Insight

Medicaid Provider Fees Explained

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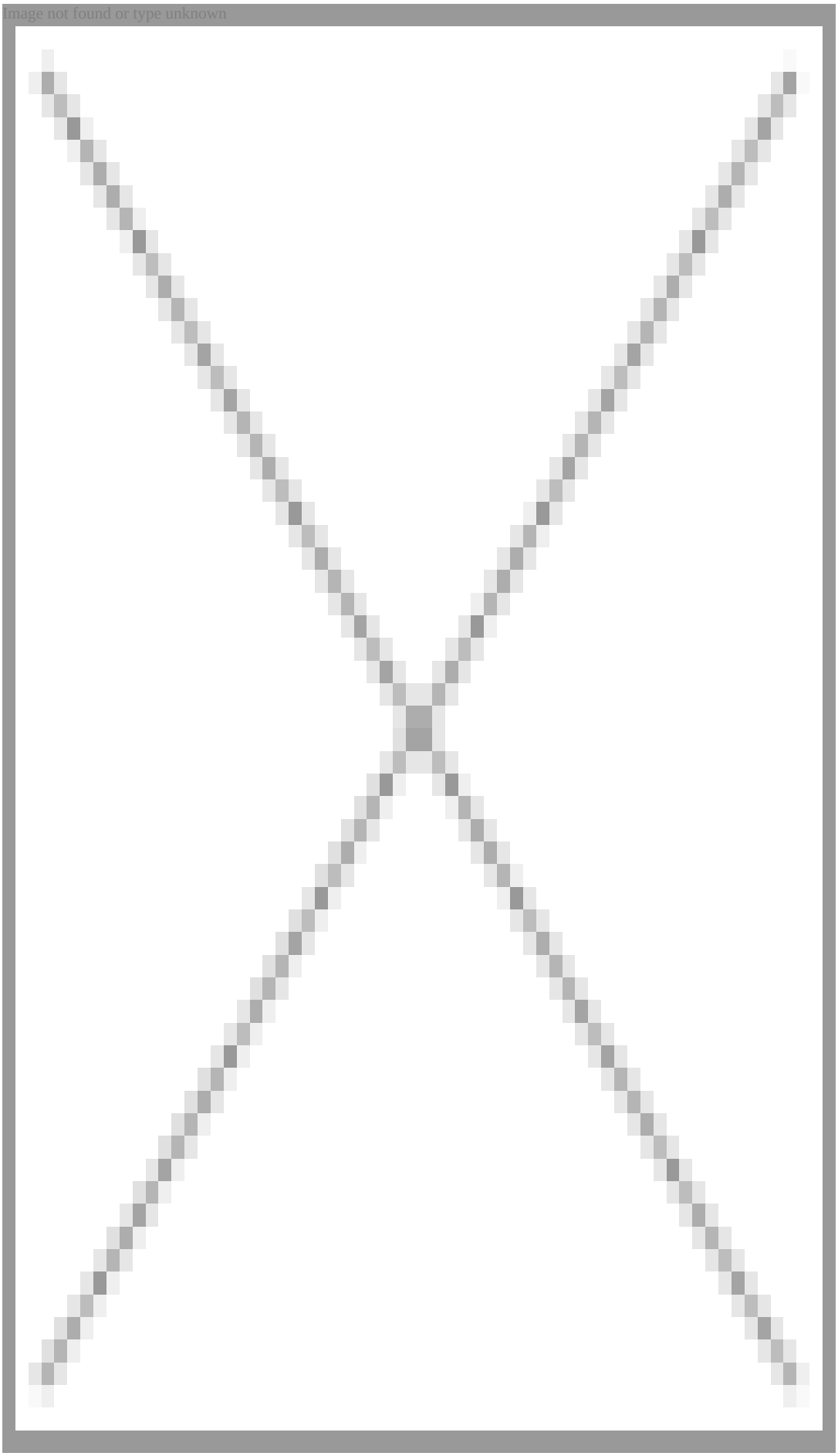

The Medicaid program is a state-federal partnership program where states and the federal government share the cost of caring for the nation's poorest citizens. The federal government matches state dollars depending on a state's per capita income. For 2015, the matching rate ranges from 50 percent to 74 percent of a program's funding.[1] One mechanism for increasing the pool of funding available to a state Medicaid program is through a provider fee, commonly known as a hospital tax or a bed tax.

