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State of Alaska Department of Health and Social Services (DHSS)

Health Care Provider Tax Feasibility Study and Recommendation

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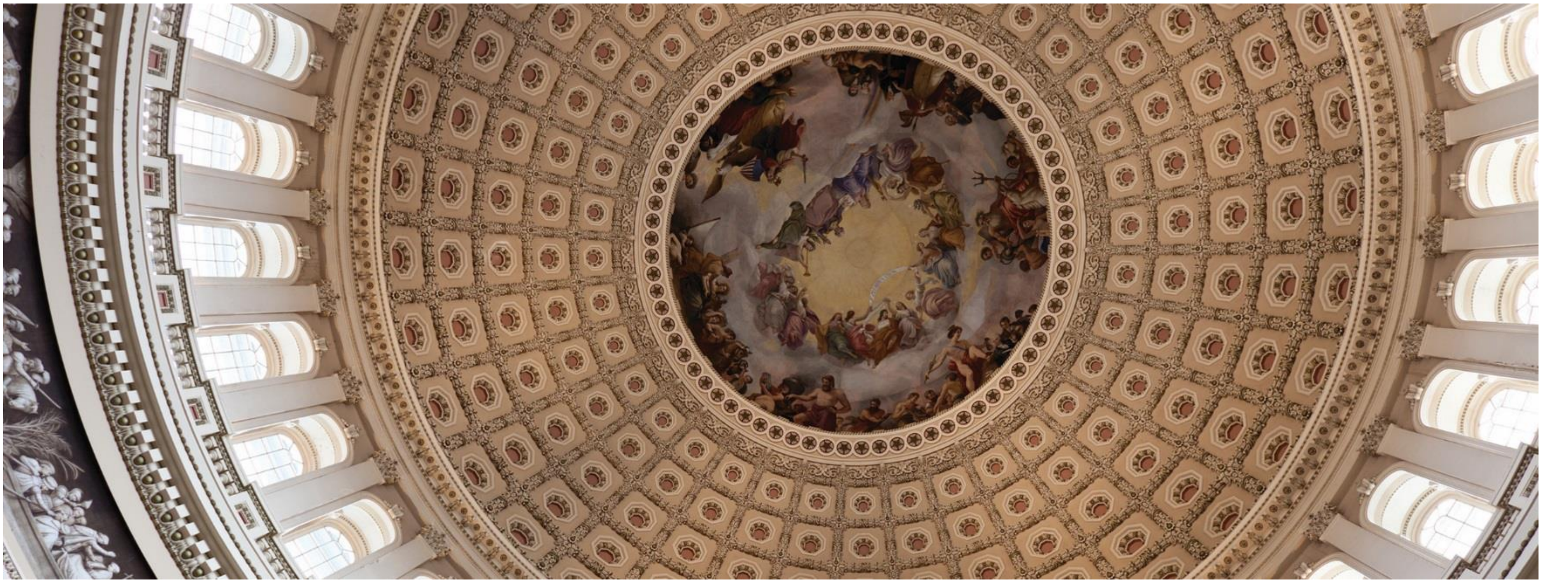

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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1. Overview

Myers and Stauffer LC was hired in June of 2015 to perform a Health Care Provider Tax Feasibility Study and Recommendation for the Alaska Department of Health and Social Services (DHSS). Key deliverables of the contract are as follows:

A. Feasibility Study and Recommendation

This report consists of the recommendation and draft tax proposal, an analysis of the key issues associated with the recommendation and provider taxes in general, and an explanation of the process, including stakeholder input, that led to the underlying recommended draft tax proposal.

B. Draft Tax Proposal

Myers and Stauffer LC concludes that nursing facilities are immediately feasible for a provider tax. Our proposal and draft models for a health care provider tax on nursing facilities are contained within Sections 2 and 3 of this report. Web links to more detailed models supporting our recommendation can be found in the Appendixes A and B.

C. Public Presentations and Subject Matter Expertise

Stakeholder meetings were held and are discussed in Section 4 of this report. In addition, Myers and Stauffer LC is available as a subject matter expert for presentations to the public and the Alaska Legislature.

2. Recommendation

A. Classes Immediately Feasible for a Provider Assessment

Alaska is the only state in the union without a health care provider tax. In fact, most states have multiple provider taxes in place. The intent of a provider assessment program in Alaska would be to generate revenue without creating an excessive administrative burden on providers, putting providers out of business, or limiting access to care. With that goal in mind, feasibility for this project is defined as: **finding balance between assessing a new provider tax to generate additional revenue for the State and causing as little negative impact to providers as possible.**

Working within these guidelines, our analysis has determined that only two provider classes, nursing facilities and inpatient hospitals, are the most feasible for implementing a health care provider tax. Of these two classes, nursing facilities present the best scenario for immediate feasibility and for striking a favorable balance between generating additional revenue for the State and causing as little negative impact to providers as possible. Subsequent sections of this report present the detailed analysis that led to these conclusions. For now, we present our recommendations for a nursing facility provider tax.

B. Draft Nursing Facility Assessment Model

There are many combinations of parameters that will produce favorable outcomes for a nursing facility provider tax. Two scenarios are presented on the following page. The first is a conservative approach. The second is a more aggressive, revenue maximizing approach. These two scenarios represent taxing both a lower range of revenue and the maximum amount of revenue that will generate favorable outcomes for nearly all providers and for the State.

For each scenario there are two tables. The first table presents the estimated fiscal impact for each Alaska nursing facility as well as to the State. The fiscal impact for each nursing facility is the difference between the total assessment paid and the supplemental payments received. The second table lists general parameters for the provider tax and differences between the models.

The table below represents a high-level fiscal impact of the models. A web link to the more detailed models can be found at Appendixes A and B.

1. Model Summaries

Fiscal Impact Analysis	Model 1: Conservative Model			Model 2: Aggressive Model		
Provider Name	Total Assessment	UPL Payment	Fiscal Impact	Total Assessment	UPL Payment	Fiscal Impact
Prestige Care & Rehabilitation Center	$654,606	$776,797	$122,191	$1,125,603	$1,351,284	$225,681
Providence Transitional Care Center (a)	352,026	158,486	(193,540)	605,313	275,696	(329,617)
Providence Extended Care (PEC) (a)	857,113	1,093,332	236,219	1,473,817	1,901,915	428,099
Wildflower Court	500,118	654,352	154,234	859,959	1,138,283	278,324
Central Peninsula/Heritage Place	719,304	770,943	51,639	1,236,852	1,307,269	70,417
Cordova Community Medical Center	96,088	176,405	80,318	165,224	299,126	133,902
Denali Center	627,644	712,313	84,669	1,079,242	1,239,111	159,869
PeaceHealth Ketchikan	184,885	293,973	109,088	317,913	498,484	180,571
Petersburg Medical Center	149,871	207,551	57,680	257,706	351,940	94,234
Providence Island Kodiak	195,361	220,785	25,424	335,925	384,068	48,142
Providence Seward	490,852	561,957	71,105	844,026	952,896	108,870
Sitka Community Hospital	123,525	225,516	101,991	212,402	382,402	170,000
South Peninsula Hospital	268,431	474,206	205,775	461,571	804,099	342,528
Providence Valdez Hospital	99,130	175,289	76,159	170,455	297,234	126,779
Wrangell Medical Center	137,645	155,145	17,500	236,683	263,076	26,393
Total Impact to Providers	$5,456,600	$6,657,052	$1,200,452	$ 9,382,690	$11,446,882	$ 2,064,192
Impact to State						
State Share of Supplemental Payment (50%)		$3,328,526			$5,723,441	
Tax Revenue Received		5,456,600			9,382,690	
Net Revenue to State		$2,128,074			$3,659,249	

(a) These providers have a related ownership status so if the fiscal impact is netted, there is a net gain.

Assessment Parameters & Summary	Model 1	Model 2
Percent of Net Patient Revenue Taxed	3.48%	5.99%
Net Revenue to State (State General Funds)	$2,128,074	$3,659,249
Net Provider Fiscal Impact	$1,200,452	$2,064,192
Number of Providers with a Gain	14	14
Number of Providers with a Loss (a)	1	1
Assessment Basis	Non MCR Days	Non MCR Days
Assessment Rate	$41.00	$70.50
General Provider Tax Tier	100%	100%
High MCD Tax Tier (> 18,000 MCD Days)	60%	60%
Small Provider Tax Tier (< 30 Beds)	70%	70%
B1/B2 Test Score	1.0232	1.0232
Estimated Assessment Revenue	$5,456,600	$9,382,690
Total Funding Leveraged (50% FMAP)	$10,913,200	$18,765,380
% to Provider Payments	61.0%	61.0%
$ to Provider Supplemental Payments	$6,657,052	$11,446,882
% to state	39.0%	39.0%

2. Differences Between the Conservative and Aggressive Models

Following is a high-level summary of the major differences between the models.

a) Percent of Net Patient Revenue (NPR) Taxed

The primary difference between the two models is the total percentage of net patient revenue being taxed. The conservative model assesses a tax of only 3.48% of net patient revenue, whereas the aggressive model maximizes revenue to the State by assessing a tax of nearly 6% of net patient revenue which is the maximum tax percentage allowed in the federal rules.

This maximum tax is referred to as a safe harbor protection to providers. This safe harbor concept is discussed in more detail in Section 3.B of this report. In general, it allows states to use revenues from taxes as the state share of Medicaid payments if those taxes meet certain requirements. While the aggressive model satisfies the safe harbor provision, Myers and Stauffer LC ran a conservative model that is about half of the 6% safe harbor provision. We did this because multiple federal proposals have been made to reduce the safe harbor threshold. The most recent reduction proposal was included in federal deficit reduction discussions and contained a plan for gradually lowering the safe harbor threshold to 3.5%.

b) Supplemental Payment Distribution

Of special note is the increase to the supplemental payment distribution between the models. This distribution represents a new supplemental payment to providers referred to as an Upper Payment Limit payment (UPL payment) proposed in our recommendation. The UPL payment is described in detail in Section 3.D of this report. As a short introduction, this is simply the difference between what Medicaid paid providers and what Medicare would have paid providers under a Medicare payment system. The Centers for Medicare & Medicaid Services (CMS) will allow states to distribute this difference to providers as a supplemental payment. The reason for the increase between Model 1 and Model 2 is that CMS will allow a state to include the Medicaid share of the provider tax expense in the UPL payment. Therefore, the increased tax assessment in Model 2 increases the expense that can be reflected as the Medicaid share of the tax, which increases the UPL distribution that can be made to each provider.

3. Why Models and Assessment Parameters Were Selected

The models above were selected as they provided the most favorable outcomes for both the providers and the State. While the two scenarios presented above represent the outer limits for revenue generated by a favorable nursing facility provider tax, there are several parameters included that we recommend not be changed, even if the State decides to pursue different revenue targets. These parameters include the assessment basis, the tiered-rate structure, exemptions, and the percent of new revenue allocated to the nursing facility reimbursement program.

We recommend using non-Medicare resident days as the basis for the assessment since this produces the best combination of outcomes for the State and providers (i.e., increased revenue to the State with the least expense to providers). Other assessment bases (licensed beds, patient revenue) were tested. However, the results produced a wider range of net gains and losses between providers than the non-Medicare resident days.

Our recommendation also includes lower assessment tiers for high Medicaid providers and small facilities. Using a lower tax rate for these groups is critical for two reasons.

First, it improves the fiscal impact for some providers that would otherwise pay more tax than they would receive in supplemental payments. Using a lower tax rate for these providers is the only way to enable them to realize a net gain.

Second, it ensures compliance with the safe harbor provisions included in federal regulations. Once again, this provision allows the State to use tax revenues as the state share of Medicaid payments if those taxes meet certain requirements. In the case of a tax that includes different assessment tiers, CMS has a specific statistical test that must be met in order for the tax program to be approved.

To comply with that statistical test and create the best fiscal outcomes for the largest number of providers, we found that lower assessment tiers needed to be used for both high Medicaid providers and small facilities. More specifically, we found the best percentage for those tiers was 70% of the general assessment rate for small facilities and 60% of the general assessment rate for high Medicaid facilities. We also determined that the most favorable results were found when small facilities were defined as those with fewer than 30 beds, and high Medicaid providers were defined as those with more than 18,000 Medicaid days.

