Meeting of the Provider Assessment Work Group
Meeting #2
Perimeter Center
9960 Mayland Drive, Board Room 2
Henrico, Virginia 23233

September 30, 2015
DRAFT Minutes

CALL TO ORDER

Ms. Anna Healy James, Policy Director in the Office of the Governor, called the meeting to order at 12:39 p.m. Ms. James welcomed members for attending and reviewed the agenda for the day.

APPROVAL OF THE JULY 8, 2015 MINUTES

Ms. James asked the members to review and approve the minutes from the July 8, 2015 meeting. Mr. Massey Whorley made a motion to accept the minutes and Ms. Beth Bortz seconded. The vote was unanimous.

MEDICAID PRIVATE HOSPITAL REIMBURSEMENT POLICIES AND PRIVATE HOSPITAL UNCOMPENSATED CARE IN THE COMMONWEALTH

Mr. William Lessard, Provider Reimbursement Division Director at the Department of Medical Assistance Services, provided background on hospital reimbursement policies and uncompensated care costs as it relates to how Medicaid targets payments to hospitals based on payments for operating, capital, medical education and disproportionate share. See attached handout.

MEDICAID'S ROLE IN COVERING GRADUATE MEDICAL EDUCATION IN VIRGINIA

Mr. Lessard explained reimbursement policies for Medicaid private hospital reimbursement for graduate medical education costs. See attached handout.

VIRGINIA HEALTH SYSTEM FINANCIAL FORECAST: OUTLOOK FOR VIRGINIA HOSPITALS

Mr. Dobson DaVanzo and Mr. Randall Haught provided a synopsis of their key findings of the potential impact on hospital operating margins based on developing a financial forecast for

Virginia's hospitals under current policy for the time period of 2014 to 2022. See attached handout.

PUBLIC COMMENT

Ms. James opened up the meeting for public comment; however, no one commented. Ms. James asked that public comments be forwarded for review at the next meeting to: providerassessmentworkgroup@dmas.virginia.gov. For information about the work group, please go to: http://www.dmas.virginia.gov/Content_pgs/pawg.aspx.

DISCUSSION

Ms. James asked the work group members to share their thoughts on next steps for discussion at the next scheduled meeting and announced the next meeting is scheduled for Wednesday, October 28, 2015, from 1:00 to 4:00 p.m. at the Virginia General Assembly Building, Capitol Square, House Room D, 201 North 9th Street, Richmond, Virginia.

ADJOURNMENT

Ms. James announced that the opportunity for public comments would be available at the end of the next scheduled meeting and thanked everyone for attending. The meeting adjourned at 2:57 p.m.

PROVIDER ASSESSMENT WORK GROUP

Members attending:

Anna Healy James
Cindi B. Jones
Beth A. Bortz
Anthony Keck
C. Novel Martin
Nancy Howell Agee
Peter Gallagher
Debbie Burcham
Matthew Turner
George Reiter
Sheryl Garland
Massey S.J. Whorley
Roderick Manifold
Linda D. Wilkinson
Kurt Hofelich
Richard V. Homan
James Cole
William A. Hazel, Jr., MD., ex officio

Member absent:
Sterling Ransone, M.D.

Department of Medical Assistance Services

Medicaid Private Hospital Reimbursement Policies

Presentation to the:
Provider Assessment Work Group

September 30, 2015

Medicaid Hospital Payment Policy

- Unlike commercial payers, Medicaid (and Medicare) target payments to hospitals based on hospital characteristics (separate payments for operating, capital, medical education and disproportionate share)
- Commercial payers pay much better than Medicaid but can negotiate different payments by hospital/system
- Medicaid hospital utilization on average is not high
  - Medicaid is 13.4% of hospital inpatient admissions (FFS and MCO)
  - Medicaid is 10.7% of hospital outpatient charges (FFS and MCO)
- DMAS pays out-of-state border hospitals almost the same as in-state hospitals because they are important providers to Medicaid members (however, the cannot be assessed)

Medicaid Hospital Payments

$2 billion (total funds) in payments (25% of total Medicaid payments)

- Operating Rates (including capital)
  - Covers 70% to 80% of Cost
- Supplemental Payments
  - Direct and Indirect Medical Education
  - Other supplemental payments
    - limited use in Virginia
    - Can be targeted
    - Requires manual administration
- Disproportionate Share Hospital (DSH) Payments

Medicaid Hospital Payment Limits

- Private Hospital Upper Payment Limit for FFS
  - Approximately $125 million
  - Comparable managed care room of approximately $300 million
- Hospital-Specific Uncompensated Care Cost Limit for DSH Hospitals
  - DMAS monitors payments closely against this limit for UVA, VCU and CHKD
  - Not an issue for private hospitals
- DSH Allotment
  - Federal funds for DSH are not available beyond the allotment which is fully utilized
  - Virginia DSH allotment is low compared to other states (Virginia allotment per Medicaid member is 41st out of 50 states plus DC)
  - State allotments were based on historical DSH expenditures in the early nineties

Medicaid MCO Hospital Payments

- Medicaid MCOs use Medicaid payment methodologies for operating payments and benchmark rates to Medicaid rates
- DMAS adjusts capitation rates for FFS rate changes so that plans can continue to benchmark rates to Medicaid rates
- Cost for medical education not included in capitation payments but are accounted for in DMAS medical education payments to hospitals
- Other supplemental payments traditionally are only for FFS
- States have started to include supplemental payments in capitation rates but CMS proposed rules may limit use of supplemental payments in MCOs

Presentation Focus

- Presentation provides reimbursement background and opportunities on the following two issues that the budget directed the provider assessment program to address
  - Health system challenges in meeting the needs of the uninsured and preserving access to essential health care services
  - Support indigent care and graduate medical education costs at hospitals

Department of Medical Assistance Services

Medicaid Private Hospital Reimbursement: Uncompensated Care Costs

Presentation to the:
Provider Assessment Work Group

September 30, 2015

Uninsured and Indigent Care Costs

Terminology	Definition	Sources of Information and Limitations
Uninsured Costs	Unreimbursed costs for treating the uninsured	A component of uncompensated care costs (see below)
State Indigent Care Costs	State defined cost of treating individuals with income below two times the poverty level who also meet Medicaid asset rules	UVA and VCU submit cost reports to state (similar information not available for private hospitals)
Charity Care Costs	No standard definition	Unaudited financial data submitted to VHI
Uncompensated Care Costs	Medicaid Losses and Uninsured Costs eligible for DSH reimbursement	Audited information available for DSH hospitals for FY11

