HMA

HEALTH MANAGEMENT ASSOCIATES

Medicaid Program Changes: Analysis of Potential Savings and Considerations

PREPARED FOR
THE ALASKA STATE HOSPITAL AND NURSING HOME ASSOCIATION

MAY 15, 2017

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

ALBANY, NEW YORK • ATLANTA, GEORGIA • AUSTIN, TEXAS • BOSTON, MASSACHUSETTS • CHICAGO, ILLINOIS • COLUMBUS, OHIO
DENVER, COLORADO • HARRISBURG, PENNSYLVANIA • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN • NEW YORK, NEW YORK
PHOENIX, ARIZONA • PORTLAND, OREGON • SACRAMENTO, CALIFORNIA • SAN ANTONIO, TEXAS • SAN FRANCISCO, CALIFORNIA
SEATTLE, WASHINGTON • SOUTHERN CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, DC

Table of Contents

Provider Focused Efforts: Hospital Provider Taxes

Overview

Provider taxes can be used to pay a portion of the state's share of Medicaid. Federal regulations guide the tax structure, how it can be imposed, and use of collected funds. Using a provider tax to supplement state Medicaid funding is more efficient than imposing a rate cut. Unlike a tax, a rate cut reduces both state spending and associated federal reimbursement. Any rate cut reduces federal support, and thus the amount of total funds available to support Medicaid. Based on an estimated blended federal matching rate of 62 percent, for every $1.00 of Medicaid hospital spending cut, Alaska saves only $0.38 in state funds. Conversely, the state can use provider tax collections as the state portion of Medicaid spending, which is then matched with federal money. HMA analyzed a provider tax that brings in revenues equal to the state savings from a 5 percent cut to hospital reimbursement.

A $1 cut to Medicaid only saves the state 38 cents.

Using a Hospital Tax Instead of a Rate Cut

While a tax can be imposed on all non-Tribal hospitals, to minimize financial stress on small hospitals we modeled a tax levied only on non-Tribal, non-rural facilities. A 0.46 percent tax on total net revenue raises $6.18 million, which the state can use as its portion of Medicaid spending. Those funds are matched with federal funds to support the program. This $6.18 million raised is equivalent to the state savings associated with the planned 5 percent hospital rate cut. The tax is equivalent to a Medicaid rate cut of 2.42 percent to tax paying hospitals.

This scenario does not raise additional funds for the state Medicaid budget beyond the "buy back" of the amount the rate cut would have saved the state. A tax equivalent to the total (combined federal and state) loss of Medicaid reimbursement under a 5 percent rate cut is a 1.20 percent tax on total net hospital revenue. A 1.20 percent tax would collect $16.25 million: the $6.18 million buy back of the state revenue, plus an additional $10.07 million. The tax funds can be used to draw down federal matching funds to support the Medicaid budget or be allocated to the state general fund.

In the aggregate, a 1.20 percent tax would have the same impact on hospitals as cutting rates by 5 percent. The tax would be levied on payers' total net revenue, meaning that only taxpayers would feel the impact of the tax, whereas a rate cut affects all non-Tribal hospitals. Maximizing federal matching funds using provider tax revenues helps explain why all states except for Alaska currently impose at least one provider tax.

Background

The state share of Medicaid costs is generally between 50 and 75 percent of overall aggregate program costs, depending on the state's match rate for each population receiving services. This share often includes funds from local jurisdictions in the state, health care providers, or other sources. Every state

except for Alaska currently levies a tax, commonly referred to as a provider tax or health care-related tax, on at least one class of health care provider in order to generate revenue to support Medicaid.[13]

Federal Regulations

Federal regulations allow states to tax health care providers and use the funds to draw down federal Medicaid matching funds. To be eligible for federal funds, the state must implement the provider tax consistent with the following conditions:[14]

1. The tax must be broad based, i.e., all providers or services in a class must be taxed.
2. The tax must be uniform, i.e., all providers in the class must pay the same tax rate.
3. No taxed entities can be guaranteed to directly or indirectly get their money back.

Broad-Based Tax

Any provider tax must be imposed on an entire class of providers or services. There are 19 classes of providers, including inpatient hospital services, outpatient hospital services, and nursing facility services. The goal is to tax providers without regard to whether they participate in Medicaid.

