Report on MHCC User Fee Assessment

As required by Senate Bill 786, *Maryland Department of Health - MHCC Modifications and Clarifications* and House Bill 800, *Maryland Health Care Commission - Program Evaluation*

December 14, 2023

Randolph S. Sergent, Esq.
CHAIRMAN

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND
Health Care
Commission

MARYLAND
Health Care
Commission

Randolph S. Sergent, Esq, Chairman Vice
President and Deputy General Counsel
CareFirst BlueCross BlueShield

I. INTRODUCTION

Chapter 702 of 1999 (House Bill 995) required the Commission to study and make recommendations on the appropriate funding level and the allocation of the user fee among those currently assessed. The Commission completed this requirement and submitted to the General Assembly in January, 2001 its recommendations. These recommendations were: 1) raise the user fee cap; 2) conduct a workload distribution study every four years to confirm that each industry's assessment is consistent with the Commission's resource commitment to oversight and support to that industry; and 3) remove the current apportionments, by industry, from statute and incorporate them into regulations after the study is complete.

The Commission, during the 2001 Legislative session, submitted these recommendations in Senate Bill 786 entitled, "Department of Health and Mental Hygiene – Maryland Health Care Commission – Modifications and Clarifications." Enacted legislation (Chapter 565) required the Commission to: 1) raise the user fee cap to $10 million; 2) use a methodology that accounts for the portion of the Commission's workload attributable to each industry assessed; and 3) adopt regulations to permit a waiver of the fee assessment requirements for certain health care practitioners. In adopting these regulations, the Commission is required to consider the hourly wages of the health care practitioner and give preference to exempting health care practitioners with an average hourly wage substantially below that of other health care practitioners.

II. REQUIREMENT UNDER CHAPTER 627 (HOUSE BILL 800) PASSED DURING THE 2007 LEGISLATIVE SESSION

Uncodified language in Chapter 627 (House Bill 800) requires the Commission to study the extent to which other health care providers, not currently subject to a user-fee assessment, utilize the Commission resources and to discuss the feasibility and desirability of extending a user fee to additional types of providers regulated by the Commission. This legislation also raised the ceiling on the Commission's current user fee cap to $12 million to include indirect costs paid to the Department of Health and Mental Hygiene.

III. RECOMMENDATION FROM THE FISCAL YEAR 2014 PRELIMINARY SUNSET REVIEW

The Commission looked retrospectively at costs over the previous four years when recalculating the apportionment among the industries in previous workload studies. During the FY 2014 Preliminary Sunset review we suggested to Department of Legislative Services (DLS), and they concurred that we explore how the workload distribution calculation might, at least in part, consider future workload requirements. The previous "Workload Study," implemented in FY 2019 considered future workload in its distribution of the assessment. Since this report was delayed due to the pandemic and the new apportionment should have been implemented in FY 2023, staff looked retrospectively at actual expenditures. Looking forward at two years of appropriation and two years of actual expenditures would drive the assessment higher for each industry than it would have been in several years. The next study, due to be released in FY 2026 and implemented in FY 2027, will again begin to look at future workload and the benefit to each industry.

IV. HOUSE BILL 353/SENATE BILL 253

House Bill 353/Senate Bill 253 passed during the 2022 Legislative Session, raised the Commission's billable maximum amount of user fees at 20 million dollars.

V. BACKGROUND OF MECHANISM THE ASSESSMENT

This report fulfills the statutory requirements by evaluating the workload of the Commission and reallocating the percentages apportioned to each industry subject to the assessment.
Under the current Commission's assessment formula, the shares by industry are as follows:

- Health Insurance Carriers – 26%
- Hospitals and Special Hospitals – 39%
- Nursing Homes – 19%
- Health Occupations Boards – 16%

The amount of an individual entity's assessment is based on an allocation formula specific to that industry. Individual carriers are assessed based on the ratio of each carrier's total premiums in the State for health benefit plans to the total health benefit plan premiums collected by all carriers in the State.
Individual hospitals are assessed on a two-part formula. Half of hospital's fee is based on a hospital's share of total inpatient admissions. The other half is based on a hospital's share total gross operating revenue. Nursing homes are assessed using the same two-part formula as hospitals; half of the assessment is based on a nursing home's share of total admissions and the other half is based on the share of total gross operating revenue. Individuals in the Health Occupations are assessed a flat fee by dividing the health occupations total assessment by the total number of licensees subject to the assessment. Health insurance carriers, hospitals, and nursing homes are billed directly by MHCC. The health occupation boards collect MHCC's assessment from Maryland members of that occupation when the individual is licensed or renews the biannual license.