States implement provider fees by collecting fees from a specific provider type, receiving the federal match for these dollars and using these new funds for the Medicaid program. Now existing in 49 states,[ii] Medicaid provider fees play a role in managing the impact of Medicaid funding on state budgets. Many states have implemented a fee specifically for hospitals; others have provider fees for nursing homes, managed care plans, surgical centers and other health care facilities. The accompanying infographic illustrates the flow of funding implemented through the provider fee.

The approval process for provider fees requires input from a variety of stakeholders to reach a funding agreement between the Medicaid agency, the federal government and the health care facilities providing care for the poor and vulnerable. The majority of the negotiations are between the federal government agency responsible for Medicaid–the Centers for Medicare and Medicaid Services (CMS)–and individual state Medicaid agencies. Health care facilities and advocates often play a part at the state level and the fee is usually enacted through the legislature –creating a political dynamic.

Every state has a Medicaid State Plan, which is a contract with CMS explaining how the state will run its Medicaid program, and how the jointly funded program's dollars will be put to use. Any major change associated with the program must be approved at the federal level and provider reimbursement changes occur through a state plan amendment (SPA).[iii] The state submits the SPA detailing changes to the program; in this case, a fee levied on Medicaid providers and the inclusion of provider add-on payments, and CMS reviews the methodology in place.

The details of provider fee calculations and redistributions will vary, but CMS has set the following requirements.[iv] The fee must:

1. Be broadly based, so as not to specifically target one group (must include providers that do not receive Medicaid funding).[v]
2. Be uniformly imposed, meaning levied equally across all Medicaid providers in that provider type.
3. Not hold providers harmless from the burden of the tax, meaning that states cannot guarantee taxed dollars will be returned to affected providers.[vi]

States vary on the amount levied, but the basic funding mechanisms function in a similar way. CMS approves the fee calculations and funding. The state receives the dollars through an intergovernmental transfer[vii]–where the state provider associations pool the fee and send it over to the state. The state then uses these fees as part of the overall Medicaid budget, making this pool of money eligible for federal financial participation known as the Federal Medical Assistance Percentage (FMAP) for Medicaid. States draw down the match from the federal government, increasing the pool of money for their Medicaid program. The state uses the dollars in a variety of ways. Usually, some of the funds go to general Medicaid programs and expenses and a portion are returned to providers as add-on payments, payments on top of traditional Medicaid reimbursement.

Take for example a small state, with a Medicaid budget of $100, plus the federal matching rate. The federal matching rate for this fictional state is 50 percent, so the states total Medicaid budget is $200. The state is looking for a way to increase their $200 budget due to rising Medicaid expenses. So the state levies a 5 percent

fee on all of its hospitals' patient revenue, totaling $50 in incurred fees sent to the Medicaid program. Since the state receives a 50 percent match, the new fee revenue totals $100 in new Medicaid funds – increasing the Medicaid budget to $300. The state then returns a portion of the fee levied to the hospitals and uses the remainder of the new money to help fund its Medicaid program.

The fee also has some specific limitations and guidelines. Provider fees can only make up 25 percent or less of Medicaid expenditures. This limits the amount of additional federal funds drawn down to state budgets. Though states cannot guarantee the return of taxed dollars, the rule includes an exception to the hold harmless provision. States can return dollars to providers as long as the amount returned to providers equals less than 6 percent of that provider's net patient revenue.[viii] This restriction effectively prevents the state from levying a fee that is over 6 percent.

Over the years, Congressional and administration budget discussions around limiting the fee have been presented as a way to cut down on federal spending. Government oversight groups have reported that provider fees limit transparency in Medicaid financing and increase federal spending,[ix] leading to discussion of the appropriate safe harbor allowances within the tax. Prior to 2011, the limit was 5.5 percent, and recent budgetary discussions have hovered around reducing the safe harbor provision to about 3.5 percent.[x] Since states implement the fee(s) differently, any changes to regulations or funding would impact each state in a unique way.

[1] Federal funding for the Medicaid expansion reaches a higher FMAP, offering states 100 percent match until 2016, and tapering to 90 percent federal funds for the expansion population in subsequent years