CRITICAL ACCESS HOSPITALS IN ALASKA

Critical Access Hospitals are an important part of rural health care in Alaska

Critical Access Hospitals (CAH) provide a broad range of services in rural Alaska, including preventative services, long-term services and supports, diagnostic imaging, laboratory, critical care, and 24/7 emergency services. When a CAH has Medicare approval to furnish swing bed services, it may use any of its inpatient beds for either acute care or skilled nursing facility (SNF)-level care.

Alaska has thirteen critical access hospitals including four that are tribally operated.

CAHs are an important part of the rural economy

- Each CAH maintains 25 or fewer beds and directly contributes an average of 204 jobs to the local economy. While their health care services have bolstered rural areas, CAHs are supported by a fragile financial foundation. Need to ensure CAHs have the resources they need to provide high-quality care and meet the needs of their communities.

- Because of their size, modest assets and financial reserves, and higher percentages of Medicare patients, small and rural hospitals disproportionately rely on government payments. CAH status is essential to their survival.

- CAHs receive cost-based reimbursement from Medicare, instead of standard fixed reimbursement rates. Cost-based reimbursement enhances the financial performance of small rural hospitals. Medicare pays CAHs nationwide for most inpatient and outpatient services to Medicare patients at 101% of reasonable costs, based on submission of a cost report.

- Alaska Medicaid reimburses most inpatient and outpatient services to Medicaid patients in a CAH at 100% of cost. Many Alaska CAHs have co-located nursing home (long-term) beds, which are primarily paid for by Medicaid. Facility-specific Medicaid rates are based on an annual cost report submitted by the CAH.

- CAHs provide cost-effective primary care. In fact, in comparing identical Medicare services in a rural setting to an urban setting, the cost of care in a rural setting is on average 3.7 percent less expensive. This focus on primary care, as opposed to specialty care, saves the Medicare program approximately $2.2 billion each year.

- If a rural hospital closes, severe economic decline in the rural community is the result. Physicians, nurses, pharmacists and other health care seek employment elsewhere. Patients travel farther for care or delay receiving care, resulting in poorer health outcomes.

- Businesses, families and retirees may not relocate to a rural area if hospital care is not available.
EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

Source: American College of Emergency Physicians  
http://www.acep.org/News-Media-top-banner/EMTALA/

What is EMTALA?  
EMTALA is a federal law that requires anyone coming to a hospital emergency department to be assessed, stabilized and treated, whether or not they can pay for that care. EMTALA was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd). Any hospital that takes Medicare is required to comply with EMTALA.

What does EMTALA require?  
Hospitals have three main requirements under EMTALA:

1. Any individual presenting at the emergency department and requesting care must receive a medical screening examination to determine whether an emergency medical condition exists. Examination and treatment cannot be delayed to inquire about methods of payment or insurance coverage. Emergency departments also must post signs that notify patients and visitors of their rights to a medical screening examination and treatment.

2. If an emergency medical condition exists, treatment must be provided until the emergency medical condition is resolved or stabilized. If the hospital does not have the capability to treat the emergency medical condition, an "appropriate" transfer of the patient to another hospital must be done in accordance with the EMTALA provisions.

3. Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.

Scope of EMTALA:  
EMTALA applies to hospital emergency departments. It does not apply to other outpatient settings, like primary care or specialty clinics. It also does not apply to inpatient care. The hospital’s EMTALA obligation ends when the patient is stabilized or admitted as an inpatient.
FACTS ABOUT MEDICAID EXPANSION IN ALASKA

Under the Affordable Care Act, Alaska has the option of expanding Medicaid eligibility to working age adults with income up to 138% of the federal poverty level. The Alaska Department of Health and Social Services recently released results of Evergreen Economics' analysis of enrollment and spending impacts of expanding Medicaid in Alaska. These facts come from this analysis along with other studies and analyses completed for Alaska.¹

**Benefits for individuals and families in Alaska:**
The primary enrollees of Medicaid expansion are working-age adults 21-64 years of age who are not caring for dependent children, are not disabled or pregnant, and are at or below 138 percent of the federal poverty level (FPL). Eligibility for low-income children and pregnant women would not change because they already qualify under Medicaid or Denali KidCare.

- Medicaid expansion will increase access to health insurance for an estimated 41,910 low-income Alaskans. Those in the expansion population include individuals who are not currently offered affordable health insurance coverage by their employer, may not be eligible for subsidized plans on the Health Insurance Marketplace, and cannot afford to purchase an individual health insurance plan on their own.
- The majority of newly eligible adults are in the labor force with nearly 44% employed and 30% unemployed. Another 21% are not in the labor force because they are retired, in school, have family responsibilities, are incarcerated, or have other circumstances that preclude them from seeking employment. Less than 6% are unable to work.
- An estimated 20,066 of the newly eligible people will enroll in Medicaid in 2016, increasing to 26,623 by 2021.
- The expansion would reduce the number of uninsured Alaskans by half. More Alaskans would receive preventative and primary care, including behavioral health services and help in managing costly chronic diseases.
- Approximately 24,000 of Alaskans (55% of the expansion population) have an annual income below 100% FPL. People earning less than 100% FPL do not qualify for a subsidy to purchase health insurance through the Health Insurance Marketplace and fall in “the gap” for access to coverage.

**Fiscal and economic impacts:**
- Studies project that over the next seven years Medicaid expansion in Alaska would likely yield ² ³:
  - $1.1 billion in new federal revenue for Alaska
  - 4,000 new jobs
  - $1.2 billion more in wages and salaries paid to Alaskans
  - $2.49 billion in increased economic activity throughout the state
- The Alaskans who will be eligible for Medicaid through the expansion live in all areas of the state. The benefits will affect all populations, regions and sectors of the economy.
- According to a presentation by Jonathan King of Northern Economics at the Governor’s transition conference, the state’s economy is headed for recession and Medicaid expansion is one of the few bright spots on the horizon that could help mitigate that recession.
- State general fund savings are projected to be $6.1 million in fiscal year 2016 and increase in the years...
following. The state will be able to offset costs of expansion by reducing or eliminating general fund contributions to programs that provide health care to the newly eligible people including Chronic and Acute Medical Assistance (CAMA) program, health care for incarcerated individuals, and behavioral health services.

- Total state expenditures for the Medicaid expansion over the 2016-2021 period are estimated to be $90.7 million. In turn, $1.1 billion in new federal funds will be generated in the State.\(^4\)
- Under expansion, the federal government will pay Alaska 100% of the health care expenses associated with the newly covered population for calendar years 2015 and 2016. The federal government will then transition its match over several years to 90% of health care expenses for the new population.

