2019 Session

Budget Bill - HB1700 (Enrolled)

Item 3-5.16

§ 3-5.16 PROVIDER PAYMENT RATE ASSESSMENT

A. The Department of Medical Assistance Services (DMAS) is hereby authorized to levy a payment rate assessment upon private acute care hospitals operating in Virginia in accordance with this item. Private acute care hospitals operating in Virginia shall pay a payment rate assessment beginning on or after October 1, 2018 when all necessary state plan amendments are approved by the Centers for Medicare and Medicaid Services (CMS). For purposes of this 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. Proceeds from the 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 to fill the "managed care organization hospital payment gap" for care provided to recipients of medical assistance services.

2. DMAS shall calculate each hospital's payment rate assessment annually by multiplying the "payment rate assessment percentage" times "net patient service revenue". 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. The "payment rate assessment percentage" for hospitals shall be calculated as (i) 1.00 times the non-federal 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 hospitals subject to the assessment. Prior to calculating the payment rate assessment percentage, DMAS shall estimate the cost of the upper payment limit gap and the managed care organization hospital payment gap. Any estimated excess or shortfall of revenue from the previous year shall be deducted from or added to the calculation of the provider rate costs. By 14 days after the Appropriation Act for the upcoming fiscal year is signed, DMAS shall report the estimated payment rate assessment 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.

3. The "upper payment limit" means the limit on payment for inpatient services for recipients of medical assistance established in accordance with 42 C.F.R. § 447.272 and outpatient services for recipients of medical assistance pursuant to 42 C.F.R. § 447.321 for private hospitals. DMAS shall complete a calculation of the "upper payment limit" for each state fiscal year with a detailed analysis of how it was determined. The "upper payment limit payment gap" means the difference between the amount of the private hospital upper payment limit and the amount otherwise paid pursuant to the state plan for inpatient and outpatient services. The "managed care organization hospital payment gap" means the difference between the amount included in the capitation rates for inpatient and outpatient services 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 according to the existing State Plan methodology but using 100% for the adjustment factors (including the capital

~~reimbursement percentage) and full inflation subject to CMS approval under 42 C,F.R. section 438.6(c). As part of the development of the managed care capitation rates, the Department shall calculate a "Medicaid managed care organization (MCO) supplemental hospital capitation payment adjustment". This is a distinct additional amount added to Medicaid MCO capitation rates to fund supplemental payments under this section to private acute care hospitals operating in Virginia for services to Medicaid recipients.~~

~~4. DMAS shall contractually direct Medicaid MCOs to disburse supplemental hospital capitation payment funds consistent with this section and 42 C.F.R. § 438.6(c), that ensure that all such funds are disbursed to private acute care hospitals operating in Virginia. In addition, DMAS shall contractually prohibit MCOs from making reductions to or supplanting hospital payments otherwise paid by MCOs.~~

~~5. DMAS shall make available monthly a report of the additional capitation payments that are made to each MCO pursuant to this subsection. Further, DMAS shall consider recommendations of the Medicaid Hospital Payment Policy and Advisory Council in designing and implementing the specific elements of the payment rate assessment and private acute care hospital supplemental payment program authorized by this item.~~

~~C. DMAS shall be responsible for collecting the payment rate assessment. Hospitals subject to the assessment shall make quarterly payments to the department equal to 25 percent of the annual "assessment" amount. In the first year, quarterly amounts for the remainder of the state fiscal year shall equal the hospital's total payment rate assessment for the fiscal year divided by the number of quarters in the remainder of the fiscal year after the effective date of the payment rates. The assessment 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 five percent penalty. Any unpaid assessment or penalty will be considered a debt to the Commonwealth and DMAS is authorized to recover it as such.~~

~~D. 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 payment rate assessment, expenditures for purposes authorized by this item, and the year-end assessment balance in the Health Care Provider Payment Rate Assessment Fund.~~

~~E. All revenue from the payment rate assessment shall be deposited into the Health Care Provider Payment Rate Assessment Fund, a special non-reverting fund in the state treasury. Proceeds from the payment rate assessment, including penalties, shall not be used for any other purpose than to fund (i) 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" and "managed care organization hospital payment gap" for care provided to recipients of medical assistance services, and (ii) the administrative costs of collecting the assessment and of implementing and operating the associated payment rate actions.~~

~~F. Any provision of this Section is contingent upon approval by the Centers for Medicare and Medicaid Services if necessary.~~

