Health Care Provider and Industry Taxes and Fees

Updated: August 2010

State provider taxes generate billions of dollars in revenue each year. In almost all states, the policy decisions tied to these taxes affect health policy as well as fiscal policy. In particular, the rate of taxation and the allocation or earmarking of the revenue can have far-reaching impacts on state health programs and on overall state budgets. Many recent legislative proposals for state health coverage expansion or reforms may rely on or reference use of these taxes. The information below integrates fiscal statutes and revenue figures with health program information to assist state policymakers understand and evaluate both areas.

In general, a "provider tax," sometimes termed a "fee" or "assessment," is a state law that authorizes collecting revenue from specified categories of providers. In most states it is used as a mechanism to generate new in-state funds and match them with federal funds so that the state gets additional federal Medicaid dollars. In a majority of cases, the cost of the tax is promised back to providers through an increase in the Medicaid reimbursement rate. Beyond Medicaid, states have the policy option to tax most types of providers and services, including health care, and to designate or earmark the revenue for any state purpose.

Under federal law and regulations, a state's ability to use provider-specific taxes to fund their state share of Medicaid expenditures has limits. Those taxes cannot generally exceed 25% of the state (or non-federal) share of Medicaid expenditures, and the state cannot provide a guarantee to the providers that the taxes will be returned to them. Despite these federal limitations, many states are now using or considering use of provider taxes, sometimes to supplement static or declining provider reimbursement rates. In part this is because of a federal "safe harbor" — if the taxes returned to a provider are less than 6% of the provider's revenues, the prohibition on guaranteeing the return of tax funds is not violated. (1a) As a result, a state can impose a provider tax of 5.5% of revenues (as of January 2008 through September 2011), return those revenues directly back to those providers in the form of a Medicaid 'payment' and receive a federal match for those amounts. This maximum amount will increase back to 6% of revenues in October 2011, unless alterd by Congress. (1b)

For both FY 2009 and FY 2010, 44 states and DC had at least one Medicaid provider tax. (1c) By comparison 41 state used these in FY 2006 and 43 states and DC by the end of FY 2007. (2)(3)

In 2009 and 2010, NCSL's, NCSL's Fiscal Affairs staff released survey results that provide a helpful snapshot of changes in tax and fees related to health care. The resulting changes are listed in Table 1.

Additional Resources

- New provider fees in more states
- Medicaid "FMAP" matching funds to states for 2011
- Health Provider Fees: State Actions- NCSL summary testimony, 8/10
- "A Colorado Story" - description of one state's provider fee legislative actions. Released 8/10.
- State Tobacco Taxes, 2009-10
- Health Finance overview, 2010
- Medicaid overview
- Submit a question to NCSL (Legislators & staff only)

Authors:
♦ Richard Cauchi (initial descriptions and history)
♦ Katie Mason (2010 Research and updates)
NCSL Health Program

RECENT NEWS:

Federal funding 2008-2010: Medicaid is financed at both the federal and state levels, but the federal match varies based on the state's poverty level and unemployment rate.

In February 2009, the U.S. Congress passed and the President signed the ARRA (American Recovery and Reinvestment Act of 2009), which included a significant increase (at least 6.2%, and averaging at least 8.7%) in the Medicaid FMAP matching funds rate, providing temporary increases to all 50 states and territories from October 1, 2008 through December 31, 2010, totaling an additional $87 billion in federal funding, giving states an added incentive to tax hospitals and health care providers. [See FMAP chart online]-posted 12/09 This increase means added revenue from many of the existing Medicaid-related provider taxes, listed below.

For 2009 sessions, at least nine states, including Arkansas, Colorado, Iowa, Oregon and West Virginia enacted legislation to establish or expand provider taxes and fees. California, Missouri, Ohio and Wisconsin also made changes.

For 2010, new or expanded health provider or hospital fees or taxes were considered in Arkansas, Michigan, Oklahoma, Vermont, and Washington. NEW

Eight states faced a federal change regarding managed care taxes in Oct. 2009: California, Georgia, Kentucky, Michigan, Missouri, Ohio, Oregon, and Pennsylvania. See: NASMD letter to Chairman Baucus re: extension of Managed Care Organization provider tax [6/16/09]

Colorado became the first state in 2009 to create a new provider fee when HB 1293 was signed into law on April 21. The money collected from each hospital will be pooled and used to draw down matching funds from the federal Medicaid program. The resulting money — as much as $1.2 billion, by some projections — will be used to expand health coverage for the state's uninsured. [Point - Counterpoint news article-2009]

Arkansas: A tax on Arkansas hospitals will "bring an estimated $105 million in new revenue to the state annually by drawing in more federal matching money for Medicaid." Under Senate Bill 582 (Signed into law as Act 562, 3/25/09), the Arkansas Department of Human Services would collect an "assessment fee" of up to 1 percent of some hospitals' annual net patient revenue. The state would use the fees to increase its federal match for Medicaid and then divide the matching funds it gets back out to Arkansas hospitals based on how many Medicaid patients they treat. NWA News article 3/8/09.

Oklahoma Supreme Court rules fee on health insurance plans unconstitutional. On 8/24/2010 the court ruled the measure violated a ban on the passage of revenue bills during the last five days of the legislative session. The court also held that the bill failed to secure three-fourths legislative approval or be submitted to a vote of the people. The measure would have imposed an annual 1 percent fee or tax on payments made by health carriers for health and medical services for Oklahoma residents. The 1 percent would have also applied to the self-insured. Read more Tulsa World article at http://www.tulsaworld.com/news/article.aspx?subjectid=17&articleid=20100824_17_0_OKLAHO855433

Oregon passed a new provider tax that will bring in $700 million and is intended to extend health insurance to "nearly all of Oregon's uninsured children and add an additional 35,000 uninsured adults to the Oregon Health Plan." More

Iowa enacted an amendment to the terms and conditions of the IowaCare waiver to eliminate the provision in which the state agrees to refrain from imposing any provider tax during the pendency of the demonstration waiver for IowaCare. No actual tax was created by the law.
S 476 signed 5/26/09.