Other parameters that we recommend remain constant include the exemption of tribal facilities and the percentage of new revenue dedicated to increasing provider reimbursement. Tribal facilities are exempt from provider taxes due to federal laws and, therefore, must be excluded from any Alaska nursing facility provider tax. As for provider reimbursement, we analyzed the impact of different ratios for splitting provider tax revenue between provider reimbursement and the State. We determined that at least 61% of the new UPL revenue generated should be returned to providers in order to create favorable fiscal impact results for providers while still allowing a significant share of new assessment revenue for the State.

C. Caution: Data and Outcomes are Subject to Change

While the nursing home tax proposal represents the best option for an immediate provider tax because it results in a scenario where nursing homes are essentially shielded from liability, and the State generates estimated revenues between $2.1 million and $3.7 million in general fund revenue (depending on the model selected), we must caution the State about the estimated fiscal and economic impact of the tax. Due to challenges identified below with accessing the most current data available, the outcomes in our models will likely change when the data is updated.

1. Data Sources and Data Challenges

The data challenges we faced, and a listing of data sources used for the nursing facility model, are as follows:

a) Old Medicaid Management Information System (MMIS) Data

State Medicaid programs utilize a computerized system known as MMIS to collect patient days billed by providers, to pay providers, and maintain beneficiary and provider enrollment information and many other data elements. The MMIS is an integral data warehouse and reporting tool for obtaining information for Medicaid program oversight and data analysis purposes, including data

needed for UPL demonstrations and provider tax calculations. In October 2013, the State adopted a new MMIS. However, some of the reporting functionality of the new system was not yet in place at the time of our study, which would have enabled the generation of reports and summary data needed for UPL and tax calculations.

Accurate Alaska Medicaid days are critical not only to the calculation of the recommended nursing facility provider tax but also to the calculation of the supplemental payments used to offset the tax payments made by each facility. While the State's MMIS MR-0-14 report is the most desirable source for Medicaid days (as it reports actual Alaska Medicaid days and expenditures), it was not available for the study due to functionality issues. Myers and Stauffer LC attempted to trend data forward from the 2011 and 2012 MR-0-14 reports; however, the results were inconsistent with data reported on the 2014 Medicare cost reports. For example, in some cases, the total trended Medicaid days exceeded the total for all resident days reported on the Medicare report. Therefore, our final model utilized Medicaid days reported on the 2014 Medicare cost reports. There is some risk associated with using provider cost reports as the days may include out-of-state Medicaid days, Medicaid pending days, or reporting errors. It is our understanding that the State will soon have usable MMIS reports. Therefore, we recommend that the models be updated as soon as these reports are available.

b) Future Recommendations for Data Sources and Policies

Following is a summary of the other data sources used for the models as well as our recommendations for data sources moving forward if the State were to implement this tax system:

(1) Cost Report Periods

Our model used cost, revenue, and patient day data from the provider cost reporting periods that ended in calendar year 2014 to calculate a provider tax for State Fiscal Year (SFY) ending 6/30/16. If the State moves forward with this tax, we recommend that moving forward a rolling calendar be used; e.g., 2015 cost reports would be used for the SFY 2017 UPL and assessment.

(2) Medicaid Days

As noted in the section above, we recommend that our model be updated to use cost report year 2014 Medicaid days from the State's MMIS MR-0-14 report when it is operational. Moving forward, we recommend the Medicaid days be obtained from the MR-0-14 report for the same cost reporting period and rolling calendar year system suggested above.

(3) Reporting Tax Expense on Cost Reports

Because the State's payment rates are based on cost, we recommend that Alaska institute a policy specifying that a provider tax expense is not a reimbursable cost on the cost report. First, the tax expense to facilities is already recognized through UPL payments. Second, reimbursing the provider tax expense through cost-based rate setting will result in increased Medicaid payment rates, which over time will erode the UPL gap that is the basis for the supplemental payments that benefit providers.

(4) Approval of Tax System by the Centers for Medicare & Medicaid Services (CMS)

We recommend that any legislation include a statement specifying that implementation of any tax is dependent on CMS approval. Since the benefits of a provider tax program hinge on the ability

of the State to draw additional federal matching funds with the provider tax revenues, the State should not commit to making payments with the tax revenues until the program has been approved by CMS. Without such approval, the State could be obligated to make reimbursement payments without the benefit of federal matching funds. This would subvert the intent to generate revenue with a provider tax. Furthermore, since the provider tax modeling is dependent on data that will change, it is important that any proposal be reevaluated with current data before it is implemented.

D. Conclusion

Based on our analysis, a nursing facility provider tax is the most immediately feasible provider tax option for Alaska. Our analysis shows that a nursing facility provider tax could be structured to generate revenue for the State at virtually no cost to providers. However, in order to fully understand the fiscal and economic impact to the State and the providers subject to the tax, it is advisable for the State to wait until more current MMIS data is accessible to recalculate and finalize the models.

3. Fundamental Provider Tax Issues

There are several concepts that are fundamental to all provider taxes. In this section, each of these concepts is first explained generally, and then additional detail is provided about how the concepts specifically relate to the nursing facility recommendation presented in Section 2.

A. Tax Base Options

1. General Discussion

The tax base refers to the statistical basis, or taxable unit, that is used to calculate the tax due from each provider. Provider taxes are most often based on a percentage of net patient revenue, licensed beds, or the number of days of care (or other service units) provided. These bases make the tax dependent upon service volume so that larger providers pay a greater tax than smaller providers. Another tax basis option is a flat fixed fee that remains the same for all providers, regardless of the provider size or number of service units.

When selecting the taxable unit, the tax can be imposed on the gross unit or on a more targeted unit that has exceptions or carve outs. For example, in the nursing facility tax, we carved out Medicare days from the tax base as is discussed below.

2. Nursing Facility Tax Base

In the nursing facility provider tax recommendation, we used non-Medicare resident days as the tax basis. We modeled many tax scenarios for nursing facilities using other tax bases, including licensed beds, net patient revenue, and a flat fee. Using non-Medicare resident days provided the best results in terms of balancing the individual fiscal impact to providers and generating revenue for the State. Although we could produce similar scenarios with licensed beds and revenue options, no base produced more consistent net gains across the nursing facility provider group than non-Medicare resident days.

B. Maximum Net Patient Revenue (NPR)

1. General Discussion

Maximum net patient revenue (NPR) refers to federal limits on the percentage of the revenue of a provider class that can be collected as a tax. This is commonly referred to as a safe harbor provision as it protects providers from being taxed at an overly burdensome rate. Currently, federal regulations restrict provider taxes to a maximum rate of 6% of the total net patient revenue of all the providers in the class of providers being assessed. The safe harbor rule prevents the tax from becoming an undue hardship on providers and also limits the federal government's liability for Medicaid funding as states use provider tax revenue to fund UPL payments back to providers with enhanced federal financial participation.

Over the years, there have been proposals at the federal level to reduce the maximum NPR rate from the current 6% to 3% - 3.5% over the course of several years. Between January 1, 2008 and

September 30, 2011, the Tax Relief and Health Care Act of 2006 changed the threshold to 5.5%. On October 1, 2011 the threshold reverted to the 6% limit that is currently effective.

2. Nursing Facility NPR Rate

Due to the safe harbor restriction and potential proposals to reduce the maximum NPR limit from 6%, we modeled two scenarios in Section 2 of our report. We proposed a conservative tax rate of 3.48% of NPR, and a more aggressive revenue-maximizing rate of 5.99% of NPR, both of which pass the safe harbor test. The rationale for providing these two options was to establish the outer bounds of the revenue that could be legally generated from a provider assessment under the current federal rules and potential amendments. While the lower bound of 3.48% does exceed the 3% limit that has been discussed in the past, it is below the 3.5% limit that has also been proposed in the past. Regardless, if a change occurs, it would likely take several years before it would take effect, giving Alaska time to comfortably realize higher revenue amounts or adjust its provider tax parameters accordingly. Therefore, a tax of up to 3.5% of revenue is considered conservative, while a tax of nearly 6% may be construed as more aggressive, yet currently allowed under federal rules.

C. Exclusions (Broad-Based) and Tiers (Uniform)

1. General Discussion

In the most simple form of a provider tax, the tax is broad-based and uniform. A broad-based provider tax refers to an assessment that is applied to every provider in a class. A common example of a tax that is not broad-based is exempting state-owned providers from a tax as it may not make sense for a state to tax a state-owned facility. The term uniform means that all providers in the class are taxed at the same rate. An example of a tax that is not uniform is one that uses tiered rates so that some providers pay a greater tax rate than other providers in the same class.

When a provider tax is not broad-based or uniform, the tax must pass certain federal statistical tests in order to be approved by the Centers for Medicare & Medicaid Services (CMS).

Broad-Based Statistical Test (P1/P2)

When a state uses a non-broad based provider tax, it must ensure that the tax complies with a statistical test called the P1/P2 test. CMS developed this test to determine if a tax that excludes certain providers is generally redistributive. This means that the tax with the exclusions is not more aligned with Medicaid units than a tax that does not have exclusions. If the value of the P1/P2 test is at least equal to 1.0, the test is passed.

Uniform Statistical Test for Tiers (B1/B2)

CMS also stipulates that when a provider tax uses different tax rates for different providers within the same class, the P1/P2 test is not applied. Instead, CMS requires that a separate statistical test called the B1/B2 test be performed to determine if the assessment is generally redistributive. If the value of this test is at least equal to 1.0, the test is passed. Provider taxes that use different tax rates for subgroups of providers are called non-uniform taxes. Provider taxes that are neither broad-based nor uniform are subject only to the B1/B2 test.

2. Nursing Facility Exclusions and Tiers

The nursing facility provider tax models we recommended in Section 2 of our report both exclude tribal facilities and use tiered rates. The tiered rates modeled are the same for both models and are as follows:

- *High Medicaid Days Reduced Tax Tier – Providers with more than 18,000 Medicaid days were taxed at a reduced rate of 60% of the general rate.*
- *Small Provider Reduced Tax Tier – Providers with less than 30 beds were taxed at a reduced rate of 70% of the general rate.*

Therefore, the recommendations are a non-broad based and non-uniform tax. CMS will evaluate such an assessment using the B1/B2 statistical test. The P1/P2 test is not required if a B1/B2 test is performed.

We included compliance testing in our modeling to evaluate all of the statistical tests that CMS might use to review a proposed provider tax. The recommended nursing facility provider tax produces a B1/B2 statistic greater than the required 1.0; therefore, the proposed provider tax complies with this requirement as it has been modeled.

Similar to the fiscal impact outcomes projected for the nursing facility provider tax recommendation, the outcome of the B1/B2 statistical test (and all other compliance testing) could change when more current data is used. Therefore, it is recommended that the State reevaluate this compliance test with current data before implementing a provider assessment.

D. Upper Payment Limit (UPL) Supplemental Payments

1. General Discussion

One of the major focuses of this tax study was the implementation of a supplemental UPL payment program. Under an approved state plan, CMS allows states to make supplemental UPL payments to providers. These payments are in addition to ordinary Medicaid payments made to providers for services. States use supplemental UPL payments in conjunction with provider taxes to help mitigate the additional cost liability to providers. As described earlier, states can distribute supplemental payments to providers in an amount equal to the difference between what Medicaid paid providers for the services and what Medicare would have paid providers for those services under a Medicare payment system. Supplemental UPL payments are funded through a combination of the revenue collected from the tax and a federal Medicaid match on the portion of the revenue that is paid back to providers in the UPL payment. Alaska is currently not paying any supplemental UPL payments to providers. Given the benefit of UPL payments to providers and the State, we strongly recommend that if Alaska implements a provider tax program, it should also implement a supplemental UPL payment program.

The UPL calculation is performed as follows:

A. Calculate a reasonable estimate of what Medicare would have paid Alaska Medicaid patients if they were paid using Medicare reimbursement principles (referred to as the

upper limit). There are many different methods that can be used for this calculation, including substituting actual costs for the estimated Medicare ceiling. The methods we modeled are discussed in each provider class section of this report.

B. Identify the actual payments paid by the Alaska Medicaid program for these patients.

C. A – B equals the UPL gap that can be distributed to providers as a supplemental payment.

Supplemental UPL payment programs are most commonly applied to institutional based providers such as nursing facilities and hospitals. This is mainly due to the availability of data to calculate the UPL gap. These provider types are required annually to submit significant amounts of data, such as annual cost reports, to state and federal agencies. Therefore, because comprehensive data is so readily available for them, calculating a UPL gap and implementing supplemental UPL payments is generally much simpler for nursing facilities and hospitals.

