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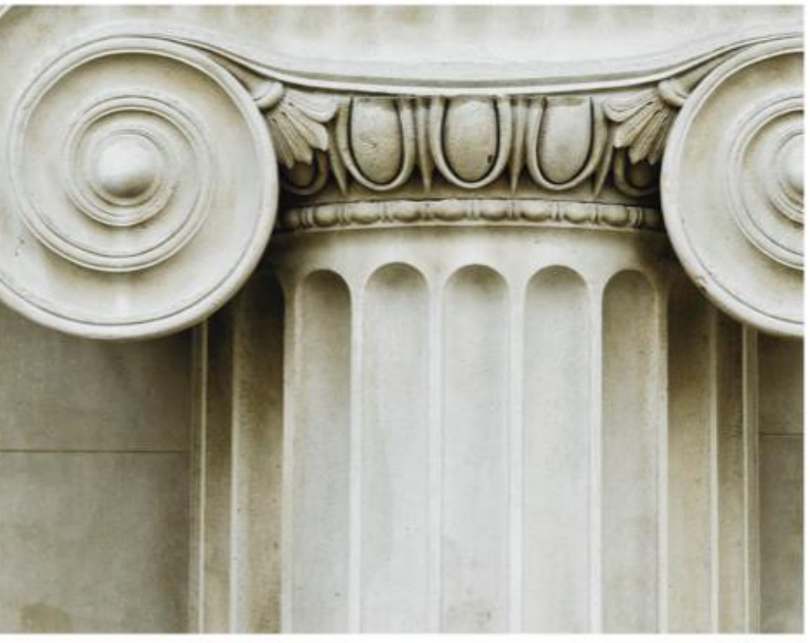
OCTOBER 2, 2015

ALASKA PROVIDER TAX FEASIBILITY STUDY STAKEHOLDER MEETING 1 – ALL PROVIDER TYPES

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



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WEBINAR INFORMATION

Web Ex Sign In

https://webinar.mslc.com

*(Note: Don't miss the "s" in http**s**)*

Meeting ID: 9246008

No password is needed

Call In Information

Telephone: 888.506.9354

Attendee code: 3567443

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WELCOME – KATHERINE TOMPKINS

- Meeting timeline
- Project timeline
- Meeting purpose

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HOUSEKEEPING

- A break will be called around the middle of presentation
- Webinar is being recorded for future retrieval
- This PowerPoint presentation and the future recording will be available at the following website:

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

- Conference call line will be open at the beginning before we start, and then muted until the end for Q&A