A. The Department of Medical Assistance Services (DMAS) is hereby authorized to levy a payment rate assessment upon private acute care hospitals operating in Virginia in accordance with this item. Private acute care hospitals operating in Virginia shall pay a payment rate assessment beginning on or after October 1, 2018 when all necessary state plan amendments are approved by the Centers for Medicare and Medicaid Services (CMS). For purposes of this 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. Proceeds from the payment rate assessment shall be used to i) fund an increase in inpatient and outpatient payment rates paid to private acute care hospitals operating in Virginia up to the "upper payment limit gap" and ii) fill the "managed care organization hospital payment gap" for care provided to recipients of medical assistance services. Payments made under the provisions of this item shall be referred to as "private acute care hospital enhanced payments".

C.1. The Department of Medical Assistance Services (DMAS) shall calculate each hospital's "payment rate assessment amount" by multiplying the "payment rate assessment percentage" times "net patient service revenue" as defined below.

2. The "payment rate assessment percentage" for hospitals shall be calculated as (i) 1.08 times the non-federal share of funding the "private acute care hospitals enhanced payments" divided by (ii) the total "net patient service revenue" for hospital subject to the assessment.

3. Each hospital's "net patient service revenue" equals the amount reported in the most recent Virginia Health Information (VHI) "Hospital Detail Report." In FY 2019, net patient service revenue shall be prorated by the portion of the year subject to the tax. Hospitals shall certify that the net patient service revenue is hospital revenue and this amount shall be the assessment basis for the following fiscal year.

D. 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.

E.1. The "upper payment limit" means the limit on payment for inpatient services for recipients of medical assistance established in accordance with 42 C.F.R. § 447.272 and outpatient services for recipients of medical assistance pursuant to 42 C.F.R. § 447.321 for private hospitals. DMAS shall complete a calculation of the "upper payment limit" for each state fiscal year with a detailed analysis of how it was determined. The "upper payment limit payment gap" means the difference between the amount of the private hospital upper payment limit and the amount otherwise paid pursuant to the state plan for inpatient and outpatient services. The "managed care organization hospital payment gap" means the difference between the amount included in the capitation rates for inpatient and outpatient services 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 according to the existing State Plan methodology but using 100% for the adjustment factors (including the capital reimbursement percentage) and full inflation subject to CMS approval under 42 C.F.R. section 438.6(c). As part of the development of the managed care capitation rates, the DMAS shall calculate a "Medicaid managed care organization (MCO) supplemental hospital capitation payment adjustment". This is a distinct additional amount shall be added to Medicaid MCO capitation rates to fund supplemental payments under this section to private acute care hospitals operating in Virginia for services to Medicaid recipients.

2. DMAS shall contractually direct Medicaid MCOs to disburse supplemental hospital capitation payment funds consistent with this section and 42 C.F.R. § 438.6(c), to ensure that all such funds are disbursed to private acute care hospitals operating in Virginia. In addition, DMAS shall contractually prohibit MCOs from making reductions to or supplanting hospital payments otherwise paid by MCOs.

3. DMAS shall make available quarterly a report of the additional capitation payments that are made to each MCO pursuant to this item. Further, DMAS shall consider recommendations of the Medicaid Hospital Payment Policy and Advisory Council in designing and implementing the specific elements of the payment rate assessment and private acute care hospital supplemental payment program authorized by this item.

F.1. DMAS shall be responsible for collecting the payment rate assessment amount. Hospitals subject to the payment rate assessment shall make quarterly payments due no later than July 1, October 1, January 1 and April 1 of each state fiscal year. In FY 2019, the first payment rate assessment payment shall be due on or after October 1, 2018.

2. Hospitals that fail to make the payment rate assessment payments within 30 days of the due date shall incur a five percent penalty that shall be deposited in the Virginia Health Care Fund. Any unpaid payment assessment or penalty will be considered a debt to the Commonwealth and DMAS is authorized to recover it as such.

G. 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 payment rate assessment, expenditures for purposes authorized by this item, and the year-end assessment balance in the Health Care Provider Payment Rate Assessment Fund.

H. All revenue from the payment rate assessment shall be deposited into the Health Care Provider Payment Rate Assessment Fund, a special non-reverting fund in the state treasury. Proceeds from the payment rate assessment, excluding penalties, shall not be used for any other purpose than to fund (i) 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" and "managed care organization hospital payment gap" for care provided to recipients of medical assistance services, and (ii) the administrative costs of collecting the assessment and of implementing and operating the associated payment rate actions.

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