2. Nursing Facility UPL Recommendation

The nursing facility UPL was calculated using several methods with the goal being to create the highest possible gap, as that increases the potential supplemental payments the State may pay providers, thereby mitigating liability to the providers at little to no expense to the State. The final methodology used was a cost-based UPL. The UPL gap was determined by comparing the actual costs incurred by providers to the payments they received from Alaska Medicaid. Costs were taken from the 2014 Medicare cost reports and inflation was applied from the midpoint of each provider’s cost report period to the midpoint of the 2016 state fiscal year (SFY). Medicaid payments were estimated by multiplying the SFY 2016 Medicaid rate for each provider by an estimate of Medicaid days (based on the 2014 Medicare cost reports). The difference between these estimates, the UPL gap, was calculated for each provider. Since the cost of the tax is an allowable expense that can be added to the UPL, the Medicaid share of each provider’s projected provider tax was then added to determine a final UPL gap. The total gap for private and non-state government owned facilities (designations used in the calculation as required by CMS) was determined by adding the individual facility gaps together.

The UPL analysis described above produced the following UPL gap amounts for each model presented in Section 2 of this report:

Model 1 – Conservative Approach = $10.4 million

Model 2 – Aggressive Revenue Maximizing Approach = $13.6 million

This means that the State could make additional payments to providers totaling between $10.4 million and $13.6 million. However, a lesser amount of the UPL gap was distributed to providers in the Models presented in Section 2 to ensure additional revenue for the State.

3. Distribution of UPL Payment

The entire UPL is calculated on a facility-by-facility basis where we calculate each facility’s UPL compared to its Medicaid payments. We used this to determine a UPL gap for each individual

provider. However, as alluded to above, CMS only considers subtotals by ownership class, not for each facility. Therefore, in the UPL, the providers' individual UPL amounts are subtotaled and separated by the ownership classes of private, non-state government owned/operated, and state owned/operated. This means that an individual facility within the ownership class is allowed to be paid Medicaid funds that are higher than the UPL limit, as long as the sum of the ownership class is not overpaid. The table below summarizes the UPL for nursing facilities. It identifies the UPL limit calculations by provider and is organized by ownership class, for the UPL calculation.

Table 1: Calculation of Nursing Facility UPL (Conservative Approach)

Facility Name	Medicaid Costs Inflated to 12/31/15	MCD Payments SFY '16	UPL Gap
Non-State Government Owned (NSGO)			
Central Peninsula/Heritage Place	$6,685,890	$6,770,354	$(84,464)
Cordova Community Medical Center	3,572,213	2,887,862	684,351
PeaceHealth Ketchikan	5,383,153	4,192,553	1,190,600
Petersburg Medical Center	3,016,436	2,960,341	56,095
Providence Seward Mountain Haven	10,272,999	9,562,961	710,038
Providence Valdez Hospital	3,156,441	3,226,994	(70,553)
Sitka Community Hospital	3,972,253	4,061,612	(89,359)
South Peninsula Hospital	8,511,296	8,284,969	226,327
Wrangell Medical Center	2,132,214	1,839,933	292,281
Total NSGO	$46,702,895	$43,787,580	$2,915,315
Add: Medicaid Share of Assessment			1,850,818
Final UPL Gap			$4,766,133
Private Owned			
Denali Center	$16,310,372	$14,084,482	$2,225,890
Prestige Care & Rehabilitation Center	8,857,838	9,022,503	(164,665)
Providence Extended Care (PEC)	22,141,792	23,148,061	(1,006,269)
Providence Island Kodiak Medical Center	6,065,106	4,795,552	1,269,554
Providence Transitional Care Center	4,230,616	2,592,417	1,638,199
Wildflower Court	10,139,090	10,895,971	(756,881)
Total Private Owned	$67,744,814	$64,538,986	$3,205,828
Add: Medicaid Share of Assessment			2,461,537
Final UPL Gap			$5,667,365

Since CMS only considers UPL subtotals by ownership class, the UPL gap is distributed to facilities within each ownership class as a supplemental payment on a prorated basis. This is

usually accomplished using a Medicaid statistic like number of Medicaid days per year. Our recommended nursing facility model allocated payments using Medicaid days. The following table lists the modeled UPL supplemental payments for each facility organized by ownership class.

Table 2: Distribution of Nursing Facility Supplemental UPL Gap to Providers (Conservative Approach)

Facility Name	MCD Days	% of Days	UPL Distribution
Non-State Government Owned			
Central Peninsula/Heritage Place	14,505	25.35%	$770,943
Cordova Community Medical Center	3,319	5.80%	176,405
PeaceHealth Ketchikan Medical Center	5,531	9.67%	293,973
Petersburg Medical Center	3,905	6.83%	207,551
Providence Seward Mountain Haven	10,573	18.48%	561,957
Providence Valdez Hospital	3,298	5.76%	175,289
Sitka Community Hospital	4,243	7.42%	225,516
South Peninsula Hospital	8,922	15.59%	474,206
Wrangell Medical Center	2,919	5.10%	155,145
Total Non-State Government Owned	57,215	100.00%	$3,040,986*
Private Owned			
Denali Center	21,187	19.70%	$712,313
Prestige Care & Rehabilitation Center	23,105	21.48%	776,797
Providence Extended Care (PEC)	32,520	30.24%	1,093,332
Providence Island Kodiak Medical Center	6,567	6.11%	220,785
Providence Transitional Care Center	4,714	4.38%	158,486
Wildflower Court	19,463	18.10%	654,352
Total Private Owned	107,556	100.00%	$3,616,066*

* This represents paying 63.8% of the UPL gap calculated in Table 1. Only a portion of the gap was distributed so that some of the tax assessment can be kept by the State as additional State revenue.

E. Fee vs. Tax

The distinction between tax and fee has implications of how the provider assessment is administered. Based on our research of federal rules regarding provider taxes, we believe a health care tax is more appropriately considered a fee rather than a tax. There is some gray area between the two terms, but the distinction based on court decisions appears to be in the purpose and usage of the collection. The purpose of a tax is to raise revenue for the taxing authority to be used generally for the benefit of all under its jurisdiction. A fee is imposed specifically on certain targeted entities/parties for purposes of paying for the costs of something for which the payer of the fee benefits. Because stakeholders and states tend to use the term tax more commonly in

conversations regarding health care assessments, our report uses the terms tax, fee, and assessment interchangeably.

The distinction between tax and fee is important to Alaska because our recommendation includes a plan for generating revenues from nursing facilities that will then be used for reimbursement enhancements for those same facilities. Thus our recommendation would be considered a fee rather than a tax even though it is referred to as a provider tax. Most states handle the processing of such provider tax receipts within the agency responsible for reimbursing the provider group being assessed. Because the DHSS is responsible for Medicaid reimbursement to nursing facilities and is already equipped to handle the operations necessary to implement a nursing facility provider tax, we do not believe there is a need to involve any other departments (i.e., the taxing and revenue-collecting arm for the State) in this program.

F. Taxing Non-Profits

1. General Discussion

Related to the discussion of tax vs. fee is the concern about whether non-profits can be included in the provider tax. Alaska code currently contains a provision for a nonprofit exemption from Alaska's Corporate Income Tax. For purposes of the Corporate Income Tax, Alaska adopts large portions of the Internal Revenue Code (IRC) by reference (see AS 43.20.021). The IRC exempts nonprofits from taxation (see I.R.C. § 501(c)(3)). Therefore, nonprofit corporations are exempt from Alaska Corporate Income Taxes. Part of this study included researching this code to determine if this would apply to the healthcare assessments being evaluated for a provider tax.

The above citation appears to refer to income taxes (Alaska corporate income tax, which incorporates the Internal Revenue Code, Section 501 by reference). We do not believe a health care provider tax is an income tax in that context (see Section E. Fee vs. Tax). Therefore, since we believe that it is most appropriate to consider health care taxes as fees, we conclude that non-profits can be included in a health care tax.

2. Non-Profit Nursing Facilities

Again, the biggest distinction between tax and fee is the entities that benefit from the revenue generated, with fees mainly benefitting the providers that pay it. The proposed nursing facility provider assessment would pay additional reimbursement to all fifteen (15) nursing facilities that would pay the assessment. In all but one case, this additional reimbursement would exceed the assessment paid. The one facility that would have a net loss is a non-profit facility but the net loss of that facility is offset by the net gain of its sister facility. Thus, in the case of non-profits, all of the non-profit nursing facilities would have a net gain except one and that facility's loss is actually counteracted by the gain of its related party facility. We recommend that the non-profit nursing facilities be included in the provider tax and, in fact, believe that they should want to be included in order to maximize their own benefits.

4. Project Process

Federal regulations addressing permissible health care related taxes are located at 42 CFR 433.56 and permit states to tax health care providers and use these funds as the state-share of Medicaid program expenditures. While these federal regulations permit health care taxes on a wide range of providers and services, the most frequently taxed entities among state tax programs are typically those that provide the highest volume of Medicaid services, including nursing facilities, hospitals, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), and managed care organizations.

The project processes used in this study were as follows and are described in detail below:

A. Identify all potential classes of health care providers that may be assessed a tax in accordance with federal rules.

B. Initiate stakeholder involvement through an in-person project kick-off meeting.

C. Determine which classes can be eliminated as unfeasible either immediately or upon further modeling or research.

D. Focus stakeholder involvement through webinars and breakout meetings for the remaining classes still considered feasible for a tax. Classes continued to be eliminated after further research.

A. Permissible Classes for Taxing

As outlined in the federal regulations at 42 CFR 433.56, following is a list of the permissible classes of health care providers and services for taxing:

1. *Inpatient hospital services*
2. *Outpatient hospital services*
3. *Nursing facility services*
4. *Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)*
5. *Physician services*
6. *Home health care services*
7. *Outpatient prescription drugs*
8. *Services of managed care organizations*
9. *Ambulatory surgical center services*
10. *Dental services*
11. *Podiatric services*
12. *Chiropractic services*

13. *Optometric/optician services*
14. *Psychological services*
15. *Therapist services*
16. *Nursing services*
17. *Laboratory and x-ray services*
18. *Emergency ambulance services*
19. *Other health care items or services on which the state has enacted a licensing or certification fee*

B. Project Kick-Off Meeting

On October 2, 2015, a project kick-off meeting was held for all provider categories and stakeholders identified in Section A above. This meeting was held in Anchorage as both an in-person meeting and a webinar for those who could not attend in person. This meeting was very thorough and was intended to be educational and to provide background on the processes, terminology, time lines, and options that would be included in the modeling and final report. Following is a high-level summary of the presentation and discussion:

- *Background and intent of the study*
- *Detailed work plan for the project*
- *Description and definition of provider taxes*
- *Narrowed scope from classes already eliminated as not feasible for a tax*
- *Explanation of classes still being evaluated for a tax*
- *Description of who regulates provider taxes, CMS restrictions, and provider protections*
- *Tax modeling approaches and evaluating financial impact to providers*

C. Classes Eliminated from the Study

The first step in this project was to meet with the DHSS and identify any provider classes that could be immediately eliminated from the study. Many of these were immediately eliminated based on high-level, obvious reasons for excluding the provider class from the study. Others were eliminated after performing additional review and modeling.

Following is a list of the providers eliminated and the reasons for elimination:

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

There are no ICF/IID facilities in Alaska. Therefore, a tax on this provider class is not possible.

Physician Services

Unlike institutional-based providers such as hospitals and nursing facilities, providers in this class are not subject to regular financial reporting requirements by the State or federal government.

Without regular financial reporting, there is inadequate data to base a tax on, so we eliminated this class from the study on grounds that a tax is not immediately feasible.

Managed Care Organizations

Alaska's health care system is fee-for-service, meaning there are no managed care organizations in the State. Therefore, a tax on this provider class is not possible.

Dental Services

Unlike institutional-based providers such as hospitals and nursing facilities, providers in this class are not subject to regular financial reporting requirements by the State or federal government. Without regular financial reporting, there is inadequate data to base a tax on, so we eliminated this class from the study on grounds that a tax is not immediately feasible.

Podiatric Services

Unlike institutional-based providers such as hospitals and nursing facilities, providers in this class are not subject to regular financial reporting requirements by the State or federal government. Without regular financial reporting, there is inadequate data to base a tax on, so we eliminated this class from the study on grounds that a tax is not immediately feasible.

Chiropractic Services

Unlike institutional-based providers such as hospitals and nursing facilities, providers in this class are not subject to regular financial reporting requirements by the State or federal government. Without regular financial reporting, there is inadequate data to base a tax on, so we eliminated this class from the study on grounds that a tax is not immediately feasible.

