JOINT COMMISSION ON HEALTH CARE

INFORMATION BRIEF: IMPACT OF CHANGES TO THE MEDICAID PROGRAM REQUIRED BY H.R. 1 (2025) ON VIRGINIA'S HOSPITALS

REPORT TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT #840

COMMONWEALTH OF VIRGINIA
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2026

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Information Brief: Impact of Changes to the Medicaid Program Required by H.R. 1 (2025) on Virginia's Hospitals

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Information Brief: Impact of Changes to the Medicaid Program Required by H.R. 1 (2025) on Virginia's Hospitals

Executive Summary

Medicaid is a federal-state partnership. Federal rules establish the framework of the Medicaid program and states must comply with federal requirements to receive federal funding. State Medicaid programs are an important source of funding for health care providers, particularly rural and safety net hospitals. H.R. 1, Pub. L. No. 119-21, enacted July 4, 2025, makes substantial changes to rules governing the financing and administration of Medicaid that are anticipated to reduce the revenue available to state Medicaid programs and, as a result, acute care hospitals. The law caps the amount of state directed payments states may require managed care organizations pay to certain health care providers, including hospitals, for certain services. The law also imposes new restrictions on health care provider taxes, one of the mechanisms states may use to finance the nonfederal share of Medicaid expenditures, reducing the maximum amount of permissible taxes from six percent of net patient revenue to 3.5 percent over a period of five fiscal years, among other changes.

In Virginia, these changes are expected to have significant negative impacts on hospitals. In state fiscal year 2026, state directed payments represented approximately 20 percent of participating hospitals' net patient revenue statewide and as much as 43 percent for certain rural, safety-net, and economically distressed hospitals. Because the health care provider taxes that fund state directed payments (SDPs) are measured as a share of net patient revenue, declining hospital revenue and a declining federal threshold on provider taxes that reduces the amount the state may collect through the health care provider tax are likely to compound, further limiting the funds available to support hospital payments over time. The full magnitude of these reductions will depend on federal regulations that have not been finalized and that, as proposed, would extend beyond the statutory provisions.

H.R. 1 also establishes new eligibility and administrative requirements, including a community engagement requirement and more frequent eligibility renewals for adults in the Medicaid expansion population, that are anticipated to reduce Medicaid enrollment in the Commonwealth. Published estimates project substantial reductions in Virginia's Medicaid enrollment over the next decade, although the magnitude of coverage loss will depend on how the requirements are implemented and how successfully eligible individuals complete the required processes. As coverage declines, hospitals are likely to

experience increased self-pay volume and uncompensated care, with the greatest effects anticipated among hospitals with high Medicaid utilization and limited financial capacity.

H.R. 1 created the Rural Health Transformation Program (RHTP), through which Virginia received $189.5 million for the first year of a five-year program. The RHTP will support investments in rural health care access, workforce, technology, and prevention. However, the RHTP's permitted uses, funding structure, and rural focus preclude it from replacing the Medicaid revenue hospitals are anticipated to lose.

Because most of H.R. 1's major provisions take effect between October 2026 and October 2031, the effects described in this report are anticipated rather than observed.

Information Brief: Impact of Changes to the Medicaid Program Required by H.R. 1 (2025) on Virginia's Hospitals

Medicaid is a federal-state partnership. Federal rules establish the framework of the Medicaid program and states must comply with federal requirements to receive federal funding. State Medicaid programs finance a large share of the health care services delivered in acute care hospitals. For hospitals with high Medicaid volume, particularly rural and safety-net hospitals, Medicaid payments can determine which services they are able to sustain. H.R. 1, Pub. L. No. 119-21, enacted July 4, 2025, changes rules governing two mechanisms that states use to pay for services provided to Medicaid enrollees. H.R. 1 also changes rules governing who qualifies for Medicaid coverage and what enrollees must do to keep their coverage. These changes are expected to have significant negative impacts on hospitals in Virginia.

H.R. 1 also created the Rural Health Transformation Program (RHTP), which appropriates $50 billion nationally over five years for rural health. The RHTP was added to H.R. 1 in the context of concerns about how the law's changes to the Medicaid program would affect rural hospitals, and contemporaneous descriptions of the legislation characterized the RHTP as additional support for those hospitals. However, while the RHTP provides targeted investments to strengthen rural healthcare systems, expand access to care, and help providers and communities adapt to the potential impacts of broader federal healthcare policy changes under H.R. 1, it does not replace the Medicaid funding reductions anticipated to occur as a result of enactment of H.R. 1.

Pursuant to the request of the Joint Commission on Health Care (JCHC) in June 2026, this report provides information about the impact of changes to the Medicaid program required by H.R. 1 on Virginia's acute care hospitals, and the extent to which the RHTP addresses those effects. Because most of the law's major provisions take effect between October 2026 and October 2031, the findings described in this report are anticipated rather than observed effects.

Medicaid is a federal-state partnership that provides access to health care for individuals and funding for health care providers

State Medicaid programs operate within a framework of federal statutes and regulations and receive federal matching funds to augment state funding. Medicaid programs provide

health care access for eligible individuals and are a significant source of revenue for hospitals and other health care providers that serve program enrollees.

State Medicaid programs must follow federal rules to receive federal matching funds

Federal law and regulations create the framework of the Medicaid program while granting states flexibility to design programs that meet their unique needs and goals, as long as state programs operate within federal limits. Federal statutes enacted by Congress and federal rules administered by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services establish minimum requirements for state Medicaid programs. Federal rules specify mandatory and optional eligibility criteria for different groups of individuals; enrollment procedures for individuals seeking health care coverage through state Medicaid programs; services that must be covered by state programs and those that states may choose to cover; requirements for provider participation and payment; administrative structures and processes; data collection and reporting requirements; and various other aspects of state programs. States must designate an agency to administer their Medicaid programs and develop a Medicaid State Plan that describes the nature and scope of their programs and provide assurance that the program will be administered consistently with federal requirements.[1] In Virginia, the Medicaid program is administered by the Department of Medical Assistance Services (DMAS). A state's Medicaid State Plan must be submitted to and approved by CMS before the state may implement a Medicaid program.

State Medicaid programs are jointly financed by the federal government and the states, and federal participation is conditioned on compliance with federal requirements. Once approved by CMS, a state's Medicaid State Plan becomes the basis for federal financial participation (FFP) in the state program.[2] States pay a share of the cost of the program described in the plan, known as the nonfederal share, and the federal government matches that spending. The rate at which the federal government matches state spending, known as the Federal Medical Assistance Percentage (FMAP), varies by type of state and type of expenditure.[3] In Virginia, Medicaid services are matched at rates ranging from approximately 50 to 90 percent.[4]

Federal rules specify how states may raise funds to pay the nonfederal share of Medicaid program costs. At least 40 percent of the nonfederal share must be financed by the state, while up to 60 percent may come from local governments.[5] Funds for the nonfederal share may be collected through various mechanisms, including general fund appropriations, health care-related taxes (commonly called health care provider taxes), health care provider-related donations, intergovernmental transfers, and certified public expenditures, subject to federal restrictions.[6]

The Commonwealth has enacted two health care provider taxes to pay a portion of the nonfederal share of Virginia's Medicaid program costs. The Provider Coverage Assessment

finances the nonfederal share of the cost of expanded Medicaid coverage under the PPACA.[7] The Provider Payment Rate Assessment supports the nonfederal share of enhanced payments for private acute care hospitals that provide health care services for Medicaid program enrollees.[8] The Commonwealth collects the taxes, uses the funds collected to finance the nonfederal share of the specified Medicaid expenditures, draws federal matching funds, and distributes the combined amounts to providers through separate payment mechanisms.

Federal rules also provide states with flexibility regarding selection of provider payment and delivery systems. States may choose to offer Medicaid benefits through fee-for-service (FFS) models or managed care arrangements, or a combination of both. When states select FFS models, providers bill the state agency, and the state agency pays providers directly for each covered service provided to a Medicaid program enrollee. Under managed care arrangements, state agencies contract with managed care organizations (MCOs) to administer health care benefits for Medicaid enrollees and pay the MCOs a fixed monthly amount per enrollee, called a capitation payment, to cover the cost of services provided. Health care providers bill the MCOs for services provided to Medicaid enrollees covered by plans administered by the MCOs, and the MCOs pay hospitals and other health care providers for covered services delivered to Medicaid program enrollees using funds from capitated payments.[9] Virginia historically provided services to Medicaid enrollees through FFS arrangements but began implementing risk-based managed care in 1996. As of June 2024, more than 90 percent of Virginia's Medicaid program enrollees were enrolled in managed care.[10] FFS remains in place for populations and services that managed care does not cover.[11]

Medicaid payments support hospital finances through base and supplemental or directed payments

State Medicaid programs fund two types of payments to health care providers: (i) base payments that reimburse for services delivered to eligible individuals, and (ii) supplemental or directed payments provided for a specified purpose. Federal rules afford states some flexibility around the amount of provider payments and the design of supplemental or directed payments, though states must comply with statutory and regulatory criteria.

State Medicaid programs provide base payments to reimburse health care providers for services delivered to eligible individuals

Base payments that health care providers receive as reimbursement for covered services provided to eligible Medicaid program enrollees differ among states and payment models. Each state sets its own reimbursement rates. When a state implements an FFS payment model, the state must submit its FFS methodology to CMS as part of its Medicaid State Plan. CMS will review the FFS methodology to determine: (i) whether the proposed methodology

is sufficiently consistent with statutory goals of efficiency, economy, quality, and access; and (ii) whether the payment is sufficient to enlist enough providers so that services are available to Medicaid-enrolled patients at least to the extent that they are available to the general population in the same geographic area.[12] On average, FFS base payment rates are below hospitals' costs of providing services to Medicaid enrollees and are below Medicare payment rates for comparable services.[13] When a state implements a managed care payment model, managed care base payment rates are negotiated between individual providers and MCOs. MCOs have flexibility to negotiate rates but must ensure that their provider networks meet network adequacy requirements.[14]

States can provide additional payment amounts to supplement base payments for health care providers

Federal rules permit state Medicaid programs to supplement low base payments with additional, targeted payments to health care providers who provide health care services to Medicaid program enrollees, including:

- Disproportionate Share Hospital payments to hospitals that serve a high share of Medicaid and low-income patients, and that cover, among other things, the difference between the hospital's cost of serving Medicaid-enrolled patients and the payment it receives for those services.[15]
- Upper Payment Limit payments to health care providers to cover the difference between FFS base payments and the amount that Medicare would have paid for the same service.[16]
- Uncompensated Care Pools payments implemented pursuant to § 1115 waivers to supplement base Medicaid reimbursement rates in states that implemented managed care and were unable to continue Upper Payment Limit payments in the absence of FFS base payments against which to measure supplemental payments.[17]
- State Directed Payments that increase capitation payments to MCOs and require MCOs to provide additional payments to a defined group of providers to increase base payment rates, subject to federal approval.[18]

For Virginia's Medicaid program, the Commonwealth has implemented additional payments to supplement base payment amounts. Virginia makes Disproportionate Share Hospital payments to qualifying hospitals and supplemental payments up to the applicable Upper Payment Limits to private acute care hospitals through FFS, and it uses state directed payments to require MCOs to make additional payments to hospitals for services delivered through managed care.[19] CMS has approved 10 state directed payment arrangements for Virginia for the rating period beginning July 1, 2026.[20] Virginia's approved arrangements cover inpatient and outpatient hospital services, practitioner services at academic medical centers, nursing facility services, and other provider services. The largest arrangement, covering inpatient and outpatient hospital services, was approved in July 2026 with up to

$4.99 billion in total computable funding, including approximately $1.54 billion in nonfederal funds.[21]

Medicaid provides health care coverage to approximately 1.5 million Virginians

An individual's eligibility for the Medicaid program is typically based on both financial and non-financial criteria. Federal law requires state Medicaid programs to provide coverage to some groups of individuals and allows states the option to provide coverage to other groups. Mandatory groups, those traditionally covered by state Medicaid programs, include low-income children and their parents, pregnant individuals, individuals with disabilities, and individuals age 65 and older. States may also choose to cover other categories of individuals consistent with federal rules.

In 2010, Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (PPACA), expanding the Medicaid program to provide coverage for adults with household incomes at or below 138 percent of the federal poverty level who were not otherwise eligible for Medicaid. The Supreme Court's subsequent decision in *National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012),* made expansion to this group of adults, generally known as the Medicaid expansion population, optional for states.[22] As of October 2026, 40 states and the District of Columbia have expanded their Medicaid programs consistent with the provisions of the PPACA, as amended.[23] Virginia expanded its Medicaid program effective January 1, 2019.

As of October 1, 2026, approximately 1.54 million individuals were enrolled in Virginia's Medicaid program. Approximately 976,000 low-income children and their parents, pregnant individuals, older adults, and people with disabilities, who meet income and categorical criteria set in federal and state law are enrolled through Virginia's traditional Medicaid program. Approximately 566,000 Virginians, or more than one-third of all individuals enrolled in Virginia's Medicaid program, were enrolled through Medicaid expansion, including approximately 49,000 who receive a limited benefit, such as coverage of emergency services only.[24] Medicaid enrollment has declined in each of the past several months and is approximately 215,000 lower than in January 2025.[25]

H.R. 1 limits two mechanisms states may use to fund hospitals that provide services to Medicaid enrollees

H.R. 1 restricts both the state directed payments that determine what MCOs pay hospitals and the health care provider taxes that help generate funding for some portions of the nonfederal share of state Medicaid program financing. The result is less funding available to states for Medicaid programs and health care providers, including hospitals, that provide services to Medicaid program enrollees. In Virginia, changes to state directed payments and health care provider taxes required by H.R. 1 are anticipated to have significant, negative impacts on revenues available to the state to support the nonfederal share of funding for

portions of the Medicaid program and on hospitals that provide services to Medicaid program enrollees.

H.R. 1 caps the payment rate on state directed payments, reducing the amount states may require MCOs to pay for certain health care services

H.R. 1 limits the amount states may require MCOs to pay health care providers for certain services provided to Medicaid enrollees. New state directed payments must comply with the limits immediately, while existing payments above the limits may be grandfathered and reduced gradually over time. CMS's proposed rule implementing changes to state directed payments has not been finalized, so the full impact cannot be estimated at this time. The scope of the proposed rule is broader than the language of H.R. 1, and if the proposed rule is enacted as drafted, the impact may be further reaching than the impacts anticipated under preliminary analysis of the language of H.R. 1.

H.R. 1 limits the amount that states may require MCOs to pay health care providers for certain health care services below previously permitted levels

Before enactment of H.R. 1, federal Medicaid managed care rules permitted state directed payments for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center to be set as high as the average commercial rate, meaning what private insurers pay, subject to federal requirements and approval; federal rules did not set a comparable total payment rate limit for state directed payments for other services.[26] Because commercial payment rates are generally higher than Medicaid base payment rates, state directed payments can increase total provider payments above base reimbursement. H.R. 1 replaces the average commercial rate benchmark with a Medicare benchmark.[27] Beginning with rating periods that start on or after July 4, 2025, H.R. 1 limits the total payment rate for state directed payments for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center to 100 percent of the applicable Medicare payment rate in states that expanded their Medicaid programs and 110 percent in states that have not expanded their Medicaid programs.[28] Where no Medicare rate exists for a service, the limit is the rate under the state's Medicaid State Plan or waiver.

While all new state directed payments approved by CMS after July 4, 2025, are subject to the limits imposed by H.R. 1, H.R. 1 does not require all existing state directed payments that exceed newly established limits to immediately come into compliance. Rather, certain arrangements for inpatient hospital, outpatient hospital, nursing facility, and academic medical center qualified practitioner services that exceed the new statutory limits may qualify for temporary grandfathering that allows for a gradual reduction of payment amounts over time until the payments have come into compliance with the new statutory limits. Beginning with rating periods on or after January 1, 2028, the total payment rate for

grandfathered arrangements must be reduced by 10 percentage points annually until it reaches the applicable statutory limit.[29] Reductions to state directed payments in Virginia resulting from changes required by H.R. 1 are expected to begin on July 1, 2028.[30]

To qualify for grandfathering, a state directed payment must meet both a 180-day rating-period requirement, meaning that at least one day in the arrangement's rating period was included in the 180-business-day period before or after July 4, 2025, and at least one of the following status criteria related to preprints, the submissions states provide to CMS to request approval of a state directed payment arrangement:

- A previously approved arrangement, where federal approval was received, or for which the state made a qualifying good-faith effort to obtain approval, before May 1, 2025;
- A rural hospital arrangement that met the applicable approval or good-faith-effort criteria before July 4, 2025; or
- An arrangement for which a completed preprint was submitted to CMS before July 4, 2025.

A state may not increase a grandfathered state directed payment's total dollar amount after approval for grandfathering has been granted.

Limits on state directed payments required by H.R. 1 will reduce the amount of additional funding states can direct to health care providers, including hospitals, through MCOs. The magnitude and timing of the reductions will depend on the details of the arrangements subject to the limits and applicable grandfathering provisions.

Scope of the proposed rule implementing changes to state directed payments required by H.R. 1 may result in more far-reaching impacts for health care providers than previously anticipated

The federal rule that will implement changes to state directed payments required by H.R. 1 is not yet final. CMS published a proposed rule on May 22, 2026, that, stakeholders note, appears to be broader than the provisions of H.R. 1 in two ways. First, CMS proposes to apply the 10-percentage-point phase-down for grandfathered state directed payments to the total dollar amount of each grandfathered arrangement rather than to its payment rate, and to measure each annual reduction against the original amount rather than compounding the reductions. In practice, each year's reduction would equal 10 percent of the original grandfathered dollar amount. Stakeholders suggest that the statute instead requires the payment rate to fall by 10 percentage points relative to Medicare each year.[31] Application of the language of the proposed rule would, stakeholders claim, result in a faster phase-down of the total amount of state directed payments and more immediate impacts on health care providers who depend on state directed payments.

Second, CMS proposes to extend the Medicare-based payment limit to all state directed payments for all services, rather than just state directed payments for inpatient hospital

services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center, beginning with rating periods on or after January 1, 2029.[32] The extension would bring more services within the scope of the limit, further limiting the ability of states to direct funds to health care providers for services provided to Medicaid enrollees.

Stakeholders in Virginia, including DMAS, the Secretary of Health and Human Resources, the Virginia Hospital & Healthcare Association (VHHA), and individual Virginia hospitals have submitted comments to CMS describing the proposed rule as exceeding the statutory text. As of October 2026, the proposed rule had not been finalized.[33]

H.R. 1 restricts health care provider taxes that states may use to generate a portion of the nonfederal share of funding for Medicaid programs

Federal rules permit states to raise funds to pay a portion of the nonfederal share of Medicaid program spending through health care provider taxes, provided such taxes comply with federal rules. H.R. 1 makes several changes to rules governing health care provider taxes, eliminating exceptions to requirements that such taxes be broad-based and uniform, and lowering the ceiling on how much revenue a state may raise from health care provider taxes. These changes reduce the amount of funding states may raise for the nonfederal share of the spending of Medicaid programs. In Virginia, which has enacted two health care provider taxes, the changes required by H.R. 1 may reduce funding available to pay the nonfederal share of the spending of expanded Medicaid and enhanced payments to hospitals.

Federal rules establish criteria for permissible health care provider taxes

States may raise funds to pay the nonfederal share of Medicaid program spending through various mechanisms, including health care provider taxes, provided such taxes comply with federal requirements.[34] Federal rules permit states to impose health care provider taxes on many different classes of health care services and providers to fund the nonfederal share of state Medicaid program spending.[35] Health care provider taxes must be broad-based, apply uniformly to each class of services and providers to which they apply, and not be subject to hold-harmless arrangements in which collected taxes are returned to the taxpayer, either directly or indirectly.[36] If a state collects revenue from a health care provider tax that does not meet these requirements, the federal government may reduce the state's FFP by the amount of that revenue.[37]

H.R. 1 eliminates an exception to the requirement that health care provider taxes must be broad-based and uniform

Prior to enactment of H.R. 1, CMS was authorized to waive provisions requiring health care provider taxes to be broad-based or uniform if a state could demonstrate that the proposed health care provider tax was "generally redistributive." This means the proposed tax should

spread the tax burden broadly across the class of health care services or providers to which it applied rather than concentrating it on services or providers who receive the money back through Medicaid payments. H.R. 1 provides that certain structures no longer qualify as "generally redistributive," including those that impose lower rates on providers with relatively lower Medicaid volume or higher rates on Medicaid taxable units than on non-Medicaid taxable units.[38] The provision took effect upon enactment of H.R. 1, although the U.S. Secretary of Health and Human Services may establish a transition period of up to three fiscal years for implementation. CMS published a final rule addressing tax structures that are not generally redistributive on February 2, 2026, effective April 3, 2026, which applies the same standard H.R. 1 outlines through regulation. Virginia does not appear to be directly affected; national analyses identified seven states (California, Illinois, Massachusetts, Michigan, New York, Ohio, and West Virginia) with taxes structured in the ways the provision prohibits.[39] Virginia's Provider Payment Rate Assessment does operate under a CMS tax waiver, submitted on September 30, 2025, and approved by CMS in July 2026. The approval states that the assessment satisfies the tests for a tax to be treated as existing on July 4, 2025.[40]

H.R. 1 changes the tests used to determine whether a health care provider tax constitutes an impermissible hold-harmless arrangement

CMS may apply different tests to determine whether a health care provider tax constitutes an impermissible hold-harmless arrangement. When determining whether an indirect hold-harmless arrangement exists, CMS will apply a two-part test. The first part considers the amount of revenue earned by the state from health care provider taxes imposed on a class of health care services or providers. CMS will determine whether state revenue from a health care provider tax exceeds the "safe harbor threshold" established in federal rules, set at six percent of the net patient revenue attributable to the taxed class prior to enactment of H.R. 1. Health care provider taxes yielding amounts less than the threshold are generally approved by CMS while health care provider taxes producing amounts greater than the threshold would, historically, be evaluated under the second prong of the indirect hold-harmless test, the "75/75 test." If CMS found that 75 percent of taxpayers receive 75 percent or more of their total tax payment amount back in enhanced Medicaid payments or other state payments, in aggregate, the health care provider tax would be deemed an impermissible indirect hold-harmless arrangement.[41]

H.R. 1 changes the maximum amount of the safe harbor threshold for the indirect hold-harmless test. Effective October 1, 2026, H.R. 1 caps the safe harbor threshold for all health care provider taxes at the amount that was in effect on July 4, 2025. For states that had not expanded their Medicaid programs as of July 4, 2025, the threshold remains at this level. For states that expanded their Medicaid programs prior to July 4, 2025, including Virginia, H.R. 1 phases down the safe harbor threshold beginning in federal fiscal year (FFY) 2028. Effective October 1, 2027, the threshold is reduced to 5.5 percent of the net patient revenue attributable to the taxed class of health care services or providers. The threshold is reduced

by an additional 0.5 percentage points each year thereafter until it reaches 3.5 percent in FFY 2032. If a specific health care provider tax rate is below the currently applicable adjusted threshold, the rate that was in effect on July 4, 2025, will continue to apply until the adjusted safe harbor rate is reduced below that rate, at which time the adjusted safe harbor rate will apply.

Virginia's two hospital assessments, levied on private acute care hospitals in the Commonwealth, earn an amount equal to approximately 5.96 percent of hospitals' net patient revenues, just within the current 6 percent safe harbor threshold.[42] VHHA reports that approximately 65 private acute care hospitals are subject to the Provider Coverage Assessment, contributing approximately 2.46 percentage points of the six percent threshold and funding more than $765 million of the state's nonfederal share of the cost of Medicaid expansion in state fiscal year 2027. Payments required by the Provider Payment Rate Assessment, which fund the nonfederal share of private hospital enhanced payments including state directed payments, account for another 3.5 percentage points of the six percent threshold. Currently, Virginia's health care provider tax revenues fall below the safe harbor threshold. However, if collections continue at current levels, collections will exceed the 5.5 percent threshold that takes effect on October 1, 2027.[43] In that case, Virginia would be required to reduce the amount collected through health care provider taxes to fall below the safe harbor threshold.

A proposed rule published July 23, 2026, to implement the changes to safe harbor threshold would also eliminate the 75/75 test beginning October 1, 2026, leaving the safe harbor threshold as the only test for identifying impermissible indirect hold-harmless arrangements.[44] As of October 2026, the proposed rule had not been finalized.

H.R. 1 also effectively prohibits states from imposing new health care provider taxes on any class of health care services or providers that the state was not taxing on July 4, 2025, because the threshold for such a class is zero, and it bars states from raising existing taxes above the share of net patient revenue they represented on July 4, 2025.[45]

In Virginia, changes to state directed payments and health care provider taxes required by H.R. 1 will likely have compounding effects

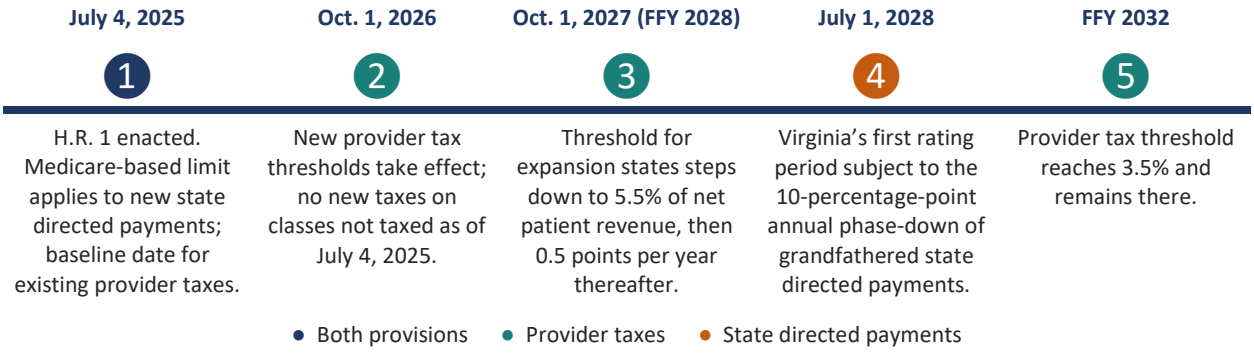
Changes to rules governing state directed payments and health care provider taxes required by H.R. 1 are expected to have short- and long-term consequences for hospitals that provide services to Medicaid enrollees in Virginia, and the consequences of changes will compound over time. In the short term, caps on state directed payments will limit the reimbursements hospitals receive from MCOs for services provided to Medicaid enrollees, reducing hospital revenues. In the long term, limits on the revenue states may raise through health care provider taxes may reduce the funds available to pay the nonfederal share of state directed payments.

The interaction between the two sets of changes creates a long-term challenge for Virginia. The nonfederal share of funding for state directed payments to hospitals serving Medicaid

enrollees in Virginia is collected through the Provider Payment Rate Assessment, a health care provider tax. The Assessment is calculated as a percentage of each subject hospital's net patient revenue. If hospital revenues decline, in part due to reductions in state directed payments, the amount of revenue available to assess may also decline. At the same time, H.R. 1 gradually reduces the amount Virginia may collect through health care provider taxes while remaining within the federal safe harbor threshold for the indirect hold-harmless test. In other words, Virginia could face two constraints: a smaller amount of hospital revenue on which to base the Assessment and a lower federal limit on the amount it may collect. Together, these changes could reduce the funding available through the Assessment to support the nonfederal share of state directed payments. The extent of this potential reduction cannot be reliably predicted at this time. Reduced funding for state directed payments could lead to further payment reductions, which could, in turn, contribute to further declines in hospital revenue.

