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BILL ANALYSIS

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House Bill 4447 (Substitute S-1 as reported)
Sponsor: Representative Al Pscholka
House Committee: Appropriations
Senate Committee: Appropriations

CONTENT

House Bill 4447 (S-1) would amend the Public Health Code to reflect Quality Assurance Assessment Program (QAAP) changes assumed in the FY 2015-16 Department of Health and Human Services budget (described below in BACKGROUND), as well as make changes concerning health facility licensure fees and inspections.

The bill would delay the sunset on the long term care QAAP to October 1, 2019. This extension would allow the State to continue to receive long term care QAAP revenue during FY 2015-16, as assumed in the budget.

The bill would increase the hospital QAAP retention on a one-time basis, for FY 2015-16 only, by $92,856,100, reflecting the assumption in the FY 2015-16 budget that the hospital QAAP retention will be increased by that amount in order to offset an equal amount of GF/GP revenue.

The bill would permit the Department of Health and Human Services to establish a QAAP on ambulance services. Total revenue from this QAAP would be capped at $20.0 million and the ambulance QAAP would sunset on October 1, 2019.

The bill also would adjust a number of fees for health facility licensure that are charged by the Bureau of Health Care Services (BHCS) within the Department of Licensing and Regulatory Affairs (LARA), listed below in Table 1, as well as delay the sunset on those fees from October 1, 2015, to October 1, 2019. Additionally, the bill would create a triennial inspection requirement for health facilities to replace annual or biennial inspections under current law, introduce new inspection requirements and fees for substance use disorder programs, and allow for inspection waivers for facilities that are accredited by an accrediting organization approved by LARA.

MCL 333.6237 et al.

BACKGROUND

Since 2002, the State has used Quality Assurance Assessment Programs to help generate restricted revenue to reduce GF/GP costs and enhance Medicaid reimbursements to certain Medicaid provider groups. The QAAPs are broad-based taxes on medical providers and are alternatively known as provider taxes.

A QAAP generally works in the following fashion: Members of an entire provider group, say hospitals, are taxed at a fixed percentage of their non-Medicare revenue, a tax base that exceeds $14.0 billion. The State retains a portion of that revenue to offset GF/GP funding. The remaining revenue is used, along with Federal Medicaid match, to increase Medicaid reimbursement rates for Medicaid hospital services.

Using round numbers, and assuming a 5.0% tax rate, the State could potentially tax hospitals $700.0 million, use $200.0 million of that to offset GF/GP support, and then use the remaining $500.0 million, along with $950.0 million in Federal Medicaid match, to increase provider rates by $1,450.0 million. The net result is that the State would be better off by $200.0 million and the providers, as a whole, would be better off by $750.0 million ($1,450.0 million in increased Medicaid payments less $700.0 million in tax paid).

It is important to note that, while the provider group is better off as a whole, there are almost always "winners" and "losers" among individual providers. For some low-Medicaid volume hospitals, the amount of tax paid exceeds the Medicaid rate increase they receive, so such hospitals are net "losers" under the QAAP. Most hospitals, however, pay less in tax than they receive from the Medicaid rate increase, so they are net "winners".

Section 1903(w) of the Social Security Act, along with subsequent Federal regulations, created the parameters for provider taxes. Taxes must be broad-based, they cannot exceed a rate of 6.0%, and the increased reimbursement rates due to the taxes also must be broad-based. In other words, the State cannot increase Medicaid reimbursements in such a way as to directly offset the cost of the tax for individual providers and avoid the "winner" vs. "loser" problem.

Michigan instituted three QAAPs over a decade ago: one for hospitals, one for long-term care services, and one for Medicaid managed care organizations. Due to a change in Federal law, the QAAP for Medicaid managed care organizations ended in 2009. The hospital and long-term care QAAPs have continued, with the hospital QAAP projected to bring in over $750.0 million in FY 2014-15 and the long-term care QAAP projected to generate over $250.0 million in FY 2014-15.

The amount the State retains from these QAAPs has varied over the years as well. Most recently, the law requires the State retention, for both QAAPs, to be equal to 13.2% of the Federal match on the QAAP revenue. In practical terms, given the current match rate, this equals about one-fourth of the total QAAP revenue. Therefore, a $600.0 million QAAP would lead to about a $150.0 million retention, with that retention offsetting $150.0 million GF/GP.

The long term care QAAP is set to expire on October 1, 2015. The hospital QAAP retention is set at 13.2% of the Federal match. There are no other QAAPs in statute at this time.

The Conference Report on Senate Bill 133, the omnibus FY 2015-16 budget, assumed three major changes to the QAAPs: extension of the sunset date for the long term care QAAP, an increase in the State retention from the hospital QAAP, and the establishment of a QAAP for ambulance services.

FISCAL IMPACT

Delaying the sunset on the nursing home QAAP would ensure the continued receipt of approximately $250.0 million in QAAP revenue. Absent such an extension, GF/GP costs would increase by $250.0 million.

Increasing the hospital QAAP retention by $92,856,100 would offset an equal amount of GF/GP funding, so the legislation would reflect the FY 2015-16 budget and would reduce GF/GP spending by $92,856,100 below what it would be otherwise.

Establishing an ambulance QAAP would result in increased payments to Medicaid ambulance providers and an unspecified GF/GP retention amount. The FY 2015-16 Department of Health and Human Services budget assumed ambulance QAAP revenue of $4.0 million, increased Medicaid payments to ambulance providers of $8.6 million, and a State retention of $1.0 million that would offset an equal amount of GF/GP revenue.

Adjustments to health facility license fees would increase revenue for the BHCS within LARA by about $1.0 million per year; further detail on the adjusted fees is available in Table 1. Additional funds would be used to support licensing and inspection activities by the BHCS. Support for licensing and inspection of these facilities is currently provided by $530,000 GF/GP and about $360,000 in fee revenue, which is not sufficient to meet current statutory inspection requirements. The FY 2015-16 LARA budget eliminates the GF/GP support for the program, but assumes the fee adjustments in the bill. Combined with the move to triennial inspections and availability of inspection waivers, the fee adjustments should provide sufficient resources for LARA to meet statutory inspection requirements.

Table 1

		CURRENT LAW		**UNDER H.B 4447 (S-1)**		
Facility Type	**Fee Type**	**Fee**	**Revenue**	**Fee**	**Revenue**	**Rev. Inc. (Decrease)**
Hospitals	Base fee	$0	$0	$500	$84,500	$84,500
	Per bed	$8.28	$215,661	$10	$260,460	$44,800
LTC/Nursing Homes	Base fee	$0	$0	$500	$224,500	$224,500
	Per bed	$2.20	$102,843	$3*	$30,789	($72,054)
Hospice Agencies	Base fee	$0	$0	$500	$63,000	$63,000
Hospice Residences	Base fee	$200	$3,400	$500	$8,500	$5,100
	Per bed	$20	$4,920	$5	$1,230	($3,690)
Freestand. Surgical Outpatient Facility	Base fee	$238	$31,178	$500	$65,500	$34,322
Substance Use Programs	Base fee	$0	$0	$500	$637,500	$637,500
Facility Initial License Application	App. Fee	$0	$0	$2,000	$20,000	$20,000
TOTAL		**N/A**	**$358,002**	**N/A**	**$1,395,979**	**$1,037,978**

*New per-bed fee for LTC/Nursing Homes applies only to each bed over 100. Facilities with not more than 100 beds would no longer pay a per-bed fee.

Date Completed: 6-5-15

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