



Arizona Hospital and Healthcare Association

THERE TO CARE: STRONGER HOSPITALS FOR A HEALTHIER ARIZONA

Healthcare Provider Assessment Options

Fact Sheet

Federal law permits states to collect revenues from certain categories of healthcare providers or services—including hospitals, nursing care institutions, health insurers and others—and use the proceeds to draw down federal Medicaid matching funds. Federal matching dollars generated through a healthcare provider assessment must be paid back to the assessed providers through enhanced Medicaid payments or expanded Medicaid coverage. Federal matching funds may also be used to pay for a portion of the state’s share of the Medicaid program. Currently, 44 states—including Arizona—have some type of provider assessment.

Upper Payment Limit and Budget Neutrality

There are two primary limitations on the amount of federal funds Arizona could generate from such assessment. The first is the federal upper payment limit (UPL), which is a federal regulation that places a ceiling on the state Medicaid expenditures that are eligible for federal matching funds for certain types of services. The second is the federal budget neutrality cap on Arizona’s Medicaid demonstration. Budget neutrality is a requirement of the current 1115 waiver that governs the Arizona Health Care Cost Containment System (AHCCCS). The federal Centers for Medicare & Medicaid Services (CMS) has oversight authority over AHCCCS and must approve any new provider assessment. One of the issues CMS will review as part of any analysis of a new provider assessment is the impact of additional spending on the state’s estimate for budget neutrality. The Special Terms and Conditions of the waiver currently state that “if at the end of this Demonstration period the overall budget neutrality expenditure cap has been exceeded, the excess federal funds must be returned to CMS.” So far, AHCCCS has been able to maintain an overall positive budget neutrality variance. In a report submitted to the Legislature in November 2009, the AHCCCS Administration projected that the variance at the end of the current waiver period, which terminates on September 2011, would be a positive \$129 million. In January, the Administration revised the projection to \$673 million through September 2011 based on the assumption that AHCCCS payments and eligibility will be significantly reduced.

Implementation Timeframe

The length of time required for CMS to review and approve a new provider assessment will

depend on the proposal's complexity. Most experts agree the process would take six months to a year. **For this reason, it is likely that any proceeds from a healthcare provider assessment would be realized in FY 2012 and years thereafter.**

A Hospital Assessment: Winners vs. Losers

To ensure that states are not attempting to circumvent their obligations for paying the non-federal share of the cost of Medicaid, federal law requires that state hospital assessments be broad-based, uniformly imposed, and cannot hold a provider harmless—that is, states may not create a mechanism that guarantees the assessed hospital is repaid for all or any portion of the cost of the assessment, whether directly or indirectly. Due to these requirements and because of the varying levels of AHCCCS utilization among Arizona hospitals, a broad-based and uniform hospital assessment would result in winners and losers. Hospitals that treat a high number of AHCCCS patients would stand to benefit from such an arrangement, while hospitals that treat a low number of AHCCCS patients would be harmed. To avoid harming hospitals, care must be taken to collect accurate data and model various options to determine their impact on specific hospitals before any assessment is implemented.

AzHHA Provider Assessment Study

The Arizona Hospital and Healthcare Association (AzHHA) has engaged the nationally recognized consulting firm Health Management Associates to conduct a study to:

- Determine the room and flexibility to draw down additional federal matching funds using a provider assessment; and
- Determine the assessment model and revenue base that minimizes the redistribution among hospitals in order to limit the number and amount of losses that could occur with a hospital assessment.

For more information, please contact Laurie Liles or Barb Fanning at (602) 445-4300.