State Notes

TOPICS OF LEGISLATIVE INTEREST

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A Review of Medicaid Provider Taxes in Michigan Since Fiscal Year 2007-08
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History of Provider Taxes

The Federal statute governing the Medicaid program directs financial responsibility to be shared between the Federal government and participating states. For fiscal year (FY) 2018-19, Michigan's State share (also known as Federal Medical Assistance Percentage (FMAP) for the program is 35.55% (for the non-Medicaid expansion population). This means that, for every $1 of State expenditure, about $1.80 is generated in Federal matching funds. To reduce the General Fund/General Purpose (GF/GP) cost of the Medicaid program, Michigan, along with many other states, has chosen to tax medical providers. In FY 2011-12, the majority (69% of the non-Federal share) of Medicaid financing nationwide was from State GF/GP with provider tax revenue making up 10%.[1] In Michigan, about 20% of non-Federal Medicaid funding comes from provider taxes.

In Michigan, these provider taxes are known as Quality Assurance Assessment Programs (QAAPs). The current provider types with a specified QAAP are nursing homes, hospitals, Community Mental Health (CMH) agencies, and ambulances. The State had a Health Maintenance Organization (HMO) QAAP up until FY 2008-09. Because of an arduous back and forth between the State and the Federal government,[2] the State has moved to a more general health insurance tax called the Insurance Provider Assessment (IPA).

In 2007, the Senate Fiscal Agency (SFA) published a *State Notes* article titled "A Summary of Quality Assurance Assessment Programs", which explained the role that these taxes played in the financing of Michigan's Medicaid program. This paper will build off of and update the provider tax history.

Medicaid provider taxes (also referred to as assessments or fees) are statutorily defined as a tax if at least 85% of the tax burden falls on the intended health care provider.[3] The main benefits of provider taxes are to offset GF/GP contributions and to increase rates paid to a provider in a given class.[4] As of the most recent National Conference of State Legislatures survey, 49 states and the District of Columbia use some form of a provider tax.[5] Under Federal rules,[6] the following types of entities are defined as a separate class of provider:

- Inpatient hospital services.
- Outpatient hospital services.
- Nursing facility services (other than services of intermediate care facilities for individuals with intellectual disabilities).
- Intermediate care facility services for individuals with intellectual disabilities, and similar services furnished by community-based residences for individuals with intellectual disabilities.
- Physician services.

[1] United States Government Accountability Office, "Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection", July 2014.
[2] Senate Bill 992, 993, and 994: Summary of Bill Reported from Committee, Senate Fiscal Agency, 5-16-18.
[3] Social Security Act, § 1903(w)(3)(A).
[4] MACPAC, "The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending", July 2017.
[5] "Health Provider and Industry State Taxes and Fees", National Conference of State Legislatures", 10-10-17. Retrieved on 3-1-19.
[6] 42 CFR 438.2.

- Home health care services.
- Outpatient prescription drugs.
- Services of managed care organizations (including health maintenance organizations, preferred provider organizations).
- Ambulatory surgical center services.
- Dental services.
- Podiatric services.
- Chiropractic services.
- Optometric/optician services.
- Psychological services.
- Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services.
- Nursing services, defined to include all nursing services, including services of nurse midwives, nurse practitioners, and private duty nurses.
- Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility.
- Emergency ambulance services.

These taxes allow non-GF/GP revenue to be collected and are used to increase Medicaid reimbursement rates paid to a given provider, which allows provider rates to be increased with no GF/GP impact.

Appendix A shows a hypothetical hospital provider tax using the FMAP percentage for Michigan for FY 2018-19, 64.45%. In Step 1, the Medicaid providers (in this example, hospitals) would remit a tax of $100 to the State. In Step 2, the State, pursuant to the QAAP statutes, designates a percentage of the revenue collected as "gainshare", or the amount of the tax that is retained to reduce GF/GP Medicaid costs. The amount retained is a ratio of the 13.2% statutory requirements and the annual FMAP percentage.[7] For FY 2018-19, the State retention ratio is approximately 0.3145, so of the $100 tax, the State will retain $31.45 as GF/GP savings in the Medicaid program. With the increased revenue to the Medicaid program, the State uses the remaining $65.55 in QAAP revenue plus Medicaid match to provide a $192.80 increase in reimbursements paid to the hospitals. As stated above, though the hospitals as a provider group are better off by $92.80 on net, this may not be true for all hospitals. A given hospital may remit more as a portion of the $100.00 tax than they receive back in the form of an increased Medicaid reimbursement.

