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GIMME A Q. GIMME AN A. GIMME AN F. WHAT'S THAT SPELL? HEALTH CARE!

As the national recession deepens, more Texas families will face shrinking incomes and job losses that make it even more difficult to access health care coverage. Texas must look for ways to generate needed revenue for vital programs like Medicaid, rather than cut the programs that low- and moderate-income Texas families rely on when they need it most. The key to preserving and improving Texas Medicaid is an adequate amount of state revenue. Texas will likely receive a significant but temporary increase in federal funding for Medicaid through the federal economic stimulus package; however, this short-term funding does not diminish Texas's need to develop stable, long-term revenues for Medicaid. Many states bolster their Medicaid financing through the use of quality assurance fees (QAFs), which generate state revenue needed to draw down federal Medicaid matching funds. Implementing a hospital QAF in Texas could generate nearly a billion dollars in state and federal funding that could be used to increase payment to Medicaid providers and expand coverage to the uninsured.

- **The key to adequately funding Medicaid services is an adequate amount of state revenue.**
- **A 1 percent QAF could generate nearly $1 billion in new state and federal funding for Medicaid.**
- **A QAF will produce stable revenue in economic downturns and keep up with medical inflation.**
- **A QAF should be designed to ensure revenue is spent on health care and hospitals are protected.**

Medicaid and Its Funding

Texas Medicaid provides health care coverage to 2.9 million low-income, aged, or disabled Texans. About three out of every four Medicaid clients are children age 18 or under.[1] Other Texans covered by Medicaid include some of the elderly, persons with disabilities, and pregnant women.

Federal and state governments jointly fund Medicaid. To receive or "draw down" federal Medicaid funds, states must match a portion of these funds by spending their own, non-federal money on Medicaid. The federal government provides $1.50 for every dollar Texas invests in Medicaid. This generous federal match makes Medicaid a cost-effective way for states to expand coverage to the uninsured. However, the state's unwillingness to put up more funds prevents Texas from receiving more federal funds.

As part of the federal economic stimulus package, Congress may significantly increase federal funding to state Medicaid programs in 2009 and 2010. States need this funding to support Medicaid programs as state budget revenues decline but the need for Medicaid services increases. This short-term aid, however, will not address the long-term financial stability of state Medicaid programs.

Consequences of Inadequate State Investment in Medicaid

After meeting federal minimum standards, Texas sets its own guidelines for the different categories of low-income people eligible for Medicaid. Our state's

investment in Medicaid fails to cover many low-income, uninsured Texans. Texas limits Medicaid eligibility more than most states, leaving many uninsured and impoverished Texans ineligible for Medicaid. In fact, Texas ranks 46th of 50 states in Medicaid clients as a percentage of the people living in poverty, due in part to the state's unwillingness to put up more state Medicaid matching funds to cover additional low-income residents.[2]

For example, Texas chose in 2003 to eliminate funding for Medicaid's Medically Needy Spend-Down program for working-poor parents. This program used to allow parents with incomes slightly higher than the regular Medicaid limits but with high medical bills to receive Medicaid coverage while they are ill or injured. Texas also chooses to severely restrict eligibility for low-income parents. Low-income parents earning more than $308 per month for a family of three ($3,696 per year) make too much to qualify for Medicaid. This low income limit has not been updated by the Legislature since 1985 and prevents as many as 500,000 uninsured poor parents with dependent children in Texas from obtaining Medicaid coverage.

Inadequate state funding of Medicaid also causes low provider reimbursements. States individually decide how much to pay doctors, hospitals, and other providers for Medicaid services. On average, Texas Medicaid pays 73 percent of Medicare rates, which are generally less than rates paid by private health insurance. In many cases, Texas Medicaid reimbursements to providers fail to cover actual costs.[3] Low reimbursements discourage providers from taking Medicaid, which compromises access to care for Medicaid clients. Providers underpaid by Medicaid make up these costs elsewhere, and research shows that some of this cost shifts to private health insurers, resulting in more expensive health insurance premiums.

Texas can choose to improve the Medicaid program by covering a greater share of Texans in poverty and paying providers adequate rates. To do this, the state must first develop ways to generate adequate, long-term revenue for Medicaid.

QAF: Targeted Revenues for Health Care

A quality assurance fee (QAF) taxes health care providers' revenues so the state can draw more federal Medicaid matching funds to increase payments to providers and expand health care coverage.[4] States often use QAFs to generate part of the state share of revenue to support Medicaid programs. As of 2009, 43 states have a QAF in place for at least one provider type, and 30 of those have QAFs on multiple provider types. QAFs are most commonly assessed on revenues from nursing homes (33 states), residential facilities for developmentally disabled persons (30 states), and hospitals (22 states).[5] Texas already has a QAF on residential facilities for developmentally disabled persons and a tax on Medicaid HMOs.

