



Medicaid Provider Taxes

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Summary

States are able to use revenues from health care provider taxes to help finance the state share of Medicaid expenditures. Federal statute and regulations define a provider tax as a health care-related fee, assessment, or other mandatory payment for which at least 85% of the burden of the tax revenue falls on health care providers. In order for states to be able to draw down federal Medicaid matching funds, the provider tax must be both 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). Also, states are not allowed to hold the providers harmless for the cost of the provider tax (i.e., they cannot guarantee that providers receive their money back).

A vast majority of states use at least one provider tax to help finance Medicaid. Many of these states use the provider tax revenue to increase Medicaid payment rates for the class of providers, such as hospitals, responsible for paying the provider tax. This financing strategy allows states to fund increases to Medicaid payment rates without the use of state funds because the increased Medicaid payment rates are funded with provider tax revenue and federal Medicaid matching funds. States also use provider tax revenues to fund other Medicaid or non-Medicaid purposes.

States first began using health care provider taxes to help finance the state's share of Medicaid expenditures in the mid-1980s. Some states were particularly aggressive in their use of provider taxes. As a result, in the early 1990s, the federal government imposed statutory and regulatory limitations on states' use of health care provider tax revenue to finance Medicaid.

While federal requirements allow states to impose provider taxes on 19 classes of health care providers, the classes of providers that are most often taxed include nursing facilities, hospitals, intermediate care facilities for individuals with mental retardation or developmental disabilities (ICF-MR/DD), and managed care organizations. During the most recent recession, a number of states took action to generate additional provider tax revenue, and these actions mainly involved hospital and nursing facility taxes.

Even with the statutory and regulatory limitations, provider taxes continue to cause tension between the federal government and the states. As a result, some deficit reduction proposals include a recommendation to limit states' ability to use provider taxes to finance the state share of Medicaid expenditures. This limitation would decrease federal Medicaid payments to states.

This report provides background regarding states' use of provider taxes in the 1980s and describes the relevant federal statutes and regulations, which were mostly established in the early 1990s. The report explains how states use provider taxes to help finance Medicaid and provides information regarding the extent to which states currently use such taxes. The report ends with a discussion of the provider tax provisions in various deficit reduction proposals.

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Introduction

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care.¹ Participation in Medicaid is voluntary for states, though all states, the District of Columbia, and five territories choose to participate. Each state designs and administers its own version of Medicaid under broad federal rules, and Medicaid is jointly financed by the federal government and the states.

States incur Medicaid costs by making payments to service providers (e.g., for beneficiaries' doctor visits) and performing administrative activities (e.g., making eligibility determinations), and the federal government reimburses states for a share of these costs.² The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP).³ The FMAP varies by state according to each state's per capita income. For FY2013, FMAPs range from 50% to 73%, with the federal contribution covering about 57% of the total cost of Medicaid in a typical year.

The state share of Medicaid expenditures is funded through a variety of sources. At least 40% of each state's share of Medicaid expenditures must be financed by the state, and up to 60% of the state's share may come from local governments.⁴ In state fiscal year (SFY) 2011, states reported that about 72% of the state share of Medicaid costs was financed by state general funds (most of which are raised from personal income, sales, and corporate income taxes). The remaining 28% was financed by other funds (including local government funds, provider taxes, fees, donations, assessments, and tobacco settlement funds).⁵

Currently, many states use provider taxes to finance a portion of their state share of Medicaid expenditures. Federal statute and regulations define a provider tax as a health care-related fee, assessment, or other mandatory payment for which at least 85% of the burden of the tax revenue falls on health care providers.⁶ In order for states to be able to draw down federal Medicaid matching funds, the provider tax must be both 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). States are not allowed to hold the providers harmless for the cost of the provider tax (i.e., they cannot guarantee that providers receive their money back).⁷

States are able to use revenues from provider taxes to help finance the state share of Medicaid expenditures when certain conditions are met. In SFY2013, 48 states and the District of Columbia are using at least one provider tax to finance Medicaid.⁸ Many of these states use the provider tax

¹ For more information about the Medicaid program, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

² For a broader overview of financing issues, see CRS Report R42640, *Medicaid Financing and Expenditures*, by Alison Mitchell.

