
VIRGINIA STATE BUDGET

2020 Session

Budget Bill - HB29 (Enrolled)

Bill Order » Part 3: Miscellaneous » Adjustments and Modifications to Tax Collections » Item 3-5.15

Provider Coverage Assessment

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§ 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 of 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 which includes the costs of administering the provisions of the Section 1115 waiver.

2.a. The “full cost of expanded Medicaid coverage” shall include: 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 Section 1115 waiver, and collecting the coverage assessment.

b. 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 this 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” times 1.08 will be insufficient to pay all expenses in 2.a. for that year.

c. This Act estimates the non-federal share of the cost of Medicaid expansion to be \$86,103,345 the first year and \$293,192,716 the second year. However, these amounts shall not be construed as a limitation on collections or override the provisions of this item that allow for periodic updates of the full cost of coverage.

C. 1. The Department of Medical Assistance Services (DMAS) shall calculate each hospital’s “coverage assessment amount” by multiplying the “coverage assessment percentage” times “net patient service revenue” as defined below.

2. The “coverage assessment percentage” shall be calculated as (i) 1.08 times the non-federal share of the “full cost of expanded Medicaid coverage” divided by (ii) the total “net patient service revenue” for hospitals 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.1. 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 30 days’ notice prior to a change in its coverage assessment amount and 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.

2. DMAS shall be responsible for collecting the coverage assessment amount. Hospitals subject to the coverage 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, quarterly amounts for the remainder of the state fiscal year shall equal one-third of the coverage assessment. In the first year, the first coverage assessment payment shall be due on or after October 1, 2018.

3. Hospitals that fail to make the coverage 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 coverage assessment or penalty will be considered a debt to the Commonwealth and DMAS is authorized to recover it as such.

E. 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, and the Virginia Hospital and Healthcare Association. 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. The report shall also include a complete and itemized listing of all administrative costs included in the coverage assessment.

F. All revenue from the coverage assessment excluding penalties, shall be deposited into the Health Care Coverage Assessment Fund. Proceeds from the coverage assessment, excluding penalties, shall not be used for any other purpose than to cover the non-federal share of the full cost of expanded Medicaid coverage.

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

H. The Hospital Payment Policy Advisory Council shall meet to consider the implementation and provisions of the Provider Coverage and Payment Rate Assessments in order to consider and make recommendations to ensure the collection and use of such funds are appropriate and consistent with the intent of the General Assembly. Specifically, the Council shall consider the level of detail and format necessary to develop the report pursuant to paragraph E. The Council shall recommend a format and associated level of detail, to be included in the report to the Joint Subcommittee for Health and Human Resources Oversight. The Joint Subcommittee shall approve the final format and associated level of detail of the report to be submitted by the Department of Medical Assistance Services.