Phased implementation of changes to state directed payments and health care provider taxes means that hospitals will begin to see impacts nearly immediately upon enactment of H.R. 1, and also that the full impact of implementation will not be understood for many years. New state directed payments will be subject to the new limits for rating periods beginning on or after enactment on July 4, 2025 (FIGURE 1). Provisions requiring gradual phase-down of payments subject to grandfathering provide some relief to hospitals but ongoing uncertainty limits hospitals' ability to plan. Pending reductions to existing payments, regardless of the exact nature of the processes and mechanisms by which the reductions occur, are likely to have a significant impact on hospitals as they begin to take effect in 2028. The gradual phase-down of the limits on the amount of revenues states may raise through health care provider taxes, beginning in October 2027 and continuing through FFY 2032, will have longer-term impacts on funding state directed payments when the cap limits the total amount available to support state directed payments to hospitals.[46]

FIGURE 1. When the H.R. 1 financing provisions take effect



CMS rules implementing both provisions were proposed, not final, as of October 2026. The proposed state directed payment rule would also extend the Medicare-based limit to all services for rating periods beginning on or after January 1, 2029.

SOURCE: Pub. L. No. 119-21, §§ 71115–71117; CMS Informational Bulletin (Nov. 18, 2025); CMS Dear Colleague letters (Nov. 14, 2025; Feb. 2, 2026); 91 Fed. Reg. 30400 (proposed May 22, 2026); 91 Fed. Reg. 46562 (proposed July 23, 2026); Office of the Secretary of Health and Human Resources, Keep Virginia Covered: H.R. 1 Briefing (Sept. 23, 2026).

Virginia's hospitals anticipate significant, negative impacts due to changes to state directed payments and health care provider taxes required by H.R. 1

Virginia hospitals project material revenue reductions from H.R. 1 changes to Medicaid, with the largest effects concentrated in the systems carrying the most Medicaid volume. To inform this study, JCHC requested comments from VHHA and from Virginia's acute care hospitals and health systems on the anticipated financial and operational effects of the law. Twelve comment letters were received, from VHHA and from eleven hospitals and health systems representing each region of the Commonwealth (see APPENDIX 1 for detailed methodology, APPENDIX 2 for the VHHA comment letter, and APPENDIX 3 for hospital and health system comment letters).[47]

The letters describe how much of hospital revenue state directed payments represent. Before state directed payments and other supplemental payments, Virginia hospitals receive approximately 78 cents for every dollar they spend caring for Medicaid patients. In state fiscal year 2026, state directed payments represented approximately 20 percent of participating hospitals' net patient revenue statewide, approximately 23 percent among participating rural hospitals, and as much as 43 percent for certain rural, safety-net, and economically distressed hospitals.[48] One Virginia hospital's comments to CMS put the statewide figure at approximately 16 percent of total hospital revenue and up to 34 percent for rural and safety-net hospitals with high Medicaid utilization, and note that Virginia's state directed payment program supports approximately 1.7 million Medicaid enrollees annually.[49] The two sets of figures use different denominators, but both indicate that a substantial share of hospital revenue is exposed to the payment limit.

Hospitals and health systems uniformly anticipate substantial Medicaid revenue reductions, and the reported range is wide. Respondents attributed the anticipated losses to changes in state directed payments, health care provider taxes, and related Medicaid financing provisions, with estimates differing according to system size, Medicaid utilization, and payment arrangements. Among respondents that quantified an annual effect:

- Sentara estimates an annual impact of approximately $700 million at full implementation, which it states could eliminate the $400 million to $700 million in annual operating margin generated by its acute care operations, and projects that Medicaid reimbursement rates could decline by 40 percent as payment moves toward Medicare levels.[50]
- Inova projects a net negative impact of at least $450 million once the law is fully implemented, measured in 2026 dollars.[51]
- Riverside Health estimates that H.R. 1 and related federal changes could reduce annual federal funding to the system by at least $200 million beginning in late 2027.[52]
- Carilion Clinic projects a reduction in state directed payments of at least 50 percent annually, approximately $140 million, and estimates that each one percentage point of payer mix moving from Medicaid coverage to uninsured status would produce a negative financial effect of approximately $5.3 million systemwide.[53]
- Valley Health reports that H.R. 1 will reduce its funding by more than $80 million annually.[54]
- Augusta Health projects that the combined effects will reduce operating performance by approximately $40 million or more annually by 2034, and that its state directed payment revenue would fall from $72.3 million in 2025 to $4.46 million in 2036 if the proposed federal rule is finalized as written.[55]
- VCU Health estimates that the statutory changes will reduce payments under the state directed payment for physicians affiliated with its academic medical center by $5.1 million in fiscal year 2027, $17.7 million in fiscal year 2028, and $29.4 million in fiscal year 2029, with reductions continuing for seven additional years.[56]
- Children's Hospital of The King's Daughters reports that the proposed federal rule, rather than the statute, would reduce its state directed payments for physician services by $8 million and its fee-for-service supplemental payments by $2.15 million, leaving approximately $3 million and $150,000 respectively.[57]

Financial losses of this magnitude cannot be absorbed indefinitely through operational efficiencies alone. Hospitals facing sustained negative margins may be forced to reduce staffing, delay investments, consolidate services, or discontinue programs that operate at a financial loss. Essential services such as obstetrics, behavioral health, and emergency care may be particularly vulnerable, especially in rural and underserved communities.

VHHA estimates that the health care provider tax and state directed payment provisions together would reduce hospital funding by approximately $34.7 billion over the decade

from 2027 through 2036.[58] VHHA also modeled one implementation scenario, using 2024 Virginia Health Information financial data, to illustrate potential magnitude rather than to forecast outcomes. Under the modeled conditions, 57 of the 71 Virginia hospitals participating in the state directed payment program, approximately 80 percent, would have negative operating margins by 2037.[59]

Respondents also drew a consistent distinction between the statutory changes included in H.R. 1 and the rules implementing those statutory changes. The Congressional Budget Office scored the state directed payment provision of H.R. 1 at approximately $149 billion in federal savings over ten years, while CMS projects that its proposed rule would reduce federal Medicaid spending by approximately $510 billion from 2026 through 2035, and total federal and state Medicaid spending by $774.8 billion. The Congressional Budget Office scored the health care provider tax provision at approximately $191 billion in reduced federal Medicaid payments to states, while CMS estimates that the health care provider tax provisions, as implemented through its proposed rule, would reduce federal Medicaid spending by approximately $246 billion. Hospitals cite the gap between those figures as evidence that the proposed rules reach beyond what Congress enacted and that, if finalized as proposed, the rules would reduce Medicaid funding substantially more than the statute alone.[60]

These reductions would fall on payment levels that hospitals already describe as below cost. Reducing those payments affects operating margins and the ability to sustain services, particularly at hospitals with high Medicaid utilization or limited financial capacity. Respondents described a common set of operational responses: modeling multiple implementation scenarios, expanding eligibility and financial assistance staffing, consolidating operations, renegotiating supply contracts, and reassessing workforce and capital plans. Several described evaluating the sustainability of specific service lines. Augusta Health reported developing a phased operational alignment plan designed to address the approximately $40 million reduction it projects and stated that services operating at a loss, including inpatient and outpatient behavioral health, skilled nursing, labor and delivery, and a mobile clinic serving 26 remote sites monthly, would come under evaluation, although it stated that it is not prepared to announce any service closures. Sentara reported a three-year plan targeting nearly $1 billion in additional value and stated that internal measures alone will not replace the reductions. Inova reported approximately $7 billion in approved capital investment over seven years and stated that it is evaluating the pace and scope of future community investment. These are projections rather than realized losses, because several of the relevant federal payment provisions have not yet taken effect.[61]

New Medicaid eligibility and administrative requirements will reduce Medicaid enrollment in Virginia, likely decreasing hospital revenue and increasing rates of uncompensated care

H.R. 1 eliminates Medicaid coverage for some previously eligible individuals while imposing new eligibility criteria and procedural requirements for others. New requirements may create procedural barriers that prevent eligible individuals from obtaining or maintaining coverage to which they are entitled. As individuals lose Medicaid coverage, hospitals will face declining income as reimbursements diminish and levels of uncompensated care increase.

H.R. 1 eliminates Medicaid coverage for some previously eligible, lawfully present noncitizens

Beginning October 1, 2026, certain lawfully residing noncitizen adults, including refugees and asylees, certain victims of human trafficking, and humanitarian parolees, who were previously eligible for Medicaid coverage if they met financial and other eligibility criteria established by the state, are no longer eligible for coverage. Section 71109 of H.R. 1 limited federally matched full-benefit Medicaid eligibility to a narrower set of noncitizen categories: lawful permanent residents ("green card holders"), Cuban-Haitian entrants, and certain Compact of Free Association migrants, who are citizens of the Marshall Islands, Micronesia, and Palau.[62] Four categories of coverage are not affected: children under 19, pregnant individuals including those covered through Family Access to Medical Insurance Security (FAMIS) Prenatal, health services initiatives under the Children's Health Insurance Program (CHIP), and emergency Medicaid, which covers emergency treatment regardless of immigration status.[63]

In August 2026, DMAS notified approximately 5,800 Medicaid enrollees that their coverage might be affected by the change.[64] Approximately 3,400 of those enrollees (58 percent) reside in Northern Virginia, which the Secretary of Health and Human Resources attributed to that region having the largest immigrant population in Virginia.[65] Approximately 300 of the affected enrollees were individuals with a severe disability or who are receiving hospice care. DMAS reports that the agency prepared and submitted a request to the Commonwealth's Federal Uncertainty Contingency Fund, created in the 2026 Appropriation Act to help state agencies respond to reductions in federal funding, for funding to provide transitional care support for enrollees with a severe disability or receiving hospice care.[66] On October 21, 2026, DMAS announced limited, temporary state funding to continue coverage of certain services, including hospital services, through June 30, 2027, or until funds are exhausted, for approximately 270 of the affected individuals who meet functional criteria for long-term services and supports.[67]

H.R. 1 separately reduces the federal matching rate for Emergency Medicaid furnished to individuals who would be eligible for regular Medicaid because they are an adult with a

household income that is less than 138 percent of the federal poverty level and their state expanded Medicaid, but they are ineligible because of their immigration status. Individuals who are ineligible for regular Medicaid coverage because of their immigration status remain eligible for Emergency Medicaid, which covers treatment of an emergency medical condition, including labor and delivery, if they meet all other eligibility requirements.[68] Prior to enactment of H.R. 1, for states that expanded Medicaid, FMAP for Emergency Medicaid services for this population was 90 percent. H.R. 1 reduces the FMAP for Emergency Medicaid services for individuals who are ineligible for regular Medicaid coverage due to their immigration status to the state's regular federal matching rate, which, for Virginia, is 50 percent.[69] The final budgetary effect of this shift has not yet been fully quantified but DMAS reports a preliminary estimate of approximately $25.5 million in FY27 and $34 million in FY28.

H.R. 1 imposes new Medicaid program eligibility criteria and procedural requirements for adults in the expansion population

H.R. 1 creates new eligibility, enrollment, and procedural requirements for adults in the expansion population, including community engagement requirements and requirements for more frequent eligibility renewals. New requirements may create procedural barriers that prevent eligible individuals from obtaining or maintaining Medicaid coverage.

H.R. 1 requires most adults in the Medicaid expansion population to work or participate in other qualifying activities to obtain and keep coverage

Beginning in January 2027, most adults ages 19 through 64 enrolled through the Medicaid expansion population must demonstrate at least 80 hours per month of qualifying work, education, job training, or community service (the community engagement requirement).[70] The requirement applies to both applicants and existing enrollees, on different schedules. New applicants applying for Medicaid coverage on or after January 1, 2027, must have met the requirement in the month before they apply for coverage. Existing enrollees must be in compliance at their first renewal in 2027, beginning with enrollees whose renewal is due in March 2027, which DMAS initiates in January.[71]

An individual may satisfy the requirement in a given month by doing at least one of the following:

- Working at least 80 hours;
- Completing at least 80 hours of community service;
- Participating in a work or training program for at least 80 hours;
- Being enrolled at least half time in an educational program; or
- Having monthly income of at least $580.

A seasonal worker may qualify by averaging that income over a six-month period, and hours from different qualifying activities may be combined to reach the 80-hour total.

Qualifying activities are defined broadly and include paid and self-employment, certain unpaid work such as internships and caregiving, volunteering for charitable or public organizations, high school and higher education, career and technical education, and workforce training programs including registered apprenticeships.

H.R. 1 exempts a number of groups from the requirement. The exemptions include:

- Former foster youth until age 26;
- American Indians and Alaska Natives;
- A parent, guardian, or family caregiver of a child under 14 or of an individual with a disability;
- Veterans with a 100 percent disability rating;
- Individuals who are pregnant or within 12 months postpartum;
- Individuals who already meet Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) work requirements;
- Individuals in substance use treatment;
- Individuals who are currently or recently incarcerated;
- Individuals living in an area covered by a federally declared emergency or in a locality with a qualifying unemployment rate;
- Individuals who received inpatient or similar care; and
- Individuals who traveled outside their community for their own care or that of a dependent.

The last three are short-term hardship exceptions that H.R. 1 permits, but does not require, states to apply.[72] Virginia will apply all hardship exemptions.

A separate exemption applies to individuals who are medically frail. H.R. 1 defines a medically frail individual as one who is blind or disabled as defined by the Social Security Administration; has a substance use disorder; has a disabling mental disorder; has a physical, intellectual, or developmental disability that significantly impairs the ability to perform one or more activities of daily living; or has a serious or complex medical condition.[73] CMS's June 2026 interim final rule narrowed that definition by requiring that the condition also affect the individual's ability to work. While implementation is ongoing, DMAS reports that CMS's change could reduce the number of projected medically frail exemptions in Virginia from approximately 300,000 to approximately 170,000, meaning roughly 130,000 Virginians who would have qualified under the statutory definition may no longer qualify or may have to take additional steps to establish that they do.[74] In 2027, DMAS will accept self-attestation as sufficient evidence that an individual meets the definition of medically frail. Beginning in 2028, additional information will be required to confirm eligibility for the exception. DMAS reports that under the broader definition of medical frailty included in H.R. 1, trusted data sources and the Commonwealth's existing medical frailty code list would have provided sufficient information to make such determinations. However, under the narrower definition included in the interim final rule, a

clinician's assessment may be needed to determine whether a condition affects an individual's ability to work.

On June 29, 2026, Virginia joined 25 other jurisdictions in a federal lawsuit challenging the narrower definition of medical frailty. On October 29, 2026, the court ruled that CMS exceeded its authority by requiring individuals who fall within one of the statutory medical frailty categories to also show that their condition significantly impairs their ability to work or engage in other qualifying activities.[75] The court vacated that requirement, restoring the statutory definition in all states, and permanently enjoined CMS from enforcing it against the plaintiff jurisdictions, including Virginia; other provisions of the interim final rule remain in place.[76] DMAS previously planned to implement the narrower federal definition while the case was pending,[77] but under the ruling, individuals need only show that they have a condition that falls within one of the statutory categories. The statutory January 1, 2027, implementation date for the community engagement requirement remains in effect. The court also gave the plaintiff jurisdictions six months of protection from federal enforcement related to medical frailty determinations while they adjust their systems.

DMAS reports that the agency intends to establish compliance with and exemptions from community engagement requirements using information the agency already holds wherever possible. In 2027, DMAS will generally accept self-attestation as evidence that an individual meets the definition of medically frail, meaning it will accept the information an individual reports on an application or renewal form without additional documentation.[78] Additional documentation will be required beginning in 2028, at which point enrollees whose information cannot be confirmed through available state data will need to supply records themselves. As a result, applicants can be expected to face additional administrative and procedural burdens beginning in 2028, as they are required to provide additional data, information, and records at the time of initial application and renewal.

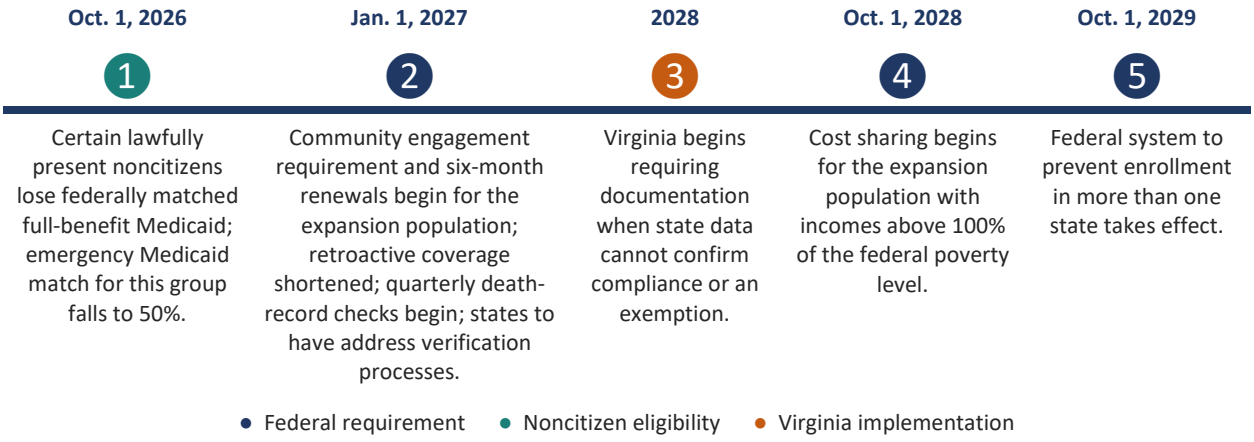
H.R. 1 requires more frequent eligibility renewals for adults in the Medicaid expansion population and imposes additional procedural requirements for data collection

Beginning January 1, 2027, most adults in the Medicaid expansion population will be required to renew their eligibility every six months, or twice as often as previously.[79] At each renewal, enrollees must provide the information needed to demonstrate compliance with all applicable eligibility criteria, including the new community engagement requirement. States must also implement new, more comprehensive eligibility checks (FIGURE 2), including:

- Beginning January 1, 2027, quarterly checks of the Social Security Administration's Death Master File to identify deceased enrollees; and
- Beginning January 1, 2027, a process to regularly obtain address information for enrolled individuals and, beginning October 1, 2029, checks of a federal system to

prevent an individual from being enrolled in Medicaid in two states at the same time.[80]

FIGURE 2. When the H.R. 1 coverage provisions take effect



Most provisions apply to adults covered through the Medicaid expansion; the retroactive coverage change and enrollment checks also reach other Medicaid enrollees.

SOURCE: Pub. L. No. 119-21, §§ 71103–71104, 71107, 71109–71110, 71112, 71119–71120; 91 Fed. Reg. 33348 (June 3, 2026); DMAS presentation to the Joint Commission on Health Care (Sept. 23, 2026).

H.R. 1's new eligibility criteria and procedural requirements may prevent eligible individuals from obtaining Medicaid coverage

More frequent eligibility renewals and additional, more comprehensive eligibility checks are intended to ensure that coverage is limited to individuals who meet Medicaid eligibility criteria. CMS has described the new community engagement requirement as intended to "empower Medicaid beneficiaries through employment, education, or volunteer service."[81] However, these changes to the Medicaid program required by H.R. 1 may have unintended impacts that prevent eligible individuals from accessing coverage to which they are entitled. The increased need for evidence and documentation to demonstrate compliance with income, residency, work and community engagement, and other eligibility requirements combined with the increased frequency with which such evidence and documentation must be provided for eligibility renewal determinations creates a burden on individuals applying for and seeking to maintain Medicaid coverage. Medicaid applicants and enrollees will be required to monitor and manage shorter application and renewal timelines and more frequent communications, handle greater information and paperwork burdens required by more frequent renewals with higher informational and administrative demands, and coordinate collection and submission of data and information from more sources more frequently than in the past, in cases in which DMAS is unable to utilize existing sources.

These demands may create procedural and administrative burdens that applicants and enrollees are unable to meet, leading eligible individuals to abandon the application or renewal process and forgo Medicaid benefits to which they are legally entitled.

Each procedural or administrative action that a Medicaid applicant or enrollee must undertake to obtain or maintain coverage creates a risk that the individual will fail to complete the application or renewal process. Virginia's 2023–2024 Medicaid unwinding shows what happens when eligible individuals are required to complete a process to maintain coverage. When pandemic-era continuous Medicaid coverage ended, the Commonwealth redetermined eligibility for more than two million Medicaid enrollees. Approximately 483,000 lost coverage, a rate of roughly 23 percent, compared with the 14 to 20 percent the Commonwealth had anticipated.[82] Of those who lost coverage, about 257,000, or slightly more than half, were terminated for administrative or procedural reasons, rather than failure to meet eligibility criteria, and were not reinstated within three months.[83]

H.R. 1 asks more of Medicaid applicants and enrollees than the unwinding did. Experience in other states indicates that administering community engagement requirements consumes substantial resources and results in fewer individuals maintaining or obtaining coverage than initially anticipated.[84,85] National data cited in the Secretary of Health and Human Resources' September 2026 briefing make the same point from the other direction: approximately 63 percent of adults enrolled in Medicaid are working, 22 percent would qualify for an exemption, and 7 percent are in school, leaving approximately 8 percent who are neither working nor exempt. In states that have implemented work requirements, approximately 25 percent of the adults subject to such work requirements have lost Medicaid coverage.[86] The difference between the share who would qualify and the share who keep coverage may reflect the impact of administrative and procedural barriers rather than a change in who is eligible.

Virginia has committed resources to reduce potential procedural barriers to accessing Medicaid coverage before new requirements take effect. The General Assembly provided $62.0 million in fiscal years 2027 and 2028 from nongeneral funds, approximately $124.0 million over the biennium, to expand Cover Virginia call center operations and implement the federal community engagement and six-month renewal requirements. The General Assembly also provided $250,000 in general funds and $250,000 in nongeneral funds each year to expand the Virginia Health Care Foundation's Project Connect, including additional outreach workers and training.[87] In August 2026, DMAS began issuing notices to enrollees in the Medicaid expansion population to inform them of eligibility, enrollment, and procedural changes required by H.R. 1, and has developed enrollee, provider, and stakeholder toolkits, paid media, coordinated outreach through managed care organizations, and virtual town halls to further disseminate information about upcoming changes. DMAS has also increased Cover Virginia call center staffing by more than 50 percent.[88]

In August 2026, Governor Spanberger issued Executive Order 20, establishing a "Keep Virginia Covered" policy that directs state agencies to minimize administrative and procedural barriers to enrollment and renewal where federal law allows, pursue public-private partnerships, and provide alternative coverage options where feasible.[89] Pursuant to Executive Order 20's directive to engage stakeholders and build public-private partnerships, the Administration established the Virginia United Coalition, a group of healthcare and advocacy organizations committed to addressing issues arising from implementation of H.R. 1. Commitments from organizations participating in the Coalition include job training, funding for outreach workers, help with presumptive eligibility, and more.

Estimates indicate H.R. 1 could substantially increase the number of uninsured Virginians, although the magnitude of the increase remains uncertain

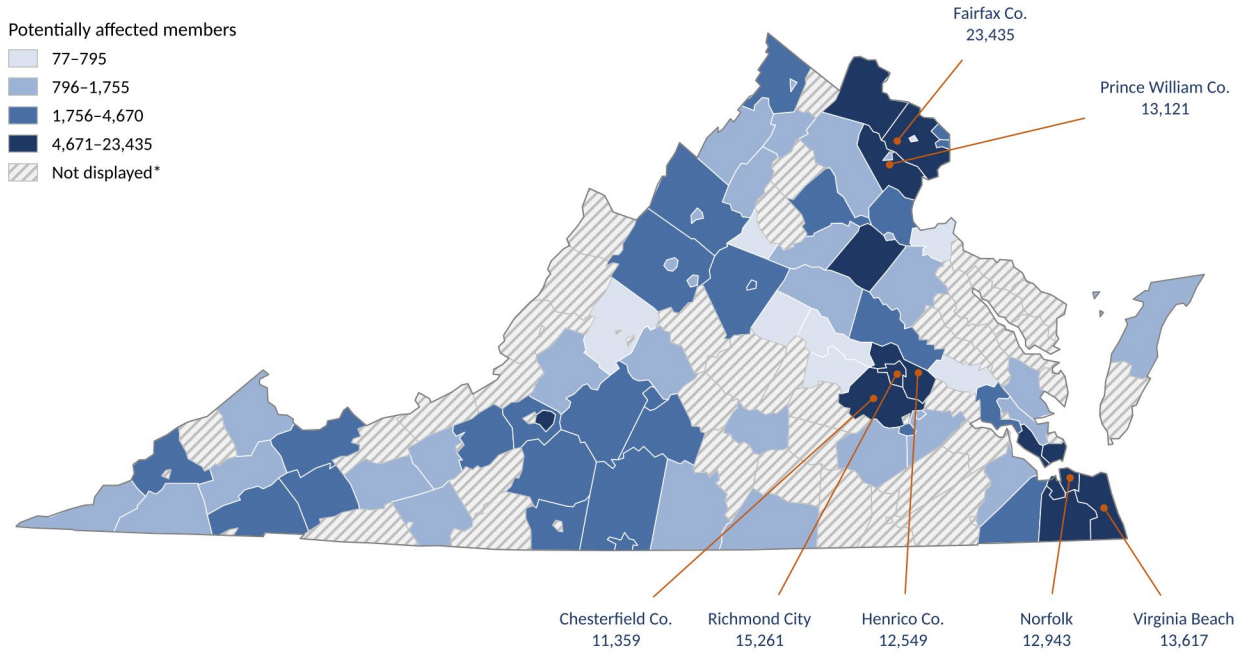
Published estimates of H.R. 1's coverage effects in Virginia vary depending on who is counted. One Virginia analysis estimates that the law's Medicaid restrictions could eliminate coverage for approximately 260,000 Virginians within the next nine years, and separately estimates that approximately 188,000 Virginians could lose coverage by 2034 as a result of the community engagement requirement alone.[90] The Congressional Budget Office estimates that the law's Medicaid provisions will increase the number of uninsured people nationally by 7.5 million in 2034.[91] For Virginia, RAND, a nonpartisan research organization, projects approximately 183,000 fewer Medicaid enrollees in 2034, most as a result of the community engagement requirement.[92]

These estimates are uncertain and indicate potential scale rather than a forecast of realized coverage loss. Their magnitude depends on how states administer the new requirements and how successfully eligible individuals complete the required processes. Because the major community engagement and renewal requirements do not take effect until January 2027, Virginia does not yet have enrollment data showing how many eligible individuals will lose coverage as a result.

The risk of Medicaid coverage loss is not evenly distributed across the Commonwealth. The Secretary of Health and Human Resources estimates that 296,288 Medicaid enrollees statewide are potentially affected by the community engagement requirement, based on data as of May 2026, and has published these estimates by locality (FIGURE 3).[93] By count, potentially affected enrollees are concentrated in the Commonwealth's most populous localities. Seven localities (Fairfax County, the City of Richmond, the City of Virginia Beach, Prince William County, the City of Norfolk, Henrico County, and Chesterfield County) each have more than 11,000 potentially affected enrollees and together account for more than one-third of the statewide total. Outside the Washington, D.C., Richmond, and Hampton Roads metropolitan areas, the largest estimates are in the City of Roanoke (5,989), the City of Lynchburg (3,556), the City of Danville (3,108), Henry County (2,993), Roanoke County (2,988), Pittsylvania County (2,735), Washington County (2,671), and Tazewell County

(2,477). The dashboard does not display estimates for 52 localities with populations under 20,000 or fewer than 10 affected enrollees. These undisplayed estimates total 27,073 enrollees constituting about 9 percent of the statewide total.[94]

FIGURE 3. Medicaid enrollees potentially affected by the community engagement requirement, by county and city



*SOURCE: Office of the Secretary of Health and Human Resources, Medicaid Work Requirement Impacts by County/City dashboard (data as of May 2026; last updated July 28, 2026; accessed Oct. 21, 2026). *Estimates are not displayed for localities with populations under 20,000 or fewer than 10 affected enrollees, per Health Insurance Portability and Accountability Act confidentiality requirements; the City of Salem is not listed in the dashboard.*

Coverage losses may increase rates of uncompensated care

When a patient is covered by a health insurance plan, including Medicaid, a hospital can bill the patient's health insurance carrier and receive reimbursement for covered services provided. If a patient is not covered by a health insurance plan, the patient is generally responsible for paying for the health care services provided themselves, as a self-pay patient. When a patient is a self-pay patient, a hospital is generally able to collect substantially less for health care services provided than the amount billed for such services.[95] In some cases, patients are not able to pay any portion of the cost of the health care services provided, leaving hospitals with unpaid costs, or uncompensated care.

