Provider Assessment Tax: IL Vs. MI

Illinois

Illinois Medicaid hospital payments have not been updated in many years but have been modified through the use of multiple adjustors to meet programmatic objectives and to reflect the political realities associated with implementing the hospital tax program.

Per Diem Reimbursed

A number of hospitals/services are exempt from the DRG system and paid using a per diem. The per diem is based upon 1988 and 1989 cost reports inflated to April 1, 1993 with capital capped at the 80th percentile of the statewide rate.

Per Diem with Teaching Cost Included

- County Hospitals in Cook County
- University of Illinois Hospital
- Children's Hospitals

Per Diem with No Teaching Cost Included

- Long Term Stay Hospitals
- Hospitals that Elect to Stay with ICARE Rate
  (ICARE is a reimbursement program from the 1980's where hospitals negotiated payment levels in exchange for guaranteed volume. Hospital have the option of keeping that negotiated per diem rate)
- Rehabilitation Hospitals
- Psychiatric Hospitals
- Sole Community (at hospital's option, otherwise paid DRG)
- Distinct Part Rehabilitation
- Distinct Part Psychiatric

DRG Reimbursed

Grouper

Payments to hospitals are based upon Medicare Grouper 12 (implemented by Medicare for FY 1995). The weights are adjusted for the Illinois Medicaid population. No weight is assigned to DRG 390 (normal newborn) as the payment is included in the delivery amount.

DRG Base Price

The DRG price has been frozen at April 1, 1993 levels and includes payment for capital. All payments for indirect medical education, direct medical education, and CRNAs were eliminated as of July 1, 1995.

Cost Outliers

Since base rates have been stagnant, cost outlier payments have continually increased. To offset that effect, the cost outlier threshold is now set at 1.47 times the level established in 1995.

Adjustors

Illinois Medicaid has implemented a number of special payments. Most of these adjustments are fixed for a five year period beginning in FY 2009 with legislative sunset at the end of FY 2013. The enabling legislation for the hospital tax specifies that a series of payments are the sole use of the tax funds and the payments are determined based upon FY 2005 hospital characteristics and utilization data. For example:

> *In addition to rates paid for inpatient hospital services, the Department shall pay $1,500 for each Medicaid obstetrical day of care provided in State fiscal year 2005 by each Illinois rural hospital that had a Medicaid obstetrical percentage (Medicaid obstetrical days divided by Medicaid inpatient days) greater than 15% for State fiscal year 2005. Note that the OB payment includes payment for normal newborns in Illinois.*

Therefore, regardless of the current year Medicaid patient volume, the tax funded adjustment payments are fixed and predictable for State FY 2009 through FY 2013.

Among the adjustments are:

- Supplemental Hardship Program
- Critical Hospital Access Payments (CHAP) which incorporated Direct Hospital Adjustment (DHA), trauma and rehabilitation payments
- Rural CHAP
- Excellence in Academic Medicaid (EIAM)
- Pediatric Inpatient Adjustment Payments (PIAP)
- Tertiary Care Program
- Safety Net Adjustment Payments (SNAP)
- Psychiatric Adjustment Payments (PAP)
- Rural Adjustment Payments (RAP)

Tax

The Illinois tax code is specific both in terms of the amount of tax and the basis for the tax. For a five (5) year period beginning in FY 2009, the amount of each hospital's tax is the same each year ($900M). The State keeps $130M in hospital tax revenue and then uses the balance to obtain an additional $1.54B in payments for a net to hospitals of $640M. The passage of the ARRA and infusion of temporary stimulus money reduced the amount of tax funds necessary to obtain the additional payments. This resulted in a temporary increase in the annual state gain during the period that the stimulus funds are available (October 1, 2008 through December 31, 2010).

89 Illinois Administrative Code Chapter I, Section 140.80

The specific wording of the Illinois tax code is:

> *Subject to Sections 5A-3 and 5A-10 of the Public Aid Code, for State fiscal years 2009 through 2013, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days. For State fiscal years 2009 through 2013, a hospital's occupied bed*

days and Medicare bed days shall be determined using the most recent data available from each hospital's 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, without regard to any subsequent adjustments or changes to such data. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

Comparison to Michigan

Michigan

The hospital tax is based upon Net Patient Revenue less Medicare Revenue and is set at a level sufficient to provide the non-federal share of the supplemental payments plus an allowed "state gain" equal to 13.2% of the federal Medicaid dollars that are obtained through the hospital tax funds.

