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Meet the MET

New Hampshire budget writers grapple with a brand new tax that's been around for 20 years.

By Grant D. Bosse

SUMMARY: New Hampshire adopted the Medicaid Enhancement Tax as a means to leverage federal matching funds without imposing any real tax liability on state hospitals. After two decades, budget writers finally ended the practice of MediScam by turning this phantom tax into a real one. Faced with a new multimillion dollar tax liability, New Hampshire hospitals took the state to court and started paying closer attention to how much they owed. As the Legislature struggles to understand a huge source of state revenue that went without much oversight for twenty years, how they change the Medicaid Enhancement Tax will have expensive implications for the state budget and state hospitals for years to come. This paper will outline the history of the Medicaid Enhancement Tax in New Hampshire, describe how the complex tax works in conjunction with the Disproportionate Share Hospital Program, and dispel some of the many misunderstandings that trip up budget writers trying to incorporate this brand new, 20-year old tax into the FY14-15 State Budget.

DSH SETS THE TABLE

Under the Federal Medicaid program, participating states split the cost for providing health care to low income recipients with the federal government. Most states, including New Hampshire, elect to reimburse hospitals for treatment based on a fee-for-service model. Reimbursement rates are set by state officials, but must be approved by the Centers for Medicare and Medicaid Services.[1]

Reimbursement rates under fee-for-service plans are not sufficient to pay for the hospitals' costs to treat Medicaid patients. The program relies on hospitals to be an implicit third partner, along with states and the federal government, in financing Medicaid. Losses incurred through treating Medicaid patients are offset by patients paying through private insurance, or in rare cases out of pocket.

Throughout the 1980's, Congress sought ways to encourage states to provide additional funding to hospitals who served a disproportionate number of low-income patients through Medicaid, and thus had fewer privately funded patients on which to shift costs. Beginning with the Omnibus Budget

Reconciliation Act of 1981, Congress established the Disproportionate Share Hospital program.[2] DSH allowed states to provide higher payments to hospitals serving more low-income patients, but states were slow to adopt the program. Congress increased state flexibility throughout the 1980s, and states began turning to DSH as a way to leverage federal matching grants to help balance their general fund budgets.

Under DSH, states could exceed the caps on assistance to hospitals under Medicaid, and receive federal matching funds for every dollar. The matching grants range from 50% for wealthy states such as New Hampshire to 75% for the poorest states. On average, the Federal Medical Assistance Percentage (FMAP) is 57% nationwide.[3]

State budget writers now had great flexibility to increase state assistance to hospitals. In states like New Hampshire, every dollar in DSH payments would receive a matching dollar in federal spending. The program was designed to help reduce the hidden subsidies built into the Medicaid program. But nothing in federal law prevented states from recapturing this new pot of money through taxes on the very hospitals the DSH program was meant to help.

State payments under DSH exploded from $1 billion in 1990 to $17.4 billion in 1992, accounting for 15% of total state medical expenditures.[4] New Hampshire quickly became one of the most aggressive states in implementing DSH payments as part of its state Medicaid program. DSH accounted for 35.8% of New Hampshire's total Medicaid spending by 1992, just two years after adopting it.[5]

ENTER THE MET

New Hampshire began making DSH payments in Fiscal Year 1992, at the same time it imposed a new revenue stream to pay them. The Medicaid Enhancement Tax was a 6% levy on hospitals' gross patient service revenue, essentially every dollar charged for patient care at all 28 New Hampshire hospitals.[6] The rate is currently 5.5%. The first payments were made in August 1991, and were credited to FY1991, which had ended on June 30th.[7]

Every hospital in the state was designated a Disproportionate Share Hospital, and captured under both MET and DSH. Upon making its MET payment, the State would refund an often identical amount to the hospital under the DSH program. The State would then apply for 50% reimbursement from the federal government.