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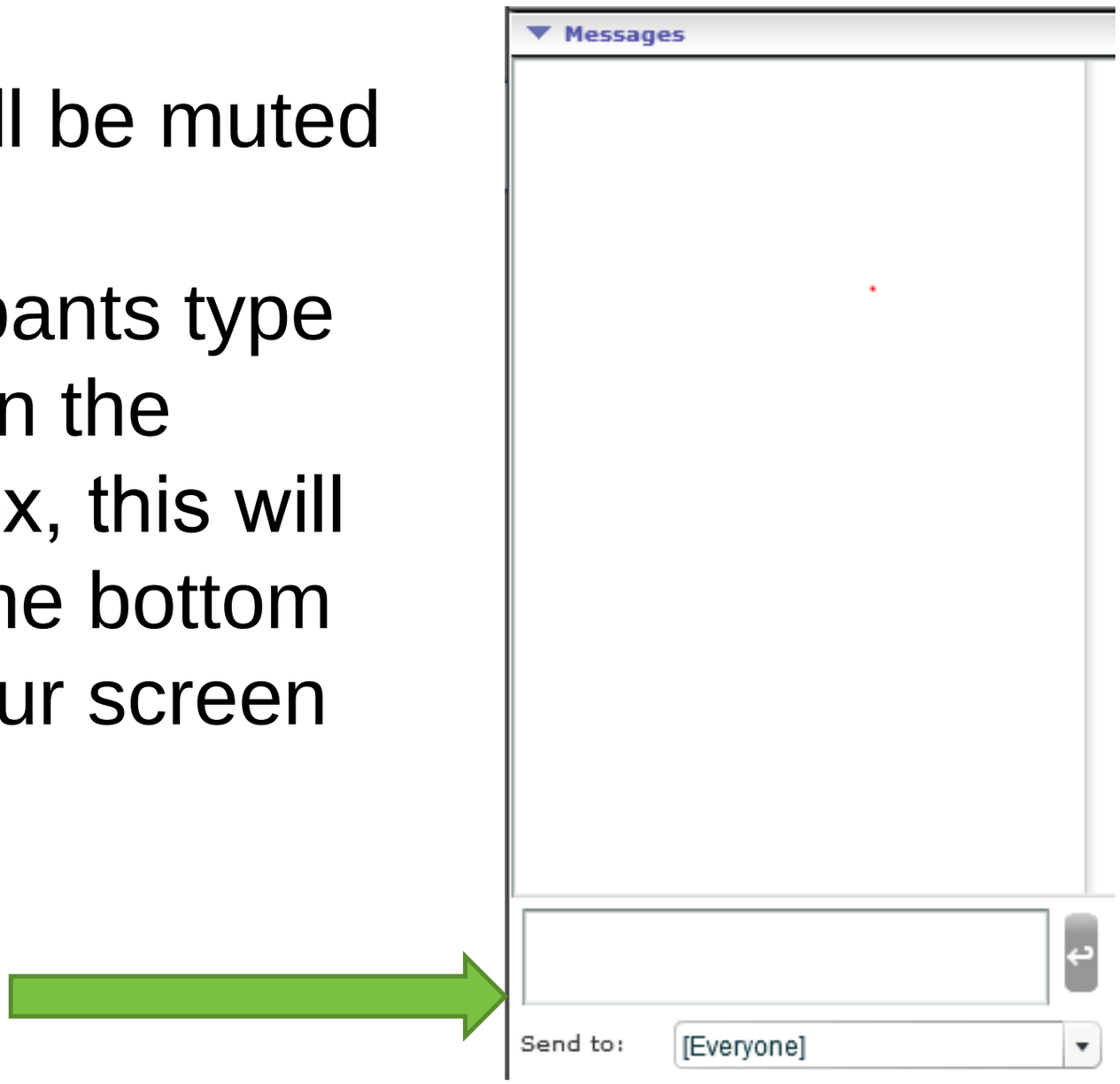
HOUSEKEEPING: QUESTIONS

- Phone lines will be muted
- WebEx participants type your question in the “Messages” box, this will be located at the bottom right side of your screen



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ALASKA STUDY

- This is a health care provider tax study
- Looking at options and feasibility of implementing a tax program
- This meeting is high level. Provider specific meetings & details later
- The word “tax” is scary – state is sensitive
- Stakeholder involvement
- Transparency

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INTRODUCTION OF MYERS AND STAUFFER (MSLC)

Tammy Martin

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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WHO AM I?

- 20 years with Myers and Stauffer
- Member/manager of the Boise, ID office
- Worked on AK projects starting in my 1st month
- Specialty areas:

Long term care	Hospitals	HHAs
UPL/Tax	FQHCs	DSH Payment
DSH Audit	EHR	Consulting
Provider Workgroups		

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MYERS AND STAUFFER INTRODUCTION

- Public accounting firm providing consulting services to Medicaid agencies for 35 years
- Sole practice focused on state and federal agencies
- 18 Offices throughout the US. This project being managed from our ID, IN, & KS offices
- 700 Employees

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MYERS AND STAUFFER INTRODUCTION

- Specialize in the following:
  - Medicaid consulting
  - Auditing
  - Rate setting
  - Program integrity
  - Other operational support services to Medicaid agencies

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EXPERIENCE

- UPL, Tax, IGT, CPEs
- Hospital audit, settlement, rate setting, DRG
- Long term care audit, settlement, rate setting
- Hospital DSH audit & DSH payment
- HHA settlement & rate setting
- Prescription drug rate setting
- ASC

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EXPERIENCE, CONT.

