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SENATE BILL NO. 956

Offered January 19, 2018

A BILL to amend the Code of Virginia by adding in Chapter 22 of Title 2.2 an article numbered 11, consisting of sections numbered 2.2-2351 through 2.2-2360, and by adding in Title 32.1 a chapter numbered 20, consisting of sections numbered 32.1-373 through 32.1-378, relating to the Virginia Health Care Access Program.

Patron—Barker

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Chapter 22 of Title 2.2 an article numbered 11, consisting of sections numbered 2.2-2351 through 2.2-2360, and by adding in Title 32.1 a chapter numbered 20, consisting of sections numbered 32.1-373 through 32.1-378, as follows:

Article 11.

Virginia Health Care Access Authority.

§ 2.2-2351. Definitions.

As used in this article, unless the context requires a different meaning:

"Authority" means the Virginia Health Care Access Authority.

"Board" means the Board of Directors of the Authority.

"Director" means the Director of the Department of Medical Assistance Services.

"Secretary" means the Secretary of Health and Human Resources.

§ 2.2-2352. Virginia Health Care Access Authority created.

A. There is hereby created as a public body and as a political subdivision of the Commonwealth the Virginia Health Care Access Authority. The authority is constituted as a public instrumentality exercising public and essential governmental functions and the exercise by the Authority of such powers and duties conferred by this article shall be deemed and held to be the performance of an essential governmental function of the Commonwealth. The exercise of powers granted by this article shall be in all respects for the benefit of the inhabitants of the Commonwealth and the purpose of providing for the health, welfare, convenience, knowledge, benefit, and prosperity of residents of the Commonwealth.

B. The Authority is authorized to exercise independently the powers conferred by this article in furtherance of its corporate and public purposes.

§ 2.2-2353. Board of Directors; membership; chairman; meetings; compensation.

A. The Authority shall be governed by a Board of Directors consisting of the Secretaries of Finance and Health and Human Resources, the Director of the Department of Medical Assistance Services, and 11 nonlegislative citizen members appointed as follows: six nonlegislative citizen members appointed by the Governor, including three nonlegislative citizen members who are members of the Virginia Hospital and Healthcare Association, one nonlegislative citizen member who is a member of the Virginia Association of Health Plans, one nonlegislative citizen member who is a licensed physician, and one nonlegislative citizen member who is a director of a local department of social services; three nonlegislative citizen members appointed by the Speaker of the House of Delegates, including two nonlegislative citizen members who represent a corporate purchaser of health care and one nonlegislative citizen member who is a consumer of health care; and two nonlegislative citizen members appointed by the Chairman of the Senate Committee on Rules, including one nonlegislative citizen member who is a representative of local government and one nonlegislative citizen member who is a representative of the licensed health carriers responsible for a managed care health insurance plan that is contracted by the Department of Medical Assistance Services to provide medical assistance services pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1. Nonlegislative citizen members of the Board shall be citizens of the Commonwealth.

The Secretaries of Finance and Health and Human Services shall serve ex officio with voting privileges. The Director of the Department of Medical Assistance Services shall serve ex officio without voting privileges. Ex officio members of the Board shall serve terms coincident with their terms of office.

Nonlegislative citizen members shall be appointed for terms of two years and shall serve until their successors are appointed. Any appointment to fill a vacancy, other than by expiration of a term, shall be for the unexpired term. All members may be reappointed; however, no member shall serve more than two consecutive terms. The remainder of any term to which a member is appointed to fill a vacancy shall not constitute a term in determining the member's eligibility for reappointment. Vacancies shall be

filled in the same manner as the original appointment.

Any member of the Board may be removed for malfeasance, misfeasance, incompetence, or gross neglect of duty or otherwise at the pleasure of the appointing authority.

B. The Board shall elect a chairman from among its membership. The Director or, with the approval of the Board, his designee shall act as secretary of the Board and shall not be entitled to any additional compensation for such service.

C. The Board shall meet at least four times each year and may hold such other meetings as it deems appropriate. A majority of the Board shall constitute a quorum for meetings, and the Board may act by a majority of those present at any meeting.

D. The Board may adopt, amend, and repeal such rules, regulations, procedures, and bylaws not contrary to the provisions of this article as it deems expedient for its own governance and the governance and management of the Authority.