**Impact on Hospitals:**

- In 2011, non-tribal Alaska hospitals provided $91 million in uncompensated care.\(^5\)
- In Alaska, if Medicaid is expanded a decrease in uncompensated care is anticipated. Based on the experience in other states a 20%-30% reduction of uncompensated care could be achieved. This could amount to decrease of between $18 and $27 million in uncompensated care at non-tribal hospitals.\(^6\)
- A decrease in uncompensated care could result in improved financial sustainability for Alaska's small/rural hospitals that are currently operating at a deficit. Additional resources will allow Alaska hospitals to better respond to community health needs and provide community benefits.
- Hospitals face looming uncertainty as federal cuts authorized by the ACA increase. These cuts amount to more than $320 million over ten years for Alaska hospitals.\(^7\) Hospitals agreed to payment reductions based on the assumption that expanding Medicaid would be mandatory for all states and would make up for ACA cuts.

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4. Ibid.
6. ASHNHA Impact of Medicaid Expansion on Uncompensated Care, January 2015.
Since 2010, Congress and the Centers for Medicare and Medicaid Services (CMS) have enacted a series of Medicare payment cuts for hospital services in their effort to address the federal deficit and offset other program costs, including the cost of expanding insurance coverage under the ACA.

This summary is intended to support an understanding of existing Medicare provider cuts that Alaska hospitals are facing now and in the future. This analysis includes estimated Medicare fee-for-service payments and payment changes from 2010-2024 based on legislative payment changes adopted by Congress and regulatory payment changes adopted CMS and additional cuts under consideration.

These cuts will cost Alaska hospitals $591 million over 15 years.1
Cuts under consideration could reduce revenue by an additional $320 million if enacted.

<table>
<thead>
<tr>
<th>Enacted Cuts as a Percent of Total FFS Medicare Revenue²</th>
<th>-10.0%</th>
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<tbody>
<tr>
<td>15 year summary value</td>
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### Cuts Enacted (2010-2024): Legislative

<table>
<thead>
<tr>
<th>Cuts Enacted (2010-2024): Legislative</th>
<th>Enacted Value</th>
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<tbody>
<tr>
<td>ACA Marketbasket Cuts</td>
<td>($266,013,300)</td>
</tr>
<tr>
<td>Sequestration</td>
<td>($93,961,800)</td>
</tr>
<tr>
<td>Medicare DSH Cuts</td>
<td>($79,844,200)</td>
</tr>
<tr>
<td>Quality</td>
<td>($6,743,300)</td>
</tr>
<tr>
<td>ATRA Coding</td>
<td>($9,932,500)</td>
</tr>
<tr>
<td>Bad Debt at 65%</td>
<td>($2,180,700)</td>
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<tr>
<td>Total Legislative Cuts</td>
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### Cuts Enacted (2010-2024): Regulatory

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<tr>
<td>Coding Cuts</td>
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<tr>
<td>2-Midnight Offset</td>
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<tr>
<td>Total Regulatory Cuts</td>
<td>($132,514,000)</td>
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<tr>
<td>Total Cuts Enacted</td>
<td>($591,189,800)</td>
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### Cuts Under Consideration (2015-2024)

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<tr>
<th>Cuts Under Consideration (2015-2024)</th>
<th>Enacted Value</th>
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<tr>
<td>Rural Cuts</td>
<td>($228,923,000)</td>
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<tr>
<td>OPD Cuts</td>
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<td>IME/DGME Cuts</td>
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<td>Bad Debt Elimination</td>
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<tr>
<td>CMS Coding Cut</td>
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<tr>
<td>Post Acute Cuts</td>
<td>($9,500,700)</td>
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<tr>
<td>Total Cuts Under Consideration</td>
<td>($319,764,800)</td>
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</tbody>
</table>
Over the past few years, law makers have repeatedly turned to cutting Medicare payments to providers to address federal budget shortfalls and/or offset the costs associated with implementing new programs including the expansion of insurance coverage provided by the Affordable Care Act (ACA). As Congress looks for ways to further reduce federal spending, address the debt ceiling, and offset costs associated with fixing the sustainable growth rate, Medicare payments to hospitals remain vulnerable. This prospect is particularly troubling in light of uncertainty surrounding implementation of the ACA, including the lack of Medicaid expansion in Alaska and the uncertainty of the subsidies received through the federal marketplace.

ASHNHA opposes additional Medicare payment cuts without full implementation of the expanded coverage promised through the ACA. ASHNHA also opposes poorly designed approaches to achieving Medicare savings through arbitrary provider cuts. Instead we support the development of more rational long-term payment methodologies that reward quality and promote better health outcomes, such as value-based purchasing and accountable care models.

**Cuts enacted – Summary of 15 year impact**

- **ACA Marketbasket Cuts: $266,013,300**
  The impact shown reflects the Affordable Care Act (ACA) of 2010 authorized hospital/health system payment cuts,

- **Sequestration Cuts: $93,961,800**
  The impact reflects the 2% sequester reduction on total Medicare payments currently in effect for years 2013-2024.

- **Medicare DSH Cuts: $79,884,200**
  Impacts reflect the estimated reductions to the national uncompensated care payment pool amount based on projected changes to the national uninsured rate provided by the CBO.

- **Quality Cuts: $6,743,300**
  Reflect payment adjustments related to ACA-mandated Quality Based Payment Reform including value based purchasing, readmissions, and hospital acquired conditions.

- **Bad Debt Payment Cuts: $2,180,700**
  The impact shown reflects the Middle Class Tax Relief and Job Creation Act of 2012-authorized reduction to Medicare payments for reimbursable bad debts for all provider settings to 65%.

- **ATRA Coding: $9,932,500**
  The impact reflects the American Taxpayer Relief (ATRA) of 2012-authorized retrospective (one-time) coding adjustment cuts totaling at least -9.3% that CMS must implement over a 4 year period.

**Total Legislative Cuts = $458,675,800**

- **Regulatory Coding Adjustments $ 127,744,400**
  The impact shown reflect annual adjustments made to the standard amount/federal rate in order to recoup for increases in gross payments due solely to the transition to new DRGs and/or DRG weights.

- **2-Midnight Rule Offset: $4,769,600**
  The impact reflects the -0.2% adjustment to the IPPS federal rate established by CMS in order to offset grown in IPPS expenditures as a result of increased inpatient admissions associated with the “2-Midnight Rule”.

