

**Meeting of the Provider Assessment Work Group
Meeting #1
General Assembly Building, House Room D
Richmond, Virginia**

**July 8, 2015
DRAFT Minutes**

CALL TO ORDER

Anna Healy James, Policy Director in the Office of the Governor, called the meeting to order at 1:05 p.m. Ms. James welcomed members for attending and asked members to introduce themselves. Members attending:

Anna Healy James, Richmond, Policy Director, Office of the Governor
Cindi B. Jones, Richmond, Director, Department of Medical Assistance Services
Beth A. Bortz, Henrico, President and CEO, Virginia Center for Health Innovation
Anthony Keck, Bristol, TN, Senior VP and Chief Development Officer, Mountain States Health Alliance
C. Novel Martin, Roanoke, CFO and Treasurer, Medical Facilities of America
Nancy Howell Agee, Roanoke, President and CEO, Carilion Clinic
Peter Gallagher, Staunton, Senior VP and CFO, Valley Health System
Debbie Burcham, Chesterfield, Executive Director, Chesterfield CSB
Matthew Turner, Richmond - VP of U.S. Employee Benefits, Genworth Financial
George Reiter, Reston, Senior VP of Total Rewards, Leidos
Sheryl Garland, Richmond, VP of Health Policy and Community Relations, VCU Health System
Massey S.J. Whorley, Richmond, Senior Policy Analyst, The Commonwealth Institute for Fiscal Analysis
Roderick Manifold, New Canton, Executive Director, Central Virginia Health Services
Linda D. Wilkinson, Richmond, CEO, Virginia Association of Free and Charitable Clinics
Kurt Hofelich, Norfolk - President, Sentara Norfolk General Hospital
Richard V. Homan, M.D., Norfolk, President and Provost, Dean of the School of Medicine, Eastern Virginia Medical School (via phone)
Sterling Ransone, M.D., Deltaville, Immediate Former President, Medical Society of Virginia
James Cole, Arlington, President and CEO, Virginia Hospital Center
William A. Hazel, Jr., MD, Richmond, Secretary of Health and Human Resources, Commonwealth of Virginia. Ex officio

CHARGE TO THE GROUP

After introductions, Dr. Hazel read portions of the charge (Authority: Title 2.2, Chapter 2; Article 6, and §2.2-200, *Code of Virginia*, Budget Item 278 C attached) which explains the purpose of establishing this work group.

NATIONAL OVERVIEW OF PROVIDER ASSESSMENTS

Deborah Bachrach, Partner, Manatt Health Solutions, presented a general overview of the national background, rules and uses of provider assessments. See attached handout.

VIRGINIA OVERVIEW OF PROVIDER ASESSEMENTS

William Lessard, Provider Reimbursement Division Director at the Department of Medical Assistance Services (DMAS), provided information on provider assessment estimates for the most common type of providers and specifically reported on the current revenue from provider assessments for Virginia’s intermediate care facilities-intellectual disability. See attached handout.

DISCUSSION

After a short break, Ms. James reconvened the members at 2:40 p.m. to discuss next steps and wrap up.

Suzanne Gore, DMAS Deputy Director for Administration, provided information regarding the address for public comments: providerassessmentworkgroup@dmas.virginia.gov and the web location for information about the work group: http://www.dmas.virginia.gov/Content_pgs/pawg.aspx

Dr. Hazel briefly provided highlights of the Virginia Freedom of Information Act (FOIA) guidelines to members as it relates to what is considered a MEETING and EMAIL AND MEETINGS under FOIA.

Ms. James announced the next meeting is scheduled for September 30, 2015, from 12:30 to 3:00 p.m. at the Virginia Department of Health Professions, located at 9960 Mayland Drive, Suite 300, Perimeter Center, Richmond, Virginia 23233, in Board Room #2.

Ms. James thanked Cindi Jones and DMAS for their staffing assistance and support to the work group.

In closing, Ms. James asked the work group members to share their thoughts and topics for discussion that would be meaningful to respond to the mandate for this study.

ADJOURNMENT

Ms. James announced that the opportunity for public comments would be available at the end of the next scheduled meeting and thanked everyone for attending. The meeting adjourned at 3:50 p.m.