Optometric/Optician

Unlike institutional-based providers such as hospitals and nursing facilities, providers in this class are not subject to regular financial reporting requirements by the State or federal government. Without regular financial reporting, there is inadequate data to base a tax on, so we eliminated this class from the study on grounds that a tax is not immediately feasible.

Psychological Services

Unlike institutional-based providers such as hospitals and nursing facilities, providers in this class are not subject to regular financial reporting requirements by the State or federal government. Without regular financial reporting, there is inadequate data to base a tax on, so we eliminated this class from the study on grounds that a tax is not immediately feasible.

Therapist Services

Unlike institutional-based providers such as hospitals and nursing facilities, providers in this class are not subject to regular financial reporting requirements by the State or federal government. Without regular financial reporting, there is inadequate data to base a tax on, so we eliminated this class from the study on grounds that a tax is not immediately feasible.

Nursing Services

Unlike institutional-based providers such as hospitals and nursing facilities, providers in this class are not subject to regular financial reporting requirements by the State or federal government. Without regular financial reporting, there is inadequate data to base a tax on, so we eliminated this class from the study on grounds that a tax is not immediately feasible.

Lab and X-Ray Services

42 CFR 433.56 defines this class as “services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department.”

Freestanding x-ray facilities in Alaska are known as independent diagnostic testing facilities. While these facilities are subject to Alaska’s certificate of need program, among other requirements, they are not licensed by the DHSS. Since the facilities are not licensed, and since the federal definition excludes laboratory or x-ray services provided in a physician’s office, hospital inpatient department, or hospital outpatient department, it is difficult to identify a reliable list of active independent diagnostic testing facilities that would fall within this class. Moreover, these facilities are not subject to regular financial reporting requirements, so there is inadequate data to base a tax on, and we eliminated this class from the study on grounds that a tax is not immediately feasible.

Emergency Ambulance Providers

Unlike institutional-based providers such as hospitals and nursing facilities, providers in this class are not subject to regular financial reporting requirements by the State or federal government. Without regular financial reporting, there is inadequate data to base a tax on, so we eliminated this class from the study on grounds that a tax is not immediately feasible.

Home Health Agencies (HHA)

The State had a significant amount of HHA data on file and we initially considered this provider type to be a good candidate for further review. Before conducting any breakout sessions with this group, we obtained provider cost reports and Medicaid payment logs and conducted the following analyses:

- *Identified 14 facilities with total Medicaid-base payments of approximately $1 million annually.*
- *Modeled a new supplemental UPL payment calculation identifying potential UPL payments to providers of approximately $250,000.*
- *Modeled a provider tax large enough to cover the state share of the supplemental UPL payment in addition to generating a small amount of excess revenue to the state.*

We were unable to find any scenarios in our models that included paying a supplemental payment and assessing a tax that was equitable among providers. Every model resulted in two providers netting large gains with the remaining twelve providers netting losses. Given this disparity and the low potential for material revenue to the State, a tax on this provider type is not immediately feasible.

Other Health Care Items or Services on which the State Has Enacted a Licensing or Certification Fee

The “other” class is a non-specific category in 42 CFR 433.56. The CFR defines this class as “Other health care items or services not listed above on which the State has enacted a licensing or certification fee.”

Because the provider types in the other class are not specifically defined in the federal rule, states are at liberty to select the specific classes of providers to include in this class. The preliminary list of provider classes Alaska wanted to evaluate for a potential provider tax was as follows:

- *Behavioral health*
- *Personal care agencies (PCAs)*
- *Residential psychiatric treatment centers (RPTCs)*
- *Home and community based waiver services (HCBS)*

Ultimately, a tax on these four provider types is not possible. The purpose of the other class in 42 CFR 433.56 is not to allow states to establish taxes on new provider types. Rather, it is intended to ensure that states are not precluded from administering licensing and certification fees for programs with other provider types. Furthermore, the other class has an additional restriction that revenue from the licensing and certification fees cannot exceed the cost to the state for operating the corresponding licensing and certification program.

In conclusion, Alaska could impose new licensing and certification fees on behavioral health providers, PCAs, RPTCs, and HCBS providers, but the fees would be limited to the cost of administering the licensing and certification effort. Given that the intent of this study is to evaluate the feasibility of a health care provider tax, and given that feasibility for this study is understood to mean a balance between generating new revenue and not creating an administrative burden for providers, we eliminated this class from the study on grounds that a tax is not immediately feasible because it will not generate additional revenue for the State.

D. Stakeholder Involvement and Breakout Meetings

Success of a potential tax program depends heavily on close collaboration between the governing agency and the impacted providers. Involvement and input of all stakeholders from the project onset is important to ensure that the calculation, data input, and methodologies are transparent and the participating entities have a vested interest and stake in the success of the program. In addition, an open and transparent process helps providers understand the tax program, which will enable them to plan appropriately for the impact the program will have on their organizations.

Stakeholder involvement was accomplished by having a series of in-person meetings, on-line webinars, and conference calls. Providers were encouraged to ask questions in person or type their questions directly onto the webinar page. Webinars were recorded for future viewing and reference. Access to the recordings can be found at the following website:

http://dhss.alaska.gov/HealthyAlaska/Pages/Medicaid_Redesign.aspx

After the all-provider project kick-off meeting discussed in section B, separate webinars and conference calls were presented for specific provider types. Each webinar began by explaining the data sources that were used to generate the models, followed by a walk-through of the models. The models were presented in a Microsoft Excel format and were set up to be very flexible and dynamic. We provided several different items that could serve as the tax base (such as net patient revenue or units). We described how the models would impact providers based on different scenarios.

Financial impact on providers was shown by illustrating the impact on three example types of providers: low, medium, and average levels of Medicaid utilization. The model for each type of provider identified how the tax may be assessed, any supplemental payment calculations, and the final fiscal impact to each example provider. In addition, the model included a summary page that identified the total statewide impact for taxes assessed to all providers, the total supplemental payments to all providers, and the net amount realized by the State from all programs.

These breakout sessions were held with the following provider classes:

- *Hospitals and Nursing Facilities*
- *Ambulatory Surgery Centers*
- *Outpatient Pharmacy Providers*

The results from the breakout sessions are further discussed in the following sections.

5. Possible Future Recommendations

Included in this section of our report are other provider tax classes and other aspects of a provider tax program that the State may want to consider implementing in the future. However, as we evaluated these classes and factors, there are certain issues and challenges, as described further below, that prevent us from recommending implementation of these items at this time.

A. Inpatient Hospital and Outpatient Hospital Tax

1. Why This Class is an Option

Within Medicaid provider tax programs, hospitals are the second most taxed provider group after nursing facilities. The feasibility of inpatient hospital and outpatient hospital tax programs in Alaska were heavily analyzed during this study, and our initial analysis suggested that these could possibly be included as an immediately feasible tax option because of the number of providers, the Medicaid enrollment of all providers, and the availability of data from a common data source such as Medicare cost reports. However, during the study of this provider group, a number of challenges were encountered, mainly related to the availability of current data from the State's MMIS. Because of these factors, we believe a tax is feasible in the very near future, but further study and evaluation of inpatient hospital and/or outpatient hospital tax programs are recommended before such programs are implemented.

2. Inpatient Hospital and Outpatient Hospital Tax Challenges

The challenges and constraints impacting inpatient and outpatient hospital tax program are as follows:

a) Old Data

State Medicaid programs utilize a computerized system known as a MMIS to collect claims billed by providers, to pay providers, and maintain beneficiary and provider enrollment information and many other data elements. The MMIS is an integral data warehouse and reporting tool for obtaining information for Medicaid program oversight and data analysis purposes, including data needed for UPL demonstrations and provider tax calculations. In October 2013, Alaska implemented a new MMIS. However, due to challenges with the new system, some of the reporting functionality of the MMIS that would have enabled the generation of reports and summary data needed for the most reliable UPL and tax calculations was not yet in place at the time of our study. Therefore, for purposes of this study, we utilized MMIS data prior to the MMIS conversion. Although using older data enabled us to generate provider tax models, calculate UPL supplemental payments to providers, and model scenarios and outcomes, because the data is from 2012 and early 2013, it is difficult to recommend models for implementation because the outcomes from the models could change when current data is available for use. Therefore, we recommend revisiting the UPL and tax calculations when the State's MMIS system can provide more current reports.

b) High Variability in Winners and Losers

Unlike the nursing facility tax modeling, our study of the inpatient and outpatient hospital tax models revealed that there would be a high degree of variance in the impact of a provider tax program among providers. This is primarily due to significant differences in size and Medicaid patient volume of Alaska hospitals. While some providers would benefit financially, others would pay significantly more in taxes than they would potentially receive in tax-funded payment increases or supplemental payments. This is not uncommon in a provider tax program as typically there are some winners and some losers; however, the wide variance among provider size and Medicaid volume in Alaska could result in a tax program that is difficult to sustain for some hospitals. The State is not aware of any issues relating to the ability of Medicaid beneficiaries to access hospital services. Therefore, because there are no access to care issues, a provider tax program that negatively impacts some providers, should be reviewed very carefully.

c) UPL Challenges: Inpatient Hospital

In a provider tax program with a goal of offsetting the tax liability on providers through supplemental Medicaid payments, the available UPL room or gap is of particular importance because it dictates the maximum amount that can be distributed to providers through the supplemental payments.

During the study, we evaluated different methodologies and approaches for calculating an inpatient hospital UPL that produces enough gap to make additional payments to providers feasible. There are many different UPL methodologies that can be employed, so the goal was to find the method that produces a UPL gap that results in the highest possible supplemental UPL payments to providers.

Cost Based UPL

One methodology analyzed was a cost-based methodology that calculates what Medicare would pay using actual cost from each provider’s cost report compared to actual payments made by Alaska Medicaid. This method produced the smallest UPL gap.

Per Discharge UPL

We also studied another methodology that in our experience typically produces a favorable UPL gap. This methodology is based on an estimate of what Medicare would pay for Medicaid services on a per-discharge basis. This calculation incorporates Medicaid and Medicare payments, Medicare and Medicaid discharges, and a case mix index (CMI) adjustment to adjust for the inherent differences between Medicare and Medicaid services.

Unfortunately, there are too many uncertainties to produce a useable UPL gap with this methodology. Uncertainties pertain to the data used in the demonstration, both in the age of the data (because of the absence of more current available data due to the aforementioned issues with the State’s MMIS reporting functionality), as well as differences between the Medicaid discharge data used in the calculation and what is reported on providers’ Medicare cost reports. There are also different methodologies for applying the CMI adjustment that can produce different results. All of those issues can cause the UPL gap to swing by millions of dollars. Because the swings are so material, this methodology is not useable at this time.

d) UPL Challenges: Outpatient Hospital

Similar to the inpatient hospital tax study, we analyzed different methodologies and approaches for calculating an outpatient hospital UPL. These primarily involved different types of cost-based UPL calculations as these typically produce a higher UPL gap than other outpatient UPL approaches, such as Medicare payment methodologies. The cost based approaches analyzed were a total cost-to-charge ratio methodology, a Medicare cost-to-charge ratio methodology, and an individual cost center cost-to-charge ratio methodology.

Similar to the inpatient hospital UPL, there are some uncertainties regarding the amount of UPL room available. Although we analyzed a number of different UPL methodologies, these methodologies did not produce substantial UPL gaps. This may be due in part to the State's payment rates that are based on cost, resulting in payment levels that are currently in line with an estimate of what Medicare would pay using cost. In addition, similar to inpatient, one factor is the age of the data because of the issues with Alaska's MMIS reporting capabilities. Because of the age of the data and the insignificant UPL gaps produced, we believe the UPL gap, supplemental payment calculations, and tax modeling should be updated to reflect more current data when it becomes available.

3. Overcoming Inpatient Hospital and Outpatient Hospital Tax Challenges

A first step towards mitigating the challenges faced in implementing a feasible inpatient and/or outpatient hospital tax is to update the tax and UPL calculations with data that is as current as possible, preferably no more than one or two years old. This may not be immediately possible given the MMIS reporting issues described above; however, we understand these issues are being actively worked on and may be close to being resolved.

Second, we recommend the State work closely with the Alaska State Hospital and Nursing Home Association regarding the structure of the tax model with respect to the distribution of any payment increases to providers as there may be other options beyond the allocation basis in the modeling that was based on cost report data.

