

Implementing the Hospital Assessment: Ensuring Fairness and No Financial Harm

The Issue

In January 2013, Governor Jan Brewer proposed lifting the enrollment freeze on Prop. 204 and further expanding Arizona Health Care Cost Containment System (AHCCCS) coverage to 133 percent of the federal poverty level (FPL), effective January 1, 2014. Funding for both the restoration of Prop. 204 and expansion would come from a new Medicaid provider assessment on hospitals. The proposal charged the AHCCCS director with developing and implementing the assessment. AzHHA was a strong supporter of the governor's proposal, including the use of a hospital assessment, which the AzHHA Board approved unanimously in March 2013. A crucial part of the Board's deliberation was how an assessment structured by AHCCCS would impact individual hospitals. The Legislature approved the governor's proposal in a special session in June 2013 (Laws 2013, First Special Session, Chapter 10). Over the summer, the AHCCCS Administration worked with hospitals to develop an assessment model, which the Centers for Medicare & Medicaid Services approved in January 2014.

AzHHA's Position

AzHHA is strongly committed to structuring a hospital assessment that assures no individual community hospital or healthcare system experiences a financial loss as a result of the hospital assessment program. This position was affirmed by the AzHHA Board in March 2013. Under any model implemented by AHCCCS, the amount of the assessment collected from any hospital/healthcare system should be accompanied by an increase in funding from newly covered patients (Prop. 204 restoration or expansion populations) in an amount at least equal to the assessment paid by the hospital. AzHHA will monitor the assessment program moving forward to evaluate how the assessment and restoration/expansion work in reality and seek changes to the methodology and/or other regulatory or legislative solutions to avert any financial harm to hospitals.

Background

Federal law permits states to fund a portion of their state Medicaid match from an assessment on healthcare providers. Nearly every state employs some form of provider assessment—on hospitals, nursing homes, managed care organizations or pharmaceuticals. These assessments have allowed state governments to expand coverage, fill budget gaps and maintain patient access to health services by avoiding cuts to provider payments.

Under provider assessment programs, healthcare providers and/or insurers pay a mandatory fee or tax, which is used to draw down federal matching funds. The total funds are then used to pay partial costs of the Medicaid program. The funds can be targeted to specific Medicaid programs or used to augment provider payments.

Arizona first implemented a provider assessment on managed care plans in 2003. Nine years later, the Legislature approved an assessment on nursing homes. And in 2013, an assessment on hospitals was approved, with revenue being used to restore funding for the Prop. 204 program and further expanding coverage to 133 FPL. The AHCCCS director is charged with developing and implementing the hospital assessment.

Provider assessment programs are subject to stringent federal regulations. Assessments cannot exceed 25 percent of the state share of Medicaid expenditures. In addition, with limited exceptions, assessments must be:

- Broad based (i.e., they must include at least all non-federal, non-public providers in a class—not just those who receive Medicaid payments);
- Applied uniformly to all providers in a class; and
- Without a “hold harmless” provision that would guarantee a provider an offset for any portion of the cost of the assessment.

Due to these requirements, hospital assessment programs often result in “winners” and “losers.” For example, providers with high Medicaid utilization rates tend to benefit more financially from hospital assessment programs than those with lower Medicaid utilization rates. If assessment programs are not carefully crafted, some providers might actually experience net financial losses.

While most hospital assessment programs are developed by the hospital industry, Governor Brewer’s proposal was distinctive in that the model would be developed by the state Medicaid director and it would not be codified in statute. The AHCCCS Administration felt this approach was appropriate since annual funding needs would fluctuate, and the agency would need flexibility with the model.

Analysis

AzHHA has long supported the Prop. 204 program. And while virtually all hospitals believed that restoration of the program and further expansion of Medicaid was the right social policy for the state, some were apprehensive about the impact of an assessment on their organizations—whether due to their Medicaid utilization rate, service structure or other unique factor. How to structure the assessment thus became a crucial item for AzHHA members and Board deliberation.

The AzHHA Board of Directors met in March 2013 to discuss the governor’s proposal, including the structure of the assessment. The Board recognized that there were ways to craft the assessment so that downside risks were eliminated or minimized. With this in mind, a vote was taken and unanimously approved to support the governor’s proposal **with an understanding that, as a matter of fairness, the model—as designed and implemented—must be constructed in a way that assures no individual community hospital or healthcare system experiences a financial loss because of the assessment.** This position allowed AzHHA to unify its member hospitals around the broader policy issue of restoration and expansion.

Over the summer, AHCCCS conferred with Arizona hospitals in developing the hospital assessment. Throughout these deliberations, AzHHA maintained the Board’s principle that the model must be constructed in a way that assures no hospital or healthcare system experiences a financial loss because of the assessment. The model developed by AHCCCS (attached) appears to meet this principle through the use of exemptions and variable rates.

However, AHCCCS’ analysis is based on prospective modeling. Once implemented, the results may differ. For this reason, it is important that the assessment be monitored, and retrospective analyses be conducted to ensure no provider experiences a net financial loss as a result of the assessment. Significantly, the enabling legislation prohibits hospitals from passing on the cost of the assessment, so the principle of “no financial harm” is reasonable and proper.

Moving forward, there are a number of factors that could affect the financial impact of the assessment on hospitals. These include, for example:

- Fluctuations in the Federal Medicaid Assistance Percentage rate;
- Fluctuations in Prop. 204 and AHCCCS expansion enrollment; and
- Fluctuations in hospital payments rates, which may result from the system migrating to a DRG system and/or changing Medicaid utilization patterns.

Our Position

AzHHA is committed to ensuring the Prop. 204 program is fully restored and, as such, was a strong supporter of Gov. Brewer's restoration proposal. The long-term success of this restoration relies on the implementation of a financially viable hospital assessment program. For such a program to work, those paying the assessment must not be harmed by it.

AzHHA supports a structure under which no hospital or healthcare system experiences a net financial loss as a result of the program. AzHHA will monitor the assessment program to evaluate how the assessment and restoration/expansion work in reality and seek changes to the methodology or other regulatory and/or legislative solutions to avert any financial harm to hospitals.