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OFFICE OF HEALTH AND HUMAN RESOURCES
§ 1-88. SECRETARY OF HEALTH AND HUMAN RESOURCES (188)

ITEM 278.

Authority: Title 2.2, Chapter 2; Article 6, and §2.2-200, Code of Virginia.

C.1. The Secretary of Health and Human Resources shall conduct an analysis and develop a plan with options for a hospital provider assessment program, including a review of other issues deemed necessary, for consideration by the General Assembly in the 2016 Session, that:

(i) complies with applicable federal law and regulations; (ii) is designed to operate in a fashion that is mutually beneficial to the Commonwealth and affected health care organizations; (iii) addresses health system challenges in meeting the needs of the uninsured and preserving access to essential health care services (e.g. trauma programs, obstetrical care) throughout the Commonwealth; (iv) supports the indigent care and graduate medical education costs at hospitals in the Commonwealth; (iv) advances reforms that are consistent with the goals of improved health care access, lower overall costs and better health for Virginians; and (v) takes into account the extent to which it provides equity in the assessment and funding distribution to affected health care organizations. In the development of this program, the Secretary's office shall be assisted by the Department of Medical Assistance Services, the Virginia Center for Healthcare Innovation, the Virginia Hospital and Healthcare Association and other affected stakeholders.

2. As part of the analysis and development of a plan for a hospital provider assessment program, the Secretary of Health and Human Resources shall also develop as an option a more limited program that is focused on supporting the indigent care and graduate medical education costs at private teaching hospitals in the Commonwealth.

3. The Secretary of Health and Human Resources shall also undertake a review of a program that would provide supplemental payments for qualifying private hospitals as provided for in the State Plan for Medical Assistance Services amendments 11-018 and 11-019 submitted to the Centers for Medicare and Medicaid Services on or about December 20, 2011.

4. The Secretary shall report to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2015 on the appropriate details regarding the plan and options for a hospital provider assessment program, which shall include: (i) the structure, collection process, and amount of the assessment; (ii) the process for supplemental payments; (iii) an estimate by hospital of the net financial impact of the program; and (iv) an implementation timeline. In addition, the Secretary shall include in his report details on the options and requirements of subparagraphs 2 and 3.

5. The Secretary may work with the appropriate federal agencies as part of the development of a plan for a program or other options developed pursuant to subparagraphs 1, 2 and 3 in order to ensure compliance with federal requirements.

Overview of Provider Assessments

Virginia Provider Assessment Work Group

July 8, 2015



Provider Assessments and Medicaid

Medicaid Financing

- Medicaid is jointly funded by the state and federal governments
- States must use non-federal dollars to draw down the federal matching funds for Medicaid expenditures
- CMS verifies the state's source of funding the non-federal share **before** it will approve a waiver or State Plan Amendment

Potential Funding Sources for State Share

 State General Funds	 Provider Assessments/Fees	 Designated State Health Programs (by waiver only)	 Intergovernmental Transfers
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Today's Focus



What Constitutes a Provider Assessment?

Definition of Provider Assessment

A health care-related fee, assessment or mandatory payment for which at least 85% of the burden of the assessment falls on health care providers.

- CMS may find fees or assessments to be “health care related” (and thus subject to the provider assessment requirements) even if less than 85% of the burden of the assessment falls on health care providers but the fee or assessment is targeted in some way toward Medicaid providers or Medicaid payments
- For example, if only Medicaid MCOs are subject to a state sales tax, but other MCOs are not, CMS may find that the sales tax constitutes a provider assessment

Classes of Health Care Providers

- Inpatient hospital services
- Outpatient hospital services
- Nursing facility services
- Intermediate care facility services
- Physician services
- Home health care services
- Outpatient prescription drugs
- Services of managed care organizations
- Ambulatory surgical center services
- Dental services
- Podiatric services
- Chiropractic services
- Optometric/optician services
- Psychological services
- Therapist services
- Nursing services
- Laboratory and x-ray services
- Emergency ambulance services
- Other licensed health care items or services

Managed care organizations are considered “providers” under the provider assessment rules

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Source: 42 C.F.R. § 433.55; 42 C.F.R. § 433.56; 42 C.F.R. § 433.68

What Rules Apply to Provider Assessments?