Uncompensated Care Costs

- Uncompensated Care Costs include
  - Medicaid Losses for both FFS and MCO
  - Uninsured Costs
- Disproportionate Share Hospital (DSH) payments can be used to pay for both Medicaid losses and uninsured costs
- Other Medicaid payments can pay for Medicaid and reduce Medicaid losses

Uncompensated Care Costs

- DMAS has audited uncompensated care costs for 26 private DSH hospitals in FY2011 (excluding CHKD)
- DSH Hospitals have Medicaid utilization in excess of 14%

Uncompensated Care Costs After DSH	**$362,686,116**
Medicaid Losses	$140,979,908
Uninsured Costs	$244,613,469
DSH Payments	$17,977,807

- 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

Uncompensated Care Costs

- Top 6 Hospitals Ranked by Uncompensated Care Costs (UCC) after DSH as a percent of Total Hospital Costs

	UCC as % of Total Costs
Franklin Memorial Hospital	16.0%
Sentara Norfolk General	15.9%
Prince William Hospital	14.2%
Southside Community Hospital	12.5%
Potomac Hospital	11.8%
Winchester Medical Center	10.1%

Options to Address Uncompensated Care Costs

- Increase DSH payments
  - No available allotment
- While not as targeted, increasing non-DSH Medicaid hospital payments reduces Medicaid losses
  - Hospitals with large uninsured costs also have high Medicaid utilization
  - 17 private in state DSH hospitals also have medical education programs
- Expand Medicaid

Medicaid Private Hospital Reimbursement: Graduate Medical Education Costs

Presentation to the:
Provider Assessment Work Group
September 30, 2015

Three Medical Education Payments

- Graduate Medical Education for Interns and Residents
- Indirect Medical Education for Interns and Residents
- Direct Medical Education for Nursing and Paramedical Programs

Graduate Medical Education Payments

- Per resident payment based on 1998 FFS costs
  - Payments increase with new FTEs
- Inflated annually except when inflation has been frozen
  - Payments have not kept up with actual costs per resident
- Managed care was not a significant factor in 1998
- 36 private hospitals qualify in FY16
  - 26 in state
  - 10 out of state

Graduate Medical Education Payments

- FY12 Medicaid costs for graduate medical education for private hospitals excluding CHKD inflated to FY16
  - $10.7 million FFS
  - $11.1 million HMO
- FY12 Medicaid graduate medical education payments inflated to FY16
  - $8.7 million
- FY16 Interim Medicaid graduate medical education payments
  - $10.3 million
  - Increase primarily due to growth in Carilion Medical Center

Graduate Medical Education Payments

- On average, Medicaid GME payments cover 40% of Medicaid GME costs based on FY12 data inflated to FY16
- Since payments have not been rebased since 1998, the percent of cost varies from 10% of cost to over 100% of cost
- Private hospitals making the largest investment in medical education have lower percent of cost reimbursed

Hospital	GME Cost	GME Payments	% of Costs Reimbursed
Carilion	$5.2 million	$1.8 million	34.4%
Sentara Norfolk	$3.1 million	$1.0 million	32.5%
Riverside	$2.6 million	$0.9 million	32.5%
Inova Fairfax	$2.6 million	$1.0 million	37.0%

Indirect Medical Education Payments

- To cover costs at hospitals with teaching programs (increased diagnostic and treatment costs related to educational mission)
- Reimbursement Formula based on
  - Operating payments at 70% to 80% of cost times
  - An IME factor using the ratio of residents to beds
    - The current Medicare formula increases payments 5.5 percent for each 10 percent increase in the resident to bed ratio
    - The DMAS formula is about 80% of the Medicare formula
- Interim FY16 Medicaid payments for Indirect Medical Education
  - $29 million
  - About 3 times graduate medical education
- Rehab hospitals and out of state hospitals with limited Virginia Medicaid business do not qualify

Direct Medical Education Payments

- Estimated FY16 Medicaid costs for paraprofessional medical education at 18 private hospitals
  - $1.3 million
- Medicaid payments cover 100% of the hospital Medicaid cost

Hospital Payment Summary

- If there is funding, there are options to increase Medicaid payments to private hospitals for
  - Operating costs
    - Increase rates
    - Implement supplemental payments
  - Medical education costs
- There is no available DSH allotment to increase DSH payments to private hospitals
- Payments for operating costs and medical education reduce Medicaid losses for hospitals who serve a high proportion of Medicaid and uninsured
- Expanding Medicaid will most directly reduce uninsured costs for Virginia hospitals at limited state cost

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Virginia Health System Financial Forecast: Outlook for Virginia Hospitals

PRESENTED and PREPARED BY:
Dobson DaVanzo and Associates

September 30, 2015

Dobson | DaVanzo

Dobson DaVanzo & Associates, LLC Vienna, VA 703.260.1760 www.dobsondavanzo.com

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Study Purpose

- **Develop a financial forecast for Virginia's hospitals under current policy for the time period of 2014 to 2022 that includes rapid changes in the health care landscape, including:**
  - Affordable Care Act (ACA) coverage expansions through the federal health insurance marketplace
  - Payment reductions under Medicare
  - Reduced uncompensated care funding from Medicare and Medicaid Disproportionate Share Hospital (DSH) cuts
  - Aging of the population, as a higher proportion of the population become eligible for Medicare
- **These estimates reflect the potential impact on hospital operating margins due to the above factors, actual results may vary and will be affected by hospitals' responses to these forces**