Uniform Tax

A uniform tax is one that is imposed at the same rate on all affected taxpayers. The rate may not vary by whether the provider serves Medicaid patients. However, there are exceptions to the uniformity standard. States do not have the authority to tax Tribal providers, so Tribal providers are automatically excluded from any tax. States may also exclude governmental providers without obtaining a waiver.

The state can request a waiver of the broad based and/or uniformity requirements if it passes statistical tests consistent with the requirements outlined in federal regulation. The statistical tests are meant to ensure that the tax structure does not unfairly burden high Medicaid providers when compared to a broad-based and uniform tax.

Hold-Harmless Standard

No provider tax payer can be guaranteed that it will get its tax payment back or be "held harmless." The hold harmless standard is measured through a direct test and an indirect test of the provision. A direct hold harmless exists under two conditions. First, this exists if the amount of a provider's Medicaid reimbursement varies only based on the amount of tax it paid. Second, a hold harmless situation exists if the amount of tax paid by a provider is positively correlated with a non-Medicaid payment to the provider. Taxes paid must be a true tax, and if a tax paid is associated with payments to the provider, this could suggest that the state was reimbursing the provider for the tax. It is likely that high volume providers will pay more tax than smaller providers and receive higher gross Medicaid reimbursement, but Medicaid payments to a provider cannot be associated only with the amount of tax paid.

While the direct hold harmless test is evaluated at any tax rate, the indirect hold harmless test measures whether the tax rate is greater than 6 percent of provider revenue. Under federal regulations, the state may only assess a provider tax that produces revenue under this threshold. There are no waivers to the hold harmless requirement.

[13] The Kaiser Commission on Medicaid and the Uninsured, *States and Medicaid Provider Taxes or Fees*. http://kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/. March 2016.
[14] 42 CFR 433.68

Uses of Provider Tax Revenue

States utilize provider taxes to fund a variety of initiatives including supporting enhanced provider reimbursement under Medicaid, supplementing current levels of provider reimbursement under Medicaid (sometimes referred to as "buying out a cut"), funding new Medicaid eligibility groups or benefits, and supplementing the state's general revenue fund.

Previous analyses done by HMA for ASHNHA showed little to no room to enhance Alaska Medicaid's hospital and nursing facility rates under federal spending limits. However, pending reimbursement changes including the removal of cost inflators on hospital and nursing facility reimbursement rates, the freeze on the rebasing of prospective payments, and the 5 percent cut to inpatient and outpatient hospital services will result in lowered spending on hospital and nursing facility services which will make room under federal spending limits. Alaska providers could utilize a tax to fund a buy-out of these cuts or to create enhanced payments to offset decreases in spending.[15]

Data Sources and Model Assumptions

HMA reviewed several options for provider tax bases using Medicare cost report data ending in state fiscal year 2016 (e.g., for hospitals with calendar year fiscal years, HMA utilized calendar year 2015), including inpatient and outpatient net revenue, total hospital days, and total hospital discharges. To model the impact of the pending 5 percent cut to hospitals, HMA used a combination of state estimates provided by ASHNHA, calendar year (CY) 2012 actual inpatient and outpatient Medicaid payments by hospital, and assumptions related to the impact of the expansion of Medicaid.

In CY 2017, the federal medical assistance percentage (FMAP), the federal matching rate on state funds used for allowable Medicaid purposes, for the Medicaid expansion population dropped from 100 percent to 95 percent. In CY 2018, that rate will drop to 94 percent. In Alaska, reimbursement for utilization related to traditional Medicaid enrollees, individuals eligible for Medicaid enrollment under the guidelines in place prior to Medicaid expansion, is matched at a rate of 50 percent. The federal government funds at 100 percent services furnished to American Indians and Alaska Natives provided at Tribal facilities or if care coordination agreements with non-Tribal providers are in place.

