UTILIZING HEALTH CARE PROVIDER FEES TO PREVENT PROPOSED MEDICAID REDUCTION

Current total Medicaid budget for FY17: $5,787 million (state share = $1,218M)
(This reflects proposed cuts in provider reimbursements of $161 million.)

Total budget without cuts of $161 million: $5,948 million.

Objective: keep the state government share at $1,218 million while restoring cuts.

Scenario 1: Provider fee of $33 million held by HSD would support federal reimbursement of $128 million at the current FMAP of 79% (State share 21%) ($33M & $128M = $161M).

In Scenario, providers would not be allowed to increase their rates to cover this fee.

In that case, providers would get $161 million more in reimbursements than in current budget, but they would have to pay $33 million to HSD to supply the state match; they would lose $33 million instead of $161 million.

(Requires legislation but no change to State Plan because no change in reimbursement rates to providers.)

Scenario 2: If the providers' reimbursements were increased (above the $5,948) to reimburse them for a provider fee of $42 million, for a total reimbursement of $5,990 million, the federal share at 79% would be $4,730 million. The state share of $5,990M would be $1,260.M

The providers would have paid HSD $42 million (which they get back—on average—through higher Medicaid rates), leaving the state government to pay $1,218 million, as in the current budget.

(Requires legislation and most likely, a change to the State Plan.)

FACT SHEET: Health Care Provider Assessments: States' Option for Medicaid Revenue

- Provider assessments were made legal under section 1903(w) of the Social Security Act.
- The provider assessment is used by almost all states to generate new in-state revenue and the federal match of the revenue to generate additional Medicaid dollars.
- Began to be used extensively by states in the 1980's as a revenue mechanism to assist finance the state share of Medicaid expenditures, especially increases. By the end of the last recession, all but Alaska using some form of the provider assessment and/or added categories of assessment.
- In 1991 (and 2006), CMS imposed regulations:
    1. Most be **broad-based** (imposed on all providers within a specified type of provider) and **uniform** (same tax on all providers - cannot limit to only Medicaid providers. 19 classes of providers are used to ensure the tax is board based. (i.e.. inpatient hospital services, outpatient hospital services, nursing facilities, intermediate care facilities for the mental retardation, physician services, home health , HMO's/MCO's, ambulatory surgery centers dental services, etc)
    2. Assessments **cannot exceed 25%** of the non-federal share of Medicaid expenditures.
    3. States **cannot directly or indirectly guarantee that providers receive their money back** (hold harmless).
- It is not legal to reimburse specific providers for the exact amounts of fee they were assessed, but is OK to target the entire category so that on average providers recoup the fee.

Summary:

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.

More information and sources:

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-andrev.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-selectstates/** 3 Ma, A. (March 2015). How Closing the Coverage Gap Benefits Hospitals.

3 Community Catalyst. http://www.communitycatalyst.org/initiatives-and-issues/issues/medicaid/Impact-of-the-coverage-gap-on-hospitalfinances-03.30.15_formatted.pdf

4/National Conferences of State Legislators 2.1.16 http://www.ncsl.org/research/health/health-provider-and-industry-state-taxes-and-fees.aspx.