Step 4 shows that the State has made the increased reimbursements to the hospitals, so a Federal match reimbursement request will be made in the amount of $124.26, or 64.45% of the $192.80 Medicaid rate increase made to hospitals. In the alternative case, without the provider tax, had the State wanted to make the same rate payments to the providers, it would have required $68.54 of GF/GP to draw down the additional Federal reimbursement. Additionally, without the tax, the $31.46 in GF/GP Medicaid savings due to the provider tax retention would not have been realized.

In addition to defining the provider classes eligible for a tax under Federal statute, rules, and regulations, a provider tax must meet other requirements. First, the tax must be broad-based, so all nongovernmental providers of a class are taxed, not just the providers with Medicaid participation. The tax must be uniform with a fixed rate for a given provider of that class.[8]

[7] MCL 333.20161
[8] MACPAC, "Health Care Related Taxes in Medicaid", MACfacts - Key Findings on Medicaid and CHIP, August 2012. Retrieved 3-1-19.

Second, states cannot "hold harmless" any providers through a direct or indirect guarantee to reimburse the providers for the taxes paid. Effectively, this means the tax must create net "winners" and "losers", with the latter reflecting individual providers whose Medicaid rate increases do not exceed their tax liability. However, there is a "safe harbor" exception to the indirect guarantee if the tax rate on the providers does not exceed 6.0% of net patient revenue. Because of these rules, a state may implement a multi-tiered tax if it meets certain statistical tests to reflect a broad-based nature.

The Social Security Act and Federal rules and regulations allow for the Center for Medicare and Medicaid Services (CMS) to waive the broad-based and uniform provisions of the provider tax requirements, but do not allow the CMS to waive the "hold-harmless" elements of the rules and regulations.

From FY 2001-02 to FY 2006-07, the total State gainshare, the amount of provider tax revenue that offset GF/GP, was $504.5 million. As shown in Table 1, Michigan's gainshare from FY 2007-08 through FY 2016-17 was about $2.5 billion. [The net provider impact of the net increase in Medicaid reimbursements less the tax] over that six-year period was $2.1 billion. Over the 10-year period from FY 2007-08 through FY 2016-17, the total provider impact was approximately $9.5 billion.

Michigan Medicaid Provider Tax Developments since FY 2007-08

On December 10, 2018, the CMS approved a waiver of the broad-based and uniformity requirements for the IPA, also known as a Health Plan/HMO provider tax. The IPA will differ from traditional Michigan HMO QAAPs in that the tax burden will be borne by all health plans, regardless of their participation in Medicaid, and that there is no corresponding rate increase paid to the providers. Customarily, the QAAPs provider base have significant Medicaid volume, so an increase in a provider tax will generate revenue to increase reimbursement rates. Thus, although an individual provider, e.g. a hospital, may be "worse off", on a net basis, the total reimbursement to the provider class has increased. For the IPA, the tax structure was designed to minimize the burden on health plans with little or no Medicaid "member months" or volume.

The 2007 SFA *State Notes* article discussed the future of QAAPs in Michigan. At that time, the circuitous saga of moving from an HMO provider tax/HMO QAAP, to the Use Tax, then to the Health Insurance Claims Assessment (HICA), and ultimately the IPA, could not have been predicted.

Also mentioned in the 2007 *State Notes* article was the concept of a QAAP on physician revenue. At that time, the proposal was for a 1.0% tax on physician revenue that could have raised an estimated $40.0 million, and would have increased in Medicaid reimbursement to physicians by $120.0 million. In 2009, the Michigan House passed House Bill 5386, which would have established a physician QAAP in Michigan. The proposed provider tax would have levied an amount equal to 3.0% on the reimbursement of physician services which would have raised an estimated $321.4 million in revenue, with the State retaining $116.3 million. The physician QAAP would have generated enough revenue to increase Medicaid physician rates to Medicare levels, by using $191.0 million of the physician QAAP revenue and $523.6 million in Federal Medicaid match. Because of the perceived impacts on the physician provider base in the State, the bill was not taken up for a vote in the Michigan Senate and, since the 2009-2010 legislative session, no bills have been introduced to institute a physician QAAP. Some of the benefits of the proposed physician QAAP were addressed through other means, such as increased reimbursement through the Healthy Michigan Plan, the Specialty Network Access Fee (SNAF), and the Physician Adjustor Program.

In 2015, the Legislature passed and the Governor signed House Bill 4447 (Public Act 104 of 2015), which allowed the Department of Health and Human Services to establish a QAAP on ambulance services not to exceed $20.0 million in collections. The ambulance QAAP initially was interpreted

to tax all local revenues associated with ambulance services, which could have been interpreted to include all mileage revenue associated with fire departments or emergency medical services. The Department issued a public notice on April 18, 2018, which stated a change in policy that increased Medicaid non-air ambulance services rates by 20%.[9] This increase was funded using ambulance QAAP revenue. The ambulance QAAP base appears to focus exclusively on commercial type of ambulance services.

