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Proposed Regulation Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation(s)	12 VAC 30-70-411; 12 VAC 30-70-429; 12 VAC 30-80-20; 12 VAC 30-160-10
Regulation 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	August 20, 2019

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 (1 VAC7-10), and the *Virginia Register Form, Style, and Procedure Manual for Publication of Virginia Regulations*.

Brief Summary

Please 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 an emergency 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

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the “Definition” section of the regulations.

DMAS = Department of Medical Assistance Services

Mandate and Impetus

Please identify the mandate for this regulatory change, and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, board decision, etc.). For purposes of executive branch review, “mandate” has the same meaning as defined in Executive Order 14 (as amended, July 16, 2018), “a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part.”

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 (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.)

Emergency regulations were promulgated to implement the General Assembly mandates; this proposed stage action follows the emergency regulations.

Legal Basis

Please identify (1) the agency or other promulgating entity, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia or Acts of

Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency or promulgating entity's overall regulatory authority.

The *Code of Virginia* (1950) as amended, § 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* (1950) as amended, § 32.1-324(c), authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance and to promulgate regulations according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

The 2018 and 2019 Appropriation Acts, Items 3-5.15 and 5.16 instruct DMAS to levy a provider coverage assessment and a provider payment rate assessment beginning on or after October 1, 2018. In addition, the 2018 and 2019 Acts of Assembly, 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 supplemental payments that are sunset in this regulatory package (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.)

Emergency regulations were promulgated to implement the General Assembly mandates; this proposed stage action follows the emergency regulations.

Purpose

Please 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 300,000 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

Please 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 are being terminated on the date the new payments (in #2, above) are effective.

The following supplemental payments will sunset in this regulatory action: Supplemental Inpatient Payments for Certain Teaching Hospitals (Sentara Norfolk General and Carilion Medical Center).

Supplemental payments for Private Hospital Partners of Type One Hospitals are being sunsetted in a separate Fast Track regulatory action.

Issues

Please 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 300,000 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

Please identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements, or no requirements that exceed applicable federal requirements, 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

Please identify any other state agencies, localities, or other entities particularly affected by the regulatory change. "Particularly affected" are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, 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.

Economic Impact

Pursuant to § 2.2-4007.04 of the Code of Virginia, please identify all specific economic impacts (costs and/or benefits), anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Please keep in mind that this is change versus the status quo.

Impact on State Agencies

<p><i>For your agency:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including:</p> <ul style="list-style-type: none"> a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources 	<p>The coverage and payment rate assessments collected total funds in the amount of \$237,448,497 in FY 2019, which is used to fund the non-federal share of Medicaid payments for expansion as well as the cost of the supplemental payments. There are no general funds associated with these payments.</p> <p>The sunset of supplemental payments is expected to create decreased expenditures of \$101,839,993 in state fiscal year 2019 and \$135,698,326 in state fiscal year 2020.</p> <p>The total paid to Sentara was \$102,500,000 and the total available to Carilion for payment is \$69,271,811. The federal portion is half of these amounts. An IGT from EVMS and VA Tech provides the non-state match.</p>
<p><i>For other state agencies:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.</p>	<p>None</p>
<p><i>For all agencies:</i> Benefits the regulatory change is designed to produce.</p>	<p>Increase in the number of Virginians with health insurance.</p>

Impact on Localities

Projected costs, savings, fees or revenues resulting from the regulatory change.	None
Benefits the regulatory change is designed to produce.	Increase in the number of Virginians with health insurance.

Impact on Other Entities

Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.	Hospitals will be affected by the assessment and supplemental payments.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million.	69 hospitals, none of which are small businesses
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Please be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	There are no projected costs related to reporting, recordkeeping, the development of real estate, or purchases of equipment or services.
Benefits the regulatory change is designed to produce.	Increase in the number of Virginians with health insurance.

Alternatives

Please describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

There are no alternatives that would meet the General Assembly mandate.

Regulatory Flexibility Analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business.

Alternative regulatory methods include, at a minimum: 1) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the regulatory change.

There are no alternative regulatory methods that would meet the requirements of the General Assembly mandate. These regulations do not include reporting requirements, and do not affect small businesses.

