kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

May 2011

MEDICAID FINANCING ISSUES: PROVIDER TAXES

Since its enactment in 1965, Medicaid has been a joint financing partnership between the states and the federal government. Under this partnership, the states and the federal government share in the cost of providing health and long-term care services to low-income Americans. State participation in Medicaid is voluntary; those states that elect to participate (as all now do) are guaranteed federal financing for a percentage of the cost of their programs specified by a statutory formula. Under that formula, the federal government pays at least half of the costs and as much as three quarters in some states. States are responsible for the remainder of the costs.

States have discretion as to the source of the state share of Medicaid program costs. Current law allows states to use revenue from provider taxes to help make up the state share of Medicaid; however, states must follow federal rules in designing their provider tax structures. Almost all states (47) have at least one provider tax in place (see Table 1). The President's FY 2012 budget proposes to modify federal rules so as to limit the amount of provider tax revenues that states may use to fund their share of Medicaid program costs. This brief reviews the use of provider taxes as a mechanism for financing the state share of Medicaid spending and explores the implications of proposed changes in the current federal provider tax rules.

HOW DO STATES FINANCE MEDICAID?

Medicaid is jointly financed by the states and the federal government. By statutory formula, the federal government pays between 50 and 76 percent of all the costs incurred by states in purchasing covered services on behalf of Medicaid beneficiaries. Matching rates vary by state, with states that have lower per capita incomes receiving higher federal match rates. On average, the federal share of Medicaid is 57 percent and the states' share is 43 percent.[i] Under federal rules, the state share must be "public funds" that are not federal funds. The non-federal public funds may come from one of three sources: (1) direct appropriations to the state Medicaid agency; (2) intergovernmental transfers (IGTs); or (3) certified public expenditures (CPEs).[ii] IGTs are funds transferred from other state or local agencies to the administrative control of the state Medicaid agency. CPEs are funds certified by the contributing public agency as representing expenditures for which federal matching payments are allowable.

Provider taxes generally produce revenues that flow into state treasuries and are then directly appropriated to the state Medicaid agency. Provider taxes are common among states and have become an integral source of financing for Medicaid. Currently, nearly all states (47) have at least one provider tax in place: 38 states have nursing home taxes, 34 states have hospital taxes, 34 states have taxes on intermediate care facilities for individuals with mental retardation or developmental disabilities (ICF-MRs), and 11 states impose taxes on managed care organizations.[iii] Particularly during economic downturns, states are more likely to impose or increase provider tax rates to help fund the state share of Medicaid.

In the past, certain state financing techniques, including provider taxes, enabled states to receive higher effective federal matching rates than the statutory formula provides. Following the documentation of some of these practices by the Government Accountability Office (GA0), the Congress in 1991 enacted legislation curbing abusive provider tax arrangements.[iv] This legislation, and its implementing regulations, specifies standards that are designed to ensure that provider taxes are, in fact, taxes generating revenue for a state rather than a mechanism for drawing down federal Medicaid matching funds without a state contribution.

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WHAT ARE PROVIDER TAXES, AND WHAT REQUIREMENTS MUST THEY MEET?

Provider taxes are any mandatory payment, including licensing fees or assessments, in which at least 85 percent of the burden falls on health care providers. The tax can apply to health care items or services, or to the provision of or payment for such services.[v] Assessments or fees imposed on health insurance premiums paid by individuals or employers are not provider taxes.[vi] Federal regulations list 19 different classes of health care services on which provider taxes may be imposed. These include inpatient hospital services, nursing facility services, intermediate care facility services for individuals with mental retardation or developmental disabilities, physician services, and services furnished through managed care organizations.[vii] States may not use the revenues from a provider tax as state share unless the tax meets three basic requirements. Provider taxes must be broad-based, uniformly imposed, and the tax must not hold providers harmless.[viii] The Centers for Medicare & Medicaid Services (CMS) is responsible for determining whether these requirements are met.

Taxes Must Be Broad-Based. In order to be considered broad-based, a provider tax must be imposed on all the health care items or services furnished by all the non-federal, non-public providers in the class in the state. For example, in the case of a tax on inpatient hospital services, a tax would not be broad-based if it exempted private nonprofit hospitals generally, or if it applied only to the hospitals in one region of the state. Public hospitals, however, could be exempt from the tax.

