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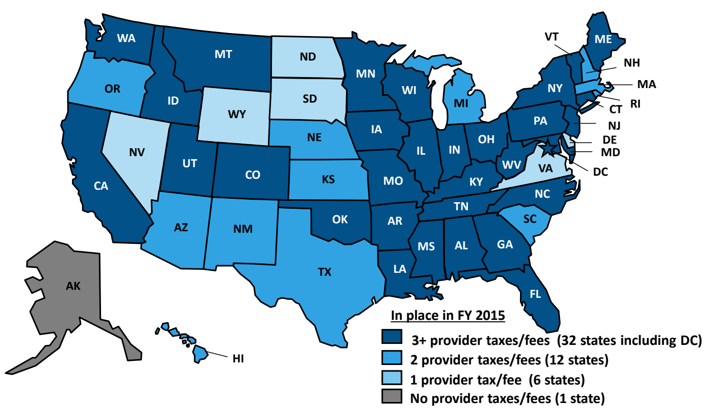
States and Medicaid Provider Taxes or Fees

Medicaid is jointly financed by states and the federal government. Provider taxes are an integral source of Medicaid financing governed by long-standing regulations. Currently, all but one state (Alaska) reported a provider tax in FY 2015. (Figure 1) Congress is currently considering proposals to limit the use of provider taxes. This would restrict states' ability on how to come up with the state share to finance Medicaid and could therefore shift additional costs to states. If states were not able to find additional funds to replace provider tax funding with other state sources, limits on provider taxes could result in program cuts with implications for Medicaid providers and beneficiaries. Since states use provider taxes differently, limits would have different effects across states. This factsheet briefly highlights the role of provider taxes in states and the possible impact of proposals to limit the use of these taxes. Data is based on findings from the most recent survey of Medicaid programs conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates.

Figure 1

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.

HOW IS THE MEDICAID PROGRAM FINANCED? States and the federal government share in the financing of the Medicaid program. Under federal Medicaid law, the federal government pays between 50 and 74 percent of all the costs of providing services to beneficiaries under the program. These matching rates (FMAPs) vary across states based on the state's per capita income in comparison to the national average (i.e. states with lower per capita income have higher matching rates.) The remaining share of program funding comes from state and local sources. One of the ways states raise funds for their share of Medicaid spending is through provider taxes/fees. Some states also indicated that they planned to use provider taxes/fees to fund the state share of the Medicaid expansion when the federal match drops to from 100% to 95% in January 2017.[1]

WHAT ROLE DO PROVIDER TAXES PLAY IN STATE FINACING OF MEDICAID? Provider taxes are imposed by states on health care services where the burden of the tax falls mostly on providers, such as a tax on inpatient hospital services or nursing facility beds. Provider taxes have become an integral source of financing for Medicaid. For FY 2015, all but one state (Alaska) reported having at least one Medicaid provider tax and nearly two-thirds of states reported three or more provider taxes. (Table 1, Figure 1)

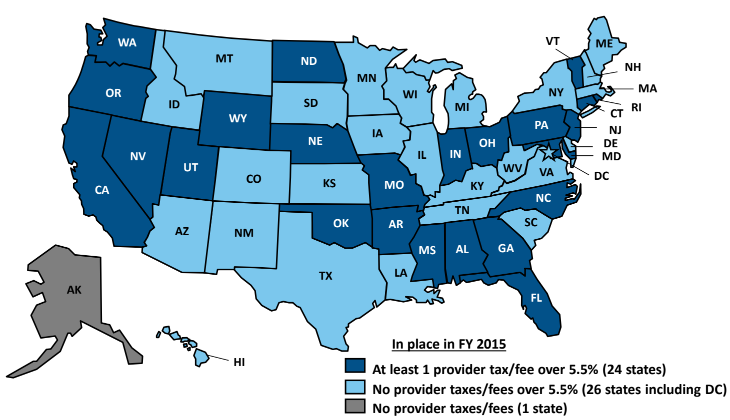
States use the additional revenue collected by provider taxes in a number of ways to support Medicaid programs. For example, provider taxes help to support provider rate increases or to help mitigate provider rate cuts. States also have used funds collected from provider taxes to support the Medicaid program more broadly. For example, Colorado used some of the funds raised through their Hospital provider fee to expand eligibility to parents and children. During economic downturns, when state tax revenues fall at the same time that demand for public services like Medicaid increases, states are more likely to impose or increase provider taxes to help fund the state share of Medicaid.

