2018 Special Session I

Budget Bill - HB5002 (Enrolled)

Item 3-5.15

§ 3-5.15 PROVIDER COVERAGE ASSESSMENT

A. The Department of Medical Assistance Services (DMAS) is authorized to levy an assessment upon private acute care hospitals operating in Virginia in accordance with this item. Private acute care hospitals operating in Virginia shall pay a coverage assessment beginning on or after October 1, 2018. For the purposes of this coverage assessment, the definition of private acute care hospitals shall exclude public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, long stay hospitals, long-term acute care hospitals and critical access hospitals.

B.1. The coverage assessment shall be used only to cover the non-federal share of the full cost for expanded Medicaid coverage for newly eligible individuals pursuant to 42 U.S.C. § 1396d(y)(1)[2010] of the Patient Protection and Affordable Care Act, including the administrative costs of collecting the coverage assessment, and implementing and operating the coverage for newly eligible adults.

2. The Department of Medical Assistance Services (DMAS) shall calculate each hospital's “coverage assessment" annually by multiplying the “coverage assessment percentage" times “net patient service revenue" as defined below.

3. The “coverage assessment percentage" shall be calculated as (i) 1.08 times the non-federal share of the “full cost of expanded Medicaid coverage" for newly eligible individuals under the Patient Protection and Affordable Care Act (42 U.S.C. § 1396d(y)(1)[2010]) divided by (ii) the total “net patient service revenue" for hospitals subject to the assessment. By May 1 of each year, DMAS shall report the estimated assessment payments by hospital and all assessment percentage calculations for the upcoming fiscal year to the Director, Department of Planning and Budget and Chairmen of the House Appropriations and Senate Finance Committees.

4. The “full cost of expanded Medicaid coverage" shall equal the amount estimated in the official Medicaid forecast due by November 1 of each year as required by paragraph A.1. of Item 307 of this Act. This Act estimates the non-federal share of the cost of coverage for FY 2019 as $80,823,953 and FY 2020 as $226,123,826.

5. Each hospital's “net patient service revenue" equals the amount reported in the most recent Virginia Health Information (VHI) “Hospital Detail Report" as of December 15 of each year. In the first year, net patient service revenue shall be prorated by the portion of the year subject to the tax.

6. Any estimated excess or shortfall of revenue from the previous year shall be deducted from or added to the “full cost of expanded Medicaid coverage" for the next year prior to the calculation of the “coverage assessment percentage."

7. DMAS shall be responsible for collecting the coverage assessment. Hospitals subject to the coverage assessment

shall make quarterly payments to the department equal to 25 percent of the annual “coverage assessment" amount. In the first year, quarterly amounts for the remainder of the state fiscal year shall equal one-third of the coverage assessment. The 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 five percent penalty. Any unpaid coverage assessment or penalty will be considered a debt to the Commonwealth and DMAS is authorized to recover it as such.

8. DMAS shall submit a report due September 1 of each year to the Director, Department of Planning and Budget and Chairmen of the House Appropriations and Senate Finance Committees. The report shall include, for the most recently completed fiscal year, the revenue collected from the coverage assessment, expenditures for purposes authorized by this Item, and the year-end coverage assessment balance in the Health Care Coverage Assessment Fund.

9. All revenue from the coverage assessment including penalties shall be deposited into the Health Care Coverage Assessment Fund. Proceeds from the coverage assessment, including penalties, shall not be used for any other purpose than to cover the non-federal share of the full cost of enhanced Medicaid coverage for newly eligible individuals, pursuant to 42 U.S.S. § 1396d(y)(1)[2010] of the Patient Protection and Affordable Care Act, including the administrative costs of collecting the assessment, and implementing and operating the coverage for newly eligible adults.

10. Any provision of this Item is contingent upon approval by the Centers for Medicare and Medicaid Services if necessary.