VI. BACKGROUND OF THE WAIVER PROCESS

When considering the assessment for Health Occupation Boards, the Commission is required to establish a methodology that uses the average annual wage of a health care professional for creating a waiver process that excludes those classes of health care professionals that earn substantially below the average for all occupations. To determine the average wage staff uses information easily obtained from both the Health Occupation Boards and the State Personnel Classification and Salary Guide (SPCSG) to develop a benchmark average wage for the methodology. Each Health Occupation Board submits to MHCC: 1) each professional category that they are responsible to either license or certify; 2) number of licensees; and 3) whether the board assesses that category of licensee. To complete the task of finding the average wage, staff uses the SPCSG system to match classification by grade level, including all levels under that classification (i.e., Occupational Therapist I, II, III, and what the compensation is from lowest to highest for each category of licensee).

This information provides the Commission an overall average for health care practitioners and a tool to comparatively evaluate each category and determine the applicability of the criteria of "substantially below the average." Because the SPCSG encompasses all classes of health care professionals, with only a few exceptions, using this source provides a consistent benchmark average wage. Using the SPCSG as the primary source provides greater transparency than would be possible if a proprietary wage source is used. Transparency is an important consideration for all the Health Occupational Boards. However, the SPCSG salaries are low and should not be interpreted to reflect salaries paid in general for a given health care occupation.

The Commission currently collects the practitioner assessment from:

1) Chiropractors; 2) Dietitians/Nutritionists; 3) Occupational Therapists; 4) Social Workers; 5) Speech Language Pathologists, Audiologists, Hearing Aid Dispensers; 6) Nurses; 7) Podiatrists; 8) Physical Therapists; 9) Physicians; 10) Psychologists; 11) Pharmacists; 12) Optometrists; 13) Professional Counselors and Therapists; 14) Dentists; 15) Massage Therapists; and 16) Acupuncturists.

WAIVER PROCESS – Requirement for Annual Average Wage – Health Occupation Boards

The exemption process is determined in two ways. The current average was determined in FY 2018 as a grade 14/base or $38,629 or $18.57 hourly. Once again, we utilized the SPCSG to list all classes of health care professionals and their compensation from minimum to maximum. After including all classes of a health care professional, the average annual wage remains at a grade 14/base or an average annual wage of $42,846 or $20.60 hourly.

Secondly, staff looked at each category of health professional and their respective compensation level on the state scale to determine if the Commission may "exempt" any classification of health care provider who would be considered earning substantially below this new average.

There were no new additions to the "exempted categories", and they remain as follows: 1) Occupational Therapist Assistants; 2) Social Worker Associates; 3) Psychology Associates; 4) Licensed Practical Nurses; 5) Nursing Assistants; 6) Nurse Psychotherapists; 7) Animal Acupuncturists; 8) Dental Hygienists; and 9) Dental Assistants.

VII. ALLOCATION OF COSTS – Senate Bill 786 - Requirements for Fiscal Year 2023 Implementation of New Apportionments

The Commission's budget is prepared by the distribution of costs to five centers. These centers are separated by Project Coding Appropriation codes and are:

- **Executive Direction** – incorporates all administrative costs/salaries needed to operate the Commission daily.
- **Center for Analysis and Information Analysis** – incorporates all costs for Data Base Applications Development, Cost and Quality Analysis, and Network and Operating Systems

- **Center for Quality and Reporting -** incorporates all costs for HMO Quality, Long Term Care, and Hospital Quality Reporting, including Health Associated Infections.
- **Center for Health Facilities Planning and Development –** incorporates all costs for State Health Planning and Certificate of Need.
- **Center for Health Information Technology and Innovative Care Delivery** – incorporates the costs for Health Information Technology, Electronic Data Interchange, Electronic Health Records, Electronic Health Networks, Health Information Exchange, Telehealth, and Mobile Health.

