



Possible Sources of Additional Federal Funding for New Mexico Medicaid

Prepared for Con Alma Health Foundation
and its Blueprint for Health New Mexico Advisory Network

By Nick Estes, New Mexico Voices for Children
August 31, 2011



Possible Sources of Additional Federal Funding for New Mexico Medicaid

By Nick Estes, New Mexico Voices for Children
August 31, 2011

Introduction and Executive Summary

There are a number of steps New Mexico should investigate and consider to increase the federal funds available to the state to maximize its Medicaid program. This paper covers a list of possibilities, but each would have to be carefully evaluated for financial, administrative, and political feasibility:

1. Seek a Tier 2 Medicaid performance bonus under CHIPRA.
2. Explore enacting provider assessments to be matched with federal funds
3. Seek to maximize Certified public expenditures and intergovernmental transfers

Discussion

1. Seek a Tier 2 Medicaid Performance Bonus under CHIPRA

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included a provision designed to encourage states to make every effort to enroll eligible children in Medicaid. Section 104 provides that states may receive a once-per-year "performance bonus" if they adopt at least five of the eight specified enrollment streamlining mechanisms (which New Mexico has done) and their enrollment exceeds certain targets. The targets are based on children's enrollment in Medicaid in 2007, adjusted each year by the state's population growth plus an enrollment growth factor specified in CHIPRA that started at 4 percent but is declining to 2 percent per year. If the state exceeds its target in a year, the state gets a "Tier 1" bonus payment equal to 15 percent of the state's cost per child in Medicaid multiplied by the number of enrolled children over the target. For every child enrolled over 110 percent of the target, the state gets a "Tier 2" bonus equal to 62.5 percent of the state cost per child.

New Mexico won a performance bonus in each of the first two years after CHIPRA's passage: federal fiscal years (ending September 20) 2009 and 2010. The bonus awards were \$5.1 million and \$8.5 million, respectively. This year (FFY 2011) the state is on track to receive a Tier 2 bonus because it looks likely that children's enrollment will exceed 110 percent of the target. The same could happen next year (FFY 2012) if HSD makes a strong push to enroll more children. Techniques that could help with such an effort are the subject of a companion paper.

2. Explore Provider Assessments to be Matched with Federal Funds

New Mexico is one of only four states that currently does not have any type of “provider assessment” or “provider tax” on the books.¹ Provider assessments are fees or taxes imposed on Medicaid health care providers (such as hospitals or nursing homes), including managed care organizations that enroll Medicaid patients. These assessments are expressly permitted under federal law, although there are detailed limitations imposed by statute. These arrangements (called “health care-related taxes” in federal law) are covered under 24 USC 1396b(w), enacted in 1991, together with regulations at 42 CFR 433.68. The fee must be imposed by state legislation. The fee can be used to increase the state’s contribution to Medicaid funding, which is approximately 30 percent in New Mexico. As with any other state Medicaid spending, the federal government will match the fee with another 70 percent in Medicaid funding, meaning total Medicaid spending could be increased by about three times the amount of the provider fee.

If the appropriate CMS (U.S. Centers for Medicare and Medicaid Services) rules are followed, it is possible to use some or all of these new total funds in Medicaid reimbursements so that most of the providers who paid the fees come out financially as well or better than if there had been no fee assessed.² The law provides a “safe harbor” for health care-related taxes that do not exceed 6 percent of a provider’s net operating revenues. Usually the providers themselves support the imposition of the fee because it increases the amount of federal funds available for the state’s Medicaid program, from which they derive significant portions of their operating income.

