Mandate: *Budget Item 297.D*: *"The Secretary of Health and Human Resources shall conduct an analysis and develop a plan with options for a hospital provider assessment program…In the development of this program, the Secretary's office shall be assisted by the Department of Medical Assistance Services (DMAS), the Virginia Center for Health Care Innovation, the Virginia Hospital and Healthcare Association and other affected stakeholders"* (see Attachment A).

Background*:* *Title 42 CFR Part 433; Subpart B:* *A provider assessment* is a health care-related fee, assessment or mandatory payment for which at least 85 percent of the burden falls on health care providers. Provider assessments can be used to claim federal matching funds. Assessments cannot exceed 25 percent of the non-federal share of Medicaid costs. States cannot guarantee that a provider will receive its assessment back in the form of a supplemental payment.

Meetings: In response to the Budget Item, the Secretary of Health and Human Resources formed an advisory Work Group which included a broad cross section of the health care community and was chaired by the Governor's Policy Director (see Attachment B for a list of Work Group members). The Work Group met several times over the ensuing months (see Attachment C for meeting dates).

While the work group focused on a hospital provider assessment, it also examined other provider assessment programs including assessment programs for Intermediate Care Facilities for Intellectually Disabled (ICF-ID), nursing facilities and managed care organizations (MCOs). Virginia has an existing provider assessment program for ICF-IDs. The following presentations were made by stakeholders at Work Group meetings[1]:

- Provider Assessment Background Presentation by Manatt and Associates
- Provider Assessment Revenue Options Presentation by DMAS
- Hospital Reimbursement Options Presentation by DMAS
- Virginia Health System Financial Forecast by Dobson Davanzo and Associates
- GME Presentation by the Joint Commission on Health Care (see the complete presentation to the Joint Commission at http://jchc.virginia.gov/2%20GME%20Staff%20Review-2.pdf).

[1] See Attachment C for links to meeting agendas and presentations.

At the October 28, 2015 meeting of the Work Group, the following organizations were invited to make public comments regarding the development of a provider assessment program.

- Virginia Hospital and Healthcare Association
- Virginia Health Care Association
- LeadingAge Virginia
- Virginia Association of Health Plans

In addition to input presented at the meetings, interested parties were encouraged to submit comments during a public comment period.

Also included as Attachment D to the report is a letter from the Virginia Hospital and Healthcare Association on "Reimbursing the Cost of Hospital and Health Care Services Provided to Virginians". The letter includes six principles necessary for the association to support a provider assessment program.

Criteria:

The General Assembly asked the Secretary to analyze criteria for a hospital provider assessment among other issues. Specific recommendations on a hospital provider assessment are at the end of this report.

Criterion 1: ***Complies with applicable federal law and regulations:***

Manatt outlined the federal requirements for a provider assessment in a presentation at the first meeting of the work group. Provider assessments must:

- Be broad-based, meaning that the assessment is imposed on at least all health care items or services in the class furnished by all non-federal, non-public providers in the state,
- Be imposed uniformly on all providers within a specified class of providers,
- Not exceed 25 percent of the non-federal share of Medicaid costs,
- Not hold providers "harmless" or guarantee providers will receive their money back (there is a presumption that the providers are not held harmless if the assessment rate is less than 6 percent of revenue).

Payments made with revenues derived from provider assessments must also be consistent with other Medicaid limitations, such as the Upper Payment Limit (UPL) requirements (the UPL is an estimate of the

amount that would be paid for Medicaid services under Medicare payment principles and is the maximum that can be paid for inpatient and outpatient services under fee-for-service).

The state can receive a federal waiver of the requirement that the provider assessment must be broad-based and uniform, if the state can prove that the assessment is generally redistributive (i.e., there are "winners" and "losers"). Most states apply for federal waivers, as this allows states to minimize the impact on losers; however, in order to satisfy complicated waiver requirements, most states use consultants to model programs that CMS will approve. Thirty-nine states have successfully implemented hospital provider assessments, including all of the states bordering Virginia.