³ For more information about the FMAP, see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by Alison Mitchell and Evelyne P. Baumrucker.

⁴ Section 1902(a)(2) of the Social Security Act.

⁵ National Association of State Budget Officers, *State Expenditure Report: Examining Fiscal 2010-2012 State Spending*.

⁶ Section 1903(w)(3)(A) of the Social Security Act. 42 C.F.R. 433.55.

⁷ Section 1903(w)(3) of the Social Security Act. 42 C.F.R. 433.68. These requirements are explained in more detail in the "Federal Statutes and Regulations" section below.

⁸ Vernon K. Smith, Kathleen Gifford, Eileen Ellis, et al., *Medicaid Today; Preparing for Tomorrow A Look at State* (continued...)

revenue to increase Medicaid payment rates for the class of providers, such as hospitals, responsible for paying the provider tax. This financing strategy allows states to fund increases to Medicaid payment rates without the use of state funds because the increased Medicaid payment rates are funded with provider tax revenue and federal Medicaid matching funds. States also use provider tax revenue to fund other Medicaid or non-Medicaid purposes.

This report provides background regarding states' use of provider taxes in the 1980s and describes the relevant federal statutes and regulations, which were mostly established in the early 1990s. The report explains how states use provider taxes to help finance Medicaid and provides information regarding the extent to which state's currently use such taxes. The report ends with a discussion of the provider tax provisions in various deficit reduction proposals.

States' Initial Use of Provider Taxes in the 1980s

In the mid-1980s, states began using provider taxes along with provider donations⁹ to help finance Medicaid. Essentially, Medicaid providers would donate funds or agree to be taxed, and the revenue from these taxes and donations would be used to finance a portion of the state's share of Medicaid expenditures. In some cases, Medicaid providers initiated these provider tax and donation arrangements because states would often use the provider tax and donation 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 or donations.¹⁰

Here is an example of how the provider tax arrangements operated in the 1980s. In a state, hospitals with high Medicaid utilization could agree to pay \$10 million in provider taxes, and the state would increase Medicaid reimbursement rates for hospitals with high Medicaid utilization by \$20 million. Assuming the state had a 60% FMAP, the state would then receive \$12 million in federal Medicaid matching funds (60% of \$20 million). In the end, hospitals with high Medicaid utilization would have gained \$10 million (\$20 million in increased Medicaid rates minus \$10 million in tax payments), the state would have gained \$2 million (\$22 million from the hospitals and the federal government minus the \$20 million paid to the hospitals), and the federal government would have paid \$12 million.¹¹

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 or donated funds. The providers were often fully reimbursed for the cost of their tax payment or donation. For this reason, provider tax mechanisms were politically viable for states.

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Medicaid Program Spending, Enrollment and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013, Kaiser Commission on Medicaid and the Uninsured, October 2012.

⁹ Provider donations are any donation or other voluntary payment made to a state or unit of local government by a health care provider. Section 1903(w)(2) of the Social Security Act.

¹⁰ Andy Schneider, Risa Elias, Rachel Garfield, David Rousseau, and Victoria Wachino, *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, July 2002.

¹¹ In this example, the provider tax arrangement allowed for hospitals with high Medicaid utilization to receive increased Medicaid payment rates. Without the provider tax arrangement, the Medicaid payment rates to hospitals with high Medicaid utilization would have been less.

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 and donations in financing Medicaid. This aggressive use of these Medicaid financing strategies motivated congressional action to curb states' use of the provider tax and donation arrangements.

Federal Statutes and Regulations

In 1991, Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234) to restrict the use of provider donations in financing Medicaid to extremely limited situations¹² and to limit states' ability to draw down federal Medicaid matching funds with provider tax revenue.¹³

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; 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 (HHS) is authorized to waive the broad-based and uniform requirements of provider taxes. In order to waive either the broad-based or uniform requirement, a state needs to prove that the net impact of the tax is “generally redistributive” and the amount of the tax is not directly correlated to Medicaid payments.¹⁴

“Generally redistributive” is defined as the tendency of a state's provider tax to derive revenues from non-Medicaid services in a class and to use these revenues as the state's share of Medicaid expenditures. According to the quantitative tests set forth in regulation, a provider tax is perfectly redistributive if the tax burden for Medicaid providers is the same under a tax without the waiver as under the tax with the waiver. The redistributive nature of a provider tax increases as the tax burden falls more heavily on providers with relatively fewer Medicaid patients.¹⁵

