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The use of taxes or assessments on healthcare providers to help fund the Medicaid program has raised new policy design questions for state officials. Beginning in the late 1980s, states began increasing use of an obscure 1985 revision of the federal Medicaid regulations that allowed "donations" by hospitals, nursing homes, and other providers to be used as part of the state share of Medicaid. These private donations enabled states to leverage substantial additional amounts of federal money for their Medicaid programs. This added a burden on the federal government while providers and states reaped the benefit. Providers often got the amount they paid in taxes back in the form of increased Medicaid reimbursements. While the states paid for increases in Medicaid without increasing taxes or cutting spending in other areas. This led to the federal Healthcare Financing Administration (HCFA) making repeated attempts to disallow federal matching payments for provider donations and provider-specific taxes. In November 1991, Congress passed the Medicaid Voluntary Contribution and Provider Specific Tax Amendment of 1991 (H.R. 3595 102nd Congress) that permits voluntary contributions and provider-specific taxes to be used as the state share in certain specified circumstances. The main limitations are that taxes on providers must be broad-based and uniform and must not be combined with reimbursement increases or other measures that hold providers harmless in certain specified ways for the tax they pay. The 1991 legislation also established eight provider classes and required that the tax or assessment on each class be uniform and broad-based with respect to that class. These eight classes described in 42 CFR 433.56 were inpatient hospital services, outpatient hospital services, nursing services, intermediate care facilities for individuals with intellectual disabilities, physician services, home health care services, outpatient prescription drugs, and health maintenance organizations. 42 CFR 433.56 has been amended multiple times to now include 19 different classes. Now with the federal government match decreasing for the cost of extending Medicaid to adults up to 138 percent of the federal poverty level, states are looking for additional revenues to cover their costs. Many states have added new or increased their provider assessment as an immediate solution. Over the years all states except Alaska have implanted one or more type of provider assessment. The most common of these provider assessments are on nursing facilities, hospitals, intermediate care facilities for individuals with intellectual disabilities, and managed care organizations. There are limitations on these assessments. They cannot exceed 6 percent of a provider's net operating revenues and they generally cannot exceed 25% of the state share of Medicaid expenditures. There is no limit on the number of assessments a state can utilize however. Some states like South Dakota, who use a provider assessment on intermediate care facilities for individuals with intellectual disabilities, only utilize one provider tax. In Minnesota, they utilize six different provider assessments which are on hospitals, intermediate care facilities for individuals with intellectual disabilities, managed care organizations, nursing homes, providers, ambulatory surgical centers, and wholesale drugs. In Oregon, we currently use four of these provider classes to provide funds to be matched by the federal government. Those are hospitals, MCOs, long term care facilities and health insurers. Michigan also has a provider assessment on health insurers, however unlike Oregon they include ERISA plans which was tried and upheld by the federal District Court. I believe it is time to start looking ahead and considering every possibility to maximize the funds that these provider assessments can produce. There are nineteen different provider classes that can participate in theses assessments and the success and feasibility of provider assessments depends on policymakers and the affected healthcare providers working together.

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SD	ICF/MR-DD (M)	ICF/MR-DD: Began in FY 2008.
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. 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.Other- Providers, ambulatory surgical centers, and wholesale drugs have a tax of 2%.
MI	Hospital (M) Nursing Home Health Insurers (claims assessment)	Hospital: Increased in 2006. Nursing Home: Increased in 2006. Health Insurers: The Michigan Health Insurance Claims Assessment (HICA) Act imposes a 1-percent tax on "paid claims" for health-related services of employer-sponsored health and welfare plans. The HICA tax affects insurance carriers (including HMOs and stop loss insurers), TPAs and group health plan sponsors. Certain plans are exempt from the tax, including Medicare Advantage plans, Medicare prescription drug plans and plans covering federal

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	Other: Community Mental Health	employees, but Medicare supplemental insurance is not exempt. ▪ MI Department description - - http://www.michigan.gov/taxes/0,4676,7-238-43519-264498--,00.html ▪ Michigan Treasurer slide deck -- Health Insurance Claims Assessment (HICA) Overview ▪ Effect of New Michigan Health Insurance Claims Assessment Act on Group Health Plans -- Law firm analysis, February 2012 ▪ The HICA Act was upheld by the federal District Court, which found it is not preempted by ERISA. (Self-Insurance Institute of America v. Rick Snyder, et. al., 2012 U.S. Dist. LEXIS 124405 (E.D. Mich. Aug. 31, 2012). ▪ 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.
OR	Hospital (M) Managed Care Org. (M) Temporary Nursing Home (M) Health Insurers (M) Temporary	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.

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		Nursing Home: The long-term care tax is assessed based on a rate set by the Director of the Department of Human Services. Health Insurers: 1.5 % tax on Insurance premiums excluding ERISA plans

§ 433.56 Classes of health care services and providers defined.

(a) For purposes of this subpart, each of the following will be considered as a separate class of health care items or services:

(1) Inpatient hospital services;

(2) Outpatient hospital services;

(3) Nursing facility services (other than services of intermediate care facilities for individuals with intellectual disabilities);

(4) Intermediate care facility services for individuals with intellectual disabilities, and similar services furnished by community-based residences for individuals with intellectual disabilities, under a waiver under section 1915(c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/IIDs prior to the grant of the waiver;

(5) Physician services;

(6) Home health care services;

(7) Outpatient prescription drugs;

(8) Services of managed care organizations (including health maintenance organizations, preferred provider organizations);

(9) Ambulatory surgical center services, as described for purposes of the Medicare program in section 1832(a)(2)(F)(i) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures;

(10) Dental services;

(11) Podiatric services;

(12) Chiropractic services;

(13) Optometric/optician services;

(14) Psychological services;

(15) Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services;

(16) Nursing services, defined to include all nursing services, including services of nurse midwives, nurse practitioners, and private duty nurses;

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(17) Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department;

(18) Emergency ambulance services; and

(19) Other health care items or services not listed above on which the State has enacted a licensing or certification fee, subject to the following:

(i) The fee must be broad based and uniform or the State must receive a waiver of these requirements;

(ii) The payer of the fee cannot be held harmless; and

(iii) The aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program.

(b) Taxes that pertain to each class must apply to all items and services within the class, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43180, Aug. 13, 1993; 73 FR 9698, Feb. 22, 2008]

Summary:

- 1985 States start utilizing revision of the federal Medicaid regulations that allowed "donations" by hospitals, nursing homes, and other providers to be used as part of the state share of Medicaid

- 1991 Congress passed the Medicaid Voluntary Contribution and Provider Specific Tax Amendment of 1991

- Classes of Healthcare providers now currently at 19 different services. Amended in 1992, 1993, and 2008

- Different states have complete discretion and can use as many provider assessments as needed with some limitations.

- Time to start preparing for 2020 when the federal government only pays 90% (170 million-dollar reduction) for the expanded population of adults up to 138% of the federal poverty line and the sunset on the MCO tax and the Health Insurers tax which is estimated (1.3 billiion-dollar budget hole)

- It is time for a task for that can address:

- Public Access and Transparency
- Sunset on HB 2391 (1.3 billion-dollar budget hole)
- ACA match reduction (170 million-dollar reduction)

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- Expanding and stabilizing provider tax base by using fair and equitable mechanisms such as Michigan (adding ERISA plans), exploring the other 19 health provider classes, or bonding healthcare with a 4-6 year bond (HIRB)

Sources

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- Community Catalyst, Health Care Provider Assessments: A State-based Funding Solution for Closing the Coverage Gap, June 2015
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