To model the federal match applicable to proceeds from a provider tax, HMA required an estimate of a blended FMAP rate to account for the rates applicable to different populations served and provider types. The 5 percent cut does not apply to Tribal facilities, so the blended FMAP rate must account for the mix of traditional Medicaid, expansion Medicaid, and American Indian and Alaska Native populations served by non-Tribal Alaska hospitals. HMA based the blended FMAP rate on the estimate of the state savings related to the 5 percent cut and HMA's estimates of hospital spending at non-Tribal facilities. This resulted in an estimated FMAP rate of 62 percent. The Governor's fiscal year (FY) 2018 budget

[15] Some states have used provider taxes to fund increased Medicaid provider rates.

includes federal and total spending on Medicaid health services with an effective blended FMAP rate of 73 percent; however, this blended rate includes services provided at Tribal facilities.[16]

Analysis

Utilizing a Provider Tax to Buy Out the 5 Percent Rate Cut

To illustrate the impact of a provider tax on hospitals, HMA modeled a provider tax to buy out the 5 percent rate cut for inpatient and outpatient hospital services at non-Tribal facilities using the state estimated savings of $6.18 million. The additional reimbursement changes were not included in the modeling as their impact will be more varied across hospitals and other providers. Additionally, this model represents a somewhat generous scenario in which the state levies a tax on hospitals in an amount equal to the state savings under the pending rate cut and does not require additional funding for other purposes.

In the aggregate, because reimbursement paid to hospitals is a combination of both state and federal matching funds, buying out a 5 percent rate cut through a tax on Alaska's non-Tribal hospitals would require a collection of the state portion (38 percent) of the total reimbursement expected to be cut rather than the full amount.[17] Said differently, for every $1.00 in reimbursement the state cuts from hospitals, only $0.38 is a savings to the state and the remaining is federal funding no longer claimed. To make a direct comparison, if all non-Tribal hospitals paid a tax equivalent to the state savings related to a 5 percent rate cut, the taxed amount would be equivalent to an aggregate Medicaid rate cut of 1.90 percent, only 38 percent of a 5 percent cut. As previously noted, federal regulations limit provider taxes to 6.0 percent of total net revenue. A tax to generate the $6.18 in state savings would require a tax rate of 0.36 percent.

Table 3: Effective Cut if All Hospitals Taxed

	Inpatient	Outpatient	Total
Total Estimated Medicaid Payments to Non-Tribal Facilities	$218,717,368	$106,369,055	$325,086,423
5% Cut to Payments	$10,935,868	$5,318,453	$16,254,321
Estimated State Savings from 5% Cut (62% FMAP)	$4,155,630	$2,021,012	$6,176,642
Aggregate Medicaid Cut Equivalent to Tax Cost if All Hospitals Taxed	1.90%	1.90%	1.90%
Net Revenue Tax Rate to Generate Amount Equivalent to State Savings Under the Pending Cut			0.36%

Although leveraging federal matching funds through a tax allows providers to forgo a rate cut at a cost of 38 percent of the total impact, due to the federal requirements governing provider taxes, the tax must be levied on a hospital's total book of business, not just Medicaid, and would therefore have redistributive impacts on the hospitals paying the tax. If buying out the rate cut through the

[16] Alaska Office of Management and Budget. *Unrestricted General Fund/Designated General Fund/Other/Federal Summary Budget information, Health and Social Services*. https://www.omb.alaska.gov/ombfiles/18_budget/HSS/Amend/18compsummary3scen_hss.pdf

[17] The analysis used the 62 percent estimated blended FMAP rate that excludes payment to Tribal facilities.

implementation of a hospital tax, hospitals with a payer mix relatively slanted toward Medicaid would benefit more than hospitals at which other payers predominate.

Impact on Rural Hospitals

Approximately one third of the population of Alaska lives in a rural area, and of Alaska's total land mass, 99.95 percent is classified as rural.[18] Rural hospitals provide essential access to care to Alaska's population across the state. Currently, rural hospitals are reimbursed under the same reimbursement methodology as urban acute care providers, and as such the 5 percent rate cut will apply. However, rural hospitals may have the opportunity to apply for an alternate payment rate methodology available only to small facilities.[19]

Assuming rural hospitals do not apply for the alternate payment methodology and continue to receive reimbursement under the same methodology as urban hospitals, the state could lessen the burden of a cut on rural hospitals by buying out the rate cut through a provider tax that is structured as non-broad-based and/or non-uniform. Exempting rural hospitals from the tax completely would shift the burden of the rate buy out to the non-Tribal urban hospitals. Implementing this structure would require the state to receive a waiver of the broad-based requirement, which is achieved by passing the federal P1/P2 test.