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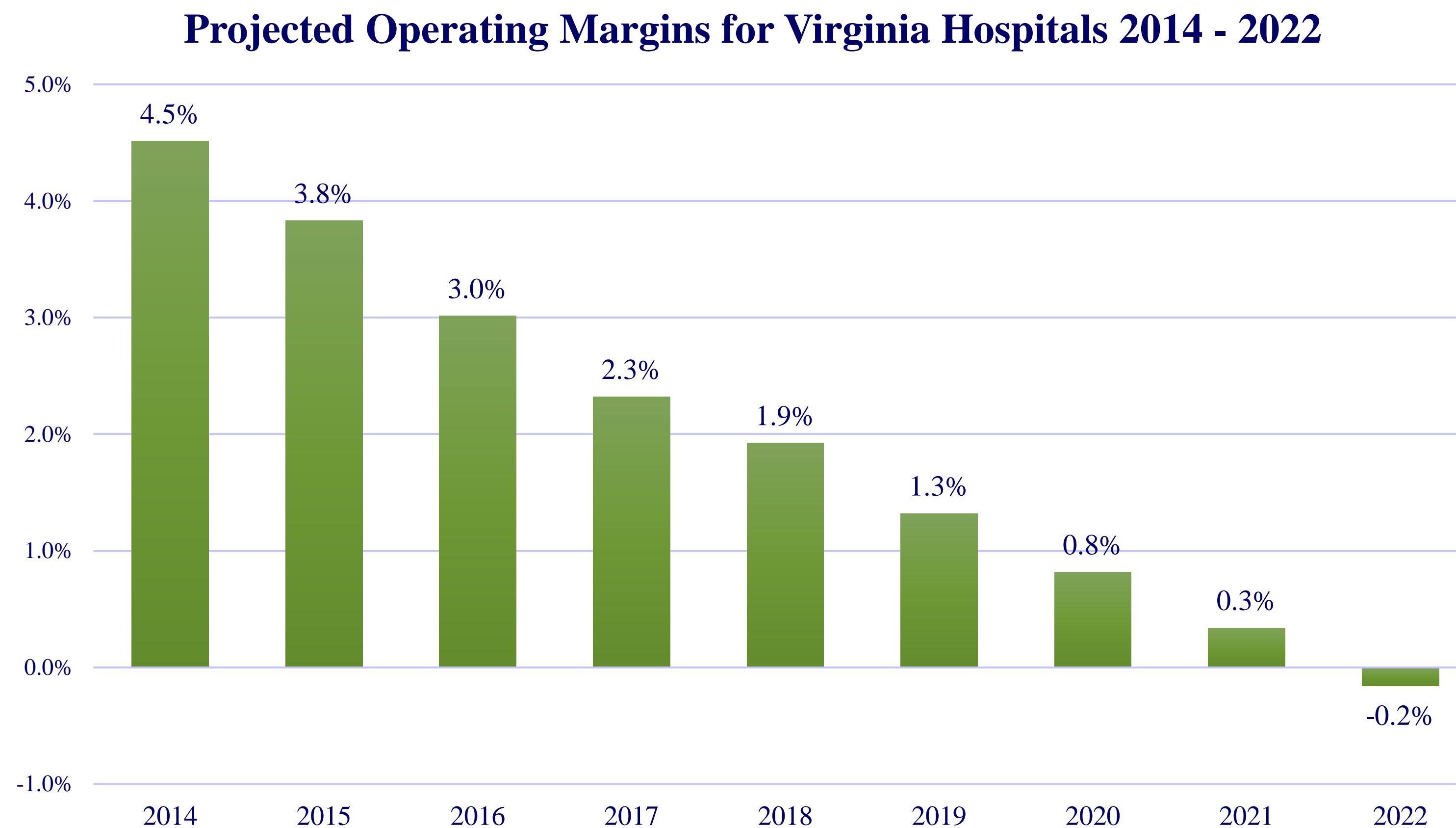
Synopsis of Key Findings

- **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**



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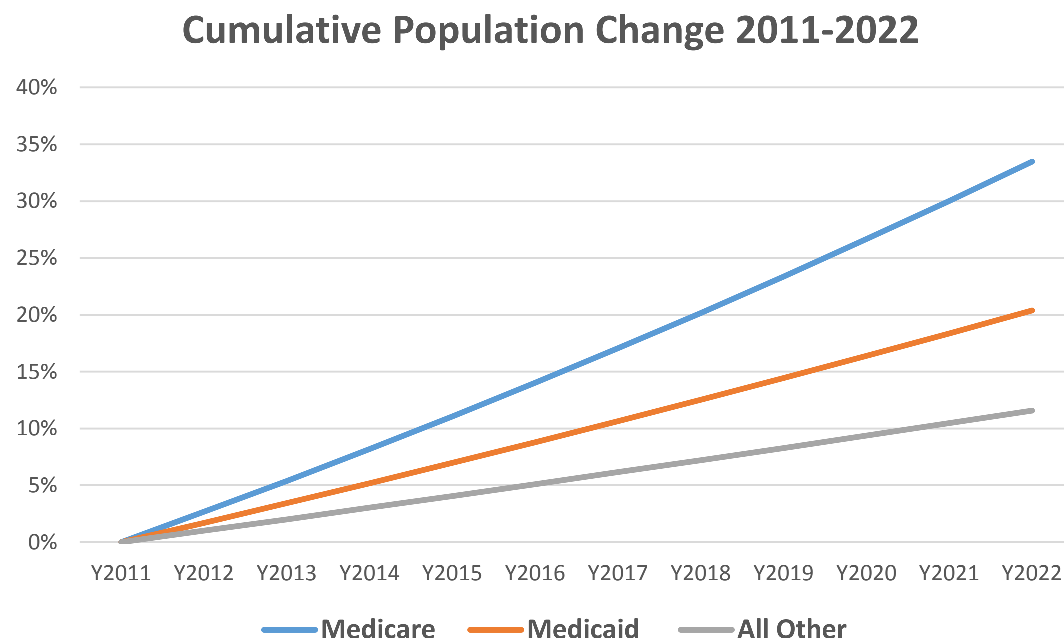
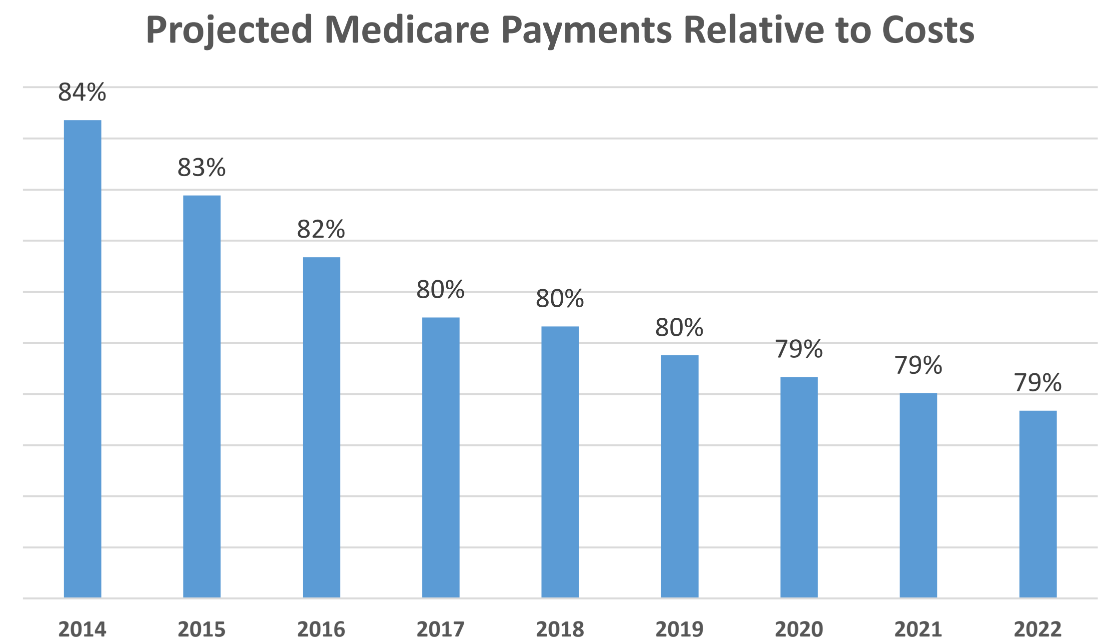
Key Findings – Aging of the Population in Virginia