West Virginia amended an annual broad-based health care-related tax on providers of physicians' services; expanding the definition of physicians' services to mean those services furnished by a physician within the scope of the practice of medicine or osteopathy,whether furnished in the physician's office, the recipient's home, a hospital, a skilled nursing facility or any other location. S 724 was signed into law as Chapter 215 of 2009 on 6/9/09.

Michigan House speaker: Doctor tax may stall in Senate - Specter of Medicaid cuts not swaying votes. News Article, Crains Business, 10/19/09

In 2007-08 the Centers for Medicare and Medicaid Services (CMS) promulgated multiple rules which could have potentially adversely affected state Medicaid programs. The rules which have prompted congressional legislative activity as well as litigation by several states include Health Care-Related Taxes (originally scheduled to be effective April 22, 2008). In April 2008 a major change in federal interpretation and requirements delayed the change in the state provider taxes for Medicaid. As of mid-2009, the final rule on provider taxes and related Medicaid issues extended the moratorium until June 30, 2010.

As background see:

NCSL Federal Alert: NCSL has supported a delay of several Medicaid rules promulgated by the Center for Medicare and Medicaid Services (CMS) over the last couple of years which would affect intergovernmental transfers and select services and benefits within state Medicaid programs. The Administration has been asked several times the impact of implementing two Medicaid rules when an existing moratorium expires May 25, 2008. --
Cost limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership -- CMS 2259-FC -- final rule with comment period, published on May 29, 2007.

On May 23 United States District Court for the District of Columbia, Judge James Robertson, granted a motion for summary judgment to Alameda County Medical Center, the National Association of Public Hospitals and Systems, the American Hospital Association, and the Association of Medical Colleges in their action against Secretary Leavitt, Secretary, DHHS and Kerry Weems, Acting Administrator, CMS regarding the final rule issued on May 29, 2007 regarding "Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of the Federal-State Financial Partnership." This rule would have placed additional restrictions on how states can use money from units of local government (intergovernmental transfers) toward the state contribution of the Medicaid match. The judges action vacates the rule.

On May 22 the Senate approved an amendment, 75 yeas to 22 nays, to the Iraq Supplemental containing a number of domestic spending provisions including the moratorium on the seven Medicaid regulations and the August 17th Directive related to SCHIP.

Secretary Leavitt made the following statement May 21, 2008 concerning two of these rules: "I reiterate the Administration's willingness to work with Congress and Governors to discuss their concerns before the rules go into effect," Secretary Leavitt said. "We will voluntarily refrain from making these rules effective until August 1, 2008, more than 60 days after the moratorium expires. I invite interested parties to sit down with me and my staff in the coming weeks to ensure that we meet our mutual commitments to protect health care for low-income individuals." NCSL staff is making every effort to keep you informed on the activities surrounding these rules. We post updated information on these actions on the Health Policy-Federal Issues webpage. Legislators and staff with questions please contact Rachel Morgan or Joy Wilson at NCSL's DC office. (5/22/08) Countdown to Medicaid Rule Update on May 25, 2008.

Medicaid Provider Taxes by the Congressional Research Service (CRS) - This report provides background information on provider-specific taxes and describes recent legislative and administrative action on the tax programs. [Posted on the NCSL website, 5/7/08]

"Can a Sales Tax on Medical Services Help Fund State Coverage Expansions?" This brief encourages states to consider a medical sales tax—or provider tax—as one financing mechanism for expanding coverage. Because provider tax revenue grows with medical spending, it is more stable and less susceptible to changes in the business cycle. In addition, it is less likely to decrease demand for services than other sales taxes might, and it has the potential to recapture savings from uncompensated care that are no longer being provided in a more comprehensive coverage environment. By Health Management Associates for Academy Health/State Coverage Initiatives 7/08. [8 pages]

Table 1

2010 Health Care Provider Tax Changes				
State	FY 2011 Amount (in millions)	FY 2012 Amount (in millions)	Effective Date	Description
Alabama	$20.9	$20.9		Raised the nursing home bed tax.
Idaho	$18.0	$18.0		Approved the Idaho Hospital Assessment Act, which calls for calls for private hospitals to pay an extra hospital tax for Idaho's Medicaid program for two years.
Kansas	$15.3	$15.3		Created a new assessment on skilled nursing facilities.
Maine	$4.2	$15.6		Approved a one-time hospital assessment.
	$11.4			Updated hospital tax base year from 2006 to 2008.
New Jersey	$45.2	$45.2		Lifted the cap on hospital and ambulatory facilities assessments.
Ohio	$32.4	$32.4		Raised the tax assessed on hospitals for one year from 1.52 percent to 1.61 percent.
Tennessee	$286.0	$286.0		Adopted a new hospital assessment fee of 3.52 percent.
Utah	$30.9	$30.9		Imposed new assessments on hospitals.
Washington	$352.0	$352.0		Increased the hospital safety net assessment.
Wisconsin	$10.6	$10.6		Created a 1.6 percent assessment on gross inpatient revenues of critical access hospitals.

* State Tax Update: July 2010 (Preliminary Report)

2009 Health Care Provider Tax Changes				
State	**FY 2010 Amount** (in millions)	**FY 2011 Amount** (in millions)	**Effective Date**	**Description**
Alabama	$200.0	$200.0	10/1/2009	Establishes a hospital tax.
Arizona	$0.0	$0.0		Adds insurance providers to the existing corporate income tax credit for contributions made to school tuition organizations.

