SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS

STATEMENT TO THE

SOUTH DAKOTA STATE LEGISLATURE'S
MEDICAID REIMBURSEMENT COMMITTEE
August 6, 2009

Chairman Rave and members, my name is Dave Hewett, President/CEO of the South Dakota Association of Healthcare Organizations (SDAHO). I apologize for not being able to appear before you in person today but a long-held meeting commitment relating to national health care reform and its potential impact on the providers of this state has required me to be elsewhere.

I will briefly address two of three specific topic areas assigned to this Study Committee – the structure and adequacy of the reimbursement formula(s) for Medicaid providers and exploring options for generating revenues for matching Federal Medicaid funds.

With respect to the reimbursement formulas, SDAHO agrees with Secretary Bowman's testimony and analysis presented at the first meeting of this Interim Study Committee – that the Medicaid reimbursement formulas and methodologies for the various provider groups are working. It is a lack of state revenues that brings us to this table today. And as SDAHO has pointed out to this Legislature on several occasions, this is true for all the provider groups represented in our membership – hospitals, nursing facilities, home health agencies, and assisted living centers – the State's Medicaid reimbursement rates are well below the costs we incur for providing care to Medicaid beneficiaries. We will continue to say that with the hope that at least the cost increases we incur from year-to-year are recognized with adequate inflationary updates.

The challenge for this Legislature is to ensure that there is adequate revenue to meet the commitment South Dakota has made to care for those who cannot care for themselves – in this case through the Medicaid program. As DSS demonstrated in its testimony at your last meeting, people on Medicaid are poor. They cannot afford to pay for their health care expenses much less private coverage. They are not in a situation that even provides them with access to affordable health insurance through the workplace. So the question is "how do we fund this program?"

Chairperson Rave has challenged us all to address the "elephant in the room", i.e., options for generating revenues for matching Federal Medicaid funds *through provider taxes.* For the record, SDAHO strongly opposes the use of provider taxes to generate additional Federal Medicaid matching revenue. The Association has consistently delivered this message for several years – most recently when the concept was explored by the Zaniya Task Force. Funding for programs that provide broad societal benefit should be funded by broadly based revenue sources. We don't ask schools to pay a tax to fund education; we don't ask farmers and ranchers to pay new taxes to generate more federal support for agriculture.

Exacting new taxes on at least some of our hospital patients, those keeping a physician's appointment, and/or those who have been responsible enough to accumulate savings over a lifetime to pay for long-term care, is not how we should proceed to fund Medicaid.

Please appreciate that SDAHO has not come to this position without a great deal of discussion and policy analysis. The Association has engaged consultants, tapped the expert resources of our national Associations (the American Hospital Association and the American Association of Homes and Services for the Aging), and otherwise researched the topic to better understand the intricacies of the many approaches being taken by states that have opted for this approach. What we have learned is:

1. The DSS statement that "once you've seen a provider tax, you've seen a provider tax" is correct. The development and approval processes are very complex with federal regulations guiding their formulation and the distribution of revenues – regulations that change periodically as the Feds attempt to keep up with new approaches developed by the states.
2. There is little, if any, assurance that the revenue generated by a provider tax will be returned to the taxed provider group(s). That's true in many of the states that have the taxes and would appear to be the general approach taken by South Dakota when revenues generated from health related sources find their way to the general fund.
3. If one or more provider groups were taxed, it remains unclear who or what would pay the tax. Medicaid would pay the tax but immediately recoup it to pay for its lost revenue. Medicare rates would not change (about 50% of hospitals revenue comes from Medicare). And many of the rates paid by private insurance companies are already established by contract. For nursing facilities, it would simply be the private pay residents who currently account for 40% of the residents but provide 60% of the nursing homes' revenue.

SDAHO therefore urges this Interim Study Committee to resist the allure of a provider tax and focus on the overall spending priorities of the State taking into account needs of those who cannot care for themselves.