P1/P2 Test

The federal P1/P2 test measures whether Medicaid services are disproportionately taxed under a non-broad-based tax. The test looks at the tax paid on Medicaid services under a broad-based tax (P1) as compared to the tax paid on Medicaid services under a proposed non-broad-based tax (P2). By dividing P1 by P2, a result of 1.0 or greater means more Medicaid services are taxed under a broad-based tax than the proposed structure, and the test passes rendering the state eligible for an automatic waiver. A result of less than 1.0 means an automatic fail, and the structure is ineligible for a waiver of the broad-based requirement.

If applying for a broad-based waiver for a tax based on inpatient net revenue, for example, the test would measure what portion of the total tax paid is related to Medicaid payments using each hospital's Medicaid payments as a percentage of their total inpatient net revenue. If the tax paid related to Medicaid is less under the proposed non-broad-based tax, the test passes, and the state would receive an automatic waiver of the broad-based requirement. The test will not pass if the state only excludes low Medicaid providers.

Using the CY 2012 Medicaid inpatient and outpatient payments by hospital, as well as Medicaid day and discharge utilization statistics captured on the Medicare cost reports, HMA ran the P1/P2 test against different tax bases. The hospital groups exempted under the structure tested included:

- Rural/Critical Access Hospitals
- State-owned hospitals

Additionally, Tribal hospitals are excluded from the test entirely because the state cannot tax them. Under this structure, six of the 18 non-Tribal Alaska hospitals remain in the tax base. HMA considers the

[18] U.S. Census Bureau, 2010

[19] 7 AAC 150.190. Optional payment rate methodology and criteria for small facilities.

results of the P1/P2 test to be preliminary because Medicaid payment data represent a relatively old snapshot of Medicaid utilization, and day and discharge data were obtained from an unaudited portion of the Medicare cost report rather than the state's MMIS. Based on HMA's preliminary assessment, the results of the P1/P2 test are shown in Table 4 below. The results should be utilized only to promote further review of possible tax structures. Although the results may appear very close to the 1.0 threshold, the test is pass/fail and any result above 1.0 is eligible for an automatic waiver. Based on these preliminary results, outpatient net revenue and total hospital discharges could be considered as viable tax bases for a non-broad-based tax.

Table 4: P1/P2 Test Preliminary Results

	P1/P2 Result	Interpretation
Total Inpatient Net Revenue	0.9891	Automatic Fail
Total Outpatient Net Revenue	1.0011	Automatic Pass
Total Hospital Days	0.9213	Automatic Fail
Total Hospital Discharges	1.0057	Automatic Pass

For each of the ways a hospital tax can be levied, the above results show whether a non-broad based tax disproportionately weigh on Medicaid services. The P1/P2 test identifies whether Medicaid services are taxed as much by a broad based tax (P1) as under a non-broad-based tax (P2). Where the result is 1.0 or larger, Medicaid services are taxed at least as much under a broad-based tax than the proposed structure, and the test passes. This means the state is eligible for an automatic waiver. If the result is less than 1, the broad-based requirement cannot be waived.

Impact of a Non-Broad-Based Tax on Non-Rural Hospitals

If the state implemented a non-broad-based tax excluding rural and critical access hospitals and state-owned hospitals, all hospitals would continue to receive current Medicaid reimbursement, while taxed hospitals would have an additional cost in the form of the tax. Under this scenario, the tax would continue to collect the $6.18 million, but fewer hospitals would contribute, resulting in larger impacts on the taxed hospitals.

The state can use tax revenue as state share to leverage federal Medicaid match. In the aggregate, taxed hospitals see a net benefit from a non-broad based provider tax compared to a 5 percent rate cut. Using a tax to provide state funding reduces state spending, while maintaining Medicaid spending (and continuing to access federal match). Conversely, a cut to Medicaid funding only saves the state 38 cents for every dollar cut.

