2026 Special Session I

Budget Bill - HB30 (Enrolled)

Item 3-5.14

§ 3-5.14 PROVIDER PAYMENT RATE ASSESSMENT

A. The Department of Medical Assistance Services (DMAS) is hereby authorized to levy a payment rate assessment upon private hospitals operating in Virginia in accordance with this item. Private 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 hospitals shall include acute care hospitals and critical access hospitals and shall exclude public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, long stay hospitals, and long-term acute care 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 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 i and ii of this paragraph shall be referred to as “private 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) the non-federal share of funding the “private hospital enhanced payments" 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." 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. DMAS is authorized to define hospital classes and set variable assessment rates for different hospital classes in accordance with CMS regulations.

D. DMAS is authorized to update the payment rate assessment amount and payment rate assessment percentage on a quarterly basis to ensure amounts are sufficient to cover the non-federal share of the full cost of the private hospital enhanced payments based on the department's quarterly claims and encounter data. Hospitals shall be given no less than 15 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 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 hospitals operating in Virginia are priced for the contract year equivalent to the maximum managed care directed payment amount as allowed by CMS 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 that shall be added to Medicaid MCO capitation rates to fund supplemental payments under this section to private 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 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 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 August 15, November 15, February 15 and May 15 of each state fiscal year.

2. Hospitals that fail to make the payment rate assessment payments on or before the due date in subsection F.1. 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 Chairs of the House Appropriations and Senate Finance and Appropriations 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 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.

I. The department shall have the authority to submit a State Plan amendment and preprint to the Centers for Medicare and Medicaid Services (CMS) to revise the “net patient service revenue" calculation for the state in accordance with CMS regulations to include currently excluded providers to attain the maximum assessment allowed under federal law as the upper limit of total assessments. The department shall have the authority to

implement this change effective July 1, 2024, and prior to the completion of any regulatory process undertaken in order to effect such change.

J. The Department of Medical Assistance Services shall not provide private enhanced payments in the form of state directed payments to any rural hospital that does not currently operate a labor and delivery unit but such unit was operational in the rural hospital on January 1, 2026. For the purposes of this item, rural hospital is the same as defined by the Centers for Medicare and Medicaid Services.

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