The tax is paid by all hospitals in Michigan in compliance with the federal requirements that provider taxes be broad based and uniform. Therefore, a hospital like Zeeland might pay $1.2M in annual hospital taxes and receive $1.0M in additional payments while a hospital like Covenant in Saginaw can net in the neighborhood of $17M after paying $9.2M in taxes and receiving $26.2M in supplemental payments.

In FY 2009, the Michigan hospital tax was just over $500M and supported payments to hospitals of $1.2B. The State gain was $165M for use in funding other Medicaid services. The flexibility in the tax law in Michigan provides for both hospital and State benefit during the period that stimulus funding is available.

Michigan's tax supports both FFS hospital supplemental payments and parallel payments through Medicaid HMOs.

Because of its design, the Michigan tax is flexible in two ways:

1. The amount of the gross tax increases or decreases in response to changes in the amount of supplemental payments to hospitals and in response to changes in the required non-federal share of Medicaid payments.

2. The enabling legislation allows for supplemental payments either in conjunction with FFS or through Medicaid HMOs. Therefore, a shift between FFS and HMO paid services is accommodated within the law.

	Michigan	Illinois
Tax Basis	Net Patient Revenue less Medicare	Occupied Bed Days less Medicare Days
Tax Base	2 years prior to current year (e.g., FY 2008 for FY 2010)	FY 2005
Gross Tax	$500M in FY 2009	$900M per year for FY 2009 through 2013
State Gain	$13.2% of new federal dollars	$130M each year
Payment Pools	Follows base payments but lags 2 years	Specified as fixed amount using FY 2005 data
HMO Impact	Payments and Tax Adjust	Would require legislative and rule changes
State Funded Base	Approximately 60% of Medicare	Approximately 65% of Medicare (includes some adjustments not funded with hospital tax)
Special Hospitals (Not in DRG)	Psychiatric & Rehabilitation	Psychiatric & Rehabilitation, Children's, Cook County Public, University of Illinois, Sole Community, optional for former ICARE contractors.
Base Period for DRG	Rebased every 3 years (currently 2002 to 2006)	Using 1993 Rates (will not be updated until 2013)

Options

The Illinois Hospital Association's concern with any substantial shift of patients from FFS to managed care would be to compromise the sustainability of the tax funded payments to hospitals. On the FFS side, the maximum amount of tax supported payments is limited to the amount Medicare would pay for FFS business (the UPL) less the "regular" FFS payments. The Illinois system is predicated upon a gap of roughly $1.5B in order to maintain the established configuration that is defined through FY 2013.

Illinois Assumptions:

	2009	2010	2011	2012	2013
UPL	$4.3B	$4.3B	$4.3B	$4.3B	$4.3B
Base Paid	$2.8B	$2.8B	$2.8B	$2.8B	$2.8B
Gap (UPL less Base)	$1.54B	$1.54B	$1.54B	$1.54B	$1.54B
Tax Funded Pools	$1.54B	$1.54B	$1.54B	$1.54B	$1.54B
Tax	$0.90B	$0.90B	$0.90B	$0.90B	$0.90B
State Kept	$0.13B	$0.13B	$0.13B	$0.13B	$0.13B
Hospital Net from Tax	$0.64B	$0.64B	$0.64B	$0.64B	$0.64B

In Illinois, any decrease in the difference between the UPL and the base payments limits hospitals' gain from the hospital tax program.

In Michigan, this situation existed prior to the implementation of the HRA payments to hospitals through HMOs. The HRA allowed for an expansion of the tax funded payments to hospitals. Since Illinois has negligible amount of Medicaid payments to hospitals through the HMOs, maintaining the existing hospital benefit requires implementing a parallel payment pool arrangement on the HMO side. The goal in Illinois is to maintain the status quo with respect to tax funded payments to hospitals rather than expand it. Therefore, from a hospital perspective, expansion of HMOs is only a threat to the status quo and not an opportunity.

Auto-Assignment of Members Based on Quality and Access

Recommendation:

Meridian Health Plan is recommending that HFS implement an auto-assignment methodology as a pilot program in all counties where a Medicaid health plan is offered in addition to Illinois Health Connect.

This proposed auto-assignment methodology would be utilized for enrollees that fail to voluntarily choose Illinois Health Connect or a Medicaid Health Plan at the time of enrollment. In that case, they would automatically be assigned to one of the two options based on a pre-determined formula. The auto assignment methodology could only be used in counties where a choice between Illinois Health Connect and a Medicaid Health Plan is available.