E. Nonlegislative citizen members of the Board shall be entitled to such compensation as provided in § 2.2-2813 for their services. All members shall be entitled to reimbursement for all reasonable and necessary expenses incurred in the performance of their duties as provided in §§ 2.2-2813 and 2.2-2825. Funding for the costs of compensation and expenses of the members shall be provided by the Authority.

F. The provisions of the State and Local Government Conflict of Interests Act (§ 2.2-3100 et seq.) shall apply to the members of the Board and any directors, officers, employees, or agents of the Authority.

§ 2.2-2354. Powers and duties of the Authority.

A. The Authority shall have all the powers necessary or appropriate to carry out and effectuate the purposes and provisions of this article, including:

1. To impose and collect an assessment upon hospitals and managed care health insurance plans operating in the Commonwealth in accordance with Chapter 20 (§ 32.1-373 et seq.) of Title 32.1 to obtain funding to improve access to health care services for recipients of medical assistance services and other medically needy, low-income underinsured and uninsured residents of the Commonwealth; to support the financial stability of rural hospitals and access to care in rural areas of the Commonwealth; and to fund programmatic and financial support for health professional education by public and private teaching hospitals within the Commonwealth;

2. To disburse and expend funds contained in the Virginia Health Care Access Fund established pursuant to § 32.1-375 in accordance with Chapter 20 (§ 32.1-373 et seq.) of Title 32.1;

3. To make and execute contracts, guarantees, or any other instruments and agreements necessary or incidental to the exercise of its powers and duties, including contracts to operate and manage its operations, and to incur liabilities and secure the obligations of any entity or individual;

4. To develop partnerships with and among public and private entities to coordinate delivery of health care services designed to improve the health of recipients of medical assistance services and other medically needy, low-income underinsured and uninsured residents of the Commonwealth and to reduce the cost, including the per capita cost, of such services;

5. To conduct or engage in any lawful business, activity, effort, or project consistent with the Authority's purposes or necessary or incidental to exercise its powers;

6. To exercise, in addition to its other powers, all powers that are granted to corporations by the provisions of Title 13.1 or similar provisions of any successor law, except in those cases where, by the express terms of the provisions thereof, the power is confined to corporations created under such title, and that are not inconsistent with the purposes and intent of this article or the limitations included in this article; and

7. To provide for the appointment, employment, terms, compensation, and removal of a director and such other officers, employees, or agents of the Authority, including consultants, attorneys, and accounts, as the Board deems appropriate.

B. The Authority shall not have the power to borrow money or issue or incur debt on behalf of the Commonwealth or itself.

C. The Authority shall have the duty to:

1. Implement and oversee the administration of the Virginia Health Care Access Fund and Virginia Health Care Access Program created pursuant to Chapter 20 (§ 32.1-373 et seq.) of Title 32.1; and

2. Identify and take necessary steps to obtain funding from public and private sources to fund improved access to health care services for recipients of medical assistance services and other medically needy, low-income underinsured or uninsured residents of the Commonwealth; to support the financial stability of rural hospitals and access to care in rural areas of the Commonwealth; and to fund programmatic and financial support for health professional education by public and private teaching hospitals within the Commonwealth.

§ 2.2-2355. Acceptance of public or private funds; moneys held in trust.

A. The Authority may seek, accept, receive, disburse, and expend the proceeds of the annual assessment imposed pursuant to § 32.1-376 and such federal and state funds and other such other

moneys, public or private, to accomplish, in whole or in part, any of the purposes of this article. Funds received pursuant to this section shall be deposited into the Virginia Health Care Access Fund established pursuant to § 32.1-375. All federal moneys accepted under this section shall be accepted and expended upon such terms and conditions as are prescribed by the United States and as are consistent with state law, and all state moneys accepted pursuant to this section shall be accepted and expended upon such terms and conditions as are prescribed by the Commonwealth.

B. All moneys received pursuant to this section shall be deemed to be trust funds to be held and applied solely as provided in this article. The resolution authorizing the receipt of any moneys shall provide that any officer with whom, or any bank or trust company with which, such moneys shall be deposited shall act as a trustee of such moneys and shall hold and apply the same for the purposes hereof, subject to the requirements of this article.

