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TO: **EMILY MCCELLAN**
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FROM: **MICHELLE A. L'HOMMEDIEU**
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DATE: **October 4, 2019**

SUBJECT: **Proposed Regulations – Fee For Service Supplemental Payments and Hospital Assessments (5100/8442)**

I am in receipt of the attached proposed regulations to amend the current emergency regulations regarding supplemental payments to certain teaching hospitals, to add regulations regarding the hospital assessments identified as the Coverage Assessment and Provider Rate Assessment, and to add regulations for a new supplemental or increased payment to qualifying private acute care hospitals. You have asked the Office of the Attorney General to review these regulations determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to promulgate these regulations, and if they comport with state and federal law.

Based on that review, it is this Office's view that the Director, acting on behalf of the Board of Medical Assistance Services under Virginia Code §§ 32.1-324 and 325, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act ("APA"), and has not exceeded that authority.

The authority for these proposed regulations is in the Virginia 2018 and 2019 Appropriations Acts, Items 3-5.15, 3-5.16, and Item 303.XX.6.b. These regulations will replace the emergency regulations that became effective October 1, 2018. These regulations also amend the State Plan and approval by the Centers for Medicare and Medicaid Services ("CMS") will therefore be required. It is my understanding that DMAS has received such approvals from CMS to amend the State Plan to incorporate these changes.

If you have any questions or need additional information about these regulations, please contact me at 786-6005.

cc: Kim F. Piner, Esq.

Attachment

Project 5591 - Proposed

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Fee For Service Supplemental Payments and Hospital Assessment

12VAC30-70-411. Supplemental payments for certain teaching hospitals.

A. Effective for dates of service on or after July 1, 2017, quarterly supplemental payments will be issued to qualifying private hospitals for inpatient services rendered during the quarter. These quarterly supplemental payments will cease for dates of service on or after October 1, 2018.

B. Qualifying criteria. Qualifying hospitals are 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.

C. Reimbursement methodology. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter equal to the difference between the hospital's Medicaid payments and the hospital's disproportionate share limit (Omnibus Budget Reconciliation Act 93 disproportionate share hospital limit) for the most recent year for which the disproportionate share limit has been calculated divided by four. The supplemental payment amount will be determined prior to the beginning of the fiscal year.

D. Limit. Maximum aggregate payments to all qualifying hospitals shall not exceed the available upper payment limit per state fiscal year (SFY). In SFY 2019, the upper payment limit shall be prorated for the time period these supplemental payments are in effect.

12VAC30-70-429. Supplemental payments for private acute care hospitals.

A. Starting October 1, 2018, supplemental payments will be issued to qualifying hospitals for inpatient services provided to Medicaid patients.

B. Definitions. The following words and terms when used in this section shall have the following meanings unless otherwise stated:

"Acute care hospital" means any hospital that provides emergency medical services on a 24-hour basis.

"Children's hospital" means a hospital (i) whose inpatients are predominantly younger than 18 years of age and (ii) that is excluded from the Medicare prospective payment system pursuant to the Social Security Act.

"Critical access hospital" means a facility that meets the requirements of the State Medicare Rural Hospital Flexibility Program, 42 USC § 1395i-4, for such designation.

"Freestanding psychiatric and rehabilitation hospital" means a freestanding psychiatric hospital, which means a hospital that provides services consistent with 42 CFR 482.60, or a freestanding rehabilitation hospital, which means a hospital that provides services consistent with 42 CFR 482.56.

"Hospital" means a medical care facility licensed as an inpatient hospital or outpatient surgical center by the Department of Health or as a psychiatric hospital by the Department of Behavioral Health and Developmental Services.

"Long-stay hospital" means specialty facilities that serve individuals receiving medical assistance who require a higher intensity of nursing care than that which is normally provided in a nursing facility and who do not require the degree of care and treatment that an acute care hospital is designed to provide.

"Long-term acute care hospital" or "LTACH" means an inpatient hospital that provides care for patients who require a length of stay greater than 25 days and is, or proposes to be, certified by CMS as a long-term care inpatient hospital pursuant to 42 CFR Part 412. A LTACH may be either a freestanding facility or located within an existing or host hospital.

"Public hospital" means a hospital that is solely owned by a government or governmental entity.

"Supplemental payment" or "private acute care enhanced payment" means an increased payment to a qualifying hospital up to the upper payment limit gap from the Health Care Provider Rate Assessment Fund as authorized in the 2018 and 2019 Appropriation Acts.