Criterion 2: Designed to operate in a fashion that is mutually beneficial to the Commonwealth and affected health care organizations:

A provider assessment is considered a user fee rather than a tax, because it is usually paired with payment increases. Given the Medicaid federal match rate, which is 50 percent in Virginia, there are opportunities to maximize benefits to both the Commonwealth and affected health care organizations if a provider assessment is imposed. See the table 1 below for provider assessment scenarios.

Table 1: Provider Assessment Scenarios

Scenario Number	Provider Assessment Total	Additional Medicaid Provider Reimbursement	Net Provider Revenue	Net State Revenue
1	$1 million	$0	-$1 million	$1 million
2	$1 million	$1 million	$0	$500,000
3	$1 million	$1.5 million	$500,000	$250,000
4	$1 million	$2 million	$1 million	$0

Scenario 1 is a pure tax. Under this scenario, there would be no benefit to the affected health care organizations. Under Scenario 2, providers do not lose revenue as a group; however, there would be individual winners and losers except in unusual circumstances[2].

[2] Scenario 2 is similar to the current ICF-ID provider assessment. There are no winners or losers in the Virginia ICF-ID provider assessment because providers are reimbursed cost (including the assessment) and utilization is 100 percent Medicaid.

Hospital representatives favor scenario 4, where the revenue from the provider assessment would be used exclusively to fund the non-federal share for additional Medicaid reimbursement (plus any additional Medicaid administrative cost). In a narrow sense, this would also benefit the Commonwealth by funding additional reimbursements to hospitals that the state could not otherwise afford; however, in the 2015 Introduced Budget, the Governor proposed that 35 percent of the revenue from a provider assessment would be deposited to the Virginia Health Care Fund.

Using a hospital provider assessment to fund the non-federal share of a Medicaid expansion, as some states have pursued, would be a variation of scenario 3. The federal match rate for a Medicaid expansion is $9 federal to $1 of state funds, which is much more favorable than the $1 to $1 match rate for Virginia Medicaid[3].

Hospitals have expressed concern that any agreement may eventually turn into a version of scenario 1 as a result of fiscal pressures. If this occurred, an assessment would not meet the criterion that the provider assessment be beneficial to the affected health organizations. The hospital representatives have asked for safeguards to prevent the provider assessment from becoming a pure tax. Possible safeguards might include a non-reverting fund, code language and/or the creation of an independent governing body.

Criterion 3: Addresses health system challenges in meeting the needs of the uninsured and preserving access to essential health care services (e.g. trauma programs, obstetrical care)

The most direct way to meet the needs of the uninsured and reduce hospital losses for uncompensated care is to expand Medicaid. There would be no general fund cost to the Commonwealth through 2016 and only a modest general fund cost that would not exceed 10 percent of the total cost thereafter. DMAS estimates the following general fund costs for a Medicaid expansion (see below). It is important to note that the cost of expanding Medicaid is offset by savings from expanding coverage so that there is no net cost to the state until SFY2021 and minimal cost thereafter.

[3] The FAMIS and other smaller DMAS programs have higher federal match rates than does the Medicaid program.

Table 2: General Fund Impact of Expanding Medicaid

State Fiscal Year	General Fund Cost to State Budget	General Fund Savings to State Budget	Net (Savings)/Costs to State Budget
2017	$32,151,611	($91,323,426	($59,171,815)
2018	$162,808,760	($260,495,015)	($97,686,254)
2019	$196,758,432	($280,628,733)	($83,870,301)
2020	$259,762,871	($293,530,034)	($33,767,163)
2021	$313,346,268	($307,282,459)	$6,063,809
2022	$324,711,763	($321,565,013)	$3,146,750

Except for the state's teaching hospitals and Children's Hospital of the King's Daughters, Medicaid pays little or nothing to support the costs of treating the uninsured. Disproportionate Share Hospital (DSH) funding can be used to pay for uninsured costs, but there is no additional DSH funding available to the Commonwealth. While the most cost effective use of provider assessment funds would be to support the general fund costs of a Medicaid expansion, using a provider assessment to fund the non-federal share of increases in Medicaid rates could indirectly help meet the needs of the uninsured and preserve access to essential but less profitable health care services, such as trauma programs and obstetrical care. However, most hospitals incur losses in serving Medicaid members, and any additional payments from Medicaid not only reduces hospital Medicaid losses, but improves the hospital's overall operating margin, making it more feasible to serve the uninsured and maintain less profitable but vital services.

