State Notes

TOPICS OF LEGISLATIVE INTEREST

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A Summary of Quality Assurance Assessment Programs
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Since fiscal year (FY) 2001-02, the State of Michigan has made use of targeted tax programs for medical providers, known as Quality Assurance Assessment Programs (QAAPs), to fund increases in Medicaid reimbursement and generate General Fund/General Purpose (GF/GP) savings. The State currently makes use of QAAPs to enhance Medicaid reimbursement to Medicaid health maintenance organizations (HMOs), nursing homes, hospitals, and Community Mental Health (CMH) agencies.

While there is a great deal of discussion about the role of these taxes in Medicaid finance, there is still some confusion about how these programs are structured and administered. This article will review how QAAPs are structured, summarize provider taxes in Michigan, and explore other provider groups that may be able to make use of this arrangement to increase Medicaid reimbursement rates.

How a QAAP Works

The structure of provider tax arrangements is relatively straightforward. A QAAP is generally operated in the following way:

1. The State imposes a tax upon a class of medical providers and collects the revenue.

2. A portion of the revenue collected by the State replaces GF/GP dollars as the non-Federal share of Medicaid funding. The GF/GP saving achieved by the State through the QAAP is often called gainsharing.

3. Remaining revenue generated through the tax is used to increase the reimbursement rates paid to the taxed provider group for services to Medicaid recipients. When the funding is used to increase provider rates it generates Federal matching funds, about $1.30 Federal for every $1 in State expenditure. With a Federal match included in the rate increase, a provider group (as a whole) will receive more revenue in Medicaid reimbursement than it paid in taxes.

The hospital QAAP in FY 2005-06 provides a good example of how this structure works.

1. Michigan taxed each hospital in the State 1.8% of its net patient revenue. In FY 2005-06, this tax generated about $243.1 million in revenue.

2. Michigan retained $46.4 million of the $243.1 million as gainsharing.

3. Michigan used the remaining $196.7 million in QAAP revenue to increase Medicaid rates paid to hospitals. These funds generated $256.5 million in Federal matching funds leading to a total rate increase of $453.2 million.

The example provided above demonstrates how this type of program can be popular with provider groups. In FY 2005-06, hospitals provided a little over $240.0 million in tax and through the process increased Medicaid reimbursement by over $450.0 million. Hospitals in Michigan saw a net increase in funding of $210.1 million; and the State was able to reduce GF/GP spending for Medicaid by $46.4 million.

Legal Basis for QAAPs

The Federal Social Security Act specifically allows states to impose taxes on health care providers and use the revenue generated by the assessment for use as non-Federal Medicaid matching funds. The following provider groups and services are identified in the Social Security Act as eligible for provider tax programs:

- inpatient and outpatient hospital services,
- nursing facility services,
- services provided in facilities for the mentally retarded,
- physician services,
- home health services,
- outpatient prescription drugs, and
- services through Medicaid managed care organizations.

Federal law establishes some mandates on the structure of these provider taxes. There are three major criteria that a Medicaid provider tax must meet to be acceptable in the eyes of the Federal government.

1. The tax rate imposed upon providers may not exceed 5.5%. For many years this standard was 6.0% but the Federal government modified it in 2006.

2. The tax must be "broad-based". This means that the tax must be applied to an entire provider group (for example, all the hospitals in a state).

3. If possible, the tax must create winners and losers. States may not establish a provider tax that is structured to minimize or eliminate financial loss by providers.

While the Federal government relies upon these standards to judge the worthiness of provider tax programs, there are loopholes in the Social Security Act that have permitted states (including Michigan) to establish provider assessment programs that conflict with these conditions.

The most significant loophole that states have used relates to taxes imposed upon Medicaid HMOs. The Federal statute that defines the providers eligible for provider tax programs refers to most provider groups in general terms (for example, inpatient and outpatient hospital services). Since the language refers only to the provider type and because taxes must be broad-based to earn Federal approval, a tax on hospitals would have to be equally imposed upon hospitals with high Medicaid volume (organizations that would benefit from the provider tax) and hospitals with very low Medicaid volume (which would lose financially through a provider tax).

In the case of HMOs, however, the statute refers to this provider class as *Medicaid managed care organizations*, instead of managed care organizations. This has permitted HMOs in Michigan to spin off their Medicaid business into separate entities and make only their Medicaid business subject to the tax; it also permits the State to tax only Medicaid mental health business through the CMH QAAP. Because these agencies pay tax only on their Medicaid business, there is no way a participating provider could pay more through the QAAP than it would receive back in increased Medicaid reimbursement. Because of this loophole, the Medicaid HMO QAAP and the CMH QAAP are not broad-based (i.e., they are imposed only on Medicaid providers) and the QAAPs only tax organizations that will benefit financially through the arrangement.

This loophole was addressed by Congress in the Federal Deficit Reduction Act of 2005. Beginning in FY 2008-09, Michigan will no longer be able to tax Medicaid managed care organizations exclusively.

The History of QAAPs in Michigan

Table 1 details use of QAAPs in Michigan and the financial benefit associated with their implementation. The table demonstrates the two major advantages of the provider taxes. First, the assessment permits significant increases in Medicaid reimbursement for providers. From FY 2001-02 to FY 2006-07, participating providers have paid nearly $2.6 billion in tax under the QAAPs and through this process have increased Medicaid rates by over $4.7 billion. Higher reimbursement for Medicaid services is important for safety-net health care institutions and creates greater financial incentive for providers to participate in the Medicaid program, thereby improving access for Medicaid recipients.