Table 1

Michigan QAAPs FY 2007-08 to FY 2016-17

Provider Group	QAAP Revenue	Medicaid Rate Increase	Net Provider Impact	State Gainsharing
Fiscal Year 2007-08				
Nursing Home	$216,745,800	$422,066,300	$205,320,500	($39,900,000)
Medicaid HMO	162,200,000	285,300,000	123,100,000	(43,700,000)
Hospital	496,200,000	1,059,100,000	562,900,000	(98,900,000)
Community Mental Health	97,000,000	133,300,000	36,300,000	(41,200,000)
Total	**$972,145,800**	**$1,899,766,300**	**$927,620,500**	**($223,700,000)**
Fiscal Year 2008-09				
Nursing Home	$182,555,400	$450,560,000	$268,004,600	($48,000,000)
Hospital	560,300,000	1,234,000,000	673,700,000	(185,800,000)
Community Mental Health	79,300,000	113,100,000	33,800,000	(15,200,000)
Total	**$822,155,400**	**$1,797,660,000**	**$975,504,600**	**($249,000,000)**
Fiscal Year 2009-10				
Nursing Home	$204,749,600	$488,833,800	$284,084,200	($74,100,000)
Hospital	574,500,000	1,310,600,000	736,100,000	(218,100,000)
Community Mental Health	22,000,000	30,000,000	8,000,000	(4,500,000)
Total	**$801,249,600**	**$1,829,433,800**	**$1,028,184,200**	**($296,700,000)**
Fiscal Year 2010-11				
Nursing Home	$218,183,800	$506,500,000	$288,316,200	($72,500,000)
Hospital	582,100,000	1,321,700,000	739,600,000	(202,900,000)
Community Mental Health	29,600,000	45,000,000	15,400,000	(6,300,000)
Total	**$829,883,800**	**$1,873,200,000**	**$1,043,316,200**	**($281,700,000)**
Fiscal Year 2011-12				
Nursing Home	$231,083,600	$506,500,000	$275,416,400	($59,600,000)
Hospital	639,100,000	1,426,800,000	787,700,000	(160,000,000)
Community Mental Health	29,800,000	45,000,000	15,200,000	(5,300,000)
Total	**$899,983,600**	**$1,978,300,000**	**$1,078,316,400**	**($224,900,000)**

[9] Michigan Department of Health and Human Services Medical Services Administration, "Public Notice - Medicaid Ambulance Rate Adjustment", 4-18-18. Retrieved 3-1-19.