**Total Regulatory Cuts = $132,514,000**

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1 15-Year Medicare Cut Analysis, DataGen, February 2015.
2 This value is calculated by first estimating and aggregating Medicare Fee-for-Service (FFS) revenue overall a 15 year period (2010-2024) without the effect of existing legislative or regulatory payment cuts. Then the estimated impact of the existing cuts over the same 15 year period are aggregated and divided by the aggregated revenue calculated in the first step. The result is a 15 year summary value of cuts as a percent of total Medicare FFS revenue. This does not include any of the cuts under consideration.
A provider tax, is defined as any fee, assessment, tax, or other mandatory payment where 85% or more of the cost is paid by health care providers. These types of taxes are regulated by the federal Centers for Medicare and Medicaid Services (CMS) and are subject to certain requirements. Although commonly referred to as hospital taxes, CMS has identified 19 different types of provider classes or services for which a tax is allowed including:

1. Inpatient hospital services;
2. Outpatient hospital services;
3. Nursing facility services;
4. Intermediate care facility;
5. Physician services;
6. Home health care services;
7. Outpatient prescription drugs;
8. 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 not listed above subject to certain requirements.

How taxes are used: Medicaid is jointly funded by the federal government and each state government. Funding is based on a variety of factors, but states must make available a certain percentage of state general funds in order to receive federal matching funds to cover Medicaid expenditures. In the 1980s states realized that they could tax providers and use those tax dollars to increase their state match, which in turn increased the federal government’s required match. The extra funding the state received from the federal government was returned to providers though increased rates or supplemental payments from state Medicaid programs. It is not clear if this mechanism would work in Alaska, because Medicaid rates are generally higher than in other states. Most recently, Arizona implemented a provider tax to pay for Medicaid expansion. In the 1990s, in an effort to reduce the increasing cost of Medicaid the federal government focused on limiting state’s ability to leverage provider taxes in such a way. Now provider taxes are subject to certain federal requirements.

Currently, most states have some type of provider tax. The most common type of tax is a tax on nursing homes, followed by inpatient hospital services, however this can vary widely. Minnesota is the only state that taxes all allowable types of providers (although they will be altering that within the next few years) while seven other states only have one type of provider tax. In general, about 34% of states report enacting 1-2 types of provider taxes, 36% report 3 types of provider taxes, and 28% report taxing 4 or more provider services.

Federal regulations: In order for states to count income from provider taxes as state dollars that can be put towards the state’s share of Medicaid funding, the tax must comply with several requirements outlined by CMS.

1. The tax must be broad based, meaning it must be applied to both Medicaid and non-Medicaid providers. It must also be applied to all providers or services within that class.
2. The tax must be uniformly applied, meaning it must be applied to the same degree on each provider or services within a class.
   - Example 1: A tax on hospital beds must tax the same amount per bed across all facilities.
   - Example 2: A licensing fee must be the same amount for each license.
Example 3: A tax on revenue (net or gross) must apply the same tax rate across all facilities or providers within that class.

3. The tax must not hold providers harmless, meaning it cannot guarantee that providers will be made financially whole through direct or indirect means.

CMS has established a safe harbor threshold for the hold harmless provision when the taxes collected are 6% or less of patient revenues. CMS also has a provision that allows for a waiver from the broad-based requirement and the uniformity requirement and these waivers are most commonly used by states to protect critical access or sole community hospitals from shouldering additional costs.

If a state enacts a provider tax that does not meet the three requirements listed above, CMS will subtract the amount of the provider tax in total from the amount of the state’s match before calculating the federal match for Medicaid expenditures.

**How provider taxes have benefitted other states:**
- Increased income for state governments to pay for Medicaid programs.
- Acted as a way to leverage additional federal funds (albeit on a more limited basis).
- Avoided cuts to Medicaid payment rates or eligibility thresholds.

**Problems with provider taxes in other states:**
- Taxes increase the cost of doing business for providers.
- The hold harmless requirement can create winners and losers with some providers benefitting from increased revenue associated with the tax while others pay more in taxes than they gain in revenues.
- State legislatures have redirected provider taxes to fund other non-health related portions of state government during challenging budget environments. This has cascading negative effects on providers as it reduces federal dollars to the Medicaid program overall which results in reduced payments or rate reductions to providers, who are still paying taxes for their services.

**Process of developing a provider tax:** Developing a methodology for a provider tax can be very complicated, especially if the goal is to avoid having a provider pay more in taxes than it receives in new revenue, thus avoid increasing the overall cost of care. Arizona, which recently enacted a tax, went through a year-long process with a consultant contracted by the state Medicaid program.

**How Alaska’s hospitals contribute:** Alaska’s hospitals already, without regulation, provide considerable financial benefits to the state and the communities they serve. These include providing more than $90 million in uncompensated care annually, paying municipal property tax, employer tax, and funding community benefit programs.

Just like the rest of the state, Alaska’s hospitals are bracing for challenging economic times. Hospitals in Alaska are experiencing almost $600 million in federal legislative and regulatory cuts from 2010 to 2024. Additionally, there are another $320 million in proposed reductions from 2015 to 2024 currently under consideration. These cuts impact hospitals across the state, magnifying the impact of any additional financial burden.

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2. 42 CFR § 433.56
5. 42 CFR § 433.68
PROVIDER TAXES – A COMPREHENSIVE OVERVIEW

Provider taxes are a strategy that almost every state employs to help fund Medicaid programs while leveraging additional federal dollars. To control federal costs of the Medicaid program, there are certain limitations, restrictions, and other requirements that policy makers and health care providers must be aware of and take into consideration when contemplating the use of provider taxes to support Medicaid programs. Additionally, the type, amount, and use of provider taxes vary dramatically among states. This briefing will provide case studies of tax models used in different states as well as an overview of how provider taxes are being used to leverage Medicaid expansion in various states.

Key Points

General
• Provider taxes are defined as any fee, assessment, or mandatory payment where 85% of the burden falls upon health care providers.¹
• There are 19 classes of providers that may be taxed as identified by CMS.²

Requirements
• Provider taxes must meet three general requirements in order for the funds to be eligible to count as part of the state’s Medicaid match. These three requirements are:³
  1) The tax must be broad based, meaning it must apply to all non-federal, non-public providers or services within that class;
  2) The tax must be uniform, meaning the same fee (amount, rate, percentage, etc.) must be applied to all providers or services within that class; and
  3) The tax cannot hold providers harmless, meaning it cannot guarantee that providers will be made financially whole through direct or indirectly means. However states can provide an indirect guarantee if the tax is 6% or less of net patient revenues within the class of providers or services being taxed.