Changes to Medicaid program criteria that restrict eligibility and create procedural barriers to enrollment, leaving more Virginians without coverage, are likely to increase the burden

of uncompensated care on Virginia's hospitals. Losing Medicaid coverage does not eliminate a patient's need for care or a hospital's obligation to provide it. It changes who pays. National analysis projects that recent federal policy changes, including H.R. 1 and the expiration of enhanced premium tax credits, could increase hospital uncompensated care costs by $466 billion between 2025 and 2034, with a disproportionate share falling on hospitals that serve high shares of Medicaid and uninsured patients.[96] Modeling of the community engagement requirement likewise projects reductions in hospital operating margins concentrated among hospitals with greater Medicaid exposure. When a share of a hospital's Medicaid patients becomes uninsured, revenue that was previously billable becomes uncompensated care, and because Medicaid margins are already thin, hospitals with the most Medicaid volume have the least room to absorb that shift.[97] The effect is likely to be most significant for rural and safety-net hospitals, which have less capacity to absorb additional uncompensated care and which in many communities are the only local source of emergency, obstetric, or behavioral health services.[98] In Virginia, about a third of the state's licensed inpatient hospitals are located in rural localities or serve primarily rural populations.[99]

Changes to retroactive Medicaid coverage and cost-sharing requirements may create additional financial burdens for hospitals

In some cases, a patient who lacks health care coverage may be able to apply for and obtain retroactive Medicaid coverage for health care services even after the services have been provided, if they meet Medicaid eligibility criteria. However, changes included in H.R. 1 substantially reduce the period during which such coverage may apply. For applications made prior to January 1, 2027, eligible individuals may obtain retroactive coverage for covered services provided up to three months prior to the month of application. For applications made on or after January 1, 2027, H.R. 1 reduces retroactive Medicaid coverage to one month prior to the month of application for individuals in the Medicaid expansion population and two months prior to the month of application for individuals in most other eligibility groups.[100] This reduction in retroactive Medicaid coverage combined with the increase in the number of individuals without coverage altogether will likely increase financial burdens on hospitals as the change to retroactive coverage eliminates a source of payment for health care services.

Even if patients are covered by Medicaid, hospitals may experience some challenges in obtaining the full amount of payment in some cases beginning in 2028. Prior to enactment of H.R. 1, states were not required to impose cost-sharing requirements on Medicaid enrollees. Beginning October 1, 2028, however, H.R. 1 requires states to impose cost sharing on adult enrollees in the expansion population with income above 100 percent of the federal poverty level, while prohibiting states from charging that group premiums or enrollment fees.[101] The amount of cost sharing generally may not exceed $35 for an item or service, and aggregate cost sharing is limited to 5 percent of family income over the applicable period. H.R. 1 exempts specified services, including primary care, mental health

services, substance use disorder services, and services provided by federally qualified health centers, rural health clinics, and certified community behavioral health clinics. For a hospital, the practical effect is that responsibility for a portion of the payment for a health care service provided to a patient shifts from the Medicaid program to the patient: Medicaid payment to the hospital is generally reduced by the cost-sharing amount whether or not the hospital collects it.[102] Hospitals will need to collect the cost-sharing amount from patients to receive full reimbursement for services provided. If patients are unable to pay cost sharing amounts, hospitals will not receive full reimbursements, and amounts not collected become uncompensated care.

Hospitals anticipate more self-pay patients, uncompensated care, and administrative work as coverage declines

Hospitals are already planning and preparing to address the potential impacts of changes to the Medicaid program required by H.R. 1. Loss of Medicaid coverage is the concern they raise most often. Respondents to JCHC's request for comment consistently identified the same three sources of anticipated coverage loss: procedural disenrollment, more frequent eligibility renewals, and the community engagement requirement, particularly among individuals who remain eligible but do not complete the required processes. Bon Secours framed the issue as whether eligible patients remain actively enrolled at the moment they receive care rather than whether they qualify, and reported that Medicaid represents approximately 119,500 patient accounts, about 6.8 percent of its Virginia volume, while its approximately 119,300 self-pay accounts generate only about 0.3 percent of payments. That contrast illustrates how directly a change in coverage status converts billable care into uncompensated care.[103]

Several stakeholders across the Commonwealth quantified the expected effect:

- Riverside Health estimates that approximately 1,000 current or prospective patients may be unable to re-enroll and that uncompensated care could increase by approximately $60 million annually; it currently spends approximately $2 million a year on a third-party eligibility and enrollment contract and expects that support may need to double or triple.[104]
- Augusta Health projects approximately $5 million in additional uncompensated care from the community engagement requirement and six-month renewals, and approximately $1 million annually at risk from the shortened retroactive coverage period.[105]
- Bon Secours, citing state data, identified more than 28,000 potentially affected Medicaid enrollees in the localities it serves.[106]
- Carilion Clinic estimates that each percentage point of payer mix moving from Medicaid to uninsured status represents approximately $5.3 million systemwide.[107]

These figures are not directly comparable; each reflects a different measure and the responding system's own planning assumptions. The letters also describe effects that do not appear in a dollar estimate. Sentara reported that it already provides care to an average of 177 patients a day who are unable to pay, that its number of self-pay patients increased 14 percent in 2026, and that it expects its Medicaid health plan to retain a smaller and more medically complex membership as enrollment declines. Several systems reported that uninsured patients present later and in emergency departments, which is the most expensive setting and the one where capacity is already constrained.[108]

How large these effects become depends on factors that are not yet settled. Stakeholder estimates rest on assumptions about how many individuals lose coverage, how successfully hospitals can help eligible patients maintain coverage, and how much care is subsequently provided to uninsured patients. Hospitals are planning for increased administrative workload, self-pay volume, and uncompensated care, but the principal H.R. 1 coverage provisions have not taken effect in Virginia. These figures illustrate potential scale rather than realized losses.

These Medicaid effects will occur in the context of broader health insurance coverage losses that also affect heath care providers that serve Medicaid enrollees. In addition to changes affecting the Medicaid program, H.R. 1 changes requirements governing access to health insurance coverage through state health insurance marketplaces. These changes include stricter eligibility verification requirements, narrower eligibility for premium tax credits, and a bar on premium tax credits for adults who lose Medicaid coverage because they do not meet community engagement requirements. Expiration of enhanced federal premium subsidies at the end of 2025, a policy change that was unrelated to H.R. 1, further reduced health insurance coverage during this same time period. Enrollment through Virginia's individual market declined by approximately 94,000 between 2025 and September 2026. Virginia has responded with $150 million in temporary state subsidies for individuals with incomes between 138 and 250 percent of the federal poverty level, but the effect of those subsidies on enrollment is not yet known. Loss of health insurance coverage resulting from changes to access to health insurance coverage through state health insurance marketplaces required by H.R. 1 and expiration of enhanced federal premium subsidies are likely to result in a substantial number of individuals without health insurance coverage in Virginia. These individuals are in addition to individuals who may lose coverage as a result of changes to the Medicaid program required by H.R. 1.

H.R. 1 created the Rural Health Transformation Program to strengthen rural health care

The RHTP provides funding to states over a period of five years, beginning in FFY 2026, to invest in strengthening rural health care.[109] Virginia applied for and received its first-year award in FFY 2026 and is in the process of disbursing funds to Key Implementation Partners and community organizations to implement strategies and projects to improve

access to and the quality of health care for individuals residing in rural communities throughout the Commonwealth. However, while the RHTP may result in significant investment in rural health care over the next five years, the program will not replace lost hospital revenues resulting from changes to the Medicaid program required by H.R. 1 and will not ameliorate the challenges Virginia's hospitals face as the Medicaid program changes required by H.R. 1 are implemented in the coming years.

The RHTP provides funding to states to strengthen rural health care

Section 71401 of H.R. 1 created the Rural Health Transformation Program (RHTP) and appropriated $10 billion per year to CMS for five federal fiscal years, beginning with FFY 2026, to invest in and strengthen rural health.[110]

States wishing to receive funding through the RHTP were required to submit applications to CMS by November 5, 2025. States were required to submit a single application for funding for the duration of the five-year program. States that failed to submit an application by November 5, 2025, would not be eligible for funding in subsequent years. Applications were required to include a rural health transformation plan describing the state's rural health needs, goals, proposed initiatives and ways in which funds would be used, implementation timeline, and evaluation and sustainability plans, along with a budget. States could also commit to state policy actions that CMS considered in scoring applications.[111]

Permitted uses of funds available through the RHTP include:

- Prevention and chronic disease management;
- Payments to health care providers for health care items or services, subject to federal limits;
- Consumer-facing technology that helps rural residents manage their own care;
- Recruitment, training, and retention of the rural health workforce;
- Information technology, including electronic health records, cybersecurity, and data systems;
- Initiatives that expand access to care, including behavioral health and substance use treatment;
- Innovative models of care delivery; and
- Infrastructure and capital investments in rural facilities and equipment.

States receiving funds through the RHTP must use awards for at least three of the permitted purposes.[112]

RHTP funding is distributed annually to eligible states, in two allotments. Half of each year's funding is divided equally among states with approved applications. In FFY 2026 every state had an approved application and received $100 million from the first allotment. The remaining half of the annual appropriation for the RHTP, or $5 billion, is allocated by CMS among states with approved applications using a formula that takes into account rural

facility and population measures; state policy actions that CMS identified in the funding opportunity as supporting rural health, whether already taken or committed to, such as scope-of-practice laws, licensure compacts, and certificate-of-need laws; and the quality and potential impact of the initiatives proposed in each state's application.[113]

CMS describes the program as supporting expanded access to care, rural workforce development, modernization of facilities and technology, and innovative approaches to care delivery.[114] Investments of this kind can strengthen hospitals and other rural providers by improving the infrastructure, workforce, technology, and delivery systems rural care depends on.

States must use their awards consistent with their approved applications, and federal law authorizes CMS to withhold, reduce, or recover funds when a state fails to comply.[115] As a result, states have very limited ability to redirect funds away from the purposes specified in initial RHTP applications toward needs that emerge after approval. Continued funding through the RHTP is subject to annual federal review and rescoring, meaning CMS re-evaluates and re-scores each state's performance and plans before setting the next year's award.[116] A first-year award therefore does not establish the amount a state will receive in later years. Rather, future funding is tied to progress toward the initiatives a state proposed in its approved application.

Virginia is using its award for four rural health initiatives delivered through partner organizations

Virginia's RHTP application proposed a nearly $1 billion investment in rural health care known as "VA Rural Vitality." Subsequent awards are anticipated in each of the next four federal fiscal years of the RHTP, though the amount available in later years will depend on the federal review and rescoring process.[117] The plan is organized around four initiatives that address how rural care is accessed and delivered, the technology and workforce that support it, and factors affecting health outside clinical settings:

- Connected Care, Closer to Home, supports mobile and hybrid care, community paramedicine, and innovative maternal care. It funds mobile care units, telehealth kiosks, self-contained prefabricated clinic units, electronic consultations, and arrangements connecting smaller rural providers with larger facilities and specialists, along with expanded emergency medical services (EMS) and remote monitoring and video-based specialist consultation for maternal care.[118] Virginia's application budgets approximately $412 million (41 percent of the proposed five-year budget) for this initiative, including $85.9 million in the first year.[119]
- CareIQ includes a technology innovation fund, provider productivity and interoperability investments, and remote patient monitoring, ranging from electronic health record modernization and cybersecurity to technology intended to reduce administrative burden. The application budgets approximately $283 million

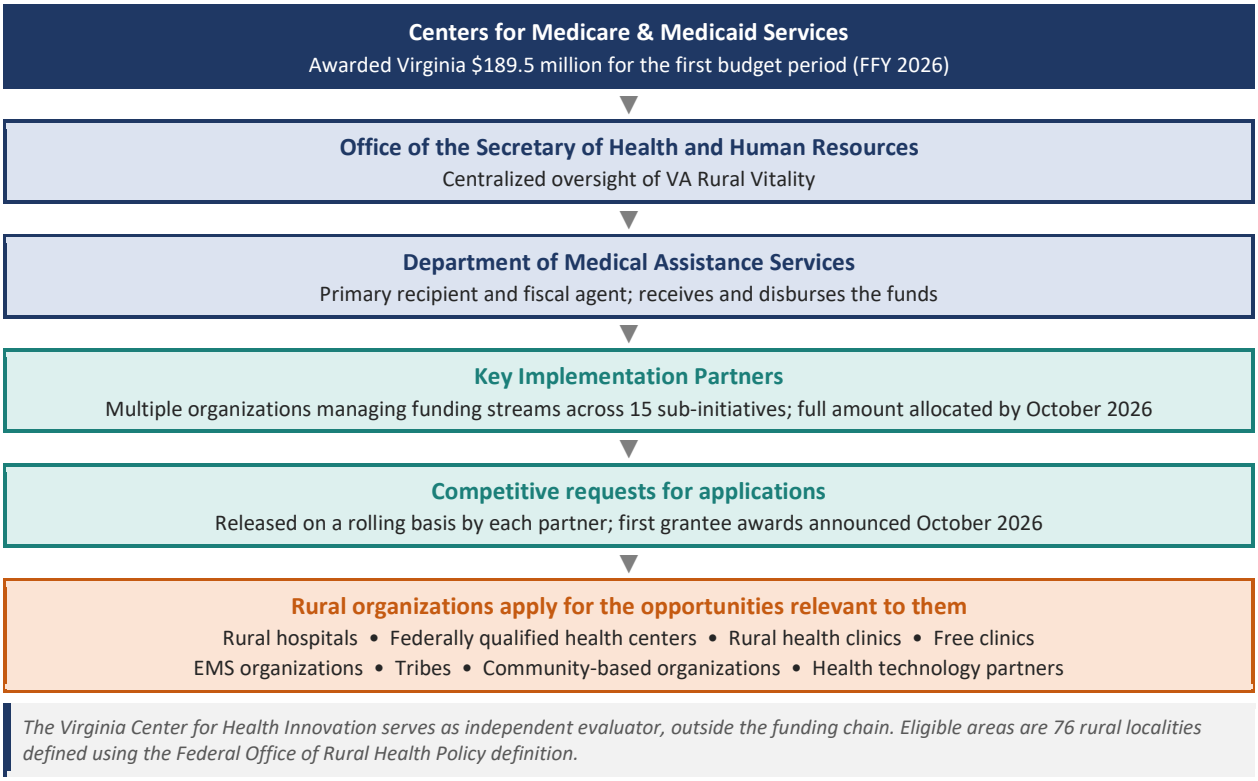
(28 percent of the proposed five-year budget) for this initiative, including $53.7 million in the first year.[120]

- Homegrown Health Heroes funds rural residency positions, allied health programs through community colleges, paid health care apprenticeships, and high school career pathways, with roughly 80 to 100 residency positions proposed in priority specialties. The application budgets approximately $132 million (13 percent of the proposed five-year budget) for this initiative, including $32.5 million in the first year.[121]
- Live Well, Together focuses on prevention and community health through food as medicine, consumer health technology, programs to increase physical activity among children, and integrated care for individuals dually eligible for Medicare and Medicaid. The application budgets approximately $124 million (12 percent of the proposed five-year budget) for this initiative, including $16.5 million in the first year.[122]

Approximately $49 million of the proposed five-year budget is allocated at the program level for administration, evaluation, and indirect costs.[123] As of October 30, 2026, Virginia reported obligating 100 percent of the RHTP funds investing over $180 million through Key Implementation Partners and $1.7 million for evaluation.

Virginia administers the program through a distributed model (FIGURE 4). The Office of the Secretary of Health and Human Resources provides centralized oversight of VA Rural Vitality. DMAS is the primary recipient of the federal award and acts as the fiscal agent, receiving and disbursing the funds. Day-to-day administration of individual initiatives sits with organizations the Commonwealth designates as Key Implementation Partners, which manage specific funding streams across the 15 sub-initiatives in collaboration with state agencies, providers, and community organizations. Partners include the Virginia Health Care Foundation, the Virginia Hospital Research and Education Foundation, the Virginia Innovation Partnership Corporation, Virginia Works, the Virginia Foundation for Community College Education, the Virginia Department of Education, the Virginia Department of Health, six regional Planning District Commission Collaboratives, the Virginia Foundation for Healthy Youth, and the Virginia Department for Aging and Rehabilitative Services. The Virginia Center for Health Innovation serves as independent lead evaluator and is outside the funding chain.[124]

FIGURE 4. Virginia administers the RHTP through a distributed model



SOURCE: Commonwealth of Virginia, Virginia Rural Health Transformation (2026); DMAS, VA Rural Vitality project narrative and application summary (2025); Office of the Secretary of Health and Human Resources (Aug. 28, 2026); Virginia Health Care Foundation (Oct. 2026).

Rural organizations interested in obtaining RHTP funds for initiatives in their communities apply for funds through competitive application processes administered by Key Implementation Partners. In partnership with the Secretariat of Health and Human Resources and the Department of Medical Assistance Services, Key Implementation Partners release initiative-specific requests for applications on a rolling basis and interested organizations apply for the opportunity that matches the services or investment they intend to undertake. Virginia's application identifies rural hospitals, federally qualified health centers, rural health clinics, free clinics, Tribes, EMS organizations, community-based organizations, health technology partners, and other local providers as potential participants. To be eligible, organizations generally must be located in qualifying rural areas, as defined in Virginia's RHTP application, or demonstrate that their projects will serve residents of those areas.[125] The Commonwealth has established a Rural Health Transformation Request for Applications Navigator to help prospective applicants identify relevant opportunities, application periods, and contacts.[126]

The competitive application process allows the Commonwealth to match funding to defined projects, evaluate applicants, and build in accountability for how funds are spent. It also

means access depends in part on whether an eligible organization has the capacity to identify the right opportunity, prepare an application, and administer the resulting award.

Implementation is underway but at an early stage. By late August 2026, approximately $122 million of Virginia's first-year award had been allocated to Key Implementation Partners.[127] The first awards to local organizations followed in October 2026. The Virginia Health Care Foundation, which administers two CareIQ sub-initiatives, announced nearly $23 million in awards to 31 organizations: $14.39 million for provider interoperability on October 2 and $8.6 million for provider productivity on October 16. Recipients include rural hospitals, federally qualified health centers, free clinics, community services boards, and independent practices. Requests for applications for other sub-initiatives continue to be released on a rolling basis.[128]

Rural organizations may face several barriers to participation in the RHTP. State officials have identified limited grant-writing and administrative capacity among some rural organizations as a potential barrier to participation. Virginia's structure also adds a layer of administrative complexity: funding is spread across 15 sub-initiatives managed by multiple Key Implementation Partners, each with its own process and timelines. Prospective applicants must determine which of several funding streams fits their project, find the right opportunity, and navigate the various processes and timelines to compete for opportunities.[129] The Commonwealth has developed technical assistance and an application-navigation process to help organizations address both of these barriers. The grant-award cycle of the RHTP may create challenges for some rural organizations. Because awards are made one budget period at a time, an organization funded in the first year has no assurance of funding in subsequent years, which matters for organizations that depend on the funding provided for sustained staffing or operating support.[130]

The RHTP offers an opportunity to invest in rural health care but does not offset revenue losses resulting from Medicaid program changes required by H.R. 1

The RHTP provides funding to states to invest in a broad range of rural health initiatives designed to improve rural health care capacity and strengthen rural health care services and systems. While some contemporaneous descriptions of H.R. 1 characterized the RHTP as a response to concerns over the impacts of changes to the Medicaid program on rural hospital finances, the RHTP is much broader in scope and purpose and the size and structure of the RHTP are inadequate to offset the losses to hospitals resulting from changes to the Medicaid program required by H.R. 1. Rural provider organizations themselves noted this at the time, pointing out that the RHTP would fall short of addressing the impacts of the other provisions of the legislation.[131]

States may use funds received through the RHTP for a range of initiatives intended to expand access to and the quality of rural health care. While states may use funds for direct payments to providers under certain circumstances (no more than 15 percent of a state's award in a budget period), federal rules prohibit states from using RHTP funds to replace

payments for clinical services that would otherwise be reimbursed by insurance or to duplicate existing federal or state benefits.[132] Because the financial effect at issue is a reduction in Medicaid financing and payment for covered services, Virginia would not be permitted to use RHTP funds to make payments to hospitals for services that would otherwise be covered by Medicaid.

Even absent restrictions on the use of funds available through the RHTP, available funding would be insufficient to offset reductions in hospital revenues resulting from changes to the Medicaid program required by H.R. 1. The RHTP allocation formula does not take a state's projected Medicaid losses into account, so award amounts are not tied to the revenue a state's hospitals lose.[133] When the Senate passed the legislation in July 2025, VHHA estimated that it would cost Virginia hospitals more than $2 billion annually, a reduction that continues year after year; VHHA's August 2026 comments to JCHC estimate that the health care provider tax and state directed payment provisions alone would reduce hospital funding by approximately $34.7 billion from 2027 through 2036.[134] Virginia's first-year award is $189.5 million, and the Commonwealth's full five-year plan totals approximately $1 billion across all five years. The comparison establishes a difference in order of magnitude rather than an offset calculation.

The RHTP also differs from Medicaid with regard to reliability and consistency of funding. The RHTP is a five-year program, the amount of funding awarded to a state is not guaranteed to be the same each year, and the state will have limited control over the process by which the award amount is determined.[135] Hospital financial planning depends on anticipating recurring revenue when making decisions about staffing, capital investments, debt service, and clinical capacity. The limited duration, uncertainty, and unreliability of funding available through RHTP limit the effectiveness of the funds as a replacement for Medicaid revenues lost as a result of changes to the Medicaid program required by H.R. 1.

The RHTP reaches only part of the health care system affected by the changes to the Medicaid program required by H.R. 1. Funding awarded through Virginia's RHTP competitive grants is generally limited to organizations located in, or projects serving, federally designated rural areas, while the Medicaid financing and coverage changes apply statewide. As Inova noted, hospitals serving large Medicaid and uninsured populations in urban and suburban communities absorb the same reductions without comparable federal support.[136] Carilion Clinic, which serves a largely rural service area, made the same observation from the other direction, noting that targeted rural funding alone does not address the broader coverage and reimbursement challenges facing hospitals that care for substantial Medicaid and uninsured populations across multiple settings.[137]

While the scope, structure, and size of the RHTP make clear that the program does not offer an alternative source of funding for hospital revenues lost as a result of the changes to the Medicaid program required by H.R. 1, health systems describe RHTP funding as a complement to, rather than a replacement for, Medicaid funding and broader action.[138]

Health systems have indicated interest in applying for RHTP funding to support services in rural communities.[139] Virginia's award supports mobile and hybrid care, community paramedicine, maternal care, rural residencies and apprenticeships, provider technology, and prevention programs, each of which meaningfully responds to access and capacity problems that rural hospitals and their communities face.[140]

APPENDIX 1: Information Brief Methodology

I. Statutory, Regulatory, and Subregulatory Analysis of H.R. 1 Medicaid Changes Impacting Acute Care Hospitals

Document Review

JCHC staff conducted document reviews to examine the impact of changes to the Medicaid program required by H.R. 1 on Virginia's acute care hospitals. The reviews focused on policies related to Medicaid financing, reimbursement, eligibility, enrollment, enrollee cost sharing, and other provisions with the potential to influence hospital revenues, payer mix, and uncompensated care. JCHC staff reviewed the language of H.R. 1 to identify Medicaid provisions affecting hospital financing, eligibility, enrollment, enrollee cost sharing, provider taxes, state directed payments, and other payment-related policies. Provisions were reviewed to determine legislative intent, implementation timelines, and required changes to state Medicaid programs.

JCHC staff reviewed relevant federal statutes, regulations, and subregulatory guidance issued by the Centers for Medicare & Medicaid Services (CMS), including Interim Final Rules, Final Rules, State Medicaid Director letters, Frequently Asked Questions (FAQs), informational bulletins, and other implementation guidance to clarify state responsibilities, compliance requirements, operational expectations, and implementation timelines. These materials were reviewed to identify implementation requirements affecting hospital reimbursement, Medicaid eligibility and enrollment, administrative processes, enrollee cost sharing, and other policy changes influencing hospital finances.

JCHC staff also reviewed state statutes, regulations, and budget language, as well as reports, fiscal analyses, and other materials prepared by the Virginia Departments of Medical Assistance Services (DMAS) and Planning and Budget, staffs of the Virginia Senate Finance and Appropriations Committee (SFAC) and House Appropriations Committee (HAC), and other organizations to evaluate how H.R. 1 is expected to affect the Commonwealth's Medicaid program and how those changes are expected to affect Virginia's acute care hospitals. Materials were reviewed to understand anticipated implementation activities, enrollment impacts, reimbursement changes, and fiscal implications for Virginia's Medicaid program.

The review also incorporated official fiscal projections and policy analyses to evaluate the anticipated magnitude of H.R. 1's effects on Virginia acute care hospitals. These sources included Congressional Budget Office (CBO) estimates, federal and state fiscal analyses, agency implementation documents, and, where available, projections related to Medicaid enrollment, federal Medicaid expenditures, hospital reimbursement, and uncompensated care. To contextualize the expected effects on hospitals, the document review also incorporated peer-reviewed literature, government reports, and published policy analyses examining Medicaid expansion, hospital reimbursement, uncompensated care, hospital

financial performance, and supplemental Medicaid payment mechanisms. Secondary analyses from nationally recognized policy organizations were used to provide contextual information and policy interpretation where appropriate but did not replace primary legal, regulatory, or governmental sources.

Stakeholder Engagement

To incorporate stakeholder perspectives, JCHC staff conducted a structured stakeholder engagement process to collect information from Virginia's licensed acute care hospitals. Acute care inpatient hospitals were identified using the Virginia Department of Health's hospital licensure portal, and specialty hospitals such as psychiatric, rehabilitation, or long-term acute care hospitals were excluded. Facilities were categorized by their affiliated health system or as independent hospitals. Requests for stakeholder input were distributed to each identified health system and each independent hospital to ensure all licensed acute care hospitals had an opportunity to participate while avoiding duplicate requests to facilities represented through a centralized health system. Legislative contacts were identified primarily through Virginia Public Access Project (VPAP) and cross-referenced for currency through organizational websites and professional networks.

The initial request for feedback was distributed on Monday, July 20, 2026, with responses requested by Friday, August 14, 2026. Health systems were asked to describe the anticipated impacts of changes to the Medicaid program under H.R. 1 on their organization, including any unique impacts across individual facilities where applicable. Independent hospitals were asked to describe the anticipated impacts on their facility. All respondents were also asked to discuss how their organization was preparing for these anticipated changes, including any strategic or operational adjustments under consideration, and to identify the types of policy, financial, or technical support that would be most helpful in mitigating anticipated impacts. To maximize participation, reminder communications were distributed on Monday, August 10, 2026, preceding the response deadline. Organizations that had not responded were contacted again following the deadline and provided an additional opportunity to submit comments through the following Friday, August 21, 2026. Requests were sent to 20 licensed acute care health systems and independent hospitals, and as of Friday, August 21, 2026, 11 comment letters were received. VHHA submitted an additional comment letter. Responses received after the second deadline were included in the appendix but were not included in the qualitative analysis. Organizations that did not provide written comments were informed that they would have an opportunity to provide public comment following presentation of the report to JCHC.

