Update on the Provider Assessment Work Group

K. Joseph Flores
Deputy Secretary of HHR
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Overview of Presentation

- Review of Budget Language
- Composition of the Work Group and Summary of Activities
- Highlights from Work Group Meetings
- Next Steps

Review of Budget Language

- The Secretary of HHR is required **to develop options for a provider assessment program** for consideration by the 2016 General Assembly. The program must:
- (i) comply with applicable federal law and regulations;
- (ii) be designed to operate in a fashion that is mutually beneficial to the Commonwealth and affected health care organizations;
- (iii) **address health system challenges** in meeting the needs of the uninsured and preserving access to essential health care services (e.g., trauma programs and obstetrical care);
- (iv) **support indigent care and graduate medical education costs** at hospitals;
- (v) advance reforms that are consistent with the goals of improved health care access, lower overall costs and better health for Virginians; and
- (vi) take into account the extent to which it provides equity in the assessment and funding distribution to affected health care organizations.

Review of Budget Language

- The Secretary of Health and Human Resources is also required to:
  - **Develop as an option a more limited program** that is focused on supporting the indigent care and graduate medical education costs at private teaching hospitals; and
  - **Review a program that would provide supplemental payments** for qualifying private hospitals as previously submitted to the Centers for Medicare and Medicaid Services.
- A report is due to the money committees by November 1, 2015 that must include:

  (i) the structure, collection process, and amount of the assessment;

  (ii) the process for supplemental payments;

  (iii) an estimate by hospital of the net financial impact of the program; and

  (iv) an implementation timeline.

Composition of the Provider Assessment Work Group

Anna Healy James – Office of the Governor – Chair	
Cindi B. Jones – Department of Medical Assistance Services	Sheryl Garland – VCU Health System
Beth A. Bortz – Virginia Center for Health Innovation	Massey S.J. Whorley – The Commonwealth Institute for Fiscal Analysis
Anthony Keck – Mountain States Health Alliance	Roderick Manifold – Central Virginia Health Services
C. Novel Martin – Medical Facilities of America	Linda D. Wilkinson – Virginia Association of Free and Charitable Clinics
Nancy Howell Agee – Carilion Clinic	Kurt Hofelich – Sentara Norfolk General Hospital
Peter Gallagher – Valley Health System	Richard V. Homan, M.D. – EVMS
Debbie Burcham – Chesterfield CSB	Sterling Ransone, M.D. – Medical Society of Virginia
Matthew Turner – Genworth Financial	James Cole – Arlington – Virginia Hospital Center
George Reiter – Leidos	William A. Hazel, Jr., MD – Secretary of Health and Human Resources, *ex officio*

Summary of Work Group Activities

- The Provider Assessment Work Group has met two times.
  - Wednesday, July 8th, and
  - Wednesday, September 30th.
- The final meeting is scheduled for October 28, 2015.
- The work group's final report is due on November 1, 2015.

Highlights from July 8th Meeting

Initial Meeting Began to Frame the Issue on Provider Assessments

- Deborah Bachrach, a consultant from Manatt, described:
  - provider assessments nationally,
  - detailed the rules and regulations that apply, and
  - explained what states are funding with additional revenues.
- Bill Lessard from DMAS zeroed in on specific provider groups to determine what an assessment in Virginia could generate.

Provider assessments levied on heath care providers are a way for states to fund a portion of their Medicaid programs.

- 49 states, including DC, impose provider assessments to generate additional revenue for their Medicaid programs.
- Virginia enacted a provider assessment on Intermediate Care Facilities (ICFs) in 2010.

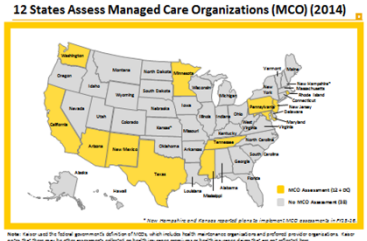
Assessments Tend to be Levied on Certain Health Care Providers

43 States Assess Nursing Facilities (2014)

39 States Assess Hospitals (2014)

36 States Assess Intermediate Care Facilities (ICF) (2014)

12 States Assess Managed Care Organizations (MCO) (2014)



Use of Provider Assessments

States use provider assessments to fund:

- **The non-federal share of the general Medicaid program**
  - Examples: Minnesota and Wisconsin
- **Supplemental payments to hospitals and nursing facilities**
  - Examples: Arkansas, Colorado, Oklahoma, and Wisconsin
- **The non-federal share of Medicaid expansion**
  - Examples: Colorado and Indiana
- **Rates or rate increases to providers**
  - Examples: Arkansas, Colorado, Oklahoma, and Wisconsin

States that have expanded Medicaid have seen provider assessment receipts increase, as the coverage expansion generates more revenue for providers.