DMAS estimates that it could increase reimbursement to private hospitals (excluding CHKD) by almost $400 million total funds based on FY13 data. See table below. Medicaid can pay up to $114 million more for FFS up to the "Upper Payment Limit". While there is no similar Upper Payment Limit for managed care, DMAS believes that CMS would approve comparable reimbursement increases ($284 million) to hospitals through managed care capitation rate adjustments.

On average, DMAS estimates Medicaid paid about 76 percent of Medicaid inpatient and outpatient hospital allowable costs in FY13. In the current year, due to withholding of inflation updates in the intervening years, Virginia is reimbursing private hospitals approximately 71 percent of costs. VHHA's estimate in the current year is closer to 66 percent, due in large part to their reliance on different sources of hospital cost information. Regardless of which estimate is used, there is clearly a

large and growing gap between current operating payments and the costs of hospital services for private hospitals. If 100 percent of the provider assessment is used to increase Medicaid hospital payments, the net payments to hospitals (after accounting for the provider assessment) would increase Medicaid payments from 76 percent of cost to 88 percent of cost. In general, additional funding would go disproportionately to hospitals that serve a high percentage of Medicaid beneficiaries, which are the same hospitals that serve a high percentage of uninsured and furnish trauma services and obstetrical care. This would be in compliance with the federal requirement that payments sourced by provider assessment revenues be distributive.

Table 3: Payments for Private Hospitals Excluding CHKD, FY13 (in millions)

Payment Type	Total Payments	UPL (Cost)	Total Payment Minus UPL (Gap)
Inpatient FFS	$377.9	$467.5	$89.6
Outpatient FFS	$82.0	$116.5	$34.5
Inpatient MCO	$468.4	$597.8	$129.3
Outpatient MCO	$318.0	$462.7	$144.7
Total	$1,245.3	$1,644.4	$398.1

Criterion 4: Supports the indigent care and graduate medical education costs at hospitals in the Commonwealth

The report addresses how a provider assessment could support indigent care costs at hospitals in the Commonwealth in the previous section. Total payments sourced with provider assessment revenues are limited to 100 percent of costs, but some of the increase in payments could be directed to support graduate medical education costs. Most hospitals that support graduate medical education also serve a high percentage of Medicaid and uninsured and provide less profitable services. Medicaid currently pays for 40 percent of the Medicaid share of the direct costs of interns and residents and 60 percent of the Medicaid share of the indirect medical education costs. However, the Medicaid share of the hospital cost for medical education is proportional to its utilization. For most hospitals with medical education programs, Medicaid utilization is between 15 percent and 25 percent. Therefore, even if Medicaid fully funded the Medicaid share of medical education, it would only cover 15 to 25 percent of the hospital's medical education cost.

Criterion 5: Advances reforms that are consistent with the goals of improved health care access, lower overall costs and better health for Virginians

The single most effective way to improve health care access is to expand Medicaid. More funding for hospital payment rates may marginally improve access and health care for Virginians, but increasing payment rates alone will not lower overall costs or provide better health for Virginians (e.g., through the use of preventive services). Virginia must spend health care dollars more wisely. The Department of Medical Assistance Services is committed to delivery system reform and value based purchasing. DMAS is counting on hospitals as partners in this transformation. Additional reimbursement may facilitate hospital cooperation with these goals, but achieving lower overall costs and better health is a DMAS priority independent of a provider assessment.

Criterion 6: Takes into account the extent to which it provides equity in the assessment and funding distribution

The Secretary understood this statement to mean that the design of a provider assessment program should minimize “losers”. It would be perceived as ideal if each provider’s reimbursement was roughly proportional to the amount of each provider’s assessment, without directly holding providers harmless. It is probably not possible to prevent all hospitals from losing from a provider assessment program, but it is a reasonable goal to prevent all hospital systems from losing.