- **As more Virginians become eligible and enroll in Medicare, the portion of hospital costs attributed to treating this population increases**
- **Medicare payments are below the hospital's cost of providing care and will continue to fall over time**



Medicare – projected growth in VA population over age 65
Medicaid – based on historical enrollment growth 2010-2013
All Other – projected population growth for VA population
- Population projections from the Demographics Research Group, Weldon Cooper Center, UVA.



Medicare payments include scheduled reductions under the ACA, value based purchasing, Hospital Readmission Reduction Program, Hospital Acquired Condition Reduction, ATRA coding adjustment, bad debt reimbursement reduction, LTCH budget neutrality Adjustment, IPPS prospective and retrospective coding adjustment, HHA prospective coding adjustment, 2-midnight rule offset, and MACRA

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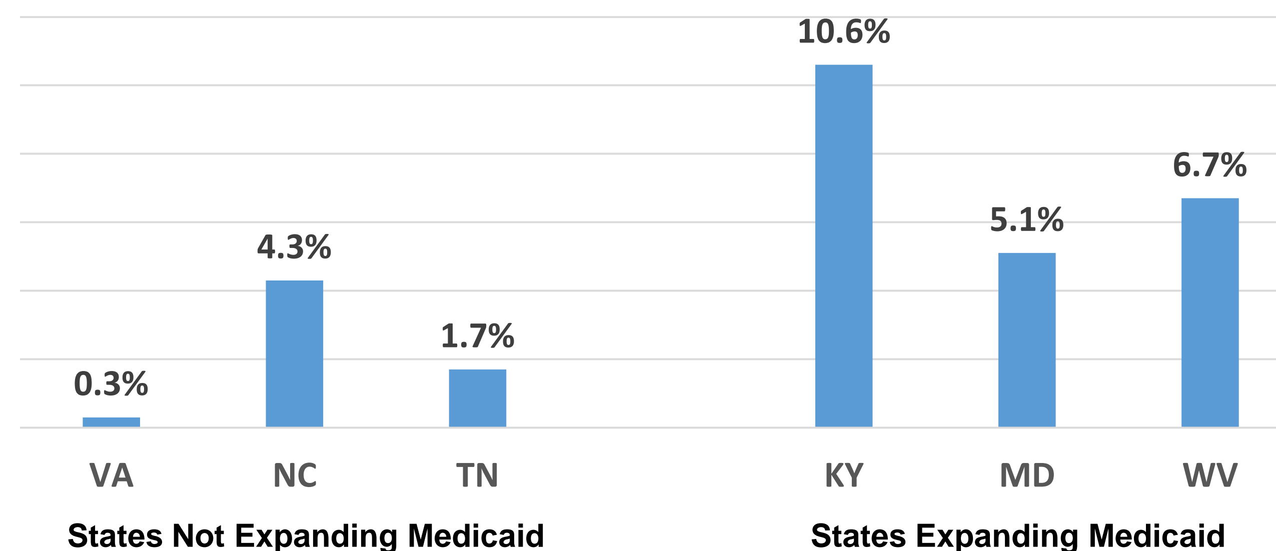
Key Findings – Impact of ACA Coverage Expansion

- **Early data show that the ACA marketplace subsidized-coverage expansion had little effect on the uninsured in Virginia in 2014**
- **In turn, we estimate this could have a limited initial effect on hospital uncompensated care expenditures, but will increase in the future as the ACA penalties for being uninsured increase**



Source: Gallup – Healthways, Well-Being Index , February 24, 2015

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Key Findings – Uncompensated Care Burden will Continue

- **As insurance coverage moves toward consumer driven healthcare and increased co-payments and deductibles, hospital bad debt may increase for the population covered by commercial insurance**
  - 89% of Marketplace enrollees selected Silver or Bronze plans with deductibles of $3,000 or more for single coverage
  - The percentage of workers with high-deductible health plans (HDHP) has increased from 4% in 2000 to 26% in 2014
  - In 2014, 36.9% of persons under age 65 were enrolled in HDHP
  - In comparison to those with no deductibles, adults with deductibles over $1,000 are more likely to incur medical bill or debt problems
- **Uncompensated care burden for hospitals will continue to be an issue even as the number of uninsured are reduced**

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Sources: Blumenthal D, Stremikis K, Culter D. (2013). Health Care Spending—A Giant Slain or Sleeping? *New England Journal of Medicine* 369(29): 2551-2557
Solomon, P. (2014, July) High-Deductible Insurance and Rising Bad Debt. HealthWorksCollective.
Dody, R. (2014) High-Deductible Health Insurance Policies with Health Savings Accounts: A Policy Review. SPNHA Review: Vol. 10: Iss. 1, Article 5.