Tax-paying hospitals would pay a tax equivalent to the value of an aggregate Medicaid rate cut of 2.42 percent, less than half of the pending 5.00 percent cut, but greater than the 1.90 percent rate for a tax on all non-Tribal hospitals (shown in Table 3). Under this scenario, exempt hospitals would continue to get current rates and have no cost related to the tax.

Table 5: Effective Cut if Only a Portion of Hospitals Taxed

	Inpatient	Outpatient	Total
Total Estimated Payments	$218,717,368	$106,369,055	$325,086,423

	Inpatient	Outpatient	Total
State Hospital – Total Estimated Payments	$4,683,643	$0	$4,683,643
Non-Tribal Rural Hospitals - Total Estimated Payments	$26,203,923	$38,821,028	$65,024,951
Non-Tribal Urban Hospitals - Total Estimated Payments	$187,829,803	$67,548,027	$255,377,829
5% Cut to Payments	$10,935,868	$5,318,453	$16,254,321
Estimated State Savings from 5% Cut	$4,155,630	$2,021,012	$6,176,642
Aggregate Medicaid Cut Equivalent to Tax Cost to Rural/CAHs and State Hospitals (Hospitals Not Taxed)	0.00%	0.00%	0.00%
Aggregate Medicaid Cut Equivalent to Tax's Cost to Tax-Paying Hospitals	2.21%	2.99%	2.42%
Tax Rate to Generate Amount Equivalent to State Savings Under the Pending Cut			0.46%
Number of Hospitals Taxed			6

B1/B2 Test

The state and hospitals may also have interest in lessening the tax burden on rural hospitals without completely exempting them from the tax. This could be done by implementing a tax with a lower rate on rural hospitals than all other hospitals. This structure would require the state to receive a waiver of the uniformity requirement, achieved by passing the federal B1/B2 test.

The federal B1/B2 test measures the correlation between the tax burden and Medicaid utilization under a uniform tax (B1) and compares it to the correlation between the tax burden and Medicaid utilization under a proposed non-uniform tax (B2). If the correlation of the tax burden and Medicaid utilization is less under the proposed non-uniform tax (B1/B2 ≥ 1.0), the test passes, and the state would receive an automatic waiver of the broad-based requirement.

Due to the number of forms a non-uniform tax could take, HMA will run the B1/B2 test based on further guidance if provider taxes are chosen as a topic for further explanation under Phase 2 of this project.

Nursing Facility Provider Tax

Because the FY 2018 5 percent rate cut applies to inpatient and outpatient hospital services only, Alaska nursing facilities will not be as significantly impacted by reimbursement changes as Alaska hospitals. However, as previously noted, a state could implement a provider tax to supplement state general fund revenue in the overall Medicaid budget, creating a new cost to providers without any added advantage either through new payments or forgone rate cuts. To understand how such a tax would impact individual nursing facilities, HMA modeled three potential tax bases.

Most commonly, states use the following as tax bases for nursing facility taxes: total net revenue; total discharges; and total beds. If the state implemented a tax on nursing facilities to generate $1 million in state funds, for example, that funding would support approximately $2.6 million in total Medicaid spending with the federal match. Table 6 shows the impact of an example tax on individual nursing facilities. A tax of 0.99 percent on total net nursing facility revenues would garner $1 million in tax

revenue.[20] Federal regulations limit provider taxes to 6.0 percent of net revenue, so the maximum the state could collect through a nursing facility provider tax of 0.99 percent is just over $6 million.

Table 6: Estimated Tax Rate Required to Raise $1 Million in State Funds

	Total Net Revenue Tax Base	Total Days Tax Base	Total Beds Tax Base
Rate Nursing Facilities Would Pay to Raise $1 Million if All Non-Tribal Nursing Facilities Taxed	0.99%	$4.93	$1,567.40
Rate Nursing Facilities Would Pay to Raise $1 Million if Non-Rural, Non-Tribal Nursing Facilities Taxed	1.71%	$8.43	$2,645.50

The estimated tax rates in the table are based on tax bases calculated using each facility's Medicare Cost Report ending in SFY 2016 (e.g., for nursing facilities with calendar year fiscal years, HMA utilized calendar year 2015). Tribal facilities are excluded.