2009 Health Care Provider Tax Changes				
State	FY 2010 Amount (in millions)	FY 2011 Amount (in millions)	Effective Date	Description
Colorado	$336.5	$389.8	4/21/2009	Authorizes collection of provider fees from hospitals to obtain federal financial participation for the state's medical assistance programs.
Florida	$8.0	$12.1		Provides for a quality assessment to be imposed upon privately operated intermediate care facilities for the developmentally disabled.
Indiana	$101.0	$99.9	7/1/2009	Extends the Medicaid health facility quality assessment fee.
Iowa	$33.0	$33.0	TY 2009	Creates a nursing facility quality assurance fee (requires federal approval before implementation).
Mississippi	$60.0	$60.0	7/1/2009	Provides a hospital assessment tax.
New Mexico	-$11.0**	-$16.1**		Phases in the hospital gross receipts tax credit (phased in completely in FY 2012, from 2007 session).
New York	$124.3	$135.6	4/1/2009	Changes the hospital assessment tax.
	$14.2	$16.0	4/1/2009	Changes the home care assessment.
	$99.0	$108.0	4/1/2009	Raises the hospital surcharge.
	$240.0	$120.0	10/1/2008	Adjusts a covered lives assessment (insurance surcharge).
	$5.0	$5.0	4/7/2009	Changes an out-of-state covered lives assessment.
Ohio	$100.0	$100.0	7/1/2009	Raises the franchise fee for nursing facilities.
	$338.5	$370.9	10/1/2009	Changes the hospital assessment.
	$3.0	$3.0	8/1/2009	Increases the franchise fee for intermediate care facilities for the mentally retarded.
Oregon	$102.0	$204.0	10/1/2009	Raises the hospital assessment tax.
	$85.0	$78.0	10/1/2009	Changes to insurance premium for Medicaid managed care.
Pennsylvania	$528.0	$529.0		Changes the gross receipts tax on managed care to draw additional federal matching funds for medical assistance.
Rhode Island	-$12.7	$0.0		Changes the Medicaid global waiver and eliminates the group home tax.
	$13.6	$0.0	1/1/2009	Increases health industry gross premiums tax and base expansion to managed care health plans.
	$0.0	$0.0		Sets the recurring hospital license fee for FY 2010.
Wisconsin	$31.8	$40.0	7/1/2009	Raises the nursing home bed assessment.
	$103.2	$139.1	7/1/2009	Imposes a hospital assessment.
	$22.0	$22.0	7/1/2009	Imposes a tax on ambulatory surgical centers.

State Provider Taxes and Medicaid (updated July 22, 2010) - Table 2

This table summarizes each state's current provider tax, fee or assessment, including recent history. The data below is summarized from three sources.

NCSL surveys, State Budget & Tax Actions 2007, 2008, 2009, 2010 Preliminary Tax Actions. Health Program telephone interviews with selected Medicaid offices, July 2010.

The Health Management Associates (HMA) Medicaid Budget Survey as reported October 2006, 2007 and 2009. The latest report shows 26 states taxing hospitals, 11 states taxing managed care organizations, 31 states/district taxing Intermediate Care Facilities/Mental Retardation-DD, 37 states/district taxing nursing homes, 4 taxing pharmacies and 2 taxing Residential care and day rehabilitation providers.

A separate compilation by Commerce Clearinghouse (CCH) in 2008, noted as "**" below, includes additional taxes or fees not reported by Medicaid agencies.

Notes: Many laws imposing an annual tax or fee provide formulas for prorated payments as well as exemption for designated public or private providers; these details are not listed in this table. "FFP" means "Federal Financial Participation" or Medicaid federal matching funds granted to the state. The match rates vary by state according to 1) relative wealth or poverty of the state and 2) the aspect of the Medicaid program being funded. About half the states receive a "base" rate, currently, 61.59% FFP while the least well-off state (Mississippi) receives 84.87% for FY 2010. All SCHIP Medicaid expenditures (for children) receive an "enhanced" match rate. See Medicaid FMAP Table for FY 2010.

The code (**M)** below indicates taxes or fees that are used to obtain Medicaid Federal Financial Participation (FFP) or matching funds.

State	Tax Applies to:	Description and Notes
AL	Hospital (M) Nursing Home (M) Other: Pharmacy (M)	Hospitals: Hospitals were added for FY 2010. NEW Nursing Home: Levies a privilege tax on nursing facilities, at an annual rate of $1,899.96, imposes a new supplemental tax of $1,063.08 for the period September 1, 2010 through August 31, 2011, to reduce the percentage of total nursing facility revenues used when considering a reduction of the tax and to provide for the prepayment of the supplemental privilege tax through an increase in the Medicaid per diem rate beginning in January 2011. Signed as Law chapter 520. This tax is expected to generate $200 million. NEW Other- Pharmacy:A pharmacy tax of 0.10 per prescription exists except for prescriptions below $3.00. This has been in place since approximately 1990. Tax is valid only if allowed for FFP under federal Medicaid. *Note:* Provider tax revenue was $58 million in FY 2006, $58 million in FY 2007 and $59 million in FY 2008.[6]
AZ	Managed Care Org. (M)	Managed Care Org.: 2% of net premiums, for hospital and medical service corporations, health care service organizations, health care providers of Medicaid services. *Note:* From 2003 through 2008, the premium tax on Arizona's Medicaid health insurers generated $575 million.
AR	Hospital (M) ICF/MR-DD (M) Nursing Home (M)	Hospitals: "Assessment fee" of up to 1 percent of some hospitals' annual net patient revenue added for FY 2010 (Act 562 of 2009). ICF/MR-DD: Establishes a provider fee for intermediate care facilities for individuals with developmental disabilities added for FY 2010 (Act 433 of 2009). From July 31, 2009, to June 30, 2010, the multiplier shall be set at $15.15 per patient day. Nursing Home: Quality assurance fee of 6% of the aggregate annual Arkansas gross receipts (Act 635, §2 (H.B. 1274), Laws of 2001).
CA	Hospital ICF/MR-DD (M) Nursing Home	Hospital: As of 2009, establishes an unspecified "coverage dividend fee" on private hospitals with the purpose of increasing payments to Medi-Cal managed care plans, hospitals, and expanding health coverage to children. Sunset: December 31, 2013, signed as Law chapter 627 (AB 1383). Awaiting CMS approval. ICF/MR-DD: Quality assurance fee up to 5.5% of gross revenue on skilled nursing facilities (CA Health and Safety §1324.21, signed as Law chapter 875 (AB 1629), Sept. 2004). Nursing Home: Began in 2006. As of 2009, expansion of Quality Assurance Fee for AB 1629 Nursing Homes. AB 1629 nursing homes presently pay a quality assurance fee. Expanded this fee to include Medicare revenues, as well as Medi-Cal and private pay revenues. Signed as Law chapter 5 (AB 5 d). *Note:* Discontinued Managed Care Org. fee in 2010.
CO	Hospital (M) ICF/MR-DD (M) Nursing Home	Hospitals: Fee was determined by a 13-member oversight committee. Managed care days are taxed at $60.47 per inpatient hospital day. Non-managed care days are taxed at $270.26 per inpatient bed day. Discounts are applied to high volume Medicaid and indigent care providers and essential access hospitals. Mental disease, rehabilitation, and long term care hospitals are excluded (Signed as Chapter 152 of 2009). ICF/MR-DD: Service fee up to 5% of the costs incurred by each intermediate care facility, effective 2003-04. (Co. Rev. Stat. 25.5-6-204(c)). Fee is valid only if allowed for FFP under federal Medicaid.