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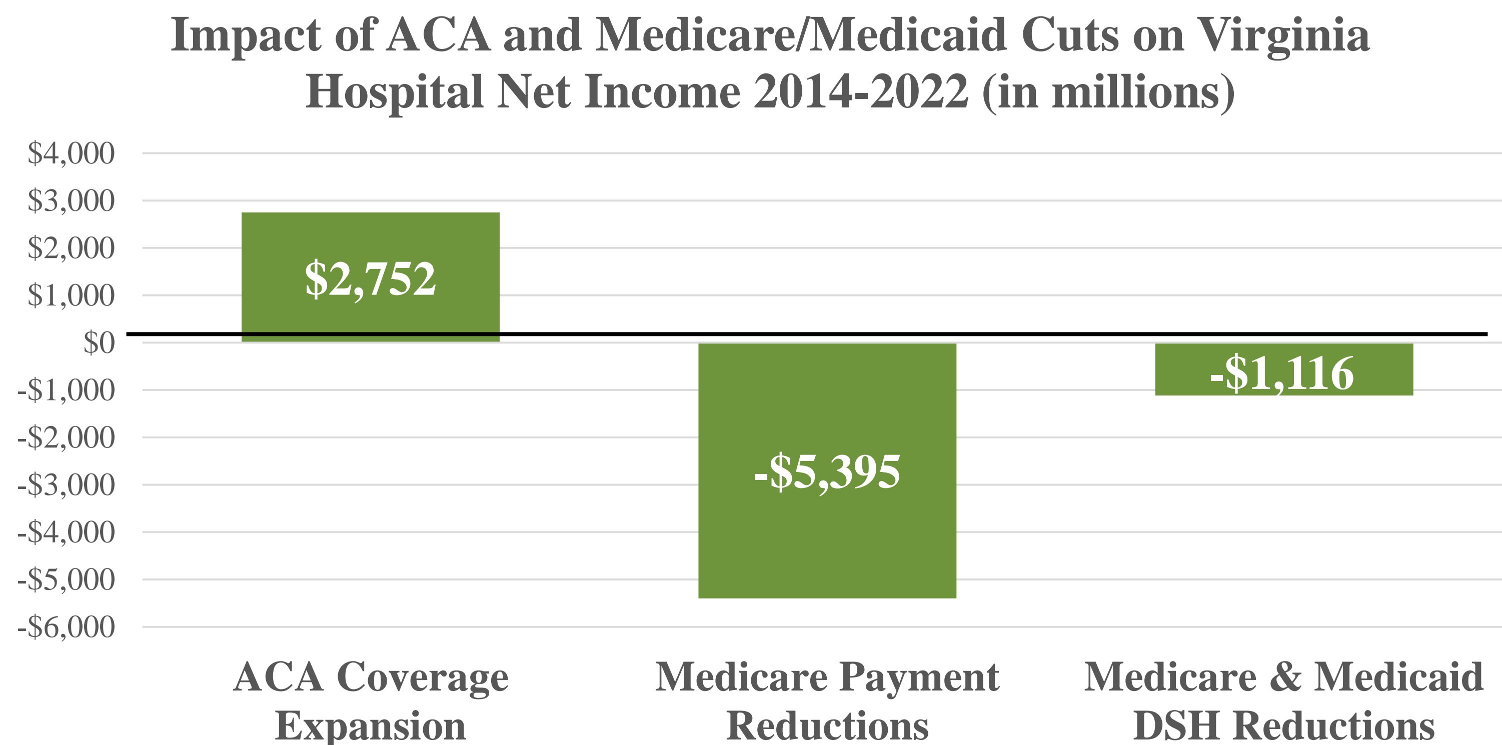
Key Findings – Medicare and Medicaid Payment Changes

- **Medicare and Medicaid DSH payment cuts will reduce the funding for uncompensated care by $1.1 billion for years 2014 to 2022**
- **Most importantly, a total of $5.4 billion in legislative Medicare payment reductions, which take effect over the study period overwhelm the positive efforts of the ACA coverage expansion**



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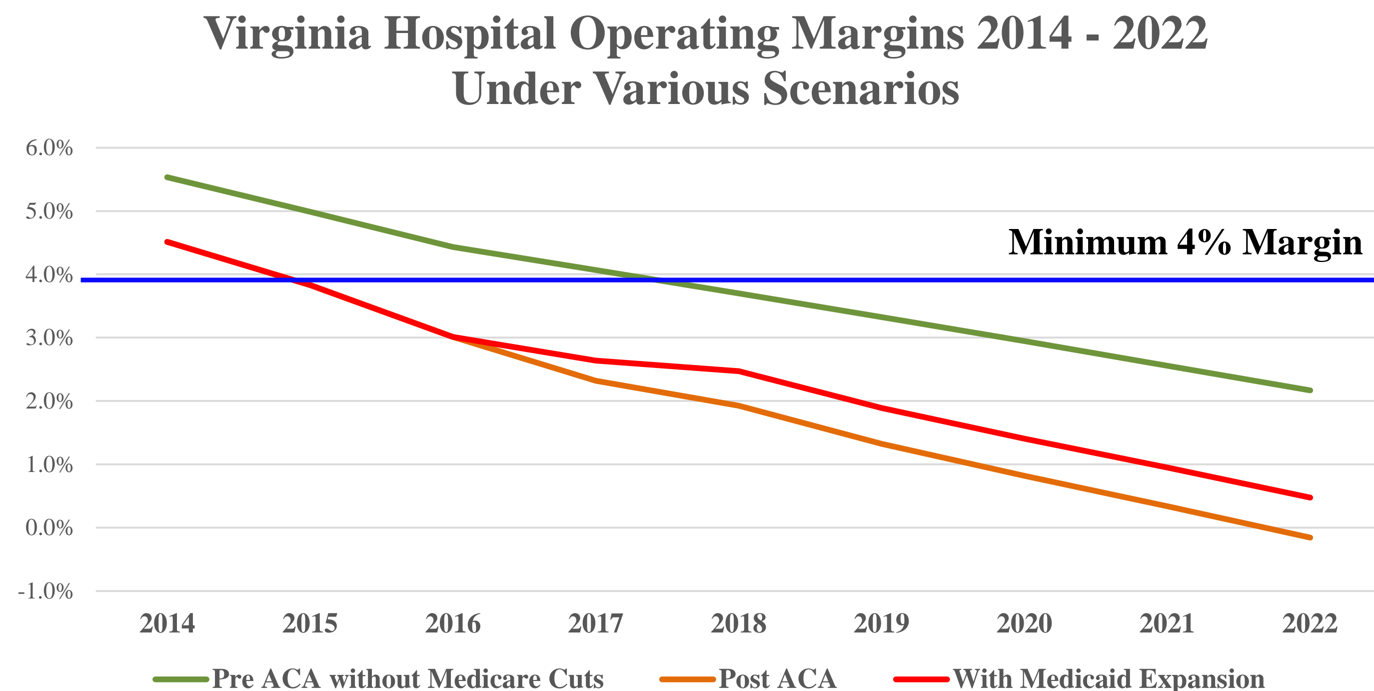
Key Findings – Major Drivers of the Financial Forecast