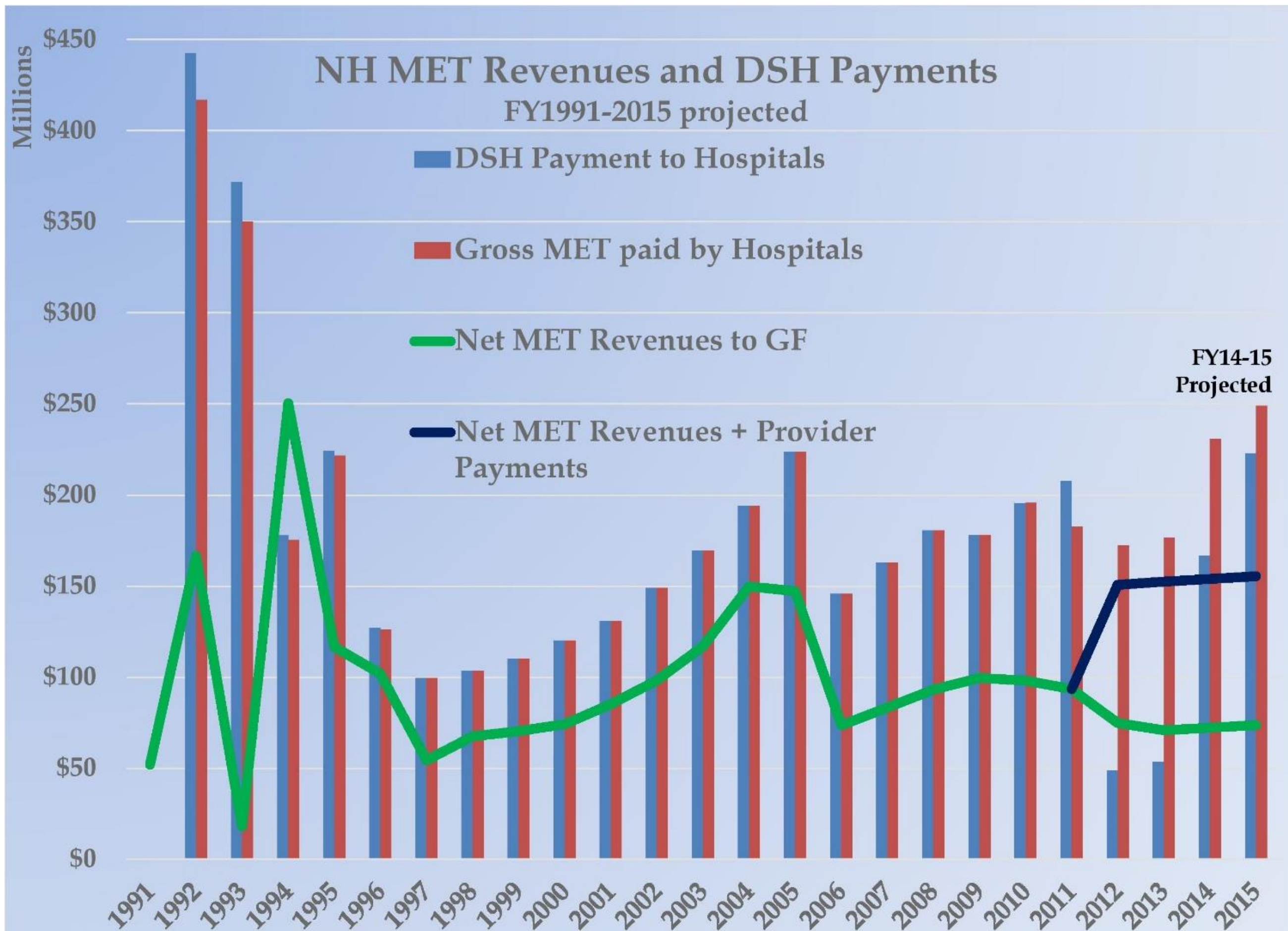
For example, if a hospital owed $10 million under the MET, it would send its payment to the State, which would send a $10 million DSH payment to the same hospital later that same day. The federal government would soon get an application for a $5 million DSH matching grant, which would be deposited directly into New Hampshire's General Fund.

Though the DSH program was meant to help narrow the gap between what hospitals spent to treat Medicaid patients and the low reimbursement rates they received, DSH and MET cancelled each other out for New Hampshire hospitals. It resulted in a windfall in unrestricted revenue for the New Hampshire General Fund.[8]

While many states passed new revenue sources like the Medicaid Enhancement Tax to claw back some or most of the new DSH matching grants, New Hampshire was particularly aggressive, recapturing all of its DSH spending through the MET.

The following chart shows DSH and MET payments tracking each other until very recently (Blue and Red Columns), with approximately half that amount making its way into the New Hampshire General Fund (Green Line). Net MET revenues were not always credited in the same Fiscal Year that gross MET revenues were paid.