		Article: Gov. Ritter Announces Colorado Healthcare Affordability Act, released February 26, 2009.
CT	Nursing Home (M)	Nursing Home: "Resident day user fee" on nursing homes of 6% on each Medicaid nursing home bed (CT Sec. 17b-321, enacted as P.A. 05-251, effective for 2006). Fee amount is subject to federal Medicaid waiver approval.
DC	ICF/MR-DD Nursing Home (M)	ICF/MR-DD: 1.5% per annum of gross revenue. (Sec. 47-1273, signed as D.C. Law 16-68, March 2006, effective for FY 2008). FY 2011 Budget reflects $1.7 million from a 1.5 percent tax on the gross revenue of intermediate care facilities that was adopted in 2006 but has not been implemented. NEW Nursing Home: Assessment on nursing homes of $3,600 per licensed bed annually; may be increased up to 6% of net resident revenue (Sec. 47-1263, signed as Law 15-205). The tax is estimated to generate $11 million in revenue annually from FY 2010 through FY 2014. *Note:* Hospital assessment of 0.45% of net patient services revenue was discontinued (Sec. 47-1242- Repealed by Law 15-205).
FL	Hospital (M) ICF/MR-DD Nursing Home Other: Clinical Labs, Ambulatory Surgical Centers, Diagnostic Imaging	Hospital: Hospitals are assessed 1.5% of the annual inpatient net operating revenues, and 1 percent of the annual outpatient net operating revenues; funds administered by the "Public Medical Assistance Trust Fund" (§ 395.701, F.S. amended by Chapter 2007-230). ICF/MR-DD: ICF/MR-DD taxes were added, effective FY 2010. Sunset date of the assessment is October 1, 2011. NEW Nursing Home: Created a quality assessment on nursing home facility providers and required the assessment to be imposed beginning April 1, 2009. The assessment may not exceed the federal ceiling of 5.5 percent of the total aggregate net patient service revenue. Signed as Law chapter 4. Note: Florida no longer taxes health care entities (including clinical labs, ambulatory surgical centers, diagnostic imaging) at an assessed 1% rate of annual net operating revenues (§ 395.7015, F.S.). This revenue is used for administrative expenses, not matching funds.
GA	Nursing Home	Nursing Home: Reduced for 2006. *Note:* Managed Care Org. fee was dropped for FY 2010.
ID	Hospital (M) Nursing Home	Hospital: Began in 2008. Not greater than 1.5 percent of the assessment base. Repeals July 1, 2012.
IL	Hospital (M) ICF/MR-DD (M) Nursing Home (M)	Hospital: Occupied beds less Medicare occupied beds from hospital's fiscal year Medicare cost report. The tax rate is $218.38 per occupied bed and is based on Fiscal Year 2005. The annual tax is $900.0 million. ICF/MR-DD: Adjusted gross revenues reported on HFS tax report. The tax rate is 5.5 percent and is based on the previous state fiscal year. The annual tax is $19.1 million. Nursing Home: Licensed beds multiplied by # of days in the current quarter. The tax rate is $1.50 per licensed bed day and is based on the current state fiscal year. The annual tax is $55.2 million.
IN	ICF/MR-DD (M) Nursing Home	ICF/MR-DD: Revised 2008. "Each facility's assessment shall be based on a formula set forth in regulations promulgated by the Department of Mental Health;" effective June 29, 2009. Nursing Home: SB 169 of 2006; effective July 1, 2006, extends an expiring levy on nursing facilities' non-Medicare total annual patient days. The extension of the $10 per non-Medicare patient day Quality Assessment is estimated to result in total additional payments to nursing facilities of approximately $215.8 million. Estimated total annual collection of $102.5 million for FY 2007.
IA	ICF/MR-DD (M) Nursing Home	ICF/MR-DD: The assessment fee equals 5.5 percent of the total revenue of the facility for the facility's preceding fiscal year. Nursing Home: Imposes a quality assurance assessment on nursing facilities for each patient day. The assessment rate is 3.0%. The quality assurance fee is expected to generate roughly $33 million. Signed as Law chapter 160 (S 476).
KS	Hospital (M) Nursing Home	Hospital: Annual assessment on hospital inpatient services of 1.83% of net inpatient operating revenue.