Other Alternatives to a Broad-Based Hospital Provider Assessment Program

In addition to the above criteria, the budget item directed the Secretary to (a) develop, as an option, a more limited program that is focused on supporting indigent care and graduate medical education costs at private teaching hospitals in the Commonwealth and (b) undertake a review of a program that would provide supplemental payments for qualifying private hospitals.

Leading up to the 2015 General Assembly, several hospital systems proposed a provider assessment option targeted at supporting indigent care and graduate medical education costs at their flagship hospitals. These hospitals asserted that their commitment to indigent care and graduate medical education is similar to the state teaching hospitals, but that state funding to these private institutions was not adequate. These proposals may have been motivated by a desire to make up for budget decisions to remove inflationary increases to Medicaid hospital rates from SFY 2009 through SFY 2016; the decision by the Commonwealth to not expand Medicaid; and, Medicare cuts by the federal

government. In the absence of a more broad-based provider assessment program that hospitals have opposed in the past, these systems proposed a limited option to increase funding to targeted hospitals. However, it appears that hospitals would now support a broad-based hospital provider assessment initiative, if there are adequate safeguards. There was no discussion in the Work Group of a more limited option applicable to select hospital systems.

In 2011, a private hospital system approached the Secretary of Health and Human Resources regarding the implementation of a supplemental payment program for private hospitals similar to programs that operate in Texas, Louisiana and a few other states. The non-federal share of the private hospital supplemental payments are financed by a complicated arrangement that uses intergovernmental transfers from public entities. Intergovernmental transfers are often used to fund the non-federal share of supplemental payments to public providers. Similar direct transfers by private hospitals are not allowed. Private hospitals, however, can address this prohibition by voluntarily taking over certain government programs. The public entities voluntarily transfer some or all the funding previously used for these governmental programs to Medicaid as the non-federal share for private hospital supplemental payments. DMAS submitted two state plans to CMS to implement a supplemental payment program for this purpose. The amendments have not yet been approved by CMS, but DMAS is continuing to work with CMS to submit a revised plan that is approvable and retroactive to October 25, 2011.

Only a portion of the hospitals have chosen to commit to this program. And it is unclear if the revenue opportunity in Virginia is as significant as it is in other states, because of the more limited scope of public hospitals in Virginia. However, the Commonwealth has been willing to pursue this in the absence of a feasible and broad-based alternative proposal, such as a hospital provider assessment program. If CMS eventually approves these State Plan Amendments, there is no reason that the Commonwealth shouldn't implement them to the extent possible, but with the understanding that they would be replaced by a broad-based hospital provider assessment when and if one is approved.

Implementation Issues

While this report does not present a specific proposal, which would be up to the Governor and the General Assembly to develop, we believe it is feasible to implement a provider assessment as early as July 1, 2016. It may take several months to obtain CMS approval, but once approved, the assessment could be retroactive to July 1. DMAS has not modeled the elements of a provider assessment program

and therefore does not have an estimate, by hospital, of the net financial impact of a provider assessment program. However, based on experience of other states, DMAS is reasonably confident that a provider assessment can be implemented in a way that benefits all hospital systems in the state. We are aware that the Virginia Hospital and Healthcare Association has contracted with consultants to develop a model. Access to this modeling effort would assist the state in evaluating an estimate by hospital of the net financial impact of a provider assessment program.

Practical issues that the budget amendment asked the Secretary to address include (a) the structure, collection process, and amount of the assessment; and, (b) the process for supplemental payments. In many states, the equivalent of the Department of Taxation administers the assessment program while, in other states, the Medicaid agency administers the assessment program. The current ICF-ID provider assessment is administered by DMAS. DMAS finalizes the assessment amount using the ICF-ID cost report. While a hospital provider assessment would be significantly more complicated, it would be possible for DMAS to administer a hospital provider assessment program by relying on the hospital cost report, given adequate administrative resources. The department would recommend that the assessment be based on hospital revenue using hospital cost reports as the bases for determining the assessment.