Submitted responses were analyzed using a qualitative thematic approach. Responses were reviewed to identify recurring themes regarding anticipated operational and financial impacts, organizational preparedness strategies, and recommendations for state or federal support. Common themes were synthesized to inform the report's discussion of stakeholder perspectives, while complete, unedited responses were included as an

appendix and provided to members of JCHC to ensure transparency and preserve the full context of stakeholder feedback.

II. Rural Health Transformation Program

Document Review

JCHC staff conducted a document review to examine the relationship between the Rural Health Transformation Program (RHTP) and the impact on Virginia's hospitals resulting from changes to the Medicaid program required by H.R. 1. The document review included examination of federal and state statutory, regulatory, legislative, and administrative materials governing the program and its implementation. Federal materials reviewed included CMS's Notice of Funding Opportunity (NOFO), program guidance, frequently asked questions, implementation materials, reporting and oversight guidance, and related CMS fact sheets. These materials were used to identify the program's statutory requirements, allowable uses of funds, state application and award requirements, federal oversight responsibilities, and implementation conditions.

Virginia-specific materials reviewed focused on implementation of the Commonwealth's VA Rural Vitality application and supporting materials, budget language and subsequent legislative actions governing the administration and reporting of RHTP funds, and reports, presentations, and other documents prepared by the Department of Medical Assistance Services and other stakeholders in the implementation process.

Stakeholder Engagement

JCHC staff interviewed multiple stakeholders for this information brief to supplement the document review and gain additional information and insight regarding implementation, administration, funding priorities, and anticipated effects of RHTP in Virginia. Interviews focused on stakeholders with direct knowledge of the RHTP at the state, implementation, and rural health delivery levels.

Stakeholders interviewed for this information brief included:

- Virginia Center for Health Innovation
- Virginia Health Care Foundation
- Office of Secretary of Health and Human Resources

APPENDIX 2: VHHA Comment Letter to JCHC

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION
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804-965-1227 FAX: 804-965-0475

August 14, 2026

Ms. Mayesha Alam
Associate Staff Attorney & Health Policy Analyst
Joint Commission on Health Care
411 E. Franklin Street, Suite 505
Richmond, Virginia 23219

Re: Impact of H.R. 1 and Related Federal Action on Patient Access, Medicaid Finance, and Hospital Stability in Virginia

Dear Ms. Alam,

On behalf of the Virginia Hospital & Healthcare Association (VHHA) and Virginia's hospitals and health systems, thank you for the opportunity to provide comments on the effects of H.R. 1 and related state and federal policy changes on Virginia's health care system.

Virginia hospitals are deeply concerned that several provisions of H.R. 1, together with related federal rulemaking and state policy actions, will create significant financial and operational challenges for hospitals, patients, and communities throughout the Commonwealth. These changes affect Medicaid eligibility and enrollment, the financing of Medicaid expansion, and the State Directed Payment (SDP) programs that help sustain access to care for Medicaid beneficiaries.

Although these policy actions are often considered in isolation, they are all interrelated and pointing in the same direction: increasing coverage disruptions and uncompensated care while simultaneously reducing the resources available to care for Medicaid beneficiaries and uninsured patients. Rural hospitals, safety-net providers, and hospitals serving communities with high Medicaid enrollment are likely to experience the greatest impact.

To address these concerns, VHHA respectfully asks the Joint Commission on Health Care to recommend that the Commonwealth restore Medicaid inflation and rebasing adjustments, minimize preventable Medicaid coverage losses, preserve available Medicaid financing flexibility, establish a formal process to monitor the hospital and patient impacts of H.R. 1, and avoid imposing additional unfunded financial or regulatory burdens on hospitals during the federal implementation period.

Executive Summary

H.R. 1 affects both sides of Virginia's Medicaid program: the number of Virginians who retain coverage and the resources available to reimburse the providers who care for them. Virginia hospitals anticipate:

- Increased Medicaid coverage churn and uncompensated care;

- Substantial reductions in Medicaid State Directed Payments;
- Restrictions on provider assessments that finance Medicaid expansion and hospital reimbursement;
- Increased administrative demands on patients, hospitals, and state agencies;
- Additional pressure from the elimination of Medicaid inflation and rebasing adjustments; and
- Disproportionate effects on rural, safety-net, and high-Medicaid hospitals.

These policies are particularly consequential in Virginia because private acute care hospitals finance the entire state share of Medicaid expansion through provider assessments while also relying on State Directed Payments to partially offset longstanding Medicaid underpayment.

VHHA recommends that JCHC:

1. Assess the cumulative hospital, patient, and state budget effects of H.R. 1 and related federal rules;
2. Restore Medicaid inflation and rebasing adjustments to avoid compounding impacts of federal changes;
3. Monitor enrollment losses, procedural disenrollments, uncompensated care, hospital financial performance, and service reductions;
4. Minimize avoidable coverage losses and administrative burdens; and
5. Preserve all permissible state Medicaid financing and reimbursement options.

Overview of H.R. 1 and Why It Matters for Virginia

H.R. 1 represents the most significant change to Medicaid financing and eligibility policy in decades. For Virginia hospitals, the legislation affects two fundamental components of the Medicaid program:

- **Coverage** through changes to eligibility, enrollment, and community engagement requirements that are expected to increase administrative churn and uncompensated care.
- **Financing** through §71115 and §71116, which modify the mechanisms Virginia relies upon to reimburse hospitals and finance Medicaid expansion.

Although these provisions address different parts of the Medicaid program, their combined effect is expected to increase coverage losses and disruptions while simultaneously reducing the financial resources available to hospitals that provide care. Virginia is unusually exposed to these changes because hospitals simultaneously finance the entire state share of Medicaid expansion through provider assessments while relying on State Directed Payments to offset chronic Medicaid underpayment. Few states depend on both mechanisms to the same degree.

The following sections describe the major Medicaid coverage provisions of H.R. 1, the financing changes contained in §71115 and §71116, and the expected effects on patient access and hospital stability.

Medicaid Coverage and Eligibility Changes (§71109, §71110, §71103, §71107, §71112, §71119, §71104, §71121, §71106, §71120)

H.R. 1 establishes new community engagement requirements and makes other changes to Medicaid eligibility and enrollment. Virginia hospitals recognize that Congress has adopted these requirements as federal law. Hospitals are anticipating that eligible individuals may lose coverage because of administrative barriers, paperwork requirements, reporting obligations, verification challenges, or misunderstandings regarding applicable exemptions and exclusions.

Experience from prior work requirement demonstrations suggests that administrative complexity can become a significant driver of coverage loss, including among individuals who remain substantively eligible for Medicaid. Coverage disruptions do not eliminate patients' health care needs. Instead, patients may delay treatment, forgo preventive and primary care, or seek care in hospital emergency departments after their conditions have worsened.

Virginia faces a particularly difficult circumstance because hospitals directly finance Medicaid expansion coverage. When eligible individuals lose coverage because of administrative barriers, hospitals not only absorb additional uncompensated care costs, but also continue supporting the financing structure that underlies the program. Hospitals are expecting:

- Increased eligibility churn among individuals who remain otherwise eligible for Medicaid;
- Disruptions in ongoing treatment for chronic conditions;
- Reduced access to preventive and primary care services;
- Increased pressure on hospital financial counselors and patient access staff;
- Growth in uncompensated care; and
- Additional strain on rural providers with limited financial reserves.

An estimated 300,000 Virginians will need to take action to maintain their Medicaid coverage, while approximately 7,500 lawfully present noncitizens in Virginia are estimated to lose Medicaid eligibility because of changes enacted under H.R. 1.[1] The legislation also requires substantial investments in eligibility determination and payment systems while imposing additional financial penalties for administrative errors. Together, these changes will increase administrative burdens on states and providers and place additional strain on Virginia's health care safety net.

As implementation proceeds, Virginia should use every available administrative flexibility to prevent eligible individuals from losing coverage solely because of paperwork, reporting, or verification barriers. VHHA recommends that the Commonwealth:

- Use existing state data to verify compliance automatically whenever possible;
- Establish clear and accessible processes for identifying exemptions;
- Provide advance notice and meaningful opportunities to correct errors before termination;

[1] Governor Spanberger: "300,000 Virginians at Risk" on Anniversary of Medicare, Medicaid. Accessible at: https://www.governor.virginia.gov/newsroom/news-releases/2026/july-releases/name-1121836-en.html

- Permit rapid reinstatement when an individual demonstrates continued eligibility or compliance;
- Provide standardized training and materials to hospitals and community partners; and
- Publicly report procedural disenrollments, exemptions, reinstatements, appeals, coverage gaps, and associated uncompensated care trends.

JCHC should also request regular implementation reports from DMAS and other relevant agencies so that the General Assembly can respond promptly if administrative processes produce avoidable coverage losses or threaten continuity of care.

Marketplace Affordability and Coverage Disruption
Changes in federal Marketplace premium assistance may increase net premium costs for some Virginians and contribute to plan downgrades, coverage churn, or loss of coverage. These effects should be evaluated alongside Medicaid eligibility changes because both may increase the number of uninsured and underinsured patients seeking care from hospitals and health systems.

JCHC should monitor Marketplace enrollment, premium changes, plan selection, and uninsured rates and assess whether additional state affordability measures are needed to preserve coverage.

How CMS Proposed to Implement It: Medicaid Program; Community Engagement Requirement for Certain Individuals (CMS-2454-IFC)
On June 29, 2026, CMS published interim final rule CMS-2454-IFC implementing the Medicaid community engagement provisions enacted by Congress in H.R. 1. Unlike the proposed State Directed Payment rule, CMS-2454-IFC generally implements the statutory framework established by Congress. However, the rule leaves important implementation decisions to CMS and the states that will determine whether eligible individuals maintain coverage or lose Medicaid because of avoidable administrative barriers rather than actual ineligibility.

Virginia hospitals recognize that the community engagement requirement is now federal law. The principal issue for the Commonwealth is therefore not whether the requirement should be implemented, but how it is implemented. Policies governing verification, documentation, beneficiary outreach, hardship exceptions, medically frail exclusions, presumptive eligibility, reconsideration, and reinstatement will directly influence coverage continuity, administrative burden, and uncompensated care.

Key implementation issues include:

- Maximizing *ex parte* verification by requiring states to rely on existing governmental data before requesting documentation from beneficiaries.
- Broadly identifying medically frail individuals using diagnoses, claims, encounter, pharmacy, and other clinical data so that eligible patients with serious medical conditions do not lose coverage because of administrative complexity.
- Applying hardship exceptions automatically whenever possible, particularly for hospitalized patients and individuals traveling for medically necessary care, rather than requiring beneficiaries to submit additional requests during periods of illness or recovery.

- Maintaining streamlined hospital presumptive eligibility processes and avoiding new administrative responsibilities or financial liability for hospitals making good-faith eligibility determinations.
- Providing sufficient implementation time, funding, technical assistance, and beneficiary outreach before coverage consequences begin so that states can build accurate eligibility systems and minimize avoidable coverage losses.
- Publicly reporting implementation outcomes, including procedural disenrollments, reinstatements, and coverage restoration, so policymakers can distinguish administrative coverage losses from actual findings of noncompliance.

For Virginia, these implementation decisions have unique significance because hospitals finance the entire non-federal share of Medicaid expansion, including expenses to administer work requirements, while simultaneously serving as the primary safety-net providers for patients who lose coverage. When eligible individuals become uninsured because of administrative complexity rather than actual ineligibility, hospitals experience higher uncompensated care costs while continuing to finance the Medicaid program through provider assessments. Accordingly, Virginia has a strong interest in implementing the community engagement requirement in a manner that maximizes coverage continuity for eligible beneficiaries, minimizes unnecessary administrative burden, and preserves access to care.

Changes to the Provider Tax (§71115)

Virginia's Current Provider Tax Structure

Since Virginia expanded Medicaid in 2019, approximately 65 private acute care hospitals subject to the Coverage Assessment have contributed more than $3.7 billion toward the Commonwealth's share of expansion costs. Hospitals also finance the Rate Improvement Assessment, which supports the non-federal share of Virginia's hospital supplemental payment and State Directed Payment programs. Virginia hospitals therefore serve not only as Medicaid providers, but also as financial partners supporting Medicaid coverage and enhanced reimbursement.

What Congress Enacted (§71115)

Beginning October 1, 2027, §71115 reduces the applicable indirect hold-harmless threshold for certain Medicaid provider taxes from 6% of net patient revenue by 0.5 percentage points annually until the threshold reaches 3.5% in 2032.

In Virginia, the Coverage Assessment currently equals approximately 2.46% of the maximum 6% and fully finances the Commonwealth's share of Medicaid expansion, which is currently estimated to exceed $765 million in SFY 2027. As the hold-harmless threshold is reduced, the ability of the state to finance Medicaid expansion is correspondingly reduced.

Provider taxes are a foundational component of Medicaid financing in Virginia and support both coverage and provider payment programs. The §71115 changes are therefore significant not only because they affect the amount hospitals may contribute, but also because they may reduce the

financing available to the Commonwealth to sustain Medicaid expansion and existing hospital payment arrangements.

Although H.R. 1 established the statutory framework for changes to provider taxes and State Directed Payments, many of the ultimate impacts on Virginia will depend on how CMS implements those provisions through regulation. In several important respects, CMS's proposed rules extend beyond the changes Congress expressly enacted. As a result, the projected financial impact of the proposed regulations substantially exceeds the Congressional Budget Office's estimate of the legislation itself.

How CMS Proposed to Implement It: Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes (CMS-2452-P)

On July 21, 2026, CMS published a proposed rule to implement the provider tax provisions contained in §71115 of H.R. 1. While H.R. 1 established a statutory schedule to reduce the indirect hold-harmless threshold from 6% to 3.5%, the proposed rule will determine how those statutory changes are applied to individual state provider assessment programs. The Congressional Budget Office (CBO) estimated H.R.1 would reduce federal Medicaid payments to states by **$191 billion** over the 2025-2034 period; this CMS proposed rule is estimated to reduce federal Medicaid expenditures by **$246 billion**.

Because Virginia relies on provider assessments to finance the entire state share of Medicaid expansion and a significant portion of its hospital reimbursement programs, the final CMS regulations will have a substantial effect on the Commonwealth's available financing options. As CMS finalizes this rule, Virginia should carefully evaluate the interaction between the federal requirements and the state's existing provider assessment structure to preserve as much financing flexibility as federal law permits.

While much of CMS-2452-P implements the provider tax provisions enacted by Congress, the proposal also contains several policy changes not expressly required by H.R. 1, including elimination of the existing 75/75 Test, creation of a new permissible class for health insurers subject to provider tax restrictions, and expanded reporting requirements for states.

Because these regulations have not yet been finalized, Virginia should continue working with hospitals, DMAS, and other stakeholders to evaluate their potential effects and advocate for implementation that remains consistent with the statutory framework enacted by Congress.

Expected Impact on Virginia

Hospitals have already implemented extensive cost containment initiatives, workforce restructuring, supply chain optimization, revenue cycle improvements, and service consolidation following the COVID-19 pandemic and recent inflationary pressures. As a result, many providers have limited remaining ability to offset reductions through operational efficiencies alone.

As the permissible assessment threshold declines, Virginia will face a growing gap between available provider-financed revenue and the amount required to maintain current Medicaid commitments. The precise impact will depend on final federal regulations, the treatment of Virginia's individual assessments, future Medicaid expenditures, and decisions made by the Commonwealth.

These changes also cannot be evaluated independently from the State Directed Payment reductions contained in §71116. The Commonwealth may simultaneously face reduced provider assessment capacity and lower federal limits on the hospital payments that those assessments help finance. VHHA recommends that JCHC request a joint analysis by DMAS, the Secretary of Finance, and affected providers that identifies, by fiscal year:

- Projected reduction in permissible provider assessment revenue;
- Amount of state general funds or other financing needed to maintain existing Medicaid coverage and reimbursement;
- Impact on the financing of Medicaid expansion; and
- Potential options available to the Commonwealth under federal law.

This analysis should be updated as federal regulations are finalized and should be provided to the General Assembly before decisions are made that materially alter Virginia's Medicaid financing structure.

Changes to State Directed Payments (§71116)

Virginia's Current State Directed Payment Program

State Directed Payments are federally authorized Medicaid managed care payment arrangements that states use to improve provider reimbursement and preserve beneficiary access to care. In Virginia, SDPs help address the longstanding gap between base Medicaid reimbursement and the actual cost of providing care.

Before accounting for SDPs and other supplemental Medicaid payments, Virginia hospitals receive approximately 78 cents for every dollar spent caring for Medicaid patients. As a result, SDPs have become a foundational component of hospital reimbursement, helping support emergency departments, labor and delivery services, trauma care, behavioral health, pediatric services, and other essential programs.

In SFY 2026, SDPs represented approximately 20% of participating hospitals' annual net patient revenue statewide, approximately 23% among participating rural hospitals, and as much as 43% for certain rural, safety-net, and economically distressed hospitals. SDPs are funded entirely through assessments on private acute and critical access hospitals. These assessments account for 3.5% of the current 6% hold harmless threshold.

What Congress Enacted (§71116)

Currently, payment can be made up to the average commercial rate. §71116 fundamentally alters this arrangement. Beginning with applicable rating periods in 2028, grandfathered State Directed Payments above the applicable Medicare-based payment limit will be reduced by 10 percent of the grandfathered preprint amount (example, $500 million off $5 billion) each year until they reach 100% of Medicare.

How CMS Proposed to Implement It: Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2449-P)
On May 22, 2026, CMS published a proposed rule to implement §71116 from H.R.1. While Congress established a phased transition to a Medicare-based payment limit for certain State Directed Payments, the proposed rule would significantly expand the scope of those statutory changes.

The magnitude of the projected savings illustrates the distinction between the statute and CMS's implementation. The Congressional Budget Office (CBO) estimated that the H.R. 1 SDP provisions would reduce federal Medicaid spending by approximately **$149 billion** over ten years. By comparison, CMS estimates that its proposed rule would reduce federal Medicaid expenditures by approximately **$510 billion**, suggesting that the proposal reflects policy choices extending beyond those expressly directed by Congress.

For Virginia hospitals, several proposed policy changes are particularly significant.

- **Expand Medicare payment limits beyond the statutory framework:** H.R. 1 identifies four categories of services subject to the Medicare-based payment limit. CMS instead proposes a methodology that would ultimately apply Medicare-equivalent payment limits across virtually all hospital services furnished through State Directed Payments, substantially expanding the scope of the statutory provisions.
- **Require service-level Medicare comparisons:** Rather than permitting states to demonstrate compliance using broad inpatient and outpatient payment categories or provider classes, CMS proposes comparing Medicaid payments to Medicare at the individual service level. This service-by-service methodology is significantly more restrictive than the framework established by Congress and introduces substantial administrative complexity.
- **Replace aggregate methodologies with provider-specific calculations:** The proposed rule moves away from methodologies that evaluate payments across provider classes and instead requires increasingly granular provider- and service-specific calculations. This limits state flexibility while increasing administrative burden for states, managed care organizations, and providers.
- **Restrict operational flexibility:** The proposal would also eliminate or significantly restrict several operational flexibilities currently available to states, including limitations on separate payment terms and retroactive payment adjustments that have historically allowed states to administer State Directed Payment programs efficiently.

Collectively, these proposals would substantially reduce the flexibility Congress historically afforded states in designing Medicaid managed care payment programs. Virginia is concerned

that these regulatory changes could reduce Medicaid reimbursement far beyond what Congress contemplated when enacting §71116.

Because these regulations have not yet been finalized, Virginia should continue working with hospitals, DMAS, and other stakeholders to evaluate their potential effects and advocate for implementation that remains consistent with the statutory framework enacted by Congress.

Expected Impact on Virginia Hospitals
Over time, §71116 will substantially reduce one of the principal mechanisms Virginia uses to offset chronic Medicaid underpayment while hospitals continue financing Medicaid expansion through provider assessments.

As SDP reimbursement declines, some hospitals may contribute more through Medicaid-related assessments than they receive in net benefit from the associated hospital payment programs. This creates a long-term structural challenge for a Medicaid financing model that relies heavily on hospitals to contribute the non-federal share of coverage and reimbursement programs while offering increasingly fewer mechanisms to offset the cost of Medicaid underpayment.

If SDP funding is phased down while provider financing flexibility is simultaneously restricted, private acute care hospitals may face increasing difficulty continuing to support the financing structure that underlies Virginia's Medicaid expansion program. The effects extend beyond hospital balance sheets. Reduced Medicaid reimbursement may affect hospitals' ability to:

- Recruit and retain staff;
- Maintain labor and delivery programs;
- Sustain behavioral health, trauma, and emergency services;
- Invest in facilities, equipment, and technology;
- Preserve capital projects; and
- Continue investing in rural and underserved communities.

To illustrate the potential magnitude, not predict individual hospital performance, VHHA modeled one reasonable implementation scenario analysis using the most recent publicly available Virginia Health Information (VHI) financial data for 2024. The analysis applied estimated annual SDP reductions to each hospital's reported revenue and excess of revenues over expenses while holding other financial conditions constant. Under this illustrative scenario, by **2037, 57 of the 71 Virginia hospitals participating in the SDP program, approximately 80%, would have negative operating margins under the modeled conditions.** This estimate is not intended to predict each hospital's future financial position. Rather, it demonstrates the scale of the anticipated payment losses absent mitigating state or federal action.

Combined Operational and Fiscal Impacts

The coverage and financing changes described above do not operate independently. Taken together, they will affect both the revenue and expense sides of hospital operations. **Operationally**, hospitals expect to devote substantial additional resources to helping patients navigate eligibility redeterminations, community engagement reporting requirements, coverage

reinstatements, financial assistance programs, and other administrative processes. Financial counselors, patient access staff, case managers, social workers, and revenue cycle personnel will experience increasing demands as patients move on and off Medicaid coverage.

The uncertainty associated with pending federal regulations is itself producing operational consequences. Hospitals are making workforce, capital investment, service line, and budgeting decisions before final federal implementation requirements are known.

Financially, current estimates of the tax and state directed payment provisions are expected to reduce hospital funding by $34.7 billion in the next decade (2027-2036). Hospitals are alarmed about the combined impact of:

- Increased uncompensated care resulting from Medicaid coverage losses and churn;
- Reductions in Medicaid enrollment;
- Substantial reductions in Medicaid State Directed Payments;
- Restrictions on provider assessment financing;
- Changes in federal Marketplace premium assistance;
- Elimination of Medicaid inflation adjustments and rebasing updates; and
- Other federal reimbursement proposals affecting hospitals.

Individually, these changes present meaningful challenges. Collectively, they represent one of the most significant financing and reimbursement pressures Virginia hospitals have faced.

How Virginia Hospitals Are Preparing

Virginia hospitals are modeling multiple implementation scenarios, expanding eligibility and financial assistance support, evaluating the sustainability of Medicaid-dependent service lines, and reassessing workforce and capital plans.

These actions may help mitigate some effects, but hospitals cannot independently offset simultaneous coverage losses, reimbursement reductions, and restrictions on Medicaid financing. State partnership and timely policy action will therefore be essential.

State Elimination of Medicaid Inflation Adjustments and Rebasing Compounds Federal Reductions

Although not part of H.R. 1, Virginia's recent state budget actions will compound the effects of the federal Medicaid changes. Historically, inflation adjustments and rebasing have helped account for rising costs associated with labor, pharmaceuticals, medical supplies, technology investments, cybersecurity, regulatory compliance, and other operational expenses. These updates help narrow the gap between Medicaid reimbursement and the cost of delivering care. Recent state budget actions eliminated inflation adjustments for hospitals, nursing facilities, and disproportionate share hospital payments for FY 2027 and FY 2028 and permanently excluded those forgone updates from future inflation calculations and rebasing. This effectively results in base Medicaid payments to hospitals that will never reach the statutorily required 78% of costs unless action is taken to reverse budget language in the next General Assembly session.

According to estimates developed during the budget process, these changes are expected to reduce funding for Virginia hospitals and nursing facilities by approximately $700 million in general funds in SFY27. Of equal concern, permanently excluding forgone inflation adjustments from future calculations will cause Medicaid reimbursement to diverge further from actual costs over time. Viewed alongside H.R. 1, SDP reductions, provider tax restrictions, Medicaid enrollment changes, and expected increases in uncompensated care; these state actions become substantially more consequential.

Additional Federal Policy Considerations

340B Drug Pricing Program: Virginia hospitals are also concerned about ongoing federal discussions involving the 340B Drug Pricing Program. The 340B program allows eligible hospitals and providers to stretch limited resources and reinvest savings into services that benefit vulnerable and underserved populations. Across Virginia, hospitals use 340B savings to support behavioral health services, pharmacy access, community health programs, workforce investments, community outreach, and uncompensated care. At a time when hospitals face reductions in Medicaid reimbursement and increasing uncompensated care, further reductions in 340B-related resources could compound financial pressures and limit providers' ability to maintain services in underserved communities.

Site-Neutral Payment Policies: Virginia hospitals are also monitoring proposals that would expand site-neutral payment policies within Medicare and other federal programs.
Broad site-neutral payment proposals may not fully account for the unique obligations that hospitals assume, including maintaining emergency departments, trauma services, standby capacity, regulatory compliance infrastructure, teaching programs, and care for all patients regardless of ability to pay. Further reductions in hospital reimbursement through site-neutral payment policies could create additional financial pressure at the same time providers are absorbing changes associated with H.R. 1. Policymakers should evaluate the cumulative effect of these policies rather than considering each proposal in isolation.

Recommended Actions for JCHC and the Commonwealth

Although many of these federal policies cannot be altered by the Commonwealth, Virginia retains important policy choices regarding Medicaid administration, reimbursement policy, monitoring, and implementation. Timely state action can assist in mitigating unnecessary coverage losses, preserve hospital stability, and protect access to care for Virginians.

As Virginia prepares for implementation of H.R. 1 and related federal policy changes, state policymakers have an important opportunity to preserve access to care and strengthen the stability of the health care delivery system. VHHA recommends that JCHC take the following actions:

1. Restore Medicaid inflation and rebasing adjustments to avoid compounding impacts of federal changes: Restore hospital Medicaid inflation and rebasing adjustments and ensure that forgone FY 2027 and FY 2028 updates are not permanently excluded from future rate calculations.

2. Monitor the implementation and impact of H.R. 1 and related federal regulations: Direct DMAS, in coordination with the Secretary of Finance and affected stakeholders, to report annually on:

- Enrollment changes and procedural disenrollments;
- Provider assessment revenue;
- State Directed Payment reductions;
- State funding exposure;
- Uncompensated care;
- Hospital margins; and
- Service reductions.

3. Establish an early-warning process for hospital and service-line instability: Monitor rural hospitals, safety-net hospitals, obstetric services, behavioral health programs, trauma capacity, and emergency departments for material deterioration associated with federal or state policy changes.

4. Minimize avoidable coverage losses: Maximize automated verification, simplify exemptions and renewals, support rapid reinstatement, and provide hospitals and community partners with timely implementation guidance and data.

5. Preserve available Medicaid financing flexibility: Evaluate all options available under federal law to maintain Medicaid expansion, sustain hospital reimbursement, and preserve access to care.

6. Apply a cumulative-impact review to new state mandates: Before imposing new reporting, regulatory, liability, or reimbursement requirements, identify their fiscal and operational costs and evaluate how they interact with federal Medicaid reductions and existing hospital financial pressures.