While the money raised by a nursing facility tax is not insignificant, $1 million in state revenue may not justify the work involved to implement this tax. Both affected facilities and the state would have costs to administer and pay the tax, making it a less appealing way to raise revenue than a hospital tax.

Assessment of Provider Tax Based on ASHNHA-Identified Principles

Principle 1: Promotes Access

By utilizing a tax to forgo provider rate cuts or fund alternative payments to offset the pending reimbursement changes, the state would lessen the impact of budget cuts on providers and therefore lessen the potential risk of cuts to access. As rates are frozen and/or cut, providers will receive rates which cover less than the cost of providing Medicaid services. Providers must then make up that lost revenue through payments from other payers. This is especially difficult for rural providers with low service volume.

Principle 2: Share the Burden

Without obtaining a waiver of the broad-based or uniformity requirements, the burden of provider taxes must fall across facilities in the class of taxed providers, excluding Tribal facilities. This allows for the burden to be shared equally; however, because the distribution of the burden cannot match the distribution of the tax-funded benefit, it may not be shared equitably. As discussed above, under federal regulations, the state must obtain a waiver if facilities other than Tribal facilities or governmental facilities are excluded from the taxed or providers are taxed at different rates. By obtaining a waiver, there is flexibility to design a tax structure which excludes certain providers or taxes providers at lower rates, but in the aggregate, lower Medicaid providers cannot pay lower share of the tax. A variety of tax base options and tax structures must be reviewed to determine the most equitable solution.

Principle 3: Leverage Available Financing Sources

A Medicaid rate cut impacts state costs based on state dollars saved and the loss of matching federal funds. The cut has a more significant impact on providers than a tax. As noted above, an estimated $16.25 million cut to hospitals would result in the same state general fund savings as a tax on all non-

[20] This is based on a tax imposed on non-Tribal nursing facilities.

Tribal hospitals generating $6.18 million because every $1.00 of Medicaid reimbursement cut only generates $0.38 in state savings. Paying providers at any rate lower than the maximum under federal limits leaves federal matching funds on the table.

Additionally, if Congress passes a health care reform bill which includes Medicaid block grants or per capita caps, the bill will utilize a prior spending period as the base on which to set each state's funding amounts. States paying at higher levels in that base period as compared to current federal spending limits will maximize their share of total Medicaid federal funding available to all states.

Implementation Considerations

Future Reliance on Provider Taxes

With Alaska facing a significant budget deficit, the possible implementation of a provider tax must be done with caution and must come with strong legislative protections. While the tax scenarios proposed above could turn a 5 percent rate cut into a cost equivalent to an aggregate cut of as low as 1.90 percent, as shown by the popularity and scale of provider taxes utilized in other states across the nation, once instituted, increases to provider taxes are often seen as easy fixes for tough budget situations.

Additionally, the modeled scenario does not account for the state requesting any additional funding on top of the amount necessary to buy out the cut, a common practice across states with provider taxes to, at a minimum, offset the administrative costs associated with implementing the provider tax or to more generally supplement the Medicaid budget. If the state required additional funding from the tax, the net benefit to the hospitals resulting from forgone cuts would decrease and the redistributive aspects of the tax versus the rate cut would become more pronounced. One way to protect against this future is the inclusion protections in the provider tax authorizing legislation stating the tax only applies if provider reimbursement rates do not drop below a certain level (e.g., FY 2018 rates), and outlining a strict dollar amount or formula limiting the tax collection to the amount agreed upon.

Drop in Medicaid Expansion FMAP Rate

HMA based the analysis above on a blended FMAP rate of 62 percent. Consistent with the Patient Protection and Affordable Care Act (ACA), the FMAP rate applicable to the population eligible under the Medicaid expansion will continue to drop from the current CY 2017 rate of 95 percent until it reaches 90 percent in CY 2020 as shown in the table below.