Third, we believe further analysis of the inpatient and outpatient hospital UPL demonstration methodologies would be prudent as more study of these calculations, in conjunction with updated MMIS reporting, may produce the desired results.

A web link to the model can be found at Appendix C.

4. Pay Percentage of Cost and Fund the Remaining Gap with Provider Tax

Another approach Alaska could consider is reducing regular Medicaid inpatient and/or outpatient hospital payment rates below actual cost, and then funding the reduced rates back to cost using supplemental UPL payments from an inpatient hospital and/or outpatient hospital tax program.

A reduction in rates would equate to an instant savings to the State. It would also increase the UPL gap for increased supplemental payments. Since supplemental UPL payments are predominately funded by the tax revenue and the Federal Medicaid Assistance Percentage (FMAP), under ideal conditions, the State would effectively maintain existing rates, but at a lower cost to the budget because a portion of general funds would be replaced by tax revenue and

federal funds. Following is a summary of a modeled inpatient rate reduction of 2%, including a supplemental UPL payment and provider tax.

Inpatient 2% Rate Reduction Model

Provider Name	Estimated Rate Reduction	Estimated Assessment	Estimated UPL Payment	Net Impact - Profit / (Loss)
Providence Alaska Medical Center	$(1,204,720)	$(560,045)	$1,081,842	$(682,923)
Mat-Su Regional Medical Center	(176,927)	(97,993)	117,636	(157,284)
Bartlett Regional Hospital	(92,002)	(46,295)	124,485	(13,812)
Fairbanks Memorial Hospital	(224,801)	(172,083)	164,524	(232,360)
Alaska Regional Hospital	(204,388)	(173,256)	140,970	(236,673)
Central Peninsula Hospital	(108,719)	(61,047)	103,539	(66,227)
Providence Valdez.	(8,676)	(2,269)	2,509	(8,436)
Providence Seward	(1,142)	(471)	564	(1,048)
Sitka Community Hospital	(6,256)	(4,746)	3,575	(7,427)
Petersburg Medical Center	(1,370)	(1,008)	1,819	(560)
Wrangell Medical Center	(1,415)	(1,622)	941	(2,097)
Providence Kodiak Island	(38,604)	(11,782)	21,308	(29,078)
Cordova Community	(55)	(296)	251	(100)
PeaceHealth Ketchikan	(45,600)	(16,254)	46,345	(15,509)
South Peninsula Hospital	(29,863)	(10,587)	39,823	(628)
St. Elias Specialty Hospital	(106,555)	(58,099)	67,623	(97,030)
North Star Hospital	(288,514)	(224,647)	966,671	453,510
Total	$(2,539,605)	$(1,442,500)	$2,884,424	$(1,097,682)
State Share	50%			
Savings to State	$(1,269,803)			

A web link to the detailed model can be found at Appendix D.

a) Paying a Percentage of Cost Challenges

A model of this nature would achieve state savings through lower initial reimbursement rates. However as described previously, due to the differences in size and volume of hospitals, and depending on the methodology in which payment increases are distributed to hospitals, some hospitals could benefit more greatly than others. In addition, a program such as this may be looked upon unfavorably by hospitals if their total reimbursement level is the same because the hospitals would then be contributing a portion of the state share of their payment rather than the state paying the state share.

b) Overcoming Paying a Percentage of Cost Challenges

We understand that access to more current MMIS data is being developed and is expected soon. Once this data is available, we recommend updating our modeling of various rate reduction percentages in order to determine the actual impact of these reductions to each individual facility.

As described above, it is critical to identify the actual impact for each individual facility because some hospitals may benefit more than others based on size and volume of Medicaid services. This means the hospitals that benefit less could be vulnerable to total Medicaid reimbursement that is below cost.

B. Ambulatory Surgery Center (ASC) Tax

1. Why This Class is an Option

ASCs were another class of providers that initially appeared to be immediately feasible for a tax in Alaska. This was especially supported by the number of providers and the available UPL gap for supplemental payments to allow for revenue to the State while mitigating liability to providers.

2. ASC Tax Challenges

The challenges impacting an ASC tax program are as follows:

a) Available Data

Alaska reimburses ASCs using a methodology that is based on Medicare's ASC payment system. Under this system, the surgical procedure performed, as specified by the procedure code recorded on the claim, is assigned to a pre-defined payment group to determine the payment rate. Because the reimbursement methodology does not require information from ASC providers other than what is coded on the claim submitted to the MMIS for payment, the State does not collect any type of regular financial reports from ASC providers. Without cost reports or financial statements, there is no mechanism in place for collecting non-Medicaid data to use for tax modeling. Therefore, for purposes of ASC tax modeling, Medicaid data was used as a substitute for total facility information. For example, because total net patient revenue was not available, the provider's billed charges from Medicaid claims data was substituted as a proxy amount for net patient revenue. While this approach to modeling produces a conservative (low) outcome from the perspective of the taxable basis because Medicaid charges are likely significantly lower than total net patient revenue, the outcomes are unreliable for decision-making purposes because not all ASCs serve Medicaid recipients, and for those that do, Medicaid likely represents a small percentage of patient volume. Therefore, without actual financial information from ASCs, it is impossible to estimate the impact of a tax on this provider class.

3. Overcoming ASC Tax Challenges

Because there is no current need for the State to collect financial data from ASCs under the existing Medicaid rate structure, if an ASC tax program is considered further, Alaska should develop a data collection process in order to obtain comprehensive financial data from ASCs.

A web link to the model can be found at Appendix E.

C. Pharmacy Tax

1. Why This Class is an Option

Pharmacy providers were considered to be a viable option for Alaska because of the volume of providers in this class and because of the availability of a recent cost study conducted by the State. There are approximately 113 in-state pharmacy providers so even a small tax could generate revenue for the State. However, structuring a pharmacy provider tax and related reimbursement changes to have minimal impact to providers presents a unique challenge.

2. Pharmacy Challenges

The challenges impacting a pharmacy tax program are as follows:

a) Mechanism to Enhance Reimbursement

The greatest obstacle to implementing a pharmacy provider tax is finding a mechanism to enhance pharmacy reimbursement to help mitigate liability to providers in a new tax system. For nursing facilities and hospitals, we were able to model rate enhancements in the form of supplemental UPL payment programs. After discussing the current reimbursement of pharmacies with the State pharmacy program staff, it was determined that the current reimbursement for ingredient costs and dispensing fees has little or no room for increases using a UPL methodology. Since these are the two components of Medicaid pharmacy reimbursement, this leaves few options for offsetting the cost of a new provider tax.

One mechanism that is available is to pass-through the Medicaid share of the assessment through an add-on to the dispensing fee. This has been implemented in at least one other state (Mississippi). However, this would only pass-through a portion of the assessment paid by each pharmacy and even with such a pass-through, a provider tax would still result in a net loss for every provider. That loss being the tax paid on the non-Medicaid share of services.

b) Clinical Reimbursement Programs

There is a potential opportunity in the future that may make a pharmacy provider tax feasible involving the development of clinical reimbursement programs such as medication therapy management. The State's pharmacy program manager suggested that implementing clinical reimbursement programs could enhance pharmacy reimbursement and may improve access to some services. Implementing a system like this would require a significant amount of resources and data collection.

c) Stakeholder Input

Another challenge we experienced in our evaluation of a provider tax for pharmacies is minimal input from stakeholders. Although we held a pharmacy-specific webinar and the DHSS posted a public version of our pharmacy provider tax modeling, we did not receive any comments or input from Alaska pharmacy providers.

d) Data Availability

Our review of a potential tax was based on a 2012 Medicaid Dispensing Fee Study. Because of the reimbursement system in place for pharmacies, Alaska does not currently have a need to collect any form of financial reporting or data from pharmacies on a regular basis. Therefore, the data used in the 2012 study was the most currently available data.

3. Overcoming Pharmacy Challenges

While a pharmacy provider tax does have potential, it is not immediately feasible due to challenges in finding balance between generating revenue for the State and minimizing the impact to providers. We believe the first step for pursuing a pharmacy tax is to develop a work group consisting of providers, the pharmacy association, and the DHSS to begin studying the potential for a clinical reimbursement program. If at that time the State believes there is potential for some rate enhancements, then the State should consider conducting its Medicaid Dispensing Fee studies more frequently so data will be available to determine a tax basis.

A web link to the model can be found at Appendix F.

D. Enhancing Disproportionate Share Hospital (DSH) Payments

1. Why This is an Option

The State of Alaska administers a federally funded DSH payment program. The DSH program is meant to provide additional compensation to hospitals related to their uncompensated costs of providing care to patients with no insurance. The funding comes in the form of a federal allotment that is determined annually by CMS. The allotment is a fixed amount that the State may draw down either all, or a portion of, the allotment. Alaska's current state share on these allotments is 50%.

The annual federal allotment to Alaska is currently approximately $40 million dollars. This means that the federal government will match the State for a maximum $40 million in total funds (i.e., $20 million State; $20 million Federal). The State has historically only put up $10 million to produce a combined $20 million in total funds for DSH payments. Therefore, the State has an opportunity to draw down substantially more DSH funding. We believe that the DHSS should study this program in the upcoming year to determine whether expanding it to draw down the additional federal funds is a beneficial opportunity for the State of Alaska. Due to the challenges identified below, we were unable to conclude whether expanding the DSH program would be beneficial for Alaska.

2. DSH Challenges

The challenges impacting the DSH program are as follows:

a) Maximizing Federal Allotment

If Alaska were to maximize the use of the entire $40 million DSH allotment, the State will need to find a way to fund the 50% state share of the additional money drawn down. We recommend that the State consider assessing a provider tax on at least the additional DSH allotment drawn down.

b) Number of Providers Paid DSH Funds

Attachment 4.19-A, Section XI, of the Alaska State Plan addresses the DSH payment classifications and which provider types may qualify for a DSH payment distribution. The State Plan is consistent with federal regulations, but it imposes additional requirements to qualify for a DSH payment that goes beyond the federal rules.

The federal regulations for DSH qualifications are much broader and allow payments to reach more hospitals. The federal regulations require the following mandatory requirements be met to qualify for DSH payments:

- *Medicaid inpatient utilization rates (Medicaid % of total days) be greater than 1%.*
- *The hospital must have at least two obstetricians who had staff privileges at the hospital who agree to provide obstetric services to Medicaid-eligible individuals during the DSH year. In the case of a hospital located in a rural area, the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.*
- *The hospital should report their total uncompensated cost of care (total cost of services less payments) for services provided to uninsured patients. The DSH payment to each hospital must not exceed their total uncompensated cost of care.*

Under the current Alaska state plan, of the total 18 non-tribal hospitals, only four hospitals qualify to receive DSH payments. If the state plan was less restrictive (i.e., more closely aligned with the broader federal rules), more hospitals may qualify for DSH payments. For example, many states use a formula-driven allocation that distributes the DSH allotment to providers based on Medicaid days and total uncompensated care costs. Again, this type of approach would allow DSH funds to flow to more hospitals in Alaska.

c) Data Not Available to Calculate a Reliable Model

All providers that receive a DSH payment are subject to an audit of those DSH payments three years after the year in which the payments were received. The purpose of the audit is to calculate the total uncompensated cost of care for each provider in the DSH program that year because a provider's DSH payment cannot exceed its audited uncompensated cost of care. If the payment exceeds this limit, the overpayment must be paid back to the State and the federal government.

Because the State is currently only required to audit four hospitals, there is not enough data to model a DSH payment under a new formula-based methodology that pays the entire $40 million federal allotment. The Alaska State Hospital and Nursing Home Association performed a high level data collection of the items needed to model the DSH payment, but we have concerns that the detail is not at the level needed to develop a reliable model. We used this data to model a revised DSH payment distribution, but due to the concerns with the data, we do not believe it is at a level of reliability that should be used to make a recommendation.

We recommend that Alaska begin gathering data from all of the hospitals in order to model a new distribution of the allotment.

3. Overcoming DSH Challenges

The four providers currently receiving DSH payments will be subject to the annual DSH audit beginning in February 2016. The audit requires that detailed data be gathered (referred to as a DSH survey) to calculate each provider's uncompensated cost of care. We recommend that this DSH survey be distributed to all hospitals, not just to the four hospitals subject to the DSH audit. Using these surveys, we suggest modeling a formula driven DSH payment methodology using the data reported on the DSH surveys. We recommend a model that pays based on Medicaid day utilization and total uncompensated cost of care. We also recommend that the model include maximizing the use of the full federal allotment of $40 million.