Conclusion

Virginia's health care system is highly interconnected. The effects of H.R. 1 extend beyond any single Medicaid policy and should be evaluated collectively. Increased eligibility churn, reductions in Medicaid enrollment, restrictions on provider assessments, reductions in State Directed Payments, changes in Marketplace coverage, elimination of inflation adjustments, and other federal reimbursement proposals all have the potential to increase financial pressure on hospitals and reduce access to care.

Virginia's hospitals remain committed to serving their communities and ensuring access to high-quality care. That commitment, however, cannot by itself offset simultaneous reductions in coverage, reimbursement, and Medicaid financing flexibility. Without coordinated state action, these changes may result in higher uncompensated care, weaker hospital financial performance, delayed investments, and reduced access to essential services.

VHHA respectfully asks JCHC to recommend restoration of Medicaid inflation and rebasing adjustments, establishment of a formal H.R. 1 monitoring and reporting process, adoption of safeguards to minimize preventable coverage losses, preservation of all permissible Medicaid financing options, and careful evaluation of additional state mandates during the federal implementation period.

Thank you for your consideration. VHHA looks forward to working with JCHC, the General Assembly, the Administration, and other stakeholders to preserve a strong and sustainable health care delivery system for patients and communities throughout the Commonwealth.

Sincerely,



Sean T. Connaughton
President & CEO
Virginia Hospital & Healthcare Association

APPENDIX 3: Hospital and Health System Comment Letters to JCHC

Chief Executive Officer of VCU Health System Authority

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Marlon F. Levy, MD, MBA
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August 14, 2026

Ms. Mayesha Alam
Associate Staff Attorney & Health Policy Analyst
Joint Commission on Health Care
411 E. Franklin Street, Suite 505
Richmond, Virginia 23219

Dear Ms. Alam and members of the Joint Commission on Health Care:

On behalf of VCU Health System ("VCU Health"), thank you for the opportunity to provide comments regarding the potential impacts of H.R. 1, including VCU Health's preparations for implementation and ways the Commonwealth can help providers respond to these anticipated changes.

VCU Health is the primary provider of services to Medicaid beneficiaries and uninsured individuals in the Commonwealth. It is comprised of VCU Medical Center in Richmond (the region's safety net and No. 1-ranked hospital in the state), the Children's Hospital of Richmond at VCU, VCU Health Community Memorial Hospital in South Hill, Virginia, VCU Health Tappahannock Hospital in Tappahannock, Virginia and a 1992 clinician faculty practice plan. VCU Health also provides comprehensive, coordinated care through our outpatient care centers, an ambulatory surgery center, and joint venture collaborations with both Sheltering Arms Institute and Bayada Home Health Care. We are driven by our mission, which is to preserve and restore health for all people in Virginia, and we are committed to leading the nation in quality, affordability, and impact as a trusted and preferred academic health system.

As one of two "Type One" public teaching hospitals in the Commonwealth, VCU Health plays an indispensable role in delivering care to Medicaid beneficiaries, uninsured individuals, rural communities, and medically complex patients. Importantly, our institution also trains the next generation of physicians, nurses, and other health professionals while serving as a cornerstone of the Commonwealth's trauma, transplant, neonatal, and specialty care infrastructure.
We are concerned that several Medicaid-related provisions contained in H.R. 1 could have significant consequences for Virginia's health care delivery system, particularly for hospitals and health systems that care for a disproportionate share of low-income and vulnerable patients, like ours. These provisions will simultaneously impact both coverage and financing; in other words, VCU Health expects to see reductions in the number of patients insured through Medicaid, while also having fewer funding tools available to offset losses associated with increased uncompensated care.

Medicaid Coverage Changes and Increased Uncompensated Care
At VCU Health, nearly 30% of our patients are covered through Medicaid. The Congressional Budget Office has estimated that H.R. 1's Medicaid and related health coverage changes will reduce federal Medicaid spending substantially and increase the number of uninsured individuals by roughly 10 million people over the next decade. While it is difficult to predict how many of our patients will lose coverage and subsequently have no payer source, we are concerned that given the vulnerability of the population we serve, coverage loss could be considerable. In particular, we are concerned with the following policies in H.R. 1 that have the potential to significantly reduce Medicaid coverage in the Commonwealth:

1. *Medicaid Work Requirements*
Beginning in January 2027, states generally will be required to ensure that many Medicaid expansion adults ages 19 to 64 years document at least 80 hours per month of work, education, job training, community service, or other qualifying activities to maintain coverage, unless exempt. Exemptions include certain parents/caretakers, people with

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disabilities, individuals who meet medical frailty eligibility requirements, and some individuals receiving treatment for substance use disorders or mental illness.
Experience with Medicaid work requirement demonstrations in other states indicates that administrative burdens can be a major factor in coverage loss, even for individuals who remain substantively eligible for benefits. When beneficiaries encounter challenges meeting reporting or documentation requirements, coverage may be terminated for procedural rather than eligibility-related reasons. Given the medical and social complexities that our patients experience, we believe that this impact could be amplified at VCU Health.

2. *More Frequent Eligibility Redeterminations*
Medicaid expansion enrollees will now be required to undergo eligibility reviews every six months, rather than the annual renewal process generally used under prior law. This change is expected to significantly increase the administrative workload for DMAS, local Department of Social Services (DSS) agencies, and hospital financial counselors/patient access staff. As with work requirement verification, this may lead to some otherwise eligible individuals losing coverage because of paperwork or reporting issues.

3. *Reduced Retroactive Coverage*
The law also shortens certain retroactive Medicaid coverage protections, meaning some beneficiaries may have fewer months of prior medical expenses covered before the date of application.
Importantly, loss of coverage will not reduce the underlying need for health care services. Patients will continue to seek treatment after becoming uninsured – often in an emergent setting, with exacerbated health conditions – thereby shifting costs to providers and increasing uncompensated care burdens for hospitals and health systems. We are concerned that the downstream effects of these coverage changes will lead to disruptions in ongoing treatment for chronic conditions, reduced access to preventive and primary care services, and increased pressure on hospital financial counselors and patient access staff. Operationally, VCU Health is preparing to devote substantial additional resources to helping patients navigate eligibility redeterminations, community engagement reporting requirements, coverage reinstatements, financial assistance programs, and other administrative requirements. Financial counselors, patient access staff, case managers, social workers, and revenue cycle personnel will likely experience increased workload demands as patients move on and off Medicaid coverage.

It is critical to note that the aforementioned changes in Medicaid eligibility are coinciding with the recent expiration of enhanced Affordable Care Act premium tax credits. Until the end of calendar year 2025, the enhanced subsidies helped many individuals obtain and maintain coverage in the individual health insurance market. Following the expiration of those federal subsidies, premiums have increased in the individual marketplace, and some consumers have discontinued coverage because of affordability concerns. VCU Health is closely monitoring disenrollment trends in the Virginia Insurance Marketplace, which will potentially further increase uninsured rates and create greater uncompensated care burdens for safety net providers like VCU Health.

Limitations on Medicaid State-Directed Payments
VCU Health is particularly concerned about H.R. 1 provisions affecting Medicaid state-directed payments (SDPs). These payments have become an important tool used by states to support providers serving large numbers of Medicaid beneficiaries and to sustain access to specialized health care services. For many safety-net institutions, these supplemental payments support services that are not financially sustainable through Medicaid base payments alone, including trauma and burn services, neonatal intensive care, transplant services, graduate medical education, specialty care for complex patients, and essential community health programs.

The Commonwealth of Virginia has several different SDP programs organized around provider classes. Specific to VCU Health, the Virginia Department of Medical Assistance Services (DMAS) uses SDPs to ensure that "physicians affiliated with academic medical centers" and Type One hospitals (i.e., VCU Health and UVA Health) receive competitive Medicaid reimbursements. Effective January 2019, DMAS established a payment initiative for physicians affiliated with VCU Health and UVA Health to strengthen Medicaid beneficiaries' access to primary care networks and ensure effective management of Medicaid patients' chronic conditions. The payment is intended to supplement the base managed care and fee-for-service rates negotiated between MCOs and VCU Health's clinicians. Section 71116 of H.R. 1 caps the provider payment rate increases that could be provided under SDP programs for inpatient and outpatient hospital services, nursing home services or qualified practitioner services at an academic medical center at levels well below the average commercial reimbursement for rating periods beginning after the date

of enactment of the new law. Specifically, beginning January 1, 2028, the amount that may be paid through state-directed payment programs (SDPs) to hospitals and other providers will be reduced by 10% each year until they reach Medicare payment levels (which are currently only about 87% of costs). These statutory changes to state directed payments will reduce expected payments from this funding source by an estimated $5.1M in FY27, $17.7M in FY28 and $29.4M in FY29. The reductions will continue for an additional 7 years, jeopardizing the ability to cover costs for this patient population. This compounded with the no inflation adjustments to payments quickly depletes the available sources of funding to care for not only the safety net population but the broader population as well. Reductions in these funding streams could undermine the financial stability of providers that are critical to Virginia's health care infrastructure, including academic health systems. Academic health systems like VCU Health and UVA Health are uniquely vulnerable to reductions in Medicaid financing because they serve a disproportionate share of Medicaid beneficiaries while simultaneously fulfilling missions related to education, research, and highly specialized patient care. In Virginia, these institutions train physicians and other health care professionals who ultimately practice throughout the Commonwealth, including in underserved areas. Financial instability resulting from reduced Medicaid funding could affect our workforce training capacity, residency and fellowship programs, access to highly specialized care, research activities, and investments in community health initiatives. The long-term effects would be felt not only by the academic medical centers themselves but by patients and communities across Virginia that rely on these institutions for care.

Other Trends and Policies Impacting Hospital and Health System Finances

It is important to recognize that the impacts of H.R. 1 will not occur in isolation and may be compounded by several external factors that are already affecting hospitals and health systems. In Virginia, hospitals are already managing significant financial pressures associated with workforce shortages, rising labor costs, pharmaceutical inflation, supply chain challenges, and increasing administrative requirements. Many hospitals, particularly those serving rural communities, operate with limited financial flexibility.

Additional federal and state policy proposals may further impact hospitals' financial viability. These policies include:

State removal of Medicaid inflation adjustments

Historically, Virginia Medicaid inflation adjustments and rebasing have served as important mechanisms to account for rising costs associated with labor, pharmaceuticals, medical supplies, technology investments, regulatory compliance, cybersecurity, and other operational expenses. These regular state budget updates help narrow the gap between Medicaid reimbursement and the cost of delivering care.

Recent General Assembly action eliminates inflation adjustments for hospitals, nursing facilities, graduate medical education payments, and disproportionate share hospital payments for FY 2027 and FY 2028 and permanently excludes those forgone updates from future inflation calculations and rebasings. According to estimates developed during the budget process, these changes are expected to reduce funding for Virginia hospitals and nursing facilities by approximately $700 million.

Of equal concern, permanently excluding these forgone inflation adjustments from future calculations means reimbursement rates will continue to diverge from actual costs over time. As health care costs continue to rise, reimbursement will increasingly fall behind, widening gaps between Medicaid payment and the cost of providing care.

340B Drug Pricing Program

VCU Health is also concerned about ongoing state and federal discussions involving the 340B Drug Pricing Program. The 340B drug discount program allows eligible providers like VCU Health to purchase outpatient drugs at a discounted price, thereby allowing us to stretch scarce resources and reinvest savings into services that benefit vulnerable and underserved populations. At VCU Health and across Virginia, hospitals utilize 340B savings to support pharmacy access (including no cost/discounted medications for patients), workforce investments, and community health programs, such as VCU Health's medical-legal partnership that helps patients maintain housing, employment, public benefits and more.

At the federal level, multiple legislative and regulatory proposals are being considered that would significantly reduce the availability of discounted 340B drug pricing for hospitals. Similarly, just this year, Virginia considered a budget proposal that would have eliminated 340B drug savings for Medicaid outpatient drugs, instead allowing DMAS to recoup a more limited amount of savings through drug rebates. While this proposal was ultimately not

included in the final budget, it is our understanding that it may be discussed as part of the broader study mandated by the General Assembly around the 340B program.

Site-Neutral Payment Policies
VCU Health is also monitoring a number of proposals that would expand site-neutral payment policies within Medicare and other federal programs. While often framed as payment reforms, broad site-neutral payment proposals that reduce or eliminate hospital outpatient facility payments do not fully account for the unique obligations hospitals assume, including maintaining 24/7 emergency departments, trauma services, standby capacity, regulatory compliance infrastructure, teaching programs, and care for all patients regardless of ability to pay.
Further reductions in hospital reimbursement through site-neutral payment policies could create additional financial pressure at the same time providers are absorbing changes associated with H.R. 1. Policymakers should carefully evaluate the cumulative impact of these policies rather than considering each proposal in isolation.

How VCU Health Is Preparing
Since the passage of H.R. 1, VCU Health has been actively engaged in analyzing the legislation's statutory provisions, monitoring subsequent CMS regulations and preparing for implementation. Beginning on January 27, 2026, we convened an internal group of stakeholders, which includes representatives from patient access, social work, finance, revenue cycle, community health, health policy and our providers to discuss legal and regulatory updates, as well as to begin planning for implementation. This workgroup currently meets monthly, but this cadence may be altered as needed to meet operational needs.

Additionally, VCU Health is reviewing long-range financial projections under multiple implementation scenarios, assessing the impact of potential increases in uninsured patients, expanding patient coverage assistance efforts, and reviewing future workforce and capital investment plans. Where appropriate, we will attempt to apply for other available funding sources (including Rural Health Transformation grants) in order to continue offering services to populations in need.

VCU Health (along with UVA Health) has historically met with the DMAS Finance team on a quarterly basis to discuss financial and regulatory updates; however, we are exploring modifications to this cadence to better respond to the rapidly changing landscape.

How the Commonwealth Can Assist
As Virginia prepares to implement H.R. 1 and navigate associated federal policy changes, the Commonwealth has an important opportunity to support continued access to care and promote the long-term stability of its health care delivery system, including its two public academic medical centers. The implications of federal policy changes should not be evaluated in isolation. Rather, policymakers should consider their cumulative impact alongside existing financial and operational pressures, including rising labor and supply costs, growing uncompensated care burdens, increased administrative complexity, ongoing workforce challenges, and additional federal and state regulatory requirements.

To help mitigate these pressures and preserve access to care for patients across the Commonwealth, VCU Health respectfully encourages consideration of the following policy priorities:

- **Restore state Medicaid inflation adjustments** and reimbursement rebasing methodologies to help ensure payment rates more accurately reflect the increasing costs associated with delivering care in the Commonwealth.
- **Reduce avoidable Medicaid coverage losses** among individuals who remain eligible for benefits but may lose coverage due to administrative barriers, reporting requirements, or eligibility churn.
- Promote continuity of coverage by **streamlining eligibility and renewal processes and minimizing unnecessary administrative burdens** for both patients and providers. A key tactic to explore to support this process is the alignment of information systems among state agencies to minimize duplication of data collection for individuals who qualify for programs such as SNAP and Medicaid.
- **Maintain flexibility in Medicaid financing**, to the greatest extent permitted under federal law, to support reliable access to care and preserve the financial sustainability of Virginia's two public teaching hospitals.

- **Sustain investments in workforce development initiatives**, including graduate medical education, behavioral health workforce programs, nursing and clinical training opportunities, and other strategies that strengthen the health care workforce pipeline.
- **Preserve programs that support care for vulnerable populations**, including services supported through the 340B Drug Pricing Program, federally qualified health centers, free clinics, and community-based partnerships that expand access to care.

Conclusion

The Commonwealth's health care delivery system functions as an integrated ecosystem in which policy changes affecting one component can have significant implications for providers, patients, and communities throughout the state. Policymakers should evaluate these changes holistically, recognizing the potential interaction among increased eligibility churn, overall reductions in Medicaid and Marketplace enrollment, constraints on supplemental payment programs that sustain safety net providers, freezes to inflationary payment adjustments, and other federal reimbursement modifications.

As stated at the outset, VCU Health remains committed to its statutorily-grounded mission of providing high-quality, accessible care for all patients. Achieving that goal will require careful consideration of the collective impact of federal and state policy changes and a continued commitment to policies that support a strong, stable, and sustainable health care delivery system.

Thank you for your consideration of our comments. As your state partner, VCU Health looks forward to continuing to work closely with the Joint Commission on Health Care, the General Assembly, the Governor's Administration, and other stakeholders to advance policies that preserve access to care and strengthen Virginia's health care system for the patients and communities it serves.

Respectfully submitted,

DocuSigned by:
Marlon Levy
994C8F43EEE4499...

Marlon F. Levy, MD, MBA, FACS
Chief Executive Officer
VCU Health Authority

August 14, 2026

Ms. Mayesha Alam and the Joint Commission on Health Care
411 E. Franklin Street, Suite 505
Richmond, Virginia 23219

Re: Implications of H.R. 1 on UVA Health, Our Patients, and Our Community

Dear Ms. Alam and members of the Joint Commission on Health Care:

UVA Health appreciates the opportunity to provide comments to the Joint Commission on Health Care (JCHC) regarding the anticipated impacts of H.R. 1 on Virginia's Medicaid program and our health system. We are deeply concerned about how these changes will affect Medicaid beneficiaries and our ability to continue meeting the growing health care needs of patients across the Commonwealth.

UVA Health's Role as a Safety-Net Provider in Virginia

UVA Health serves patients from across Virginia and beyond, providing a broad range of primary, specialty, and highly complex care. The health system includes UVA Medical Center, the University of Virginia's lead teaching and research hospital in Charlottesville; three community hospitals; and an integrated network of primary and specialty care clinics throughout Charlottesville, Culpeper, Northern Virginia, and surrounding communities.

As one of Virginia's two public safety-net health systems, UVA Health serves all patients who come through our doors, regardless of their ability to pay. UVA Medical Center is home to Virginia's only Comprehensive Transplant Center for adults and children, a Level I Trauma Center, an NCI-designated Comprehensive Cancer Center, and the Commonwealth's top-ranked children's hospital. These and other highly specialized services mean UVA Health frequently cares for patients with serious and complex conditions who may have limited options for receiving care elsewhere. As an academic health system, UVA Health also plays a critical role in educating and training the next generation of physicians, nurses, and other health care professionals needed to meet Virginia's growing health care workforce needs.

Medicaid is particularly important to UVA Health and the patients we serve. Approximately 24% of UVA Medical Center inpatients are Medicaid beneficiaries, including 46% of pediatric and neonatal inpatients under age 18. At UVA Family Medicine, approximately 40% of patients are either uninsured or enrolled in Medicaid.

Our safety-net role is significant and extends well beyond the communities immediately surrounding our facilities. In FY25, UVA Medical Center provided over $250 million in indigent care, with the majority of indigent care patients residing outside of the Blue Ridge Health District. We anticipate that the number of patients requiring indigent care will grow as the new Medicaid eligibility requirements take effect and more Virginians experience coverage losses.

Given UVA Health's significant Medicaid population, safety-net responsibilities, and role in providing highly specialized care for patients across Virginia, changes to Medicaid coverage and reimbursement have a substantial impact on both our health system and the communities we serve.

Changes to State Directed Payments (§71116 and CMS-2449-P)

State Directed Payments (SDPs) are an important component of Medicaid financing in Virginia and help address the longstanding gap between Medicaid reimbursement rates and the cost of providing care. UVA Health is one of Virginia's two "Type One" hospitals, along with VCU Health. As state-owned academic medical centers and safety-net providers, Type One hospitals have a distinct Medicaid financing structure that recognizes their role in serving a disproportionate share of Medicaid and high-acuity patients and providing specialized services to patients across the Commonwealth.

H.R. 1 significantly changes this financing structure by establishing new limits on certain SDPs and requiring existing grandfathered payments to be phased down over time. For Medicaid expansion states such as Virginia, the law generally limits applicable SDP rates to 100% of the Medicare payment rate, well below the average commercial rate that serves as the current upper limit for these payments. Grandfathered SDPs above the new limits will be reduced annually by 10% until they reach the applicable cap. CMS has also proposed implementation approaches that could accelerate this phase-down, resulting in larger reductions in earlier years of implementation and creating additional uncertainty around the timing of the financial impact. These changes will substantially reduce an important source of Medicaid funding for UVA Health at a time when patient volumes and the cost of providing care continue to increase.

Medicaid Coverage and Eligibility Changes (§71109, §71110, §71103, §71107, §71112, §71119, §71104, §71121, §71106, §71120 and CMS-2454-IFC)

UVA Health is concerned that several Medicaid eligibility provisions included in H.R. 1 will result in coverage losses and disruptions among the patients and communities we serve. Of particular concern are:

> **Community engagement requirements:** Beginning in 2027, certain Medicaid expansion adults will be required to meet and document community engagement requirements to maintain coverage unless they qualify for an exemption. Additional reporting and verification requirements increase the risk that otherwise eligible individuals, particularly those with complex medical or social needs, could lose coverage because of difficulties navigating documentation or demonstrating an exemption.
>
> **More frequent eligibility redeterminations:** Medicaid expansion enrollees will be required to complete eligibility redeterminations every six months rather than annually, creating additional opportunities for coverage disruptions related to paperwork, reporting, or verification.

Reduced retroactive coverage: H.R. 1 shortens the period of retroactive Medicaid coverage available to certain beneficiaries, increasing the potential for care provided before an eligibility determination to go unreimbursed.

Patients who lose coverage will continue to need health care, and as a public safety-net health system, UVA Health will continue to provide that care regardless of a patient's ability to pay. Coverage disruptions may cause patients to delay preventive or routine care, interrupt treatment for chronic or complex conditions, or postpone filling prescriptions and other necessary services. These delays can allow manageable conditions to worsen, ultimately resulting in patients requiring more intensive and costly care, including emergency or inpatient services.

Implementation of the new eligibility requirements will also increase administrative costs for UVA Health. Helping patients navigate more frequent eligibility reviews and new reporting requirements will require additional staff time and resources across patient access, social work, financial counseling, and revenue cycle teams.

Broader Financial and Policy Pressures

The impacts of H.R. 1 will not occur in isolation. Hospitals are already navigating a challenging operating environment marked by persistent health care workforce shortages, rising labor and supply costs, growing medical malpractice pressures, and other regulatory and reimbursement changes. For UVA Health, several policy developments are particularly relevant to our ability to respond to the changes ahead: the suspension of Medicaid inflation and rebasing adjustments, growing uncertainty surrounding the 340B Drug Pricing Program, and site-neutral payment proposals.

Elimination of Medicaid Inflation and Rebasing Adjustments

Inflation adjustments are one of the ways the Commonwealth helps account for the rising cost of providing care to Medicaid patients. These adjustments recognize year-over-year increases in expenses such as labor, pharmaceuticals, medical supplies, technology, and other operating costs. For FY27 and FY28, the Commonwealth suspended the inflation adjustments that would otherwise be applied to Medicaid reimbursement, further widening the gap between Medicaid payments and the cost of providing care.

The long-term impact of foregoing inflation adjustments is evident from Virginia's previous Medicaid inflation freeze from 2008 through 2018. UVA Health continues to experience an estimated $14.5 million annual reduction in Medicaid payments as a result of those forgone adjustments. The FY27-28 inflation adjustments will similarly be excluded from future rate calculations, including rebasing, effectively carrying those reductions forward into future years. This is particularly concerning as UVA Health experiences patient volume growth beyond DMAS projections while Medicaid reimbursement increasingly diverges from the cost of providing care.

340B Drug Pricing Program Changes

The 340B Drug Pricing Program is an important resource that helps UVA Health stretch limited resources to expand access to care for vulnerable patients and communities. Savings generated through the program support clinical care, workforce training, research, and community outreach, including discounted medications and services for patients with financial needs and training physicians beyond federally funded GME positions. As H.R. 1 increases the number of uninsured patients and places additional financial pressure on hospitals, programs like 340B will become even more important to meeting growing community needs.

> **HRSA and manufacturer changes:** The future of the program is increasingly uncertain as the Health Resources and Services Administration (HRSA) considers changes to how discounts are provided and drug manufacturers continue efforts to impose additional restrictions on participating providers. Policy discussions in Virginia have also raised concerns about changes that could reduce the 340B savings available to hospitals. H.R. 1 creates an additional concern for UVA Culpeper Medical Center, where anticipated Medicaid enrollment declines are expected to result in the hospital losing 340B eligibility, further reducing resources available to support care in this largely rural community.
>
> **Medicare reimbursement reductions:** Separate from changes to the 340B program itself, CMS has proposed significant reductions in Medicare reimbursement for certain outpatient drugs purchased through 340B beginning in 2027. These changes would disproportionately impact large 340B programs like UVA Health and reduce the resources available to support patient care and other essential services.

Site-Neutral Payment Proposals

UVA Health is also closely monitoring site-neutral payment policies at both the federal and state levels. Federal proposals continue to seek reductions in Medicare reimbursement for certain services provided in hospital outpatient settings. These policies do not fully account for the higher costs and responsibilities associated with hospital-based care, including the infrastructure and specialized services necessary to care for complex patients.

Site-neutral payment proposals have also emerged in the Virginia General Assembly in recent years. If implemented, these policies could significantly reduce reimbursement for hospital outpatient services, further compounding the financial pressures facing hospitals and potentially affecting their ability to sustain services and invest in patient care.

UVA Health's Preparation and Response

UVA Health is preparing for the changes ahead across multiple areas of the health system, with a focus on supporting patients and preserving access to care.

Preparations are underway to support Medicaid expansion enrollees subject to new community engagement requirements. We are working with Albemarle County Department of Social

Services and internal patient-facing teams to provide information and resources to help patients understand and meet the new requirements.

As patient demand grows, UVA Health is exploring new ways to expand access to care, including through our growing telehealth programs. Funding through the Rural Health Transformation Program will help support this work in rural communities but is not intended to offset reductions in Medicaid funding.

Internal cross-functional teams meet regularly to assess developments and coordinate planning, including modeling changes to Medicaid coverage and reimbursement, patient volume and rising costs, and potential implications for future investments and expansion projects. We are evaluating a range of potential financing strategies to help address these pressures and look forward to working with DMAS as these options are further developed.

UVA Health remains actively engaged in the federal implementation process, including reviewing CMS rules and guidance and providing comments on proposals of particular concern, such as more aggressive SDP phasedowns and narrow definitions of medical frailty for purposes of community engagement exemptions.

Opportunities for Commonwealth Action

While many of the changes resulting from H.R. 1 are outside of the Commonwealth's control, Virginia can take steps to mitigate their impact on patients and providers.

1. **Restore Medicaid Inflation and Rebasing Adjustments**

   Restore Medicaid inflation and rebasing adjustments beginning in FY28 and ensure that the forgone FY27 updates are not permanently excluded from future rate calculations.

2. **Minimize Avoidable Coverage Losses**

   Simplify reporting, verification, exemptions, and renewals to help eligible Virginians maintain coverage, and provide clear and timely implementation guidance and resources to beneficiaries and providers.

3. **Support the Health Care Workforce and Provider Environment**

   Continue investing in workforce programs, including GME and loan repayment, and avoid unnecessary regulatory and administrative burdens that make it more difficult to recruit and retain providers in Virginia. UVA Health invests significantly in the Commonwealth's workforce through GME positions beyond those supported by state and federal funding and programs like Earn While You Learn. Growing financial pressures could limit the ability to expand these investments.

4. **Strengthen Virginia's Health Care Safety Net**

   Preserve and strengthen resources that support care for vulnerable populations, including allocating additional indigent care funding and modernizing eligibility guidelines to reflect current financial realities, protecting the 340B Drug Pricing Program, and considering targeted support for safety-net providers experiencing increased uncompensated care as H.R. 1 is implemented.