§ 2.2-2356. Form of accounts and records; audit; annual report.

The accounts and records of the Authority showing the receipt and disbursement of funds from whatever source derived shall be in a form prescribed by governmental generally accepted accounting standards. Such accounts shall correspond as nearly as possible to the accounts and records for such matters maintained by enterprises.

The accounts of the Authority shall be audited annually by an independent certified public accountant or the Auditor of Public Accounts.

The Authority shall annually, following the close of each fiscal year and prior to December 1, submit a report of its activities for the preceding year to the Governor and the General Assembly. Each report shall set forth a complete operating and financial statement for the Authority during the preceding fiscal year.

§ 2.2-2357. Public purpose.

The exercise of the powers granted by this article shall be in all respects for the benefit of the inhabitants of the Commonwealth and for the promotion of their safety, health, welfare, convenience, and prosperity. No part of the assets or earnings of the Authority shall inure to the benefit of, or be distributable to, any private individual, except as permitted or required by Chapter 20 (§ 32.1-373 et seq.) of Title 32.1 and except that reasonable compensation may be paid for services rendered to or for the Authority affecting one or more of its purposes, and benefits may be conferred that are in conformity with said purposes.

§ 2.2-2358. Exemption from taxation.

The Authority is declared to be performing a public function and to be a public body corporate and a political subdivision of the Commonwealth. Accordingly, the Authority shall not be required to pay any taxes or assessments upon any project or any property or upon any operations of the Authority or the income therefrom, or any taxes or assessments upon any project or any property or local obligation acquired or used by the Authority under the provisions of this article or upon the income therefrom. The exemptions hereby granted shall not extend to persons or entities conducting on the Authority's property businesses for which payment of state or local taxes would otherwise be required.

§ 2.2-2360. Article liberally construed.

This article shall constitute full and complete authority, without regard to the provisions of any other law, for the doing of the acts and things herein authorized and shall be liberally construed to effect the purposes hereof. Insofar as the provisions of this article are inconsistent with the provisions of any other law, general, specific, or local, the provisions of this article shall be controlling.

CHAPTER 20.

VIRGINIA HEALTH CARE ACCESS PROGRAM.

§ 32.1-373. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Authority" means the Virginia Health Care Access Authority established pursuant to Article 11 (§ 2.2-2351 et seq.) of Chapter 22 of Title 2.2.

"Covered hospital" means any hospital, as defined in § 32.1-123, other than those exempt pursuant to § 32.1-376, that has permanent facilities located in the Commonwealth that include inpatient beds.

"Covered teaching hospital" means a covered hospital that is a private teaching hospital located in the Commonwealth.

"Department" means the Department of Medical Assistance Services.

"Director" means the Director of the Department of Medical Assistance Services.

"Fund" means the Virginia Health Care Access Fund established pursuant to § 32.1-375.

"Managed care organization" means a health carrier licensed to operate in the Commonwealth pursuant to Chapter 58 (§ 38.2-5800 et seq.) of Title 38.2.

"Managed care organization hospital payment gap" means the additional amount that must be added to capitation rates paid by a managed care organization to make payment of all hospital services at the maximum allowable rate rather than rates based on the amount included in the capitation rate for

hospital services financed without using hospital assessment funds actuarially sound for managed care organizations.

"Newly eligible adult" means an individual described in 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

"Newly eligible adult payment gap" means the total amount of the nonfederal share of the cost of providing medical assistance services to newly eligible adults in accordance with the provisions of 42 U.S.C. § 1396d(y) less the projected annual general fund savings for the Commonwealth and other nonfederal net savings associated with implementation of coverage for newly eligible adults.

"Program" means the Virginia Health Care Access Program established pursuant to § 32.1-374.

"Rural hospital" means any covered hospital identified as rural under the Wage Index File S-3 issued by the Centers for Medicare and Medicaid Services or any Sole Community Hospital redesignated as rural in Table 9C issued by the Centers for Medicare and Medicaid Services.

"State Plan" means the state plan for medical assistance under Title XIX (§ 42 U.S.C § 1396 et seq.) of the Social Security Act.

"Secretary" means the Secretary of Health and Human Resources.