Once the new DSH payment model has been completed, we recommend modeling a new tax to fund all, or a portion of, the State share of the expanded DSH payment allotment. This could provide significant additional funding to the hospitals at virtually no cost to the State.

A web link to the model can be found at Appendix G.

6. Procedures for Levying Tax and Complying with Federal Reporting

A. Considerations for Managing Provider Assessments

Issues that should be considered when establishing the process for levying and collecting a provider tax include cash flow, availability of data to base the assessment on, agency resources, provisions for encouraging timely payments, and addressing changes of ownership or provider closures. This section will address each of these concerns.

1. Cash Flow

Cash flow is a critical issue for many Medicaid providers especially those that rely heavily on one payer source. The Alaska nursing facilities are heavily dependent on Medicaid payments with over 80% of the State's nursing facility days paid for by Medicaid. Implementing a provider assessment creates a new expense that can disrupt the normal cash flow of the nursing facility business. The nursing facility provider assessment proposals included in this report would produce individual annual facility assessments ranging from a low of approximately $120,000 to a high of almost $1.5 million. Making such large payments can be challenging for providers even when they are tied to Medicaid reimbursement enhancements. At the same time, the State will face its own cash flow concerns related to making supplemental payments that will total over $12 million, requiring more than $6 million in state funds. A couple of options to consider when establishing the provider tax payment schedule and related supplemental payment time line is the frequency in which these payments are made and the due dates for both sets of payments.

The simplest payment schedule would call for one annual assessment payment. This would minimize the administrative burden for both the State and providers. However, in the case of the proposed nursing facility assessment, these payments would be very large and could cause a cash flow issue for providers. Even at the lower proposal of 3.45% of annual NPR, the annual payment would represent more than 40% of the average monthly nursing facility revenue. Timing these payments relatively close to the proposed supplemental payments would mitigate the cash flow issue some, but there will be some gap between when the assessment is paid to the State and when supplemental payments to providers are processed. The State should work with providers to determine a schedule for assessment payments and supplemental payments that will ease cash flow concerns for both providers and the State.

2. Availability of Data

Regardless of the schedule for assessment payments, the State will need access to timely provider data in order to calculate the assessment payment. The availability of this data is another concern that must be addressed. In the case of the proposed nursing facility provider tax, the best available data source for resident day information would be the Medicare cost reports (Form CMS 2552 for hospital-based facilities and Form 2540 for freestanding facilities) in conjunction with the State's MMIS MR-O-14 report. These reports include resident day totals for all nursing facility services and also for Medicare nursing facility services. When determining the data to be used to calculate the assessment, the State should consider the timing of cost report

submissions and reviews. It is not in the State's interest to establish a schedule that forces it to use cost report data that may not be available at the time the calculations are being made.

This concern over the timing of the availability of data is also relevant for the proposed supplemental payment program. However, in this case, not only is the State relying on cost report data, but it is also dependent on the UPL demonstration that will determine the supplemental payment pools for each group of nursing facilities (private and non-state government-owned). Therefore the timing of the UPL demonstration will also be critical to determining the schedule for provider assessment payments since the two sets of payments need to be linked. Again, the State should work with providers to establish a schedule that best meets the needs of providers and the agency. Following is a timeline summarizing the necessary steps and activities:

Alaska Nursing Facility Provider Tax Timeline (SFY '17 example)

Task Name	Start	End	Duration (days)
Cost Report Period Year End 2015 (state fiscal year facilities, calendar year facilities, fed fiscal year facilities)	07/01/14	12/31/15	548
Cost Reports Filed with DHSS (use for patient days and cost)	11/30/15	05/31/16	183
UPL Demonstration Period (SFY '17)	07/01/16	06/30/17	364
Request MMIS Medicaid Day Reports	03/01/16	05/31/16	91
Prepare Draft UPL and Tax Calculations	06/01/16	06/30/16	29
Provider Comment Period	07/01/16	07/31/16	30
Comment Review Period	07/31/16	08/15/16	15
Revised Calculations	08/15/16	08/31/16	16
CMS Review Period for SPA Approval	09/01/16	11/30/16	90
Assessment Payment Window	12/01/16	01/15/17	45
Supplemental Payment Delivery Period	02/01/17	02/15/17	14

Alaska Nursing Facility Provider Tax Timeline

07/01/14 01/01/15 07/01/15 01/01/16 07/01/16 01/06/17 06/30/17

Cost Report Period

Cost Reports Filed with DHSS (days, cost)

UPL Demonstration Period (SFY '17)

Request MMIS Medicaid Day Reports

Prepare Draft UPL and Tax Calculations

Provider Comment Period

Comment Review Period

Revised Calculations

CMS Review Period for SPA Approval

Assessment Payment Window

Supplemental Payment Delivery Period

3. Agency Resources

Another area of concern for establishing the provider assessment collection processes is the resources of the agency responsible for the assessment. The agency's staffing, the agency's ability to process different payment types, and the communications systems between the agency and providers, are all critical to how the State establishes the processes for levying and collecting the assessment. The DHSS will need to determine which staff will manage the provider assessment calculations and collections and whether these activities can be absorbed by the current workforce or if additional staffing is required. The agency will also need to assess its ability to collect payments in different forms such as checks, electronic funds transfers, and credit

card or cash transactions. Finally, the agency will want to review the communications systems it uses to interact with providers (i.e., U.S. mail, electronic mail, provider portals, etc.). All of these aspects of agency resources will be important in developing the provider assessment processes and should be considered when the provider tax rules and regulations are developed.

4. Encouraging Timely Payments

A final area that needs to be considered when establishing the processes for managing the provider assessment is provisions for encouraging timely payments. This might include restrictions on payments to providers, penalties for failure to make timely payments, and the ability for the agency to use its discretion to work with providers that encounter difficulty in making assessment payments. The most straight forward of these provisions is to make supplemental UPL payments contingent on the timely payment of the provider assessment. This contingency could also be extended to regular Medicaid payments, if necessary, by establishing rules that prevent the State from making any Medicaid payments to a provider that has an outstanding assessment balance. Finally, provisions could also be included to assess penalties for late payments. The agency does need to have some flexibility to work with providers in extraordinary cases to manage assessment collections. Providers that encounter cash flow issues due to circumstances beyond their control should not be put in jeopardy by a provider tax program. The State's rules and regulations should include some provision for the agency's leadership to waive late fees or payment holds when a provider fails to make an assessment payment due to an extreme situation. These rules should be worded carefully to avoid creating abuse but they are critical to the management of a provider assessment.

5. Changes of Ownership and Provider Closures

We recommend that Alaska develop clear rules on how to address cases when providers change ownership or close. In these cases it can be difficult to determine which owner is liable for an assessment payment to the State or which owner should receive the benefit of the supplemental UPL payment. We recommend that Alaska create regulations to make this process administratively easy so the State is not in a position of tracking down old owners to collect payments. We recommend making regulations that look forward to which owner maintains the current provider number for that facility. For example, if a provider changed ownership a month before the assessment calculations were made, it would be administratively easier for the State to make the current owner responsible for the assessment payment. This way if the current owner is late on their payment, or does not send in their assessment, the State has a current Medicaid provider number to use to possibly recoup the assessment from regular Medicaid payments. The Wyoming regulations included in Appendix J include an example of language to use.

B. Tracking and Reporting Provider Assessments

There are no federal requirements for tracking and reporting provider assessments. As discussed earlier, provider assessments that include provisions for variable tax rates or that exclude certain providers do require waiver approval from CMS. However, once that approval is gained, there is not an ongoing annual reporting process. Nonetheless, it is possible that CMS could review an ongoing provider tax program and might ask for an updated demonstration that the provider tax complies with the waiver provisions in the federal regulations. For this reason, and to stay informed about the impact of the provider assessment program, it is advisable that the State maintain a tracking and reporting process.

The documentation that the State includes in its tracking and reporting for a provider assessment should include the same documentation used to gain CMS approval as well as an annual record of the collections and use of provider assessment funds. This documentation should include an annual estimate of the revenue that will be generated from the provider assessment. It should also include an annual demonstration that the assessment complies with the federal hold harmless restrictions included in 42 CFR 433.68. The State should also track actual collections for the provider assessment and expenditures made from the funds received.

C. State Plan Amendment Language

Supplemental UPL payment programs must be approved by CMS through a state plan amendment (SPA). The SPA is required because CMS participates in funding the federal share of any UPL payment. Although there are federal rules and limits on how to implement an assessment program, CMS typically does not require any SPA language on the assessment program because they do not participate in any funding related to the actual assessment.

A draft SPA has been included in Appendix H. This draft SPA includes language that corresponds to the methodology used in our models. The draft language should be reviewed and updated if the actual version or data sources change at a later date.

So that Alaska has some examples of statutes and regulations used by other states, we have included examples for the States of Wyoming and Kansas in Appendixes I through L.

7. Appendix

Appendix A through G - Web Link to Models

Following is a summary listing of all of the models presented to the state of Alaska. The models may all be accessed at the following website:

http://dhss.alaska.gov/HealthyAlaska/Pages/Provider-Tax.aspx

A. Nursing Home Tax and UPL Model – Conservative Approach

B. Nursing Home Tax and UPL Model – Aggressive Approach

C. Inpatient Hospital Tax and UPL Model

D. Hospitals – Analysis of Paying a Reduced % of Cost, UPL, and Tax

E. ASC Tax and UPL Model

F. Pharmacy Tax Model

G. DSH Payment Model Maximizing Entire DSH Allotment

Following is a listing of additional Appendix items located on the following pages:

H. Draft Nursing Facility State Plan Amendment

I. Wyoming Nursing Facility Statute

J. Wyoming Nursing Facility Regulations

K. Kansas Nursing Facility Statute

L. Kansas Nursing Facility Regulations

Appendix H – Draft Nursing Facility State Plan Amendment Language

Subject to the provisions of this section, eligible providers of Medicaid nursing home facility services shall receive a *(quarterly, annually, etc. to be determined)* supplemental payment each state fiscal year. Eligible providers include non-state government owned and privately owned providers. Tribal facilities are excluded from this program.

The supplemental payment pool will be based on the aggregate difference in the estimated amount paid by the Medicaid program and the estimated amount that would have been paid under Medicare payment principles in accordance with 42 CFR 447.272 of the federal regulations.

The supplemental payments shall not exceed the upper payment limit as defined in 42 CFR 447.272. The upper payment limit analysis will be performed prior to making the supplemental payments.

The computation of the Medicare upper limit, or the amount that Medicare would have paid under Medicare principles of reimbursement, will be calculated using cost data derived from cost report form CMS 2552-10 for hospital-based facilities and form CMS-2540-10 for freestanding nursing facilities. The cost reports used will be the most currently available reports on file that are not more than two years old. Cost report data will be inflated from the midpoint of each provider's cost reporting period to the midpoint of the state fiscal year. Medicaid payments will be calculated using the Medicaid rates in effect for the state fiscal year multiplied by the Alaska Medicaid days for each provider's cost reporting period. Alaska Medicaid days will be derived from the State's Medicaid Management Information System (MMIS). The estimated Medicaid payments will be subtracted from the Medicare upper limit to arrive at each facility's contribution to the group's aggregate UPL room for each UPL category (private or NSGO).

A portion of the UPL gap for each category (private or NSGO) will be available for distribution to the providers within that ownership class. The supplemental payments will be calculated on an annual basis and paid *(quarterly, annually, etc. to be determined)* to providers. The UPL room for each provider category of NSGO or privately owned will be distributed to each eligible provider within that category based on their percentage of Medicaid patient days. Medicaid day data will be derived from the state's Medicaid Management Information System (MMIS).

Appendix I – Wyoming Nursing Facility Statute (example statute language)

TITLE 42
WELFARE

CHAPTER 8
NURSING CARE FACILITY ASSESSMENT ACT

42-8-101. Short title.

This article shall be known and may be cited as the "Wyoming Nursing Care Facility Assessment Act."

42-8-102. Definitions.