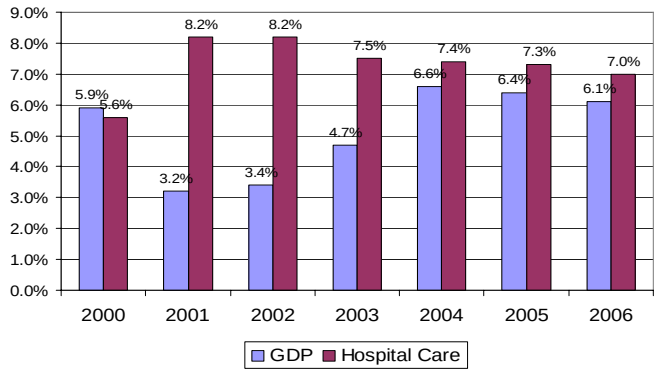
States commonly use QAFs to generate Medicaid revenue because of their targeted impact, return on investment, and sustainability. A few key attributes of QAFs make them a good way to fund health care programs.

- **A QAF can return substantially more funding to the sector being taxed than it costs** because revenue generated by a QAF can receive a generous federal match.[6] For every $1 of QAF paid by a provider, Texas will draw down about $1.50 in federal Medicaid match, which returns to the health care sector through Medicaid payments. Federal guidelines prohibit an explicit quid pro quo payment through a QAF. This prevents states from collecting state revenue through a QAF, using it to draw down federal match, and then directly repaying providers for their share of QAF revenues. But within these rules, states structure their QAFs so that most providers are made whole through legitimate increases in Medicaid provider reimbursement rates and health coverage expansions that reduce uncompensated care.
- **A QAF can be a more stable source of revenue in economic downturns that other types of taxes.** Revenues from income taxes and sales taxes generally increase when the economy does well and decrease during recessions. But people's needs

for medical services do not fluctuate with the economy, and actual utilization of health care drops less than other goods and services, making revenue from a QAF more "recession-proof" than other taxes.[7] Data in Figure 1 show that the growth in nationwide spending on hospital care generally matched or exceeded gross domestic product growth from 2000 through 2006. During the last recession beginning in 2001, the rate of growth in GDP declined, but the rate of growth in hospital spending did not.[8] Revenue sources like QAFs that are relatively stable throughout the business cycle are especially useful when funding safety net services like Medicaid that experience increased demand in recessions.

- **A QAF would allow revenue to keep pace with medical inflation.** The cost of health care tends to grow faster than the economy and tax revenues that generally keep pace with the economy—like sales, income, payroll, and business margins taxes. Over time, health care programs funded by these revenues tend to fall short of what is needed due to medical inflation. Because a QAF is pegged to health care spending, it is a good way to adequately fund health care programs over time.[9]

Figure 1: Growth Rate of U.S. Gross Domestic Product and Hospital Spending, 2000-2006



Adapted from Wicks, E., "Can a Sales Tax on Medical Services Help Fund State Coverage Expansions?" State Coverage Initiatives Issue Brief, AcademyHealth, July 2008.

Source: Centers for Medicare and Medicaid Services, Department of Health and Human Services, National Health Expenditure Accounts. http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage.

QAF Proposals in Texas and Provider Reactions

QAF proposals to improve Medicaid nursing home reimbursement rates were debated in recent legislative sessions, but did not pass or were vetoed by the Governor. In Texas, Medicaid helps pay for the long-term care of nearly 70 percent of nursing home patients, so a QAF on nursing home revenue could improve care for most nursing home residents. Some nursing homes, however, do not participate in Medicaid, and would have to pay a QAF without benefiting from higher Medicaid reimbursement rates in return. In 2005, the proposed nursing home QAF was designed so that only 2.5 percent of nursing homes in the state would have to pay the QAF without benefiting from higher Medicaid reimbursements. Opposition from the small minority of nursing homes that would fare worse as well as leadership opposition to new taxes of any kind likely prevented enactment.