Federal Statutory and Regulatory Requirements

In order to receive federal matching funds for provider assessment revenue, the assessment must:

- be **broad-based**, meaning that the assessment is imposed on at least all health care items or services in the class furnished by all non-federal, non-public providers in the State
 - ⇒ *Example:* A hospital assessment must apply to all non-federal, non-public hospitals. A Veterans’ Administration or county hospital may be exempt, but a private academic medical center may not.
- be **imposed uniformly** on all providers within a specified class of providers (or the state must prove that the assessment is generally redistributive in order to receive a federal waiver of the broad-based and/or uniformity requirements)
 - ⇒ *Example:* An assessment on nursing facility revenue must apply at the same rate to all providers. High-volume Medicaid providers cannot be assessed 4% of revenue, while low-volume Medicaid providers are assessed 2% of revenue
- **not exceed 25% of the non-federal share of Medicaid costs**
- **not hold providers “harmless”** or guarantee providers will receive their money back (there is a presumption that the providers are not “held harmless” if the rate < 6%)
 - ⇒ *Example:* A state cannot guarantee that a hospital will receive its assessment back in the form of a supplemental payment

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Source: 42 C.F.R. § 433.55; 42 C.F.R. § 433.68

Overview of States Use of Provider Assessments



49 states (and DC) have provider assessments.

As of FY 2013, Alaska is the only state that does not use provider assessments.



Nursing homes, hospitals and ICFs are the most common providers that are subject to an assessment.

States also impose assessments on other provider classes, including health plans.



Public data on provider assessments is limited.

There are three key sources on provider assessments: Kaiser Family Foundation, National Conference of State Legislatures and the US Government Accountability Office. Data sources are cited throughout the presentation; we did not independently confirm the data validity.

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43 States Assess Nursing Facilities (2014)



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Source: Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015. Published October 2014, by Kaiser Family Foundation and the National Association of Medicaid Directors.

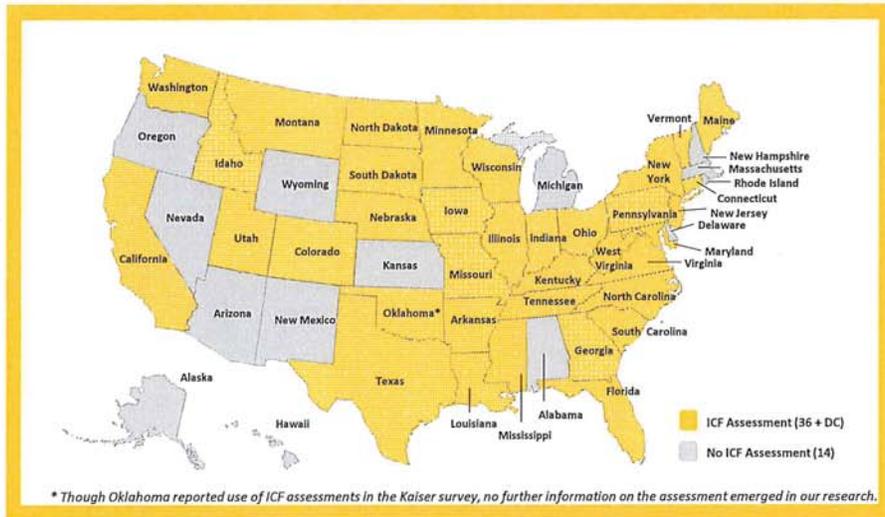
39 States Assess Hospitals (2014)



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Source: Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015. Published October 2014, by Kaiser Family Foundation and the National Association of Medicaid Directors.

36 States Assess Intermediate Care Facilities (ICF) (2014)



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Source: Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015. Published October 2014, by Kaiser Family Foundation and the National Association of Medicaid Directors.

12 States Assess Managed Care Organizations (MCO) (2014)



Note: Kaiser used the federal government's definition of MCOs, which includes health maintenance organizations and preferred provider organizations. Kaiser notes that there may be other assessments collected on health insurance premiums or health insurance claims that are not reflected here.



Source: Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014. Published October 2013, by Kaiser Family Foundation.