After conferring with the VHHA, which collected revenue information included in cost reports on all hospitals in the state in FY13, DMAS believes that the hospital revenue basis for a provider assessment is $18.1 billion for all hospitals. Most provider assessment programs only assess private acute hospitals and exclude public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, long-term acute care hospitals and critical access hospitals. The revenue basis for private acute hospitals is $14.8 billion. Using a 6 percent assessment rate on private acute hospitals, the maximum assessment revenue would be $839.6 million, which is approximately 5 percent less than DMAS' estimate in July which used Virginia Health Information (VHI) data. We attribute the difference to the probable inclusion of patient revenue for skilled nursing facilities in the VHI data. Each 0.5 percent assessment rate would raise $74.0 million. An assessment rate of 1.35 percent would raise $200 million needed to fund the non-federal share to increase hospital rates by $400 million, the maximum increase we have estimated.

Budget language appears to assume that additional reimbursement would be in the form of supplemental payments. Supplemental payments are an option, but general rate increases in

combination with supplemental payments for medical education are an alternative option. Supplemental payments may be desirable to the hospitals from the point of view of assuring hospitals that the revenue from the hospital provider assessment is being used to fund specific hospital rate increases. There is additional administrative effort required to implement supplemental payments. While supplemental payments have been incorporated into managed care capitation rates in the past, CMS appears to be uncomfortable with this approach. Proposed managed care regulations issued June 1, 2015 would "not permit the state to direct the MCO [Managed Care Organization] … to reimburse specific providers specific amounts at specified intervals." We do not believe that CMS would object to including general hospital rate increases through adjustments to the capitation rates. Capitation rate adjustments to fund higher hospital payments and contractual safeguards may be adequate to assure hospitals that the revenue from the provider assessment is being used to fund hospital rate increases. CMS is more likely to approve this approach.

RECOMMENDATIONS

Recommendation 1-That the General Assembly authorize an assessment from private acute hospitals coupled with other changes that ensures that hospitals benefit as a whole and that hospital systems have a net benefit.

Recommendation 2-That revenue from the provider assessment is used to fund the non-federal share of higher payments to hospitals up to the equivalent of the upper payment limit. The total available room is $400 million and the non-federal share of that is $200 million. In addition to across the board rate increases, some of the funding should be dedicated to increases in payments for medical education and higher payments for rural hospitals.

Recommendation 3-That the provider assessment can also be used to support expanded coverage, and to the extent they do so, the assessment should be considered for entities that stand to benefit from the newly insured.

Recommendation 4-That the General Assembly includes safeguards to ensure that a hospital provider assessment is only used for the purposes in this report, including creation of a segregated fund with limited purposes for the receipt of provider contributions and maintenance of effort provisions.

Recommendation 5-That the General Assembly and Administration engage the provider community in the development and implementation of any provider assessment program.

Attachment A
Budget Item 278.C

1. *The Secretary of Health and Human Resources shall conduct an analysis and develop a plan with options for a hospital provider assessment program, including a review of other issues deemed necessary, for consideration by the General Assembly in the 2016 Session, that: (i) complies with applicable federal law and regulations; (ii) is designed to operate in a fashion that is mutually beneficial to the Commonwealth and affected health care organizations; (iii) addresses health system challenges in meeting the needs of the uninsured and preserving access to essential health care services (e.g. trauma programs, obstetrical care) throughout the Commonwealth; (iv) supports the indigent care and graduate medical education costs at hospitals in the Commonwealth; (iv) advances reforms that are consistent with the goals of improved health care access, lower overall costs and better health for Virginians; and (v) takes into account the extent to which it provides equity in the assessment and funding distribution to affected health care organizations. In the development of this program, the Secretary's office shall be assisted by the Department of Medical Assistance Services, the Virginia Center for Healthcare Innovation, the Virginia Hospital and Healthcare Association and other affected stakeholders.*