Public Comment

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

Commenter	Comment	Agency response
Virginia Hospital and Healthcare Association	<p>As currently designed, the rate improvement assessment is fixed for each year and collected quarterly based on the forecasted fiscal impact of the state matching funds necessary to make pre-determined hospital rate improvements on anticipated Medicaid hospital utilization. The commenter believes that instead, the rate improvement assessment should be dynamic and change based on each quarter's utilization. This would ensure the Commonwealth collected exactly the amount needed from hospitals for the state share of enhanced payments for each quarter, avoid the need for corrections and reconciliations, and ensure that the rate assessment tracks actual utilization.</p> <p>The commenter also recommends that the components of the rate assessment related to current vs. expansion members be tracked separately.</p>	<p>This comment was correct relative to the method of determining the provider payment rate assessment. DMAS has changed the method, reflected in 2019 budget language, with concurrence of the commenter, to allow collection of the exact amount needed from hospitals for the non-federal share of enhanced payments for each quarter. DMAS has developed assessment reports that track provider supplemental claims payments by various variables, including those payments attributable to traditional versus expansion recipients.</p>

Public Participation

Please include a statement that in addition to any other comments on the regulatory change, the agency is seeking comments on the costs and benefits of the regulatory change and the impacts of the regulated community. Also, indicate whether a public hearing will be held to receive comments.

In addition to any other comments, the agency is seeking comments on the costs and benefits of the proposal and the potential impacts of this regulatory proposal. Also, the agency/board is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include: 1) projected reporting, recordkeeping and other administrative costs; 2) probable effect of the regulation on affected small businesses; and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: <https://townhall.virginia.gov>. Written comments must include the name and address of the commenter. Comments may also be submitted by mail, email or fax to Emily McClellan at DMAS, 600 E. Broad Street, Richmond, VA 23219, Emily.McClellan@dmas.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will not be held following the publication of this stage of this regulatory action.

Detail of Changes

Please list all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation.

If the regulatory change will be a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory change. Delete inapplicable tables.

If the regulatory change is intended to replace an emergency regulation, please follow the instructions in the text following the three chart templates below. Please include citations to the specific section(s) of the regulation that are changing.

Changes in the Emergency Regulation:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, and likely impact of proposed 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 outpatient services.
	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 Regulation and the Proposed Stage regulation:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, and likely impact of proposed requirements
12 VAC 30-70-411			<p>A – updated with date the State Plan Amendments went into effect.</p> <p>C – acronyms are spelled out</p>
	12 VAC 30-70-429		<p>A – updated with date the State Plan Amendments went into effect.</p> <p>B – rewording initial sentence for definitions section</p> <p>Definition of “supplemental payments” – “private acute care enhanced payment” is added because this term is used in the 20-19 Appropriation Act.</p> <p>Definition of “upper payment limit gap” – the second instance of “payment” in the last sentence is removed.</p> <p>D1 and E – the word “annual” is removed prior to “UPL gap percentage.”</p> <p>E – updated with a specific date</p>
	12 VAC 30-80-20		<p>D 5 – updated with date the State Plan Amendments went into effect.</p> <p>D 5 c (1) and (2) and D 5 d - the word “annual” is removed prior to “UPL gap percentage.”</p> <p>D 5 d- updated with a specific date</p>
	12 VAC 30-160-10	N/A	<p>A – updated to reflect revisions of the 2019 Appropriation Act.</p> <p>B – rewording initial sentence for definitions section</p> <p>The definition of “full cost of expanded Medicaid coverage” was revised.</p> <p>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...”.</p>

		<p>The word “adjustment” was added to the defined term “managed care organization supplemental hospital capitation payment adjustment” and the definition was revised.</p> <p>The following was added to the definition of “net patient service revenue”: “subject to the certification in subsection C of this section.”</p> <p>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</p> <p>D - updated with date the State Plan Amendments went into effect</p> <p>D1 – the word “annually” was removed</p> <p>D2 – the last sentence was removed</p> <p>D3 and D4 – paragraphs D3 and D4 were deleted and replaced.</p> <p>D5 – shortened because the term “full cost of Medicaid coverage” is now defined.</p> <p>D6 – references to the first year are removed. Also, added that penalties shall be deposited in the Virginia Health Care Fund.</p> <p>E - updated with date the State Plan Amendments went into effect</p> <p>E1 – the word “annually” was removed.</p> <p>E2 – 1.00 was changed to 1.08.</p> <p>E2 – all but the first sentence is stricken.</p> <p>E3 – paragraph was deleted and replaced.</p> <p>E4 – a sentence was added at the end of this paragraph.</p> <p>E5 – references to the first year are removed. Also, added that penalties shall be deposited in the Virginia Health Care Fund.</p>
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			<p>F1 - shortened because the term “full cost of Medicaid coverage” is now defined.</p> <p>F1 and F2 – first sentence in each paragraph – “including” changed to “excluding.”</p> <p>The phrase “including penalties” removed from the second sentence in each paragraph.</p> <p>F3 – first sentence - added the Virginia Hospital and Healthcare Association. Second sentence – removed “by hospital.” Added a new last sentence.</p>
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