States Impose Assessments on Other Providers

Select Provider Classes:	Select States Using Assessment (2012):
 Outpatient Prescription Drugs	Alabama, Louisiana, Missouri, Vermont
 Practitioners (e.g., physicians, nurses, dentists, chiropractors, psychologists, etc.)	Minnesota, West Virginia
 Emergency Ambulance	Minnesota, Missouri, West Virginia
 Laboratory/X-Ray	West Virginia
 Ambulatory Surgical Center	Minnesota, West Virginia, Wisconsin



Source: Medicaid Financing: Questionnaire Data on States' Methods for Financing Medicaid Payments from 2008 through 2012 (GAO-15-227SP, March 2015), an E-supplement to GAO-14-627. Published March 2015, by the United States Government Accountability Office.

Use of Provider Assessments in Select States



More details on each state are in the appendix

State	FY 2012		Percentage of State Share Funded with Provider Assessment Revenue	Provider Assessments (2014)				
	State Share of Medicaid Expenditures*	Provider Assessment Revenue		Nursing Homes	Hospitals	ICFs	Health Plans	Other
Arkansas	\$1,091,681,218	\$139,712,997	12.80%	x	x	x		
Colorado	\$2,289,072,342	\$587,401,602	25.70%	x	x	x		
Maryland	\$3,634,166,238	\$717,307,156	19.70%	x	x	x	x	
Minnesota	\$4,304,258,916	\$226,630,666	5.30%	x	x	x	x	x
Oklahoma	\$1,558,015,278	\$190,006,111	12.20%	x	x	x		
Wisconsin	\$2,586,229,227	\$527,086,836	20.40%	x	x	x		x

*Includes four types of Medicaid payments: fee-for-service Medicaid payments, capitation payments to MCOs, Medicaid Disproportionate Share Hospital (DSH) supplemental payments, and Medicaid non-DSH supplemental payments and other Medicaid payments.

Source: Medicaid Financing: Questionnaire Data on States' Methods for Financing Medicaid Payments from 2008 through 2012 (GAO-15-2275P, March 2015), an E-supplement to GAO-14-627. Published March 2015, by the United States Government Accountability Office.

Uses of Provider Assessments

States use provider assessments to fund:

- The non-federal share of the general Medicaid program
 - Examples: Minnesota and Wisconsin
- Supplemental payments to hospitals and nursing facilities
 - Examples: Arkansas, Colorado, Oklahoma, and Wisconsin
- The non-federal share of Medicaid expansion
 - Examples: Colorado and Indiana
- Rates or rate increases to providers
 - Examples: Arkansas, Colorado, Oklahoma, and Wisconsin

States that have expanded Medicaid have seen provider assessment receipts increase, as the coverage expansion generates more revenue for providers

- Arkansas estimates a \$29.7 M increase in SFY 2015 from its insurer assessment
- Michigan estimates a \$26 M increase in SFY 2015 from its insurer assessment

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Source for Revenue Increases: D. Bachrach, P. Boozang, and D. Glanz, States Expanding Medicaid See Significant Budget Savings and Revenue Gains, Robert Wood Johnson Foundation, April 2015

Some Observations about Provider Assessments

The most prevalent provider assessments are on **nursing homes, hospitals and ICFs**.

States adopt different assessment methodologies:

1. **Fixed Rate** – fixed dollar value or percentage
2. **"Backed Into" Rate** – state identifies the total amount it will collect using the assessment (e.g., the difference between actual Medicaid payments and the Upper Payment Limit) and "backs into" the assessment rate to identify how much each provider must contribute in order to reach the total amount.

Many states allocate a small portion (typically less than 5%) of the assessment for an **administrative fee** to support the administration and oversight of the assessment.

Exclusions

Many states **exclude certain sub-types of providers** (e.g., nursing homes with ≤ 45 beds) from the provider assessment and thus must seek **federal waivers of the broad-based and/or uniformity requirements** to receive federal matching funds. The states must submit a statistical test, outlined in 42 CFR § 433.68(e), illustrating that the assessment is **generally redistributive** and that no direct correlation exists between the provider's assessment amount and Medicaid payment amount.