The second major advantage of this program is the GF/GP savings to the State. The State of Michigan has reduced GF/GP expenditure on Medicaid by over $500.0 million through use of QAAPs since FY 2001-02.

Table 1

Michigan QAAPs FY 2001-02 to FY 2006-07				
Provider Group	**QAAP Revenue**	**Medicaid Rate Increase**	**Net Provider Impact**	**State Gainsharing**
FY 2001-02				
Nursing Home	$11,319,500	$25,938,400	$14,618,900	$0
FY 2002-03				
Nursing Home	$43,625,900	$97,859,800	$54,233,900	$0
Medicaid HMO	41,947,800	94,095,600	52,147,800	0
Hospital	103,030,000	188,716,900	85,686,900	(18,900,000)
Total	**$188,603,700**	**$380,672,300**	**$192,068,600**	**($18,900,000)**
FY 2003-04				
Nursing Home	$123,551,400	$237,251,000	$113,699,600	($18,900,000)
Medicaid HMO	98,355,900	222,978,700	124,622,800	0
Hospital	102,269,400	177,499,400	75,230,000	(23,974,400)
Total	**$324,176,700**	**$637,729,100**	**$313,552,400**	**($42,874,400)**
FY 2004-05				
Nursing Home	$139,497,500	$271,650,500	$132,153,000	($21,900,000)
Medicaid HMO	114,662,300	229,758,100	115,095,800	(15,200,000)
Hospital	236,138,000	434,409,900	198,271,900	(47,300,000)
Community Mental Health	15,233,100	16,708,500	1,475,400	(8,000,000)
Total	**$505,530,900**	**$952,527,100**	**$446,996,200**	**($92,400,000)**
FY 2005-06				
Nursing Home	$218,327,900	$411,029,500	$192,701,600	($39,900,000)
Medicaid HMO	119,038,700	201,350,100	82,311,400	(20,632,600)
Hospital	243,144,400	453,223,700	210,079,300	(46,400,000)
Community Mental Health	95,705,000	129,474,800	33,769,800	(39,500,000)
Total	**$676,216,000**	**$1,195,078,100**	**$518,862,100**	**($146,432,600)**
FY 2006-07				
Nursing Home	$222,683,200	$419,035,300	$196,352,100	($39,900,000)
Medicaid HMO	157,398,500	249,370,000	91,971,500	(48,623,300)
Hospital	386,020,000	732,737,200	346,717,200	(66,400,000)
Community Mental Health	110,424,700	140,934,400	30,509,700	(48,949,100)
Total	**$876,526,400**	**$1,542,077,000**	**$665,550,500**	**($203,872,400)**
Total				
Nursing Home	$795,005,400	$1,462,764,500	$703,759,100	($120,600,000)
Medicaid HMO	531,403,200	997,552,500	466,149,300,	(84,455,900)
Hospital	1,070,601,800	1,986,587,100	915,985,300	(202,974,400)
Community Mental Health	221,362,800	287,117,700	65,754,900	(96,449,100)
All QAAPs Total	**$2,582,373,200**	**$4,734,021,800**	**$2,151,648,600**	**($504,479,400)**

Source: State Budget Office

Future of QAAPs in Michigan

As noted previously, several changes in Federal rules governing the structure of provider taxes will limit Michigan's ability to save GF/GP money through QAAPs in the near future. A change in the maximum QAAP rate from 6.0% to 5.5% will affect the Community Mental Health and Medicaid HMO QAAPs. In FY 2007-08, this will increase GF/GP cost for Medicaid by over $21.4 million. The Federal Deficit Reduction Act of 2005 also will eliminate the Medicaid HMO loophole in FY 2008-09. This means that Michigan either will have to subject all managed care organizations in the State to the provider tax (an arrangement that would be a financial loser to many organizations) or will have to eliminate the Medicaid HMO and CMH QAAPs, which could increase GF/GP cost for Medicaid by $100.0 to $200.0 million.

While changes in Federal rules may limit Michigan's ability to operate some current provider taxes as they have been generated in the past, the State has some opportunities for expanding provider groups participating in QAAPs. The best opportunity Michigan has to expand QAAP revenue would be through the creation of a physician QAAP. This arrangement was included in the Governor's budget recommendation in FY 2005-06 but was strongly opposed by several physician organizations and was not enacted by the Legislature.

The physician QAAP would have established a 1.0% tax on physician revenue. The revenue from this tax would have been used to create $40.0 million in GF/GP savings and increase Medicaid reimbursement to physicians by $120.0 million. It was determined at the time that a 2.3% tax, with a similar level of gainsharing, would permit the State to increase Medicaid physician reimbursement to that offered through the Federal Medicare program, the maximum level of reimbursement a state can offer Medicaid providers.

Some type of provider tax arrangement for physician services is probably the best chance Michigan has to use a QAAP to drive significant GF/GP savings to the State and provide a large rate increase to a large Medicaid provider group. Michigan has previously explored expanding the QAAP to pharmaceutical services but this concept ran into similar political opposition and the creation of the Medicare prescription drug benefit has minimized the financial benefit associated with this program.

Conclusion

At a time when spending and revenue pressures have made it difficult for Michigan to make positive rate adjustments to participating Medicaid providers, use of the QAAP has permitted the State to keep rates competitive. This has been important as Medicaid caseload in Michigan has grown significantly since 2000. As the Federal government has become more aggressive in identifying and eliminating states' strategies to minimize their Medicaid cost exposure, it is important for this State to continue to identify and exploit strategies to maximize financial support for medical providers participating in Michigan Medicaid.