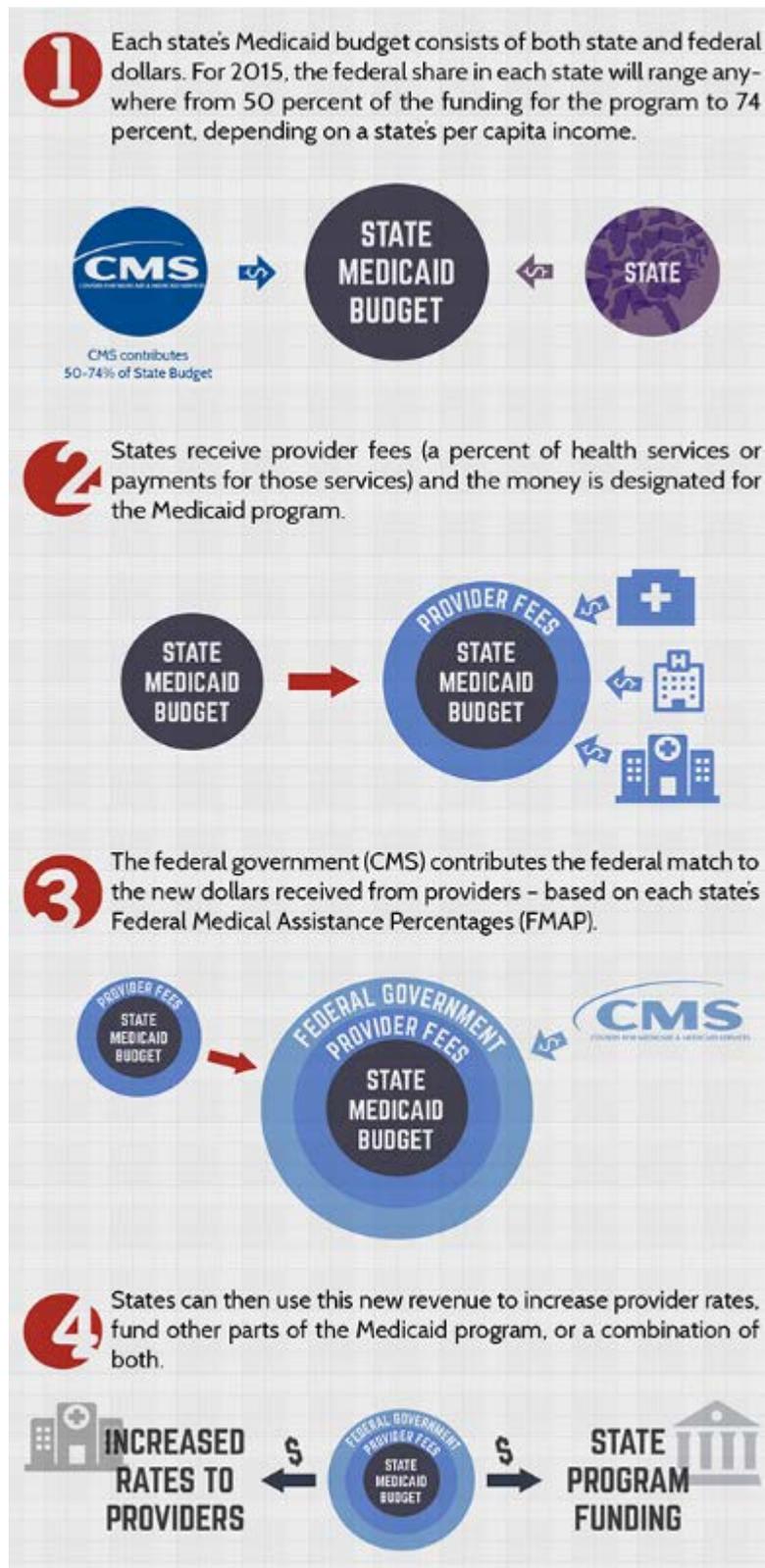


Health Care Provider Taxes

In the mid-1980s, states began using provider taxes to help finance Medicaid. Essentially, Medicaid providers would agree to be taxed, and the revenue from these would be used to finance a portion of the state's share of Medicaid expenditures. The mechanism of assessment took many forms including gross receipts, per resident day, or per licensed bed. In some cases, Medicaid providers initiated these provider tax arrangements because states would often use the provider tax revenue to raise Medicaid payment rates. Plus, these arrangements were often designed in such a way as to hold the Medicaid providers harmless for the cost of their taxes.

Essentially, states were borrowing funds from Medicaid providers in order to draw down federal funds and increase Medicaid payment rates to the providers that had paid taxes. The providers were often fully reimbursed for the cost of their tax payment. For this reason, provider tax mechanisms were politically viable for states.

These financing arrangements became a point of contention between the federal government and the states. While not all states were using these Medicaid financing strategies, some states were particularly aggressive in their use of provider taxes in financing Medicaid. This aggressive use of these Medicaid financing strategies motivated congressional action to curb states' use of the provider tax.