"Upper payment limit" means the limit on payment for inpatient services for recipients of medical assistance established in accordance with 42 CFR 447.272, and on payment for outpatient services for recipients of medical assistance pursuant to 42 CFR 447.321 for private hospitals. The limit applies only to fee-for-service claims.

"Upper payment limit gap" or "UPL gap" means the difference between the amount of the private acute care hospital upper payment limits estimated for the State Plan rate year using the latest available cost report data, and the amount estimated that would otherwise be paid for the same State Plan rate year pursuant to the State Plan reimbursement methodology for inpatient and outpatient services. The upper payment limit gap shall be updated annually for each rate year.

C. Qualifying criteria. Qualifying hospitals are all in-state 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.

D. Reimbursement methodology. The supplemental payment shall equal inpatient hospital claim payments times the UPL gap percentage.

1. The UPL gap percentage is the percentage calculated when the numerator is the upper payment limit gap for inpatient services for private hospitals and the denominator is Medicaid claim payments to all qualifying hospitals for inpatient hospital services provided to Medicaid patients in the same year used in the numerator.

2. The UPL gap percentage will be calculated annually.

E. Quarterly payments. After the close of each quarter, beginning with the quarter ending December 31, 2018, each qualifying hospital shall receive supplemental payments for the inpatient services paid during that quarter. The supplemental payments for each qualifying hospital for each quarter shall be calculated based on the Medicaid inpatient hospital payments paid in that quarter multiplied by the UPL gap percentage.

12VAC30-80-20. Services that are reimbursed on a cost basis.

A. Payments for services listed in this section shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program with the exception provided for in subdivision D 1 e of this section. The upper limit for reimbursement shall be no higher than payments for Medicare patients in accordance with 42 CFR 447.321. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform Centers for Medicare and Medicaid Services-approved cost report by participating providers. The 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, DMAS or its designee shall take action in accordance with its policies to assure that an overpayment is not being made. All cost reports shall be reviewed and reconciled to final costs within 180 days of the receipt of a

completed cost report. The cost report will be judged complete when DMAS has all of the following:

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

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

3. The provider'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 changes in financial position;

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

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

C. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

D. The services that are cost reimbursed are:

1. For dates of service prior to January 1, 2014, outpatient hospital services, including rehabilitation hospital outpatient services and excluding laboratory services.

a. Definitions. The following words and terms when used in this section shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency department and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Emergency hospital services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse for nonemergency care rendered in emergency departments at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services rendered in emergency departments that DMAS determines were nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services performed by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for subdivision 1 b (2) of this subsection. Services not meeting certain

criteria shall be paid under the methodology of subdivision 1 b (1) of this subsection. Such criteria shall include~~, but not be limited to~~:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD diagnosis codes and necessary supporting documentation. As used here, the term "ICD" is defined in 12VAC30-95-5.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD code designations, and the impact on recipients and providers. As used here, the term "ICD" is defined in 12VAC30-95-5.

c. Limitation of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at various percentages as noted in subdivisions 1 c (1) and 1 c (2) of this subsection of allowable cost, with cost to be determined as provided in subsections A, B, and C of this section. For hospitals with fiscal years that do not begin on July 1, outpatient costs, both operating and capital, for the fiscal year in progress on that date shall be apportioned between the time period before and the time period after that date, based on the number of calendar months in the cost reporting period, falling before and after that date.

(1) Type One hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating reimbursement shall be at 91.2% of allowable cost and capital reimbursement shall be at 87% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating reimbursement shall be at 90.2% of allowable cost and capital reimbursement shall be at 86% of allowable cost.

(2) Type Two hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating and capital reimbursement shall be 77% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating and capital reimbursement shall be 76% of allowable cost.

d. The last cost report with a fiscal year end on or after December 31, 2013, shall be used for reimbursement for dates of service through December 31, 2013, based on this section. Reimbursement shall be based on charges reported for dates of service prior to January 1, 2014. Settlement will be based on four months of runout from the end of the provider's fiscal year. Claims for services paid after the cost report runout period will not be settled.

e. Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12VAC30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

2. Rehabilitation agencies or comprehensive outpatient rehabilitation.

a. Effective July 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities that are operated by community services boards or state

agencies shall be reimbursed their costs. For reimbursement methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

b. Effective October 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities operated by state agencies shall be reimbursed their costs. For reimbursement methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

3. Supplement payments to Type One hospitals for outpatient services.

a. In addition to payments for services set forth elsewhere in the State Plan, DMAS makes supplemental payments to qualifying state government owned or operated hospitals for outpatient services furnished to Medicare members on or after July 1, 2010. To qualify for a supplement payment, the hospital must be part of the state academic health system or part of an academic health system that operates under a state authority.

b. The amount of the supplemental payment made to each qualifying hospital shall be equal to the difference between the total allowable cost and the amount otherwise actually paid for the services by the Medicaid program based on cost settlement.

c. Payment for furnished services under this section shall be paid at settlement of the cost report.

