



## **Special Healthcare Assessment Fact Sheet**

Arizona hospitals are deeply committed to preserving healthcare coverage for members of the Arizona Health Care Cost Containment System (AHCCCS) and are concerned that an additional 280,000 Arizonans could soon become uninsured under the proposed rollback of Prop. 204. Not only will this reduction in coverage impact the health status of these patients, the increase in uncompensated care will reverberate throughout the economy--with 30,000 total job losses projected in the first year the reduction is in effect.

In light of this situation, the Arizona Hospital and Healthcare Association (AzHHA) is proposing a special healthcare assessment on hospitals for the specific purpose of generating matching federal Medicaid funds and protecting current levels of AHCCCS eligibility. These funds would be used to partially fill the current FY 2012 shortfall in the AHCCCS program. In conjunction with other revenue enhancements or budget reduction options identified by lawmakers and other stakeholders, this financing stream provides a viable alternative to the proposed rollback of Prop. 204.

### **Special Healthcare Assessment**

AzHHA proposes a \$300 million one-year hospital assessment based on inpatient days to be allocated as follows:

- \$200 million for the specific purpose of preserving Prop. 204 eligibility; and
- \$100 million to provide a financing stream for hospitals to mitigate cost-shifting pressure that would otherwise cause hospitals to pass on the assessment to private insurers and patients.

### **Federal Matching Funds**

The \$200 million allocated for Prop. 204 protection will draw down federal Medicaid matching dollars at a two-to-one rate, making \$600 million in total funds available for the Prop. 204 program. However, federal monies may not be used to backfill the state match, so only the \$200 million assessment is available to reduce the general fund deficit for AHCCCS.

The \$100 million allocated for hospital payments will draw down federal Medicaid matching dollars at a two-to-one rate, making \$300 million in total funds available. These payments are intended to mitigate any pressure to cost-shift the \$300 million assessment on to private insurers, businesses and patients.

### **Other Conditions of the Proposal**

1. During the time the assessment is in place, there would be no additional cuts to hospital payments.
2. During the time the assessment is in place, there would be no reductions in AHCCCS eligibility.
3. The assessment will be for one-year only.
4. AHCCCS, health plans and healthcare providers would be directed to work on collaborative payment arrangements to improve quality of care, reduce utilization, and lower costs. These would include such delivery system reforms as accountable care organizations, medical homes, and payment reforms such as moving to per case payments.



## Frequently Asked Questions

### 1. Why limit the assessment to one year?

*Answer:* Consensus on the assessment is very fragile, and one of the key elements is limiting it to one year. There are several reasons for this:

First, while the assessment is designed to limit the number of hospital “losers,” there are no guarantees for hospitals. Restricting the assessment to one year will limit the risk exposure for those hospitals that might not be made “whole” under the program.

Second, some hospitals may experience cash flow problems, which would become financially stressful over a multiple year period.

Third, because payments flow to hospitals through the health plans, hospitals are accepting a risk in paying an assessment up front with no absolute guarantee of payment at the back end.

Fourth, the federal Deficit Reduction Commission report criticizes healthcare assessments as a way to fund state Medicaid programs, and Congress is expected to look hard at these funding streams. Given this federal scrutiny, we are concerned that a multiple year assessment may place hospitals in jeopardy. (i.e., Hospitals could be locked into a statutory assessment but lose the payments if the Centers for Medicaid and Medicare Services (CMS) or Congress decide to prohibit the federal match in future years.)

Finally, hospitals are concerned that future Legislatures may be tempted to redirect or expand the assessment. Such expansion or redirection of the assessment could trigger cost-shifting pressure that the current proposal is designed to avoid.

**2. If hospitals are paid back the assessment through increased payments (i.e., they are “made whole”), why can’t the assessment be increased to cover more of the state obligation for Prop. 204?**

*Answer:* There are several reasons why the assessment is limited to \$200 million:

First, there is no guarantee that every hospital will be “made whole.” While the model developed by AzHHA is designed to minimize the number of “losers,” CMS—which must approve the plan—will not allow any hospital to be held harmless. Payments to hospitals must be based on Medicaid utilization or uncompensated care.

Second, in all of our modeling, we have found that increasing the size of the assessment will increase the number of hospital “losers.”

Third, increasing the size of the assessment will create a cash flow burden for many hospitals that are already under financial strain.

Fourth, \$200 million is 37 percent of the projected FY 2012 Prop. 204 shortfall of \$540 million. Based on 2009 data (the most recent year available), this amount is proportional to the total payments hospitals receive from AHCCCS.

**3. I understand that the \$300 million assessment will draw down a two-to-one federal match, which results in \$900 million in total funds. If hospitals are paid back \$300 million from the \$900 million, why is only \$200 million used to reduce the state shortfall (i.e.,  $\$900 - \$300 = \$600$ ; not \$200)? Why can’t more of the \$600 million be used to fund the \$540 million shortfall?**

*Answer:* The federal government prohibits federal matching funds to be used to fulfill the state obligation/match. Only state revenue (i.e., state general fund, local funds or special assessments) may be used for the state match. Since \$100 million of the \$300 million assessment is reserved to make hospitals “whole” in the aggregate, only the remaining \$200 million can be used for “deficit reduction.”

**4. I have heard that this assessment is merely a tax that will be passed on to commercial insurers, businesses, and patients. Is this true?**

*Answer:* The assessment is designed to draw down federal funds to make hospitals whole in the aggregate. AzHHA has worked closely with consultants to design an assessment and distribution formula that results in the fewest number of “losers.” AzHHA is in the process of refining the formula even further.

**5. The proposal is conditioned on no further cuts to hospital payments while the assessment is in place. Does this apply to the five-percent cut effective April 1, 2011 and to the freeze on hospital payments that has been in place since 2008?**

*Answer:* This condition does not apply to the April 1, 2011 five-percent cut. AHCCCS forewarned hospitals about this cut last fall, and hospitals have been taking steps to prepare for it. Also, hospitals do not expect the statutory inflation factor to be funded. However, because total hospital payments will be increased in order to offset the assessment, the freeze must technically be lifted or the session law language revised. The condition does apply to any new cuts that would result from the proposed capitation freeze or other new budget proposals.