- FQHC & RHC audit, settlement, rate setting
- MDS 2.0 & 3.0 submission support & rate setting
- MMIS implementation consulting & review
- EHR audits
- Regulation, statute, & state plan assistance
- Independent, neutral, and unbiased

TAX & UPL EXPERIENCE – 22 STATES

AL	KY	NC
AK	LA	ND
CO	MD	PA
GA	MS	VA
ID	MO	WV
IN	MT	WY
IA	NJ	
KS	NM	

- Nursing facility
- Inpatient & Outpatient Hospital
- IMD
- PRTF
- Clinic
- Physicians

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EXPERIENCE IN AK

MSLC has consulted with AK since the 1990s

- DSH Audits: 2009 to present
- HCBS & Behavioral health: Developed a cost collection survey. 2012-2014
- EHR Audits: 2012 – present
- Pharmacy Dispensing Cost Survey: 2012
- HCBS Reimbursement Methodology: 2007-2010

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EXPERIENCE IN AK

- MMIS Audits: 2003-current
- Telehealth Reimbursement Research Project: 1990s
- NF & Hospital Cost Report Audits: 1990s

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GENERAL PROVIDER TAX EDUCATION

Dave Halferty

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GENERAL PROVIDER TAX INFORMATION

Who am I? – Additional Background

- Worked for the State of Kansas, Department for Aging and Disability Services before joining Myers and Stauffer
- Worked with nursing facility reimbursement program including considerable modeling of provider tax options
- State implemented a nursing facility provider tax in 2010

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GENERAL PROVIDER TAX INFORMATION

What is a Provider Tax?

- Assessment on health care providers allowed by CMS
- Can be based on revenue, licensed units, or service units
- Revenue generated can be used as state share of Medicaid provider payments

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GENERAL PROVIDER TAX INFORMATION

Who regulates a Provider Tax?

- The state taxing authority, generally the state Legislature, authorizes a provider tax and then delegates administrative responsibilities to a state agency
- The Centers for Medicare and Medicaid Services (CMS) maintains rules and regulations that provider taxes must comply with

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GENERAL PROVIDER TAX INFORMATION

Why do states use a Provider Tax?

- Allows the state to generate additional funding for the Medicaid program
- Enables the state to leverage additional federal funding by using tax revenue as state match
    - In Alaska every $1 of tax revenue could be used to pay providers $2, netting providers $1

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GENERAL PROVIDER TAX INFORMATION

Why do states use a Provider Tax?

- Some states have funded budget gaps with provider tax revenues allowing for provider rate increases that would not have occurred otherwise
- Some states have implemented or enhanced performance based payment systems with provider tax revenues
- Some states use this to fund administrative costs

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GENERAL PROVIDER TAX INFORMATION

How common are Provider Taxes?

- All states except Alaska have at least one approved provider tax
- Nursing facility provider taxes are the most common, 41 states, followed by hospitals, 39 states, and ICFs, 34 states
- In 2012 the GAO reported that $18.7 billion was raised from provider taxes

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GENERAL PROVIDER TAX INFORMATION

How does a provider tax work?

- Providers are typically assessed based on one of three measurements:

1. Net Patient Revenue
2. Licensed Units (beds)
3. Service Units (resident days)

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GENERAL PROVIDER TAX INFORMATION

How does a provider tax work?

- Net Patient Revenue (NPR)
  - Revenue is offset by contractual allowances
  - Revenues from ancillary services are added on
  - Tax due is percent of NPR

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GENERAL PROVIDER TAX INFORMATION

How does a provider tax work?

- Licensed Units
  - Examples would be hospital or nursing facility beds
  - A tax rate is set per licensed unit, such as $100 per bed per year
  - Tax due equals licensed units x rate

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GENERAL PROVIDER TAX INFORMATION

How does a provider tax work?

- Service Units
  - Examples would be nursing facility days or prescriptions filled
  - A tax rate is set per service unit, such as $5 per resident day
  - Tax due equals service units x rate

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GENERAL PROVIDER TAX INFORMATION

How does a provider tax work?

- Exclusions
  - Sometimes states exclude certain providers within a class
  - Example, state owned and operated facilities might be excluded
  - CMS refers to taxes that include all providers in a group as broad based

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GENERAL PROVIDER TAX INFORMATION

How does a provider tax work?

- Variable Rates
  - Sometimes states use different rates for providers within a class
  - Example, small providers pay half as much per licensed unit as others
  - CMS refers to such arrangements as non-uniform taxes

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GENERAL PROVIDER TAX INFORMATION

What restrictions does CMS impose?