¹² Provider donations are permissible if they do not exceed \$5,000 per year in the case of an individual provider or \$50,000 per year in the case of a “health care organization entity” (42 C.F.R. 433.66(a)(1)). Also, provider donations are allowed if the donations are made by a hospital, clinic, or similar entity (such as federally qualified health centers) for the direct costs of state or local agency personnel who are stationed at the facility to determine the eligibility of individuals for Medicaid or to provide outreach services to eligible (or potentially eligible) Medicaid individuals (i.e., outstationed eligibility workers) (42 C.F.R. 433.66(a)(2)). Provider donations for outstationed eligibility workers may not exceed 10% of a state's administrative costs for the Medicaid program (42 C.F.R. 433.67).

¹³ The statute regarding provider taxes can be found in Section 1903(w) of the Social Security Act, and the accompanying regulations can be found at 42 C.F.R. Part 433.

¹⁴ Rural and sole community providers are expressly cited as allowable exemptions to both the broad-based and uniform requirements with Secretary approval.

¹⁵ Health Care Financing Administration, “Medicaid Program; Limitations on Provider-Related Donations and Health-Care Related Taxes; Limitations on Payments to Disproportionate Share Hospitals,” 57 *Federal Register* 55118, (continued...)

Classes of Providers

The specified 19 classes of providers used to ensure that tax programs are “broad-based” are those that provide the following:¹⁶

- inpatient hospital services,
- outpatient hospital services,
- nursing facility services,
- services of intermediate care facilities for the mentally retarded,
- physicians’ services,
- home health care services,
- outpatient prescription drugs,
- services of Medicaid managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation),¹⁷
- ambulatory surgical centers,
- dental services,
- podiatric services,
- chiropractic services,
- optometric/optician services,
- psychological services,
- therapist services,¹⁸
- nursing services,¹⁹
- laboratory and X-ray services,²⁰
- emergency ambulance services, and
- other health care items or services for which the state has enacted a licensing or certification fee.²¹

(...continued)

November 24, 1992.

¹⁶ 42 C.F.R. 433.56.

¹⁷ The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) modified this class of providers by changing “Medicaid managed care organizations” to all “managed care organizations.” This change further broadened the group upon which a tax could be imposed, thereby reducing the potential for abusive tax programs.

¹⁸ Therapist services include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological therapy, and rehabilitative specialist services.

¹⁹ Nursing services include nurse midwives, nurse practitioners, and private duty nurses.

²⁰ 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. Prior to the 1991 law, provider taxes were often imposed only on Medicaid providers. These provider tax arrangements were agreed to (and sometimes initiated) by the Medicaid providers because the Medicaid providers could be held harmless from the cost of the tax through increased Medicaid payment rates. However, because non-Medicaid providers cannot be as easily held harmless from the cost of the tax, the broad-based requirement restricted the use of provider taxes because the non-Medicaid providers are more likely to oppose the imposition of provider taxes.

Hold Harmless

Regulations describe three tests that are applied to provider taxes in order to determine whether taxpayers are held harmless. Taxes that fail any of these tests are determined to have a hold harmless provision in violation of the law. The three tests are as follows:

- A *positive correlation test* is used to determine whether a state or other unit of government imposing the tax provides directly or indirectly for a non-Medicaid payment to the taxpayers in an amount that is positively correlated to either the tax amount or the difference between their Medicaid payment and the tax amount.²²
- The *Medicaid payment test* is violated if all or any portion of the Medicaid payment to the taxpayer varies based *only* on the amount of the total tax payments.
- The *guarantee test* is violated if the state or other unit of government imposing the tax provides directly or indirectly for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

Under the guarantee test, the existence of an indirect guarantee is determined through a two-prong test. The first prong of the guarantee test relates to the rate at which taxpayers are taxed. That is, if the provider tax is applied at a rate less than 6%²³ of the net patient service revenues received by the taxpayer, the tax is permissible under the guarantee test.²⁴

The second prong of the guarantee test is the “75/75 rule,” which is applied to provider taxes imposed at a rate greater than the threshold amount specified in the first prong of the guarantee test (currently 6%). When the provider tax produces revenue in excess of the threshold amount, the tax is considered to hold the taxpayers harmless (i.e., violate the hold harmless test) if more

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²¹ The licensing or certification fee must be broad-based and uniform. In addition, the payer of the fee cannot be held harmless for the cost of the fee. Also, the aggregate amount of the fee cannot exceed the state’s estimated cost of operating the licensing or certification program.