FIGURE 1



Sources: Office of the NH Treasurer, Department of Administrative Services, Governor's Budget, HB 1-2013

The Urban Institute's 1997 paper on the DSH program found that New Hampshire was not alone in using this corner of the federal Medicaid program to shore up its state budget. "In sum, federal DSH payments provided a much needed source of revenue for states."[9]

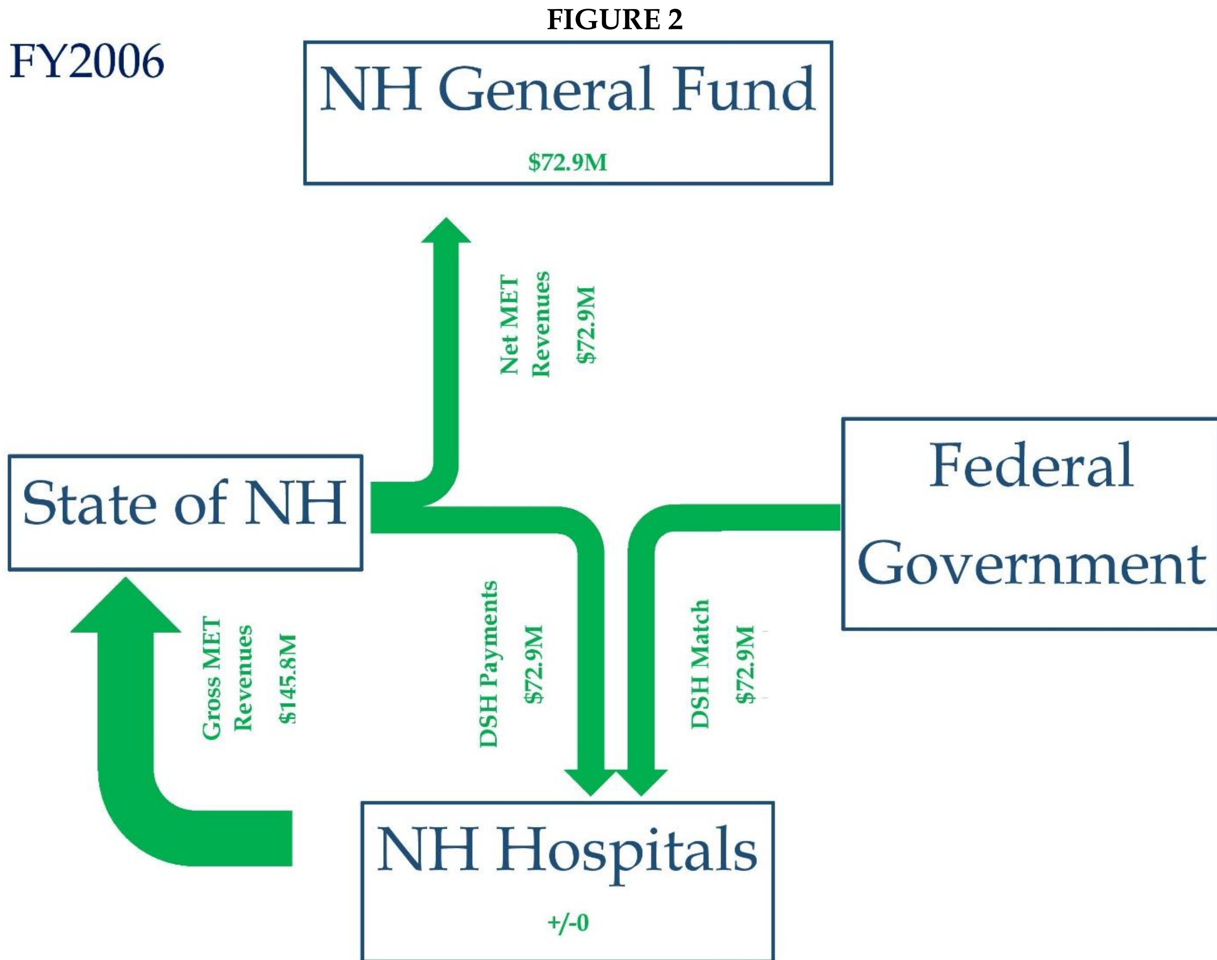
Governors and legislative budget writers from both parties have relied on this diversion of DSH funds to help balance the state budget for the past 20 years, in a practice often referred to as "MediScam".[10]

New Hampshire's aggressive use of the DSH program to backstop its budget, without providing any additional resources to hospitals serving Medicaid patients earned the attention of federal regulators. In fact, state officials have been fighting a 20-year battle with the Centers for Medicare and Medicaid Services over how much New Hampshire could receive under the DSH program. However, Congress

has never stepped in to clarify that federal DSH grants must eventually make their way to Medicaid hospitals, allowing states to continue the practice.