- Eligible Provider Classes

Ambulatory Surgical Centers	Lab and X-ray	Physicians
Chiropractors	Managed Care Organizations	Podiatrists
Dentists	Nursing	Psych. Residential Treatement Facilities
Emergancy Ambulance	Nursing Facility	Psychologists
Home Health Agencies	Outpatient Hospital	Therapists
Inpatient Hospital	Outpatient Pharmacy	Other*
Intermediate Care Facilities		

*For other provider types the assessment is limited to the cost of the state's licensing program

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GENERAL PROVIDER TAX INFORMATION

What restrictions does CMS impose?

- Maximum 6% of Net Patient Revenue (NPR)
- Waiver tests for taxes that are not broad based and/or uniform
  - P1/P2 test
  - B1/B2 test
- Tests help protect providers from being overly burdened

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GENERAL PROVIDER TAX INFORMATION

What restrictions does CMS impose?

- P1/P2 Statistical Test
  - Applies to taxes that are not broad based
  - Percent of the tax without a waiver (P1) is equal to or greater than the percent of the tax with a waiver (P2)
  - CMS will review if the P1/P2 ratio is between 0.90 and 1.00

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GENERAL PROVIDER TAX INFORMATION

What restrictions does CMS impose?

- B1/B2 Statistical Test
  - Applies to taxes that are not uniform
  - The waivered tax must not have a stronger correlation to Medicaid payments than a non-waivered tax
  - B1 is the slope of the non-waivered tax, and B2 is the slope of the waivered tax
  - B1/B2 must be greater than one (1)

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GENERAL PROVIDER TAX INFORMATION

What are the goals of this Study?

- Investigate the feasibility of implementing provider taxes in Alaska
- Develop recommendations based on analysis and stakeholder input
- Collaborate with all stakeholders to determine the best options available to the state

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GENERAL PROVIDER TAX INFORMATION

How will we accomplish those goals?

- Eliminate taxable classes that we can determine are not feasible or practical
- Develop detailed modeling to evaluate remaining provider classes

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GENERAL PROVIDER TAX INFORMATION

How will we accomplish those goals?

- Conduct provider-specific stakeholder meetings to review and adjust modeling parameters
- Work with trade associations and their consultants to ensure modeling accuracy

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GENERAL PROVIDER TAX INFORMATION

How will we accomplish those goals?

- Avoid creating burdens for providers
  - We'll utilize existing data sources when possible (e.g. cost reports, claims data)
  - Possibly conduct brief surveys to collect data we do not have access to otherwise

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CLASSES ELIMINATED FROM STUDY

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POTENTIAL CLASSES OF HEALTHCARE PROVIDERS 42 CFR §433.56

1. Inpatient hospital
2. Outpatient hospital
3. Nursing facility
4. Intermediate care facility services for individuals with intellectual disabilities
5. Physician services
6. Home health 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
14. Psychological services
15. Therapist services
16. Nursing services
17. Lab and x-ray services
18. Emergency ambulance services
19. Other

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CLASSES ELIMINATED: CLASSES 1 - 18

- Step 1 in project – met with the state to determine logistics, availability of data, etc. to eliminate classes immediately
- Draft plan as of today
  - 12 Eliminated
  - 6 Included (discussed in detail later)

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BASIS FOR ELIMINATION

- State doesn't have the program (ICF/IID)
- Availability and access of data
- Administrative cost to tax the class
- Lack of state licensure of the provider type (lab)
- Little knowledge of providers (non MCD cert)
- Cost / benefit of program
- Burden to providers not used to working with Medicaid

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CLASSES INCLUDED IN THE STUDY

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CLASSES INCLUDED

Draft List as of Today:

1. Inpatient hospital
2. Outpatient hospital
3. Nursing facilities
4. Home Health Agency (HHA)
5. OP Prescription drugs
6. Ambulatory surgical center (ASC)
7. Class 19 “Other” – (next slide)

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CLASSES INCLUDED: "OTHER CLASS"

1. RPTCs
2. PCAs
3. HCBS Waiver
4. Behavioral Health

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CRITERIA FOR INCLUSION

- Access to data
  - Cost reports (cost, revenue, units)
  - MMIS
  - Units – days, encounters, etc. (total and Medicaid)
  - Licensed facilities
  - Many of these have UPL calculations already completed