²² An example of a violation of the positive correlation would be if a state gave a portion of the tax revenue to private pay patients in the form of grants in order to compensate the patients for the tax added to their bill from the provider.

²³ For the period of January 1, 2008, through September 30, 2011, the Tax Relief and Health Care Act of 2006 (P.L. 109-432) changed the threshold to 5.5% of net patient service revenues. On October 1, 2011, the threshold reverted to 6% of net patient service revenues.

²⁴ 42 C.F.R. 433.68(f)(3)(i)(A). Some interpret this provision as a waiver of the hold harmless tests when the tax is applied at a rate below the 6% threshold. For this reason, the threshold has been referred to as a “safe harbor.”

than 75% of the taxpayers in the provider class receive 75% or more of the cost of the tax back through enhanced Medicaid payments or other state payments.²⁵

In other words, a state can impose a provider tax above the threshold amount (currently 6%) and draw down federal matching funds on the tax revenue, as long as the state can prove that the “75/75 rule” has not been violated (i.e., more than 75% of the taxpaying providers do *not* receive more than 75% of the cost of the tax back through enhanced Medicaid rates).

If a state imposes a provider tax above the threshold amount and violates the “75/75 rule” (i.e., more than 75% of the taxpaying providers receive more than 75% of the cost of the tax back through enhanced Medicaid rates), then the full amount of the tax revenue would be offset from the state’s Medicaid expenditures. This means the provider tax revenue could still be used to fund Medicaid, but the state would not be able to draw down federal Medicaid matching funds on the provider tax revenue. Specifically, the revenue from provider taxes that do not meet federal requirements would be deducted from the state’s Medicaid expenditures prior to the calculation of the federal financial participation.²⁶

To date, no state has imposed a provider tax at a rate above the threshold amount specified in the first prong of the guarantee test.

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.²⁷ A simple example of this is illustrated in **Figure 1**. In this example, a state with a 60% FMAP imposes a provider tax on all nursing homes in the state, and the state collects \$10 million in tax revenue through this provider tax. The state then increases Medicaid reimbursement rates to nursing homes, which means nursing homes with Medicaid enrollees receive an additional \$8 million. With these Medicaid expenditures, the state draws down \$4.8 million (60% of \$8 million) in federal Medicaid matching funds. In this example, the state was able to increase Medicaid payment rates to nursing homes without the use of any state general funds, and the state is left with \$6.8 million to use for other Medicaid or non-Medicaid purposes.²⁸