- **Declining operating margins are primarily driven by increased Medicare/Medicaid case load at lower payment rates and reduced funding for uncompensated care**
- **A possible Medicaid expansion program in Virginia would increase hospital margins, but not overcome the effect of Medicare cuts**



A minimum 4% operating margin is required for hospitals to maintain fiscal stability and modernize and replenish capital stock

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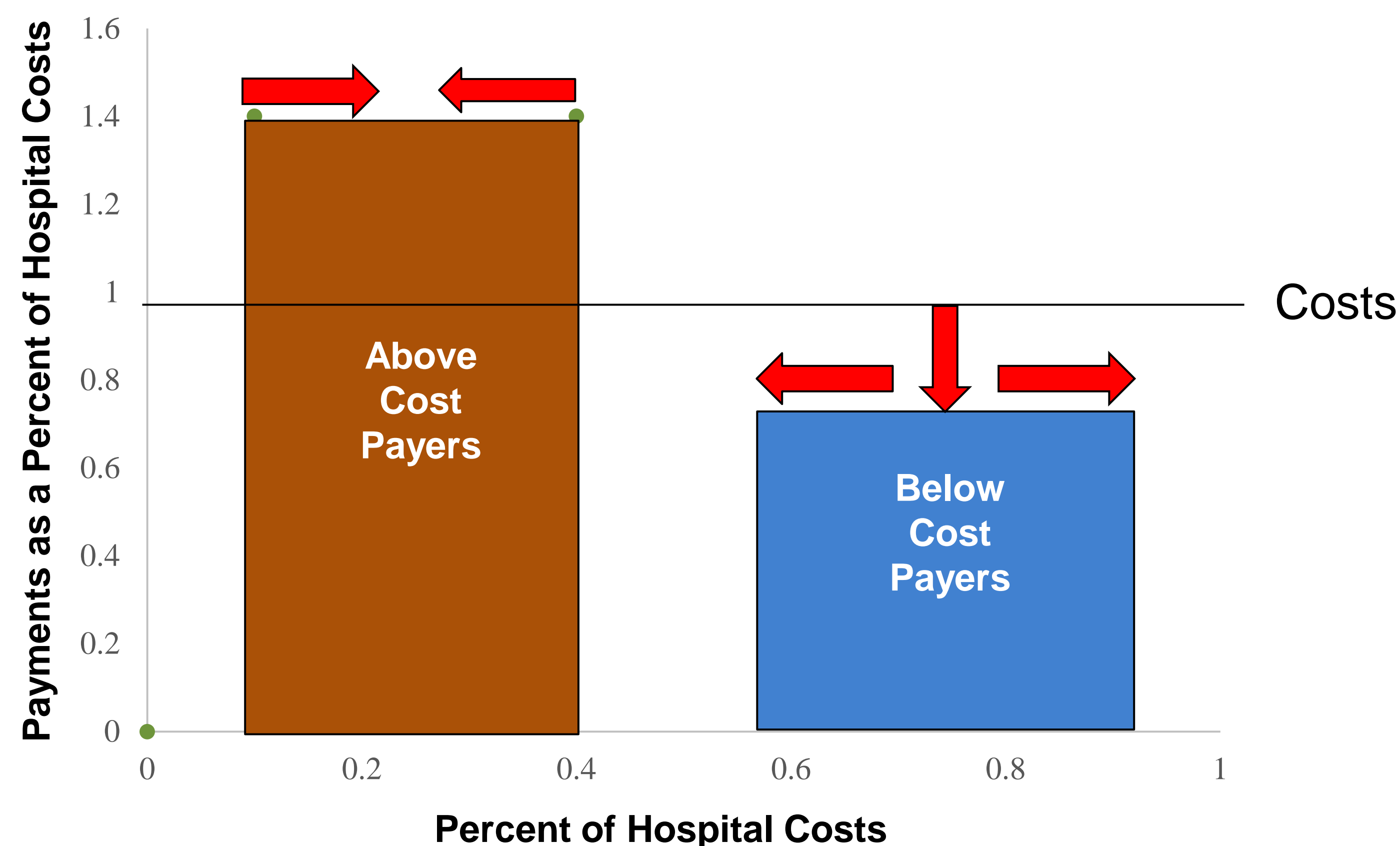
Key Findings – Dynamics of Major Drivers of Financial Forecast

- **Hospitals must offset losses from below cost payers with gains from above cost payers**
- **Declining operating margins are primarily driven by increased Medicare/Medicaid case load at lower payment rates and reduced funding for uncompensated care**