"Type One teaching hospital" means a hospital that was a state-owned teaching hospital on January 1, 1996.

"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.

"Upper payment limit payment gap" means the difference between the amount of the upper payment limit and the amount actually paid for inpatient and outpatient hospital services pursuant to the state plan for medical assistance services.

§ 32.1-374. Virginia Health Care Access Program established; administration.

A. There is hereby established the Virginia Health Care Access Program to (i) develop and fund programs to improve access to health care services for recipients of medical assistance and other medically needy, low-income underinsured and uninsured residents of the Commonwealth; (ii) support the financial stability of rural hospitals and access to health care in rural areas of the Commonwealth; and (iii) fund programmatic and financial support for health professional education provided by public and private teaching hospitals within the Commonwealth.

B. The Authority shall enter into a contract with the Virginia Hospital and Healthcare Association to conduct the administrative and operational functions necessary to implement, conduct, and maintain the Program. Pursuant to such contract, the Virginia Hospital and Healthcare Association shall (i) assist the Authority in calculating and verifying the assessment bases and assessment rates and imposing and collecting the assessment required pursuant to § 32.1-376 and (ii) monitor the use of the proceeds of the assessment in accordance with § 32.1-377.

§ 32.1-375. Virginia Health Care Access Fund.

There is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Health Care Access Fund, referred to in this section as "the Fund." The Fund shall be established on the books of the Comptroller. All revenues collected or received from assessments imposed on covered hospitals and managed care organizations pursuant to § 32.1-376, any interest or penalties imposed in accordance with the provisions of this chapter, and federal and state funds and other such other moneys, public or private, received in accordance with this chapter or Article 11 (§ 2.2-2351 et seq.) of Chapter 22 of Title 2.2 shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purposes set forth in this chapter. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the Secretary of Health and Human Resources.

Funds contained in the Fund shall not be used to replace any funds otherwise appropriated to the Department or for the administration of the state plan by the General Assembly or to replace any other funds appropriated for the administration of the state plan.

§ 32.1-376. Assessment imposed; method of calculating.

A. To carry out the purposes of the Program, the Authority shall impose an annual assessment on each covered hospital and managed care organization in the Commonwealth, which shall include (i) an upper payment limit payment gap assessment, (ii) a managed care organization hospital payment gap assessment, and (iii) a newly eligible adult payment gap assessment.

B. The Department shall calculate the upper payment limit payment gap assessment rate for all covered hospitals and managed care organizations. To calculate the rate, the Department shall:

1. Determine the upper payment limit payment gap;

2. Determine the assessment base for all covered hospitals and managed care organizations in accordance with subsection E; and

3. Determine the upper payment limit payment gap assessment rate by dividing the amount of the

upper payment limit payment gap by the total amount of the assessment base.

C. The Department shall calculate the managed care organization hospital payment gap assessment rate for all covered hospitals and managed care organizations. To calculate the rate, the Department shall:

1. Determine the managed care organization hospital payment gap;

2. Determine the assessment base for all covered hospitals and managed care organizations in accordance with subsection E; and

3. Determine the managed care organization hospital payment gap assessment rate by dividing the amount of the managed care organization hospital payment gap by the total amount of the assessment base.

D. The Department shall calculate the newly eligible adult payment gap assessment rate for all covered hospitals and managed care organizations. To calculate the rate, the Department shall:

1. Determine the newly eligible adult payment gap;

2. Determine the assessment base for all covered hospitals and managed care organizations in accordance with subsection E; and

3. Determine the newly eligible adult payment gap assessment rate by dividing the amount of the newly eligible adult payment gap by the total amount of the assessment base.

E. The assessment base used to calculate assessment rates in accordance with this section shall be the total of the covered hospital assessment base and the managed care organization assessment base.

The covered hospital assessment base shall be the total amount of a covered hospital's net patient revenue for the fiscal year for which the assessment shall be imposed, which shall be determined using the Medicare cost report for such hospital maintained by the Department on June 30 of the fiscal year for which the assessment shall be imposed, without regard for any subsequent adjustments or changes to such data. For Fiscal Year 2018, a covered hospital's net patient revenue shall be determined using the data contained in the covered hospital's Fiscal Year 2016 Medicare cost report contained in the Centers for Medicare and Medicaid Services Health Care Cost Report Information System as of March 1, 2018, without regard to any subsequent adjustments or changes to such data.