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Thank You

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Appendix: Select State Profiles

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Arkansas

Provider Class	Assessment Name	Assessment Rate	Special Conditions	Assessment Use	Statute
Nursing Homes	Quality Assurance Fee	Per diem rate (\$) established annually to generate 6% of the aggregate gross receipts of all nursing facilities	<ul style="list-style-type: none"> Exemptions: Facilities that only use prayer for treatment 	<ul style="list-style-type: none"> Rate Enhancement: Reimburse additional costs paid to nursing facilities 	HB 1274 of 2001
Hospitals	Assessment Fee on Hospitals to Improve Health Care Access	Rate (%) established annually on net patient revenue to generate an amount up to the non-federal portion of the Upper Payment Limit (UPL) gap (1.510% in FY12)	<ul style="list-style-type: none"> Exemptions: public hospitals, rehabilitation and specialty hospitals 	<ul style="list-style-type: none"> Supplemental non-DSH Payments: Inpatient and outpatient services 	Ark. Code Ann. §§ 20-77-1901 et seq.
ICFs	Provider Fee for ICFs	Fee established annually to generate 6% of the aggregate gross receipts of all ICFs		<ul style="list-style-type: none"> Rate Increases: Continued operation and rate increases for developmentally disabled (DD) service providers Waiver Coverage Expansion: Expansion of the state's DD waiver program (Alternative Community Services Waiver) Other: Public guardianship of adults 	Ark. Code Ann. § 20-48-902

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Colorado

Provider Class	Assessment Name	Assessment Rate	Special Conditions	Assessment Use	Statute
Nursing Homes	Nursing Facility Provider Fee	Non-Medicare per diem rate (\$) established annually based on aggregate gross or net revenue of all nursing homes subject to the assessment (\$12.35/day in FY12)	<ul style="list-style-type: none"> Exemptions: Facilities operated by continuing care retirement communities, facilities operated by the state and by acute care hospitals, or a facility with ≤45 beds Assessment Discounts: Facilities with high volume receive discount (facilities with >55,000 patient days received 85% discount in FY12) 	<ul style="list-style-type: none"> Rate Add-Ons: Fund supplemental add-ons to daily rates for: <ul style="list-style-type: none"> o Offsetting the provider fee o Acuity or patient case-mix o Higher quality performance (P4P) o Residents with mental/cognitive conditions 	Colo. Rev. Stat. § 25.5-6-203
Hospitals	Hospital Provider Fee	Inpatient and outpatient rates established annually: <ul style="list-style-type: none"> Inpatient: MCO and non-MCO per diem rates (\$76.16 and \$340.39/day, respectively for FY14-15) Outpatient: fee on total outpatient charges (1.9477% for FY14-15) 	<ul style="list-style-type: none"> Exemptions: psychiatric, long-term care, Critical Access and rehabilitation hospitals Assessment Discounts: High-volume Medicaid, indigent care and Essential Access hospitals pay reduced fees (47.79-60.00% discount on inpatient fees in FY14-15)* 	<ul style="list-style-type: none"> Coverage Expansion: Medicaid and CHIP expansion Supplemental non-DSH & DSH Payments: Inpatient and outpatient services, uncompensated care, DSH and quality incentive payments 	Colo. Rev. Stat. § 25.5-4-402.3
ICFs	ICF Provider Fee	Per diem rate (\$) established annually to generate up to 5% of the total costs incurred by all ICFs		<ul style="list-style-type: none"> Rates: Reimburse ICFs 	Colo. Rev. Stat. § 25.5-6-204

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Maryland

Provider Class	Assessment Name	Assessment Rate	Special Conditions	Assessment Use	Statute
Nursing Homes	Nursing Facility Quality Assessment	Non-Medicare per diem rate (\$) established quarterly to generate 6% of the operating revenue for all nursing facilities subject to the assessment (\$22.94/day in FY13)	<ul style="list-style-type: none"> Exemptions: Facilities with ≤45 beds and those operated by continuing care retirement communities Assessment Discounts: Providers with the highest number of Medicaid days are assessed at discounted rate (75.81% discount in FY13) 	<ul style="list-style-type: none"> Rates: Fund reimbursements to nursing facilities under the Medicaid program 	Md. Code Ann., Health General, § 19-310.1
Hospitals	Averted Uncompensated Care & Maryland Health Insurance Plan (MHIP) Assessments	Two hospital assessments: <ul style="list-style-type: none"> Averted Uncompensated Care: 1.25% of net patient revenue MHIP: Up to 0.3% of net patient revenue 	<ul style="list-style-type: none"> Rate Limit: Total assessment in aggregate may not exceed 3% of any hospital's net patient revenue 	<ul style="list-style-type: none"> Coverage Expansion: Supplement Medicaid coverage MHIP: Funding for operation and administration 	Md. Code Ann., Health General, § 19-214
ICFs		6% of gross revenues of each facility			Md. Code Ann., Health General, § 7-517
HMOs and MCOs	Maryland Health Care Provider Rate Stabilization Fund	2% annual premium assessment (on gross receipts and subscription charges)		<ul style="list-style-type: none"> Rate Increases: Increase payments to Medicaid providers and MCOs 	Md. Code Ann., Insurance, § 6-102; § 19-802