In the process of allocating projected expenditures apportioned between the industries assessed, staff examined statutory requirements set forth for each division and the projects associated with them for FY 2020, FY 2021 and FY 2022.

Four of the Commission's centers have very defined projects, both in scope and with respect to who the targeted audience is, which makes allocation of those costs straightforward (Summary Workload Analysis 1, 2, 3 and 4). The exception is Executive Direction.

Executive Direction budget consists of the salaries of the Executive Director, the administrative staff, the IT staff, the legal staff, all other adjustments to salaries for staff, and most importantly, all costs associated with operations that cannot be allocated to a specific MHCC Center. Therefore, expenditures associated with this Center are more difficult to allocate (Summary Worksheet 5). Staff considered a variety of ways to apportion these MHCC-wide operational costs and determined that they should be distributed evenly between all industries at 25% each.

Using this methodology, actual expenditures break down as follows:

Fiscal Year 2020

1) Hospitals - $5,866,480
2) Nursing Homes - $2,934,738
3) Insurance Companies - $3,801,717
4) Health Occupational Boards - $2,295,843

Fiscal Year 2021

1) Hospitals - $6,057,175
2) Nursing Homes - $2,958,861
3) Insurance Companies - $4,067,367
4) Health Occupational Boards - $2,414,279

Fiscal Year 2022

1) Hospitals - $6,483,731
2) Nursing Homes - $2,914,791
3) Insurance Companies - $3,877,303
4) Health Occupational Boards - $2,521,501

Taking an average of three years of actual expenditures per Center, including Executive Direction and residual charges, the allocation per industry is:

- Hospitals – 39.8%
- Nursing Homes – 19/1%
- Insurance Companies – 25.4%
- Health Occupation Boards – 15.6%

VIII. INCLUSION OF ADDITIONAL HEALTH CARE INDUSTRIES

The Commission studied the feasibility of bringing ambulatory surgery facilities, home health agencies and hospice providers into the user-fee process. Projects associated with work associated with these three industries require labor hours only. Listed below is the cost for those hours.

Ambulatory Surgical Facilities (342)

- FY 2020 Actual Expenditures - $195.223 1%
- FY 2021 Actual Expenditures - $225,114 1%
- FY 2022 Actual Expenditures - $231 250 1%

Hospice Providers (27)

- FY 2020 Actual Expenditures - $27,462 <1%
- FY 2021 Actual Expenditures - $87,559 <1%
- FY 2022 Actual Expenditures - $56,008 <1%

Home Health Agencies (55)

- FY 2020 Actual Expenditures - $155,754 1%
- FY 2021 Actual Expenditures - $157,406 1%
- FY 2022 Actual Expenditures - $124,776 1%

Staff will consider options for inclusion for ambulatory surgery facilities and other health care providers in all future workload distribution studies.

RECOMMENDATIONS TO THE COMMISSION

1. Release the "Workload Study" to the Legislature.

2. Continue the current assessment distribution in COMAR 10.25.02 – User Fee Assessment on Health Care Practitioners and COMAR 10.25.03 – User Fee Assessment of Payers, Hospitals, and Nursing Homes. Update COMAR 10.25.03, to reflect the dates of July 1, 2023, to June 30, 2026, to keep regulations on track with the Workload Study, which was delayed due to the pandemic.

3. Continue to study the feasibility of bringing in other health care providers who benefit from services provided by the Commission but are not assessed.

4. During the next study, which will be due to the Commission in FY 2026, and implemented to the industries in FY 2027, begin again to look forward to appropriated and projected expenditures that can be attributed to the industries who benefit from the Commission's services.

MARYLAND
Health Care
Commission

4160 Patterson Avenue
Baltimore, MD 21215

mhcc.maryland.gov