Federal Statutes and Regulations

In 1991, Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234) to limit states' ability to draw down federal Medicaid matching funds with provider taxes.

The 1991 law defines a provider tax as any licensing fee, assessment, or other mandatory payment in which 85% or more of the burden falls upon health care providers. In order for states to claim federal matching payments for provider tax revenues, the 1991 law:

- requires provider taxes to be broad-based (i.e., imposed on all providers within a specified class of providers) and uniform (i.e., the same tax for all providers within a specified class of providers)—in other words, states cannot limit the provider taxes to only Medicaid providers;
- prohibits taxes that exceed 25% of the state (or non-federal) share of Medicaid expenditures; and
- prohibits states from a direct or indirect guarantee that providers receive their money back (or be “held harmless”).

The Secretary of Health and Human Services is authorized to waive the broad-based and uniform requirements of provider taxes if a state can prove the net impact of the tax is “generally redistributive” and the amount of the tax is not directly correlated to Medicaid payments. Additionally, federal regulations create a safe harbor from the hold-harmless test for taxes where collections are 6.0 percent or less of net patient revenues. To date, no state has imposed a provider tax at a rate above that threshold.

Classes of Providers

The specified 19 classes of providers used to ensure that tax programs are “broad-based” are those that provide the following:

- inpatient hospital services,
- outpatient hospital services,
- nursing facility services,
- services of intermediate care facilities for individuals with intellectual disabilities,
- physicians' services,
- home health care services,
- outpatient prescription drugs,
- services of Medicaid managed care organizations
- ambulatory surgical centers,
- dental services,
- podiatric services,
- chiropractic services,
- optometric/optician services,
- psychological services,
- therapist services,
- nursing services,
- laboratory and X-ray services,
- emergency ambulance services, and
- other health care services for which the state has enacted a licensing or certification fee.

**Therapist services include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological therapy, and rehabilitative specialist services.*

**Nursing services include nurse midwives, nurse practitioners, and private duty nurses.*

**Laboratory and X-ray services are defined as services provided in a licensed, free-standing laboratory or X-ray facility. The definition does not include laboratory or X-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department.*

Requiring that all providers within a class be taxed, as opposed to only Medicaid providers, dampened the appeal of provider taxes.

Oversight of Provider Taxes

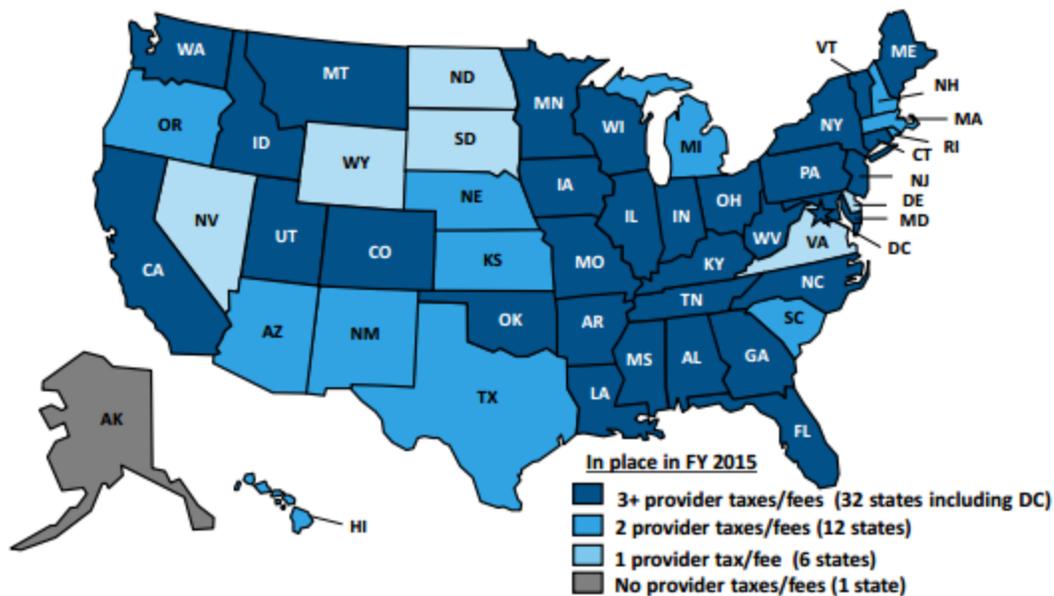
The Centers for Medicare and Medicaid Services (CMS) is responsible for determining whether states abide by the statutory and regulatory requirements pertaining to provider taxes. States are not required to receive CMS approval for provider taxes that adhere to the federal requirements. However, states seeking waivers from the broad-based and uniform requirements do need CMS approval.

States' Current Use of Provider Taxes

States' use of provider tax revenue varies from state to state, but states often use provider tax revenue to draw down federal Medicaid matching funds in order to increase Medicaid payment rates for the same providers that are responsible for paying the tax.

