HB 1078

Department of Legislative Services

Maryland General Assembly
2002 Session

FISCAL NOTE

House Bill 1078 (Delegate Hurson, *et al.*)
Environmental Matters and Appropriations

Temporary Nursing Home Provider Assessment - Supplementary Appropriation - Medical Care Programs Administration

This bill establishes a temporary nursing home provider assessment. The purpose of the assessment is to raise revenue on a temporary basis from nursing homes in a manner that complies with the provider-specific tax requirements of the federal Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991. Revenues generated from the assessment must be used to pay for services provided in the Maryland Medicaid Program.

The bill takes effect June 1, 2002 and terminates June 30, 2005.

Fiscal Summary

State Effect: Medicaid revenues could increase by $182.3 million (50% special funds, 50% federal funds) in FY 2003. Medicaid expenditures could increase by $182.6 million ($91.1 million special funds, $91.1 million federal funds, $359,000 general funds). Future year estimates reflect inflation and the bill's June 30, 2005 termination date.

($ in millions)	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
SF Revenue	$91.14	$95.70	$100.44	$0	$0
FF Revenue	91.14	95.70	100.44	0	0
GF Expenditure	.36	.28	.28	0	0
SF Expenditure	91.14	95.70	100.44	0	0
FF Expenditure	91.14	95.70	100.44	0	0
Net Effect	($.36)	($.28)	($.28)	$0	$0

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary:

Assessment: The Department of Health and Mental Hygiene (DHMH) must assess each nursing home located in the State. DHMH must calculate the assessment to produce an aggregate assessment on nursing homes equal to 6% of annual gross receipts of all nursing homes in the State. DHMH must determine each nursing home's monthly assessment by multiplying the nursing home's patient days by a multiplier that has been calibrated. To ensure annual aggregate assessments equal 6% of the aggregate annual gross receipts of all nursing homes the multiplier may be adjusted prospectively.

The multiplier must be $9.80 for the period beginning July 1, 2002 through December 31, 2002. From January 1, 2003 to June 30, 2003, the multiplier must be determined using the patient days and gross receipts reported to DHMH for the prior six months. Beginning July 1, 2003, the multiplier must be determined using the patient days and gross receipts for a period of at least six months and must be annualized.

By the tenth day of each month, each nursing home must file a report with DHMH that lists the patient days and gross receipts for the preceding month. Nursing homes must pay the 6% assessment to DHMH on a quarterly basis. The assessment payment must be reported as an allowable cost for Medicaid reimbursement purposes. A nursing home that fails to file the reports may be subject to a fine not to exceed $1,000 for each report. A nursing home that fails to pay the assessment may be subject to a fine not to exceed $5,000 plus interest that accrues each day the assessment remains unpaid. All assessments collected must be credited to the Maryland Medicaid Provider Payments Fund.

Maryland Medicaid Provider Payments Fund: The bill establishes a special, nonlapsing fund to make payments to Medicaid providers that will qualify for federal reimbursement under the Medicaid program. The fund consists of nursing home provider assessments collected by DHMH, any funds received as federal Medicaid matching funds, and any fund interest or investment earnings. The fund may be used only to pay nursing homes and outpatient mental health clinics for services provided to Medicaid enrollees that qualify for federal Medicaid reimbursement.

For fiscal 2003, the bill appropriates $183 million (50% special funds, 50% federal funds) from the Maryland Medicaid Provider Payments Fund to pay for services provided to Medicaid enrollees in the Medicaid nursing home reimbursement system. Each fiscal

year thereafter, 85% of the funds must be used to provide payments for services to Medicaid enrollees under the Medicaid nursing home reimbursement system and 15% must be used to provide payments for services to Medicaid enrollees provided by outpatient mental health clinics (see **Exhibit 1**).

Current Law: The federal Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 placed restrictions on states' use of provider-generated revenues. State provider taxes cannot exceed 25% of a state's share of Medicaid expenditures, must be broad based, uniform, and cannot hold providers harmless. A broad based tax is a health care related tax imposed with respect to a permissible class of items or services on all providers in the class. A uniform health care related tax is a tax imposed with respect to a permissible class of items or services at the same rate for all providers.

Background: There are approximately 245 nursing homes in Maryland with about 29,000 licensed and operating beds. The average statewide occupancy rate of nursing homes is 88.4%. In fiscal 1999, the State spent over $559 million, or 20% of its Medicaid budget, on financing nursing home care. Approximately two-thirds of nursing home patient days are funded by Medicaid.