Using Fiscal Year 2006 as an example, the following chart shows how state and federal DSH payments were entirely recaptured by the MET, with federal money eventually making its way into the New Hampshire General Fund. Hospitals were held harmless.

FIGURE 2



In 2007, the Office of the Inspector General at the federal Department of Health and Human Services ordered the state to reimburse the federal government $35 million in DSH payments based on $70 million in state DSH spending that was deemed ineligible for federal matching funds.[11] The OIG report did not force New Hampshire to end MediScam, but did force state officials to lower their annual DSH payment applications. At issue was New Hampshire's decision to use gross patient service charges. The OIG report found that the state should have been using net patient service charges, allowing deductions for bad debt, charity care, and patient discounts that never resulted in real revenue to the hospital.

Following the OIG audit, the Legislature amended the MET to apply to net patient service revenue[12], resulting in a $78 million drop in gross MET revenues in FY2006 and a $39 million cut to the amount of MET proceeds transferred to the General Fund.

CMS continued to pressure New Hampshire to end MediScam and use federal DSH funds for their intended purpose. Beginning in FY2010, the Legislature finally decoupled DSH payments from a hospital's MET liability. No longer would a hospital be guaranteed a full refund of its MET payment through the DSH program. As the New Hampshire Center for Public Policy Studies found in 2011, "This arrangement created 'winners' and 'losers,' whereas previously the program essentially ensured that hospitals received in return exactly what they provided in taxes."[13]

The impact was quite substantial for several hospitals. Portsmouth Regional Hospital paid nearly $6 million more in MET than it received under DSH, while Mary Hitchcock Memorial Hospital netted more than $4.7 million from the change.[14] But overall, the state continued to divert about half of its total DSH spending to the General Fund through federal matching grants.

It wasn't until the next budget cycle that the Legislature truly dismantled MediScam.

THE 2011 BUDGET- ENDING MEDISCAM

The Fiscal Year 2012-2013 State Budget, passed by the Legislature as House Bill 1, contained the largest revision of New Hampshire's DSH and MET programs since they were established in 1992.

In the 20 years since its enactment, the Medicaid Enhancement Tax had existed only on paper, with little economic effect on New Hampshire hospitals. The 2010 changes meant that hospitals were no longer guaranteed a refund of their full MET payments, but all revenues were distributed among New Hampshire's 28 hospitals. Federal matching funds, and not the MET itself, fueled the transfer to the General Fund. The 2012-13 budget decoupled MET revenues from DSH payments entirely. For the first time, the MET was a real tax, and not just a way to leverage federal matching funds. Legislative leaders could legitimately claim that their budget contained no new taxes, without mentioning the new tax burden on hospitals that had previously been borne only in theory.