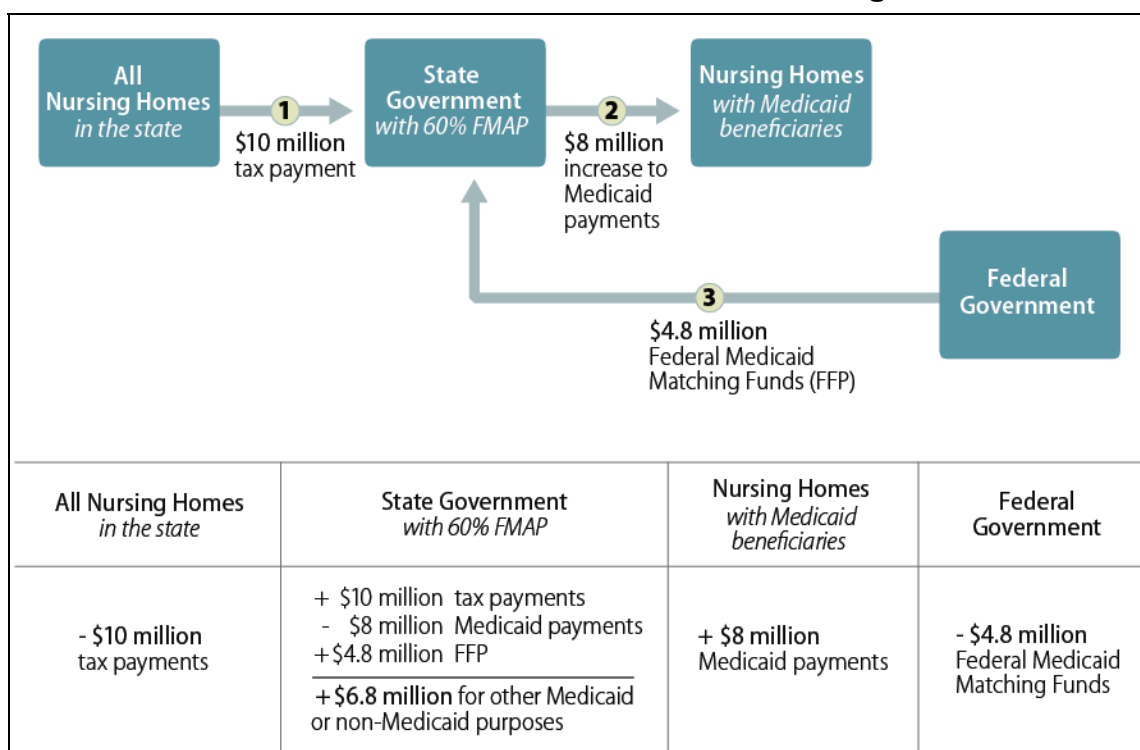
²⁵ 42 C.F.R. 433.68(f)(3)(i)(B).

²⁶ 42 C.F.R. 433.70.

²⁷ Congressional Budget Office, *Budget Options Volume I: Health Care*, December 2008.

²⁸ In this example, the provider tax arrangement allowed for nursing homes to receive increased Medicaid payment rates. Without the provider tax arrangement, the Medicaid payment rates to nursing homes would have been less.

**Figure 1. Provider Tax Example for a State with 60% FMAP
Using Nursing Home Provider Tax Revenue to
Increase Medicaid Reimbursement Rates to Nursing Homes**



Source: Teresa A. Coughlin and Stephen Zuckerman, *States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and*, Urban Institute, June 2002. Based on Figure 1.

In SFY2013, 48 states and the District of Columbia are using 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 mental retardation or developmental disabilities (ICF-MR/DD), and managed care organizations. Details regarding the types of provider taxes used by each state is provided in **Table A-1** of the **Appendix**.

Provider Tax Revenue

The full amount of provider tax revenues used by states to help finance the state share of Medicaid expenditures is unknown. The Center for Medicare & Medicaid Services (CMS) collects some information from states regarding the amount of provider tax revenue through data included on the CMS-64 form,²⁹ but this information is underreported. The National Association of State Budget Officers (NASBO) augments the information collected by CMS, but the NASBO information is also incomplete.

²⁹ States submit the CMS-64 form to CMS on a quarterly basis, and the CMS-64 form is a statement of expenditures for which states are entitled to federal Medicaid matching funds. States are required to provide supporting documentation for total Medicaid expenditures. The provider tax information is reported in section CMS-64.11 of the form, and the provider tax information is provided to CMS for informational rather than reimbursement purposes.

A portion of the CMS-64 form collects information regarding the provider donations, taxes, fees, and assessments collected by states. While states are required to provide this information to CMS for informational purposes, states report this information inconsistently, and the provider tax information is likely underreported. For example, in FY2011, 9 states did not report any provider tax revenue on the CMS-64 form, even though 48 states and the District of Columbia reported having at least one provider tax during that period of time.³⁰

NASBO publishes an annual State Expenditure Report³¹ that provides information regarding the state and federal shares of Medicaid expenditures. The report specifies the sources of the states' share of Medicaid expenditures as either state general funds or "other state funds," which are revenues collected by the state that are restricted by law for particular governmental functions or activities. Provider taxes comprise a significant portion of "other state funds," while tobacco tax revenue, donations, and local funds are also common sources of "other state funds."