UVA Health remains committed to its mission of providing high-quality care to patients across the Commonwealth. The changes resulting from H.R. 1 will create significant financial and operational challenges for health systems while increasing the risk of coverage losses for the patients we serve. As these changes are implemented, we look forward to continuing to work with state partners to mitigate their impact, support Virginia's health care safety net, and preserve access to care for Virginians.

Thank you for the opportunity to provide comments and for JCHC's work to evaluate the impact of these changes on Virginia's hospitals and health systems. We would be pleased to provide any additional information that would be helpful and look forward to continued collaboration as the Commonwealth navigates the changes ahead.

Sincerely,



Mitchell H. Rosner, MD, MACP, FRCP
Chief Executive Officer, UVA Health
Executive Vice President for Health Affairs, University of Virginia
Henry B. Mulholland Professor of Medicine

Stephanie Schnittger

Stephanie Schnittger
Chief Financial Officer, UVA Health

CARILION CLINIC

August 21, 2026

The Honorable Barbara A. Favola
Chair, Joint Commission on Health Care
Commonwealth of Virginia
411 East Franklin Street
Richmond, VA 23219

Re: Carilion Clinic Comments — JCHC Study on the Impact of H.R. 1 to Virginia's Hospitals

Dear Chair Favola and Members of the Joint Commission on Health Care:

Carilion Clinic appreciates the opportunity to provide input for the Joint Commission on Health Care's review of H.R. 1 and its implications for Virginia hospitals. Because these policy changes will be felt differently across regions and communities, we welcome the Commission's focus on hospital-level effects, including the potential consequences for access, service availability, and financial sustainability.

Carilion's role in preserving care for Medicaid and uninsured patients

Carilion Clinic is a not-for-profit, mid-sized health system based in Roanoke and serving a broad region of western Virginia, as well as patients from neighboring communities in West Virginia, North Carolina and Tennessee. Our integrated model was built in part to sustain access across rural and medically underserved areas by connecting physicians, hospitals, outpatient practices, specialty programs, and community partnerships into a coordinated system of care. Medicaid coverage is a critical part of that care framework, particularly in communities where patients have fewer alternatives for local access to health care services.

Carilion provides care to approximately 98,000 unique annual Medicaid patients across the communities we serve — representing approximately 48,200 emergency department visits, 14,700 hospitalizations, 132,000 outpatient hospital visits, and 487,000 physician visits that help keep essential care available close to home for Medicaid patients and families throughout western Virginia.

For many patients across our service area, Carilion hospitals and clinical programs are the points of access for primary care, emergency care, inpatient services, obstetrics, behavioral health, trauma care, specialty consultation, and follow-up treatment. Carilion's ability to sustain this access depends on a systemwide approach that uses modest operating margin from our academic medical center and regional services to fill gaps in care across a broad, diverse, and primarily rural service area. This includes recruiting and supporting physicians in rural communities so primary and specialty care remain available locally, even when the cost of maintaining those services significantly exceeds payments generated by patient care.

Carilion also maintains small rural hospitals and an extensive network of ground and air ambulance transportation services that are essential to access but routinely operate at a loss. In many of the communities we serve, these services represent the only realistic pathway to timely emergency, inpatient, or complex care. Many of our patients are older and medically complex, with approximately **70%** of them covered by government-sponsored programs, primarily Medicare and Medicaid.

Carilion's responsibility to the region includes extensive support for people who are uninsured or underinsured. In FY2025, Carilion reported approximately $102.4M in total community benefit, including $25.8M in financial assistance or charity care, $4.2M in subsidized health services, $7.0M in community health improvement activities and $8.6M in donations and other in-kind contributions for community benefit. Carilion's community benefit investments also include health professionals' education and research totaling $56.8M.

Federal Medicaid changes most relevant to Virginia hospitals

The Medicaid provisions in H.R. 1 will affect both coverage and hospital finances. Taken together, the changes will make it harder for some eligible Virginians to remain enrolled and will place additional pressure on the funding streams that help hospitals care for Medicaid patients. The discussion below identifies the provisions most important to Carilion's patients and communities; we also support the broader analysis provided by the Virginia Hospital & Healthcare Association.

- *Coverage and eligibility:* H.R. 1 will add new eligibility, enrollment, and community engagement processes for Medicaid beneficiaries. Even when individuals remain eligible, additional bureaucracy, reporting rules, verification steps, and renewal requirements can interrupt coverage and / or payment for services rendered. The practical result may be more patients moving in and out of coverage, with delays in care and greater reliance on emergency or uncompensated services.
- *Provider assessments:* Virginia's Medicaid program depends in part on hospital provider assessments that help finance coverage expansion and hospital payments. H.R. 1 would narrow the federal parameters for those assessments over time, reducing flexibility for the Commonwealth and limiting a financing mechanism that has helped sustain coverage and reimbursement for the most vulnerable. In evaluating payment reductions, it is also important to recognize that hospitals do not retain the full gross amount of Medicaid supplemental payments because provider assessments finance a significant portion of the program; gross payment levels therefore overstate the net resources available to support care.

- *State Directed Payments:* Related to the provider assessments, State Directed Payments are another critical component of Medicaid financing because they help move payment closer to the cost of providing care. These payments support services that are costly but essential, including emergency medicine, trauma, obstetrics, pediatrics, behavioral health, and other hospital-based services. Under H.R. 1, reductions beginning in 2028 would lower reimbursement for Medicaid patients whom hospitals would continue to treat.

These provisions should be assessed as a combined effect. If fewer patients remain continuously covered while hospital Medicaid payments also decline, hospitals will face higher uncompensated care and lower reimbursement at the same time. Additional federal rulemaking currently being considered by CMS could further enhance the magnitude of those reductions, making it important for Virginia to evaluate the full range of potential outcomes.

Economic Impact of H.R. 1 Implementation

The changes in Medicaid eligibility and reduction in State Directed Payments because of H.R.1 will have a negative economic impact.

- Patients without health insurance avoid care at a higher rate than those with health insurance and, as a result, a less healthy workforce is a lower productivity workforce.
- A reduction of services would mean a reduction in people employed who provide those services.
- Less access to care close to home increases travel to receive care and lowers employee availability and productivity.
- Finally, and most importantly, we will continue our work to become more efficient and reduce costs to deliver care. Still, a significant portion of the reduction in Medicaid payments will be passed on in insurance rates for employers, employees and individuals purchasing commercial insurance coverage.

Higher employment costs and higher cost-of-living for individuals may lead to Virginia being less attractive to both existing and new businesses already struggling with persistent inflation.

How H.R. 1 would affect Carilion and access across western Virginia

Carilion's chief concern is the effect on patients, families, and communities across western Virginia. Based on the experience of state's who have implemented similar legislation, added administrative requirements will cause some eligible Virginians to lose or experience gaps in Medicaid coverage, while payment reductions would weaken the resources available to hospitals that remain obligated to provide care. For Carilion, these pressures will be most significant where communities already depend heavily on local hospitals and clinical programs for essential services, keeping in mind the greatest financial impact of reduced payments

will be for our academic medical center in Roanoke, which serves the higher level care needs for a large part of western Virginia.

Patients who lose coverage often postpone preventive care, medications, specialty follow-up, and management of chronic conditions. Those delays can lead to more acute needs and higher-cost care later. In western Virginia, where transportation, provider availability, and local service capacity already create barriers, coverage disruptions would place additional strain on emergency departments, rural hospitals, behavioral health services, and specialty programs.

Regulations for the implementation of H.R.1 related to State Directed Payments are not finalized. Projected reduction based on estimates available until final regulations are published indicate a reduction of at least 50% annually, which equates to approximately $140 million for Carilion Clinic.

Carilion also estimates that each 1% of payor mix movement from Medicaid coverage to uninsured status would result in a negative financial impact of approximately $5.3M systemwide.

The combined effect is a double strain on access: Medicaid payments would decline for covered patients, while coverage losses would increase the amount of care provided without insurance reimbursement.

Carilion respectfully recommends the Commission consider the following:

- **Make coverage continuity a central implementation goal.** Virginia should design its administrative processes to keep eligible people covered whenever possible. That includes using data matching, streamlined renewals, clear notices, reasonable opportunities to resolve discrepancies, and prompt reinstatement when coverage is interrupted. Carilion can support this work locally by helping patients understand coverage options, complete required steps, and connect to financial assistance when coverage is unavailable.
- **Prioritize state responses that protect patient access.** Virginia's policy response should focus on preserving adequate Medicaid reimbursement, supporting care for uninsured patients, and investing in workforce and behavioral health capacity. One immediate step would be to restore routine Medicaid rate inflation adjustments that were not included in the recently approved budget, which would better reflect rising care costs and preserve more than $450M in federal matching funds.
- **Analyze the financing changes as a package.** The provider assessment limits and State Directed Payment reductions should be modeled together because their effects will occur in the same financing environment and because gross Medicaid payment levels do not reflect the provider-assessment dollars hospitals contribute back into the

CARILION CLINIC

program. We recommend coordinated analysis by the Department of Medical Assistance Services, the Department of Planning and Budget, and affected providers to estimate statewide, hospital-level, and community-level impacts and identify available options under federal law.

- **Do not compound federal reductions with additional state-level cuts or cost pressures.** As hospitals prepare for the effects of H.R. 1, state proposals that would further reduce hospital resources or increase delivery costs should be approached with caution. Policies affecting the 340B program, site-neutral payment, or medical malpractice liability should be evaluated not only on their individual merits, but also for how they would add to the cumulative pressure on hospitals and the patients who depend on them.
- **Design solutions for all affected communities.** The impact of H.R. 1 will not be confined to one region or one type of hospital. A meaningful state response should account for large referral centers, rural and community hospitals, and every locality where Medicaid and uninsured patients rely on hospitals for access.
- **Use rural funding as a complement, not a replacement, for broader action.** Any dedicated federal support for rural services could help some communities, including portions of western Virginia. However, targeted funding alone will not address the broader coverage and reimbursement challenges facing hospitals that care for substantial Medicaid and uninsured populations across multiple settings.

Carilion appreciates the Commission's attention to these issues and stands ready to provide additional data as it becomes available. If you have any questions, please give me a call.

Sincerely,



Mark S. Lawrence
Vice President of Governmental and External Affairs
Carilion Clinic

Bon Secours Virginia
Comments to the Virginia Joint Commission on Health Care
Anticipated H.R. 1 Impacts on Our Virginia Facilities

Bon Secours appreciates the opportunity to share input with the Joint Commission on Health Care ("JCHC") as it studies the impacts of H.R. 1 on Virginia's Medicaid program and health care system. Bon Secours operates 11 hospitals and medical centers across the Commonwealth — spanning the Greater Richmond and Hampton Roads areas — including facilities serving rural and medically underserved communities such as Kilmarnock, Emporia, Richmond's East End, and Petersburg.

The following reflects Bon Secours' anticipated operational and fiscal impacts, viewed through the lens of coverage continuity and revenue cycle operations. Our primary concern is ensuring Virginians who remain eligible for Medicaid maintain uninterrupted access to coverage and care.

(1) Coverage continuity is our central concern.

- The greatest risk is not whether patients are *eligible* for Medicaid, but whether eligible patients remain *actively enrolled* when they receive care.
- Medicaid represents roughly **119,500 patient accounts (about 6.8% of our Virginia volume)**. As a result, disruptions in Medicaid coverage have the potential to affect a large number of patients and the care they receive.
- When coverage lapses, otherwise-covered care shifts into self-pay and uncompensated care. We already carry approximately **119,300 self-pay accounts**, yet self-pay generates only about **0.3% of payments** — illustrating how directly coverage loss erodes reimbursement.

(2) Work requirements and six-month renewals create additional opportunities for eligible patients to lose coverage for procedural reasons.

- New community-engagement requirements and semi-annual redeterminations, effective January 2027, create more frequent opportunities for eligible patients to lose coverage for procedural reasons.

- State data identifies **more than 28,000 potentially impacted Medicaid members in localities we serve** (including Henrico, Chesterfield, and Hanover) - exposure that maps directly to our markets.
- Even patients who are compliant or exempt could be at risk of coverage disruptions if their status is not documented or verified correctly, adding screening, financial counseling, and downstream rework.

(3) Reduced retroactive coverage narrows our window to secure reimbursement.

- Shortening retroactive coverage (to one month for Expansion members, two for others) leaves less time to establish Medicaid eligibility for care already delivered — particularly for emergency and unscheduled encounters — increasing uncompensated care.

(4) Financing changes adds to the pressure, independent of coverage.

- Provider tax and state-directed payment limits are expected to reduce the Commonwealth's ability to make supplemental payments to hospitals — support that is not currently scheduled to be backfilled by other state funds.
- This lands on a system already absorbing significant uncompensated care: approximately **$201 million in charity care and $12 million in bad debt** in the period reviewed, the majority of it driven by self-pay patients.

(6) Impact will be uneven across our footprint.

- These pressures will fall hardest on facilities serving rural, safety-net, and high-Medicaid communities, where margins are thinnest and the ability to absorb coverage loss is most limited.

(7) What would help most:

- Clear, well-resourced state implementation — including **timely member communication**, **streamlined renewals**, and **reliable eligibility-system readiness** — to minimize avoidable coverage loss among Virginians who remain eligible for Medicaid.

Bon Secours welcomes the opportunity to serve as a resource to the Commission as this study proceeds.

August 14, 2026

Ms. Mayesha Alam
Associate Staff Attorney & Health Policy Analyst
Joint Commission on Health Care
411 E. Franklin Street, Suite 505
Richmond, Virginia 23219

Dear Ms. Alam,

Thank you for the opportunity to provide comments on the anticipated impacts of H.R. 1 on Sentara Health, our patients, Medicaid members and the communities we serve. We appreciate this opportunity to share our perspective and provide insight into the challenges and decisions facing our health system as these policies are implemented.

Sentara is an integrated delivery network, operating 12 hospitals and a health plan whose central mission is to support Virginia's Medicaid members. With more than 34,700 employees across the Commonwealth, Sentara plays a significant role in Virginia's healthcare system and economy, contributing an estimated $20.7 billion in economic impact statewide in 2025. H.R. 1 will have significant impacts on how care is financed, delivered and accessed in our system.

Impacts of H.R. 1

The fundamental challenge Sentara faces is that federal healthcare funding is declining even as demand for healthcare services increases. As an organization committed to providing care to every patient who enters our system, regardless of insurance status or ability to pay, Sentara must continue to meet this growing demand with fewer resources available to do so. The impacts of H.R. 1 will extend across virtually every part of our health system, including reduced Medicaid funding and reimbursement, changes in coverage and enrollment, increased pressure on healthcare delivery, and financial and operational challenges for our health system. These impacts are interconnected and will affect not only Sentara's ability to provide care but also the patients and communities we serve.

Financial Impacts

H.R. 1 will place significant financial pressure on Virginia hospitals by reducing Medicaid payments available to providers through state-directed payments. These payments have historically helped hospitals bridge the gap between Medicaid reimbursement rates and the actual cost of providing care. The proposed rule issued by the Centers for Medicare and Medicaid Services (CMS) to guide implementation of H.R. 1 vastly exceeds the intent of the statute and would severely limit the ability of states to use this tool to

ensure fair reimbursement for providers caring for Medicaid members. According to the Virginia Hospital and Healthcare Association, the proposed rule could result in more than $31 billion in reduced Medicaid funding in Virginia over the next decade. These reductions could make it more difficult for hospitals to maintain essential services, including emergency care, behavioral health treatment, and labor and delivery. Sentara estimates that Medicaid reimbursement rates could decrease by 40% as Virginia moves toward Medicare-level rates, a substantial cut in reimbursement even as we continue to provide the same level of care to all of our patients, including Medicaid members.

Sentara currently operates on narrow margins of 3–5%, leaving limited room to absorb reimbursement reductions. Our acute care operations generate $400 million to $700 million in annual operating margin, which supports the continued delivery of care and investment in the workforce, facilities, technology, and access to care in the communities Sentara serves. We estimate H.R. 1 could have an annual financial impact on Sentara of $700 million per year upon full implementation, potentially eliminating the margin generated by acute care operations.

The proposed regulations for state-directed payments under H.R. 1 would not only exacerbate those cuts but would also impede our ability to determine the financial impacts and plan accordingly. Under the proposed rule, reimbursement would be applied at the individual service level, with the Medicare rate serving as the ceiling for each service, rather than applying the cap across the average for all services. Because of the large number of individual services and payment rates involved, Sentara has been unable to precisely model the full financial impacts of the proposed rule. The proposal will be onerous for hospitals and managed care organizations (MCOs) to implement and accurately administer.

Maintaining Medicaid Coverage

The implementation of H.R. 1 will also introduce new and more complex requirements for obtaining and maintaining Medicaid coverage. These new barriers will inevitably result in a decrease in Medicaid enrollment. More uninsured patients will seek care in the emergency department, where our hospitals will incur higher costs to treat patients with greater medical needs while receiving little or no reimbursement. Sentara hospitals had approximately 693,000 emergency department visits in 2025, and an increase in uninsured patients seeking treatment in emergency departments would place additional pressure on a system already managing a substantial volume of emergency care.

Sentara has been working to prevent avoidable emergency department use by connecting patients with primary and preventive care, including outpatient services and telehealth, before their conditions require more intensive treatment. However, disruptions in coverage will make it more difficult for patients to maintain an ongoing connection to their primary care providers and other healthcare services, potentially interrupting access to medications, chronic disease management, preventive care, behavioral health treatment, and specialty care. Sentara already provides services to an average of 177 patients each day who are unable to pay for their care, and the number of self-pay patients has increased by 14% in 2026. Sentara anticipates that, as a result of these disruptions, more patients may delay or forgo care and ultimately seek treatment in emergency departments after their conditions have become more serious.

The changes to Medicaid enrollment and eligibility requirements under H.R. 1 will also significantly impact Sentara's Medicaid health plan. Sentara has already begun to see enrollment declines in anticipation of these changes and expects additional members to lose coverage as new administrative hurdles arise. As

more members are disenrolled, Sentara expects the remaining population to be more medically frail, leaving the health plan with a smaller enrollment base with more costly treatment needs. We saw a similar phenomenon during the "unwinding" period following the COVID public health emergency, but expect the H.R.1 impacts to be more concentrated.

Access to Community-Based Care

This combination of historic cuts and uncertainty emerges at a time when we are already confronting a multitude of operational challenges, including rising costs of labor, pharmaceuticals, technology, and other resources needed to provide care. This confluence of financial headwinds raises significant questions about our ability to maintain the level of support that we have historically committed through our annual community benefit. That commitment has been substantial. In 2025, Sentara invested $382 million in our communities, including $182 million in uncompensated care, $25 million in health and prevention programs, $148 million in teaching and training healthcare professionals, as well as $27 million in community giving. While we expect the amount of uncompensated care to increase significantly due to H.R.1, the resources for targeted community expenditures such as workforce training and public health programs will be significantly reduced.

Sentara invested $3.7 billion in our workforce in 2025, demonstrating our dedication to maintaining and supporting a strong healthcare workforce. Financial pressure from H.R. 1 could affect Sentara's ability to invest in and retain the healthcare workforce needed to meet continued demand for care. As hospitals are asked to provide the same level of care with fewer resources, there may be less flexibility for employee compensation, professional development and workforce expansion. Lower Medicaid reimbursement may also make it more difficult to maintain an adequate provider network, as some providers may be less willing or able to accept Medicaid members as patients.

Preparation for H.R. 1

Sentara recognizes that we do not have the financial capacity to absorb these reductions, and we have already begun taking steps to mitigate the anticipated decrease in federal reimbursement and funding. Internally, we are preparing to consolidate operations, renegotiate with suppliers and identify ways to improve efficiency. Sentara is also pursuing changes to how care is delivered, including expanding primary care capacity, increasing the role of advanced practice providers and other members of the care team, implementing recruitment goals for 2026-2028, and actively recruiting physicians, advanced practice providers, and other members of the care team. These efforts include evaluating whether some care can be safely provided in more efficient ambulatory and outpatient settings, developing team-based models for managing complex chronic conditions, expanding ambulatory care capabilities, and using telehealth and other technologies to improve access and support clinical capacity. As part of these efforts, Sentara is implementing a three-year plan focused on increasing value, with a goal of creating nearly $1 billion in additional value. Even with these internal cost reductions and efficiency efforts, however, Sentara will not be able to fully replace the cuts from H.R 1.

As we work internally, Sentara is also seeking to educate patients, members, front-line staff, and community partners on H.R.1, its potential impacts, and new requirements, as they become known. This education ensures that all stakeholders are aligned and working collaboratively.

The uncertainty surrounding H.R. 1 has placed significant strain on Sentara's ability to plan for the future. Even with the law's staggered implementation, Sentara must make long-term budgeting and strategic decisions before the full financial and operational impacts are known. As policies, regulations, and implementation requirements continue to evolve, Sentara must plan for the worst-case scenario, including making major decisions regarding capital investments, workforce, services, and operations to mitigate potential impacts. While this approach allows Sentara to prepare for the most significant impacts of H.R. 1, lingering uncertainty and policy dissonance create challenges as we attempt to make strategic decisions around how resources should be allocated and which investments can be sustained over time.

Other Considerations

Beyond H.R. 1, federal regulators and Congress are also implementing or considering significant changes related to longstanding health policies that have supported the health care safety net. These changes affect the 340B Drug Pricing Program, hospital nonprofit status, vertical integration and provider consolidation, as well as access to care in rural settings, telemedicine, and medications.

In August 2026, the Health Resources and Services Administration proposed a revised 340B rebate model that would replace current upfront discounts with a rebate process for certain drugs negotiated by Medicare under the Inflation Reduction Act, beginning January 1, 2027. This change would add a new layer of uncertainty and lead to inevitable interruptions in reimbursements for hospital financing.

Congress is also examining the tax-exempt status of nonprofit hospitals and questioning the value of the community benefits they provide. H.R. 9504 would impose significant and duplicative new reporting requirements on tax-exempt hospitals. Proposals surrounding vertical integration and consolidation threaten to limit growth necessary for mid-sized health systems to survive and thrive in the current policy and budget environment. The consequence of such market interference is likely to be a smaller number of siloed entities that are less motivated to work collaboratively on solutions to pressing health care challenges. Smaller providers will be left with fewer options, leading to closures, particularly in rural regions.

Support Needed to Mitigate Impacts

Sentara urges state leaders to continue efforts to minimize avoidable procedural disenrollment and provide effective renewal education and assistance so that eligible individuals can maintain coverage or regain it when disruptions occur. Without adequate education and outreach, members may lose their connection to the healthcare system and become more likely to delay or forgo care. Maintaining that connection will be critical to preventing disruptions in care and reducing avoidable emergency department use.

To support this effort, Sentara also urges state leaders to provide clear and timely guidance on implementing H.R. 1. Sentara will continue to face challenges in effectively training staff, communicating changes to members and providers, and preparing our operations if implementation guidance is delayed or unclear. Rushed implementation could also increase administrative burdens and make it more difficult to ensure that patients and providers understand how the new requirements will affect them. However, we cannot communicate these changes effectively without the resources to do so. Sentara urges state leaders to

provide resources and support for educating communities about the implementation of H.R. 1 and how the changes may affect their coverage and access to healthcare.

The state can also help mitigate these impacts by investing in Virginia's healthcare workforce and broader healthcare safety net. Expanding training opportunities for physicians and advanced practice providers, as well as providing loan forgiveness and other incentives to retain healthcare professionals in Virginia, would strengthen the workforce needed to meet the continued demand for care.

Federally qualified health centers, free clinics, community-based providers, behavioral health organizations and other safety-net partners will be essential to meeting increased demand as Medicaid coverage changes take effect. Hospitals should be recognized as essential anchors for the safety net and included in strategies to maintain access to care across the Commonwealth. These investments will be particularly important as hospitals face increasing financial pressure while continuing to serve patients with complex healthcare needs.

Sentara remains committed to providing high-quality care to the communities we serve and to adapting to changes resulting from H.R. 1. However, the combination of reduced Medicaid funding, lower reimbursement rates, increased administrative requirements, and potential coverage losses will pose significant challenges for our health system and the patients who rely on it. Sentara will continue to identify opportunities to improve efficiency and prepare for these changes, but the health system cannot address these challenges alone. Continued state support, timely implementation guidance, community education, preservation of coverage, and investment in Virginia's healthcare workforce and healthcare safety net will be essential to maintaining access to care and ensuring that patients continue to receive the care they need.

Sincerely,

August 13, 2026

The Honorable Barbara Favola
Chair, Joint Commission on Health Care
Commonwealth of Virginia
411 East Franklin Street
Richmond, VA 23219

Re: Inova Health Comments — JCHC Study on the Impact of H.R. 1 to Virginia's Hospitals

Dear Chair Favola and Members of the Joint Commission on Health Care:

On behalf of Inova Health, thank you for the opportunity to comment on the operational and fiscal impacts of H.R. 1's Medicaid changes on Virginia's hospitals. We appreciate the Commission's attention to an issue with direct consequences for patients and communities across the Commonwealth.

Inova's commitment to quality and access for patients with Medicaid coverage and those who are uninsured

As Northern Virginia's leading nonprofit health system, Inova reinvests our resources in the communities we serve. Inova is one of the largest providers of services to Medicaid enrollees in Virginia, with 265,000 unique annual Medicaid patients and more than 910,000 annual Medicaid patient visits. Approximately one-third of the 19,200+ annual births at Inova hospitals are to patients with Medicaid coverage. Demonstrating our commitment to this patient population, Inova's outcomes on key quality and safety metrics – for example, c-section rates – exceed our commercially-insured population. Delivering world-class care to this patient population is core to our mission as our community's trusted health partner.

Inova has a similar commitment to patients across our region who do not have insurance coverage. Inova's financial assistance, or charity care, policy is among the most generous of any health system in the Commonwealth or the greater Washington region. Patients whose incomes are at or below 400% of the federal poverty level are eligible for 100% free care with no sliding scale. Patients who reside in the Commonwealth for six months are eligible, and once qualified they remain eligible for a 12-month period without having to reapply. In 2025, Inova provided $193 million in at-cost charity care, a 28% increase year over year.

Accessible, integrated care to this patient population is foundational at Inova. We operate a growing network of more than 30 care sites – the Inova Cares network – dedicated exclusively to patients who are covered by Medicaid, uninsured, underinsured, or who qualify for Inova charity care. Located in communities with the highest social vulnerability, the network provides primary care, OB-GYN, pediatric, behavioral health, hospital discharge transition, and HIV/AIDS care to patients across our region. Inova Cares sites stretch from as far south as Dumfries, as far north and east as Alexandria, and as far west as Leesburg and Manassas.

Medical providers at these sites exclusively serve this patient population and collaborate closely with community health workers, case managers, and our government and non-profit community partners to ensure we address the full social drivers of health that meaningfully contribute to each patient's unique health needs.

The major Medicaid changes driven by federal policy

H.R. 1 makes several interrelated changes to how Medicaid is financed and administered. Individually, each is significant; together, they reduce both the number of Virginians with coverage and the resources available to care for them. We summarize the most consequential changes below and refer the Commission to the Virginia Hospital & Healthcare Association's comment letter for additional detail.

Coverage and eligibility
H.R. 1 establishes new eligibility, enrollment, and community engagement requirements. The added administrative complexity around reporting, verification, and documentation creates a risk that some Virginians who remain eligible will lose coverage. When patients lose coverage, their health needs do not disappear. How these requirements are implemented will largely determine how many eligible individuals keep their coverage.

