



American Hospital
Association®

Oppose Further Restrictions on Medicaid Provider Assessments

AHA View

The AHA urges Congress to reject options that restrict states' ability to fund their Medicaid programs, in part, using provider assessments. The Medicaid provider assessment program has allowed state governments to expand coverage, fill budget gaps and maintain patient access to health services to avoid additional provider payment cuts by helping states finance their portion of the joint federal/state program. But some policymakers have called for restricting states' ability to use assessments as a financing tool.

Provider assessment cuts are just another name for Medicaid cuts that harm the millions of children, poor and disabled Americans who rely upon this vital program. Hospitals already experience payment shortfalls when treating Medicaid patients. Medicaid, on average, covers only 90 cents of every dollar spent treating Medicaid patients. Further cuts to hospital funding would put enormous pressure on already stretched state budgets and could jeopardize this critical health care safety-net program.

Background

The president's fiscal year (FY) 2013 budget proposed to phase down, but not eliminate, Medicaid provider assessments beginning in 2015. The administration estimated this would save \$21.8 billion over 10 years. The House-approved FY 2013 budget reconciliation package contained cuts to Medicaid provider assessments of \$11.2 billion over 10 years. The administration dropped provider assessment cuts in subsequent budgets.

The Medicaid provider assessment program is a critical component to funding Medicaid programs across the country. Over its 46-year history, Medicaid has become the nation's health care safety net, serving as a buffer to the perils of an uncertain economy by providing access to health services for those who cannot afford private insurance. Nearly all states employ some form of provider assessments – on hospitals, intermediate care facilities, nursing homes, managed care organizations or pharmaceutical companies – as a means to fund their Medicaid programs and fulfill their providers' missions to care for the neediest of our society.

Following a congressional request, the Government Accountability Office in July 2014 released a report on states' use of various sources of funds to finance the non-federal share of Medicaid, such as provider assessments. This report found an increased state reliance on providers and local governments and the need for more transparency around state financing methods and payments to providers. In addition, the Centers for Medicare & Medicaid Services issued guidance on permissible health-related taxes in response to a May 2014 Department of Health and Human Services Office of Inspector General report on the taxing of Medicaid managed care plans.

Key Facts

- **Nearly 69 million low-income Americans rely on the Medicaid program to provide access to health care.** That includes:

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- 1 in 3 children;
- 1 in 3 births;
- 8 million people with disabilities;
- More than 9 million low-income Medicare beneficiaries; and
- 1 in 4 poor non-elderly adults.
- **Medicaid also is the major payer for long-term care services for low- and middle-income elderly.** Medicaid pays for seven out of 10 people living in nursing homes. More than a quarter of all mental health funding is from Medicaid. And according to the Kaiser Family Foundation, during the recession from 2007 to 2009, 6 million people were covered by Medicaid who would have otherwise gone without health care coverage.
- **With implementation of the Affordable Care Act, as many as 11 million more people may be enrolled in Medicaid beginning in 2015** (based on January 2015 Congressional Budget Office estimates).
- **Any reduction or elimination of Medicaid provider assessments would be on top of Medicaid cuts made at the state level.**