COMMUNITY CATALYST

Health Care Provider Assessments:
A State-Based Funding Solution for Closing the Coverage Gap

The federal government pays 100 percent of the costs of extending Medicaid to adults up to 138 percent federal poverty level (FPL) through 2016. After that, states begin gradually contributing to pay for the newly eligible until the state share is capped at 10 percent from 2020 on. Numerous reports on states that have already closed the coverage gap[1] have demonstrated that state savings from reduced uncompensated care costs, coupled with new revenues from existing provider taxes, will more than compensate for new state costs. [2] Nevertheless, the state share is a commonly cited reason by conservative policymakers to not provide health coverage to more people. In addition, some states may need to identify short-term revenues to pay for the state portion before savings accrue.

New or increased provider assessments provide an immediate solution. Many hospitals and other provider groups have already stepped up to pay the state share of Medicaid expansion through increased or new provider assessments. Other providers in states with expansion proposals still on the table are offering to be assessed. Hospitals are eager to reduce the number of uninsured as a way to lower uncompensated care costs.[3] These potential savings to hospitals are especially relevant in light of federal Disproportionate Share Hospital (DSH) payment cuts that are scheduled to phase in beginning in 2017.[4]

This policy brief walks through the rules governing the use of provider assessments to fund Medicaid, and gives some state examples of provider assessment proposals in the context of closing the coverage gap.

Summary of Provider Assessment Rules

Provider assessments – also sometimes referred to as taxes or fees – have been a vital source of revenue to fund the state share of Medicaid. Over the years, all states except Alaska have implemented one or more type of provider assessment. These assessments are collected by states and then put up as a match for federal dollars. States can then use the cumulative money to increase payments to providers for Medicaid services or to support the Medicaid program more broadly.

The federal government has several rules that define the use of provider assessments to generate Medicaid matching funds, including:

- **They must be broad-based** – imposed on all providers within a specified class of providers. There are **19 classes of health care providers**. The most frequently-used assessments are on nursing facilities, hospitals and intermediate care facilities for individuals with intellectual disabilities and managed care organizations.
- **They must be uniform** – the same assessment is placed on all providers within a specified class.
- **They cannot exceed 6 percent of a provider's net operating revenues –** providers cannot be "held harmless" from the burden of the assessments. This means that states

cannot guarantee that the providers will receive back the money that they were assessed. However, if the assessment is capped at 6 percent of net patient revenues, the assessment revenue *can* be used to reimburse providers for Medicaid services.[5]

- **They generally cannot exceed 25 percent** of the state share of Medicaid expenditures.[6]

There are several steps in the provider assessment approval process:

- **On a state level**, health care facilities and the state government often negotiate to set new or increased provider assessments, as well as the subsequent Medicaid provider reimbursement amount. The fee is usually enacted through the legislature. The state Medicaid agency then submits a state plan amendment to the Medicaid State Plan for federal approval.[7]
- **On the federal level**, the Centers for Medicare and Medicaid Services (CMS) works with individual state Medicaid agencies to ensure that a proposed provider assessment or provider assessment waiver proposal meets federal parameters. States may waive uniform and broad-based requirements on a case by case basis.[8]

Hospital Assessments in States that Have Already Closed the Gap

A number of states that have already closed the gap are relying on new or increased provider assessments to finance their state share of Medicaid expansion costs. The following describes provider assessments across a variety of those states:

- **Arizona**. Arizona began assessing its hospitals to help fund the state's Medicaid expansion starting in 2014. The state hospital association supports continuing the hospital assessment especially since the resulting 33 percent drop in uncompensated care in 2014.[9] New regulations allow adjustments to the assessment based on updated estimations of the number of beneficiaries and projections of costs. Starting April 1, 2015, Arizona's hospital assessment will increase.[10]