		Nursing Home: Imposed annual quality care assessment per licensed bed on each skilled nursing care facility. The assessment on all facilities in the aggregate shall not exceed $1,950 annually per licensed bed, and shall be imposed uniformly on all skilled nursing care facilities. Excludes skilled nursing care facilities that are part of a continuing care retirement facility, small skilled nursing care facilities and high Medicaid volume skilled nursing care facilities. Signed as Law chapter 159 (H 2320). Pending CMS approval. NEW *Note:* All assessments are valid only if allowed for FFP under federal Medicaid (Ch. 89 (HB 2912), Laws of 2004). Former Managed Care Org. Fee: Assessment fee of 5.9% of non-Medicare premiums collected by HMO. Fee is no longer waived for Medicaid MCOs.
KY	Hospital (M) ICF/MR-DD Nursing Home Other: Home Health Care (M)	Hospital: Hospital Services Tax of 2.5% on gross revenues (KRS Sec. 142.303, as amended by Ch. 9, Laws of 2007). ICF/MR-DD: Intermediate Facility Services Assessment of 5.5% on the gross revenues; effective July 1, 2004 (KRS Sec. 142.363-1). Nursing Home: Nursing Facility Services Assessment of 2% of gross revenues for non-Medicare patients, with variations (KRS Sec. 142.361, as created by Ch. 142, Laws 2004). Other- Home Health Care: Health Care Provider Tax of 2% on gross revenues of licensed home-health-care services and HMO services (KRS Sec. 142.307 as amended by Ch.. 73, Laws of 2005). *Note:* Managed Care Org. fee discontinued in 2010. A Pharmacy Tax of 15¢ per prescription ended in 1999 (see KRS Sec. 142.311).
LA	ICF/MR-DD (M) Nursing Home (M) Other: Pharmacy (M), Medical Transportation Providers (M)	ICF/MR-DD: "Health Care Providers' Medicaid Fees" are $30 per occupied bed per day for intermediate care facilities. Actual fee collected is $14.30 per day. Nursing Home: $10 per occupied bed per day for nursing facilities. Actual fee collected is $8.02 per day. Other- Pharmacy: 10¢ per out-patient prescription. Other- Medical Transportation Providers: $7.50 per medical service trip for medical transportation providers (Sec. 46:2625, La R.S.). No fee collected. This is the amount authorized by state law, but not implemented. Note: All fees are valid only if allowed for FFP under federal Medicaid.
ME	Hospital (M) ICF/MR-DD Nursing Home Other: Private Non-Medical Institutions (PNMI), Residential Care & Day Hab.	Hospital: "Health Care Provider Tax"- Hospitals subject to 2.23% tax of net operating revenue (36 M.R.S.A. Sec. 2892 as enacted by Act 513 (H.B. 1351), Laws of 2004). The hospital assessment has an updated tax base year of 2008 (changed from 2006). Nursing Home: Nursing homes tax is 5.5% of annual net operating revenue. Other- Residential Care & Day Hab.: Residential treatment facilities is 6% of annual gross patient services revenue (36 M.R.S.A. Sec. 2872, as amended by Act 467 (S.B. 424), Laws of 2003). *Note:* All taxes are valid only if allowed for FFP under federal Medicaid (Sec. HH-6, Ch.673, 2004).
MD	Hospital ICF/MR-DD Managed Care Org. Nursing Home (M)	Hospital: HB1587/SB 974 passed during the 2008 Legislative Session. By the end of FY 09, the Department estimated that it will receive $41 million in hospital assessment funds. Chapter 7. Nursing Homes: Added in FY 2008.The aggregate amount of the quality assessment necessary to support the Medicaid nursing facility reimbursement system in the FY 2009 was equivalent to the statutory cap of 2% of operating revenue. (SB 101 - Chapter 503 of the Acts of 2007).
MA	Hospital ICF/MR-DD (M) Nursing Home (M)	Hospital: Assessment; payment of expenses for Health Policy office and health safety net office by acute hospitals. (MGL Ch. 118, §5 as amended by Ch. 58 "health reform" law of 2006). ICF/MR-DD: Provider donations from hospitals or health centers. Massachusetts established a new tax on intermediate care facilities for the developmentally disabled in FY 2007. Nursing Home: Began in FY 2007. Extended to 4/4/10.
MI	Hospital (M)	Hospital: Increased in 2006.

	Nursing Home Other: Community Mental Health	Nursing Home: Increased in 2006. Other- Community Mental Health: Provider tax revenue was $674.0 million for fiscal 2006; $856.0 million for fiscal 2007 and $1,008.0 million for fiscal 2008.[6] *Note:* Managed Care Org. fee discontinued in 2010. NEW
MN	Hospital (M) ICF/MR-DD (M) Managed Care Org. (M) Nursing Home (M) Other: Providers (M), Ambulatory Surgical Centers (M), and Wholesale Drugs (M)	"MinnesotaCare Tax:" Hospitals, surgical centers, health care providers, and surgical centers' wholesale drug distributors pay 2% of estimated tax gross revenues (Sec. 295.52(4a)). Hospital: "Hospital Surcharge" is 1.56% of net patient revenues (Sec. 256.9657). ICF/MR-DD: Tax is $1040 per licensed bed annually. Managed Care Org.: HMO and Integrated Network surcharge is 1.6% of total premium revenues. Nursing Home: "Nursing Home License Surcharge:" Licensed non-state-operated nursing homes pay an annual surcharge of $2,815 per licensed bed. Increased from $625 in 2002 & 2003 (Sec. 256.9657). Other- Providers, ambulatory surgical centers, and wholesale drugs have a tax of 2%.
MS	Hospital ICF/MR-DD Nursing Home Other: Psychiatric Residential Treatment Facilities	ICF/MR-DD and Nursing Home: Assessment not to exceed $2 per patient bed per day (Miss. Code Sec. 43-13-145, as amended by ch. 470, Laws of 2005).
MO	Hospital (M) ICF/MR-DD (M) Nursing Home (M) Other: Pharmacy (M)	Hospital: Began in FY1992. Amount is set by regulations (13 CSR70-15.110). For FY2011, the rate is set at 5.45% of inpatient and outpatient adjusted net revenues. ICF/MR-DD: Began in FY2009. For FY2011, the rate is set at 5.49% of net operating revenues. Nursing Home: Began in FY1995. Amount is set by regulations (13 CSR70-10.110). For FY 2011, the NFRA is $9.27 per patient occupancy day. Other- Pharmacy: Began in 2002. For FY2011, the rate is set at 1.97% of Gross Retail Prescription Sales. *Note:* Ambulance: This provider tax is pending CMS approval. The rate is anticipated to be 5.45% of gross receipts. Managed Care Org.: Tax was discontinued in FY2010. Certification Fee for providers of health benefit services for home and community based waiver services for persons with developmental disabilities: Authorized by General Assembly in 2009. Fee is pending CMS approval.
MT	Hospital (M) ICF/MR-DD (M) Nursing Home (M)	ICF/MR-DD: FY 2007 set at 6% of revenue (15-67-102, MCA). Nursing Home: FY 2007 it was increased to $8.30/bed day (15-60-102, MCA). *Report:* MT Report on provider facilities fees -2009 budget.
NE	ICF/MR-DD (M)	ICF/MR-DD: In effect 2007-2008.
NH	Hospital Nursing Home	Nursing Home: Senate Bill 376 passed in 2004, established the Nursing Facility Quality Assessment which imposes an assessment of 6% on net patient services revenue on all nursing facilities licensed by the State. Effective for taxable periods beginning on or after 1/1/2008 this rate is reduced to 5.5%.
NV	Nursing Home (M)	Nursing Home: In the 2003 Legislative Session, legislation was passed to impose fees on free-standing nursing facilities. It was amended in 2005. The title of the program is "Assessment of Fees on Nursing Facilities to Increase the Quality of Nursing Care." It can be found in the Nevada Revised Statutes NRS 422.3755.
NJ	ICF/MR-DD (M) Managed Care Org. Nursing Home	Nursing Home: The current rate is $11.89 per non-Medicare day to applicable nursing homes. It may be up to a maximum of 6% of the aggregate amount of annual revenues received by applicable nursing homes.
NM	Managed Care Org. (M) Other	Managed Care Org.: NM has a broad-based "gross receipts sales tax"; in 2004 the state exempted all commercial managed care providers from this sales tax [see explanation 4A].

