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2002-01 A publication of the Citizens Research Council of Michigan April 2002

Proposed New Federal Medicaid Funds for Michigan

The Governor has announced a plan to implement a program using funds from Qualified Health Plans (also known at Managed Care Organizations) and nursing homes to provide a new source of state Medicaid matching monies. Assessments paid by these Medicaid providers will be used to secure an estimated $122.8 million in additional federal funds in FY 2002-3 permitting a 5 percent overall increase in payments to Qualified Health Plans and a 7 percent overall increase for nursing homes.

Background

Title XIX was established as a federal state financial partnership to make health care services available to persons eligible for what were then called categorical public assistance programs and for certain persons whose expenses for health care reduced their income to a low enough level to qualify them as well. It generally provided that the federal government would be responsible for 50 percent of costs and states would provide the other half. In a few states, local units of government – primarily counties – provide a portion of the state financial "match".

Over the years, states have been successful in getting the federal government to pay for more than 50 percent of some costs. These have included a 75 percent match for certifying certain providers institutional providers like hospitals and nursing home as eligible to participate in Medicare and Medicaid and a 90 percent federal match for improved information technology systems. Additionally, the basic federal Medicaid matching rate was altered and now changes each year based on per capita personal income data from three previous years. The fiscal year 2003 rates are based on 1998, 1999 and 2000. For the upcoming budget year, 2002-2003, the federal match now ranges from 50 percent for 12 states to a high of 76.62 percent in Mississippi. Michigan's rate dropped from 56.36 percent in 2001-2002 to 55.42 percent for 2002-2003 with a resulting $64.5 million loss in federal funds. Because the formula is based on historic data, changes in federal match lag economic conditions. Thus, a reduced federal matching percentage based on prior strong economic performance can and does occur during economic slowdowns thereby exacerbating budget problems.

As states became more sophisticated in seeking an increased portion of federal funds, new approaches were tried and many were successful. Among them was what came to be known as "provider-related donations" and "provider taxation". Under these programs, providers either donated funds to the state or were assessed an amount by the state for the explicit purpose of getting monies that could be used as state matching dollars to claim more federal Medicaid funds.

By 1991, there were enough states and sufficient amounts of money involved that Congress enacted limiting legislation in Public Law 102-234 by adding subsection W to section 1905 of Title XIX.

Key provisions of the legislation include:

1. *Broad Based.* The assessment must be uniformly imposed on an entire type of providers such as all hospitals or all nursing homes.
2. *Uniform.* The assessment must be the same for all providers within the type of provider – one rate per bed for all nursing homes for example.
3. *No Hold Harmless.* The assessment cannot be structured in a way that results in an individual provider receiving dollar for dollar the amount of its assessment.
4. *Dollar Limit.* In general, states are limited to a 6 percent rate.

As of 1999, there were 26 states with such programs. Michigan was not one of these. The Table on page 2 shows the states and whether the assessment was based on revenues or beds.

The Michigan Proposal

Early this year, various providers were invited to meetings in Lansing to discuss the possibility of using this mechanism to increase federal revenue in the 2002-2003 Medicaid budget. Michigan has designated the program as a Quality Assurance Assessment Program. In early April, it was announced that there was sufficient support from nursing homes and Qualified Health Plans to introduce enabling legislation.

This CRC Note was made possible by grants from the W.K. Kellogg Foundation and the Hudson-Webber Foundation

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26 States Use Provider Assessment Programs

	Revenue Assessment			Bed Assessment			Other
	Hospitals	Nursing Homes	Other	Hospitals	Nursing Homes	Other	
Alabama					X		X
Connecticut	X						
Florida	X		X				
Illinois					X	X	
Indiana							X
Kentucky	X						
Louisiana					X	X	X
Massachusetts							X
Minnesota	X	X	X				
Mississippi		X					
Missouri							X
Montana		X					
New Hampshire	X						
New Jersey	X		X				
New York							X
Ohio	X				X	X	
Oklahoma			X				
Oregon			X				
Rhode Island	X	X	X				
South Carolina	X		X				
Tennessee			X				
Utah							X
Vermont	X		X		X		
Washington	X		X				
West Virginia	X	X	X				
Wisconsin					X	X	

Source: Major Health Care Policies * 50 State Profiles: 2001, National Conference of State Legislatures, Tenth Edition, January 2002

Specifically, nursing homes would be assessed $2.77 per bed (about a 3 percent rate) while Qualified Health Plans would pay an assessment of 1.93 percent of premiums. The combination of these two revenues is expected to raise $100.4 million dollars. When matched by federal funds ($122.8 million) a total of $223.2 million would permit a 7 percent overall increase for nursing homes and a 5 percent amount for Qualified Health Plans. Because the assessments come from the providers, the net increase to both groups on an overall basis is $122.8 million or the amount of new federal Medicaid funds.

According to figures released by the Office of the Governor, among the Qualified Health Plans, 17 of 19 would have a net gain ranging from $952,300 to $7,954,800. Losses would range from ($709,400) to ($1,435,300).

Nursing homes show 355 with net gains ranging from $569 to $659,500 and 45 with net loses ranging from ($594) to ($262,700).