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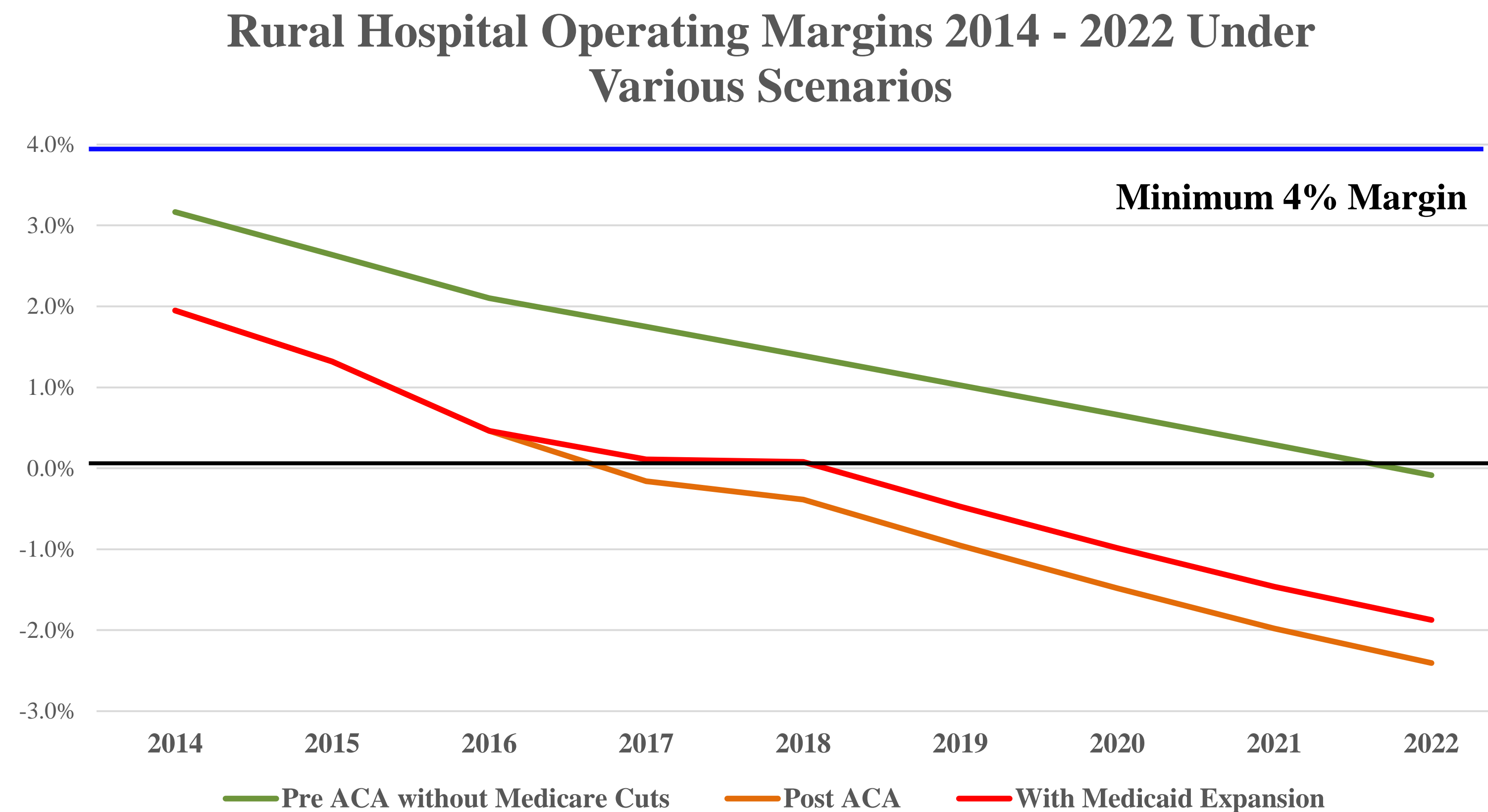
Key Findings – Financial Forecast for Rural Hospitals

- **Rural hospitals in Virginia may be in particular jeopardy as we estimate that operating margins for rural hospitals could fall from 2.0% in 2014 to a negative 2.4% by 2022**



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Discussion – Additional Pressures on Hospitals

- **Changes described in this study are projected to take place in an environment where payers (especially Medicare) will also implement a series of Value Based Purchasing (VBP) and payment system transformation programs**
- **CMS has shown a willingness to expand its Accountable Care Organization (ACO) and bundled payment programs and at the same time use these programs to reduce Medicare expenditures**
- **This will change the hospital finance, business, and delivery models by requiring providers to accept greater financial risk**
- **A possible Reconciliation Bill may likely be introduced in 2017, based on Medicare alternative payment models (APM) under development, to reduce Medicare spending and will have an unknown impact upon hospital operations and resulting finances**

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Discussion – Hospital Reaction to Forecasted Pressures

- **As prudent fiscal managers, hospitals will react to the pressures identified in our study to remain financially viable**
- **The current overall slowdown in hospital and health care costs we have seen in recent years is in part an early response to these pressures**
- **However, a minimum 4% operating margin is required for hospitals to maintain fiscal stability, employ emerging technologies, and develop infrastructure to implement APMs. In order to reach this benchmark from the projected negative 0.2% operating margin, hospitals leaders have four fundamental strategies:**
  - Reduce costs through labor or wage reduction. For example, these measures would translate into either 6.6% reduction in wages or a loss of 6,600 jobs
  - Eliminate unprofitable service lines
  - Reduce the amount of charity care delivered
  - Seek increased payment from private insurers

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Virginia Health System Financial Forecast: Outlook for Virginia Hospitals

Study Highlights

Authors: Al Dobson, Ph.D., Randall Haught

Contact: Randall Haught, randy.haught@dobsondavanzo.com; 703-722-8944

Purpose

Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) developed a financial forecast for Virginia's hospitals based on current policies. The forecast here includes the impact of the following, significant and known forces:

- Affordable Care Act (ACA) coverage expansions through the federal health insurance marketplace
- Medicare payment reductions
- Reduced uncompensated care funding from Medicare and Medicaid Disproportionate Share Hospital (DSH) cuts
- Aging of the population, as a higher proportion of the population become eligible for Medicare

Additionally, there are major changes underway to how health care services are delivered and paid for, with a shift away from fee-for-service payments that reward greater volume to more value-based and bundled payments that require providers to coordinate care and accept greater risk. This transformation requires significant investment in technology and integration of services. The costs are foreseeable. What remains unclear is how it will affect financial results. Therefore, the impact of this transformation is not reflected in the current model.

Although these estimates reflect the potential impact on hospital operating margins due to the above mentioned factors, actual results may vary and will be affected by hospitals' responses to these forces.

Synopsis of Key Findings

We estimate that operating margins for Virginia hospitals could decline from 4.5% to negative 0.2% between 2014 and 2022. This would move the potential operating margin for the industry as a whole into negative territory by 2022. This result is driven by several key factors:

- An aging of the population. As more people become eligible and enroll in Medicare, the portion of hospital costs related to treating this population increases. Because Medicare payments are below the hospitals' cost of providing care, the increase in the Medicare population drives down the hospital margin.