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Minnesota

Minnesota collects two types of provider assessments:

- **Provider Surcharges** are used to fund the state Medicaid program.
- **MinnesotaCare Provider Assessments** were designed to fund MinnesotaCare, the State's long-standing Medicaid 1115 demonstration, which provided coverage to individuals above Medicaid eligibility levels. The program is transitioning to the Basic Health Program in 2015.

Provider Class	Provider Surcharge	MinnesotaCare Provider Assessment
Nursing Homes	\$2,815 per bed per year	N/A
Hospitals	1.56% of net patient revenues	2% of gross revenues
ICFs	\$3,679 per bed per year	N/A
Health Plans	0.6% of gross premium revenues (HMOs and community integrated service networks)	1% of gross premium revenues (HMOs, nonprofit health plans and community integrated service networks)
Other Provider Classes		2% on gross revenues of: <ul style="list-style-type: none"> o "Health care providers" (e.g., practitioners and ambulance services) o Surgical centers o Wholesale drug distributors
Statutes	Minn. Stat. § 256.9657	Minn. Stat. § 295.52 Minn. Stat. § 2971.05

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Oklahoma

Provider Class	Assessment Name	Assessment Rate	Special Conditions	Assessment Use	Statute
Nursing Homes	Nursing Facilities Quality of Care Fee	Per diem rate (\$) established annually to generate 6% of the total patient gross receipts of all nursing facilities in the state	<ul style="list-style-type: none"> • Exemptions: Facilities operated by the Oklahoma Department of Veterans Affairs 	<ul style="list-style-type: none"> • Rates and Rate Enhancements: Fees distributed into the Quality of Care Fund used to fund required staffing ratios, minimum wage for staff and other program initiatives 	Okla. Stat. tit. 56, § 56-2002
Hospitals	Supplemental Hospital Offset Payment Program (SHOPP)	Rate (%) established annually on net patient revenue to generate an amount up to the non-federal portion of the Upper Payment Limit (UPL) gap (3.00% in CY15)	<ul style="list-style-type: none"> • Exemptions: <ul style="list-style-type: none"> o Critical Access hospitals o Hospitals operated by state, federal government or Indian tribe o Specialty hospitals o Long-term care hospitals o Children's hospitals o Hospitals that provide the majority of care under a state agency contract • Rate Limit: Assessment rate should not exceed 4% 	<ul style="list-style-type: none"> • Supplemental non-DSH Payments: Inpatient and outpatient services, including to Critical Access Hospitals (even though they do not pay the assessment) 	Okla. Stat. tit. 63, § 63-3241.1 et seq.

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Note: In the Kaiser Commission's FY14-15 50-State Medicaid Budget Survey, Oklahoma reported use of ICF provider assessments. However, no further information on the ICF provider assessment emerged in our research.