Taxes Must Be Uniformly Imposed. In general, a provider tax is uniformly imposed if it is the same amount or rate for each provider in the class. For example, a licensure fee imposed on a facility would have to be the same amount for each facility; a licensure fee imposed on the basis of the number of beds in a facility would have to be the same for each bed in each facility. Similarly, a tax imposed on provider revenues or receipts would have to be imposed at a uniform rate for all providers in the class. However, if a tax allows for credits or exclusions that result in the return to the provider of all or a portion of the tax paid, and if the net effect of the tax program is not "generally redistributive," then the tax would not be considered to be uniformly applied.

Taxes Cannot Hold Providers Harmless. A provider tax is considered to hold the provider harmless if the providers paying the tax receive, directly or indirectly, a non-Medicaid payment from the state or any offset or waiver that guarantees to hold the provider harmless for all or a portion of the tax. A provider tax is also considered to hold the provider harmless if the Medicaid payments to the provider vary based only on the amount of the taxes paid by the provider. Federal regulations create a safe harbor from this hold-harmless test for taxes that produce revenues at 5.5 percent or less of the revenues received by a provider; this threshold will increase to 6 percent on October 1, 2011.[ix]

Secretary of HHS Can Waive Certain Provider Tax Requirements if Certain Conditions are Met. The Secretary is authorized to waive the broad-based and uniform tax requirements (but not the hold-harmless requirement).[x] Thus, a tax might not apply to all providers in a class, or it might not be applied uniformly to the providers to which it does apply (rural and sole community providers are expressly cited as allowable exemptions). The Secretary may waive the broad-based and uniformity requirements, however, only if the net impact of the tax is "generally redistributive" (as determined by quantitative tests set forth in regulations) and not directly correlated with Medicaid payments to the providers subject to the tax.[xi]

THE COLORADO HOSPITAL PROVIDER FEE

Colorado is one of 34 States that relied in part on revenues from a hospital tax to fund the state share of its Medicaid program during FY 2011. The Colorado Hospital Provider Fee, as it is formally known, was enacted in 2009 as part of legislation that increased hospital reimbursement rates, funded Medicaid and CHIP eligibility expansions, and created a buy-in program for disabled adults.

How Does the Fee Work? The fee applies to both inpatient and outpatient hospital services.[xii] The fee on inpatient hospital services is equal to $60.47 per day for managed care days and $270.26 per day for non-managed care days. There is a fee on outpatient hospital services of 0.35 percent of total charges. Certain hospitals (including psychiatric hospitals, Medicare-certified long-term care hospitals, and Medicare-certified rehabilitation hospitals) are exempt from the fee. High-volume Medicaid Hospitals, Colorado Indigent Care Program (CICP) hospitals, Critical Access Hospitals and other rural hospitals are assessed discounted fees. After conducting a statistical analysis to determine that the tax was "generally redistributive" and a review to determine that there was no correlation between the tax and the Medicaid reimbursement, CMS approved waivers of the broad-based and uniformity requirements for provider taxes.[xiii]

How Does the Reimbursement Work? Reimbursement under the Hospital Provider Fee program takes the form of eleven different types of supplemental payments (lump sum above the normal Medicaid reimbursement levels for inpatient or outpatient hospital services). The supplemental payments vary, but the objective is that "higher volume Medicaid providers receive proportionately higher payments." Almost half (47 percent) of the supplemental payments are targeted at CICP (disproportionate share) hospitals.

What is the Impact on Hospitals? During the first year of the program (July 1, 2009 – June 30, 2010), total supplemental hospital payments totaled $590 million.[xiv] After accounting for the total amount hospitals paid in fees ($303 million) and the amount that the CICP hospitals received prior to the fee, there was a net gain to hospitals of about $124 million. For most of the 54 general, acute care hospitals subject to the tax, supplemental payments received exceeded fees paid. The net gains ranged from $50,900 at a small rural hospital to $17.8 million at Denver Health, the state's largest public hospital. Not all of the participating hospitals came out ahead, however; ten hospitals paid fees that exceeded their payments by an amount ranging from $13,000 to $2.8 million.