4. Supplemental payments for private hospital partners of Type One hospitals. Effective for dates of service on or after October 25, 2011, quarterly supplemental payments shall be issued to qualifying private hospitals for outpatient services rendered during the quarter.

a. In order to qualify for the supplemental payment, the hospital shall be enrolled currently as a Virginia Medicaid provider and shall be owned or operated by a private entity in which a Type One hospital has a nonmajority interest.

b. Reimbursement methodology.

(1) Hospitals not participating in the Medicaid disproportionate share hospital (DSH) program shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than two years after the year in which the qualifying hospital's entitlement arises. The annual supplemental payments in a fiscal year shall be the lesser of:

(a) The difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid individuals during the fiscal year; or

(b) $1,894 per Medicaid outpatient visit for state plan rate year 2012. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor) under contract with the department.

(2) Hospitals participating in the DSH program shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than two years after the year in which the qualifying hospital's entitlement arises. The annual supplemental payments in a fiscal year shall be the lesser of:

(a) The difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid individuals during the fiscal year;

(b) $1,894 per Medicaid outpatient visit for state plan rate year 2012. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor) under contract with the department; or

(c) The difference between the limit calculated under § 1923(g) of the Social Security Act and the hospital's DSH payments for the applicable payment period.

c. Limit. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

5. Supplemental outpatient payments for private acute care hospitals. Starting October 1, 2018, supplemental payments will be issued to qualifying private hospitals for outpatient services provided to Medicaid patients.

a. Definitions. See definitions in 12VAC30-70-429.

b. Qualifying criteria. Qualifying hospitals are all in-state 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. A qualifying hospital is the same as a "covered hospital" in § 32.1-331.02 of the Code of Virginia.

c. Reimbursement methodology. The supplemental payment shall equal outpatient hospital claim payments times the UPL gap percentage.

(1) The UPL gap percentage is the percentage calculated where the numerator is the UPL gap for outpatient services for private hospitals and the denominator is Medicaid claim payments to all qualifying hospitals for outpatient hospital services provided to Medicaid patients in the same year used in the numerator.

(2) The UPL gap percentage will be calculated annually.

d. Quarterly payments. After the close of each quarter, beginning with the quarter ending December 31, 2018, each qualifying hospital shall receive supplemental payments for the outpatient services paid during that quarter. The supplemental payments for each qualifying hospital for each quarter shall be calculated based on the Medicaid outpatient hospital payments paid in that quarter multiplied by the UPL gap percentage.

CHAPTER 160

HOSPITAL ASSESSMENT

12VAC30-160-10. Hospital assessment.

A. Authority. The Department of Medical Assistance Services (DMAS) is authorized to levy a Health Care Coverage Assessment and a Health Care Provider Payment Rate Assessment upon private acute care hospitals operating in Virginia in accordance with §§ 32.1-331.01 and 32.1-331.02 of the Code of Virginia and §§ 3-5.15, 3-5.16, and 4-14 as revised by the 2019 Appropriation Act.

B. Definitions. The following words and terms when used in this section shall have the following meanings unless otherwise stated:

"Covered hospital" means any in-state private acute care hospital other than a hospital classified as a public hospital, freestanding psychiatric and rehabilitation hospital, children's hospital, long-stay hospital, long-term acute care hospital, or critical access hospital.

"Full cost of expanded Medicaid coverage" means 1) any and all Medicaid expenditures related to individuals eligible for Medicaid pursuant to 42 U.S.C. 1396d(y)(1) (2010) of the Patient Protection and Affordable Care Act, including any federal actions or repayments and 2) all administrative costs associated with providing coverage, which includes the costs of administering the provisions of the 1115 waiver, and collecting the coverage assessment.

"Managed care organization," "MCO," or "Medicaid MCO" means an entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed contractual agreement with DMAS to provide services covered under a mandatory managed care program.