Provider assessments
Virginia hospitals are financial partners in the Commonwealth's Medicaid program by financing the state share of Medicaid expansion and hospital reimbursement through provider assessments. H.R. 1 reduces the federal hold-harmless threshold applicable to these assessments over time, limiting the revenue available to support coverage and reimbursement.

State Directed Payments
State Directed Payments help close the longstanding gap between base Medicaid reimbursement and the actual cost of care, supporting essential services such as emergency, trauma, labor and delivery, behavioral health, and pediatric care. Beginning in 2028, H.R. 1 phases these payments down by 10 percentage points annually — reducing reimbursement for the Medicaid patients we will continue to serve.

These changes are best understood together, not in isolation. Because provider assessment flexibility is being restricted at the same time State Directed Payments decline, hospitals face a structural challenge in sustaining the financing model that has supported Virginia's Medicaid expansion. The federal rules also remain in progress, and CMS has proposed to apply these limits more broadly and through more restrictive methodologies than Congress expressly required. This threatens to deepen the reimbursement reductions beyond what H.R. 1 envisioned on its own.

Impact of changes in federal policy to Inova and the communities we serve

Our primary concern is the impact to the communities we have the privilege to serve. H.R. 1

will raise out-of-pocket costs for lower-income working adults in the Medicaid expansion population and add new administrative requirements to maintain coverage. Evidence consistently shows that higher costs and added barriers lead patients to delay or forgo care. When routine and chronic care is deferred, conditions too often present later and more severe. These are often treated in the emergency department, the least coordinated and most expensive setting, when earlier intervention would have been better for the patient and less costly for the system.

That strain contributes to longer wait times for every patient who needs emergency care — something especially meaningful at Inova Fairfax Hospital, home to Northern Virginia's only Level I Trauma Center and the fourth-busiest emergency department in the nation. As a non-profit health system, Inova has intentionally reinvested in community access — growing our Inova Cares network, expanding primary and specialty care, and tripling our urgent care footprint — not only because it is right for our community's health, but because it relieves pressure on our emergency departments and enables us to operate a more efficient system for everyone.

Additionally concerning are the operational and financial realities of the H.R. 1 cuts. Once fully implemented, our financial projections indicate the net negative impact of H.R.1 cuts to be at least $450 million (when compared to 2026 dollars). We are also beginning to experience the impact of coverage changes at the federal level in our health system through higher than anticipated volume of uninsured patients and a reduction in patients whose coverage comes from Affordable Care Act exchange plans. When combined with the anticipated increase in uninsured patients due to Medicaid changes, this is a meaningful impediment to our success in better serving our patients and community. **H.R. 1 reduces reimbursement for hospital care provided to the Medicaid enrollees we will continue to serve, while at the same time increasing the number of patients who lose coverage and come to Inova as uninsured**. These two consequences compound one another: lower reimbursement for the patients we continue to treat, and more patients for whose care we receive no reimbursement at all. This is a structural change in how essential care is financed, not a temporary budget fluctuation.

Inova investments in community access and operational response to H.R. 1

Despite these considerable financial headwinds, Inova is committed to reinvesting our non-profit resources to sustain and enhance access to care, and we are planning accordingly. In fact, Inova has approximately $7 billion in Board of Trustees approved capital investments planned over the coming seven years – an unprecedented commitment to re-investment in our community. Recent and current investments include:

- **Replacing Inova Alexandria Hospital at two sites** – this $2+ billion project includes a new Inova Alexandria Hospital at the former Landmark Mall site, and a new hospital in the Franconia-Springfield community.
- **Three Inova Health Centers** – primary, multispecialty, and ambulatory surgery services in Alexandria/Oakville (2024), Woodbridge (2025), and Gainesville (2030). The Oakville

and Gainesville sites include 24/7 emergency services.

- **Additional acute care beds at Inova Loudoun Hospital** to meet the needs of our region's fastest growing locality.
- **Renovated Adult and Pediatric Emergency Department at Inova Fairfax Hospital** to modernize Northern Virginia's only Level 1 Trauma Center.
- **Establishing the region's only Critical Illness Recovery Hospital** so patients do not have to travel outside of our region for long term acute care services.
- **Continued growth in our Inova Cares network** including new primary and specialty care clinics in Herndon and Dumfries opened in the past year.

Inova is committed to these investments – many are underway, and all have the full support of our Board of Trustees. These are long-term commitments that meet our community's needs and expectations now and for decades to come. They were made with the expectation of a stable foundation for investing in a financially responsible, sustainable manner. H.R. 1 changes that foundation, and we are carefully evaluating what it means for the pace and scope of future community investments as well as the expense structure of our current operations. Maintaining status quo from a pre-H.R. 1 world is simply not responsible or feasible given the fundamental restructuring of the reimbursements associated with the high volume of services we provide, and will continue to provide, to Medicaid enrollees. As we evaluate any changes we must make in response to the shifts driven by H.R. 1, our organizational priority is to ensure the nationally recognized patient care we provide to all patients - regardless of ability to pay - is fully preserved.

We respectfully offer the following observations for the Commission's consideration:

- **Prioritize a best-in-class Medicaid enrollment program.** The Commonwealth must ensure it minimizes Medicaid coverage losses among individuals who remain eligible for coverage but risk losing access because of administrative barriers, increased reporting requirements, or eligibility churn. The Commonwealth should use every available administrative flexibility — including automated data matching, simplified exemption and renewal processes, clear advance notice, opportunities to correct errors, and rapid reinstatement — to maximize coverage continuity for those who remain eligible while minimizing administrative burden and uncompensated care. Inova will do its part through our hospital and community-based enrollment teams who help patients identify coverage options or access Inova financial assistance.
- **Support that sustains patient access and adequate provider reimbursement is most helpful.** Stability in Medicaid provider reimbursement, continued support for services to Medicaid and uninsured patients, and investment in workforce and behavioral health capacity would do the most to protect access for Virginians. The Administration and General Assembly can first prioritize restoring the routine Medicaid rate inflation adjustments that were not incorporated in the recently approved budget – a choice that does not reflect the rising cost of providing care and forgoes more than $450 million in federal matching funds.
- **Conduct a coordinated analysis of the combined impact**. Because the provider

assessment and state directed payment changes take effect at the same time, we encourage the Commission to recommend a joint analysis by the Department of Medical Assistance Services, the Department of Planning and Budget, and affected providers to identify the statewide and hospital-level impacts and the financing options available under federal law.

- **Reject policies that would further compound H.R. 1 cuts**. The General Assembly has recently considered legislation and budget proposals that would further cut hospitals as we brace for the H.R. 1 cuts. Proposals related to the 340B program and "site neutral" payments are both poorly timed and harmful policy to hospitals and the patients we serve, and we urge the General Assembly to continue to reject them. Moreover, policies that threaten to add substantial cost to healthcare delivery and destabilize the provider community – such as drastic modifications to the medical malpractice cap – should be evaluated through the lens of their cumulative impact when combined with these cuts.
- **The impact of these changes is felt statewide.** Every Virginia hospital is affected, and hospitals serving the largest numbers of Medicaid enrollees are among the most exposed. Any effective response should be statewide in scope and should reach every hospital and community affected.
- **Federal relief is not evenly available.** H.R. 1 includes a dedicated fund for services provided in rural communities. Hospitals like Inova, which serve large Medicaid and uninsured populations in more urban and suburban communities, absorb these impacts without comparable federal support.

Inova shares the Commission's goal of a stable, accessible health care system for every Virginian. We welcome the opportunity to serve as a resource as this study proceeds, and I am glad to discuss any of these points further.

Sincerely,

Michael Forehand
Vice President
Government Relations and Public Affairs
Inova Health

Riverside Health

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August 21, 2026

Ms. Mayesha Alam
Associate Staff Attorney & Health Policy Analyst
Joint Commission on Health Care
411 E. Franklin Street, Suite 505
Richmond, Virginia 23219

Re: Riverside Health Comments, JCHC Study on the Impact of H.R. 1 on Virginia's Hospitals

Dear Ms. Alam:

Riverside Health appreciates the opportunity to provide information regarding the potential impact of H.R. 1 and related policy changes to our health system and the communities we serve. While important implementation details remain under development, Riverside's preliminary analysis indicates the direction is clear: the combined effect of H.R. 1 and related federal regulatory changes will significantly reduce Medicaid-related funding and increase uncompensated care—potentially reshaping how hospitals across Virginia fund care and maintain services. For Riverside, the challenge is to understand the combined impact of these changes and plan responsibly while continuing to provide and expand access to high-quality care and support the communities we serve.

Our mission is to care for others as we would care for those we love, to enhance their well-being and improve their health. We live that mission through five acute care hospitals, three specialty hospitals and a medical group of more than 800 physicians and advanced practice providers. Our network covers approximately 8,000 square miles, including Virginia's Eastern Shore, the Middle Peninsula, the Virginia Peninsula, and Isle of Wight County. Patients can access preventive and primary care through over 25 primary care and internal medicine locations, virtual visits, and five urgent care centers open seven days a week.

Our hospitals, medical practices, and community programs work together to keep care close to home. Riverside's residency programs and Riverside College of Health Sciences also prepare the physicians, nurses and other health professionals our region needs. In some communities, Riverside is one of the few, and at times the only, providers of emergency care, obstetrics, behavioral health, trauma care and advanced specialty services. Policy decisions that reduce coverage or reimbursement affect our ability to maintain that care, build the workforce, and improve outcomes for every patient, regardless of payer status.

Commitment to Medicaid, Uninsured, Underserved Patients, and the Communities We Serve

Riverside's role can be seen in the patients we serve and the services we maintain. This includes:

- Serving nearly 59,000 Medicaid patients annually through more than 380,000 outpatient visits and approximately 9,900 emergency visits, including 2,200 psychiatric emergency visits
- Providing approximately 6,000 inpatient admissions for Medicaid patients, including 2,000 psychiatric admissions
- Delivering 1,600 babies each year that are covered by Medicaid
- Providing over $240 million in uncompensated care annually
- Employing more than 10,500 team members throughout Eastern Virginia
- Generating over $1.6 billion in economic impact in Virginia annually
- Sustaining emergency, maternity, pediatric, behavioral health, cancer, cardiovascular, surgical, rehabilitation, primary, specialty, senior, home health, hospice, and critical access services in rural communities.

Riverside also provides advanced care that is not widely available elsewhere in the region. Riverside Regional Medical Center is home to the Virginia Peninsula's only Level II Trauma Center and certified Comprehensive Stroke Center. Primary Stroke Centers in Williamsburg, Gloucester, Smithfield and on the Eastern Shore extend rapid diagnosis and treatment across our service area. These programs connect patients to emergency, surgical, critical care, and rehabilitation services when minutes matter.

Sustaining this network requires predictable funding for 24/7 clinical capacity, workforce, facilities, technology and care for patients who cannot afford it. Riverside helps finance Virginia's Medicaid program through provider assessments and relies on State Directed Payments to offset a portion of the gap between Medicaid reimbursement and the cost of care. These responsibilities leave Riverside especially vulnerable to the combined effects of H.R. 1 and related federal regulations.

The potential impact of H.R. 1 can be considered in four primary areas:

1. Coverage and eligibility

H.R. 1 and CMS's interim final rule add eligibility, enrollment and community engagement requirements. Additional reporting, verification and documentation increase the risk that people who still qualify will lose coverage. Some may postpone preventive care, interrupt treatment for chronic conditions, or turn to an emergency department after their condition has worsened.

For Riverside, current planning estimates suggest that approximately 1,000 current or prospective patients may be unable to reenroll in Medicaid and uncompensated care could increase by approximately $60 million annually. Riverside currently invests approximately $2 million each year in a contract with a third-party organization that helps patients with eligibility and enrollment. That support may need to double or even triple as requirements become more complex. These estimates remain subject to validation as federal and state implementation decisions are finalized.

Coverage losses would affect people who already face the greatest barriers to care, including low-income families, rural residents, patients with behavioral health or substance use

needs, people with chronic conditions, mothers and babies, children, older adults, and individuals facing transportation, housing, food access, or care-navigation challenges.

2. Provider assessments

Virginia hospitals, including Riverside, help finance the Commonwealth's Medicaid program through provider assessments. Those contributions support Medicaid expansion and hospital reimbursement, making hospitals both care providers and financial partners in the program.

H.R. 1 gradually narrows the federal rules governing these assessments, reducing the revenue states may use to support coverage and reimbursement. At the same time, CMS has proposed additional limits and reporting requirements that could further restrict Virginia's flexibility. Because these policies are still being finalized, the ultimate effect on Riverside and the Commonwealth remains under review.

3. State Directed Payments

State Directed Payments allow Virginia to strengthen Medicaid reimbursement and support access where base rates do not cover the cost of care. For Riverside, these resources help sustain emergency, trauma, maternity, pediatric, behavioral health, cancer, cardiovascular, primary, specialty, and rural services, as well as workforce development and medical education.

H.R. 1 limits future State Directed Payments and phases down certain existing arrangements. CMS has proposed broader Medicare-based payment limits and more restrictive methodologies that could deepen and accelerate the reductions. Riverside's annual and cumulative financial exposure remains under review as these policies are finalized.

4. Other reimbursement, regulatory and liability pressures

Medicaid is only part of the financial pressure facing hospitals. Reductions to Medicare funding through sequestration and payment updates that lag behind the cost of labor, supplies, technology, and pharmaceuticals continue to reduce purchasing power. Site-neutral policies would lower payment for hospital outpatient diagnostic and specialty services without fully recognizing the staffing, equipment, readiness, and quality safeguards those settings require.

Drug acquisition rules, rebate administration, and compliance reporting also shift substantial work to health systems, even when related savings do not return to providers. Hospitals must meet expanding transparency, quality, enrollment, claims, and payment reporting requirements. Changes to Virginia's medical malpractice structure or liability framework could add cost and make recruitment more difficult. Together, these obligations consume resources that could otherwise support patient care. The cumulative effect will influence access, quality, workforce stability, and the ability to invest in community needs.

Impact of Policy Changes on Riverside Health and the Communities We Serve

Our greatest concern is what these changes will mean for patients, team members, and communities. Higher out-of-pocket costs and more complex Medicaid requirements may cause people to postpone preventive care, follow-up visits, and treatment for chronic conditions.

Delayed care often means more serious health needs and greater reliance on the emergency department for services that could have been provided earlier in a more coordinated setting.

That added demand can lengthen waits for every patient and is especially important at Riverside Regional Medical Center, home to the Virginia Peninsula's only Level II Trauma Center. As a nonprofit health system, Riverside invests in primary care, urgent care, specialty services, virtual access, and community programs that help patients receive care earlier and preserve emergency capacity for the most serious needs.

Taken together, Riverside currently estimates that H.R. 1 and related federal policy changes could reduce annual federal funding to the health system by at least $200 million beginning in late 2027, while simultaneously increasing uncompensated care. The combination of lower reimbursement and higher levels of unpaid care presents a significant challenge to maintaining services, workforce investments, and planned community access initiatives.

Riverside's Investments in Community Access

Riverside continues to invest in facilities and services that respond to documented community needs. These commitments depend on a stable financial base. Recent investments include:

- Riverside Smithfield Hospital: Riverside opened the new 200,000-square-foot, 50-bed hospital in January 2026, an investment of more than $250 million. Early inpatient activity has exceeded projections, and emergency department-to-inpatient conversion is well above typical community hospital expectations. Strong demand for treatment of sepsis, heart failure, respiratory failure, and renal disease reflects pent-up need in a community where many residents previously traveled outside the area for hospital care.
- Psychiatric emergency care: Riverside invested $18 million to open Virginia's first stand-alone psychiatric emergency department, expanding 24/7 crisis care for adults and children and supporting outpatient behavioral health, bridge clinic, and substance use disorder treatment services.
- Rural access: Riverside sustains comprehensive care on Virginia's Eastern Shore, including one of only nine rural hospitals in Virginia that continues to offer obstetric services, and supports provider-based services that operated at a $4.6 million loss in 2024.
- 340B investments: Riverside Regional Medical Center and Riverside Shore Memorial Hospital participate in the 340B Drug Pricing Program. In fiscal year 2024, Riverside provided $31 million in community benefit because of savings realized from the 340B program. These savings help sustain safety-net, rural, behavioral health, medication access and advanced specialty services, including reduced or no-cost medications for uninsured and underinsured patients.

Riverside is also planning investments to expand hospital capacity, behavioral health, rehabilitation, pharmacy, diagnostic technology, cardiovascular care, and ambulatory access. Priorities include additional inpatient capacity in Smithfield, a medical center in Carrollton, a

neuro-transitional rehabilitation program in Williamsburg, and new MRI, CT, cardiac catheterization, emergency and interventional radiology capacity. These projects are intended to improve access, quality, and outcomes. Changes in coverage and reimbursement may affect their timing, scope and sequence.

Recommendations for the Commission's consideration

Based on Riverside's experience to date, several steps could help mitigate the anticipated impacts of H.R. 1. These include:

1. Restore Medicaid inflation and rebasing adjustments

Restore routine Medicaid inflation and rebasing adjustments and ensure that FY 2027 and FY 2028 updates are incorporated into future rate calculations. Restoring these adjustments would help offset growing federal funding reductions and support continued access to care across Virginia. According to estimates provided during the 2026 General Assembly session, the exclusion of this adjustment forgoes over $450 million in federal matching funds to Medicaid providers over the biennium.

2. Monitor implementation, analyze the combined impact and establish an early-warning process

Direct DMAS, in coordination with the Department of Planning and Budget, the Secretary of Finance and affected providers, to conduct a joint statewide and hospital-level analysis and report annually on:

- Enrollment changes and procedural disenrollments;
- Provider assessment revenue;
- State Directed Payment reductions;
- State funding exposure;
- Uncompensated care;
- Hospital margins; and
- Service reductions.

3. Establish an early-warning process for hospital and service-line instability

Monitor rural and safety-net hospitals, obstetric and behavioral health services, trauma capacity and emergency departments for material deterioration associated with federal or state policy changes.

4. Minimize avoidable coverage losses

Maximize automated verification, simplify exemptions and renewals, support rapid reinstatement and provide hospitals and community partners with timely implementation guidance and data. Support targeted outreach and enrollment assistance funding to help eligible Virginians maintain Medicaid coverage during implementation of new eligibility and community engagement requirements.

5. Preserve available Medicaid financing flexibility

Use every option available under federal and state law to maintain Medicaid expansion, sustain hospital reimbursement and preserve access to care.

6. Apply a cumulative-impact review to new state mandates

Before imposing new reporting, transparency, pharmaceutical, liability or reimbursement requirements, identify their fiscal and operational costs and evaluate how they interact with Medicaid reductions, Medicare payment pressure, sequestration, and site-neutral policies. New policies should recognize differences in patient complexity, quality expectations and the standby capacity required in hospital settings.

7. Protect the 340B Drug Pricing Program and the health care safety net

Review proposals affecting 340B, site-neutral payments, and other hospital reimbursement policies alongside the Medicaid reductions in H.R. 1. Riverside's 340B savings support rural, behavioral health, medication access, and advanced specialty services. Reducing these resources would place additional pressure on access for vulnerable patients and communities.

Conclusion

Riverside's preliminary analysis indicates changes to Medicaid eligibility, enrollment, and financing could have meaningful financial and operational effects on the health system and the communities it serves. The potential reduction in Medicaid-related funding, combined with possible increases in uncompensated care, creates a need for careful planning and continued monitoring as federal and state implementation decisions are finalized and other legal and regulatory changes impacting the delivery of health care in Virginia are considered.

We remain committed to providing safe, high-quality care and improving outcomes for every patient, regardless of insurance status or ability to pay. Riverside has cared for Eastern Virginia for more than a century, and we look forward to working with the Commission and members of the General Assembly to ensure we continue to deliver care for another century and beyond.

Sincerely,



Mark Duncan
Associate Vice President, Government Relations
Riverside Health

Children's Hospital of The King's Daughters
Health System

August 19, 2026

Ms. Mayesha Alam
Associate Staff Attorney & Health Policy Analyst
Joint Commission on Health Care
411 E Franklin St Ste 505
Richmond, VA 23219

Re: Implications of H.R. 1 on Children's Hospital of The King's Daughters, Our Patients, and Our Community

Dear Ms. Alam:

Thank you for the opportunity to comment on the implications of H.R. 1, related federal rulemaking, and recent state policy changes affecting Virginia's health care system.

I write on behalf of Children's Hospital of The King's Daughters (CHKD), which is located in Norfolk, Virginia, and is the Commonwealth's only freestanding, full-service children's hospital, and is the regional pediatric referral center for southeastern Virginia, the Eastern Shore of Virginia, and northeastern North Carolina – a service area with approximately 400,000 children. In 2025, CHKD provided more than 750,000 inpatient and outpatient visits for the children and families we serve.

Every day, CHKD cares for patients regardless of their insurance status or ability to pay. As the region's sole provider of pediatric medical and surgical subspecialty care, and as the hospital with the highest Medicaid utilization rate in Virginia, CHKD is truly a safety net provider. Therefore, we must emphasize that the cumulative effect of these policy changes threatens our patients, workforce, and ability to sustain essential services.

Current reimbursement policy changes should not be viewed independently. H.R. 1, its related federal rulemaking, and recent state and federal policy actions are making access to care more challenging for our patients and making the resources available to treat Medicaid beneficiaries and patients in underserved communities increasingly scarce. For CHKD, it is the convergence of these changes, not any single policy in isolation, that poses the greatest risk to our ability to care for the children of greater Hampton Roads.

Our Role in the Community

CHKD is an essential part of the health care and economic infrastructure of the Commonwealth. In Fiscal Year 2025, we:

- Provided care for approximately 61,552 visits to our emergency departments—35,326 of which were Medicaid beneficiaries;
- Experienced 3,010 mental health emergency department visits—a 220% increase since 2018;
- Employed more than 4,000 professionals;
- Provided comprehensive Level IV NICU services for over 500 admissions;
- Completed nearly 1,500 mobile intensive care transports;
- Supported the treatment and management of sickle cell disease through 2,500 patient encounters; and
- Delivered care to pediatric cancer patients across more than 4,000 clinical visits.

As the Commonwealth's only freestanding children's hospital, CHKD provides services no other hospital in the region offers – Level IV neonatal intensive care, pediatric trauma care, comprehensive inpatient and outpatient mental health treatment, and the full continuum of subspecialty medical and surgical care for children suffering from devastating childhood diseases or catastrophic injuries. Sustaining that scope of care requires sufficient and predictable funding. This enables our hospital to keep our emergency department and NICU staffed around the clock, recruit and retain specialized pediatric clinicians, invest in the facilities and technology those services depend upon, and continue treating every child who comes through our doors regardless of ability to pay.

Changes to State Directed Payments and FFS Supplemental Payments (§71116 and CMS-2449-P)

State Directed Payments are a critical component of Virginia's Medicaid program because they help address the longstanding difference between base Medicaid reimbursement and the actual cost of providing care.

Our organization currently receives approximately $11 million annually through State Directed Payments for physician services. Additionally, CHKD receives nearly $2.3 million in Fee-For-Service (FFS) supplemental payments. Neither of these reimbursements for CHKD were impacted by the original language of H.R. 1.

Unfortunately, the recent proposed CMS rulemaking extends the payment limits established under H.R. 1, which currently applies only to specific SDPs, to cover nearly all SDPs and certain targeted Fee-For-Service (FFS) supplemental payments. This is a significant expansion in scope and one that was not anticipated after the passage of H.R. 1. We are concerned this approach will substantially impact our health system and the patients we serve.

Based on our current analysis, the rulemaking could reduce our SDPs for physician services by $8 million and our FFS supplemental payments by $2.15 million. This would leave our health system with just $3 million in SDPs for physician services and only $150,000 in FFS supplemental payments. A reduction in this size will make it increasingly challenging to fulfill our mission as a freestanding children's hospital and affect our patients' access to care.

Loss of Medicaid Inflation and Rebasing

The loss of Medicaid inflation adjustments and rebasing at the state level compounds financial pressure at the same time hospitals are preparing for federal Medicaid reductions. Hospitals continue to experience significant increases in labor, pharmaceuticals, medical supplies, technology, cybersecurity, and regulatory compliance costs. Without regular inflation adjustments and rebasing, Medicaid reimbursement will continue to fall further behind the actual cost of delivering care.

We estimate that the elimination of the inflation adjustments will reduce funding to CHKD by approximately $8 million in the upcoming fiscal year. Of particular concern, permanently excluding forgone adjustments from future calculations would compound these losses over time and embed the reductions into the future Medicaid base rate. These state actions should be evaluated alongside H.R. 1 and related federal regulations because they compound the effects of federal Medicaid reimbursement reductions and cause Medicaid payment rates to diverge even further from the actual cost of delivering care over time.

We respectfully urge JCHC to recommend restoration of hospital Medicaid inflation and rebasing adjustments and to ensure that forgone FY 2027 and FY 2028 updates are not permanently excluded from future rate calculations.

Combined Impact on Patients and Access to Care

Individually, each of these policy changes presents meaningful operational and financial challenges for CHKD. Collectively, they represent a significant threat to our organization, affecting both the number of patients who remain covered and the financial resources available to care for them. CHKD is evaluating its workforce plans, capital investments, and clinical services because we cannot offset simultaneous reductions in coverage, reimbursement, and Medicaid financing flexibility.

For CHKD, that means creating significant barriers to care for the children and families we serve and impacting our ability to recruit and retain pediatric physicians, nurses, and specialized staff.

These consequences would extend beyond hospital finances. They would affect patients, families, employers, local governments, community partners, and the broader health care safety net.

Recommendations

We respectfully urge JCHC and the Commonwealth to:

1. Restore Medicaid inflation and rebasing adjustments

Recommend restoration of hospital Medicaid inflation and rebasing adjustments and ensure that forgone FY 2027 and FY 2028 updates are not permanently excluded from future rate calculations.

2. Monitor the implementation and impact of H.R. 1 and related federal regulations

Direct DMAS, in coordination with the Secretary of Finance and affected stakeholders, to report annually on:

- Enrollment changes and procedural disenrollments;
- State Directed Payment reductions;
- State funding exposure;
- Uncompensated care;
- Hospital margins; and
- Service reductions.

3. Establish an early-warning process for hospital and service-line instability

Monitor rural hospitals, safety-net hospitals, obstetric services, behavioral health programs, trauma capacity, and emergency departments for material deterioration associated with federal or state policy changes.

4. Minimize avoidable coverage losses

Maximize automated verification, simplify exemptions and renewals, support rapid reinstatement, and provide hospitals and community partners with timely implementation guidance and data.

5. Preserve available Medicaid financing flexibility

Evaluate all options available under federal and state law to maintain Medicaid expansion, sustain hospital reimbursement, and preserve access to care.

6. Apply a cumulative-impact review to new state mandates

Before imposing new reporting, regulatory, liability, or reimbursement requirements, identify their fiscal and operational costs and evaluate how they interact with federal Medicaid reductions and existing hospital financial pressures.

Conclusion

CHKD has served the children of Hampton Roads for generations, and today, we remain the Commonwealth's only freestanding, full-service children's hospital and the regional pediatric referral center for southeastern Virginia, the Eastern Shore of Virginia, and northeastern North Carolina. We are more than a hospital. We are Health, Healing, and Hope for all Children. That is our mission. But our commitment to this community cannot, by itself, offset the simultaneous reductions in coverage, reimbursement, and Medicaid financing flexibility that

H.R. 1, related federal rulemaking, and recent state and federal policy actions would impose. No amount of institutional resolve can substitute for sufficient and predictable funding.

Without coordinated state action and continued engagement throughout implementation of pending federal regulations, CHKD anticipates significant headwinds that will make our job of serving Hampton Roads' children more difficult.