Table 7: FMAP Rates for Medicaid Expansion Population

Calendar Year	Expansion FMAP Rate
CY 2017	95%
CY 2018	94%
CY 2019	93%
CY 2020 and Beyond	90%

The current estimated blended FMAP rate is a combination of the traditional Medicaid FMAP rate (50 percent), the Medicaid expansion FMAP rate (95 percent in CY 2017, 94 percent in CY 2018), and the Medicaid FMAP rate for American Indians and Alaska Natives (100 percent). As of March 2017, expansion enrollees make up 18 percent of the Medicaid population (31,894 of 180,179 total enrollees).

AI/AN members make up about 40 percent of the Medicaid population in the state. To model the impact of the drop in FMAP over the next three calendar years would require data on the exact ratio of spending on each group. However, to give some perspective, a 1 percent drop in the blended FMAP rate would increase the expected cost of a 5 percent rate buy out by about $163,000.

Upper Payment Limits

The federal upper payment limit (UPL) sets the ceiling for Medicaid FFS reimbursement rates. Based on HMA's previous work with ASHNHA, HMA's modeling assumes Alaska currently pays hospitals at rates equal to the federal UPL. Our provider tax estimates are based on Alaska's implementation of a 5 percent rate cut from full cost reimbursement. However, recent experience shows that state MMIS data used to calculate the UPLs are not completely reliable. As such, Alaska could currently be paying at rates above or below the federal ceiling. If paying above, the federal government may require a rate cut once it obtains a reliable estimate of the UPLs. If paying below, there may be additional opportunity to tax hospitals at a rate necessary to buy out the 5 percent cut and fund additional hospital payments.

Under the assumption that Alaska hospital payments are at the current federal maximum, provider tax funding could be used to create new payments up to the level of the funding cut. These payments could be designed to incentivize state quality objectives. For example, state tax funds can be used to support a quality fund that could reward hospitals for reporting on quality data they already collect. This benefits the state in terms of increasing its access to provider data, and reinforces hospitals' interest in tracking quality or other outcomes. However, in the current budget environment, it is unlikely the Alaska legislature will approve increases to current provider spending.

Disproportionate Share Hospital Payment Allotment

The federal government provides annual disproportionate share hospital (DSH) payment allotments to fund hospital uncompensated care for the uninsured and Medicaid populations. On an annual basis, the federal government establishes a DSH allotment for each state. The FY 2016 DSH allotment, the most recent allotment published in the Federal Register, was $44 million including both state and federal funds and matched at the traditional Medicaid FMAP of 50 percent.[21] Alaska currently only utilizes half of that available funding, leaving about $22 million on the table. A hospital tax could also be utilized to enhance DSH payments to hospitals by collecting the $11 million in state funding necessary to draw down the federal match. This would equate to a 0.64% total net revenue tax on all non-Tribal hospitals or a 0.82% tax on all non-Tribal, non-state-owned, non-rural hospitals. This would require a Medicaid state plan amendment to revise the current scale and distribution of DSH payments.

The ACA also requires a phase down of federal DSH spending in anticipation of Medicaid expansion leading to a decrease in uncompensated care costs. The implementation of these DSH reductions has been delayed to October 1, 2018 (the beginning of federal fiscal year 2019). The ACA outlines a general framework to the distribution of the DSH reductions, including limited impacts on deemed "Low DSH States" like Alaska, but no state-by-state impact has been published.

[21] https://www.gpo.gov/fdsys/pkg/FR-2016-10-26/pdf/2016-25813.pdf

Political Considerations

An April 2015 document on the DHSS Medicaid Reform and Expansion site notes "Governor Walker would not propose any tax that would result in a loss of medical providers in Alaska."[22] If hospitals and/or nursing facilities supported the implementation of a provider tax as an alternative to reimbursement cuts, providers must ensure legislators understand the different impacts of a cut to reimbursement, which includes federal matching dollars, and a provider tax, equivalent to a cut of the state share only.

Recommendations

HMA recommends further review of the potential for a provider tax solution in Alaska. As hospitals and other providers face rate cuts and freezes in reimbursement rate updates, a provider tax could help reduce the impact of these changes. Additionally, preliminary P1/P2 test results show the potential for creating a tax structure limiting the impact on some of the most vulnerable hospitals in the state.

[22] https://gov.alaska.gov/Walker_media/documents/medicaid-expansion/20150424_provider-taxes.pdf