Waivers
• States may apply to the Secretary of the Department of Health and Human Services (DHHS) for a waiver from the broad based and uniform requirements, but not the hold harmless requirement.
• In general, waivers must show that the proposed tax is generally distributive, that the tax is not directly correlated to Medicaid payments, and that it does not hold providers harmless. This is tested with specific formulas outlined in regulations.
• Establishing different thresholds or excluding rural access hospitals and sole community hospitals are specifically identified in statute as examples for which a wavier would be viewed favorably.⁴

Provider taxes are complex and require in depth analysis and modeling to avoid unintended negative consequences on the health care infrastructure.
**Federal and State Funding for Medicaid**

The Medicaid program is jointly financed by the federal government and state government. The amount the federal government pays is based on each state’s Federal Medical Assistance Percentage (FMAP). The FMAP is calculated using a variety of different factors, but is largely based on a state’s per capita income. The actual amount of federal assistance received by states is based on the FMAP and on reported Medicaid expenditures for both medical costs and administrative costs.

In order to receive federal funding for Medicaid, each state must provide matching funds to help pay for their portion of the program cost. In the late 1980s, states realized that they could leverage provider taxes to increase the federal funding they received for the program and to decrease state general funds as a portion of the state required match. They did this by taxing health care providers, collecting the taxes and putting them towards the state required match. The increased income from provider taxes resulted in an increase in state funding for the program, which in turn drew down additional federal funds. These funds were then passed back to providers through increased rates and supplemental payments above and beyond what providers had paid in taxes.

States were so successful in using provider taxes to leverage federal funds that, in an effort to contain Medicaid costs in the early 1990s, the federal government began regulating provider taxes in effect limiting a state’s ability to use these funds in a way that qualifies for federal matching dollars. In order for funds generated by provider taxes to count as part of the state’s match, the provider taxes must meet several requirements outlined and determined by the Center for Medicaid and Medicare Services (CMS). If CMS determines that a provider tax does not meet the requirements outlined in statute and regulation, then CMS will subtract the amount of ineligible provider tax dollars from the total state Medical assistance expenditures before calculating the federal match.5

In general, requirements for state matching funds include:
- At least 40% of matching funds must be state funds.6
- No more than 25% of a state’s match can come from provider tax funds.7
- Up to 60% of a state’s match can come from local government funds or Certified Public Expenditures (CPE).8 CPEs are the reported expenditures for Medicaid services performed by a hospital or provider that is owned by a local government entity. CPEs are reported to the state Medicaid program and added to the Medicaid expenditure total when calculating federal assistance. States can choose to pass all or a portion of the federal funds received for CPEs back to the local government entity.9

**Provider Tax Definition & Requirements**

Provider taxes are defined as any “fee, assessment, or mandatory payment” for which 85% or more of the burden of the payment is shouldered by health care providers.10 Although often thought of as primarily a “hospital tax,” there are 19 classes of health care providers that fall under this definition as outlined in federal regulations:11

1) Inpatient hospital services;
2) Outpatient hospital services;
3) Nursing facility services (other than services of intermediate care facilities for individuals with intellectual disabilities);
4) Intermediate care facility services for individuals with intellectual disabilities;
5) Physician services;
6) Home health care services;
7) Outpatient prescription drugs;
8) Services of managed care organizations (including HMO & PPO);12
9) Ambulatory surgical center services (facility only, not procedures);
10) Dental services;
11) Podiatric services;
12) Chiropractic services;
13) Optometric/optician services;
14) Psychological services;
15) Therapist services (including PT, SLP, OT, respiratory therapy, audiological services, and rehabilitative specialist services);
16) Nursing services (including nurse midwives, nurse practitioners, and private duty nurses);
17) Laboratory and x-ray services in a licensed, free-standing laboratory or x-ray facility (excludes those provided in a physician's office, hospital inpatient outpatient department);
18) Emergency ambulance services; and
19) Other health care items or services not listed above on when the state has enacted a licensing or certification fee, subject to the broad based, uniformity, and hold harmless requirements.

CMS has established three thresholds that a provider tax must pass in order to be eligible for federal matching funds. These include: 1) the tax must be broad based; 2) the tax must be uniform; and 3) the tax must not hold providers harmless. In general, these three requirements are evaluated based on how a tax is applied to a class of providers or services and are calculated in aggregate. States may apply to the DHHS Secretary for waiver of the broad based and uniform requirements, however there is no allowable waiver for the hold harmless provision. The details and process associated with each requirement (where applicable) are described below. From 2008 through 2012, CMS approved broad based and/or uniform waivers in 29 states.13

1. **Broad based requirement**
   This requirement states that a tax must be applied to “all services or items within a class including all non-federal or non-public providers within the class.”14 States can apply for a waiver from this requirement if they are seeking to impose a tax that excludes certain providers within a class as long as they can show that the tax is “generally redistributive in nature.”15

States are automatically granted a broad based waiver if the proposed tax is no more than $1,000 annually per provider, or if the total amount of the tax is used to cover the cost of a licensing and certification program.16 To evaluate other proposed taxes for a broad based waiver, CMS applies a formula that divides the estimated amount of the tax if it were applied to all providers within that class by the estimated amount of the tax as applied to providers under the proposed waiver. If the result is 1 or higher, the waiver is automatically approved. If the result is between 0.90 and 1, CMS will review the waiver and will approve if the proposed tax only excludes or treats differently providers in the classes listed below:17

- Providers that provide no services or who do not charge for services in the state
- Rural hospitals
- Sole community hospitals
- Physicians practicing in medically underserved areas as defined by section 1302(7) of the Public Health Service Act
- Financially distressed hospitals only if:
  1) Such hospitals are defined by state law that is applied uniformly to hospitals around the state; and
  2) No more than 10% of hospitals are excluded from the tax
- Psychiatric hospitals
- Hospitals owned and operated by HMOs
2. Uniform requirement
An additional requirement for any provider tax is that it be uniformly imposed, meaning it is applied to all providers or services within that class and that it is applied to the same degree. Examples identified in regulation are listed below:

Example 1: If the tax is a bed tax, the same amount per bed must be applied to all providers within that class.

Example 2: If the tax is a certification fee, the fee must be the same for all providers within that class.

Example 3: If the tax is based on gross revenue receipts or net operating revenue, the tax rate must be the same for all providers within that class.

Specifically, in order to be uniform the tax must be “generally redistributive in nature,” just as with the broad based requirement, but the tax must also prove that provider revenues are not correlated with Medicaid payments at any point in time. Also, there is repeated and significant emphasis that any taxes providing credits, exclusions, or direct or indirect payment to providers would violate the uniformity clause and the hold harmless clause. Some states have developed methods to work around this clause that are discussed further in this paper.