2. *As part of the analysis and development of a plan for a hospital provider assessment program, the Secretary of Health and Human Resources shall also develop as an option a more limited program that is focused on supporting the indigent care and graduate medical education costs at private teaching hospitals in the Commonwealth.*

3. *The Secretary of Health and Human Resources shall also undertake a review of a program that would provide supplemental payments for qualifying private hospitals as provided for in the State Plan for Medical Assistance Services amendments 11-018 and 11-019 submitted to the Centers for Medicare and Medicaid Services on or about December 20, 2011.*

4. *The Secretary shall report to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2015 on the appropriate details regarding the plan and options for a hospital provider assessment program, which shall include: (i) the structure, collection process, and amount of the assessment; (ii) the process for supplemental payments; (iii) an estimate by hospital of the net financial impact of the program; and (iv) an implementation timeline. In addition, the Secretary shall include in his report details on the options and requirements of subparagraphs 2 and 3.*

5. *The Secretary may work with the appropriate federal agencies as part of the development of a plan for a program or other options developed pursuant to subparagraphs 1, 2 and 3 in order to ensure compliance with federal requirements.*

Attachment B
Advisory Work Group Members

Anna Healy James, Richmond, Policy Director, Office of the Governor

Cindi B. Jones, Richmond, Director, Department of Medical Assistance Services

Beth A. Bortz, Henrico, President and CEO, Virginia Center for Health Innovation

Anthony Keck, Bristol, TN, Senior VP and Chief Development Officer, Mountain States Health Alliance

C. Novel Martin, Roanoke, CFO and Treasurer, Medical Facilities of America

Nancy Howell Agee, Roanoke, President and CEO, Carilion Clinic

Peter Gallagher, Winchester, Senior VP and CFO, Valley Health

Debbie Burcham, Chesterfield, Executive Director, Chesterfield CSB

Matthew Turner, Richmond - VP of U.S. Employee Benefits, Genworth Financial

George Reiter, Reston, Senior VP of Total Rewards, Leidos

Sheryl Garland, Richmond, VP of Health Policy and Community Relations, VCU Health System

Massey S.J. Whorley, Richmond, Senior Policy Analyst, The Commonwealth Institute for Fiscal Analysis

Roderick Manifold, New Canton, Executive Director, Central Virginia Health Services

Linda D. Wilkinson, Richmond, CEO, Virginia Association of Free and Charitable Clinics

Kurt Hofelich, Norfolk - President, Sentara Norfolk General Hospital

Richard V. Homan, M.D., Norfolk, President and Provost, Dean of the School of Medicine, Eastern Virginia Medical School

Sterling Ransone, M.D., Deltaville, Immediate Former President, Medical Society of Virginia

James Cole, Arlington, President and CEO, Virginia Hospital Center

Roger Gunter, CEO, Virginia Medicaid Aetna

William A. Hazel, Jr., MD, Richmond, Secretary of Health and Human Resources, Commonwealth of Virginia. Ex officio

Attachment C
Meeting Dates, Agendas and Presentations

Date: Wednesday, July 8th
Time: 1:00 to 4:00 p.m.
Location: Virginia General Assembly Building, Capitol Square, 201 North 9th Street, Richmond, VA 23218. House Room D
Agenda and Presentations:
http://www.dmas.virginia.gov/Content_atchs/pr/7%208%2015%20Provider%20Assessment%20Meeting%20Materials.pdf.

Date: Wednesday, September 30th
Time: 12:30 to 3:00 p.m.
Location: Perimeter Center, 9960 Mayland Drive, Suite 201, Richmond, VA 23233. Board Room #2
Agenda and Presentations:
http://www.dmas.virginia.gov/Content_atchs/pr/PAWG%20Meeting_2%209%2030%2015%20Meeting%20Materials.pdf.

Date: Wednesday, October 28th
Time: 1:00 to 4:00 p.m.
Location: Virginia General Assembly Building, Capitol Square, 201 North 9th Street, Richmond, VA 23218. House Room D
Agenda: http://www.dmas.virginia.gov/Content_atchs/pr/10.28.15%20Agenda.pdf.
Presentations:
http://www.dmas.virginia.gov/Content_atchs/pr/10.28.15%20Meeting%20Presentations.pdf.