The managed care organization assessment base shall be the total amount of premiums other than those paid under Title XVIII of the Social Security Act paid to the managed care organization during the fiscal year for which the assessment shall be imposed, which shall be determined using the most recent annual statement filed with the State Corporation Commission pursuant to § 38.2-1300 on March 1 of the fiscal year for which the assessment shall be imposed.

F. The provisions of subsection A shall not apply to, and no assessment shall be imposed on:

1. Any Type One teaching hospital or any hospital that is owned, controlled, or operated by a Type One teaching hospital;

2. Any hospital classified as a psychiatric hospital pursuant to 42 C.F.R. § 412.23(a);

3. Any hospital classified as a rehabilitation hospital pursuant to 42 C.F.R. § 412.23(b);

4. Any hospital classified as a children's hospital pursuant to 42 C.F.R. § 412.23(d);

5. And hospital classified as a long-term care hospital pursuant to 42 C.F.R. § 412.23(e); or

6. Any hospital classified as a critical care access hospital pursuant to 42 C.F.R § 485.606.

G. No assessment shall be imposed pursuant to this section until the Department has received and provided to the Virginia Hospital and Healthcare Association and the Virginia Association of Health Plans written notice that:

1. The Centers for Medicare and Medicaid Services has determined that the assessment is a permissible source of revenue that shall not adversely affect the amount of federal financial participation available to the Commonwealth under the state plan for medical assistance services; and

2. The Centers for Medicare and Medicaid Services has approved the distribution of the full amount of funds up to the amount reasonably determined by the Department to be sufficient to pay the amounts set forth in § 32.1-377.

§ 32.1-377. Use of health care assessment proceeds.

A. Moneys contained in the Fund shall be disbursed for the purposes of (i) developing and funding programs to improve access to health care services for recipients of medical assistance and other medically needy, low-income underinsured and uninsured residents of the Commonwealth; (ii) supporting the financial stability of rural hospitals and access to health care in rural areas of the Commonwealth; and (iii) funding programmatic and financial support for health professional education provided by public and private teaching hospitals within the Commonwealth.

B. Funds received by the Fund resulting from imposition of the assessments described in subsections B and C of § 32.1-376 shall be disbursed as follows:

1. $20,000,000 in each fiscal year shall be disbursed to covered teaching hospitals in the form of a per resident amount for programmatic and financial support of health professional education.

2. $10,000,000 in each fiscal year shall be disbursed to fund the costs of enhanced outpatient

payment amounts paid to rural hospitals through a supplemental payment based on the ratio of fee-for-service revenue for outpatient services provided to recipients of medical assistance services to total rural hospital fee-for-service revenue for the fiscal year.

3. Not more than $100,000 in each fiscal year shall be disbursed to fund the Authority's and Department's costs of administering the Program and the Fund.

4. All other funds remaining in the Fund shall be disbursed to fund an increase in inpatient and outpatient payment rates paid to covered hospitals through a combination of increased payment rates on inpatient and outpatient hospital services provided to recipients of medical assistance services by covered hospitals and increased capitation payments to managed care organizations that have entered into a contract with the Department for the provision of managed care health insurance for recipients of medical assistance to ensure access to hospital services. The Department shall prohibit managed care organizations receiving increased capitation payments pursuant to this section from making reductions to or supplanting payments otherwise paid by managed care organizations. Payments to managed care organizations pursuant to this section shall be consistent with an actuarial certification approved by the Department and shall be published by the Department each year. Each managed care organization shall expend all of the increased capitation payments it receives pursuant to this section to support the availability of hospital services and to ensure access to hospital services. The Department shall make available, on a monthly basis, a report of the capitation payments that are made to each managed care organization pursuant to this subsection, including the number of enrollees for which such payment is made, the per enrollee amount of the payment, and any adjustments that have been made. The Department shall issue change orders to amend contracts with managed care organizations in accordance with this section, subject to approval by the Centers for Medicare and Medicaid Services. No payments shall be made pursuant to this subsection without approval from the Centers for Medicare and Medicaid Services.