		Note: Discontinued ICF/MR-DD in 2006; Discontinued Nursing Home in 2006.
NY	Hospital (M) Nursing Home Other	Hospital: Began in 2006.
NC	ICF/MR-DD (M) Managed Care Org. Nursing Home	ICF/MR-DD : Effective November 1, 2009, the cost assessment rate that applies to all ICF/MR enrolled providers for total non-Medicare patient days is $12.32. Managed Care Org.: HMO taxes measured by 1.9% of gross premiums (NC § 105-228.5, effective 1/1/07).
ND	ICF/MR-DD (M)	
OH	Hospital (M) ICF/MR-DD Managed Care Org. Nursing Home	Hospital: Hospitals assessment on total facility costs not to exceed 2%, determined annually (Ohio Rev. Code Sec. 5112.01 et seq.). Managed Care Org.: Began in 2006. Nursing Home: Nursing home and hospital bed annual franchise permit fee at $1.25 per day per bed (Ohio Rev. Code Sec. 3721.51 as increased from $1 by HB 199 of 2007).
OK	Nursing Home (M) Health Insurance (M)	Nursing Home: Nursing Facility Quality of Care Fee iis collected from nursing facilities on a per patient day basis and placed into a revolving fund which is used to pay for a higher facility reimbursement rate, increased staffing requirements and other increased member benefits. The facilities receive monthly invoices for fee payments based on self-reported patient census and revenues. Health Insurance: HB2437 applies a 1% fee on all health insurance claims to be paid by insurance companies as well as companies that self-insure their employees. It is designed to collect an estimated $52 million in the first fiscal year that would be used to obtain $135 million in federal matching money (May 2010). This law was struck down by the state Supreme Court 8/24/2010. NEW
OR	Hospital (M) Managed Care Org. (M) Nursing Home (M)	Hospitals: The tax rate beginning July 1, 2009 is 2.32 percent. Managed Care Org.: The tax rate beginning October 1, 2009 is 1.0 percent. Nursing Home: The long term care tax is assessed based on a rate set by the Director of the Department of Human Services.
PA	Hospital ICF/MR-DD Managed Care Org. (M) Nursing Home	Managed Care Org.: Pennsylvania enacted a gross receipts tax on the managed care plans tied to the amount of revenue they received from Medicaid. Tax of 59 mills is imposed on each dollar of gross receipts received by managed care organizations pursuant to a contract with the PA Department of Public Welfare. Effective October 1, 2009.
RI	Hospital (M) ICF/MR-DD Managed Care Org. Nursing Home	Hospital: Hospital licensing fee of 3.14% for 2003. (RI Gen Laws Sec. 23-17-38.1). ICF/MR-DD: Residential facility for mentally retarded rate of 25% of the gross patient revenue. (RI Gen Laws Sec. 44-50-3). Nursing Home: Nursing facilities rate of 6% fee gross patient revenue Increased for 2006 (RI Gen Laws Sec. 44-51-3).
SC	Hospital (M) ICF/MR-DD	
SD	ICF/MR-DD (M)	ICF/MR-DD: Began in FY 2008.
TN	ICF/MR-DD Managed Care Org. (M) Nursing Home	Managed Care Org.: Premium tax; premium tax revenue for fiscal 2008 totaled $64 million. Nursing Home: Uniformly applied at the rate of $2,225 per licensed bed, effective 2003-08 (Tenn. Sec. 68-11-216; will sunset 6/30/2011). Nursing Home Tax revenue for fiscal 2008 totaled $85 million.[6]
TX	ICF/MR-DD (M) Managed Care Org.	ICF/MR-DD: The Health and Human Services Commission or the department at the direction of the commission shall set the quality assurance fee for each day in the amount necessary to produce annual revenues equal to an amount that is not more than six percent of the facility's total annual gross receipts in this state.
UT	Hospital ICF/MR-DD (M)	Hospital: Enacts the Hospital Provider Assessment Act. For fiscal year 2010-11 the department may generate an additional amount of $2,000,000 which shall be used by the department and the division as follows: $1,000,000 to offset Medicaid