States applying for a waiver to the uniform requirement must also pass a test used to evaluate if there is any correlation between the receipt of Medicaid payments and the amount of provider taxes paid. To determine if this relationship exists, and to what extent it does exist if at all, CMS divides the slope of the linear regression if the state’s tax were broad based and uniform to the slope of the linear regression of the tax as proposed in the waiver. If the result is 1 or more, the waiver is automatically approved. If the result is between 0.90 and 1, the waiver may be approved only if it applies the tax in a non-uniform manner to the following providers (note this list is slightly different than the list of providers allowed under the broad based exclusion):

- Providers that provide no services or who do not charge for services in the state
- Rural hospitals
- Sole community hospitals
- Physicians practicing in medically underserved areas as defined by section 1302(7) of the Public Health Service Act.
- Financially distressed hospitals only if:
  - Such hospitals are defined by state law that is applied uniformly to hospitals around the state; and
  - No more than 10% of hospitals are excluded from the tax
- Psychiatric hospitals
- Providers or payers with varying tax rates based exclusively on region subject to certain requirements

3. Hold harmless requirement
This requirement essentially acts as a way to prohibit states from taxing providers, using those funds to pull down enhanced federal funding, and passing those dollars back to providers through direct or indirect means. There are no waivers to this requirement which CMS evaluates two ways:

1) Does the tax use direct or indirect means to ensure the providers paying the tax are made financially whole through non-Medicaid payments; and
2) Does the amount providers receive from those payments positively correlate at any point in time to the amount the providers pay in taxes or the difference between their Medicaid
revenues and the amount they pay in taxes. The positive correlation still counts even if it is not constant over time.

Despite the lack of waiver for this requirement, there is an established “safe harbor” threshold that allows for a certain amount of flexibility. States can provide an indirect guarantee if the tax produces revenues less than 6% or more of the net patient revenue attributed to the class of health care providers or services being taxed.\(^{22}\) This safe harbor provision is currently set at 6%, but it is important to note that this has changed within the past decade falling to 5.5% from 2008 to 2011 before returning to 6%. There are ongoing discussions in Congress debating the impact and financial benefit to the federal government of lowering this threshold and at one point in the past few years President Obama’s budget proposed lowering the threshold to 3.5% as part of his administration’s effort to reduce the federal deficit.\(^{23}\)

To determine if there is a positive correlation or if the tax holds providers harmless, CMS applies a “two prong test:"

\begin{itemize}
  \item Prong 1: Does the tax create more revenue than 6% of the net patient revenue attributed to the class of health care providers or services being taxed?\(^{24}\)
  \item Prong 2: If so, do 75% of the providers taxed recover 75% or more of their total costs back through enhanced Medicaid or other state payments?
\end{itemize}

According to a 2014 report by the GAO, all of the 63 taxes implemented between 2008 and 2012 as a percentage of net patient revenues were below the safe harbor threshold and would have passed the hold harmless test.\(^{25}\) This is significant in understanding how some states are able to leverage provider taxes to fund expanded Medicaid programs, and in effect be “held harmless” despite the regulatory and statute provisions.

**Provider Donations**

Similar to provider taxes, provider donations have also come under scrutiny and both statute and regulations outline requirements that provider donations must meet in order for states to avoid reductions in federal matching funds. These requirements are:

\begin{itemize}
  \item Provider donations can be cash, in-kind, direct or indirect services or payments to the state from a health care provider offering services under the state plan.\(^{26}\)
  \item Donations from individuals of $5,000 or less annually are allowed.\(^{27}\)
  \item Donations from a health care provider/entity of $50,000 annually or less are allowed.\(^{28}\)
\end{itemize}

Bona fide donations are donations for which providers are not held harmless. Specifically this means that there is no positive correlation at any time between provider donations and the amount of Medicaid payments the provider receives.

Bona fide donations from hospitals, FQHC, clinics, or similar provider classes are specifically allowed if they cover the costs of staff providing Medicaid eligibility determinations or redeterminations for the state at that facility.\(^{29}\) These types of donations are limited to no more than 10% annually of the state’s Medicaid assistance administrative cost.\(^{30}\) The donation must be a direct donation defined as costs for salaries, training, or fringe benefits for on-site or local agency support staff. Eligibility outreach costs may also be considered an allowable donation if those costs are prorated and calculated as a percentage of the state’s aggregate outreach cost. The cost of agency overhead and the space are specifically excluded as allowable bona fide donations.\(^{31}\)

**Reporting Requirements**
Reporting requirements for both provider taxes and donations are outlined in regulations, however the requirements are rather vague. States are required to report provider taxes and donations on a quarterly basis in summary form. This information should include the source of tax or donation revenue and how the state is using these funds. Additionally the state is required to provide a legal basis for the donation or tax program.

The United States Government Accountability Office (GAO) has raised concerns that the current reporting system is not adequate and that CMS is not enforcing the existing reporting requirements. CMS has indicated that they do not agree with the GAO assessment but will consider improving the reporting system at some point in the near future.

Process for Implementing Provider Taxes
Generally provider taxes are enacted by a state legislature through statute. The state then adds the proposed tax to their Medicaid state plan through a State Plan Amendment (SPA). During the SPA process CMS evaluates the taxes based on the requirements outlined above. In some states the fees are collected by provider association groups and are then passed along to the Medicaid program through an intergovernmental transfer. In other cases, a state agency is responsible for collecting the taxes from each provider.

Provider Taxes that are not Regulated by CMS
Several states have implemented provider taxes that do not meet the definition in federal statute or regulation for provider taxes and thus are not subject to the requirements laid out by CMS. They have achieved this by making the taxable entities a mix of health care and non-health care providers so the total tax burden for health care providers is under the 85% threshold identified in statute. Specific examples are listed below:

- Washington enacted a business and occupation gross receipts tax. Health care providers, specifically hospitals are taxed based on their profit or non-profit status at 1.8% of gross revenue from health care activities. Preferential tax rates are applied to other types of health care services such as room and domiciliary care to patients in an assisted living facility which is taxed at 0.27%.
- Maine taxed 5% of the value of mental health, intellectually disabled, and autistic home-support and institutional services along with cable and satellite television, fabrication services, video equipment and media rental, and telecommunication services.
- West Virginia enacted a 5% severance and business privilege tax on behavioral health services (inpatient, outpatient, residential) and the severing, extraction, and sale of commercial coal, limestone, or sandstone.

State Trends
According to the Kaiser Family Foundation in their annual state survey, 49 states reported assessing at least one provider tax with most states reporting multiple taxes. Alaska was the only state that had not implemented a provider tax, but Delaware, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Virginia, and Wyoming all reported assessing only one type of provider tax in 2015. The other 41 states reported assessing two or more taxes on health care providers in 2015.