- **Colorado**. Since 2010, the hospital assessment in Colorado has been used to increase coverage for the new adult group as well as for the Children's Health Insurance Program (CHIP) and pregnant people up to 250 percent FPL.[11] Under the assessment, Medicaid reimbursement to Colorado hospitals has improved from 61 percent of Medicare rates in 2008 to 80 percent in 2013. [12]

- **Indiana**. Funding the state's Medicaid expansion will involve a combination of revenues from Indiana's existing cigarette tax and an increase in Indiana's existing hospital assessment starting in 2017. The Indiana Hospital Association agreed to an increase in the assessment of licensed acute hospitals and private psychiatric hospitals, which also bumps up Medicaid provider reimbursement to 75 percent of Medicare reimbursement rates (from 55 percent). From 2015-2021, the hospital assessment increase will provide $959 million of the state's $1.6 billion share of expansion costs. [13]

- **Ohio**. Ohio hospitals pay a franchise fee in part to support the state share of Medicaid. Going into the second year of Medicaid expansion, Ohio's hospital franchise fee will increase from 2.66 percent to 4 percent, which would help draw down more federal funding, while also boosting payment for Medicaid services to hospitals.

Hospital Assessment Proposals in the Works

To mitigate state budget concerns, hospitals have proposed to take on new or increased assessments to cover the state portion for closing the gap. Generally, provider categories with the most at stake and the most to gain from increased coverage were the ones offering to be assessed.

- **Alaska**. Governor Bill Walker's proposal asks the state health department to develop a plan for a provider tax, but is not specific about which providers would be assessed or how much. A provider tax could possibly generate $350 million in revenue.[14] The Alaska State Hospital & Nursing Home Association supports the provider tax funding strategy.

- **Kansas**. The Kansas Hospital Association is open to raising the hospital assessment to help fund the state share of Medicaid expansion. Kansas currently collects a hospital provider assessment at 1.83 percent of each hospital's net inpatient operating revenue as well as one on nursing facilities.[15]

- **Louisiana.** The Louisiana Hospital Association has offered up a proposal for an assessment on private hospitals to fund the potential expansion population if a resolution is passed for 2016.

- **Tennessee**. The Tennessee Hospital Association has committed to cover any state expenses created by the governor's plan to close the coverage gap, Insure Tennessee. Since 2010, private hospitals in Tennessee have been paying a 4.52 percent assessment fee to help fund the state's current Medicaid program.[16] To date, hospitals have provided $452 million to fund TennCare through these assessments, helping the program avoid more than $1 billion in service cuts and reimbursement reductions. Under the governor's expansion plan, the fee would likely increase to just under 5 percent. Tennessee hospitals could see $1 billion annual additional reimbursement with expansion.[17]

- **Utah**. Governor Gary Herbert's "Healthy Utah" plan will explore provider assessments as a funding solution for their expansion population.[18]

In considering new or increased assessments, states may be able to maximize their funding sources for their share of Medicaid expansion by targeting classes of providers who are currently not assessed and who have the most at stake (defined by having high shares of uncompensated care and uninsured patients who are in the coverage gap).

Minimizing the "Losers" and Maximizing the "Winners"

Among hospitals that are assessed, those that see larger shares of Medicaid patients may realize a net gain from the assessment (from receiving higher shares of Medicaid services reimbursement and a larger drop in uncompensated care costs), while those that see fewer Medicaid and uninsured patients may incur a net loss. Adjusting the reimbursement methodology – negotiated between CMS and the state Medicaid agency – can alleviate large differences with the assessment burden, which may become more apparent if more states close the gap. For example:

- Even though Georgia has not closed the gap, provider assessments were impacting hospitals disproportionately. For example, in 2011, Children's Healthcare of Atlanta Egleston gained a net $13.8 million from the provider fee and increased Medicaid reimbursement, while the Piedmont Hospital in Atlanta lost a net $6.4 million.[19] With CMS' approval, Georgia adopted a new methodology that uses tiers to calculate the provider assessment. Tier I provider assessments are placed on public hospitals (which see more Medicaid patients) and a Tier II assessment is placed on private hospitals.[20]

- California revised the formula of distributing the assessment funds based on whether the hospital is a qualified private hospital,[21] a non-designated public hospital or a designated public hospital.[22] These adjustments in reimbursement were made to ensure that Medicaid beneficiaries have continued access to hospitals services and to mitigate large differences in assessment impact between types of hospitals.