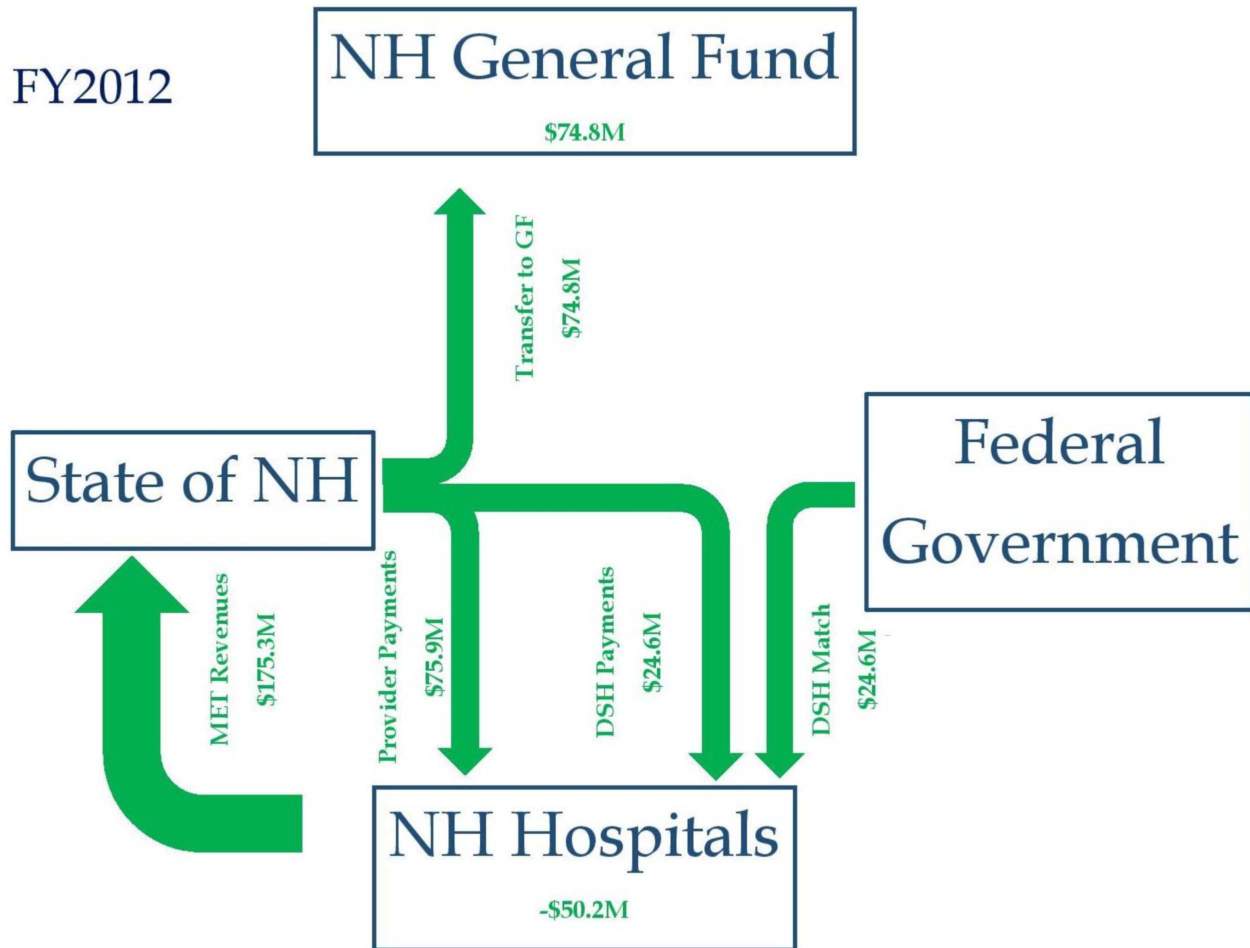
In Fiscal Year 2012 for example, gross MET revenues were no longer twice the state's annual DSH distribution to hospitals, but nine times as much. The federal match brought total DSH payments to just under $50 million, while MET payments totaled more than $175 million.

Additionally, the Legislature dedicated a significant portion of MET revenues to cover some of the state's Medicaid provider payments. These are the normal payments outside of the DSH program that the state's pays to reimburse hospitals for treating patients under Medicaid.

Since state funding for Medicaid provider payments comes from the General Fund, it makes no economic difference to dedicate MET revenues directly to them. In effect, the state was now using the MET to pay for standard Medicaid expenses, rather than for the DSH payments it had been making since 1992.

Dedicating MET revenues to provider payments did have one political advantage. It shielded the effect of decoupling DSH from the MET. Using the MET to cover a General Fund cost that had been paid with other revenues, lowered the apparent transfer to the General Fund. The state budget acknowledged a $75 million transfer from the MET to the General Fund in FY2012, but if the newly dedicated provider payments were still considered as part of the General Fund, the actual transfer topped $150 million.

FIGURE 3



The dark blue line on Figure 1 shows how shifting provider payments turned a large increase in the amount of MET used to balance the state budget into an apparent cut. Both Governor Maggie Hassan's budget and the budget approved by the New Hampshire House continue to dedicate MET revenues to Medicaid provider payments rather than the General Fund.