(a) As used in this article:

(i) "Account" means the nursing care facility assessment account created under W.S. 42-8-103;

(ii) "Department" means the department of health;

(iii) "Fiscal year" means the twelve (12) month period beginning October 1 and ending September 30;

(iv) "Medicaid" means as defined in W.S. 42-7-102(a)(iv);

(v) "Medicare resident day" means a resident day funded by the Medicare program, a Medicare advantage or special needs plan or by the Medicare hospice program;

(vi) "Net patient service revenue" means gross inpatient revenues from services provided to nursing care facility patients less reductions from gross inpatient revenue resulting from an inability to collect payment of charges. Inpatient care revenue excludes nonpatient care revenue such as beauty and barber, vending income, interest and contributions, revenues from the sale of meals and all outpatient revenues. Reductions from gross revenue includes bad debts, contractual adjustments, uncompensated care, discounts and adjustments and other revenue deductions;

(vii) "Nursing care facility" means a facility providing nursing care, but does not include a facility solely providing assisted living care, a facility solely providing rehabilitative

services or a facility solely providing a combination of assisted living care and rehabilitative services;

(viii) "Resident day" means a calendar day of care provided to a nursing facility resident, including the day of admission and excluding the day of discharge, provided that one (1) resident day shall be deemed to exist when admission and discharge occur on the same day;

(ix) "Upper payment limit" means the limitation established pursuant to 42 C.F.R. 447.272 that disallows federal matching funds when state Medicaid agencies pay certain classes of nursing care facilities an aggregate amount for services furnished by that class of nursing care facilities that would exceed the amount that would be paid under Medicare payment principles.

42-8-103. Nursing care facility assessment account.

(a) The nursing care facility assessment account is created.

(b) The state treasurer shall invest amounts deposited within the account in accordance with law, and all investment earnings shall be credited back to the account.

(c) The account shall consist of:

(i) Amounts collected or received by the department from nursing care facility assessments under this article;

(ii) All federal matching funds received by the department as a result of expenditures made by the department attributable to the account;

(iii) Any interest or penalties levied in conjunction with the administration of this article.

(d) The account is created for the purpose of receiving funds as specified in this section. Collected assessment funds shall be used to secure federal matching funds available through the state Medicaid plan, which shall be used to make Medicaid payments for nursing care facility services which exceed the amount of nursing care facility Medicaid rates, in the aggregate, as calculated in accordance with the approved state Medicaid plan in effect on October 1, 2010. The fund shall be used exclusively for the following purposes:

(i) To pay administrative expenses incurred by the department or its agent in performing the activities authorized by this article, provided that such expenses shall not exceed a total of one percent (1%) of the aggregate assessment funds collected in the fiscal year;

(ii) To increase nursing care facility payments to fund covered services to Medicaid beneficiaries within Medicare upper payment limits, as negotiated with the department. The upper payment limit for private nursing care facilities, state government-owned facilities and nonstate government-owned nursing facilities shall be calculated by the department using the higher of the cost-based or prospective payment system approach in accordance with the provisions of 42 C.F.R. 447.272;

(iii) To repay the federal government any excess payments made to nursing facilities if the state plan, after approval by the federal centers for Medicare and Medicaid services, is subsequently disapproved for any reason and after the state has appealed. Nursing care facilities shall refund the excess payments to the assessment account. The department shall return the excess payments to the federal government and nursing care facility providers in the same proportion as the original financing. Individual nursing care facilities shall be reimbursed based on the proportion of the individual nursing care facility's assessment to the total assessment paid by nursing care facilities. If a nursing care facility is unable to refund payments as provided in this paragraph, the department shall develop a payment plan and deduct amounts from future Medicaid payments. The department shall refund the federal government for the federal portion of those overpayments; or

(iv) To make quarterly adjustment payments as provided in W.S. 42-8-108.

42-8-104. Assessments.

(a) Each nursing care facility shall pay the nursing care facility assessment to the account in accordance with this article.

(b) The aggregated amount of assessments for all nursing facilities during a fiscal year shall be the lesser of the amount necessary to fund the provisions of this article or the maximum amount that may be assessed pursuant to the indirect guarantee threshold as established pursuant to 42 C.F.R. 433.68(f)(3)(i). The department shall determine the assessment rate prospectively for the applicable fiscal year on a per-resident-day basis, exclusive of Medicare resident days. The per-resident-day assessment rate shall be uniform.

The department shall promulgate rules for facility reporting of non-Medicare resident days and for payment of the assessment.

(c) The department shall collect, and each nursing care facility shall pay, the assessment under this section on a quarterly basis. The initial payment shall be due not later than forty-five (45) days after the state plan has been approved by the federal centers for Medicare and Medicaid services unless a later date is set by the department. Subsequent payments are due not later than forty-five (45) days after the end of each calendar quarter.

(d) Nursing care facility operators may increase their charges to incorporate the cost of paying the assessment under this section, but shall not create a separate line-item charge on the bill reflecting the assessment.

42-8-105. Approval of state plan.

(a) The department shall seek necessary federal approval in the form of state plan amendments in order to implement the provisions of this article.

(b) The department shall adopt rules and regulations necessary to implement the provisions of this article or obtain approval of the state plan amendments.

42-8-106. Multiple facilities.

If a person conducts, operates or maintains more than one (1) nursing care facility licensed by the department, the person shall pay the assessment for each nursing care facility separately.

42-8-107. Penalties for failure to pay assessment.

(a) If a nursing care facility fails to pay an assessment when due under this article, there shall be added to the assessment a penalty equal to five percent (5%) of the amount of the assessment that was not paid when due. The penalty under this section may be waived by the department for good cause. Any payments after a penalty is assessed under this section shall be credited first to unpaid assessment amounts rather than to penalty or interest amounts, beginning with the most delinquent installment.

(b) In addition to the penalty under subsection (a) of this section, the department may implement any of the following remedies

for failure of a nursing care facility to pay its assessment when due under this article:

(i) Withhold any medical assistance reimbursement payments until the assessment is paid;

(ii) Suspend or revoke the nursing care facility's license; or

(iii) Develop a plan that requires the nursing care facility to pay any delinquent assessment in installments.

42-8-108. Quarterly adjustment payments.

(a) Each nursing facility is eligible for quarterly adjustments as provided in this section.

(b) The department shall determine the number of days that nursing care facility services were paid for by the Wyoming medical assistance program for the applicable annual cost report. That number of days shall be utilized by the department to determine the nursing care facility adjustment payment. Adjustment payments shall be paid by the department on a quarterly basis to reimburse covered Medicaid expenditures in the aggregate within the upper payment limit. Each quarterly payment shall be made not later than thirty (30) days after the end of the calendar quarter with the initial adjustment payment due not later than thirty (30) days after the approval by the federal centers for Medicare and Medicaid services of the state's plan reflecting facility adjustment payments.

42-8-109. Discontinuation of the assessment and quarterly adjustment payments.

(a) The assessment imposed by this article shall be discontinued if:

(i) The state plan amendment reflecting the quarterly nursing care facility adjustment payments under W.S. 42-8-108 is not approved by the federal centers for Medicare and Medicaid services. The department may modify the rate adjustment provisions as necessary to obtain the federal centers for Medicare and Medicaid services approval if such changes do not exceed the authority and purposes of this article;

(ii) The department reduces rates to a level less than the rates effective on October 1, 2010 plus revenue increases from the account, including matches by federal financial participation;

(iii) The department or any other state agency attempts to utilize the money in the account for any use other than permitted by this article;

(iv) If federal financial participation to match assessments under this article becomes unavailable under federal law. In such case, the department shall terminate the imposition of assessments beginning on the date the federal statutory, regulatory or interpretive change takes effect.

(b) If collection of the assessment is discontinued as provided in this section, quarterly adjustment payments shall be discontinued and any amount in the account shall be returned to the nursing care facility from which the assessment was collected on the same basis as it was collected.

Appendix J – Wyoming Nursing Facility Regulation (example language)

WYOMING MEDICAID RULES
CHAPTER 7
WYOMING NURSING HOME REIMBURSEMENT SYSTEM

Section 24. Nursing Care Facility Assessment Act.

(a) Nursing facility adjustment payments to providers based on the upper payment limit calculation.

(i) The Department will make adjustment payments to nursing facilities under the provisions of the Nursing Care Facility Assessment Act, W.S. §§ 42-8-101 through 109.

(A) Adjustment payments will be calculated prospectively on an annual basis to be effective from October 1 through September 30 of each year. The adjustments will be paid quarterly. New providers opening during that assessment year will not be included in the program until the next assessment year.

(B) The quarterly adjustment payments will be due to the providers not later than thirty (30) days after the end of each calendar quarter.

(C) Change of ownership. If a facility changes ownership, beginning at the start of the calendar quarter following the date of the change of ownership, the new owner will collect the adjustment payment that was calculated using the prior owner's data.

(D) Adjustment payments will be calculated based on Medicaid days paid by the Wyoming medical assistance program.

(I) Wyoming Medicaid days will be collected for the dates of service represented in cost reports ended in the calendar year that precedes the assessment effective each October 1. The Medicaid days will be generated by the Department from their MMIS payment system.

(II) New facilities without a qualifying cost report. For new facilities that opened prior to the October 1 annual calculation that do not have either a full year cost report or a qualifying cost report, as described in Section 5(c) of this Chapter, resident days will be determined using more current information and will be annualized.

(E) State operated facilities are exempt from this program.

(b) Nursing facility assessment payable to the Department.

(i) The Department will collect an assessment from nursing facilities under the provisions of the Nursing Care Facility Assessment Act, W.S. §§ 42-8-101 through 109.

(A) Assessments will be calculated prospectively on an annual basis to be effective from October 1 through September 30 of each year. The annual assessments will be paid quarterly. New providers opening during that assessment year will not be included in the program until the next assessment year.

(B) The quarterly assessments will be due to the Department no later than forty-five (45) days after the end of each calendar quarter.

(C) Change of ownership. If a facility changes ownership, beginning with the quarter following the date of the change of ownership, the new owner will assume the payment schedule calculated using prior owner's data. If it is not clear to the Department which owner is responsible for the assessment, the owner who received the quarterly adjustment payment will be responsible to pay the Department for the assessment related to that same quarter.

(D) Assessments will be calculated based on a per-resident day basis, exclusive of Medicare resident days.

(I) Resident days will be collected from the Wyoming Nursing Home Reimbursement System, Financial Report for Nursing Homes (cost report) that ended in the calendar year that precedes the assessment effective each October 1. The Department will revise its cost report form to collect the appropriate patient day data. Until the revised cost report forms are in use and have been filed with the Department, the Department will utilize a provider survey to gather the necessary data.

(II) New facilities without a qualifying cost report. If a new facility opened prior to the October 1 annual calculation that does not have either a full year cost report or a qualifying cost report, as described in Section 5(c) of this Chapter, resident days will be determined using more current information and will be annualized.

(E) Assessment expenses shall be reported on the State of Wyoming Financial Report for Nursing Homes annual cost report. Expenses shall be reported on schedule B of this same cost report. For providers who do not file a Medicare cost report, assessment expenses shall be reported on line 578 of the State of Wyoming Financial Report for Nursing Homes annual cost report.

(F) State operated facilities are exempt from this program.

Appendix K – Kansas Nursing Facility Statute (example language)

http://www.ksrevisor.org/statutes/chapters/ch75/075_074_0035.html

75-7435. Quality care assessments for skilled nursing care facilities; imposition and administration by department of health and environment; rules and regulations; collection and disposition; quality care fund; authorized uses; conditions and limitations; quality care improvement panel; expiration of statute. (a) As used in this section unless the context requires otherwise:

(1) Words and phrases have the meanings respectively ascribed thereto by K.S.A. 39-923, and amendments thereto.

(2) "Skilled nursing care facility" means a licensed nursing facility, nursing facility for mental health as defined in K.S.A. 39-923, and amendments thereto, or a hospital long-term care unit licensed by the department of health and environment, providing skilled nursing care, but shall not include the Kansas soldiers' home or the Kansas veterans' home.

(3) "Licensed bed" means those beds within a skilled nursing care facility which the facility is licensed to operate.

(4) "Agent" means the Kansas department for aging and disability services.

(5) "Continuing care retirement facility" means a facility holding a certificate of registration issued by the commissioner of insurance pursuant to K.S.A. 40-2235, and amendments thereto.