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MMIS DATA CHALLENGES

- MMIS Conversion
  - System conversion 10/1/13
  - Reports are still being tested so are not considered reliable
- Solution options
  - Use 2010 – 2012 MMIS and trend it forward.
  - Use 2012 and inflate it forward

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OTHER DATA NEEDS

- Goal for this study is to use existing data on file with the state and or CMS
- Reduce burden on providers
- For some provider types, if tax program goes live, it will require some data submissions from providers
  - ie: Non Medicaid certified providers may have to submit information such as patient days, units, etc

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WORK COMPLETED TO DATE AND WORK PLAN

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WORK COMPLETED TO DATE

- Study & analysis of federal rules & methods used by other states
- Cost reports have been received
- MMIS has been received / or ordered
- Net patient revenue (NPR) has been calculated for most provider types in study
  - NPR is critical as CMS caps the total tax to 6% of NPR for each class (discussed later)

WORK COMPLETED TO DATE, CONT.

- Medicare Upper Limit (UPL) calculations
  - Determining feasibility of paying the UPL room as a supplemental payment
  - Can make tax programs more palatable to providers.
- State UPL calculations received
- New UPLs being calculated for classes with no existing UPL
- Modeling ways to increase the UPL room (good for providers)
  - Analyzed hospitals for a DRG based UPL and NFs for a RUGs based UPL
  - Modeling increasing the room by the MCD share of provider tax

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WORK COMPLETED TO DATE

- Taxing methodology templates in process
  - Dynamic models with ability to tax on varying methods (units, days, revenue), etc
  - Dynamic for varying state revenue goals

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GENERAL UPL CONCEPTS

Tim Guerrant

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PROVIDER TAX FUNDING

My background

- 14 years with Myers and Stauffer
- Focused on hospital rate setting and reimbursement issues
- Also have experience with Medicaid rate setting and reimbursement for physicians, FQHCs and RHCs, PRTFs, and other ancillary services (DME, ambulance)

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PROVIDER TAX FUNDING

What are health care provider taxes used for?

- Provider payments
- Pay for performance initiatives
- Medicaid expansion
- State portion

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PROVIDER TAX FUNDING

Provider Payments

Provider taxes can generate additional state-share funding to leverage Federal dollars to:

- Fund current payment levels
  - Avoid rate cuts
  - Shift the source of state share
- Provide reimbursement increases that would not otherwise be available

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PROVIDER TAX FUNDING

Provider Payments

- Make supplemental payments (e.g., UPL payments)
- Fund state share of hospital DSH payments

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PROVIDER TAX FUNDING

Other Purposes

- Pay for performance
  - Improve quality of care and health outcomes. Pay for results rather than volume.
- Expanding Medicaid coverage to additional populations

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PROVIDER TAX FUNDING

Other Purposes

- States can benefit in the following ways:
  - Additional revenue to state
  - Administration of provider fee program
  - Other Medicaid program payments or funding needs

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PROVIDER TAX FUNDING

Examples

- Alabama: Funds all hospital payments (base and supplemental) with provider taxes, IGTs, and CPEs
- Indiana: Shifted state share of supplemental payments from IGTs to provider tax
  - 71.5% to provider payments, 28.5% to the state for administration and other state funding needs

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PROVIDER TAX FUNDING

Examples

- Colorado: Increased reimbursement, funded quality incentive payments, expanded health coverage in Medicaid and CHIP programs
  - 84% provider supplemental payments, 11% Medicaid expansion, 5% to the state for administration and other funding

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PROVIDER TAX FUNDING

Examples

- California: Increased reimbursement, funded quality incentive payments, expanded health coverage, grants to certain hospitals
  - 79% provider payment increases, 18% Medicaid expansion, 3% grants, <1% state administration

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PROVIDER TAX FUNDING

Examples

- Kansas: Nursing facility provider assessment restored provider rate cut, funded pass-through for Medicaid share of assessment, increased prospective reimbursement, and increased funding for quality incentive payments. 1% of assessment revenue was set aside for state administration

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PROVIDER TAX FUNDING

Medicare Upper Payment Limit (UPL) Considerations

- Most commonly applied to institutional providers as well as certain other provider/service types required by CMS
- May also be a factor for additional provider types if receiving tax-funded payments or payment increases