Wisconsin

Provider Class	Assessment Name	Assessment Rate	Special Conditions	Assessment Use	Statute
Nursing Homes	Assessment for Licensed Beds	Monthly rate (\$) on licensed beds established annually (\$170 per bed per month in FY12)	<ul style="list-style-type: none"> Rate Limit: Amount not to exceed \$170/day 	<ul style="list-style-type: none"> Rates: Assessment revenue transferred to Medicaid trust fund 	Wis. Stat. Ann. § 50.14
Hospitals	Hospital Assessment	Rate (%) established annually on gross patient revenues (1.484% in FY12)	<ul style="list-style-type: none"> Exemptions: Psychiatric hospitals, institutions for mental diseases Critical Access Fund: The state has a separate fund for assessments collected from Critical Access hospitals; this fund is used only to make payments to Critical Access hospitals for Medicaid services 	<ul style="list-style-type: none"> Rates: Assessment revenue transferred to Medicaid trust fund. Supplemental non-DSH Payments: Rural hospitals, Level I adult trauma centers, performance Other: Payments to MCOs 	Wis. Stat. Ann. § 50.38
ICFs	Assessment for Licensed Beds	\$910 per bed per month		<ul style="list-style-type: none"> Rates: Assessment revenue transferred to Medicaid trust fund 	Wis. Stat. Ann. § 50.14
Ambulatory Surgical Center	ASC Assessment	Rate (%) established annually on gross patient revenues		<ul style="list-style-type: none"> Rates: Assessment revenue transferred to Medicaid trust fund 	Wis. Stat. Ann. § 146.98

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Key Resources

Federal/State

- Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014. Published October 2013, by Kaiser Family Foundation. Available here: <http://kff.org/medicaid/report/medicaid-in-a-historic-time-of-transformation-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2013-and-2014/>
- Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015. Published October 2014, by Kaiser Family Foundation and the National Association of Medicaid Directors. Available here: <http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015/>
- Medicaid Financing: Questionnaire Data on States' Methods for Financing Medicaid Payments from 2008 through 2012 (GAO-15-2275P, March 2015), an E-supplement to GAO-14-627. Published March 2015, by the United States Government Accountability Office. Available here: <http://www.gao.gov/special.pubs/gao-15-2275p/toc.htm>
 - Note: The Fiscal Year 2012 provider assessment rates referenced in the state profiles are from this source.
- Health Provider and Industry State Assessments and Fees. Updated July 10, 2014, by the National Conference of State Legislatures. Available here: <http://www.ncsl.org/research/health/health-provider-and-industry-state-assessments-and-fees.aspx>

Colorado

- Revised Federal Fiscal Year 2014-15 Hospital Provider Fee and Supplemental Payments. Published March 17, 2015, by the Hospital Provider Fee Oversight and Advisory Board, Colorado Department of Health Care Policy & Financing. Available here: <https://www.colorado.gov/pacific/sites/default/files/2015%203%2017%20Hospital%20Provider%20Fee%20Overview.pdf>
- Note: Information on the nursing homes assessed discounted fees is from the GAO E-supplement, available here: <http://www.gao.gov/special.pubs/gao-15-2275p/sectiong712.html>

Maryland

- Annual Report on Implementation of Nursing Home Quality Assessment as Required by Health – General §19-310.1(f) and SB 101 (Chapter 503 of the Acts of 2007). Published June 2, 2014, by the Maryland Department of Health and Mental Hygiene. Available here: [http://dlslibrary.state.md.us/publications/Exec/DHMH/HG19-310.1\(f\)_2014.pdf](http://dlslibrary.state.md.us/publications/Exec/DHMH/HG19-310.1(f)_2014.pdf)

Oklahoma

- SHOPP assessment to increase for 2015. Published December 10, 2014, by Oklahoma Hospital Association. Available here: http://www.okoha.com/OHA/Hotline/2014/Dec14/SHOPP_assessment_to_increase_for_2015.aspx



Department of Medical Assistance Services



Provider Assessment Estimates in Virginia

Provider Reimbursement Division
Department of Medical Assistance Services
July 8, 2015



www.dmas.virginia.gov

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Department of Medical Assistance Services



Provider Assessment Estimates

- Estimates are limited to the following provider types
 - Hospital
 - Nursing Facility
 - ICF-ID
 - MCO
- These are the most common provider assessments even though provider assessments can be implemented for 19 different provider groups
- There is easily available information on these provider types for the basis of the assessment
- Different data sources would produce slightly different results

<http://www.dmas.virginia.gov/>

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VIRGINIA'S MEDICAID PROGRAM
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**Department of Medical Assistance
Services**



Provider Assessment Estimates

- There is some flexibility within CMS rules
 - Exempt providers
 - Exempt services
 - Different assessment rates
- 6% of revenue is maximum rate but most states do not assess the maximum rate
- Percentage of revenue and per bed rates are the most common assessment methods
- Assessment rate is usually based on purpose
- The only current provider assessment is for ICF-ID providers