Date: Friday, December 4th
Time: 9:00 to 10:30 a.m.
Location: Virginia General Assembly Building, Capitol Square, 201 North 9th Street, Richmond, VA 23218. House Room D
Agenda:
http://www.dmas.virginia.gov/Content_atchs/pr/Draft%2012-4-2015%20PAWG%20Agenda.pdf

Attachment D

December 1, 2015 letter from Sean Connaughton, President and CEO of the Virginia Hospital and Healthcare Association, to Governor Terence R. McAuliffe

4200 INNSLAKE DRIVE, SUITE 203, GLEN ALLEN, VIRGINIA 23060
P.O.BOX 31394, RICHMOND, VIRGINIA 23294
(804) 965-1227 FAX (804) 965-0475

December 1, 2015

The Honorable Terence R. McAuliffe
Governor of the Commonwealth of Virginia
Patrick Henry Building
1111 E. Broad Street
Richmond, Virginia 23219

Subj: Reimbursing the Cost of Hospital and Health Care Services Provided to Virginians

Dear Governor McAuliffe:

Considerable attention has recently been focused on a financial forecast that projects Medicaid program cost increases and how this potentially impacts the state's next biennial budget. What has been largely overlooked in the resulting discussion is that the forecast actually projects a reduction in Medicaid hospital rates next year due largely to lower hospital costs per patient. This is a bright spot in an otherwise discouraging forecast.

Virginia's hospitals are excelling at patient safety and quality in addition to addressing costs. These achievements are reflected in the results of a recent hospital survey that ranked Virginia's hospitals fourth in the nation for patient safety and quality. The Commonwealth is one of a few select states to receive an overall "A" grade in that ranking.

Virginia's hospitals and health systems are clearly doing their part to lead on health care safety, quality, and cost control. However, these successes are at risk if the Commonwealth does not address reimbursement rates for medical services rendered to patients currently covered by Medicaid, as well as the increasing number of uninsured patients whose uncompensated treatment costs are often absorbed by providers.

Historically, Medicaid reimbursements to Virginia's local hospitals and health systems have fallen short of the actual cost of care. For hospitals, things have grown worse over time. In 2002, for instance, Medicaid reimbursed hospitals and health systems at 79 percent of a patient's cost of care. This rate has fallen further since then and is now down to 66 percent. No other state contractor is asked to provide key services for compensation at two-thirds of the cost, yet hospitals are consistently put in this position.

Declining reimbursement for services rendered may improve the Commonwealth's budget outlook, but it requires Virginia's hospitals and health systems to subsidize the state's share of the current Medicaid program by more than $400 million a year. Additionally, much of the more than $600 million in free or discounted care Virginia's local hospitals and health systems provide each year goes to individuals who are eligible for federal health care programs in which the Commonwealth has declined to participate. Taken together, Virginia's hospitals and health systems underwrite more than $1 billion in care for current and potential Medicaid patients.

Compounding these problems for Virginia hospitals and health systems is the simultaneous reduction in Medicare reimbursements under the Affordable Care Act (ACA), sequestration, and other recent federal budgetary actions. These reductions include steep cuts to the disproportionate share hospital program, which provides critical help to hospitals with a higher proportion of Medicare and Medicaid patients. By federal fiscal year 2022, the combined impact of these changes will mean a $1 billion per year reduction in federal funds for Virginia's hospitals and health systems.

The cumulative effect of hospitals providing steeply discounted services, coupled with Virginia's failure to take advantage of available federal resources to insure low-income working Virginians, threatens serious harm to this key sector of Virginia's economy. Virginia's local hospitals and health systems simply cannot continue to absorb these reductions while simultaneously bearing a heavy portion of the state's indigent care costs. Immediate action is needed to remediate these serious issues.