Table 1

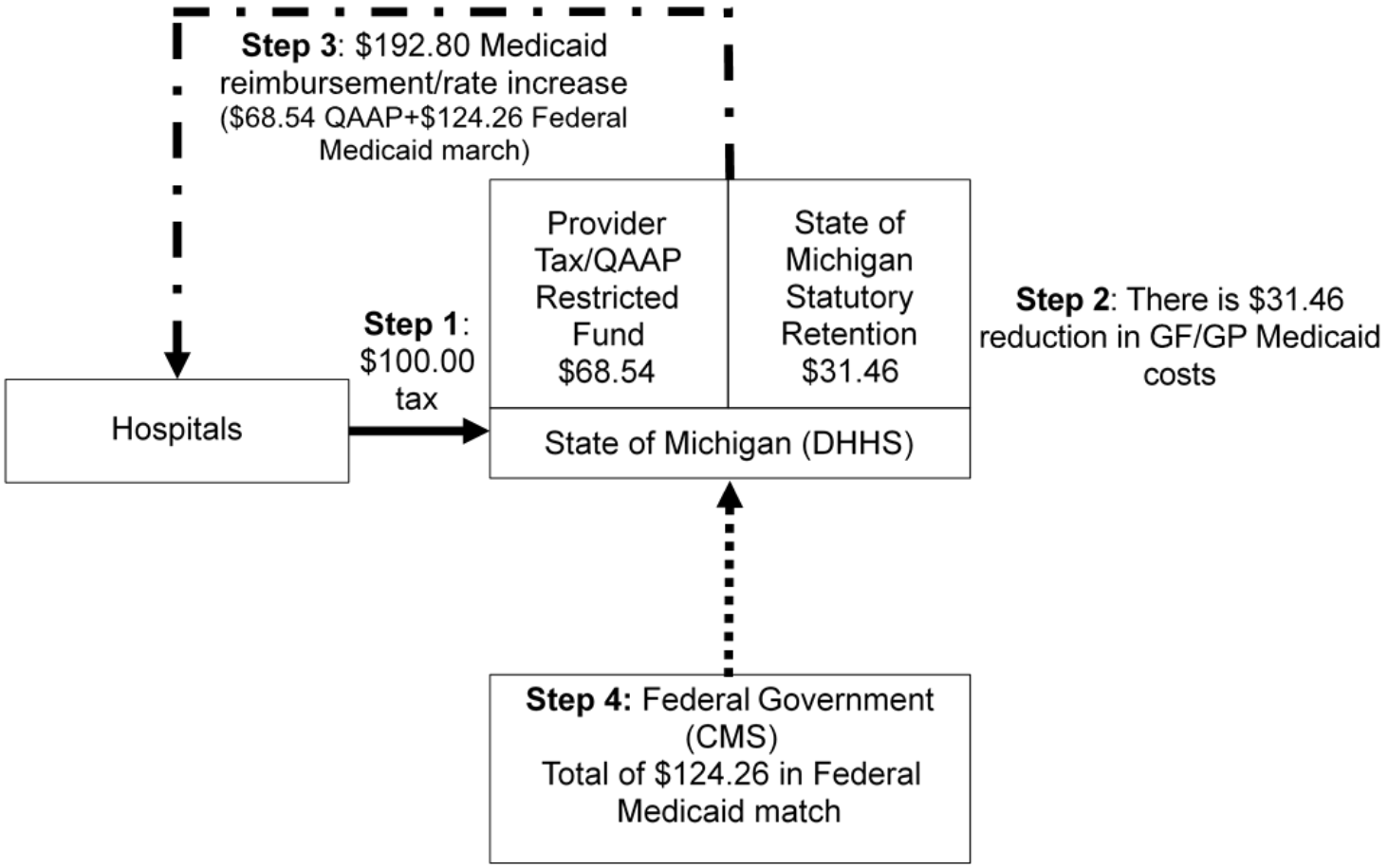
Michigan QAAPs FY 2007-08 to FY 2016-17

Provider Group	QAAP Revenue	Medicaid Rate Increase	Net Provider Impact	State Gainsharing
Fiscal Year 2012-13				
Nursing Home	$225,190,300	$495,300,000	$270,109,700	($58,700,000)
Hospital	620,600,000	1,360,800,000	740,200,000	(171,500,000)
Community Mental Health	29,900,000	45,000,000	15,100,000	(5,300,000)
Total	**$875,690,300**	**$1,901,100,000**	**$1,025,409,700**	**($235,500,000)**
Fiscal Year 2013-14				
Nursing Home	$223,028,000	$490,178,700	$267,150,700	($57,900,000)
Hospital	652,600,000	1,432,700,000	780,100,000	(168,900,000)
Community Mental Health	29,800,000	45,000,000	15,200,000	(5,300,000)
Total	**$905,428,000**	**$1,967,878,700**	**$1,062,450,700**	**($232,100,000)**
Fiscal Year 2014-15				
Nursing Home	$224,321,400	$486,650,000	$262,328,600	($56,600,000)
Hospital	696,200,000	1,536,000,000	839,800,000	(179,100,000)
Community Mental Health	29,500,000	45,000,000	15,500,000	(5,200,000)
Total	**$950,021,400**	**$2,067,650,000**	**$1,117,628,600**	**($240,900,000)**
Fiscal Year 2015-16				
Nursing Home	$223,723,400	$486,650,000	$262,926,600	($56,300,000)
Hospital	650,600,000	1,412,900,000	762,300,000	(165,100,000)
Community Mental Health	29,500,000	45,000,000	15,500,000	(5,200,000)
Total	**$903,823,400**	**$1,944,550,000**	**$1,040,726,600**	**($226,600,000)**
Fiscal Year 2016-17				
Nursing Home	$225,500,900	$487,630,100	$262,129,200	($55,600,000)
Hospital	616,000,000	1,331,300,000	715,300,000	(154,000,000)
Community Mental Health	29,300,000	45,000,000	15,700,000	(5,100,000)
Total	**$870,800,900**	**$1,863,930,100**	**$993,129,200**	**($214,700,000)**
Total				
Nursing Home	$2,175,082,200	$4,820,868,900	$2,645,786,700	($579,200,000)
Medicaid HMO	162,200,000	285,300,000	123,100,000	(43,700,000)
Hospital	5,449,100,000	11,999,100,000	6,550,000,000	(1,704,300,000)
Community Mental Health	405,700,000	591,400,000	185,700,000	(98,600,000)
All QAAPs Total	**$8,192,082,200**	**$17,696,668,900**	**$9,504,586,700**	**($2,425,800,000)**

Source: State Budget Office

APPENDIX A

Example of Hypothetical Medicaid Provider Tax using Michigan Federal Medicaid Assistance Percentage



Source: Medicaid and CHIP Payment Access Commission (MACPAC), *Health Care Related Taxes in Medicaid,* August 2012