The most popular type of tax was a tax on nursing facilities (44 states), followed by hospital services (38 states), and intermediate care facilities (37 states). Among states that tax additional services beyond hospital, intermediate, and nursing facilities, the most common taxes were on ambulatory surgical center services, laboratory and x-ray services and emergency ambulance services.
States have been creative with the way that they implement taxes. Some examples of provider taxes include licensing fees, bed taxes, a tax per hospital admission, a tax per hospital discharge, a tax on gross revenue, a tax on net revenue, prescription taxes, etc.\textsuperscript{40}

![Type of Provider Taxes Among All States (2008 - 2012)](image)

A recent report from the GAO highlights the increasing reliance of state Medicaid funding through provider taxes. According to their report, the amount of provider taxes funding Medicaid programs across the US increased from $10 billion in 2008 to around $19 billion by 2012 and increases were largely seen in provider taxes on inpatient hospitals and nursing homes.\textsuperscript{41} Specifically, in 2008 there were 117 provider taxes implemented in 42 states, and by 2012 that increased to 159 provider taxes implemented across 47 states. This represents a 36\% increase over the 5-year period and a net increase of 42 taxes.\textsuperscript{42}

Increasingly, states have turned to provider and local government funds in order to finance the non-federal portion of supplemental payments. In 2012, seven states reported relying exclusively on provider taxes and local government funds for the non-federal portion of their Disproportionate Share Hospital (DSH) match.\textsuperscript{43} Seven other states used a mix of provider taxes and local funding to provide their portion of matching funds for supplemental non-DSH payments.\textsuperscript{44} Notably, Idaho and Nevada made both lists and reported funding all of their supplemental payments, DSH and non-DSH, with 100\% provider taxes and local government funds. From 2009 through 2010, Idaho eliminated the use of state general funds for supplemental payments by increasing or establishing new taxes for inpatient and outpatient hospital services and nursing homes.\textsuperscript{45} This increase in provider taxes and local government funding made Idaho the state with the largest increase in provider taxes in the U.S. during that time period. While Idaho is at one end of the spectrum of choices states have made in funding their Medicaid programs, the overall 5-year trend has been an increase in taxes on provider and services.

Just as every Medicaid program is unique to each state, so is their provider tax structure. Summarized below are some notable models/elements of provider taxes in a variety of states.

**Kansas**

Assesses a 1.83\% tax on hospital net inpatient operating revenue and a flat rate of $1,950 per nursing home bed. State statute dictates that at least 80\% of the revenues from the hospital tax must be redistributed to hospital providers, and 20\% is redistributed to physicians. Additionally all of the revenue from the nursing home tax must be used to improve quality of health care in those facilities including offsetting nursing home rate reductions and covering the cost of the assessment.\textsuperscript{46} Critical access hospitals, teaching hospitals and public hospitals are exempted and state legislation specifies that the cost of the tax may not be passed onto consumers.
Minnesota
This state has enacted some of the widest variety of provider taxes among all of the states with a focus on using provider taxes to fund public health programs for those who were uninsured and previously ineligible for Medicaid under a health plan called MinnesotaCare. MinnesotaCare was funded through the creation of the Health Care Access fund. This fund was made up of state taxes totaling 2% of hospital, surgical centers, health care providers, and wholesale drug distributor's gross revenues. While the fund was created with the intention of funding MinnesotaCare, during challenging budget times provider tax funds were actually used to balance the state budget and were not fully put towards supporting health care programs. As a result of a combination of advocacy by provider associations and the expansion of Medicaid to uninsured, childless adults, the state decided to slowly phase out the provider taxes with the intention of eliminating them by 2019.

Washington
Aside from the Business and Occupation Tax described on page 8, the State of Washington implemented a hospital assessment to support safety net services in 2010 when the state was facing a budget shortfall. The assessment was intended to pull down matching federal funds which would then be passed onto hospitals through increased rates with a small portion ($50 million) being put towards the general fund. A year later, the legislature reversed course reducing Medicaid rates and directing $110 million in Safety Net Assessment funds to the general fund. This in turn reduced the state’s federal match for Medicaid and resulted in an estimated $260 million impact. This disproportionately impacted Prospective Payment System (PPS) hospitals in the state as they ended up paying more in taxes than they were receiving. Critical access hospitals, public hospitals, and psychiatric hospitals were not impacted as deeply by the changes.

The Washington State Hospital Association filed a lawsuit in 2011 and, in an effort to avoid a contentious legal battle, the hospital association and the legislature crafted a provider tax structure that is currently in place. Under this structure the state established a dedicated fund within the treasury called the Safety Net Assessment Fund. The stated legislative intent is that as Medicaid expansion brings additional federal dollars to the state health care system to cover individuals in the safety net, the need for this assessment will decrease. Beginning in state fiscal year 2016, the assessment program will be phased out ending entirely in 2019. Additionally, the legislation contains stipulations that protect hospitals from having the fund be misused or diverted as they were in the past.

- The state cannot pull more than $100 million per year from the assessment fund to put towards general fund spending in the Medicaid program.
- The bulk of the funds must be used to help hospitals support vulnerable patients.
- Any dollars remaining in the fund in 2019 must be distributed back to the hospitals.
- Hospitals engage in a contract with the state Health Care Authority each biennium to ensure there are no additional legislative changes to the supplemental payments, rates, assessments, DSH payments, capitation payments, or other financial arrangements outline in statute.

Hospitals agreed to accept 2009 Medicaid rate levels for inpatient and outpatient services for both Fee for Service (FFS) and Managed Care (MC). For PPS hospitals, the assessment is based on a flat rate per non-Medicare inpatient bed day up to a set limit of 54,000 bed days per year. Once that threshold is reached, any additional bed patient days are assessed at a lower rate. Overall, the assessment rate is higher for PPS hospitals than for critical access hospitals, psychiatric hospitals, and rehabilitation hospitals.
In turn, hospitals receive direct quarterly supplemental payments from the state for inpatient and outpatient FFS Medicaid services. The quarterly payments are based on a set amount fixed in statute for fiscal years 2014 and 2015 per hospital class. Should the combination of Medicaid revenues and additional supplemental payments exceed the Upper Limit (UL), the supplemental payments must be reduced until they are within the UL threshold. The remaining funds will be paid to Medicaid Managed Care organizations.57

Notably, the statute also includes a provision requiring hospitals to treat the assessment as part of their operating overhead and restricts them from passing on these costs to consumers and third-party payers through increased charges.58

**Arizona**

In 2013 Arizona established a hospital assessment intended to cover the state’s portion of the cost to expand Medicaid coverage to non-disabled, childless adults with incomes between 100% and 133% of the Federal Poverty Level (FPL) along with restoring funding for a program called Prop 204 which provided coverage for childless adults with incomes 100% FPL or less.59 Rather than the Legislature developing the assessment, Governor Brewer directed the Director of the Arizona Health Care Cost Containment System (AHCCS) to develop an assessment model not codified in statute in order to retain flexibility.60

Ultimately the assessment model was supported by the Arizona Hospital and Healthcare Association (AHHA) because of a shared understanding that the assessment would be designed in such a way that no hospital would experience financial harm.61 In order to achieve this, the assessment model uses a variety of exemptions and variable rates to ensure the assessment does not harm different hospital models. In a move similar to that of Washington state, legislation was crafted that specifically prohibits hospitals from passing on the cost of the assessment to consumers.