In the past, states were able to use provider taxes and other state financing arrangements to enable states to receive higher effective federal matching rates than the statutory formula provides. However, legislation enacted in 1991 restricted the use of provider taxes to curb abusive practices. Under current regulations, states may not use provider tax revenues for the state share of Medicaid spending unless the tax meets three requirements: must be broad-based, uniformly imposed, and cannot hold providers harmless from the burden of the tax. 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.[2]

WHAT WOULD THE IMPACT OF LIMITING THE USE OF PROVIDER TAXES BE ON STATES? Recent legislative proposals have suggested lowering the safe harbor threshold from 6.0 percent to 5.5 percent of net patient revenues. States have indicated that nearly 3 in 10 provider taxes currently in use by states are above that threshold. During our survey conducted in July 2015, 24 states estimated that at least one provider tax above this 5.5 percent threshold (Figure 2); half of these states (12) reported 2 or more provider taxes/fees above this threshold.[3] (Table 1)

Figure 2

States with at least 1 provider tax or fee over 5.5% net patient revenues



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.

Limitations on provider taxes would have a more notable impact in those states that are heavily dependent on provider tax revenues to fund their state share of Medicaid spending. If provider taxes are limited, states would need to increase state funds to maintain current programs or make program cuts. Such changes in available financing could have negative implications for providers and beneficiaries under the current operation of the program as well as for the implementation of the ACA.

Table 1: Provider Taxes and Fees in Place in FY 2015				
State	Have at least 1 provider tax	# of taxes	Have at least 1 provider tax over 5.5% of net patient revenue	# of taxes over 5.5%
AK	-	0	-	0
AL	X	3	X	1
AR	X	3	X	2
AZ	X	3	-	0
CA	X	4	X	2
CO	X	3	-	0
CT	X	3	X	1
DC	X	4	-	0
DE	X	1	-	0
FL	X	3	X	2
GA	X	3	X	2
HI	X	2	-	0
IA	X	3	-	0
ID	X	3	-	0
IL	X	3	-	0
IN	X	3	X	1
KS	X	2	-	0
KY	X	5	-	0
LA	X	3	-	0
MA	X	3	-	0
MD	X	4	X	2
ME	X	4	-	0
MI	X	2	-	0
MN	X	4	-	0
MO	X	5	X	3
MS	X	4	X	4
MT	X	3	-	0
NC	X	3	X	1
ND	X	1	X	1
NE	X	2	X	1
NH	X	2	-	0
NJ	X	5	X	1
NM	X	2	-	0
NV	X	1	X	1
NY	X	5	-	0
OH	X	3	X	2
OK	X	3	X	2
OR	X	2	X	1
PA	X	5	X	3
RI	X	3	X	1
SC	X	2	-	0
SD	X	1	-	0
TN	X	4	-	0
TX	X	2	-	0
UT	X	3	X	1
VA	X	1	-	0
VT	X	5	X	4
WA	X	3	X	2
WI	X	4	-	0
WV	X	5	-	0
WY	X	1	X	1
Total	**50**	**151**	**24**	**42**

NOTES: This table includes Medicaid provider taxes as reported by states. Some states also have premium or claims taxes that apply to managed care organizations and other insurers. Since this type of tax is not considered a provider tax by CMS, these taxes are not counted as provider taxes in this report. CA, DC, MD, NM, RI, TN, TX reported MCO taxes that were counted as Medicaid provider taxes; none of these taxes exceeded 5.5% of net patient revenues.

SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2015.

Endnotes

[1] As part of the July 2015 survey, at least seven states Arizona, California, Colorado, Indiana, Kentucky, Nevada and Ohio) indicated plans to use provider taxes/fees to fund at least some of the state share of the Medicaid expansion when the federal match rate declines from 100% for those newly eligible.

[2] Prior to October 2011, this safe harbor threshold was temporarily reduced to 5.5 percent of net patient revenues.

[3] State responses reflect estimates; some taxes are imposed in a way that is not directly tied to the % of net patient revenue (e.g. nursing home bed tax.)