State Health Reform Assistance Network
Charting the Road to Coverage

**ISSUE BRIEF**
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# Provider Donations and Assessments: Options for Funding State Costs of Medicaid Expansion

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This report is the sixth in a series prepared by the Robert Wood Johnson Foundation's *State Health Reform Assistance Network* exploring the fiscal implications of Medicaid expansion. Earlier briefs focused on the state general fund savings associated with expansion. In this brief, we explore two revenue sources states may deploy to fund the non-federal share of expansion: provider assessments and provider donations. Both are authorized by federal law and both have been used by states in connection with expansion.

## Provider assessments, taxes, and fees

Provider assessments, taxes, and fees (referred to as "provider assessments") are a common tool states use to generate funds to cover the non-federal share of Medicaid payments.[1] Currently, 49 states and the District of Columbia—all but Alaska—impose provider assessments.[2] Federal rules permit assessments to be levied against many provider classes. However, states most commonly impose provider assessments on hospitals, nursing homes, and intermediate care facilities.[3] As of 2014, 12 states[4] also impose assessments on managed care organizations—a class of health care providers under the federal provider tax rules.[5] Some states use provider assessments to fund the Medicaid program, generally;[6] while others use provider assessments to fund supplemental payments or rate enhancements for the class of providers subject to the assessment.[7]

There are a host of rules that states must follow when using provider assessments to fund the non-federal share of Medicaid; these rules are intended, among other things, to insure the integrity of Medicaid financing. In short, the tax must be broad-based and uniform (in other words, not targeted to high-Medicaid providers) and the revenue raised must not be returned to the taxed entities so that they are effectively held harmless for the amount of the tax.[8] Notably, when the tax revenue



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is used to fund the non-federal share of the Medicaid expansion, by its terms, it cannot be targeted back to the entities taxed; rather, it is used to support all Medicaid services. This does not mean that providers or plans that pay the tax may not benefit from the tax; where providers pay a tax that helps fund the Medicaid program, they realize a benefit from increased Medicaid patient volume and revenue. The tax rules are designed to ensure that there is no direct relationship between the taxes paid and the payments received.

In many cases, states with existing assessments found that no additional legislation was required to secure funding for expansion-related costs. As additional Medicaid patients and enrollees generated additional revenue for providers and plans, the existing assessment generated additional revenues for the state. For example, Arkansas saw a $29.7 million increase in revenue in state fiscal year 2015 from its insurer assessment after expansion.[9] Similarly, New Mexico received $30 million in additional premium tax revenue in 2014 related to expansion adults.[10] Other states have chosen to implement a new or modify an existing provider assessment specifically for the purpose of covering the costs of expansion. For example, Colorado modified an existing hospital provider fee to cover the costs of Medicaid expansion.[11] Indiana is slated to increase its existing hospital assessment beginning in 2017 to offset the costs of the Medicaid expansion as federal matching funds begin to decline.[12] Other states, including Tennessee and Utah, have explored using revenue from a provider assessment to fund a possible expansion.[13]

## Provider donations

States may also use provider donations to fund the non-federal share of their Medicaid programs, provided that the donations meet the federal requirements. Provider donations are only permitted as a source of funding for the non-federal share if they qualify as a "bona fide" donation, meaning that the provider donation has no direct or indirect relationship to Medicaid payments to the provider making the donation, providers of the same type as the donating provider, or an entity related to the donating provider.[14]

Few states have chosen to use provider donations to fund their Medicaid programs. Louisiana, however, recently received approval from the Centers for Medicare & Medicaid Services (CMS) to use provider donations to fund a portion of the non-federal share of Medicaid's administrative costs.[15] To obtain approval of the proposed donations, Louisiana assured CMS that donations would be given by providers to a third-party (in this case a foundation); the state would not be informed as to which providers made donations nor the amount of any donation; the state would not suggest amounts to be donated; and the funds would be used exclusively to fund the non-federal share of administrative expenses. The state was also required to represent that donations would be in no way linked to provider payments or rate setting.