The assessment itself is at the heart of a legal challenge to Arizona’s decision to expand Medicaid. Arizona requires that state taxes be approved by a two-thirds majority rather than a simple majority. Governor Brewer’s administration determined the assessment was not a tax, and the enabling legislation for the hospital assessment was passed with a simple majority, however that is now being challenged in the court system.62

**Indiana**

In order to maintain his commitment to not use taxpayer funds to support Medicaid expansion, Governor Pence worked with the hospital association to develop a funding mechanism that uses tobacco tax revenues and increases an existing provider tax to cover the state’s portion of the cost to expand Medicaid.63 Specifically, Indiana’s expansion model uses a tax on acute and private psychiatric hospitals that was established in 2011 with proposed increases taking effect as the federal funding match for the expansion population begins to drop in 2017. The hospital tax will provide $959 million of the estimated $1.6 billion state required match while revenue from a tobacco tax increase will cover the additional $640 million.

In return for the assessment, the hospitals will benefit by avoiding rate reductions and increased reimbursement for physician services from around 55% of Medicare rates to 75%.64 Additionally, some of the assessment funds will be used to establish a trust fund to cover administrative costs for the program. Indiana also established a Hospital Assessment Fund board that oversees the formula used to determine the assessment. The board is made up of two members from the hospital association and two appointees from the state.65
Considerations for Provider Taxes in Alaska
Should Alaska providers and policy makers engage in the discussion of enacting a provider tax or assessment, some considerations are listed below:

1) Ensure that the tax is not misappropriated by future legislatures as much as possible. With Alaska’s constitutional prohibition against dedicated funds, it may be appropriate to consider taking Washington’s approach and having a state agency contract with hospitals and using the contract terms to protect against misappropriation.

2) Can tribal health providers be included in a provider tax structure? This is an important issue that would need to be resolved early in the process. A discussion on what providers are included in a tax structure is a critical question.

3) Ensure that supplemental payments to hospitals or other provider classes are not in excess of the upper payment limit and develop a plan to manage any excess payments in advance.

4) Consider establishing a board made up of state agency representatives and hospital association or provider representatives to manage the assessment process on an annual or biennial basis.

5) Consider the staff time necessary to manage the tasks associated with an assessment. Specifically staff would be needed to manage the quarterly reporting requirements, the collection of the assessment, and the development of any waivers.

6) Ensure providers are not financially harmed by an assessment. This would require a balance of the following:
   - Staying under the 6% safe harbor threshold;
   - Ensuring that supplemental payments to make hospitals whole do not exceed Medicaid upper payment limit; and
   - Providing variable tax rates or exemptions for critical access hospitals and/or sole community hospitals.

7) States typically require outside expertise to assist in the development of a provider tax through modeling the impact of rates and types of taxes (e.g. bed, revenue, discharge, etc.) on different providers. Arriving at a methodology that will meet the needs of diverse providers and fulfill complex CMS requirements makes consultant support critical.
ASHNHA - Provider Taxes Comprehensive Overview, April 2015 v.2

1 42 C.F.R. § 433.55
2 42 C.F.R. § 433.56
3 42 C.F.R. § 433.68
4 Social Security Act § 1903 (w)(3), 42 U.S.C. § 1396b
5 42 C.F.R. § 433.57
6 42 C.F.R. § 433.53
7 Social Security Act § 1903(w)(5), 42 U.S.C. § 1396b
9 Ibid.
10 42 C.F.R. § 433.55
11 42 C.F.R. § 433.56
12 Health insurance and HMO premiums are not considered a provider tax and are specifically excluded per 42 CFR § 433.55.
14 42 C.F.R. § 433.68
15 Ibid.
16 Ibid.
17 Ibid.
18 Ibid.
19 42 CFR § 433.68
20 Ibid.
21 Ibid.
22 42 CFR § 433.68
24 42 CFR § 433.68
26 Social Security Act § 1903 (w)(2), 42 U.S.C. § 1396b
27 42 CFR § 433.55
28 42 CFR § 433.55
29 42 CFR § 433.66
30 42 CFR § 433.67
31 42 CFR § 433.66
32 42 CFR § 433.74
37 WAC § 458-20-168
42 Ibid.
43 Ibid. The seven states are Colorado, Florida, Idaho, Mississippi, Nevada, South Carolina, and Tennessee.
44 Ibid. The seven states are Alabama, Idaho, Illinois, Nebraska, Nevada, North Carolina, and Wyoming.
45 Ibid.
47 Minn. Stat. § 295.52
50 Ibid.
51 Wash. Rev. Code § 74.60
52 Wash. Rev. Code § 74.60
53 Wash. Rev. Code § 74.60
54 Wash. Rev. Code § 74.60.160
55 Wash. Rev. Code § 74.60.020
56 Wash. Rev. Code § 74.60.030
57 Wash. Rev. Code § 74.60.120
58 Wash. Rev. Code § 74.60.070
59 Hospital Assessment. (n.d.)
64 Ibid.
1. 42 C.F.R. § 433.55
2. 42 C.F.R. § 433.56
3. 42 C.F.R. § 433.68
5. Social Security Act § 1903 (w)(3), 42 U.S.C. § 1396b
6. 42 C.F.R. § 433.57
7. 42 C.F.R. § 433.53
10. Ibid.
11. 42 C.F.R. § 433.55
12. 42 C.F.R. § 433.56
13. Health insurance and HMO premiums are not considered a provider tax and are specifically excluded per 42 CFR § 433.55.
15. 42 C.F.R. § 433.68
16. Ibid.
17. Ibid.
18. Ibid.
19. Ibid.
20. 42 CFR § 433.68
21. Ibid.
22. Ibid.
23. 42 CFR § 433.68
25. 42 CFR § 433.68
27. Social Security Act § 1903 (w)(2), 42 U.S.C. § 1396b
28. 42 CFR § 433.55
29. 42 CFR § 433.55
30. 42 CFR § 433.66
31. 42 CFR § 433.67
32. 42 CFR § 433.66
33. 42 CFR § 433.74
38. WAC § 458-20-168
40 Pacific Health Policy Group. (2012)
41 Kaiser Family Foundation. (2014).
43 Ibid.
44 Ibid. The seven states are Colorado, Florida, Idaho, Mississippi, Nevada, South Carolina, and Tennessee.
46 Ibid.
48 Minn. Stat. § 295.52
51 Ibid.
52 Wash. Rev. Code § 74.60
53 Wash. Rev. Code § 74.60
54 Wash. Rev. Code § 74.60
55 Wash. Rev. Code § 74.60.160
56 Wash. Rev. Code § 74.60.020
57 Wash. Rev. Code § 74.60.030
58 Wash. Rev. Code § 74.60.120
59 Wash. Rev. Code § 74.60.070
60 Hospital Assessment. (n.d.)
65 Ibid.
TRIBAL UNCOMPENSATED CARE

