States use the provider assessment program – also known as a quality fee or tax – to provide financing for the states’ share of Medicaid costs in the wake of state budget shortfalls and additional federal requirements. First established in the 1980s, 43 states and the District of Columbia currently use the proceeds and corresponding federal matching funds from provider assessments to stabilize Medicaid rates to nursing homes and more adequately fund quality, long term care services for individuals with disabilities and seniors. The maximum fee states can set their provider assessments at is 6 percent.

Recent budget proposals have suggested reducing this maximum fee anywhere from 5.5 to 3.5 percent. Limiting states’ ability to use assessments to finance their Medicaid programs is misguided and harmful. These reduction proposals shift more Medicaid costs onto state budgets that are already struggling to pay for the requirements in the Medicaid program. These cuts do nothing to reduce the cost of health care or make Medicaid more efficient. While Congress must find ways to reduce federal spending and fund a wide variety of programs, it should consider more productive methods to encourage efficiency in federal health programs.

Provider assessments have been used to expand coverage, offer additional benefits and increase reimbursement rates, alleviating those gaps in patient access caused by inadequate reimbursement. Moreover, health care providers generally support paying these assessments because they benefit from participating in a robust, well-financed Medicaid program.

Additionally, provider assessments allow Medicaid-dependent providers to offer high-quality care despite chronically low reimbursement. In many cases, this additional financial resource allows providers to accept Medicaid patients without putting the viability of their facilities at risk. Medicaid fails to fully reimburse hospitals, doctors and long term care facilities the total cost required to care for patients. Nursing centers lose nearly $20 a day for each Medicaid resident, resulting in about a $6.3 billion loss in 2011. At the center of this funding crisis are individuals with disabilities and the poor and frail elderly who currently reside in America’s nursing homes – 63 percent of whom rely on Medicaid to cover the cost of their care.

Federal budget challenges must be tackled in a careful, deliberate manner that does not undercut hardwon improvements in quality, long term care or undermine the tools states rely on to bring economic stability. AHCA agrees that the provider assessment program is not a long term funding solution and is committed to working with Congress to find a more permanent solution to the continuous underfunding of Medicaid. However, until such reform is achieved and long term care is properly funded, provider assessments are essential to help facilities increase staff-to-patient ratios and enhance recruitment efforts to attract quality workers to care for individuals with disabilities and the elderly.

**Key Facts**

These 43 states & D.C. have established provider assessment programs:

- Alabama
- Arizona (pending)
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New York
- North Carolina
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- Tennessee
- Utah
- Vermont
- Washington
- West Virginia
- Wisconsin
- Wyoming

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