What is the Impact on the State Share of Medicaid? Of the $590.2 million in supplemental payments, the federal government paid $341.4 million, and the state paid the remaining $248.7 million.[xv] The fees paid by the hospitals, a total of $302.9 million, exceeded the state's share by $54.15 million; this excess was used to pay for the coverage expansions, General Fund relief, and the costs of administering the provider fee program. The $590 million in supplemental payments represents about one seventh of the $4.2 billion in federal and state Medicaid spending in Colorado in federal FY 2010. The state revenues generated by the tax during the first year of the program were equal to 3.25 percent of net patient revenue (inpatient and outpatient) for the fee-paying hospitals.[xvi] Fees are expected to increase to 3.4 percent in the current fiscal year and then to 4.2 percent next year due to needs to finance the coverage expansions.[xvii]

What is the Status of the Coverage Expansions? On May 1, 2010, Colorado implemented two coverage expansions authorized by the hospital tax enabling legislation: increasing the income eligibility thresholds for parents in the state's Medicaid program to 100 percent of the Federal Poverty Level (FPL) and for children in the state's CHIP program to 250 percent of FPL. By September 30, 2010, approximately 25,000 parents and 2,500 children had enrolled under these coverage expansions. These expansions occurred in the context of overall state revenue declines during the recession that resulted in cutbacks in other state programs as well as other parts of Medicaid.[xviii]

WHAT ARE CURRENT ISSUES WITH PROVIDER TAXES?

Currently, almost all (47) states rely on provider taxes to help finance their share of Medicaid program costs. National data on the percentage of state share accounted for by provider tax revenues are not available. In recent years, states have increasingly relied on provider tax revenue to fund their Medicaid programs as other funds have been constrained due to the economic downturn. The total number of provider taxes in place has remained relatively constant, but the number of hospital provider taxes has increased from 19 in state fiscal year 2008 to 34 in 2011. Some states have also increased the amount of the tax imposed.

A number of proposals have been offered to reduce Medicaid provider taxes. The National Commission on Fiscal Responsibility and Reform (Bowles-Simpson) issued a series of deficit reduction proposals in November 2010, including a proposal to reduce taxes that states may levy on Medicaid providers, estimated to reduce federal spending by $49 billion over the 2012-2020 period.[xix] The Congressional Budget Office's budget options publication included an option to lower the safe harbor threshold for provider taxes from 6 percent to 3 percent of revenues.[xx] The President's FY 2012 budget proposed to reduce the safe harbor threshold from 6 percent in 2014 to 3.5 percent from 2105 to 2017 and beyond, reducing federal Medicaid spending by an estimated $18.4 billion over the 2012-2021 period. The President's Framework for Shared Prosperity and Shared Fiscal Responsibility released April 13, 2011 also would limit states' use of provider taxes.

Reducing the safe harbor threshold will have the effect of reducing the amount of revenues that a state can raise from provider taxes and apply towards its share of Medicaid program costs. This proposal and other similar efforts to limit currently available sources of state Medicaid financing reflect the on-going tensions in the balance of federal and state financing for the program. Changes from current financing policies will have very different implications across states, and if states are unable to replace these sources of financing with alternative revenues, then states will likely have to lower Medicaid spending by reducing payments to providers, reducing benefits, and/or reducing the use of services. In the case of states facing economic downturns and high unemployment, it will be difficult to find replacement revenues at the same time as caseloads are increasing. Thus, federal budget savings may be achieved at the expense of fewer funds available to finance state Medicaid programs.

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[i] With the implementation of health reform in 2014, the average state share will decrease to between 38 and 40 percent according to the Congressional Budget Office, *Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicaid* (March 18, 2011) note 1. The 57 percent average does not include the temporary enhancement in federal matching payments under the American Recovery and Reinvestment Act (ARRA), P.L. 111-5, that expires on June 30, 2011.

[ii] 42 CFR 433.51.

[iii] Smith et al., *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011* (September 2010), Appendix A-3.

[iv] GAO, *State Medicaid Financing Practices*, HEHS-96-76R (January 23, 1996), http://archive.gao.gov/paprpdf1/156091.pdf

[v] Section 1903(w)(3) of the Social Security Act, 42 U.S.C. 1396b(w)(3).

[vi] 42 C.F.R. 433.55(c).

[vii] 42 CFR 433.56.

[viii] 42 CFR 433.68.