<http://www.dmas.virginia.gov/>

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VIRGINIA'S MEDICAID PROGRAM
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**Department of Medical Assistance
Services**



Current ICF-ID Provider Assessment

- Implemented in SFY12
- The rate is 5.5% of revenue (the maximum rate at the time)
- DMAS administers the assessment
- ICF-ID providers are held harmless because of two unique conditions
 - Cost-based payment methodology (assessment is an allowable cost)
 - 100% of utilization is for Medicaid
- Revenue is deposited in the Virginia Health Care Fund used to offset general fund requirements for Medicaid
- Net benefit to the state is 50% of the assessment

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**Department of Medical Assistance
Services**



Current ICF-ID Assessment Revenue Summary

ICF-ID Type	Pre-Assessment Cost	Current 5.5% Assessment	Additional Assessment Potential
State	\$145,141,305	\$8,474,353	\$725,707
CSB	\$31,553,705	\$1,735,424	\$157,769
Private	\$49,899,399	\$2,740,756	\$249,497
Total	\$226,594,408	\$12,950,533	\$1,132,972

ICF-ID Providers are reimbursed for the assessment cost.
Net revenue to the state is \$6,475,267

<http://www.dmas.virginia.gov/>
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**Department of Medical Assistance
Services**



Hospital Assessment Revenue Estimate

Hospital Type	Patient Revenue	1% Assessment	6% Assessment
Private Acute	\$14,781,515,486	\$147,815,155	\$886,890,929
Public Acute	\$2,538,577,083	\$25,385,771	\$152,314,625
Children's	\$309,836,877	\$3,098,369	\$18,590,213
Critical Access	\$159,166,820	\$1,591,668	\$9,550,009
Long-Term Acute	\$74,911,952	\$749,120	\$4,494,717
Psych	\$100,834,965	\$1,008,350	\$6,050,098
Rehab	\$155,799,270	\$1,557,993	\$9,347,956
Total	\$18,120,642,453	\$181,206,425	\$1,087,238,547

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 Department of Medical Assistance Services 			
Nursing Facility Assessment Revenue Estimate			
Nursing Facility Type	Patient Revenue	1% Assessment	6% Assessment
Private	\$2,141,580,112	\$21,415,801	\$128,494,807
Non-State Government-Owned	\$51,922,544	\$519,225	\$3,115,353
State	\$51,936,854	\$519,369	\$3,116,211
Total	\$2,245,439,510	\$22,454,395	\$134,726,371

Nursing Facility Type	Non-Medicare Patient Revenue	1% Assessment	6% Assessment
Private	\$1,375,702,797	\$13,757,028	\$82,542,168
Non-State Government-Owned	\$34,701,982	\$347,020	\$2,082,119
State	\$47,582,418	\$475,824	\$2,854,945
Total	\$1,457,987,197	\$14,579,872	\$87,479,232

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 Department of Medical Assistance Services 			
MCO Assessment Revenue Estimate			
	Premiums	1% Assessment	6% Assessment
Medicaid (7 HMOs)	\$2,826,044,451		
Total (17 HMOs and 3 Dental Plan Organizations)	\$6,825,108,293	\$68,251,083	\$409,506,498

Does not include information on PPOs and other managed care entities that also may be assessed

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VIRGINIA'S MEDICAID PROGRAM				Department of Medical Assistance Services		
DMAS						
INNOVATION • QUALITY • VALUE						
Provider Assessment Revenue Summary						
Provider Type	Source	Year	Basis for Assessment	1% Assessment	6% Assessment	
Hospital	VHI	PFY13	\$18,120,642,453	\$181,206,425	\$1,087,238,547	
Nursing Facility	VHI	PFY13	\$2,245,439,510	\$22,454,395	\$134,726,371	
ICF-ID	DMAS	SFY14	\$226,594,408	\$2,265,944	\$13,595,664	
MCO	BOI	CY14	\$6,825,108,293	\$68,251,083	\$409,506,498	

Assumes no exempted providers or sources of revenue and a uniform assessment percentage
ICF-ID Providers currently pay a 5.5% assessment

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