(b) (1) Except as otherwise provided in this section and in subsection (f), there is hereby imposed and the secretary of health and environment shall assess an annual assessment per licensed bed, hereinafter called a quality care assessment, on each skilled nursing care facility. The assessment on all facilities in the aggregate shall be an amount fixed by rules and regulations of the secretary of health and environment, shall not exceed $1,950 annually per licensed bed, shall be imposed as an amount per licensed bed and shall be imposed uniformly on all skilled nursing care facilities except that the assessment rate for skilled nursing care facilities that are part of a continuing care retirement facility, small skilled nursing care facilities and high medicaid volume skilled nursing care facilities shall not exceed ⅙ of the actual amount assessed all other skilled nursing care facilities. No rules and regulations of the secretary of health and environment shall grant any exception to or exemption from the quality care assessment. The assessment shall be paid quarterly, with one fourth of the annual amount due by the 30th day after the end of the month of each calendar quarter. The secretary of health and environment is authorized to establish delayed payment schedules for skilled nursing care facilities which are unable to make quarterly payments when due under this section due to financial difficulties, as determined by the secretary of health and environment. As used in this subsection (b)(1), the terms "small skilled nursing care facilities" and "high medicaid volume skilled nursing care facilities" shall have the meanings ascribed thereto by the secretary of health and environment by rules and regulations, except that the definition of small skilled nursing care facility shall not be lower than 40 beds.

(2) Beds licensed after July 1 each year shall pay a prorated amount of the applicable annual assessment so that the assessment applies only for the days such new beds are licensed. The proration shall be calculated by multiplying the applicable assessment by the percentage of days the beds are licensed during the year. Any change which reduces the number of licensed beds in a facility shall not result in a refund being issued to the skilled nursing care facility.

(3) If an entity conducts, operates or maintains more than one licensed skilled nursing care facility, the entity shall pay the nursing facility assessment for each facility separately. No skilled nursing care facility shall create a separate line-item charge for the purpose of passing through the quality care assessment to residents. No skilled nursing care facility shall be guaranteed, expressly or otherwise, that any additional moneys paid to the facility under this section will equal or exceed the amount of its quality care assessment.

(4) The payment of the quality care assessment to the secretary of health and environment shall be an allowable cost for medicaid reimbursement purposes. A rate adjustment pursuant to paragraph (5) of subsection (d) shall be made effective on the date of imposition of the assessment, to reimburse the portion of this cost imposed on medicaid days.

(5) The secretary of health and environment shall seek a waiver from the United States department of health and human services to allow the state to impose varying levels of assessments on skilled nursing care facilities based on specified criteria. It is the intent of the legislature that the waiver sought by the secretary of health and environment be structured to minimize the negative fiscal impact on certain classes of skilled nursing care facilities.

(c) Each skilled nursing care facility shall prepare and submit to the secretary of health and environment any additional information required and requested by the secretary of health and environment to implement or administer the provisions of this section. Each skilled nursing care facility shall prepare and submit quarterly to the secretary for aging and disability services the rate the facility charges to private pay residents, and the secretary shall cause this information to be posted on the web site of the department for aging and disability services.

(d) (1) There is hereby created in the state treasury the quality care fund, which shall be administered by the secretary of health and environment. All moneys received for the assessments imposed pursuant to subsection (b), including any penalty assessments imposed thereon pursuant to subsection (e), shall be remitted to the state treasurer in accordance with K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the quality care fund. All expenditures from the quality care fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the secretary of health and environment or the secretary's agent.

(2) All moneys in the quality care fund shall be used to finance initiatives to maintain or improve the quantity and quality of skilled nursing care in skilled nursing care facilities in Kansas. No moneys credited to the quality care fund shall be transferred to or otherwise revert to the state general fund at any time. Notwithstanding the provisions of any other law to the contrary, if any moneys credited to the quality care fund are transferred or otherwise revert to the state general fund, 30 days following

the transfer or reversion the quality care assessment shall terminate and the secretary of health and environment shall discontinue the imposition, assessment and collection of the assessment. Upon termination of the assessment, all collected assessment revenues, including the moneys inappropriately transferred or reverting to the state general fund, less any amounts expended by the secretary of health and environment, shall be returned on a pro rata basis to skilled nursing care facilities that paid the assessment.

(3) Any moneys received by the state of Kansas from the federal government as a result of federal financial participation in the state medicaid program that are derived from the quality care assessment shall be deposited in the quality care fund and used to finance actions to maintain or increase healthcare in skilled nursing care facilities.

(4) Moneys in the fund shall be used exclusively for the following purposes:

(A) To pay administrative expenses incurred by the secretary of health and environment or the agent in performing the activities authorized by this section, except that such expenses shall not exceed a total of 1% of the aggregate assessment funds collected pursuant to subsection (b) for the prior fiscal year;

(B) to increase nursing facility payments to fund covered services to medicaid beneficiaries within medicare upper payment limits, as may be negotiated;

(C) to reimburse the medicaid share of the quality care assessment as a pass-through medicaid allowable cost;

(D) to restore the medicaid rate reductions implemented January 1, 2010;

(E) to restore funding for fiscal year 2010, including rebasing and inflation to be applied to rates in fiscal year 2011;

(F) the remaining amount, if any, shall be expended first to increase the direct health care costs center limitation up to 150% of the case mix adjusted median, and then, if there are remaining amounts, for other quality care enhancement of skilled nursing care facilities as approved by the quality care improvement panel but shall not be used directly or indirectly to replace existing state expenditures for payments to skilled nursing care facilities for providing services pursuant to the state medicaid program.

(5) Any moneys received by a skilled nursing care facility from the quality care fund shall not be expended by any skilled nursing care facility to provide for bonuses or profit-sharing for any officer, employee or parent corporation but may be used to pay to employees who are providing direct care to a resident of such facility.

(6) Adjustment payments may be paid quarterly or within the daily medicaid rate to reimburse covered medicaid expenditures in the aggregate within the upper payment limits.

(7) On or before the 10th day of each month, the director of accounts and reports shall transfer from the state general fund to the quality care fund interest earnings based on:

(A) The average daily balance of moneys in the quality care fund for the preceding month; and

(B) the net earnings rate of the pooled money investment portfolio for the preceding month.

(e) If a skilled nursing care facility fails to pay the full amount of the quality care assessment imposed pursuant to subsection (b), when due and payable, including any extensions of time granted under that subsection, the secretary of health and environment shall assess a penalty in the amount of the lesser of $500 per day or 2% of the quality care assessment owed for each day the assessment is delinquent. The secretary of health and environment is authorized to establish delayed payment schedules for skilled nursing care facilities that are unable to make installment payments when due under this section because of financial difficulties, as determined by the secretary of health and environment.

(f) (1) The secretary of health and environment shall assess and collect quality care assessments imposed pursuant to subsection (b), including any penalty assessments imposed thereon pursuant to subsection (e), from skilled nursing care facilities on and after July 1, 2010, except that no assessments or penalties shall be assessed under subsections (a) through (h) until:

(A) An amendment to the state plan for medicaid, which increases the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal medicaid program and which is proposed for approval for purposes of subsections (a) through (h) is approved by the federal government in which case the initial assessment is due no earlier than 60 days after state plan approval; and

(B) the skilled nursing care facilities have been compensated retroactively within 60 days after state plan approval at the increased rate for services provided pursuant to the federal medicaid program for the period commencing on and after July 1, 2010.

(2) The secretary of health and environment shall implement and administer the provisions of subsections (a) through (h) in a manner consistent with applicable federal medicaid laws and regulations. The secretary of health and environment shall seek any necessary approvals by the federal government that are required for the implementation of subsections (a) through (h).

(3) The provisions of subsections (a) through (h) shall be null and void and shall have no force and effect if one of the following occur:

(A) The medicaid plan amendment, which increases the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal medicaid program and which is proposed for approval for purposes of subsections (a) through (h) is not approved by the federal centers for medicare and medicaid services;

(B) the rates of payments made to skilled nursing care facilities for providing services pursuant to the federal medicaid program are reduced below the rates calculated on December 31, 2009,

increased by revenues in the quality care fund and matched by federal financial participation and rebasing as provided for in K.S.A. 2015 Supp. 75-5958, and amendments thereto;

(C) any funds are utilized to supplant funding for skilled nursing care facilities as required by subsection (g);

(D) any funds are diverted from those purposes set forth in subsection (d)(4); or

(E) upon the governor signing, or allowing to become law without signature, legislation which by proviso or otherwise directs any funds from those purposes set forth in subsection (d)(4) or which would propose to suspend the operation of this section.

(g) On and after July 1, 2010, reimbursement rates for skilled nursing care facilities shall be restored to those in effect during December 2009. No funds generated by the assessments or federal funds generated therefrom shall be utilized for such restoration, but such funds may be used to restore the rate reduction in effect from January 1, 2010, to June 30, 2010.

(h) Rates of reimbursement shall not be limited by private pay charges.

(i) If the provisions of subsections (a) through (h) are repealed, expire or become null and void and have no further force and effect, all moneys in the quality care fund which were paid under the provisions of subsections (a) through (h) shall be returned to the skilled nursing care facilities which paid such moneys on the basis on which such payments were assessed and paid pursuant to subsections (a) through (h).

(j) The department of health and environment may adopt rules and regulations necessary to implement the provisions of this section.

(k) For purposes of administering and selecting the reimbursements of moneys in the quality care assessment fund, the quality care improvement panel is hereby established. The panel shall consist of the following members: Two persons appointed by Kansas homes and services for the aging; two persons appointed by the Kansas health care association; one person appointed by Kansas advocates for better care; one person appointed by the Kansas hospital association; one person appointed by the governor who is a member of the Kansas adult care executives association; one person appointed by the governor who is a skilled nursing care facility resident or the family member of such a resident; one person appointed by the Kansas foundation for medical care; one person appointed by the governor from the department for aging and disability services; and one person appointed by the governor from the department of health and environment. The person appointed by the governor from the department for aging and disability services and the person appointed by the governor from the department of health and environment shall be nonvoting members of the panel. The panel shall meet as soon as possible subsequent to the effective date of this act and shall elect a chairperson from among the members appointed by the trade organizations specified in this subsection. The members of the quality care improvement panel shall serve without compensation or expenses. The quality care improvement panel shall report annually on or before January 10 to the legislature concerning the activities of the panel during the preceding calendar year and any recommendations which the

panel may have concerning the administration of and expenditures from the quality care assessment fund.

(l) The provisions of this section shall expire on July 1, 2016.

History: L. 2010, ch. 159, § 1; L. 2012, ch. 102, § 53; L. 2013, ch. 55, § 1; July 1.

Appendix L – Kansas Nursing Facility Regulation Excerpt (example language)

http://www.sos.ks.gov/pubs/kar/2015/129_129-Department%20of%20Health%20and%20Environment—Div%20of%20Health%20Care%20Finance,%202015%20KAR%20Supp.pdf

Agency 129

Kansas Department of Health and Environment— Division of Health Care Finance

Article 10.—ADULT CARE HOME PROGRAM

129-10-31. Responsibilities of, assessment of, and disbursements for the nursing facility quality care assessment program.

(a) In addition to the terms defined in K.S.A. 2013 Supp. 75-7435 and amendments thereto, the following terms shall have the meanings specified in this subsection, unless the context requires otherwise.

(1) ''High medicaid volume skilled nursing care facility'' means any facility that provided more than 25,000 days of nursing facility care to Medicaid recipients during the most recent calendar year cost-reporting period.

(2) ''Kansas homes and services for the aging,'' as used in K.S.A. 2013 Supp. 75-7435 and amendments thereto, means leadingage Kansas.

(3) ''Nursing facility quality care assessment program'' means the determination, imposition, assessment, collection, and management of an annual assessment imposed on each licensed bed in a skilled nursing care facility required by K.S.A. 2013 Supp. 75-7435, and amendments thereto.

(4) ''Skilled nursing care facility that is part of a continuing care retirement facility'' means a provider who is certified as such by the Kansas insurance department before the start of the state's fiscal year in which the assessment process is occurring.

(5) ''Small skilled nursing care facility'' means any facility with fewer than 46 licensed nursing facility beds.

(b) The assessment shall be based on a state fiscal year. Each skilled nursing facility shall pay the annual assessment as follows:

(1) The assessment amount shall be $325 annually per licensed bed for the following:

(A) Each skilled nursing care facility that is part of a continuing care retirement facility;

(B) each small skilled nursing care facility; and

(C) each high medicaid volume skilled nursing care facility.

(2) The assessment amount for each skilled nursing care facility other than those identified in paragraphs (c)(1)(A) through (C) shall be $1,950 annually per licensed bed.

(3) The assessment amount shall be paid according to the method of payment designated by the secretary of the Kansas department of health and environment. Any skilled nursing care facility may be allowed by the secretary of the Kansas department of health and environment to have an extension to complete the payment of the assessment, but no such extension shall exceed 90 days. (Authorized by and implementing K.S.A. 2013 Supp. 75-7435; effective Feb. 18, 2011; amended Dec. 27, 2013.)