We respectfully ask JCHC to consider the cumulative impact of these policies, not in isolation but as they compound one another, and to recommend state actions that preserve Medicaid coverage, sustain hospital reimbursement, protect essential pediatric services, and support the workforce required to deliver them.

CHKD stands ready to work with JCHC, DMAS, and the General Assembly throughout this process, and we appreciate the opportunity to share our perspective on behalf of the children and families we serve.

Sincerely,



Amy Sampson
President and CEO
Children's Hospital of The King's Daughters

Augusta Health

Care that makes a lifetime.

August 7, 2026

Mayesha Alam
Staff Attorney and Health Policy Analyst
Joint Commission on Health Care
Pocahontas Building
Richmond, Virginia

Re: Impact of H.R. 1 and Subsequent Federal Medicaid Policy Changes on Augusta Health

Dear Ms. Alam:

On behalf of Augusta Health, thank you for the opportunity to provide comments regarding the anticipated operational and fiscal impacts of H.R. 1 and related federal Medicaid policy changes on hospitals throughout the Commonwealth. We appreciate the Joint Commission on Health Care's efforts to understand how recent federal actions may affect providers, patients, and communities across Virginia.

These issues are of particular importance to Augusta Health. Augusta Health operates as a sole community hospital, a CMS rural reclassified hospital, and as a CMS designated Rural Referral Center. We are the primary community health system for the residents of Augusta County, Virginia, and the municipalities of Staunton and Waynesboro. However, we also serve broader Shenandoah Valley regions. Augusta Health's total service area covers a population of 350,000 Virginians from Harrisonburg to Glasgow, and from Hot Springs to Crozet, across 42 practice sites throughout these Virginia communities.

The Medicaid program plays a **vital** role in our mission. In 2025, Augusta Health provided care to more than 22,000 Medicaid beneficiaries through nearly 97,000 encounters, including inpatient admissions, observation stays, emergency services, outpatient care, surgeries, behavioral health services, maternity services, and newborn care. Medicaid reimbursement, including Virginia's State Directed Payment program, helps support access to care for some of our region's most vulnerable populations. As you are aware, Augusta Health is located in the 6th Congressional district, a region in which 25% of Virginians are dependent on Medicaid.

Augusta Health's Long Range Financial Forecast

Like most health systems in Viriginia, when H.R. 1. became law on July 4th, 2025, Augusta Health was in the midst of a financial turnaround post the Covid-19 pandemic. In fact, we were in year two of a planned five-year recovery period. Like all health systems across America post pandemic, Augusta Health has faced substantial financial challenges from rising labor costs, increased supply and pharmaceutical expenses, workforce shortages, demographic changes, Medicare Advantage penetration, and overall reimbursement pressures from commercial payers. It is relevant to note that 70% of Augusta Health's revenue comes from government payors, who reimburse below cost.

H.R. 1 significantly disrupted the progress of our financial recovery and now places a material negative outlook for Augusta Health. Beginning in 2027, Augusta Health anticipates increases in uncompensated care resulting from Medicaid eligibility restrictions, work requirements, and more frequent eligibility redeterminations. We are already experiencing an increase in uncompensated care due to the 19% year to date decreased enrollments in the healthcare ACA marketplace due to loss of enhanced premium tax credit subsidies. Between 2028 and 2036, reductions in Medicaid reimbursement, associated with changes to provider assessments and State Directed Payments will further erode revenue. The conversion of Medicaid patients to uncompensated care will also make Augusta Health ineligible for 340B drug pricing discount program, by 2028, a program that currently results in $6 million/year of drug discounts that falls to our bottom line and allows us to fund unreimbursed community care, such as the Augusta Health Neighborhood Clinic program which provides 26 clinics/month in the deeply rural areas of our communities.

Our analysis projects that the combined effects of increased uncompensated care, declining Medicaid reimbursement, and related policy changes will negatively impact Augusta Health's operating performance by approximately $40 million plus annually by 2034.

Several specific provisions of H.R. 1 contribute to this forecast:

- Medicaid work requirements and semiannual eligibility reviews will increase coverage losses and administrative barriers for patients. As a result, Augusta Health projects a commensurate increase of $5 million in uncompensated care as formerly insured patients lose coverage but continue to require essential healthcare.

- Reduced retroactive Medicaid eligibility periods will result in approximately $1 million annually in revenue at risk.

- Changes to State Directed Payments will reduce Augusta Health's annual Medicaid rate improvement (State Directed Payment revenue). If further reductions occur as promulgated through the proposed rule as outlined below, Augusta Health will go from $72.3 million in 2025 to $4.46 million in 2036.

- Reduced Medicaid utilization places Augusta Health's eligibility for the federal 340B Drug Pricing Program at risk, eliminating $6 million annually in pharmaceutical savings.

The Long-Range Financial Forecast illustrates that these federal policy changes are occurring on top of an already challenging healthcare environment characterized by inflationary pressures, workforce shortages, increasing demand for services, and reimbursement levels that often fail to keep pace with actual costs.

Augusta Health's Alignment Plan

Recognizing these realities, Augusta Health has initiated the development of a comprehensive operational "alignment" plan to align to our new financial realties while working to preserve long-term financial stability and continuing to provide high-quality care to our community.

The alignment plan was developed immediately in 2025, in partnership with Augusta Health's community-based Board of Directors and is being implemented through a phased and adaptive approach. Because the timing and magnitude of federal reimbursement reductions remain uncertain, the plan is designed to remain flexible and responsive as future policy changes become clearer. In other words, we believe the $40 million worth of cuts may actually be a best-case scenario as the federal government aims to implement more cuts as identified in the proposed rule discussed below, pending site neutral payment reductions cited in the proposed outpatient rule, and the threat of Reconciliation 2.0.

The alignment plan currently focuses on identifying opportunities to strengthen operations while maintaining access to essential healthcare services. Areas currently being evaluated include:

- Strategic growth of service lines where Augusta Health can expand access and recapture market share;
- Workforce and labor management initiatives that improve operational efficiency while supporting employee retention and recruitment;
- Benefit plan redesign and healthcare cost management strategies;
- Optimization of clinical and operational processes; and
- Additional organizational efficiencies and potential service closures that may offset the anticipated loss of federal funding.
- Growth in philanthropic endeavors

While no final decisions have been made, it is clear that hospitals throughout Virginia will be required to evaluate difficult operational choices. Our objective is to implement thoughtful, deliberate measures that protect patient care while ensuring the organization's long-term sustainability. If the proposed rule described below were to be finalized, the proposed cuts will need to be a multiple of the current $40 million alignment plan.

Additional Concerns Regarding CMS's proposed changes to State Directed Payments compounding the challenges created by H.R. 1.

On May 22, 2026, CMS issued the Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments ("State Directed Payment rule") that would substantially alter the Medicaid State Directed Payment program increasing the national Medicaid cuts from $149.5 Billion to over $510 Billion; a 3.5 times increase. Augusta Health is deeply concerned that the State Directed Payment rule goes significantly beyond the statutory changes enacted by Congress and could result in substantial additional reductions in Medicaid funding. State Directed Payments have become an essential component of Medicaid financing and help address longstanding gaps between Medicaid reimbursement rates and the actual costs of providing care.

These funds support critical services that otherwise operate at financial losses, including behavioral health services, community outreach initiatives, medical education programs, and care delivery in rural and underserved communities. For Augusta Health, State Directed Payment funding helps sustain programs that are essential to our mission and our region.

Among our principal concerns with the State Directed Payment rule are:

- The potential reduction of allowable State Directed Payment funding levels beyond those required by Congress;
- New service-by-service Medicare-equivalent payment calculations that would create significant administrative burden for states, hospitals, and managed care organizations;
- Restrictions that reduce flexibility to support services lacking meaningful Medicare equivalents, including pediatric and behavioral health services;
- Accelerated phase-down provisions that could further destabilize providers serving high Medicaid populations; and
- Additional reporting and compliance requirements that impose substantial operational costs without corresponding improvements in program integrity.

When considered alongside H.R. 1, these proposed regulatory changes create a cumulative effect that is far more consequential than any individual policy action. Hospitals are being asked to absorb reductions in coverage, reimbursement, and supplemental payments simultaneously while continuing to meet increasing community healthcare needs.

Augusta Health remains committed to providing high-quality, accessible healthcare services to the residents of Augusta County and surrounding communities. However, the combined impact of H.R. 1 and the proposed CMS State Directed Payment rule presents significant concerns regarding patient access, uncompensated care, Medicaid reimbursement, and the long-term financial sustainability of healthcare providers.

Our Long-Range Financial Forecast demonstrates that the *status quo* is not sustainable and that substantial operational adjustments will be required to offset the projected impact of these federal policy changes. Through our alignment planning process, Augusta Health is proactively preparing for these challenges. Nevertheless, policies that significantly reduce Medicaid coverage or funding will inevitably affect hospitals' ability to maintain services and invest in their communities.

Augusta Health currently operates numerous mission related services that are essential to the community yet operate at a loss. These services include outpatient and inpatient behavioral health, skilled nursing services, labor and delivery services, numerous inpatient admissions by medical specialty, and a mobile clinic that provides needed care at 26 remote sites monthly. ***While we are not prepared to announce service closures at this time, our entire model of community-based care is at risk. As fiscal challenges increase, evaluating our ability to provide services that do not necessarily pay their own way becomes a necessity.***

Lastly, you asked what types of support would be most helpful to mitigate the impacts of H.R. 1 on our organization. One meaningful action Virginia could consider is funding some portion of the Commonwealth's Medicaid expansion obligation through General Fund appropriations rather than relying exclusively on hospital provider assessments. Virginia hospitals currently finance the state's share of Medicaid expansion coverage through these assessments, which are projected to total approximately $745 million statewide in State Fiscal Year 2027.

Recommended State Action: General Fund Support for the Commonwealth's Expansion Share

Hospitals are being asked to finance the state's expansion obligation at the same time federal policy changes are reducing coverage, reimbursement, and supplemental payments that support care delivery. Every dollar of provider assessment funding assumed by the Commonwealth would allow hospital resources to remain within Virginia's healthcare delivery system, where those dollars can support financing mechanisms that leverage substantial federal matching funds. Based on current financing structures, each dollar preserved within the provider funding system has the potential to support approximately $3.50 in federal funding for Virginia hospitals.

As a result, even partial state funding could generate a meaningful return for Virginia's healthcare system while helping hospitals offset federal Medicaid reductions and preserve patient access to care.

At Augusta Health alone, the Medicaid expansion assessment totaled approximately $11.3 million in 2025. Relief from even a portion of that obligation would materially strengthen our ability to maintain essential community services, sustain access to care, and absorb the financial impacts described above.

Few policy options available to the Commonwealth offer a comparable opportunity to preserve healthcare access, strengthen hospital financial stability, and maximize the impact of healthcare dollars already being invested in Virginia.

We greatly appreciate the Joint Commission on Health Care's interest in these issues and welcome continued dialogue regarding strategies to mitigate the impact of federal Medicaid policy changes on Virginia's hospitals and the patients we serve. We are happy to provide additional information and to serve as a resource to the Commission as it advances its work on behalf of the health of Virginians.

Sincerely,

Mary N. Mannix

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Anticipated Impacts and How We Are Preparing: As healthcare evolves nationally, health systems are increasingly seeking additional operational infrastructure, analytics, and strategic support to meet growing clinical demands and regulatory and staffing complexities. This need has become more urgent following the adoption of House Resolution 1, which will reduce Valley Health's funding by over $80 million annually.

Like many not-for-profit systems serving rural and regional communities, Valley Health is navigating growing demand, workforce constraints, and declining reimbursement. In that

environment and to address this $80 million gap, we are continuing to redesign how care is delivered, supported, and coordinated across our system so that we can preserve access, improve efficiency, and maintain high-quality care for the communities we serve.

This work requires us to think differently about longstanding models of care and to align our clinical, operational, and financial resources with today's realities. We are evaluating where services can be better integrated, where workflows can be simplified, and where partnerships, technology, or new approaches can help us meet patient needs more effectively.

These efforts are focused on strengthening care coordination, improving throughput, reducing unnecessary variation, and supporting a more sustainable operating model. They also reflect the broader reality that hospitals must continue adapting to reimbursement pressures while remaining focused on quality, safety, access, and the patient experience.

Change of this nature requires collaboration, discipline, and shared commitment. Our responsibility is both to today's operations and to preserving access to high-quality care for the communities that rely on us over time. As we continue this work, Valley Health remains focused on making thoughtful, sustainable decisions that support patients, caregivers, and the long-term health of the organization.

Helpful Supports:

1.Create a Hospital Stabilization Fund

· Appropriate state funds to hospitals experiencing large increases in uncompensated care.

· Target support to rural hospitals, safety-net hospitals, and critical access facilities.

· Tie funding to demonstrated Medicaid-related revenue losses.

2. Preserve and Maximize Medicaid Supplemental Payments

· Use all allowable federal mechanisms for:

o Directed payments

o Disproportionate Share Hospital (DSH) payments

o Upper Payment Limit (UPL) programs

· Ensure hospitals receive the maximum reimbursement permitted under federal law.

3. Increase State Funding for Safety-Net Providers

· Establish dedicated grants for hospitals serving high Medicaid and uninsured populations.

· Prioritize trauma centers, teaching hospitals, and rural facilities.

4. Support Coverage Retention Efforts

· Fund enrollment assistance, enrollment education and patient navigators.

· Simplify renewal and eligibility verification processes where state flexibility exists.

· Help eligible individuals maintain coverage and reduce avoidable coverage losses.

5. Expand State-Funded Coverage Programs

· Consider limited-benefit state health programs for populations losing Medicaid eligibility.

· Provide premium assistance or bridge coverage for low-income residents transitioning to marketplace plans.

6. Increase Rural Hospital Protections

· Create emergency operating grants for rural hospitals.

· Expand loan forgiveness, educational scholarships and workforce incentives for rural providers.

· Fund telehealth infrastructure and access to improve efficiency and access.

7. Strengthen Uncompensated Care Pools

· Develop or expand state uncompensated-care reimbursement programs.

· Use objective criteria based on charity care and bad debt burden.

8. Reduce Administrative Costs

· Streamline state reporting requirements.

· Align licensure, quality reporting, and Medicaid documentation requirements.

· Invest in technology that reduces administrative workload.

9. Support Behavioral Health and Emergency Services

· Provide separate funding streams for:

o Emergency departments

o Behavioral health services

o Substance use treatment

· These services often absorb disproportionate costs when coverage declines.

10. Advance Population Health and Wellness Programs

· Fund care coordination, population health, and preventive care initiatives, including cancer screenings.

· Support wellness programs and facilities

Submitted as Comment to JCHC

BalladHealth™

It's your story. We're listening.

July 21, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Comments on Proposed Rule — Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2449-P), 91 Fed. Reg. 30400 (May 22, 2026); Docket No. CMS-2026-1916

Dear Administrator Oz:

I write as Chief Executive Officer of Johnston Memorial Hospital, a community hospital located in Abingdon, Virginia serving Washington County and the surrounding communities of Southwest Virginia. We are affiliated with Ballad Health, and we write in express support of the comment letter submitted by Alan Levine, Executive Chairman and Chief Executive Officer of Ballad Health. I submit these comments separately because the consequences of this Proposed Rule will be felt first, and most acutely, at the level of the individual hospital and the individual patient.

Our hospital participates in Virginia's State Directed Payment arrangement under 42 C.F.R. § 438.6(c), administered by Virginia's Department of Medical Assistance Services ("DMAS"), and represents 14% of our claims system wide. We are therefore directly and disproportionately affected by four features of the Proposed Rule: the grandfathering definition it would apply, the payment ceiling it would impose, the per-claim compliance methodology it would require, and the phase-down schedule it would apply to grandfathered payments. Each of those features, as proposed, would reduce the resources available to keep services open in this community.

CMS projects that the Proposed Rule would reduce federal Medicaid spending by $510.1 billion — and total (federal and state) Medicaid spending by $774.8 billion — over 2026 through 2035, while the Congressional Budget Office scored Section 71116 of Public Law 119-21, the statute CMS is implementing, at $149.4 billion in federal savings over 2025

through 2034. Comparing the two federal figures, CMS's own projected federal savings exceed CBO's score for the statute by $360.7 billion. An agency faithfully executing a statute does not produce federal savings more than three times what the statute itself was scored to produce. The difference is not attributable to Congress; it is attributable to choices CMS has made in the Proposed Rule, and it is those choices that we ask CMS to reconsider.

I. Provisions That Distinctively Affect Virginia Hospitals

A. CMS's grandfathering definition would penalize Virginia for CMS's own delay.

Section 71116(b) establishes three independent statutory pathways by which an SDP may qualify for grandfathered status: (1) a payment for which written prior approval (or a good faith effort to receive such approval, as determined by the Secretary) was made before May 1, 2025; (2) a payment for a rural hospital for which prior approval or a good faith effort was made by the date of enactment, July 4, 2025; or (3) a payment for which a completed preprint was submitted to the Secretary prior to July 4, 2025 — with no written-approval prerequisite. Congress added this third, submission-based pathway in the final days before the statute's passage precisely because a state cannot control the pace of CMS's own internal review. CMS's proposed definition nonetheless requires "written prior approval" as a conjunctive prerequisite applicable even to the third pathway — a reading that collapses the submission-based pathway into the first and renders it surplusage, a result ordinary principles of statutory construction disfavor. Congress does not legislate in vain.

The operative facts are these. Our hospital's SDP arrangement is part of Virginia's SDP program, for which the Commonwealth submitted a completed preprint to CMS before the July 4, 2025, statutory deadline, for a rating period extending through June 30, 2026. As of the date of this letter, CMS has not granted written prior approval of that submission. Under CMS's conjunctive definition, Virginia's timely and complete preprint submission would be disqualified from grandfathering. This is not because the Commonwealth of Virginia missed the deadline Congress set. This is the result of CMS itself not acting before that deadline arrived. This hospital would lose grandfathering protection through no fault of the Commonwealth's and none of its own. Congress could not have intended a grandfathering framework in which a state's eligibility turns on the speed of CMS's internal review rather than on the state's own timely compliance. A hospital cannot be made to bear the consequences of an agency's administrative backlog.

We request that CMS strike "written prior approval" as a conjunctive element of the grandfathering definition and confirm that a timely, completed preprint submission under the third statutory pathway independently qualifies an SDP for grandfathered status regardless of whether CMS has issued written approval by the relevant deadline.

B. Ordinary payment reconciliation should not defeat grandfathered status.

CMS has stated that a preprint submitted on or before July 4, 2025, may not be revised to change the rating period or increase the total dollar amount. This misapprehends how SDP programs calculate, pay, and reconcile in practice. Virginia's SDP payments rest on managed care encounter data reported periodically — often quarterly — with interim payments reconciled once complete utilization data becomes available, a process that routinely extends past the close of the rating period. A timely, completed preprint may therefore require later data-driven revision reflecting no change whatever in approved methodology or rating period, but changing the final total as actual utilization replaces preliminary estimates. Treating that as disqualifying penalizes states and hospitals for the ordinary mechanics of encounter-based reconciliation rather than for any substantive change to the arrangement Congress protected.

We ask that CMS clarify that a completed, timely submitted preprint may be modified through ordinary CMS review and reconciliation without defeating grandfathered status, and that the grandfathered total for a rating period is the amount in the finalized preprint following reconciliation, not a preliminary pre-close estimate.

C. The phase-down methodology reads "percentage points" to mean "percent."

Section 71116(b) directs that grandfathered SDP payments "shall be reduced by 10 percentage points each year" until the total payment rate equals the rate specified in subsection (a) — for an expansion state such as Virginia, 100 percent of the specified total published Medicare payment rate. CMS instead proposes to reduce the grandfathered total dollar amount by 10 percent of its original pre-phase-down value each year. A percentage point measures the absolute arithmetic difference between two percentages; a percent measures a proportional change. Congress chose the former, and that choice produces a materially gentler and more evenly distributed reduction than CMS proposes. Because the grandfathered dollar amount and the applicable Medicare-equivalent rate do not remain in constant proportion across a multi-year phase-down, a fixed annual dollar reduction generally will not arrive at the floor in the same year for every affected payment. CMS's preamble addresses this by halting reductions once a payment reaches the floor — so the number of years required, and the size of the final truncated reduction, vary from hospital to hospital based on each hospital's starting ratio of grandfathered dollar amount to Medicare-equivalent rate. That variation bears no relationship to Section 71116. A percentage-point methodology applied to the rate itself reduces the same 10 percentage points annually for every affected payment and terminates uniformly at the statutory floor by construction.

D. Virginia's reimbursement shortfall makes SDP payments load-bearing.

SDP payments are not a supplement to comfortable margins. They are load-bearing. The environment in which our hospital operates is as follows:

- Without the SDP program, Virginia Medicaid reimburses hospitals at just 78 cents per dollar of patient care costs actually incurred.

- SDP payments represent an average of 16 percent of hospital revenue statewide in Virginia.

- For rural and safety-net hospitals with high Medicaid utilization, SDP revenue can represent up to 34 percent of total hospital revenue.

- Virginia's SDP program collectively supports approximately 1.7 million Medicaid beneficiaries annually.

When a service line closes in a community like ours, patients do not obtain it elsewhere on comparable terms. They drive, they defer, or they present later and sicker in an emergency department. Southwest Virginia's terrain and drive times make that consequence more acute still.

E. The expansion-state ceiling and wage index geography compound against this hospital.

Virginia is an expansion state, so Section 71116(a) subjects this hospital to the 100 percent ceiling rather than the 110 percent applicable to non-expansion states. CMS proposes to calculate that ceiling using the full published Medicare rate, inclusive of the Area Wage Index adjustment. Southwest Virginia hospitals carry Area Wage Index values substantially below the national average. The lower statutory percentage and a depressed wage-index multiplier therefore compound against this hospital simultaneously — a hospital in a high-wage metropolitan area receives both a higher multiplier and, if in a non-expansion state, a higher percentage ceiling.

The FY2027 proposed Medicare wage index spans from 0.3914 in rural Puerto Rico to 1.4758 in San Jose-Sunnyvale-Santa Clara, California — a nearly fourfold spread reflecting labor market composition, urbanization, and regional cost structure rather than anything Congress was legislating about in Section 71116.

Our hospital's current Medicare Area Wage Index value is well below the national average and squarely among the hospitals this distortion would penalize most.

F. Congress legislated payment levels, not payment types.

CMS proposes to eliminate uniform percentage increase SDPs beginning with the first rating period on or after January 1, 2029. Section 71116 addresses how much may be paid; it nowhere directs CMS to abolish a mechanism by which payment is made. Virginia's SDP program relies on uniform increase methodologies that have received CMS preprint

approval across multiple rating periods — an approval history that is itself evidence of the mechanism's legitimacy and administrability. Eliminating it would compel DMAS to redesign a program built through years of collaborative work among Virginia's hospitals, State officials, and Virginia's congressional delegation. Congress did not order that redesign, and the Proposed Rule offers no evidence specific to uniform increase SDPs that would justify it.

G. Separate payment terms should be restored

CMS's 2024 Medicaid Managed Care final rule prohibited separate payment terms in SDP programs, requiring SDP amounts to be embedded in MCO capitation rates. CMS acknowledges the issue in the Proposed Rule. We request that CMS reverse the prohibition and permit separate payment terms as a permissible SDP mechanism beyond the grandfathering period.

II. Additional Concerns We Share with Ballad Health

We adopt and incorporate the legal analysis set out in the Ballad Health system letter. We summarize below the points of greatest consequence to our hospital.

- **Scope overreach.** Section 71116(a) enumerates four service categories: inpatient hospital, outpatient hospital, nursing facility, and qualified practitioner services. CMS would extend the cap to every Medicaid service. Under Loper Bright Enterprises v. Raimondo, 603 U.S. 369 (2024), statutory silence is not a delegation; Congress's enumeration of four categories is a limitation, not an illustration.

- **Unauthorized fee-for-service cap.** Proposed 42 C.F.R. § 447.381 would apply a provider-specific Medicare-equivalent cap to targeted fee-for-service supplemental payments Section 71116 never addressed. The Upper Payment Limit methodology has governed these payments for decades on a provider-class basis; Section 447.381 should be withdrawn.

- **Per-claim compliance burden.** Current 42 C.F.R. § 438.6(c)(2)(iii) has always been demonstrated on a provider-class basis. CMS would instead require every individual claim repriced against Medicare's methodology, a wholesale redesign of claims processing for which CMS has published no commensurate burden estimate; provider-class compliance should be retained.

- **Medicare is the wrong benchmark for the Medicaid population.** Medicare serves an aged and disabled population. Virginia Medicaid serves substantial populations of pregnant women, infants, and children, for whom Medicare offers no reliable benchmark, and MedPAC has documented that Medicare itself pays below cost in many service categories.

- **Services without a Medicare equivalent.** CMS would default services lacking a Medicare analogue to the state plan base rate alone, while applying a supplement-inclusive rate for PPS-exempt hospitals. That unexplained asymmetry falls hardest on pediatric, obstetric, and behavioral health service lines.

- **Area Wage Index floor of 1.00.** Section 71116(b)(4)'s reference to the Medicare payment rate "(or a successor regulation)" affords CMS latitude to incorporate an AWI floor of 1.00 for hospitals whose AWI would otherwise fall below it, preventing a well-documented Medicare distortion from entering Medicaid.

- **Provider assessments should be netted.** Our hospital does not retain the gross amount of SDP payments it receives; a substantial portion returns through mandatory assessments financing the program itself. Measuring gross payments against the ceiling overstates the benefit received, a point MACPAC has recognized.

- **Non-federal share concerns do not justify deeper cuts.** 42 U.S.C. §§ 1396b(m)(1)(A)(i), 1396b(m)(2)(A)(iii), and 1396a(a)(30)(A) require payments sufficient to make care available to Medicaid enrollees to the same extent as the general population — a standard CMS may not undercut by restricting SDPs beyond Section 71116.

- **Qualifying Disadvantaged Hospital exemption.** We support the new 42 C.F.R. § 438.6(c)(8)(iv) exemption in the Ballad Health system letter, permitting rural, low-AWI, Critical Access, and non-profit safety-net hospitals to be paid up to the average commercial rate, with compliance demonstrated on an aggregate class basis.

- **Transition time.** Implementation should be delayed not less than two full rating periods from publication, giving States, MCOs, and hospitals time to redesign payment and compliance systems.

III. Requested Actions

We respectfully request that CMS take the following actions in any final rule:

1. Correct the grandfathering definition so a timely, completed preprint submission is not disqualified by the "written prior approval" requirement or by CMS's own delay in acting.

2. Confirm that data-based reconciliation revisions do not defeat grandfathered status.

3. Reverse the 2024 final rule's prohibition on separate payment terms beyond grandfathering.

4. Correct the phase-down methodology to reduce the Medicare rate percentage by 10 percentage points annually, as the statute requires, rather than the grandfathered dollar amount by 10 percent.

5. Apply an Area Wage Index floor of 1.00 in calculating the specified total published Medicare payment rate.

6. Retain uniform percentage increase SDPs as a permissible mechanism beyond grandfathering.

7. Confine the Medicare-equivalent cap to the four service categories Section 71116(a) identifies.

8. Retain provider-class compliance demonstrations and reject the per-claim methodology.

9. Withdraw proposed 42 C.F.R. § 447.381 in its entirety.

10. Adopt the Qualifying Disadvantaged Hospital exemption at 42 C.F.R. § 438.6(c)(8)(iv).

11. Permit SDP compliance to be demonstrated net of provider assessments.

12. Provide not less than two full rating periods for implementation.

Thank you for considering these comments. I am glad to discuss any of them further.

Respectfully submitted,

John Jeter, CPA, MBA
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APPENDIX 4: In-text citations

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