Under federal law, provider fees may be assessed on providers in one or more of the following major categories (and some other smaller categories that are omitted):

Inpatient hospital services

Outpatient hospital services

Nursing facility services

Intermediate care facility services for the mentally retarded (ICF/MR)

Physician services

Home health care services

Outpatient prescription drugs

Managed care organizations (including HMOs and preferred provider organizations)

Ambulatory surgical centers (only the facilities’ services, not the surgeries performed in them)

Dental services

Of the 46 states that have provider fees or taxes, 34 states assess hospitals,³ 34 states have ICF/MR fees, 38 states have nursing facility fees, 11 states assess managed care organizations, and 15 states assess other provider categories, such as pharmacies.⁴

A major provider assessment was recently imposed in Colorado on hospitals with the support of the hospital association.⁵ It has generated sufficient federal funds to expand the state's Medicaid program to cover most low-income adults. The program is expected to bring in several hundred million new federal dollars each year, at almost no cost to Colorado taxing entities.

As mentioned, because of the federal funds that can be leveraged, almost all the states have provider fee programs covering one or more types of providers, with hospitals and nursing homes being the most common. Without designing a specific program, it is impossible to say how much extra federal money could be derived by adopting a provider assessment against specified providers in New Mexico. But it would likely be in the tens and possibly hundreds of millions of dollars. Both President Obama and congressional leaders have talked about possible limits to provider taxes, but there has not been any public discussion of forbidding them altogether.⁶ If further federal budget negotiations in fact limit the use of this technique, state officials and advocates could explore whether it was still worth fashioning a program here. My prediction is that there will still be significant possibilities.

A variation on this idea was proposed by NM Voices for Children to the Legislature last year: to restore the gross receipts tax to payments by Medicaid to the seven Medicaid managed care organizations. Currently they pay only the state's insurance premiums tax of 4 percent and are exempt, along with all other insurance companies, from any other tax except the property tax. This would technically not be a "provider tax" because the gross receipts tax is not limited to health care providers, hence it would not be subject to the detailed federal rules. In this case, it would be possible for the New Mexico Human Services Department (NM HSD) to simply to repay the MCOs for the cost of the gross receipts tax as a reimbursable expense. The federal government would then pay 70 percent of the total amount of the reimbursed gross receipts tax, and this money could be used to pay the state's share of a Medicaid expansion.

CMS has informally indicated that they do not favor this approach, feeling that it circumvents the limitations on provider taxes imposed by statute in 1991. However, the government has not adopted a rule prohibiting this technique, and CMS is regularly reimbursing four other states (CA, MI, OH, and PA) that have imposed a general tax of this nature on Medicaid MCOs, thereby drawing down considerable extra federal funds. During the last legislative session NM Voices estimated that the Medicaid program would get at least an extra \$130 million in new federal funds for state and local governments if New Mexico adopted this approach.

3. Seek to Maximize Certified Public Expenditures and Intergovernmental Transfers

To the extent that local bodies are funding health care services for Medicaid beneficiaries that may not be covered by Medicaid reimbursements by NM HSD, the local bodies could transfer such funds to the state, which could use them to generate the current 30:70 federal Medicaid match for New Mexico. NM HSD could find legitimate ways to return those funds to the local governments that made the transfer and that are providing the medical services.

Health care-related expenditures incurred by state or local governments on behalf of individuals enrolled in Medicaid (that is, expenditures not paid by the state's Medicaid agency)

are permitted to either be transferred to the state as intergovernmental transfers or “certified” to the state, entitling the state to reimbursement in the amount of the federal Medicaid share (42 USC 1396b(w)(6)(A), 42 CFR 433.51)⁷. Under these provisions, the state may be able to claim credit towards the state Medicaid share for expenditures not currently being counted. For example, these might include county hospitals’ depreciation expense, allowable indirect cost or overhead, and allowable Medicaid share of charity care. In the case of cash intergovernmental transfers, NM HSD could find legitimate ways to return those funds to the local governments that made the transfer and are providing the medical services. This is an administrative matter and does not require action by the state Legislature.