	Nursing Home Other: Rural Health Care Facilities	mandatory expenditures; and $1,000,000 to offset the reduction in hospital outpatient fees in the state program. Repeals in 2013. Signed as Law chapter 179. ICF/MR-DD: Began in 2006.Other- Rural Health Care Facilities: Qualifying rural counties may adopt a rural health care facilities tax of up to 1 percent.
VT	Hospital (M) ICF/MR-DD (M) Nursing Home (M) Other: Pharmacy (M), Residential Care & Day Hab. (M), Home HealthProvider (M), Health Information Technology	Other- Health Information Technology: Health insurers pay in based on claims processed; and these funds are used as match to support the HIT/HIE initiative. NEW
WA	Hospital ICF/MR-DD Nursing Home (M)	Hospital: Creates hospital safety net assessment, which is an assessment on hospitals based on non-Medicare inpatient hospital days. The assessments increase periodically in four phases, and they range from six dollars to $174 depending on the phase and the type of hospital. Repeals on July 1, 2013. Signed as Law chapter 30 (H 2956). The increased hospital assessments may generate $352 million in additional revenue. ICF/MR-DD: The rate is .06 of revenues for services provided to intellectually disabled persons. Nursing Home: "Quality Maintenance Fee" is $6.50 per patient day. The fee is valid only if allowed for FFP under federal Medicaid. (Ch. 16 (S.B. 5341), 1st Sp. Sess., Laws of 2003). Revenue reported as reduced for 2006 & 2007. The tax was scheduled to terminate in FY 2008.
WV	Hospital (M) ICF/MR-DD (M) Nursing Home (M) Other: Independent Lab/X-ray Practitioner, Ambulatory Surgical Centers (M)	Hospital: Inpatient and outpatient hospital services are taxed at 2.5% (W.Va. Code Sec. 11-27-9; §11-27-15). Nursing Home: Nursing facility services, increased from 5.5% to 5.95% of gross receipts in 2005. Other- Laboratory/ X-ray services: Laboratory or x-ray services are taxed at 5%; MD offices are exempt (W.Va. Code Sec. 11-27-8). Other: Ambulatory surgical centers are taxed at 1.75% of gross receipts. *Note:* In June 2009, West Virginia amended an annual broad-based health care-related tax on providers of physicians' services; expanding the definition of physicians' services to mean those services furnished by a physician within the scope of the practice of medicine or osteopathy, whether furnished in the physician's office, the recipient's home, a hospital, a skilled nursing facility or any other location. S 724 was signed into law as Chapter 215 of 2009. Former Emergency Ambulance Service Providers Tax: Emergency ambulance service providers are taxed at the rate of 5.5%. Reduced for 2006 & 2007. Former Physicians' Services Tax: Physicians' services were taxed at 2% until 2001 but have been reduced annually; for 2007-08 the rate was 0.8% and was scheduled to be phased out to 0% by 2010. (W.Va. Code Sec. 11-27-36). Also formerly taxed , chiropractic (§11-27-5); dental; nursing; opticians & optometric; podiatry; psychological and therapists' services. All formerly taxed entities were eliminated effective July 1, 2010.
WI	Hospitals ICF/MR-DD Nursing Home (M) Other	Hospitals: In effect 2007-2008. ICF/MR-DD: Intermediate care facility assessment of $445 per month for fiscal year 2004-2005. Nursing Home: Nursing home assessment of $75 per month per licensed bed. Increased from $32 in 2003. (Sec. 50.14, Wis. Stats. as amended by Act 33 (S.B. 44), Laws of 2003).

NOTES:
(4) FLORIDA was the first state to establish a provider tax program in 1984. Hospitals have been assessed 1.5% of the annual net operating revenues (§ 395.701, F.S.) which are deposited into the Public Medical Assistance Trust Fund (PMATF). As of 2006 the PMATF revenue is used as state match for hospital inpatient services.

(4A) New Mexico State. §7-9-93.A. "Receipts from payments by a managed health care provider or health care insurer for commercial contract services or medicare part C services provided by a health care practitioner that are not otherwise deductible pursuant to another provision of the Gross Receipts and Compensating Tax Act may be

deducted from gross receipts, provided that the services are within the scope of practice of the person providing the service. Receipts from fee-for-service payments by a health care insurer may not be deducted from gross receipts. The deduction provided by this section shall be separately stated by the taxpayer...'commercial contract services' means health care services performed by a health care practitioner pursuant to a contract with a managed health care provider or health care insurer other than those health care services provided for medicare patients pursuant to Title 18 of the federal Social Security Act or for medicaid patients pursuant to Title 19 or Title 21 of the federal Social Security Act."

(5) According to a new federal statute (PL 109-432), from January 1, 2008 through September 30, 2011, the safe harbor provider tax rate that ensures that a state does not violate the indirect guarantee component of the hold harmless provision will be temporarily reduced to 5.5 percent. On October 1, 2011, the cap on tax rates is scheduled to revert back to 6 percent.

(6) Revenue figures were collected in a survey of state budget officials by National Association of State Budget Officers; published December 2008.

Oregon: Health-provider tax increase - 700 Million dollars are riding on a decision by lawmakers about whether to increase health-provider taxes to pay for expanded medical care. The insurance provider tax ultimately was passed by the Legislature. Rep. Ron Maurer was cited as opposing it, saying, "All those costs will be passed on to the people who pay for it. Ultimately, it's not going to end up reducing the cost of health care, and will be adding $300 million to the cost." Articles 6/29/09 & 7/8/09.

Examples of Revenue Raised from Provider Fees and Taxes:

State	Revenue Examples (2006 - 2008) [6]
AL	Provider tax revenue was $58 million in FY2006, $58 million in FY 2007 and $59 million in FY 2008.
MI	Provider tax revenue was $674.0 million for fiscal 2006; $856.0 million for fiscal 2007 and $1,008.0 million for fiscal 2008.
MT	Health care facility fees are forecast to decline to $16.665 million in FY 2008 and to $16.428 million in FY 2009. [added 11/09]
PA	In FY08, nursing home assessments raised approximately $300 million in Pennsylvania. In FY08, Managed care organizations (MCOs) that provide services to assessments generated approximately $384 million in Pennsylvania. [added 1/10] NEW
TN	Premium revenue: fiscal 2006 totaled $71 million, fiscal 2007 totaled $64 million, and fiscal 2008 totaled $64 million. Certified Public Expenditures—Local fund from Hospitals: fiscal 2006 totaled $251 million, fiscal 2007 totaled $416 million, and fiscal 2008 totaled $265 million. Nursing Home Tax: fiscal 2006 totaled $85 million, fiscal 2007 totaled $85 million, and fiscal 2008 totaled $85 million. ICF/MR 6 percent Gross Receipts Tax: fiscal 2006 totals $16 million, fiscal 2007 totals $16 million, and fiscal 2008 totals $15 million. Intergovernmental Transfers: fiscal 2006 totals $0 million, fiscal 2007 totals $0 million, and fiscal 2008 totals $0 million.
RI	For FY 2009, the Health Care Provider Assessment was estimated as $49.0 million; actual collections were $35.2 million as of 3/31/09.

State Health Reform and Provider Taxes

Three states that have enacted comprehensive health reforms and coverage expansions (2003-2006) each rely on use of provider taxes or assessments to help fund the purchase of insurance coverage and health services.