Faced with a huge pending deficit, the Legislature was already on pace to cutting a billion dollars from the state's two year budget. The MET, conceived as a creative way to leverage federal money to balance the state budget, would again help budget writers close the gap. Turning the MET from a tax paid entirely on paper to a real source of state revenue presented the Legislature with a unique opportunity. It could tap into a new source of state revenue not by raising taxes, but by declining to refund an old one.

DARTMOUTH-HITCHCOCK V. TOUMPAS

The 2011 changes to the state's tax code prompted some big changes in taxpayer behavior. When the full amount of a hospital's MET payment would be deposited back in their bank account later the same day through the DSH program, hospitals didn't spend a lot of time examining their tax bill. They had no incentive to lower their liability, and state officials had every incentive to make the tax bills as large as possible, in order to maximize DSH payments and the 50% federal match.

For years, New Hampshire hospitals had gone along with the MET/DSH swap, even though they received no additional money from the arrangement. At least they weren't paying anything. At the time of its inception, state Health and Human Services Commissioner Harry Bird assured New Hampshire Hospital Association President Gary Carter that the state wasn't targeting his group under the MET, but merely looking for a new way to qualify for DSH matching funds.

"It is our intent that, should Federal Disproportionate Share funds become unavailable, we would no longer require the State revenue and we would recommend that the rate of taxation drop to zero," Bird wrote.[15]

But now that the MET was a tax in deed as well as word, hospitals started taking a closer look at their multimillion dollar tax bills. Several filed amended returns seeking $50 million in refunds for past overpayments.[16] And they withheld $34 million from their FY2013 MET payments as they appeal the current year's tax bill.[17] That shortfall led Governor Hassan and House budget writers to assume the current budget would end with a deficit on June 30th, but strong business taxes have since made up for lower than expected MET receipts.[18]

A group of ten New Hampshire hospitals is also challenging the new tax law in court. In *Dartmouth-Hitchcock v. Toumpas*, the hospitals claim that the state significantly altered the DSH section of its Medicaid program without filing a state plan amendment with CMS, as is required by New Hampshire's long-standing Medicaid agreement with the federal government. But the heart of the lawsuit is a series of cuts to the state's Medicaid reimbursement rates over the past several years.[19]

MET REVENUE PROJECTIONS

Despite MET revenues underperforming by $34 million in the current Fiscal Year, and a pending lawsuit in U.S. Superior Court, budget writers are counting on big things from the MET in the FY2014-15 Budget. Governor Hassan's budget proposal and the version of HB1 approved by the New Hampshire House assume that gross MET revenues will top $482 million over two years, which would fuel the restoration of the previous budget's cuts to the DSH program.[20]

But state hospitals doubt that their patient revenues will grow quickly enough to satisfy the optimistic revenue projections adopted by the House, with current NHHA President Steve Ahnen calling them "overly aggressive."[21] Senate Finance Chairman Chuck Morse believes the House MET estimates may be $100 million too high. If that revenue fails to arrive, and prevents the state from increasing its DSH payments as Governor Hassan suggests, that could mean a $200 million shortfall.[22] In her March presentation to the House Finance Committee, State Medicaid Director Katie Dunn testified that these estimates need to be lowered.

"SFY 2014/2015 projected MET revenues needs (sic) adjustment downward, consistent with actual collections in SFY 2013, which will impact amounts available for distribution."[23]

Now that the MET has been decoupled from the DSH program, federal matching funds are not entirely dependent on MET revenues. DSH payments, and the 50% match from Washington, could be made from any revenue stream. A shortfall in the MET would only double its impact on the upcoming budget if lawmakers fail to provide a contingency to ensure that DSH payments are made. It would be difficult to find another way to pay for the 287% DSH increase sought by Governor Hassan.[24]

CONCLUSIONS

The Medicaid Enhancement Tax is likely to remain a key revenue stream in the New Hampshire. And the state is unlikely to resurrect MediScam. The current Legislature could take two important steps to bring stability and transparency to the Medicaid program, the Medicaid Enhancement Tax, and the state's Disproportionate Share Hospital program.

First, the Legislature should stop thinking of the MET as the primary source for DSH matching funds. If the Legislature wants to impose a tax on net patient service revenue, it should do so independent of the DSH program. If it would like to apply for federal DSH matching funds, it should do so independent of the taxes those hospitals pay. Since DSH payments are matched, it is doubly important that they have a dependable funding source.