To implement the auto-assignment methodology, HFS would establish a formula that could include quality, compliance and access to care standards. These standards would be reviewed on a quarterly, bi-annual or annual basis for scoring. An example of a possible auto-assignment formula is included in Attachment A.

Rationale:
The auto-assignment methodology allows HFS to direct members toward the health care plans that meet its quality and efficiency goals.

Suggested Contract Language:
In Article IV, Enrollment, Coverage and Termination of Coverage, revise contract Section 4.1(e) as follows:

(e) Only a Head of Case may voluntarily enroll another Potential Enrollee. A Head of Case may enroll all other Potential Enrollees in his Case. An adult Potential Enrollee, who is not a Head of Case, may enroll him or herself only.

And add a new 4.1(m) that reads as follows:

(m) Participants that do not select a health care plan at the time eligibility is determined may be automatically assigned to a health plan or Illinois Health Connect through a methodology and criteria established by the Department. Only Participants residing within a county where both a health plan and Illinois Health Connect are approved shall be subject to automatic assignment. The Department shall be the sole authority for determining which Participants and counties will be subject to automatic assignment. Participants automatically assigned through the Department's auto-assignment methodology shall have the right to disenroll from the Contractor within 60 days of assignment.

All remaining sections would be re-numbered accordingly.

General Criteria

Meridian's proposed auto-assignment methodology includes three key areas: Quality, Compliance and Access to Care. The following are the suggested weights for each of the three recommended areas:

- Quality – 50% of the Total Score
- Administrative Compliance – 25% the Total Score
- Access to Care – 25% of the Total Score

Depending upon the goals of HFS, the following are some of the performance metrics that may be included in each of the three areas:

Quality of Care

- Annual HEDIS Measures
- Encounter Data Measures

The performance expectations specified in the HFS Medicaid Health Plan contract could be utilized to create the Quality of Care portion of the Auto-Assignment Methodology.

Administrative Compliance

- Monthly Claims Processing Statistics
- Monthly Encounter Data Submission
- Complaints Per 1,000 Members

Access to Care

- Number of PCPs Open to New Members
- Percentage of Capacity previously approved by HFS

Scoring Methodology

The following is a recommended Scoring Methodology for the three key areas.

Quality of Care

HEDIS - The Medicaid Health Plan's HEDIS scores are compared to the latest NCQA percentiles. HFS would award 10 points for each HEDIS score above or equal to the 75th percentile, 5 points for each HEDIS score between the 50th percentile and the 75th percentile, and 0 points for HEDIS scores below the 50th percentile.

Encounter Data Measures - HFS would award points based on whether the plan achieves the performance monitoring standard of 50% for continuous enrollment. If the plan's 3-month average is above or equal to 50%, HFS would award 10 points; if the plan's 3 month average is above or equal to 40% but less than 50%, FHS would award 5 points; if the plan's 3 month average is less than 40%, HFS would award 0 points.

Administrative

The following are some examples of the performance standards that could be used for administrative compliance:

- 90% of clean claims processed within 30 days
- $\leq$ 1% of claims in ending inventory more than 45 days old
- Report is received by due date and passes all HFS edits
- Encounter data is submitted by due date
- Data passes all edit and volume requirements established by HFS

For the administrative measures, HFS would award points based on the number of months that the plan achieves the performance monitoring standard for that measure. For example, if the plan meets the standard 3 of 3 months, HFS would award 15 points; if the plan meets the standard 2 of 3 months, HFS would award 7 points; if the plan does not meet the standard at least twice within the time frame, HFS would award 0 points.

Access to Care

This would be a two-step process, calculated on county by county basis with the capacity and open PCPs ratio.

Step 1: Calculate plan's ratio of open PCP to approved capacity.

Ratio of open PCPs to the approved capacity = Plan's approved capacity
Plan's open PCPs

Step 2: Assign Points based on the capacity ratio of open PCP's to Capacity.

1 PCP to 500 Members or Less = 15 Points
Between 1 PCP to 500 Members and 1 PCP to 750 Members = 7 Points
1 PCP to Greater than 750 Members = 0 Points

Assignment of Membership

Under this example, a total of 90 points could be earned by each Medicaid Health Plan. Based on the points earned a tiered level of auto-assignment could be created as follows:

61-90 Points = 50% of Auto-Assignments
31-60 Points = 25% of Auto-Assignments
0-30 Points = 0% of Auto-Assignments

The remaining percentage of members that were not auto-assigned would be automatically enrolled in to Illinois Health Connect.