Kansas Department of

Social and Rehabilitation Services

Janet Schalansky, Secretary

House Appropriations Committee
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House Bill 2938

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Good morning, Mr. Chairman, and members of the Committee. I am Laura Howard, Deputy Secretary for Health Care Policy at the Kansas Department Social and Rehabilitation Services. I am pleased to appear before you today to talk about H.B. 2938 and health care-related assessments.

This bill would authorize the levying of assessments on certain health care providers. Hospitals, excluding those that are state agencies, state educational institutions, or state mental health or developmental disabilities hospitals, would be assessed a percentage of their net inpatient revenue for FY 01. Health maintenance organizations contracting with the State for Medicaid managed care would be assessed a percentage of their non-Medicare premiums.

According to the latest Kaiser Commission on Medicaid and the Uninsured survey of state Medicaid programs, at the beginning of FY 2003 twenty-one states had an approved provider tax in place. Eighteen states added an additional provider tax in FY 2004. These additions may not be approved yet; I have no information on CMS approval of these additions.

I would like to provide an overview of how a health care-related assessment works and review what is allowable under Federal regulations.

Health care-related assessments
Health care-related assessments are fees levied on health care items or services. They are only considered health care-related, by the Centers for Medicare and Medicaid Services (CMS), if at least 85 percent of the assessment revenue falls on health care providers or if health care providers are treated differently than other entities in the levying and collection of a broader assessment fee.

A wide range of health care-related items and services are eligible for assessment fees. The way in which such assessments work follows: A group of providers is assessed a fee, which must be imposed on a permissible class of items or services on all providers in that class (e.g., inpatient hospital services, etc.), which is then collected by the state. The money acquired in this way is used by the state to match Federal funds for payments to a variety of Medicaid providers, as long as those payments are not limited solely to the group of providers on whom the fee is assessed.

Federal regulations

In order for revenue from a health care-related assessment to be acceptable to CMS as legitimate potential State match, it must be broad-based, applied uniformly, and the assessed entity cannot be held harmless for the assessment fee.

The fee is **broad-based** if it is assessed on all health-care related items or services in the class or on all providers of the items or services. If the fee is levied by a local unit of government, it must extend to all items, services, or providers in the class within that governmental unit's jurisdiction. This legislation would assess all providers in each of the two classes, so the assessment meets the criterion for being broad-based.

CMS considers the assessment to be **uniformly imposed** as long as it meets one of the following tests:

- Every provider in the class is assessed the same amount;
- If it is an assessment imposed on beds in health-care facilities, the fee is the same for each bed; or,
- If the fee is assessed on revenues, it is imposed at a uniform rate for all items, services, or providers in the class.

If a fee is assessed on any basis other than the three criteria listed above, the State must demonstrate that the amount of the assessment is the same for each provider. If the fee is assessed on revenues, Medicaid or Medicare payments can be excluded in the calculation of the assessment as long as that exclusion is applied to all providers who are being assessed.

A provider assessment is not uniformly imposed if it permits credits, deductions, or exclusions that result in returning all or part of the fee paid to the providers assessed. Under this legislation, each provider in the two classes is assessed at the same rate, so the assessment is uniformly imposed.

A provider assessment violates **hold harmless** provisions if funds collected via provider fees are used to artificially inflate expenditures reported to CMS in order to draw even more Federal funds. It is not allowable for a state to reimburse the assessed providers in such a way as to compensate them for the assessed fee. Since the money collected from these assessments would be used to increase a variety of service rates, to pay for graduate medical education, and to enhance access to services, the proposed assessments do not violate the hold harmless provisions of the Federal regulations.

If H.B. 2938 is passed SRS would have to submit a State Plan Amendment to CMS detailing how the assessments would be levied and how the funds would be used. This amendment would be reviewed by the Medicaid National Institutional Reimbursement Team (NIRT) within CMS.

The passage of this bill would enable SRS to provide long-needed rate increases for critical health care services. We are willing to perform the administrative work necessary to implement the provisions of this legislation.

SRS would suggest two technical amendments to the bill. Section 12 (e) of the bill lists the source of monies deposited in the Health Care Access Improvement Fund. We would recommend deleting Section 12 (e)(2) that would direct federal matching funds into the Health Care Access Improvement Fund. The reimbursement mechanism for providers created in HB 2938 uses enhanced Medicaid rates or other existing payment mechanisms that combine state and federal dollars. Moving the federal funds into a separate fund is unnecessary to achieve the desired effect of the bill. Section 4 (a)(2) and Section 8 (a)(2) would delay when hospitals or health maintenance organizations begin making the assessment payments until after the enhanced rates are paid through Medicaid. The reimbursement mechanism in the bill is enhancing the rates paid to hospitals and health maintenance organizations and reflect an increase in the ongoing revenue stream for these providers. The plan amendment creating the provider assessment and increasing the rates would probably go into affect at the same time, therefore we do not see the advantage of a statutory requirement to pay the providers more before the assessment is applied. We also believe that making the assessment and the changes in reimbursement effective simultaneously would be more acceptable to the Centers for Medicare and Medicaid Services. SRS would suggest deleting Section 4 (a)(2) and Section 8 (a)(2) of HB 2938.

Thank you for the opportunity to testify in support of H.B. 2938. I ask the Committee for your support, and stand ready for any questions from the Committee