The primary source for NASBO's "other state funds" information is the CMS-64 expenditure data, but NASBO augments this data. Specifically, NASBO collects detailed information from some states regarding the amount of provider taxes, fees, donations, assessments, and local funds used to finance the state share of Medicaid expenditures. However, NASBO acknowledges that its State Expenditure Report does not capture 100% of the provider taxes, fees, assessments, and local funds used to finance the state share of Medicaid expenditures.

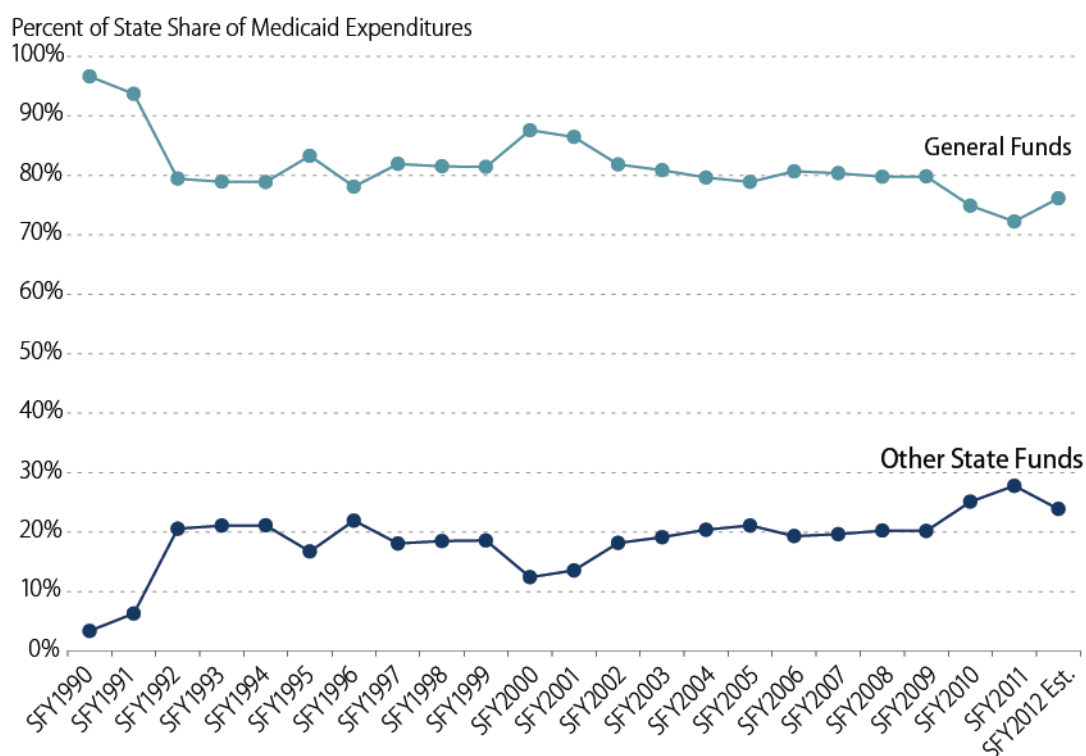
The available data (shown in **Figure 2**), while limited, indicate a trend showing that states' use of "other state funds" has increased significantly as a percent of the state share of Medicaid expenditures since SFY1990. Also, during the most recent recession, the data indicate that states' use of "other state funds" increased from 20% to almost 26% of the state share.³²

³⁰ Vernon K. Smith, Kathleen Gifford, Eileen Ellis et al., *Medicaid Today; Preparing for Tomorrow A Look at State Medicaid Program Spending, Enrollment and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013*, Kaiser Commission on Medicaid and the Uninsured, October 2012.

³¹ National Association of State Budget Officers, *State Expenditure Report: Examining Fiscal 2010-2012 State Spending*.

³² Ibid.

**Figure 2. General Fund and Other State Funds
as a Percentage of the State Share of Medicaid Expenditures**
(SFY1990 to SFY2012 estimate)



Source: National Association of State Budget Officers, *State Expenditure Report*.