[ix] The Tax Relief and Health Care Act of 2006 lowered the 6 percent threshold to 5 percent for the period January 1, 2008 through September 31, 2011.

[x] Section 1903(w)(3)(E) of the Social Security Act, 42 U.S.C. 1396b(w)(3)(E).

[xi] 42 CFR 433.68(e).

[xii] State Plan Amendment Transmittal Numbers 09-035, and 09-039, posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251574082236

[xiii] Letter from Cindy Mann, Director, Center for Medicaid and State Operations (March 30, 2010), posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251574082236

[xiv] Hospital Provider Fee Oversight and Advisory Board, Colorado Health Care Affordability Act Annual Report 2010 (January 5, 2011), Appendix A: FY 2009-10 Hospital Provider Fee Model Overview, http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251570031621

[xv] During this period, Colorado's federal Medicaid matching rate was 61.59 percent under ARRA. This enhanced rate applied to the non-DSH payments, which totaled $399.7 million. The state's regular 50 percent match rate applied to the $190.5 million in DSH payments.

[xvi] Nancy Dolson, Colorado Department of Health Care Policy and Financing, May 18, 2011.

[xvii] Ibid

[xviii] " Colorado Case Study" in Smith et al., Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends (September 2010), Kaiser Commission on Medicaid and the Uninsured, pp. 101-105.

[xix] http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/CoChair_Draft.pdf

[xx] CBO, *Budget Options, Volume I: Health Care* (December 2008) p. 137, http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf

Table 1: Provider Taxes in Place in the 50 States and the District of Columbia
FY 2010-2011

States	Hospitals		ICF/MR-DD		Nursing Facilities		Managed Care Organizations		Other		Any Provider Tax	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
Alabama	X	X			X	X			X	X	X	X
Alaska												
Arizona							X	X			X	X
Arkansas	X	X	X	X	X	X					X	X
California		X	X	X	X	X			X	X	X	X
Colorado	X	X	X	X	X	X					X	X
Connecticut					X	X					X	X
Delaware												
District of Columbia	X	X	X	X	X	X	X	X			X	X
Florida	X	X	X	X	X	X					X	X
Georgia		X			X	X					X	X
Hawaii												
Idaho	X	X			X	X					X	X
Illinois	X	X	X	X	X	X					X	X
Indiana			X	X	X	X					X	X
Iowa		X	X	X	X	X					X	X
Kansas	X	X				X					X	X
Kentucky	X	X	X	X	X	X			X	X	X	X
Louisiana			X	X	X	X			X	X	X	X
Maine	X	X	X	X	X	X			X	X	X	X
Maryland	X	X	X	X	X	X	X	X			X	X
Massachusetts	X	X			X	X			X	X	X	X
Michigan	X	X			X	X				X	X	X
Minnesota	X	X	X	X	X	X	X	X	X	X	X	X
Mississippi	X	X	X	X	X	X					X	X
Missouri	X	X	X	X	X	X			X	X	X	X
Montana	X	X	X	X	X	X					X	X
Nebraska			X	X							X	X
Nevada					X	X					X	X
New Hampshire	X	X			X	X					X	X
New Jersey	X	X	X	X	X	X	X	X	X	X	X	X
New Mexico							X	X	X	X	X	X
New York	X	X	X	X	X	X			X	X	X	X
North Carolina			X	X	X	X					X	X
North Dakota			X	X							X	X
Ohio	X	X	X	X	X	X					X	X
Oklahoma					X	X					X	X
Oregon	X	X			X	X	X		X	X	X	X
Pennsylvania	X	X	X	X	X	X	X	X			X	X
Rhode Island	X	X	X	X	X	X	X	X			X	X
South Carolina	X	X	X	X							X	X
South Dakota			X	X							X	X
Tennessee		X	X	X	X	X	X	X			X	X
Texas			X	X			X	X			X	X
Utah		X	X	X	X	X					X	X
Vermont	X	X	X	X	X	X			X	X	X	X
Virginia				X								X
Washington	X	X	X	X			X	X			X	X
West Virginia	X	X	X	X	X	X					X	X
Wisconsin	X	X	X	X	X	X			X	X	X	X
Wyoming												
Total	**29**	**34**	**33**	**34**	**37**	**38**	**12**	**11**	**14**	**15**	**46**	**47**

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.