- Little change in the uninsured. Early data show that in the absence of a state plan for covering lower income Virginians, the ACA marketplace expansion has had little effect on the overall number of uninsured in Virginia, and in turn little initial impact on hospital uncompensated care costs.[1] However, the model does include the positive impacts of those who have obtained marketplace coverage and we estimate this will increase over time.

- ACA coverage expansions will help reduce hospital uncompensated care attributed to uninsured patients. However, as insurance coverage moves toward consumer driven healthcare and increased co-payments and deductibles, hospital bad debts may increase for the population covered by commercial insurance. In other words, uncompensated care for those who are insured may also rise.

- Even as ACA coverage expansions have had little effect on reducing hospital uncompensated care burden, additional financial pressure is mounting on providers as Medicare and Medicaid DSH payment cuts are projected to reduce funding for uncompensated care by $1.1 billion from 2014 to 2022.

- Most importantly, a total of $5.4 billion in legislative Medicare payment reductions, which take effect over the study period

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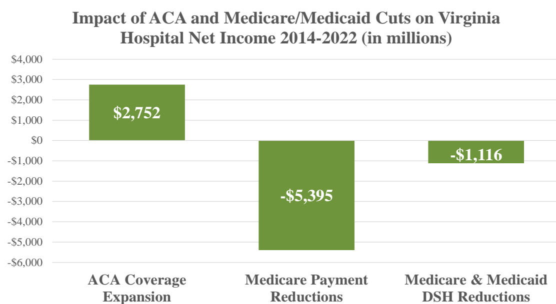
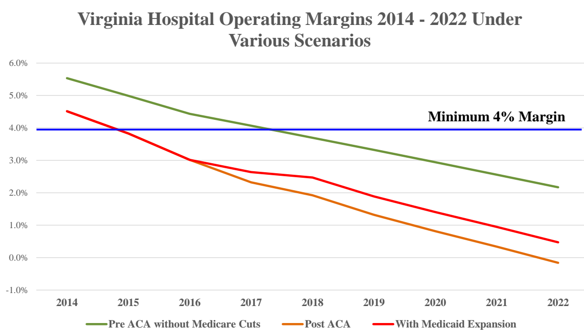
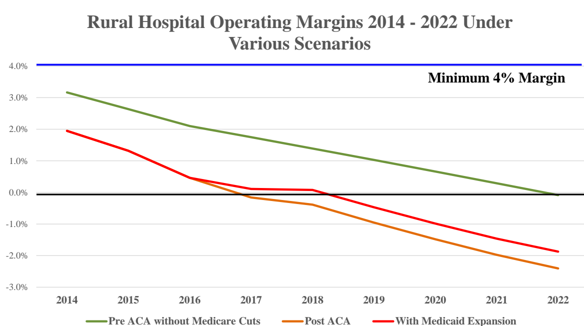
overwhelm the positive efforts of the ACA-subsidized marketplace coverage. Because the Medicare payment reductions are cumulative and increase over time, they are the primary driver of hospital margins trending negative.



- A possible Medicaid expansion program in Virginia would increase both hospital revenues and costs. The net benefit, while significant, does not overcome the effect of Medicare payment cuts.



- Rural hospitals may be in particular jeopardy as we estimate that operating margins for these hospitals could fall from 2.0% in 2014 to a negative 2.4% by 2022.



Discussion

As prudent fiscal managers, hospitals will react to the pressures identified in our study to remain financially viable. In fact, the overall slowdown in hospital and health care costs we have seen in recent years is, in part, an early response to these pressures. However, a minimum 4% operating margin is required for hospitals to maintain fiscal stability[2,3,4]. To achieve that benchmark, rather than the projected negative 0.2% operating margin, hospital leaders have four strategies:

1. Reduce costs further through labor or wage reductions. This savings strategy would translate into either 6.6% reduction in labor costs or a loss of 6,600 jobs by 2022.
2. Eliminate unprofitable service lines.
3. Lower the amount of charity care delivered.
4. Seek increased payment from private insurers.

All of the modeled changes are projected to take place in an environment where payers (especially Medicare) will also implement a series of Value Based Purchasing (VBP) and payment system reforms. Using its existing legislative authority, the Centers for Medicare & Medicaid Services (CMS) has shown a willingness to expand its Accountable Care Organization (ACO) and bundled payment programs in order to reduce Medicare expenditures. This will change the hospital finance and business model by requiring providers to accept greater financial risk.

Also on the horizon is the potential for federal action in 2017, the first year of a new presidency, when Congress is likely to enact a sweeping Reconciliation Bill attempting to further reduce Medicare spending. The precise nature of future federal health policy changes is unknown. But the bottom line is that hospital finances will most certainly be less FFS driven, and increasingly VBP driven with additional legislative "take backs" in the very near future.

These changes portend an uncertain future for the hospital industry. Collectively the Virginia hospital system has been very stable. In the absence of a Virginia solution on coverage and with a greater shift to VBP, hospitals may be placed at undue financial risk.

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About the Study

Publicly available data from Virginia Health Information (VHI) on hospital costs and revenues for 2011 was used as a baseline for the financial projections. Data from 2011 was used as a baseline because it contains financial information prior to most of the scheduled Medicare payment reductions; Medicaid payments relative to costs are in line with those reported by the Department of Medical Assistance Services (DMAS); and they contain data prior to most ACA coverage provisions.

Hospital costs for each payer group (Medicare, Medicaid, Commercial and uncompensated care) were forecasted using an approach that accounts for changes in the Virginia population, hospital utilization, and cost per unit of service. Hospital revenues for each payer were forecasted using the historical relationship between payments and costs calculated from the VHI data.

The forecast was performed in two steps:

1) without the effects of the Affordable Care Act because most of the Act's provisions are in a transitional period; and
2) separately modeling the effects of ACA coverage expansion, Medicare payment reductions and Medicaid DSH reductions.

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[1] Gallup – Healthways, Well-Being Index , February 24, 2015
[2] Sharp M (2014, March). CT Hospital Operating Income Down $175 Million in 2013. *Connecticut Hospital Association.*
[3] Ellison A (2014, October). 200 Hospital Benchmarks. *Becker's Hospital Review.*

[4] Mamula KB (2014, May). Average hospital operating margin sinks, charity care rises. *Pittsburgh Business Times.*

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