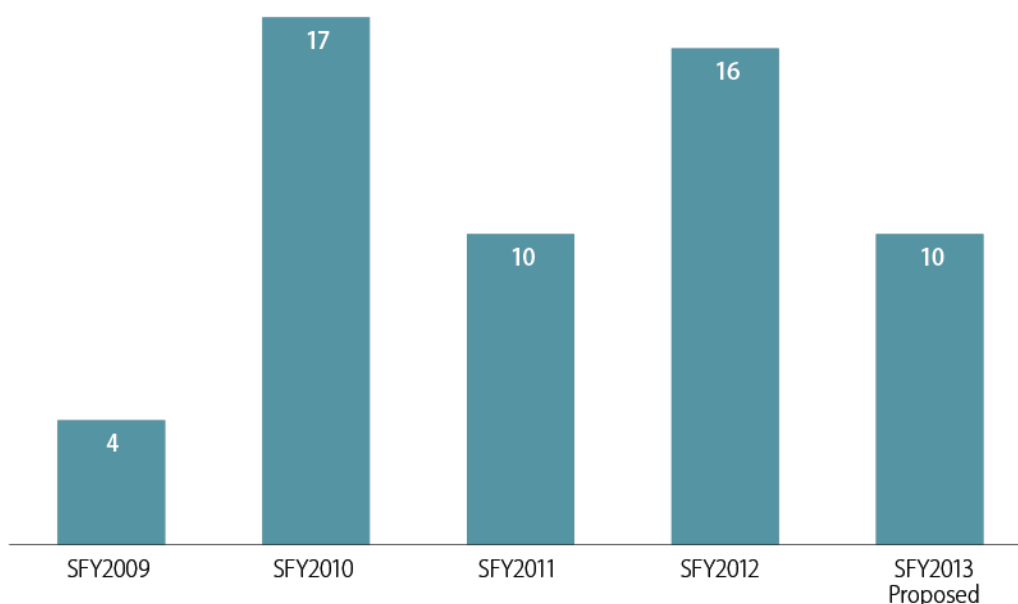
Note: SFY = state fiscal year.

During Economic Downturns

Because all states (except Vermont) have balanced budget requirements, funding Medicaid expenditure growth during economic downturns can be challenging. 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 (December 2007 to June 2009), a number of states took action to generate additional provider tax revenue. **Figure 3** shows the number of states that took at least one action to generate additional provider tax revenue in each year, since SFY2009.

Figure 3. Number of States Taking Action to Generate Additional Provider Tax Revenue
(SFY2009 to SFY2013 proposed)



Source: National Association of State Budget Officers, *The Fiscal Survey of States*.

Note: SFY = state fiscal year.

A Government Accountability Office (GAO) analysis³³ 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.

Traditionally, states have used provider tax revenue to maintain or increase Medicaid provider payment rates. For example, during the recession in the early 2000s, many states were able to avoid reducing Medicaid reimbursement rates to nursing homes by increasing nursing home provider tax revenue along with other funding sources, such as tobacco settlement funds, budget stabilization funds, and cigarette taxes.³⁴ However, during the most recent recession, the revenue from provider taxes was not always used to preserve or increase the reimbursement rates of the providers being taxed. In GAO's 2010 analysis, it found that states reduced or froze Medicaid payment rates for at least half of the providers that experienced new or increased provider taxes, which means states used the additional provider tax revenue to fund other Medicaid or non-Medicaid purposes.³⁵

³³ Government Accountability Office, *Recovery Act: Opportunities to Improve Management and Strengthen Accountability over States' and Localities' Uses of Funds*, September 2010, GAO-10-999.

³⁴ Government Accountability Office, *Medicaid Nursing Home Payments: States' Payment Rates Largely Unaffected by Recent Fiscal Pressures*, October 2003, GAO-04-143.

³⁵ Government Accountability Office, *Recovery Act: Opportunities to Improve Management and Strengthen Accountability over States' and Localities' Uses of Funds*, September 2010, GAO-10-999 (continued...)

Oversight of Provider Taxes

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.

Current Issues

Federal Deficit Reduction

In a typical year, the federal government funds roughly 57% of the total cost for Medicaid,³⁶ and these federal Medicaid expenditures account for almost 8% of all federal spending.³⁷ In FY2013, federal Medicaid payments to states are estimated to amount to \$276 billion.³⁸ Federal Medicaid payments are anticipated to grow significantly beginning in FY2014 due to the expansion of Medicaid eligibility provided in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).³⁹ As a percentage of gross domestic product (GDP), federal Medicaid expenditures are expected to increase from about 1.7% of GDP in FY2013 to 2.4% of GDP in FY2022.⁴⁰ As a result, controlling federal Medicaid spending has been a focus of federal deficit reduction proposals, and further limiting states' use of provider taxes in financing Medicaid is often identified as a way to reduce federal Medicaid spending.