"Managed care organization hospital payment gap" means the difference between the amount included in the capitation rates for inpatient and outpatient services for the contract year based on historical paid claims and the amount that would be included when the projected hospital services furnished by private acute care hospitals operating in Virginia are priced for the contract year equivalent to the fee-for-service upper payment limit subject to CMS approval under 42 CFR 438.6(c). The managed care organization hospital payment gap shall be updated annually for each contract year.

"Managed care organization supplemental hospital capitation payment adjustment" means the additional amount added to Medicaid MCO capitation rates to pay the Medicaid managed care organization hospital payment gap to qualifying private acute care hospitals for services to Medicaid recipients.

"Net patient service revenue" means the amount each hospital reported in the most recent Virginia Health Information Hospital Detail Report as of December 15 of each year excluding any nonhospital revenue that meets the requirements in subsection C of this section.

"Newly eligible individual" means an individual described in 42 USC § 1396a(a)(10)(A)(i)(VIII).

"Private acute care hospital" means 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.

"Provider payment rate costs" means the upper payment limit gap and the managed care organization hospital payment gap.

"Upper payment limit" means the limit on payment for inpatient services for recipients of medical assistance established in accordance with 42 CFR 447.272 and on payment for outpatient services for recipients of medical assistance pursuant to 42 CFR 447.321 for private hospitals. This limit applies only to fee-for-service claims.

"Upper payment limit gap" means the difference between the amount of the private acute care hospital upper payment limits estimated for the State Plan rate year using the latest available cost report data and the amount estimated that would otherwise be paid for that same State Plan rate year pursuant to the State Plan for inpatient and outpatient services. The supplemental payment methodology from the Health Care Provider Payment Rate Fund to qualifying hospitals for inpatient services is described in 12VAC30-70-429 and for outpatient services is described in 12VAC30-80-20. The upper payment limit gap shall be updated annually for each State Plan rate year.

C. Nonhospital revenue that should be excluded from a hospital's net patient service revenue as reported to the Virginia Health Information (VHI) Hospital Detail Report must be reported to DMAS by April 1 of each year. The hospital's chief financial officer must certify any changes to the data reported to VHI.

D. Health care coverage assessment. Private acute care hospitals operating in Virginia shall pay a provider coverage assessment beginning on or after October 1, 2018.

1. DMAS will calculate each hospital's coverage assessment by multiplying the coverage assessment percentage times net patient service revenue.

2. The coverage assessment percentage is calculated as (i) 1.08 times the nonfederal share of the full cost of expanded Medicaid coverage for newly eligible individuals under 42 USC § 1396d(y)(1) (as inserted by § 2001 of the Patient Protection and Affordable

Care Act (P.L. 111-148 as amended by P.L. 111-152)) divided by (ii) the total net patient service revenue for hospitals subject to the assessment.

3. DMAS shall, at a minimum, update the "coverage assessment amount" to be effective on January 1 of each year. DMAS is further authorized to update the "coverage assessment amount" on a quarterly basis to ensure amounts are sufficient to cover the full cost of expanded Medicaid coverage based on the latest estimate. Hospitals shall be given no less than thirty days' notice prior to a change in their coverage assessment amount, and shall be provided with associated calculations. Prior to any change to the coverage assessment amount, DMAS shall perform and incorporate a reconciliation of the Health Care Coverage Assessment Fund. Any estimated excess or shortfall of revenue since the previous reconciliation shall be deducted from or added to the "full cost of expanded Medicaid coverage" for the updated coverage assessment amount.

4. The "full cost of expanded Medicaid coverage" shall be updated: 1) on November 1 of each year based on the official Medicaid forecast and latest administrative cost estimates developed by DMAS; 2) no more than 30 days after the enactment of any Appropriation Act to reflect policy changes adopted by the latest session of the General Assembly; and 3) on March 1 of any year in which DMAS estimates that the most recent non-federal share of the "full cost of expanded Medicaid coverage" multiplied by 1.08 will be insufficient to pay all expenses for the full cost of expanded Medicaid coverage.

5. The coverage assessment shall be used only to cover the nonfederal share of the full cost of expanded Medicaid coverage.