In its 2006 *Code Red* report, the Task Force for Access to Health Care in Texas (Task Force) recommended creating a new 3 percent QAF on revenues of all hospitals and surgery centers. This proposal would have generated more than $1.1 billion in state general revenue that could draw down an additional $1.7 billion in federal funding. The Task Force recommended that revenues from the QAF be used to maximize federal matching funds to enhance provider reimbursements and "the quality and efficiency of health care to the uninsured."[10]

Hospital reaction to the 2006 *Code Red* proposal was mixed. Though it would generate billions of dollars that could be used to improve Medicaid reimbursements to hospitals and expand coverage to reduce uncompensated care, not all hospitals would benefit. Public safety-net hospitals with high Medicaid and charity-care caseloads would likely receive more in new Medicaid funding than they would pay through the QAF, though hospital advocates indicated that some safety-net hospitals would actually fare worse under the proposed QAF. Other hospitals that do not accept Medicaid or have low Medicaid and charity-care caseloads would pay more though the QAF than would be returned to them through

higher payment rates or expanded Medicaid eligibility. As with any tax, a QAF will have a greater impact on some providers than others.[11] The Task Force points out that this will provide an incentive for more providers to participate in Medicaid and provide indigent care.

The Texas Hospital Association (THA) believes that to be workable, a QAF must be broad-based and contingent upon a maintenance of state effort in funding Medicaid. The QAF should be designed so that new revenue generated by hospitals is generally invested in hospital care and negative impacts to hospitals are minimized. Finally, THA believes that a QAF should have a two-year sunset provision, so that it will automatically expire after two years if not found to achieve these principles.

In response to concerns from some in the provider community, the Task Force modified its QAF recommendation in its 2008 *Code Red* report and now calls for a 1 percent QAF on revenues of all hospitals and freestanding surgery centers in Texas.[12] This proposal would generate about $367 million in state funding to draw down an additional $567 million in federal matching funds. The updated proposal includes a sunset date two years out, and the QAF would continue only if evidence showed that the increased federal Medicaid funding it generated improved access to health care. The sunset date, while a good idea, would be more effective if set at four years. Within just one biennium, the state would not have adequate time to assess a tax, collect the tax, and have an opportunity to evaluate its effect.

What Would It Take to Get a Hospital QAF in Texas?

To garner necessary support from the hospital community, a Texas QAF on hospitals and surgery centers must be designed to increase Medicaid reimbursements and reduce charity-care costs enough to offset the cost of the QAF for most hospitals. The 2008 *Code Red* recommendation, if designed with this goal in mind, is a reasonable approach because it sets a low tax rate and, with the sunset date, will automatically expire if not renewed by the Legislature.

Conclusion

A QAF is certainly not the only way to improve the long-term adequacy of Texas Medicaid funding. It may be, however, the most politically realistic option on the table at this point. With that in mind, the center continues to support QAFs as a cost-effective and stable way to generate needed state matching dollars for Medicaid.

[1] Texas Health and Human Services Commission, Texas Medicaid Enrollment Statistics, *Final Count – Medicaid Enrollment by Month*, June 2008, https://www.hhsc.state.tx.us/research/MedicaidEnrollment/meByMonthCompletedCount.html.

[2] State-by-state data on Medicaid enrollment from Kaiser Commission on Medicaid and the Uninsured, "Medicaid Enrollment in 50 States: December 2006 Update" January 2008, www.kff.org/medicaid/7606.cfm; state-by-state data on 2006 population in poverty from U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007. Not all people below the poverty line are eligible for Medicaid.

[3] John Holcomb, Chair of the Texas Medical Association's Select Committee on Medicaid, CHIP, and the Uninsured, testimony to the Senate Finance and Health and Human Services Committees, September 16, 2008, www.texmed.org/Template.aspx?id=7172.

[4] QAFs are also called provider taxes or health care sales taxes.

[5] The Kaiser Commission on Medicaid and the Uninsured, "Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into

an Economic Downturn; Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2008 and 2009," September 2008, pp. 32-33 and 85, www.kff.org/medicaid/upload/7815.pdf.

[6] Task Force on Access to Health Care in Texas, "Code Red: The Critical Condition of Health in Texas," Report Summary, 2006, p. 24, http://www.coderedtexas.org/files/Summary.pdf.

[7] Wicks, E., "Can a Sales Tax on Medical Services Help Fund State Coverage Expansions?" State Coverage Initiatives Issue Brief, AcademyHealth, July 2008, http://www.statecoverage.org/files/Can%20a%20Sales%20Tax%20on%20Medical%20Services%20Help%20Fund%20State%20Coverage%20Expansions.pdf.

[8] Ibid.

[9] Ibid.

[10] Task Force on Access to Health Care in Texas, "Code Red: The Critical Condition of Health in Texas," Report Summary, 2006, pp. 23-28.

[11] In fact, to receive federal matching fund,) states cannot hold provider taxpayers harmless. In other words, states cannot use ensure that all providers who pay a QAF will receive fully offsetting financial returns.

[12] Task Force on Access to Health Care in Texas, "Code Red: The Critical Condition of Health in Texas 2008,"2008, p. 4, http://www.coderedtexas.org/files/Code_Red_2008.pdf.