IHA Legislative Position 2016
Hospital Provider Assessment

★ Overview

In 2010, the Iowa Hospital Association (IHA) worked with the Iowa General Assembly to create the Hospital Health Care Access Assessment Program (Iowa Chapter 249M). Modeled after similar programs in other states, this created a mechanism where prospective payment system (PPS) hospitals agreed to pay a set assessment (or tax) which served as additional state Medicaid funds as a means to draw down increased federal Medicaid matching revenue. Hospitals have been repaid the assessment based on their Medicaid claims volume which were paid at enhanced Medicaid base rates. Neither the University of Iowa Hospitals and Clinics nor any of the state’s 82 Critical Access Hospitals were affected by this program. Historically, the program has also provided a net financial gain to the state, which may use such revenues in manners prescribed in Chapter 249M.

The Hospital Health Care Access Assessment Program relies on bringing Medicaid payments to the upper payment limit (UPL) allowed by the federal government, essentially bringing hospital Medicaid reimbursements to Medicare levels. Importantly, under such plans the federal government disallowed “hold harmless” provisions, meaning hospitals providing a lower volume of Medicaid services actually paid more into the program than they received in increased Medicaid payments.

The program was originally set to sunset on June 30, 2013, but because of its ongoing success in bringing hospital payments to the Medicare UPL and the additional healthcare resources it provides the State, the program was extended for another three years, with a current sunset date of June 30, 2016.

★ Background

While the Hospital Health Care Access Assessment Program has proven itself beneficial in the past, Iowa’s movement to Medicaid managed care will prevent the continuation of the program in its current form. When the state utilizes managed care organizations (MCOs) to negotiate Medicaid reimbursement with individual providers, it makes the concept of aligning payments with the UPL obsolete. The volume of Medicaid claims no longer becomes a basis for returning the assessment to hospitals; rather, overall reimbursements are negotiated with the MCOs. Further, federal law (42 CFR 438.60) actually prohibits the use of UPL-based provider assessment programs under managed care, preventing the state from making direct Medicaid payments to hospitals. IHA and Iowa’s community hospitals recognize the value that has resulted from the Hospital Health Care Access Assessment Program, but it is clear that Chapter 249M as currently constructed will not meet federal approval for continuation. This means that Chapter 249M as it exists today must be allowed to sunset when managed care becomes effective.

★ Iowa Hospital Association Position

However, because the advent of Medicaid managed care will certainly mean revenue reductions for Iowa hospitals, IHA and its member institutions support exploring an alternative hospital assessment program if it can be created in a manner that benefits the overall hospital community. Some other states have turned to alternative approaches, like establishing uncompensated care pools or other delivery system reform programs to attempt to retain the benefit of UPL-based assessment programs, which have helped in transitioning their assessment programs. However, the Centers for Medicare & Medicaid Services (CMS) has been increasingly reluctant to approve or re-authorize such plans.
In addition, recently-released CMS proposed rules governing Medicaid managed care programs cast further complexity around Iowa’s ability to transition the Hospital Health Care Access Assessment Program in a manner that would provide the same financial benefit for individual hospitals.

While there is widespread support for maintaining a program that financially benefits hospitals, it is unclear at this time how such a program could be constructed to meet federal standards in a managed care environment. Additionally, any change in the current methodology would require new CMS approval that would necessitate revised calculations creating new “winners” and “losers,” likely meaning financial losses for many more Iowa hospitals. This means that any alternative proposal must be carefully modeled in order to gauge individual hospital impact.

Recreating an alternative Hospital Health Care Access Assessment Program will be a complicated endeavor, yet IHA and Iowa’s PPS hospitals support exploring potential alternatives. When the Hospital Health Care Access Program was created in 2010, the IHA Board adopted the following principles as a guide in gaining hospital support:

- All funds generated by such an assessment must be returned to hospitals in the form of higher Medicaid payments and must receive federal approval for its methodology.
- The negative impact on individual community hospitals must be minimized to the best extent possible.
- Any future reductions in hospital Medicaid payments would void the tax.
- There must be a sunset provision on any such plan to evaluate its impact on Iowa’s hospitals and overall health care system within three years after implementation.

IHA continues to support those principles; any new proposal under Medicaid managed care must also adhere to these additional principles:

- Any new program should have the same or greater aggregate financial benefit to Iowa’s hospital community as currently exists in the Hospital Health Care Access Assessment Program.
- Only hospitals paying an assessment should be allowed to receive increased Medicaid payments under any program.
- Any program should contain an ability to track the financial return to individual hospitals.
- Establishment of a base year calculation that sets a specific annual assessment amount over the period of the plan’s implementation.
- Any quality metrics included in a new assessment plan should align with similar metrics being used by Medicare and the State Innovation Model (SIM) process.
- Recognition of increased costs for programs such as inpatient psychiatric care, rehabilitation services, and neonatal intensive care units should be provided for in an assessment model (similar to programs in other states).
- Allowance of the plan to be implemented retroactive to July 1, 2016, giving CMS the opportunity to approve the plan while still making it applicable to Iowa’s FY 2017 budget year.
- There must be a governance and review process over any assessment plan that involves hospital representatives to ensure it is being appropriately implemented and to make recommendations regarding future plan modifications.

The necessary dismantling of Iowa’s Hospital Health Care Access Assessment Program, which has provided value to hospitals and the state alike, is another example of the unintended consequences of rushing prematurely into a managed care philosophy without evaluation of all its implications. However an alternative assessment program may evolve, all policymakers should be monitoring the ongoing negative consequences of Medicaid managed care on Iowa’s health care providers and the patients they serve.