- **Arkansas** estimates a **$29.7 M** increase in SFY 2015 from its insurer assessment
- **Michigan** estimates a **$26 M** increase in SFY 2015 from its insurer assessment

Source for Revenue Increases: D. Bachrach, P. Boozang, and D. Glanz, States Expanding Medicaid See Significant Budget Savings and Revenue Gains, Robert Wood Johnson Foundation, April 2015

What Rules Apply to Provider Assessments?

Federal Statutory and Regulatory Requirements

In order to receive federal matching funds for provider assessment revenue, the assessment must:

- be **broad-based,** meaning that the assessment is imposed on at least all health care items or services in the class furnished by all non-federal, non-public providers in the State
  - ⇨ *Example:* A hospital assessment must apply to **all** non-federal, non-public hospitals. A Veterans' Administration or county hospital may be exempt, but a private academic medical center may not.
- be **imposed uniformly** on all providers within a specified class of providers (or the state must prove that the assessment is generally redistributive in order to receive a federal waiver of the broad-based and/or uniformity requirements)
  - ⇨ *Example*: An assessment on nursing facility revenue must apply at the same rate to all providers. High-volume Medicaid providers cannot be assessed 4% of revenue, while low-volume Medicaid providers are assessed 2% of revenue
- **not exceed 25% of the non-federal share of Medicaid costs**
- **not hold providers "harmless"** or guarantee providers will receive their money back (there is a presumption that the providers are not "held harmless" if the rate < 6%)
  - ⇨ *Example*: A state cannot guarantee that a hospital will receive its assessment back in the form of a supplemental payment

manatt

Source: 42 C.F.R. § 433.55; 42 C.F.R. § 433.68

Virginia Provider Assessment Information

- Potential revenues to the Commonwealth could range from several million dollars to more than a billion depending on a) the level of assessment and b) the range of providers assessed.
- Most states do not assess providers at the maximum rate.
- The most common assessment methods are a) a percentage of revenue or b) a per bed rate.

Provider Type	Source	Year	Basis for Assessment	1% Assessment	6% Assessment
Hospital	VHI	PFY13	$18,120,642,453	$181,206,425	$1,087,238,547
Nursing Facility	VHI	PFY13	$2,245,439,510	$22,454,395	$134,726,371
ICF-ID*	DMAS	SFY14	$226,594,408	$2,265,944	$13,595,664
MCO	BOI	CY14	$6,825,108,293	$68,251,083	$409,506,498

Assumes no exempted providers or sources of revenue and a uniform assessment percentage
* ICF-ID Providers currently pay a 5.5% assessment

Highlights from September 30th Meeting

What Problem Are We Trying to Solve?

- The second meeting of the Provider Assessment Work Group focused on some of the needs that could be addressed with additional revenue including:
  - Medicaid payment to hospitals;
  - Uncompensated care; and
  - Graduate Medical Education.

Medicaid Payments to Hospitals

- Hospitals receive Medicaid payments through:
  - Operating rates (including capital) that cover 70 to 80% of hospital's cost.
  - Supplemental payments are another way to increase revenues to hospitals.
    - Direct and Indirect Medical Education
    - Other supplemental payments
  - Disproportionate share hospital (DSH) payments for hospitals that have high Medicaid volume.
- Medicaid funding for hospitals is constrained by several factors:
  - Upper payment limit (UPL);
  - Hospital specific uncompensated care for DSH hospitals; and
  - Limited and likely declining federal DSH allotment.

Uncompensated Care Costs

- DMAS has audited uncompensated care costs for 26 private DSH hospitals in FY2011 (excluding CHKD)
  - Uncompensated care costs are defined as Medicaid losses plus the cost of serving the uninsured.
- DSH eligible hospitals have Medicaid utilization in excess of 14%.

Uncompensated Care Costs for Private Hospitals*	
Medicaid Losses	$140,979,908
Uninsured Costs	$244,613,469
Less: DSH Payments	($17,977,807)
TOTAL, Uncompensated Care Costs After DSH	**$367,615,570**

Source: Department of Medical Assistance Services.
* Does not include uncompensated care for UVA and VCU.

- Non-DSH hospitals also have additional uncompensated care costs.
- No current estimates on reduction in uninsured costs due to expansion of insurance under the ACA.