As Governor, you and the Virginia General Assembly have the opportunity in the FY 2017 – 2018 biennial budget to address the financial pain inflicted on Virginia's hospitals and health systems, help our fellow citizens access vital health care services, and protect and enhance Virginia's economy. We recognize that addressing these complex issues is not without challenges and that finding solutions will not be easy. Even so, we eagerly seek the opportunity to engage with you and the legislature in pursuit of meaningful, productive, and pragmatic solutions.

One option to alleviate these challenges is for Virginia to avail itself to the fullest extent possible of existing federal programs. This includes the current Medicaid program, as well as provisions under the law through which the uninsured can obtain coverage.

While the simplest way to fully implement these federal programs is through the General Fund, we are cognizant that this path may not be available due to the increased costs of providing care to the elderly and disabled under the current Medicaid program. An alternative method that most states currently use involves having hospitals and other providers finance a portion of the required state match to access all available federal funds. This mechanism is being evaluated by a legislatively-created study group operating under the auspices of Virginia's Secretary of Health and Human Resources, Dr. William A. Hazel, Jr. The study group's recommendations will be submitted to the General Assembly this month.

The Honorable Terence R. McAuliffe
December 1, 2015
Page 3

The Virginia Hospital & Healthcare Association (VHHA) believes the most appropriate way to pay for care accessed through public health care programs is with General Funds. We are, however, realists. As a consequence, we are fully prepared to engage in a process to develop an appropriate mechanism for Virginia's local hospitals and health systems to contribute the funds necessary to meet federal matching requirements and draw down additional federal funding to address the challenges outlined above.

Arriving at this moment did not come easily. This Association has traditionally opposed provider contributions. However, the mounting financial burden of diminished reimbursements, increased uncompensated care, and federal funding cuts necessitate the exploration of even the previously unthinkable. The status quo is simply unsustainable.

Governor, if your Administration and the Virginia General Assembly are willing to pursue this alternative, development of a plan that embodies the following six principles is essential to our members:

1. To the greatest extent possible, the administration and implementation of the provider contribution program be placed in the hands of the private sector.
2. The contributions must be at the minimum amount necessary to fund the state match for addressing payment shortfalls, strengthening rural hospitals, and providing additional funding for Graduate Medical Education (GME).
3. The funds contributed by Virginia's local hospitals and health systems must be segregated from the state's General Fund and not be subject to any diversion of funds by either the Administration or the General Assembly.
4. The Appropriations Act and implementing legislation authorizing acceptance of the contributions, must contain a provision that the program is void if hospitals' contributions are ever used for a purpose other than the state match for payment shortfalls, assisting rural hospitals, or GME. We believe that if such an event were to occur, the contribution would clearly become a tax on health care services.
5. The Appropriations Act and implementing legislation must contain language requiring a maintenance of effort for existing General Fund revenues dedicated to the current Medicaid program, including a provision specifying that subsequent rates shall not be lower than those in effect on December 31, 2015. Further, language is also necessary to acknowledge that contributions are conditioned on the federal and state governments continuing to meet currently stipulated Medicaid match levels.
6. Any savings generated due to contributions offsetting costs within the existing Medicaid program and/or General Fund should be set aside to assist financially struggling rural hospitals.

The Honorable Terence R. McAuliffe
December 1, 2015
Page 4

Having assurances regarding the six aforementioned conditions as final budgetary and legislative provisions is critically important to Virginia's local hospitals and health systems. We need such assurances in order to support a policy position that our members have strenuously opposed in the past. It must be understood in deliberations regarding this concept, as well as in any resulting codifying language, that diversion of funds contributed under this proposal for other purposes clearly converts our potential contribution into a tax.

We believe that a proposal that adheres to the above principles is our mutual opportunity to relieve financial pressure on both the state budget and Virginia's local hospitals and health systems, improve access to care, lower overall health care costs, and enhance the health status of all Virginians. We look forward to working with you and the Virginia General Assembly in making it a reality.

Sincerely,

Sean T. Connaughton
President & Chief Executive Officer
Virginia Hospital & Healthcare Association

cc: Members, Virginia General Assembly
The Honorable William Hazel, Secretary of Health and Human Resources
Anna Healy James, Chair, Provider Assessment Work Group
VHHA Board of Directors