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PROVIDER TAX FUNDING

Medicare Upper Payment Limit (UPL) Considerations

- UPL = Maximum Medicaid payment states permitted to make
- Federal regulations and guidelines govern UPLs
- Reasonable estimate of what Medicare would pay

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PROVIDER TAX FUNDING

Medicare Upper Payment Limit (UPL) Considerations

- Important component of provider tax programs
  - Maximize the UPL to leverage Federal funds and maximize provider payments
  - Involves evaluating different UPL methodologies to identify the best approach

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PROVIDER TAX FUNDING

Medicare Upper Payment Limit (UPL) Considerations

- Maximize UPL
  - Inflationary and trending mechanisms
  - Can even involve including the Medicaid share of provider tax expense in the UPL (cost based)

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PROVIDER TAX FUNDING

Medicare Upper Payment Limit (UPL) Considerations

- CMS has prescribed certain approved methodologies. Different approach may be used but subject to CMS approval
- CMS generally will not approve changing methodology to one that is less specific. Example: costing using claim detail line charges to using overall cost-to-charge ratio

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PROVIDER TAX FUNDING

Medicare UPL Methodologies (CMS approved)

Inpatient Hospital

- Cost-based (CCR x charges)
- Payment-based (PCR x charges)
- Medicare DRG

Nursing Facility

- Cost-based (per diem x days, CCR x charges)
- Cost report
- Medicare RUG

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PROVIDER TAX FUNDING

Other Funding Mechanisms

- Provider taxes can be used in conjunction with other state-share funding mechanisms:
  - Intergovernmental Transfers (IGTs)
  - Certified Public Expenditures (CPEs)
- IGTs and CPEs can be provided only by governmental providers (e.g., city or county-owned hospital, state university hospital)

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PROVIDER TAX FUNDING

Other Funding Mechanisms

- Intergovernmental Transfer (IGTs)
  - Transfer of funds by unit of government to the state
  - Serves as state share of payment
  - Federal funds drawn down and total computable payment paid to provider
    - Example: Provider IGT transfer of $1, Federal share $1, payment to provider $2

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PROVIDER TAX FUNDING

Other Funding Mechanisms

- Certified Public Expenditures (CPEs)
  - Governmental provider incurs expenditures for providing services under the Medicaid state plan that are eligible for FFP
  - Governmental provider certifies that expenditures were made and that funds expended are public funds

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PROVIDER TAX FUNDING

Other Funding Mechanisms

- CPE based on:
  - Actual incurred cost based on CMS-approved methodology:
    - Cost report (CCR x Medicaid charges)
    - Time study
  - Certification by provider that they incurred the costs and no other Federal funds available for the costs

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PROVIDER TAX FUNDING

Other Funding Mechanisms

- Provider taxes, IGTs, and CPEs are not mutually exclusive and can be used in combination
- Example: Alabama funds all hospital payments, base claim payments and supplemental payments, with all three types

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MODELING OF TAX

Tim Guerrant & Dave Halferty

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PROVIDER TAX MODELING

General Goals

- Evaluate options for tax structure, tiers, and exemptions
- Set parameters to produce most favorable financial impact
  - Maximize net gains/minimize losses
- Ensure compliance with CMS regulations
- Develop recommendations for each class

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PROVIDER TAX MODELING

Modeling Approach

- Collect data for models
  - Cost report data (beds, days, revenue)
  - Other data sources, if no cost report
  - Medicaid claims data
  - UPL demonstrations
  - DSH allotment/payments
  - Additional tax needed for state portion

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PROVIDER TAX MODELING

Modeling Approach

- Collect data for models
  - Work with stakeholders to determine other sources for missing data
  - Develop provider surveys to capture missing data
  - Focus surveys on necessary information and avoid creating unnecessary burdens

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PROVIDER TAX MODELING

Reviewing Tax Structure Options

- Tax Basis
  - Calculate tax based on various “taxable units”, i.e., beds, days, revenue
- Tax Exemptions
  - Included/exempt providers
- Tax Tiers
  - Model different rate tiers if applicable

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PROVIDER TAX MODELING

Reviewing Tax Structure Options

- Develop flexible models to allow changing various parameters and modeling the impact