6. Hospitals subject to the coverage assessment shall make quarterly payments to DMAS equal to 25% of the annual coverage assessment amount. The assessment payments are due not later than the first day of each quarter. In the first year, the first coverage assessment payment shall be due on or after October 1, 2018. Hospitals that

fail to make the coverage assessment payments within 30 days of the due date shall incur a 5.0% penalty that shall be deposited into the Virginia Health Care Fund. Any unpaid coverage assessment or penalty will be considered a debt to the Commonwealth, and DMAS is authorized to recover it as such.

E. Health care provider payment rate assessment. Private acute care hospitals operating in Virginia shall pay a provider payment rate assessment beginning on or after October 1, 2018.

Proceeds from the provider payment rate assessment shall be disbursed to fund an increase in inpatient and outpatient payment rates paid to private acute care hospitals operating in Virginia up to the upper payment limit and the managed care organization hospital payment gap for care provided to recipients of medical assistance services.

1. DMAS will calculate each hospital's payment rate assessment by multiplying the payment rate assessment percentage times net patient service revenue.

2. The payment rate assessment percentage for covered hospitals will be calculated as (i) 1.08 times the nonfederal share of funding the upper payment limit gap and the managed care organization hospital payment gap divided by (ii) the total net patient service revenue for covered hospitals.

3. DMAS is authorized to update the payment rate assessment amount on a quarterly basis to ensure amounts are sufficient to cover the full cost of the private acute care hospital enhanced payments based on the latest estimate. Hospitals shall be given no less than 30 days prior notice of the new assessment amount and be provided with calculations. Prior to any change to the payment rate assessment amount, DMAS shall perform and incorporate a reconciliation of the Health Care Provider Payment Rate Assessment Fund. Any estimated excess or shortfall of revenue since the previous

reconciliation shall be deducted from or added to the calculation of the private acute care hospital enhanced payments.

4. As part of the development of the managed care capitation rates, DMAS shall calculate a managed care organization supplemental hospital capitation payment adjustment. This is a distinct additional amount added to Medicaid MCO capitation rates to pay the managed care organization hospital payment gap as supplemental payments to covered private acute care hospitals operating in Virginia for services to Medicaid recipients. DMAS shall make available quarterly a report of the additional capitation payments that are made to each MCO.

5. Hospitals subject to the assessment shall make quarterly payments to DMAS equal to 25% of the annual provider payment rate assessment amount. The assessment payments are due not later than the first day of each quarter. In the first year, the first assessment payment shall be due on or after October 1, 2018. Hospitals that fail to make the assessment payments within 30 days of the due date shall incur a 5.0% penalty that shall be deposited into the Virginia Health Care Fund . Any unpaid assessment or penalty will be considered a debt to the Commonwealth, and DMAS is authorized to recover it as such.

F. Collection of the assessments. DMAS is responsible for collecting the assessments.

1. All revenue from the coverage assessment, excluding penalties shall be deposited into a special nonreverting fund to be known as the Health Care Coverage Assessment Fund pursuant to § 32.1-331.01 of the Code of Virginia. Proceeds from the Health Care Coverage Assessment Fund shall not be used for any other purpose than to cover the nonfederal share of the full cost of enhanced Medicaid coverage.

2. All revenue from the provider payment rate assessment, excluding penalties, shall be deposited into a special nonreverting fund to be known as the Health Care Provider Payment Rate Assessment Fund pursuant to § 32.1-331.02 of the Code of Virginia. Proceeds from the Health Care Provider Payment Rate Assessment Fund shall not be used for any other purpose than to fund an increase in inpatient and outpatient payment rates paid to private acute care hospitals operating in Virginia up to the private hospital upper payment limit or managed care organization hospital payment gap for care provided to recipients of medical assistance services and the administrative costs of collecting the assessment and of implementing and operating the associated payment rate actions.

3. DMAS will submit a report by September 1 of each year to the Director of the Department of Planning and Budget and the Chairmen of the House Appropriations and Senate Finance Committees and the Virginia Hospital and Healthcare Association. The report will include, for the most recently completed state fiscal year, the revenue collected from each assessment, expenditures for purposes covered by each assessment, and the year-end assessment balances in each special nonreverting fund. The report shall include a complete and itemized list of all administrative costs included in the coverage assessment.

G. Appeal. A covered hospital may appeal a DMAS action that falls within the definition of agency action under the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia), including DMAS's interpretation and application of assessment methodologies. The assessment methodologies cannot be appealed.

1. Appeals will be conducted in accordance with the provider appeal regulations (12VAC30-20-500 et seq.).

2. A covered hospital shall be considered a "provider" for purposes of the appeal procedures set forth in the provider appeal regulations.