Secondly, the Legislature should end the fiscal fiction of dedicating MET revenues for provider payments, rather than depositing MET receipts into the General Fund, and paying for Medicaid from the General Fund as it always had. This may mask the true size of the MET's contribution to balancing the state budget, but it is absurd to continue to tax hospitals to pay for their own Medicaid reimbursement.

These two small steps won't end the political and legal wrangling over the Medicaid Enhancement Tax. But after over two decades of gimmickry, budget writers could finally deal with the MET as a transparent and legitimate part of New Hampshire's tax code.

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[1] Medicaid.gov, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/financing-and-reimbursement.html
[2] Mitchell, Alison, *Medicaid Disproportionate Share Hospital Payments,* Congressional Research Service, December 18, 2012, https://www.fas.org/sgp/crs/misc/R42865.pdf
[3] Ibid, Mitchell.
[4] Coughlin, Teresa A. and Liska, David, *The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues*, The Urban Institute, October 1997, http://www.urban.org/pdf/anf_14.pdf
[5] Ibid, Coughlin.
[6] New Hampshire Legislature, HB 1, 1991, http://www.gencourt.state.nh.us/legislation/1991/HB0001.html
[7] NH Department of Administrative Services, *1991-Current Year Trend-General & Education Funds Unrestricted Revenue*, http://admin.state.nh.us/accounting/interim_reports.asp
[8] Letter from Levinson, Daniel R, Inspector General, Department of Health and Human Services, July 2, 2007, http://oig.hhs.gov/oas/reports/region1/10500001.pdf
[9] Ibid, Coughlin.
[10] *Medicaid politics: New Hampshire taxpayers lost*, New Hampshire Union Leader, September 24, 2011, http://www.unionleader.com/article/20110925/OPINION01/709259991/-1/NEWS
[11] Ibid, Levinson.
[12] NH RSA 84-A, Medicaid Enhancement Tax, http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-V-84-A.htm
[13] *Understanding the Impacts of Changes in New Hampshire's Disproportionate Share (DSH) Program,* New Hampshire Center for Public Policy Studies, 2011.
[14] Ibid.
[15] Fleisher, Chris, *Why Big Hospitals Are Suing N.H.*, Valley News, August 6, 2011, http://www.nhpolicy.org/news/valley_news__why_big_hospitals_are_suing_n.h..pdf
[16] New Hampshire Hospital Association, April 1, 2011, http://www.nhha.org/files/whatsnew/DSH_NHHA%20backgrounder_updated_080111.pdf
[17] State of New Hampshire Monthly Revenue Focus, April 2013, http://admin.state.nh.us/accounting/FY%2013/Monthly%20Rev%20April.pdf
[18] Leubsdorf, Ben, *Strong April revenues put N.H. on track to finish fiscal 2013 with a surplus, not deficit*, Concord Monitor, May 3, 2013, http://www.concordmonitor.com/news/5937229-95/strong-april-revenues-put-nh-on-track-to-finish-fiscal-2013-with-a-surplus
[19] Bosse, Grant, *Lawsuit complicates budget picture*, Concord Monitor, October 7, 2013, http://www.concordmonitor.com/article/359790/lawsuit-complicates-budget-picture
[20] Leubsdorf, Ben, *With revenue down, Medicaid Enhancement Tax creates headaches*, Concord Monitor, April 14, 2013, http://www.concordmonitor.com/news/politics/5546218-95/with-revenue-down-medicaid-enhancement-tax-creates-headaches
[21] *Devil in details? Hospitals move to scuttle House budget*, Laconia Citizen, April 2, 2013, http://www.laconiadailysun.com/index.php/newsx/local-news/66961-hospitals-challenge-hosue-budget
[22] Rogers, Josh, *Morse Says Senate Budget Will Be "A Whole Lot Different",* New Hampshire Public Radio, May7, 2013, http://www.nhpr.org/post/morse-says-senate-budget-will-be-whole-lot-different
[23] Dunn, Katie, *SFY 2014/2015 Budget Worksession, House Finance Division III*, NH Department of Health and Human Services, Office of Medicaid Business and Policy, March 4, 2013, http://www.dhhs.nh.gov/ocom/documents/diviii-03042013.pdf
[24] Ibid, Dunn.