Maine's Dirigo Health reform law counts on Medicaid funding and enrollment as an element to the overall plan. The legislature increased its hospital tax from 0.74% to 2.23% of net operating revenue in 2004. [law details]

Massachusetts' 2006 universal health reform enhances outreach and enrollment for Medicaid eligibles by providing support to community-based agencies. An additional $80 million is provided to increase Medicaid hospital rates, while keeping within the budget neutrality limits of federal financing under the new Medicaid waiver. The provider tax, matched by federal funds, makes these arrangements work. [law details]

Vermont's Catamount Health, includes projected new Medicaid enrollment, an increase in provider reimbursement rates as well as a separate increase in the tobacco tax in 2006 and 2008. [law details]

Other Resources:

The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession - Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2009 and 2010. 50-state table on p. 82. - Kaiser Commission on Medicaid - Sept. 2009. [Posted by NCSL, August 2010] NEW

State Hospital and Medical Provider Taxes: Not What the Doctor Should Order- Brief by the Tax Foundation, December 9, 2009.

(1a) Federal Public Law 102-234 Medicaid Voluntary Contribution and Provider Specific Tax Amendment of 1991.

(1b) "Medicaid Topics: Financing: Intergovernmental Transfers and Other Special Financing Mechanisms" - Report by Tim Henderson for American Association of Family Physicians,

10/05.

(2) "Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007" data from unpublished supplemental results - Prepared by Vern Smith, Health Management Associates (HMA) For Kaiser Commission, 10/06.

(3) "As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey State Fiscal Years 2007 and 2008" - Prepared by Vern Smith, Health Management Associates (HMA) For Kaiser Commission, 10/07.

METHODOLOGY: The 2007 NCSL survey covers fiscal years (FY) 2007 and 2008. In most states, FY 2007 budget data were based on estimates and FY 2008 budget and tax data are based on projections. Forty-five states provided overall budget information for this survey. California, Illinois, Michigan, North Carolina and Wisconsin had not completed their budgets by the time this report was written in late July of 2007.

APPENDIX: Code of Federal Regulations -

Sec. 433.68 Permissible health care-related taxes after the transition period.

(a) General rule. Beginning on the day after a State's transition period, as defined in Sec. 433.58(b), ends, a State may receive health care-related taxes, without a reduction in FFP, only in accordance with the requirements of this section.

(b) Permissible health care-related taxes. Subject to the limitations specified in Sec. 433.70, a State may receive, without a reduction in FFP, health care-related taxes if all of the following are met:

(1) The taxes are broad based, as specified in paragraph (c) of this section;

(2) The taxes are uniformly imposed throughout a jurisdiction, as specified in paragraph (d) of this section; and

(3) The tax program does not violate the hold harmless provisions specified in paragraph (f) of this section.

(c) Broad based health care-related taxes. (1) A health care-related tax will be considered to be broad based if the tax is imposed on at least all health care items or services in the class or providers of such items or services furnished by all non-Federal, non-public providers in the State, and is imposed uniformly, as specified in paragraph (d) of this section.

(2) If a health care-related tax is imposed by a unit of local government, the tax must extend to all items or services or providers (or to all providers in a class) in the area over which the unit of government has jurisdiction.

(3) A State may request a waiver from CMS of the requirement that a tax program be broad based, in accordance with the procedures specified in Sec. 433.72. Waivers from the uniform and broad-based requirements will automatically be granted in cases of variations in licensing and certification fees for providers if the amount of such fees is not more than $1,000 annually per provider and the total amount raised by the State from the fees is used in the administration of the licensing or certification program.

(d) Uniformly imposed health care-related taxes. A health care-related tax will be considered to be imposed uniformly even if it excludes Medicaid or Medicare payments (in whole or in part), or both; or, in the case of a health care-related tax based on revenues or receipts with respect to a class of items or services (or providers of items or services), if it excludes either Medicaid or Medicare revenues with respect to a class of items or services, or both. The exclusion of Medicaid revenues must be applied uniformly to all providers being taxed.

(1) A health care-related tax will be considered to be imposed uniformly if it meets any one of the following criteria:

(i) If the tax is a licensing fee or similar tax imposed on a class of health care services (or providers of those health care items or services), the tax is the same amount for every provider furnishing those items or services within the class.

(ii) If the tax is a licensing fee or similar tax imposed on a class of health care items or services (or providers of those items or services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of those items or services in the class.

(iii) If the tax is imposed on provider revenue or receipts with respect to a class of items or services (or providers of those health care items or services), the tax is imposed at a uniform rate for all services (or providers of those items or services) in the class on all the gross revenues or receipts, or on net operating revenues relating to the provision of all items or services in the State, unit, or jurisdiction. Net operating revenue means gross charges of facilities less any deducted amounts for bad debts, charity care, and payer discounts.

(iv) The tax is imposed on items or services on a basis other than those specified in paragraphs (d)(1) (i) through (iii) of this section, e.g., an admission tax, and the State establishes to the satisfaction of the Secretary that the amount of the tax is the same for each provider of such items or services in the class.

(2) A tax imposed with respect to a class of health care items or services will not be considered to be imposed uniformly if it meets either one of the following two criteria:

(i) The tax provides for credits, exclusions, or deductions which have as its purpose, or results in, the return to providers of all, or a portion, of the tax paid, and it results, directly or indirectly, in a tax program in which--

(A) The net impact of the tax and payments is not generally redistributive, as specified in paragraph (e) of this section; and

(B) The amount of the tax is directly correlated to payments under the Medicaid program.

(ii) The tax holds taxpayers harmless for the cost of the tax, as describe in paragraph (f) of this section.

(3) If a tax does not meet the criteria specified in paragraphs (d)(1)(i) through (iv) of this section, but the State establishes that the tax is imposed uniformly in accordance with the procedures for a waiver specified in Sec. 433.72, the tax will be treated as a uniform tax.

(e) Generally redistributive. A tax will be considered to be generally redistributive if it meets the requirements of this paragraph. If the State desires waiver of only the broad-based tax requirement, it must demonstrate compliance with paragraph (e)(1) of this section. If the State desires waiver of the uniform tax requirement, whether or not the tax is broad-based, it must demonstrate compliance with paragraph (e)(2) of this section.

[et seq. -see full text]

Denver Office
Tel: 303-364-7700 | Fax: 303-364-7800 | 7700 East First Place | Denver, CO 80230

Washington Office
Tel: 202-624-5400 | Fax: 202-737-1069 | 444 North Capitol Street, N.W., Suite 515 | Washington, D.C. 20001