Assessment Parameters												
Assessment Basis	Licensed Beds											
General Assessment Rate			$1,000	Applies to all homes except those that meet criteria below								
Small Facility Assessment Ratio and Rate	50%	$500	Applies to homes with fewer than	20	beds							
High Medicaid Assessment Ratio and Rate	50%	$500	Applies to homes with more than	25,000	Medicaid days							
State Operated Facility Assessment Ratio and Rate	0%	0	Applies to facilities that are owned and operated by the state									
Average Assessment Rate			$600	The average assessment rate produced by all tiers								
Total Assessment Units			10,000									
Estimated Assessment Revenue			$6,000,000									

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PROVIDER TAX MODELING

Evaluating Financial Impact

- Estimate new Medicaid reimbursement available
- Review UPL demonstrations to evaluate the possibility of offsetting taxes with rate/payment increases
- Model options to determine the most favorable tax rate target

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PROVIDER TAX MODELING

Evaluating Financial Impact

- Review estimated overall financial analysis of modeled assessment parameters

Overall Financial Analysis			
Estimated New Medicaid Reimbursement Available		$12,000,000	Appllies 50% FMAP rate
Estimated Existing UPL Gap		$10,000,000	Determined from UPL demonstrations analysis
Portion of New Reimbursement Applied to Gap	83%	$10,000,000	Variable parameter applied to new reimbursement available
Excess/(Shortage) to Fund UPL Gap		$2,000,000	
Net Change to Provider Revenue		$4,000,000	

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PROVIDER TAX MODELING

Evaluating Financial Impact

- Review estimated impact to providers

Fiscal Impact Analysis												
Provider Fiscal Impact Analysis												
	Average Provider Impact			**20,000**								
	Number of Providers with Net Gain			**150**		**Avg Gain**	**30,000**		**Max Gain**	**50,000**		
	Number of Providers with Net Loss			**50**		**Avg Loss**	**-10,000**		**Max Loss**	**-50,000**		
	Number of Providers with 0 Impact			**0**								

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PROVIDER TAX MODELING

Ensuring Regulatory Compliance

- NPR Test
  - Limited to 6% of net patient revenue
- P1/P2 Statistical Test
  - Non-broad based tax must be generally redistributive
- B1/B2 Statistical Test
  - Non-uniform tax must not correlate to Medicaid payments

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PROVIDER TAX MODELING

Ensuring Regulatory Compliance

- Monitor outcomes of each statistical test that result from various parameter settings

Compliance Tests

Net Patient Revenue	Percent of NPR
$100,000,000	6.00%
	Must not exceed 6%

P1/P2

P1	5.80%
P2	6.00%
P1/P2	0.966667

> 1 if not broad based

B1/B2

B1	0.0000001769
B2	0.0000001454
B1/B2	1.216597

> 1 if not broad or uniform

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PROVIDER TAX MODELING

Developing Recommendations

- Provider-specific Stakeholder Meetings
- Collaboration with Stakeholder Associations
- Vetting Possible Recommendations
- Transparency – Presenting the models to stakeholders, provider specific financial impact

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NEXT STEPS

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NEXT STEPS

- Complete the draft UPL & Tax calculations for presentation to state
- Make the models “dynamic” so can discuss varying methodologies
- Research taxing options for less commonly taxed providers

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STAKEHOLDER MEETINGS

- Meeting today is high level, educational, all provider types
- Future stakeholder meetings will be provider class specific

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HOSPITAL & NF STAKEHOLDER WEBINAR

10/15/15, 10:00 AM

URL: https://webinar.mslc.com

Meeting ID: 5756165

Telephone: 888.506.9354

Phone Call code: 3567443

Password: N/A

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HHA, ASC & OP PRESCRIPTION DRUGS STAKEHOLDER WEBINAR

10/29/15, 10:00 AM

URL: https://webinar.mslc.com

Meeting ID: 2020948

Telephone: 888.506.9354

Phone Call code: 3567443

Password: N/A

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"OTHER" STAKEHOLDERS WEBINAR
RPTC, PCA, HCBS WAIVER, BEHAVIORAL HEALTH

11/06/15, 10:00 AM

URL: https://webinar.mslc.com

Meeting ID: 7220439

Telephone: 888.506.9354

Phone Call code: 3567443

Password: N/A

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Questions?

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