are no other state agencies or localities that are particularly affected by these assessments or supplemental payments.

Hospitals are particularly affected by the assessments and supplemental payments, and representatives from hospitals and hospital associations have been consulted regularly in the development of these changes.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

No comments were submitted during the proposed stage public comment period.

Detail of Changes Made Since the Previous Stage

*List all changes made to the text since the previous stage was published in the Virginia Register of Regulations and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of updated requirements
	12 VAC 30-70-429		B – in definition of the term supplemental payment, the reference to the 2019 Appropriation Act was removed and replaced with language referring to subsequent Appropriation Acts.
	12 VAC 30-80-20		Please note that changes that were made in the proposed stage to paragraph D5 appear in paragraph D7 in this final stage regulation. This is

			due to changes in a separate regulatory package, which took effect between the publication of the proposed and final stages of this regulatory action.
	12 VAC 30-160-10		A – capitalization was removed B – a new definition of coverage assessment amount was added, including a link to the DMAS website for a figure that the GA may continue to change in future years. A new definition was also added for coverage assessment percentage and private acute care hospital enhanced payments. In the definition for net patient service revenue, an incorrect date was removed. In addition, the definitions of newly eligible individual and provider payment rate costs were stricken as they no longer appear in this section or this package. D and D1 – added the word "payment" D2 – this paragraph includes the new link to the figure that may continue to change, and also includes updates required by changes in the 2020 and 2021 Budgets. D3 - this paragraph includes updates required by changes in the 2020 and 2021 Budgets. E2 - this paragraph includes updates required by changes in the 2020 and 2021 Budgets. E3 - this paragraph updates required by changes in the 2020 and 2021 Budgets. E4 - this paragraph includes updates required by changes in the 2020 and 2021 Budgets. F1 – the word enhanced is corrected to expanded F3 – this paragraph is not needed and is being removed G1 – a more specific VAC reference is included

Detail of All Changes Proposed in this Regulatory Action

*List all changes proposed in this action and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

Changes in the Emergency Regulation:

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of updated requirements
12 VAC 30-70-411			Sunsets inpatient payments for certain teaching hospitals (Sentara Norfolk General and Carilion Medical Center)
	12 VAC 30-70-429	N/A	Establishes supplemental payments for qualifying private acute care hospitals for inpatient services.
	12 VAC 30-80-20	Describes payments for outpatient hospital services	Establishes supplemental payments for private acute care hospitals for outpatientservices.
	12 VAC 30-160-10	N/A	Establishes the hospital assessments that will be used to fund the non-federal share of the cost of Medicaid coverage for newly-eligible individuals and for the hospital supplemental payments.

Changes between the Emergency and Proposed stage regulations:

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of updated requirements
12 VAC 30-70-411			A – updated with date the State Plan Amendments went into effect. C – acronyms are spelled out
	12 VAC 30-70-429		A – updated with date the State Plan Amendments went into effect. B – rewording initial sentence for definitions section Definition of “supplemental payments” – “private acute care enhanced payment” is added because this term is used in the 2019 Appropriation Act.

			Definition of "upper payment limit gap" – the second instance of "payment" in the last sentence is removed. D1 and E – the word "annual" is removed prior to "UPL gap percentage." E – updated with a specific date
	12 VAC 30-80-20		D 5 – updated with date the State Plan Amendments went into effect. D 5 c (1) and (2) and D 5 d - the word "annual" is removed prior to "UPL gap percentage." D 5 d- updated with a specific date
	12 VAC 30-160-10		A – updated to reflect revisions of the 2019 Appropriation Act. B – rewording initial sentence for definitions section The definition of "full cost of expanded Medicaid coverage" was revised. The following was removed from the definition of "managed care organization hospital payment gap: "according to the existing State Plan methodology but using 100% for the adjustment factors (including the capital reimbursement percentage) and full inflation. This was replaced with: "equivalent to the fee-for-service upper payment limit…". The word "adjustment" was added to the defined term "managed care organization supplemental hospital capitation payment adjustment" and the definition was revised. The following was added to the definition of "net patient service revenue": "subject to the certification in subsection C of this section." C – the paragraph was revised because the first year is over, and the text needs to reflect the practices in the current year and years to come D - updated with date the State Plan Amendments went into effect

			D1 – the word “annually” was removed D2 – the last sentence was removed D3 and D4 – paragraphs D3 and D4 were deleted and replaced. D5 – shortened because the term “full cost of Medicaid coverage” is now defined. D6 – references to the first year are removed. Also, added that penalties shall be deposited in the Virginia Health Care Fund. E - updated with date the State Plan Amendments went into effect E1 – the word “annually” was removed. E2 – 1.00 was changed to 1.02. E2 – all but the first sentence is stricken. E3 – paragraph was deleted and replaced. E4 – a sentence was added at the end of this paragraph. E5 – references to the first year are removed. Also, added that penalties shall be deposited in the Virginia Health Care Fund. F1 - shortened because the term “full cost of enhanced Medicaid coverage” is now defined. F1 and F2 – first sentence in each paragraph – “including” changed to “excluding.” The phrase “including penalties” removed from the second sentence in each paragraph. F3 – first sentence – changed specific references on who the report would be provided to – changed to: as required by the Appropriations Act.” Second sentence – removed “by hospital.” Added a new last sentence.

Changes between proposed and final stages:

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of updated requirements
	12 VAC 30-70-429		B – in definition of the term supplemental payment, the reference to the 2019 Appropriation Act was removed and replaced with references to subsequent Appropriation Acts.
	12 VAC 30-80-20		Please note that changes that were made in the proposed stage to paragraph D5 appear in paragraph D7 in this final stage regulation. This is due to changes in a separate regulatory package, which took effect between the publication of the proposed and final stages of this regulatory action.
	12 VAC 30-160-10		A – capitalization was removed B – a new definition of coverage assessment amount was added, including a link to the DMAS website for a figure that the GA may continue to change in future years. A new definition was also added for coverage assessment percentage and private acute care hospital enhanced payments. The definition of managed care organization hospital payment gap was changed to reflect a change in the 2022 Appropriations Act, Item 3-5.16 E.1. In the definition for net patient service revenue, an incorrect date was removed. In addition, the definitions of newly eligible individual and provider payment rate costs were stricken as they no longer appear in this section or this package. D and D1 – added the word “payment” D2 – this paragraph includes the new link to the figure that may continue to change, and also includes updates required by changes in the 2020 and 2021 Budgets. D3 - this paragraph includes updates required by changes in the 2020 and 2021 Budgets.

			E2 - this paragraph includes updates required by changes in the 2020 and 2021 Budgets. E3 - this paragraph updates required by changes in the 2020 and 2021 Budgets. E4 - this paragraph includes updates required by changes in the 2020 and 2021 Budgets. F1 – the word enhanced is corrected to expanded F3 – this paragraph is not needed and is being removed G1 – a more specific VAC reference is included