In an effort to give states greater flexibility in raising Medicaid funds, the federal Health Care Financing Administration (now the Centers for Medicare and Medicaid Services or CMS) issued a rule in 1985 that allowed states to receive donations from private medical care providers. A hospital could "donate" money to a state, which in turn paid the hospital back with the donated money. The process of paying the hospital permitted a state to receive matching federal funds for the payment without actually paying out state funds. Some states adopted provider tax programs, which operated along the same principles as donation programs. Once states discovered they could leverage additional federal dollars in this way, many established provider tax and donation programs in the early 1990s. From 1990 to 1992 the number of states with such programs grew from 6 to 39. The ability to draw federal matching funds through the donations or provider taxes came at a time when states needed fiscal relief.

The rapid rise in federal Medicaid payments, however, caused concern among federal policymakers. To resolve the issue, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 was enacted. Key provisions included: (1) the elimination of provider donations; (2) capping provider taxes so that provider tax revenues could not exceed 25% of the state's share of Medicaid expenditures; (3) imposing provider tax criteria so that taxes were "broad based;" and (4) providers could not be "held harmless."

State Revenues:

Medicaid revenues could increase by an estimated $182,280,000 (50% special funds, 50% federal funds) in fiscal 2003, which accounts for the bill's June 1, 2002 effective date. This estimate reflects special fund revenues from the nursing home assessment of $91.1 million in fiscal 2003 and federal Medicaid matching funds of $91.1 million. This estimate assumes:

- nursing homes in Maryland provide 9.3 million patient days in fiscal 2003;
- the assessment on nursing homes between July 1, 2002 and December 31, 2002 is $9.80 per patient day;
- the assessment (multiplier) for January 1, 2003 to June 30, 2003, which is based on nursing home gross revenues for the prior six-month period, remains constant at $9.80; and
- Medicaid will spend the funds collected from the assessment on nursing home reimbursements in fiscal 2003 and receive $91.1 million matching federal funds.

Future year estimates assume the assessment multiplier remains constant at $9.80 and reflects 5% annual inflation in nursing home gross revenues.

State Expenditures: Medicaid expenditures could increase by an estimated $182,638,964 in fiscal 2003, which accounts for the bill's June 1, 2002 start-up date. This estimate assumes all revenues generated from the provider assessment will be paid back to nursing homes in fiscal 2003. It reflects the cost of hiring two financial compliance auditors to track provider payments and compliance. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits	$71,518
Provider Payments	182,280,000
Systems Programming, Vendor Maintenance, and Postage	275,450
Operating Expenses	11,996
Total FY 2003 State Expenditures	**$182,638,964**

Future year expenditures reflect: (1) full salaries with 3.5% annual increases and 3% employee turnover; (2) 5% inflation in provider assessments collected; (3) 1% annual increases in ongoing operating expenses; and (4) reflects the bill's June 30, 2005 termination date.

Exhibit 1
Medicaid Payments to Providers

	FY 2003	FY 2004	FY 2005
Nursing Homes	$182,280,000	$162,684,900	$170,748,000
Mental Health Clinics	$0	$28,709,100	$30,132,000
Total	**$182,280,000**	**$191,394,000**	**$200,880,000**

Additional Comments: Medicaid may only pay back the assessment on nursing homes through the Medicaid nursing home reimbursement system; Medicaid will increase provider reimbursements for Medicaid patients only. Accordingly, nursing homes with small Medicaid populations will be disproportionately impacted by the provider assessment. In addition, the multiplier applied to each nursing home's patient days to determine the nursing home's assessment does vary across nursing homes; therefore, for specific nursing homes the assessment may be more or less than 6% depending on that nursing home's revenue per patient day.

Additional Information

Prior Introductions: None.

Cross File: SB 624 (Senators Hoffman and Bromwell) – Budget and Taxation and Finance.

Information Source(s): *The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues*, Urban Institute; *Working Paper: Future Need for Nursing Home Beds in Maryland*, Maryland Health Care Commission; National Association of State Budget Officers; Department of Health and Mental Hygiene (Medicaid, Office of Health Care Quality); Department of Legislative Services

Fiscal Note History: First Reader - February 22, 2002
ncs/jr

Analysis by: Susan D. John

Direct Inquiries to:
John Rixey, Coordinating Analyst
(410) 946-5510
(301) 970-5510