2022 Special Session I

Budget Bill - HB30 (Chapter 2)

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 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.1. The “coverage assessment amount" shall equal the non-federal share of the “full cost of expanded Medicaid coverage" times 1.02.

2. The “coverage assessment percentage" shall be calculated quarterly by dividing (i) the “coverage assessment amount" by (ii) the total “net patient service revenue" for hospitals subject to the assessment. The coverage assessment amount used in the quarterly calculation of the “coverage assessment percentage” shall include a reconciliation of the Health Care Coverage Assessment Fund prescribed in D.1 and subtract all prior quarterly assessments paid for that fiscal year before dividing the remainder by the remaining quarters in the fiscal year.

3. Each hospital's “net patient service revenue” equals the amount reported in the most recent Virginia Health Information (VHI) “Hospital Detail Report.” 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.

4. Each hospital's coverage assessment amount shall be calculated by multiplying the quarterly “coverage assessment percentage” times each hospital's net patient service revenue.

D.1. DMAS shall, at a minimum, update the “coverage assessment amount” whenever the “full cost of expanded Medicaid coverage” is updated in section B.2.b or 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 15 days' notice prior to the beginning of the quarter with associated calculations supporting the change in its coverage assessment amount. Prior to any change to the coverage assessment amount, DMAS shall perform and incorporate a reconciliation of the Health Care Coverage Assessment Fund through the most recent complete quarter. Any estimated excess or shortfall of revenue shall be deducted from or added to the "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.

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 Chairs of the House Appropriations and Senate Finance and Appropriations 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. Notwithstanding any other provision of law, the net state share of any prior year recovery of Medicaid expansion costs that were paid with coverage assessment revenue shall be deposited into the Health Care Coverage Assessment Fund.

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.