A vast majority of states use at least one provider tax to help finance Medicaid. While federal requirements allow states to impose taxes on 19 classes of providers, the classes of providers that are most often taxed include nursing facilities, hospitals, intermediate care facilities for individuals with intellectual disabilities (ICF/IDD), and managed care organizations.

States with Provider Taxes or Fees in Place in FY 2015



NOTES: Includes Medicaid provider taxes as reported by states. It is possible that there are other sources of revenue from taxes collected on health insurance premiums or health insurance claims that are not reflected here.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2015.



The following table illustrates provider tax information for all 50 states and D.C. as of October 2015:

State	Hospitals	Intermediate Care Facilities	Nursing Facilities	Other	Any Provider Tax
Alabama	X		X	X	X
Alaska					
Arizona	X		X		X
Arkansas	X	X	X		X
California	X	X	X	X	X
Colorado	X	X	X		X
Connecticut	X	X	X	X	X
Delaware			X		X
DC	X	X	X	X	X
Florida	X	X	X		X
Georgia	X	X	X		X
Hawaii	X		X		X
Idaho	X	X	X		X
Illinois	X	X	X		X
Indiana	X	X	X		X
Iowa	X	X	X		X
Kansas	X		X		X
Kentucky	X	X	X	X*	X
Louisiana		X	X	X	X
Maine	X	X	X	X	X
Maryland	X	X	X	X	X
Massachusetts	X		X		X
Michigan	X		X	X	X
Minnesota	X	X	X	X	X
Mississippi	X	X	X	X	X
Missouri	X	X	X	X*	X
Montana	X	X	X		X
Nebraska		X	X		X
Nevada			X		X
New Hampshire	X		X		X
New Jersey	X	X	X	X*	X
New Mexico				X*	X
New York	X	X	X	X*	X
North Carolina	X	X	X		X
North Dakota		X			X
Ohio	X	X	X		X
Oklahoma	X	X	X		X
Oregon	X		X		X
Pennsylvania	X	X	X	X*	X
Rhode Island	X		X		X
South Carolina	X	X			X
South Dakota		X			X
Tennessee	X	X	X	X	X
Texas		X		X	X
Utah	X	X	X	X	X
Vermont	X	X	X	X*	X
Virginia		X			X
Washington	X	X	X		X
West Virginia	X	X	X	X*	X
Wisconsin	X	X	X	X	X
Wyoming			X		X
Totals	40	37	44	22	50

* Denotes states with multiple "other" provider taxes. Source: The Kaiser Family Foundation

Use During Economic Downturns

Medicaid spending is countercyclical, which means Medicaid enrollment expands and expenditures grow when the economy is weak. At the same time, states' tax collection ability can be strained, making it more difficult for states to maintain funding for all state programs. For these reasons, states are more likely to impose or increase provider taxes during economic downturns in order to generate additional revenue to finance Medicaid. For example, during the most recent recession, a number of states took action to generate additional provider tax revenue. A Government Accountability Office analysis found that, during the period of February 2009 through July 2010, 10 states and the District of Columbia reported implementing 28 different provider tax actions to generate additional revenue. These actions consisted of 15 new provider taxes and 13 increases to existing provider taxes. States concentrated their actions on a few classes of providers, with hospitals and nursing facilities accounting for 21 of the 28 tax actions.

Current Issues: Federal Deficit Reduction

Between January 1, 2008 and September 30, 2011, the Tax Relief and Health Care Act of 2006 changed the threshold to 5.5%. On October 1, 2011 the threshold reverted to the 6.0% limit that is currently effective.

The President has released budget proposals that include a provision to phase down the Medicaid provider tax threshold from the current level of 6.0% to 3.5%. The Congressional Budget Office provided a budget option to gradually reduce the provider tax threshold to 3.0% over a period of three years.

Considerations for Managing Provider Assessments

- Rate and Mechanism
- Cash Flow
- Availability of Data
- Agency Resources
- Encouraging Timely Payments
- Changes of Ownership and Provider Closures

Provider Taxes in South Dakota

1995: The passage of House Bill 1350 placed a four percent gross receipts tax on the services of medical providers. The bill was amended by another bill, HB 1289. Both bills were eventually signed by the Governor.

House Bill 1163 was subsequently passed. That bill delayed the effective date of HB 1350 and established a special election at which voters would be asked to decide between an increase in sales, use, and excise taxes or the gross receipts tax on medical services. The Governor asked for an advisory opinion from the Supreme Court on the constitutionality of HB 1163. The Supreme Court, in Opinion #19106 filed March 17, 1995, advised that "those portions of House Bill 1163 which would result in a tax rate increase if approved by a vote of the electorate would be unconstitutional." The Governor then vetoed HB 1163 and suggested that the Legislature repeal the medical provider tax.

An effort to subject health care property to property tax in HB 1228 failed, and on the last day of the legislative session the Legislature passed HB 1358, which repealed both HB 1350 and HB 1289.

2007: House Bill 1077, *An Act to impose a tax on the net revenue of intermediate care facilities for individuals with intellectual disabilities*. Effective July 1, 2007 at 5.5% of net revenues of the South Dakota Developmental Center.