Uncompensated care at Alaska tribally operated facilities

Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital’s "bad debt" and the charity care it provides. Charity care is care for which hospitals never expected to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided.

To ensure accuracy, uncompensated care numbers are taken from hospitals cost reports that are required to be submitted annually to Medicare and Medicaid. The Schedule S-10 includes the uncompensated care cost numbers - non-Medicare bad debt on line 23 and charity care to uninsured patients line 29.

Hospitals operated by Native health organizations are required to file a Schedule E cost report. The Schedule E cost report is an abbreviated form of cost reporting. As a result they are not obligated by CMS to report charity care or bad debt, simply because this is not a component of Schedule E cost report. Schedule S-10 is not a part of their cost report.

Tribal hospitals do have uncompensated care, but because of the difference in reporting requirements it is difficult to compare their data to the non-tribal facilities. Tribal facilities report data from patient accounting and general ledger systems and the uncompensated care represents the total amount of gross charges written off for care provided to patients who have no payer source.

Some tribal hospitals do submit the Schedule S-10 worksheet because of a special payment status (for 2013 this includes SEARHC Mt Edgecumbe Hospital and Norton Sound Regional Hospital) as a result comparable uncompensated care data is available for the facilities.

ASHNHA has data representing 17 acute care hospitals for cost reporting period Oct 1, 2012 – Sept 30, 2013. For 2013, the 17 hospitals report a total of $101,940,421 in uncompensated care.¹

¹ Hospitals with no data for 2013 include Alaska Native Medical Center, Yukon Kuskokwin Delta Regional Hospital, Maniilaq Health Center, Kanakanak Hospital, and Samuel Simmonds Memorial Hospital.
IMPACT OF MEDICAID EXPANSION ON HOSPITAL UNCOMPENSATED CARE

Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital’s "bad debt" and the charity care it provides. Charity care is care for which hospitals never expected to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided.1

ASHNHA has data representing 17 acute care hospitals for cost reporting period Oct 1, 2012 – Sept 30, 2013. For 2013, 17 Alaska hospitals provided over $100 million in uncompensated care.

To ensure accuracy, uncompensated care numbers are taken from hospital’s cost reports that are required to be submitted annually to Medicare and Medicaid.2 Many tribal hospitals are not included in this data because of differences in cost reporting requirements.3 Tribal hospitals do have uncompensated care, but because of the difference in reporting requirements it is difficult to compare their data to the non-tribal facilities. Tribal facilities report data from patient accounting and general ledger systems and the uncompensated care represents the total amount of gross charges written off for care provided to patients who have no payer source.

This summary seeks to quantify the potential impact of Medicaid expansion on hospital uncompensated care.

• Early evidence shows a dramatic drop in uncompensated care for hospitals in states that have expanded Medicaid, due to an increase in Medicaid patient volume. At the same time, the proportion of self-pay and overall charity care has declined in expansion-state hospitals.4
• A Colorado study analyzed data from 465 hospitals in 30 states in the first four months of Medicaid expansion. It found that unpaid care decreased by 30 percent in expansion states and remained essentially unchanged in non-expansion states. The report links an enrollment surge in expansion states to not only the reduction in uncompensated care but also the 25-percent decrease in people paying out of pocket.5
• In Alaska, if Medicaid is expanded a decrease in uncompensated care is anticipated. Based on the experience in other states a 20%-30% reduction of uncompensated care could be achieved. This could amount to decrease of between $20 and $30 million in uncompensated care at Alaska hospitals.
• A decrease in uncompensated care could result in improved financial sustainability for Alaska’s small/rural hospitals that are currently operating at a deficit. Additional resources will allow Alaska hospitals to better respond to community health needs and provide community benefits.
• Hospitals face looming uncertainty as federal cuts authorized by the ACA increase. These cuts amount to more than $591 million over fifteen years for Alaska hospitals.6 Hospitals agreed to payment reductions based on the assumption that expanding Medicaid would be mandatory for all states and would make up for losses.
What would a reduction in uncompensated care mean for Alaska’s health care system?

Small and large hospitals are under increasing regulatory and financial pressure to adapt to a rapidly changing business model and declining reimbursement. For small, rural hospitals, a reduction in uncompensated care could have a huge impact on future sustainability. Across the country, Critical Access Hospitals (CAH) with under 25 beds are shutting their doors. Across the country, 43 CAHs have closed since 2010. In Iowa, if a CAH closes it means you might have to drive 20 miles more down the road. In Alaska, if a CAH closes it means an expensive Medevac and delayed treatment.

The health care industry is faced with significant financial pressure and at the same time being asked to transform health care, from a system that rewards volume to one that rewards value. Incentives within the current system are not aligned. Hospitals get paid when people are sick – not for keeping them well or for delivering high-quality, cost-effective care. Health care is undergoing radical transformation, away from a system that pays for volume to a system that pays for value. The reduction in uncompensated care can give hospitals the capital needed to support transformation.

1 American Hospital Association, Uncompensated Hospital Care Cost Fact Sheet
2 Hospital cost report data, schedule S-10 includes the uncompensated care cost numbers - non-Medicare bad debt on line 23 and charity care to uninsured patients line 29.
3 Hospitals operated by Native health organizations are required to file a Schedule E cost report. The Schedule E cost report is an abbreviated form of cost reporting. As a result they are not obligated by CMS to report charity care or bad debt, simply because this is not a component of Schedule E cost report. Schedule S-10 is not a part of their cost report.
4 Colorado Hospital Association, Center for Health Information and Data Analytics, June 2014
5 Ibid.
6 Medicare Payments Cuts in Alaska, February 2015, DataGen Medicare Cut Analysis report