COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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September 1, 2024

MEMORANDUM

TO: The Honorable Louise L. Lucas
Chair, Senate Finance Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

Michael Maul
Director, Department of Planning and Budget

Sean Connaughton
CEO, Virginia Hospital and Healthcare Association

FROM: Cheryl Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on Coverage Assessment and Provider Payment Rate Assessment

This report is submitted in compliance with Item 3-5.14.E. of the 2024 Appropriations Act and Item 3-5.15.G. of the 2024 Appropriations Act which states:

3-5.14.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.

3-5.15.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.

Should you have any questions or need additional information, please feel free to contact me at 804-664-2660.

CR/wf
Enclosure

Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

Report on Coverage Assessment and Provider Payment Rate Assessment

September 2024

Report Mandate:

Item 3-5.14 of the 2024 Appropriation Act states: "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."

Item 3-5.15 of the 2024 Appropriation Act states: "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."

Overview

States are allowed to "generate their share of Medicaid expenditures through multiple sources, including health care-related taxes, sometimes referred to as provider taxes, fees or assessments" under the Medicaid statute.[1]

The Department of Medical Assistance Services (DMAS) is authorized by the General Assembly to levy two assessments on private acute care hospitals operating in Virginia – the coverage assessment and the provider payment rate assessment. Monthly reports on these provider assessments are uploaded onto the DMAS website at https://www.dmas.virginia.gov/data/financial-reports/.

Coverage Assessment

In January 2019, Virginia expanded eligibility for the Medicaid program under the Patient Protection and Affordable Care Act to include caretaker adults and childless adults aged 19-64 with incomes up to 138% of the Federal Poverty Level. The state receives 90% Federal Medical Assistance Percentage (FMAP) for medical services provided to the Medicaid Expansion, hereafter referred to as "MedEX", population. The coverage assessment is used to cover the non-federal share of the full cost of MedEX, including any and all Medicaid expenditures related to individuals eligible for coverage and the administrative costs associated with providing the coverage and collecting the coverage assessment. This

[1] *Health Care-Related Taxes in Medicaid, MACPAC. May 2021. https://www.macpac.gov/wp-content/uploads/2020/01/Health-Care-Related-Taxes-in-Medicaid.pdf*

revenue is deposited into the Health Care Coverage Assessment Fund. The following table reflects the Health Care Coverage Assessment Fund balance as of June 30, 2024. Out of the $706M collected in FY24, 98% of the revenue was spent. The remaining revenue is added to the fund balance and deducted from the next quarterly coverage assessment.

Health Care Coverage Assessment Fund	
Beginning Balance, as of July 1, 2023	$ 153,612,384
Add: Assessment Collections	706,136,557
Less: Total Expenditures	(690,274,836)
Ending Balance, as of June 30, 2024	**169,474,105**

The following table summarizes the FY24 MedEx expenditures paid for using the Health Care Coverage Assessment Fund. These amounts do not include the portion of costs paid using federal funds. Additional details can be found in Appendix A and B.

FY24 MedEx Expenditures, Coverage Assessment

	FY24 Appropriation, Coverage Assessment	FY24 Actuals, Coverage Assessment	% of Appropriation Spent
Payments for MedEx Healthcare Coverage	731,149,445	670,777,452	92%
Administrative Costs	10,492,774	8,886,586	85%
Dept of Social Services Administrative Costs	6,628,196	6,628,196	100%
Enrollment and Utilization Related Contracts	6,454,427	3,982,603	62%
Total	**754,724,842**	**690,274,836**	**92%**

Category Definitions:

Payments for MedEx Healthcare Coverage: Payments for medical services provided to Medicaid Expansion population under the service area *Payments for Healthcare Coverage for Low-Income Uninsured Adults (45611)*.

Administrative Costs: The expenditure amount for administrative contracts and staffing allocated to MedEx under the service area *General Management and Direction* (49901).

Dept of Social Services Administrative Costs: Expenditures include contracts and staffing related to eligibility determination.

Enrollment and Utilization Contracts: The expenditure amount for enrollment and utilization related contracts allocated to MedEx under the services area *Medicaid Payments for Enrollment and Utilization Related Contracts (49601)*.

Provider Payment Rate Assessment

Private acute care hospitals pay a payment rate assessment. The proceeds of the assessment are used to fund private acute care hospital enhanced payments. As described in Item 3-5.15 of the 2024 Appropriation Act, these supplemental payments cover 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 fill the "managed care organization hospital payment gap" for care provided to recipients of medical assistance services. In addition to the enhanced payments to private acute care hospitals, the revenue may also be used to fund the administrative costs of collecting the assessment and of implementing and operating the associated payment rate actions. Below is a summary of the Health Care Provider Payment Rate Assessment Fund. In FY24, all expenditures using the rate assessment fund were related to funding the non-federal portion of enhanced payments; there were no administrative expenditures funded through the rate assessment fund.

