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TO: Representative Edith Clark
Joint Health and Humans Services Appropriations Chairperson

FROM: John Chappuis, Deputy Director

DATE: January 11, 2007

SUBJECT: Information Request—Hospital Tax

In response to a request from the Health and Human Services House Appropriations Subcommittee, the Department is providing information regarding the impact and implications of increasing the Hospital Utilization Fee and using revenue generated by the increase for purposes other than supplemental Medicaid payments to Montana hospitals.

General Provider Tax Requirements

Federal regulation requirements of all provider taxes from which the revenue is used to match Medicaid provider payments as outlined in 42 CFR 433.68 are described below.

1. **Broad Based:** The tax must be imposed on all services within the class. Inpatient Hospital Services are identified as a distinct class of services for the purposes of provider taxes.
2. **Uniform:** The tax must be applied in the same manner to all providers within the class. In Montana, each bed day of service provided is taxed at the same rate. The tax does not vary depending upon the provider's size or the type of service. Inpatient Hospital bed days are specifically identified in the regulations as a uniform tax basis.
3. **Hold Harmless Prohibited:** The state may not guarantee or imply that each payer of the tax will receive at least the amount of the tax paid in the form of supplemental or increased Medicaid payments. In fact, Montana had to prove to CMS prior to their approval of our supplemental reimbursement system, that it did not offer a hold harmless to any provider.
4. **Cap on Provider Tax:** No portion of a provider tax that exceeds 5.5% of the provider class' total revenue from the provision of care can be used as the state share of Medicaid payments. Currently, the Montana Hospital Utilization Fee is well below this threshold.

Upper Payment Limit

Another federally imposed requirement to consider is related to hospital reimbursement rather than provider taxes. The federal Centers for Medicare and Medicaid Services (CMS) has established an Upper Payment Limit for hospitals. The federally accepted upper payment limit employed by Montana Medicaid for hospitals is 100% of the costs of services. The upper payment limit is applied in aggregate, so it is permissible for one provider to receive more than 100% of the cost of the Medicaid services provided, as long as another provider receives less than their costs. Medicaid payments made in excess of the upper payment limit are not eligible for federal financial participation; the federal share of payments in excess of the upper payment limit must be refunded to the federal government.

Disproportionate Share Hospital Payments

Disproportionate Share Hospital (DSH) payments are designed to assist hospitals that provide services to a disproportionate share of uninsured or Medicaid eligible patients. DSH payments can be made without regard to the upper payment limit. CMS authorizes each state a specified amount to be distributed to qualifying disproportionate share hospitals.

The Montana Hospital Utilization Fee is intended to bring Medicaid reimbursement for Montana hospitals up to 100% of costs, the upper payment limit, as well as provide the state match to fully expend the available federal funding for DSH payments.

Federal Approving Authority

The supplemental reimbursement system used to calculate the supplemental Medicaid payments to hospitals was fully scrutinized and approved by CMS in 2003. It was an arduous process, and any change to the supplemental payments to hospitals or other Medicaid payments for which the state share is funded with Hospital Utilization Fee revenue will be subject to federal approval. Further, if such a change requiring CMS approval is proposed, CMS has the authority to reexamine the current reimbursement methodology and require significant changes. Any additional tax proceeds that are not used for Medicaid match should not require federal scrutiny or approval. In short, changing the way in which Medicaid services are funded by the hospital utilization fee could pose a significant risk to existing supplemental payments.

Montana Hospital Association (MHA)

The MHA was instrumental in the implementation of the Hospital Utilization Fee. It is probable that MHA, and both member and nonmember hospitals will be skeptical of any changes to the hospital utilization fee that result in diversion of tax revenue away from supplemental Medicaid payments to hospitals.

Fiscal Impact of Diverting Hospital Utilization Fee Revenue

The following table illustrates the fiscal impact of increasing the hospital utilization fee by \$1, \$5, \$10 and \$20 and diverting the revenue for use other than supplemental Medicaid payments to Montana hospitals.

**Projected Analysis of Increase in Hospital Tax - SB 118
Calendar Year 2008 Impacts at Different Levels of Additional Tax**

Additional Tax Amount (Over SB118 Rate of \$43.00)	Calendar Year	Tax Rate With Addition	Net Impact W/O Additional (Federal Match)	Hospital Payments Net Addit. Impact	"Additional" Revenue (SSR)
Additional \$ 1.00	2008	\$44.00	\$ 43,519,264	\$ 43,051,264	\$ 468,000
Additional \$ 5.00	2008	\$48.00	\$ 43,519,264	\$ 41,179,264	\$ 2,340,000
Additional \$10.00	2008	\$53.00	\$ 43,519,264	\$ 38,839,264	\$ 4,680,000
Additional \$20.00	2008	\$63.00	\$ 43,519,264	\$ 34,159,264	\$ 9,360,000

The table shows the net impact of the hospital utilization fee on Montana hospitals decreases if revenue is diverted from supplemental payments. However, the hospitals, in aggregate, still receive a significant positive net fiscal impact from the fee and related supplemental reimbursement.

Suggested Bill Language

One option that would alleviate the concerns stated above regarding the federal authority to approve or reject changes to Medicaid reimbursement is to deposit the additional fee into the General Fund. Appropriations could be made from the general fund in an equivalent amount to the additional fee revenue.

Alternatively, statute could be amended to prohibit using the additional fee revenue to match any federal revenue. The following language would suffice to protect existing reimbursement and prevent federal scrutiny of the allocation of the additional fee revenue.

Section 2. Section 15-66-102, MCA, is amended to read:

(3) (2) (a) All proceeds from the collection of utilization fees, including penalties and interest, must be deposited to the credit of the department of public health and human services in a state special revenue account as provided in 53-6-149.

(b) Proceeds from the collection of utilization fees in excess of the following amounts shall not be used as state share to fund any joint state/federal program, including Medicaid.

- (i) \$27.70 for each inpatient bed day between January 1, 2007, and June 30, 2007;
- (ii) \$47 for each inpatient bed day between July 1, 2007, and December 31, 2007;
- (iii) \$43 for each inpatient bed day between January 1, 2008, and December 31, 2008;
- (iv) \$48 for each inpatient bed day between January 1, 2009, and December 31, 2009; and
- (v) \$50 for each inpatient bed day thereafter.

The above language assumes the passage of SB 118, which increases the hospital utilization fee. The dollar amounts in the above language could be amended as needed.