NM HSD has certainly made an effort to identify these elements and get credit for them with CMS. But further efforts may be justified to search all state and local health care spending to identify non-Medicaid programs that now pay with state funds for goods or services that could qualify for Medicaid reimbursement. This is a highly technical area, of course, but has paid off in many states.⁸

Conclusion: Opportunities for New Mexico

This paper lists three areas in which New Mexico officials and Medicaid advocates should carefully explore the possibility of obtaining additional federal Medicaid matching funds under existing federal law. First, New Mexico should qualify for a Tier 2 Performance Bonus this federal fiscal year. In FFY 2012, we should try even harder to enroll more children eligible for Medicaid, so as to obtain the highest bonus rate possible. Second, 46 other states use some form of provider assessments to maximize federal matching dollars, yet New Mexico does not. New Mexico should explore this thoroughly because we may well be missing out on federal funds that are available with no net state matching requirement. Finally, the same thing may be true of intergovernmental transfers and certified public expenditures. These deserve a very close look to see if further funds might be available through state administrative action.

There are many more children in New Mexico who are eligible for Medicaid and whose health would greatly benefit by their enrollment. But a state match is required. These techniques could help generate the state funds we need to insure all the state’s children.

Endnotes

¹ National Council of State Legislatures (NCSL), “Health Care Provider and Industry Taxes and Fees” (February 2011, updated August 2011), posted at: <http://www.ncsl.org/default.aspx?tabid=14359>. The other states that have no provider taxes or fees are Alaska, Hawaii, and Wyoming. See also, Kaiser Commission on Medicaid and the Uninsured, “Medicaid Financing Issues: Provider Taxes” (April 2011), posted at: <http://www.kff.org/medicaid/upload/8193.pdf>.

² In order to be able to match the revenues from a health care-related tax:

- The tax must be “broad-based” (applied to all health care facilities in a specified class, like nursing homes).
- The tax must be uniformly imposed throughout the jurisdiction;

-
- The tax program must not violate federal “hold harmless” prohibitions designed to prevent states from guaranteeing providers that they will get back any money they pay in taxes. This requirement can be met with careful drafting.

³ The Medicaid “upper payment limit” (UPL) regulation, 42 C.F.R. Part 447, Subpart F, imposes an important restraint on the extent to which New Mexico hospitals could be assessed a provider fee. Under this limit, a state’s total payments to hospitals, other than Disproportionate Share payments, cannot exceed the amount that Medicare would pay for the same services. The UPL can limit the ability of the state to make targeted payments to hospitals. My understanding is that supplemental payments made under New Mexico’s Sole Community Provider program already cause total payments to New Mexico hospitals to come close to reaching the UPL.

⁴ References in note 1.

⁵ See discussion in NCSL paper, *op cit*.

⁶ President Obama has proposed to phase down the ceiling on matchable health care-related taxes, but not until FFY 2015. The HHS Budget in Brief publication [<http://www.hhs.gov/about/FY2012budget/fy2012bib.pdf>] summarizing the health provisions of the President’s FY 2012 budget, released February 14, 2011, contains the following statement on page 63:

Medicaid: Use of Provider Taxes to Pay State Share of Medicaid:

Limit States’ ability to use provider taxes to pay the State share of Medicaid by phasing down the Medicaid provider tax threshold from the current law level of 6 percent in FY 2014, to 4.5 percent in FY 2015, 4 percent in FY 2016, and 3.5 percent in FY 2017 and beyond. [Effective FY 2015].

⁷ “[42 CFR] § 433.51 Public Funds as the State share of financial participation.

“(a) Public Funds may be considered as the State’s share in claiming FFP [federal financial participation, i.e., federal Medicaid matching funds] if they meet the conditions specified in paragraphs (b) and (c) of this section.

“(b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.

“(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.”

⁸ Gordon Bonnyman, Tennessee Justice Center, “Optimizing Federal Medicaid Revenues in Hard Times: A Primer” (February 2011) (available upon request at NM Voices for Children); Kaiser Commission on Medicaid and the Uninsured, “Medicaid Financing Issues: Intergovernmental Transfers and Fiscal Integrity” (February 2005), posted at: <http://www.kff.org/medicaid/upload/Medicaid-Financing-Issues-Intergovernmental-Transfers-and-Fiscal-Integrity-Fact-Sheet.pdf>.