Health Care Provider Payment Rate Assessment Fund	
Beginning Balance, as of July 1, 2023	$ 602,786
Add: Assessment Collections	837,759,208
Less: Total Expenditures	(837,802,674)
Ending Balance, as of June 30, 2024	**557,320**

Appendix A: Coverage Assessment, FY24 MedEx Expenditures: Administrative

Administrative Costs	FY24 MedEx Expenditures, All Funds	FY24 Expenditures, Coverage Assessment
CoverVA - Operational	12,914,346	3,358,601
31 Full-time Equivalents	4,110,616	2,055,308
Enrollment Broker	1,109,143	698,000
Enterprise Data Warehouse	2,388,214	597,053
Fiscal Agent Services - Operational	943,808	471,904
Integration Services Solution	1,275,990	318,997
CoverVA - Postage	533,663	266,831
Expansion Impact Evaluation	436,784	218,392
Agency Mailings	326,669	163,335
Provider Services Solution	581,559	145,357
Project Connect Outreach	313,474	114,930
External Quality Review Organization	546,552	110,611
Pharmacy Benefit Management System	438,691	109,673
Appeals Information Management System	394,719	98,680
FAS - Postage	175,607	87,804
Marketing Outreach	195,843	48,961
Upper Payment Limit Audits	41,547	22,148
Total	**26,727,226**	**8,886,586**

Enrollment and Utilization Related Contracts	FY24 MedEx Expenditures, All Funds	FY24 MedEx Expenditures, Coverage Assessment
Claims Processing	$ 4,593,291	$ 883,526
Behavioral Health Service Authorization Per Member Per Month (PMPM)	2,072,625	792,931
Dental PMPM	3,629,671	1,814,836
Service Authorization	1,484,074	491,310
Total	**11,779,661**	**3,982,603**

Appendix B: Coverage Assessment, FY24 MedEx Expenditures: Medical

	FY24 Current Appropriation		FY24 Actuals		Balance Remaining	
	Total Funds	Special Funds[1]	Total Funds	Special Funds[1]	Total Funds	Special Funds[1]
General Medical Care: MCOs[2]	**6,102,015,610**	**610,201,561**	**5,352,711,205**	**536,145,831**	**749,304,405**	**74,055,730**
Capitation Payments: Low-Income Adults & Children	4,508,909,317	450,890,932	3,794,584,992	379,362,181	714,324,325	71,528,751
Capitation Payments: CCC+ Program	1,822,446,051	182,244,605	1,870,975,030	187,092,806	(48,528,979)	(4,848,201)
MCO Pharmacy Rebates	(229,339,758)	(22,933,976)	(312,848,817)	(30,309,156)	83,509,059	7,375,180
General Medical Care: Fee-For-Service	**408,047,120**	**40,804,712**	**643,515,883**	**118,681,738**	**(235,468,763)**	**(77,877,026)**
Inpatient Hospital	219,980,218	21,998,022	188,295,884	18,820,098	31,684,334	3,177,924
Outpatient Hospital	47,239,921	4,723,992	48,794,155	4,878,723	(1,554,234)	(154,730)
Physician/Practitioner Services	34,788,809	3,478,881	32,930,982	4,268,501	1,857,827	(789,620)
Clinic Services	16,403,323	1,640,332	13,191,354	989,209	3,211,969	651,124
Pharmacy	17,457,321	1,745,732	11,414,341	1,141,119	6,042,980	604,614
FFS Pharmacy Rebates	(16,959,959)	(1,695,996)	(3,950,425)	(364,300)	(13,009,534)	(1,331,696)
Medicare Premiums Part A & B	-	-	124,779,035	12,477,904	(124,779,035)	(12,477,904)
Medicare Premiums Part D	-	-	61,937,380	61,937,380		(61,937,380)
Dental	80,350,938	8,035,094	136,752,467	13,675,246	(56,401,529)	(5,640,152)
Transportation	2,371,959	237,196	4,420,229	441,980	(2,048,270)	(204,784)
Indian Health Clinics (100% Fed)			20,790,783	-		
All Other	6,414,590	641,459	4,159,698	415,880	2,254,892	225,579
Behavioral Health & Rehabilitative Services	**8,004,121**	**-**	**11,675,807**	**1,167,512**	**(3,671,686)**	**(1,167,512)**
MH Case Management	-	-	970,392	97,038	(970,392)	(97,038)
MH Residential Services	-	-	489,758	48,976	(489,758)	(48,976)
MH Rehabilitative Services	-	-	10,056,981	1,005,631	(10,056,981)	(1,005,631)
Early Intervention & EPSDT-Authorized Services	-	-	158,676	15,868	(158,676)	(15,868)
Long-Term Care Services	**68,670,781**	**-**	**71,423,501**	**7,141,757**	**(2,752,720)**	**(7,141,757)**
Nursing Facility	18,289,817	1,828,982	11,472,186	1,147,212	6,817,631	681,770
Private ICF/MRs	-	-	2,845,446	284,541	(2,845,446)	(284,541)
PACE	-	-	5,115,407	511,537	(5,115,407)	(511,537)
HCBC Waivers: Personal Support	-	-	11,276,896	1,127,271	(11,276,896)	(1,127,271)
HCBC Waivers: Habilitation	50,380,964	5,038,096	34,977,451	3,497,627	15,403,513	1,540,469
HCBC Waivers: Nursing, EM/AT, Adult Day Care, Alzheimers	-	-	2,879,862	287,980	(2,879,862)	(287,980)
HCBC Waivers: Case Management & Support	-	-	2,856,253	285,588	(2,856,253)	(285,588)
Hospital Payments[3]	92,483,933	72,475,682	107,797,687	7,640,614	(15,313,754)	64,835,068
Total Medicaid EXPANSION Expenditures (coverage)	$ 6,679,221,565	$ 723,481,955	$ 6,187,124,084	$ 670,777,452	$ 492,097,481	$ 52,704,503

[1]Special Funds in this report represent the Health Care Coverage Assessment Fund

[2]General Assembly and Intra-Agency Budget Adjustments

[3]This is not calcuated as 10% of total because it is a net of IGT Funded-PSP Expansion

About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage. The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 2 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives an approximate dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.