Uncompensated Care Costs

- Top 8 Private Hospitals Ranked by Total Uncompensated Care Costs (UCC) after DSH

	Medicaid Loss	Uninsured Cost	DSH	UCC Net DSH
Sentara Norfolk General	$28.4 million	$55.8 million	$4.9 million	$79.4 million
Inova Fairfax	$16.4 million	$39.5 million	$3.2 million	$52.7 million
Carilion Medical Center	$21.1 million	$28.4 million	$2.5 million	$47.0 million
Winchester Medical Center	$15.3 million	$19.0 million	$0.3 million	$33.9 million
Prince William Hospital	$10.0 million	$15.6 million	$0.3 million	$25.3 million
Potomac Hospital	$9.1 million	$10.6 million	$0.7 million	$19.1 million
Henrico Doctors Hospital	$8.9 million	$9.5 million	$0.03 million	$18.3 million
Maryview Hospital	$3.1 million	$11.6 million	$0.5 million	$14.1 million

Source: Department of Medical Assistance Services, September 2015.

Medicaid Medical Education Payments

- DMAS' presentation focused on how Medicaid pays for graduate medical education for private hospitals including:
  - Graduate Medical Education for Interns and Residents
  - Indirect Medical Education for Interns and Residents
  - Direct Medical Education for Nursing and Paramedical Programs

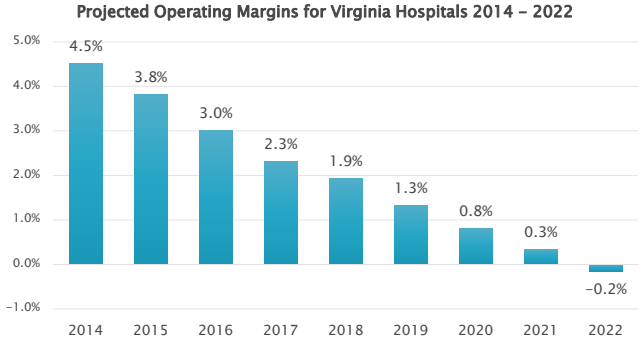
Medicaid Medical Education Payments

- DMAS funding for medical education is not significant.

DMAS Funding for Medical Education		
Category	**Formula**	**Estimated FY 16 Funding**
Graduate medical education	Direct cost of training residents (i.e., stipends and staffing) inflated from FY 1998	$10.3 million
Indirect medical education	Indirect cost to hospital of educational mission (i.e., diagnosis and treatment costs)	$29.0 million
Paraprofessionals	DMAS pays for 100 percent of hospital's Medicaid costs	$1.3 million

Outlook for Virginia Hospitals

- Operating margins for Virginia hospitals could decline from 4.5% to negative 0.2% between 2014 and 2022, moving the potential operating margin for the entire industry into negative territory by 2022.
  - According to VHHA's consultant, a 4% operating margin is required for hospitals to maintain fiscal stability and modernize and replenish capital stock.



Key Findings from Dobson/DaVanzo

Factors Driving Pessimistic Revenue Outlook for Hospitals
Aging of the population
Federal budget and policy decisions
Impact of the ACA Coverage Expansion (**Note**: consultants were not able to determine impact of marketplace on coverage)
Increasing use of high-deductible health insurance

Hospitals will Need to Make Difficult Decisions in the Face of Pessimistic Outlook	
Reduce labor costs	Reduce the amount of charity care delivered
Eliminate unprofitable lines of business	Seek increased payment from private insurers

The financial forecast for rural hospitals is worse!

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Next Steps

- Their was unanimity that a provider assessment should be pursued but additional steps must be taken.
- Determine how much funding is needed and how the additional revenues should be used.
  - Increase funds for Graduate Medical Education/residency slots
  - Improve access to care
  - Stabilize hospital finances/enhance provider rates
  - Enhance quality of care
  - Fund the state share of DSRIP
- Decide what providers should be subject to an assessment.
  - Assess the pros and cons of an assessment for the various payors
  - Determine what providers are willing to participate
- Evaluate the implementation of assessments in other states.
  - Did other states impose guardrails to safeguard assessment revenues?
  - Is it possible to "wall-off" revenues in non-reverting funds?
  - How have the programs been implemented in other states?

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Questions?

- Contact Information:
  - Joe Flores, Deputy Secretary of HHR
  - 804.692.2575
  - joe.flores@governor.virginia.gov
- Link to Agendas and Presentations:
  - http://www.dmas.virginia.gov/Content_pgs/pawg.aspx