## Conclusion

With the federal matching rate for the cost of the Medicaid expansion slated to drop in 2017 to 95 percent, expansion states, as well as states now evaluating expansion, are increasingly focused on the source of funding for the non-federal share. Several states expect the savings generated by expansion to cover a significant portion of the costs well into the future.[16] Provider assessments and donations offer additional buffers against out-year expansion costs.

## End notes

[1] Federal law permits states to use provider assessments, defined as a health care-related fee, assessment, or mandatory payment for which at least 85 percent of the burden falls on health care providers, to draw down federal matching funds so long as the assessment is broad-based, imposed uniformly, and does not hold providers harmless. 42 C.F.R. § 433.55; 42 C.F.R. § 433.68.

[2] Kaiser Family Foundation and the National Association of Medicaid Directors. 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." *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/*.

[3] *Id.*

[4] Kaiser Family Foundation. 2013. "Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014."

[5] 42 C.F.R. § 433.56.

[6] See, for example, Minnesota's provider surcharge, Minn. Stat. § 256.9657.

[7] See, for example, Arkansas's hospital assessment, Ark. Code Ann. §§ 20-77-1901 et seq., and Oklahoma's nursing facilities fee, Okla. Stat. tit. 56, § 56-2002.

[8] See 42 C.F.R. § 433.68.

[9] Bachrach, Deborah, Patricia Boozang, and Dori Glanz. 2015. "Medicaid Expansion: Early Data Shows Consistent Economic Benefits Across Expansion States." Princeton: Robert Wood Johnson Foundation. Accessed February 17, 2016. *http://statenetwork.org/wp-content/uploads/2015/04/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-April-20152.pdf*.

[10] *Id.*

[11] Colo. Rev. Stat. § 25.5-4-402.3.

[12] Ind. Code §16-21-10; Indiana Family & Social Services Administration. 2015. "HIP 2.0 Financing Overview." Accessed February 17, 2016. *http://www.in.gov/fssa/hip/files/HIP_2.0_Financing_Overview.pdf*.

[13] Boucher, Dave. 2014. "Haslam's Tennessee Plan would expand health coverage." *The Tennessean*, December 15. Accessed February 17, 2016. *http://www.tennessean.com/story/news/politics/2014/12/15/haslam-expanding-medicaid-in-tennessee/20428655/*; Governor of Utah. "Healthy Utah." Accessed February 17, 2016. *https://www.statereforum.org/sites/default/files/healthyutahplan.pdf*.

[14] 42 C.F.R.§ 433.54. Providers are also allowed to donate funds to cover the costs of state employees providing Medicaid eligibility determinations on site. 42 C.F.R. § 433.66.

[15] See, Letter from Vikki Wachino, Director, Center for Medicaid and CHIP Services, to Jen Steele, Interim Medicaid Director, Department of Health and Hospitals, January 28, 2016. http://statenetwork.org/wp-content/uploads/2016/03/Letter_to_Louisiana.pdf

[16] See, e.g., Bachrach, Deborah, Patricia Boozang, and Dori Glanz. 2015. "Medicaid Expansion: Early Data Shows Consistent Economic Benefits Across Expansion States." Princeton: Robert Wood Johnson Foundation. Accessed February 17, 2016. *http://statenetwork.org/wp-content/uploads/2015/04/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-April-20152.pdf*; The Stephen Group. 2015. "Volume I: Findings." *http://www.arkleg.state.ar.us/assembly/2015/Meeting%20Attachments/836/I14099/TSG%20Volume%20I%20Findings%20Report%20amended%20to%20include%20all%20Appendix%20refrerences.pdf*; Deloitte. 2015. "Report on Medicaid expansion in 2014." Kentucky Cabinet for Health and Family Services. (The report is no longer available online, but key findings were summarized in a Kaiser Family Foundation Report. Kaiser Family Foundation and Urban Institute. 2015. "The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States." Appendix D. Accessed March 2, 2016. *http://kff.org/report-section/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states-appendix-d/*.)