The success and feasibility of provider fees depends on policymakers and the affected health care providers working together.[23]

Conclusion

Advocates who might be interested in further understanding hospital assessment policies in their states for closing the coverage gap should start by knowing which provider assessments are already imposed and at what percent of net patient revenue. The National Conference of State Legislatures has done some tracking of health provider assessments in states throughout the years. Nevertheless, specific information is not always easily attainable.

Despite evidence that demonstrates the state fiscal benefits of closing the gap, some policymakers remain concerned about how to fund the state share for at least the short-term. New or increased provider assessments may be an accessible solution that can help states pay for their portion of expansion costs that start in 2017.

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[1] Bachrach, D., Boozang, P. & Glanz, D. (April 2015). States Expanding Medicaid See Significant Budget Savings and Revenue Gains. *State Health Reform Assistance Network.* Retrieved from http://www.rwjf.org/en/library/research/2015/04/states-expanding-medicaid-see-significant-budget-savings-and-rev.html

[2] Dorn, S., Francis, N., Urban Institute, Snyder, L., & Rudowitz, R. (March 11, 2015). The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States. *Kaiser Family Foundation.* Retrieved from http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/

[3] Ma, A. (March 2015). How Closing the Coverage Gap Benefits Hospitals. *Community Catalyst.* http://www.communitycatalyst.org/initiatives-and-issues/issues/medicaid/Impact-of-the-coverage-gap-on-hospital-finances-03.30.15_formatted.pdf

[4] DSH payments are given to qualifying hospitals that have a disproportionate share of uncompensated care and Medicaid patients. DSH cuts will go into effect starting in FY2017 and will amount to $36 billion by 2019 ($22.1 billion for Medicare and $14 billion for Medicaid).

[5] Kaiser Family foundation. (May 2011). Medicaid Financing Issues: Provider Taxes. Retrieved from https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8193.pdf

There is also a 75/75 rule – states can impose a provider assessment above the 6 percent cap and draw down federal matching funds on tax revenue as long as the state can prove that more than 75% of the taxpaying providers do not receive more than 75% of the cost of the tax back through enhanced Medicaid rates. Otherwise, the provider tax revenue could still be used to fund Medicaid, but the state would not get a complete federal match

[6] Social Security Act § 1903(w)(5), 42 U.S.C. § 1396b

[7] Medicaid.gov. (2015). Medicaid State Plan Amendments. Retrieved from http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html

[8] Cornell University Law School. 42 CFR 433.72 – Waiver provisions applicable to health care-related taxes. Retrieved from https://www.law.cornell.edu/cfr/text/42/433.72

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[10] Arizona Health Care Cost Containment System Administration. (2015). Chapter 22. Arizona Health Care Cost Containment System Administration. Retrieved from https://www.azahcccs.gov/reporting/Downloads/UnpublishedRules/NOER_HospitalAssessment2015.pdf

[11] Colorado Department of Health Care Policy & Financing. Hospital Provider Fee. Retrieved from https://www.colorado.gov/pacific/hcpf/hospital-provider-fee

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[13] Indiana Family & Social Services Administration. (2015). Healthy Indiana Plan 2.0. Retrieved from http://www.in.gov/fssa/hip/files/HIP_2_0_Roadshow_DM_FINAL.pdf

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[15] Kansas Health Institute. (January 2014). Kansas Medicaid: Beyond the Basics. Retrieved from http://media.khi.org/news/documents/2014/01/21/Medicaid-Primer_Supplement01.pdf

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