C. Funds received by the Fund resulting from imposition of the assessments described in subsection D of § 32.1-376 shall be disbursed to fund the newly eligible adult payment gap.

D. Notwithstanding any of the other provisions of this section, the Department may revise the amounts disbursed pursuant to subsection B, but only to the extent necessary to conform to any federally approved amendment to the state plan for medical assistance services. Notwithstanding any other provision of law, any changes implemented as a result of this subsection shall be given retroactive effect so that they shall be deemed to have taken effect as of the effective date of this section.

§ 32.1-378. Repeal of authority to impose assessment.

A. The authority to impose assessments pursuant to § 32.1-376 shall be automatically repealed upon the occurrence of any of the following events:

1. Final judicial determination by a federal or state court that the assessment is not a permissible source of revenue for purposes of federal financial participation in the state plan for medical assistance under 42 U.S.C. § 1396b(w), implementing regulations at 42 C.F.R. Part 433, Subpart B, or any other federal law pertaining to federal financial participation in state plans for medical assistance.

2. Denial or revocation of approval for the assessment or any waiver or state plan amendment required for imposition of the assessment or determination for any reason that the assessment is not a valid source of revenue or is an impermissible tax under Title XIX of the Social Security Act or that the methodology for distribution of payments to covered hospitals from the assessment is not valid by the Centers for Medicare and Medicaid Services or any federal agency with jurisdiction over the assessment.

3. Occurrence of any event that results in the state not receiving federal financial participation for payments required by the assessment or payments to hospitals or managed care organizations required under this article are not eligible for federal matching funds under Title XIX or XXI of the Social Security Act.

4. Appropriation of revenues from the assessment or any amounts deposited in the Fund and all corresponding matching federal funds to the General Fund or utilization of such funds for any purpose other than the payment and coverage improvement programs established pursuant to this chapter.

5. Failure to deposit proceeds of or interest upon the assessment into the Fund or depositing of the proceeds of interest upon the assessment into the general fund.

6. Use of revenues from the assessment or any amounts deposited in the Fund to replace moneys appropriated by the legislature for the program of medical assistance services or any non-health care related appropriation.

7. Adoption by the Department of any administrative rule change to reduce payment rates or alteration of payment methodology by the Department or General Assembly that reduces any payment rate made to operating hospitals under the approved state plan in effect on December 31, 2017, whether directly by the Department or indirectly through managed care organizations, including rebasing hospital payment rates below the base payment rates in effect on December 31, 2017, or reducing any hospital adjustment factor below the adjustment factor in effect on December 31, 2017.

8. Action by the Department or the General Assembly to reduce the level of general fund revenues appropriated for the delivery of medical assistance services pursuant to the state plan for medical assistance below those in effect on December 31, 2017.

B. The authority to impose assessments pursuant to subsection D of § 32.1-376 shall be automatically repealed upon the expiration or termination of coverage of newly eligible adults for any reason, including a change in federal law, regulation, or agency action that results in the federal medical assistance percentage applied to the coverage of newly eligible adults dropping below the federal medical assistance percentages set forth at 42 U.S.C. § 1396d(y) or changes to the terms and conditions of any waiver, amended waiver, state plan amendment, or other federal approval required to implement the coverage of newly eligible adults in a manner that conflicts with or is inconsistent with this chapter.

C. Within 90 days following the date of repeal of the assessment, the Authority shall promptly refund to each covered hospital the corresponding assessment proceeds collected in proportion to the amount of unexpended assessment proceeds paid by that covered hospital.

D. A covered hospital or the Virginia Hospital and Healthcare Association shall have the right to file a petition for a writ of mandamus or prohibition pursuant to § 2.2-3713 or other declaratory order to determine if there has been, and to seek judicial remedy to repair, a failure to repeal the assessment pursuant to this section.

2. That the provisions of this act shall expire on July 1, 2023.

3. That the Secretary of Health and Human Resources shall file a state plan amendment with the federal Centers for Medicare and Medicaid Services that provides for imposition of the assessment and distribution of funds collected as a result of such assessment in accordance with the provisions of this act. Upon approval of such amendment by the Centers for Medicare and Medicaid Services, the Virginia Health Care Access Authority, as created by this act, may impose the initial assessment retroactive to the effective date of the assessment specified in this act.