The President's FY2013 budget proposal includes a provision to phase down the Medicaid provider tax threshold from the current level of 6% to 3.5% from FY2015 to FY2017. The President's budget estimates that this proposal would reduce federal Medicaid expenditures by

(...continued)

Accountability over States' and Localities' Uses of Funds, September 2010, GAO-10-999.

³⁶ Office of the Actuary, *2010 Actuarial Report on the Financial Outlook for Medicaid*, Centers for Medicare and Medicaid Services, December 2010.

³⁷ Office of Management and Budget, *Historical Tables: Budget of the U.S. Government, Fiscal Year 2012*.

³⁸ Congressional Budget Office, *Medicaid Spending and Enrollment Detail for CBO's March 2012 Baseline*, March 13, 2012.

³⁹ Historically, Medicaid eligibility was generally limited to low-income children, pregnant women, parents of dependent children, the elderly, and people with disabilities; however, ACA requires Medicaid coverage for individuals under the age of 65 with income up to 133% of the federal poverty level (effectively 138% FPL with the modified adjusted gross

income.<http://www.crs.gov/pages/Reports.aspx?PRODCODE=R42865&Source=cli-fn35> 5% FPL income disregard). On June 28, 2012, the United States Supreme Court issued its decision in *National Federation of Independent Business (NFIB) v. Sebelius* finding that the federal government cannot terminate the federal Medicaid funding a state receives for its current Medicaid program if a state refuses to implement the ACA Medicaid expansion. If a state accepts the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules. However, based on the Court's opinion, it appears that a state can refuse to participate in the ACA Medicaid expansion without losing any of its current federal Medicaid matching funds. For more information about the ACA changes to Medicaid, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

⁴⁰ Congressional Budget Office, *An Update to the Budget and Economic Outlook: Fiscal Years 2012 to 2022*, August 2012.

\$21.8 billion from FY2015 through FY2022.⁴¹ According to a survey of states, in SFY2013, 41 states⁴² and the District of Columbia reported that this provision would reduce the provider tax rates for at least one provider tax in their state.⁴³

The National Commission on Fiscal Responsibility and Reform recommended restricting and eventually eliminating states' use of provider taxes. The commission estimated this provision would reduce federal Medicaid expenditures by \$44 billion from FY2012 through FY2020.⁴⁴

Lowering the threshold for provider taxes would limit states' ability to use provider taxes in financing the state share of Medicaid expenditures, which would decrease federal Medicaid payments to states.⁴⁵ This would effectively shift more of the Medicaid program's growing costs to the states.⁴⁶ As a result, states would have to weigh the impact of maintaining current Medicaid reimbursement and/or service levels against other state priorities for spending. They could choose to constrain Medicaid expenditures by reducing provider payment rates, limiting benefit packages, or restricting eligibility. These types of programmatic changes could also affect access to and the quality of medical care for Medicaid enrollees. For example, if states reduced the Medicaid reimbursement rates to providers, such as hospitals, physician, and nursing homes, these providers may be less willing to accept Medicaid patients.

⁴¹ Department of Health and Human Services, *Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans*, <http://www.hhs.gov/budget/budget-brief-fy2013.pdf>.

⁴² The states reporting that this provision would impact at least one provider tax rate in their states are Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

⁴³ Vernon K. Smith, Kathleen Gifford, Eileen Ellis et al., *Medicaid Today; Preparing for Tomorrow A Look at State Medicaid Program Spending, Enrollment and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013*, Kaiser Commission on Medicaid and the Uninsured, October 2012.

⁴⁴ The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010.

⁴⁵ Congressional Budget Office, *Budget Options Volume I: Health Care*, December 2008.

⁴⁶ Ibid.

Appendix. Types of Provider Taxes Used by States

A vast majority of states use provider taxes to finance Medicaid. As shown in **Table A-1**, 47 states and the District of Columbia used at least one provider tax in SFY2012. The three states without any provider taxes in SFY2012 were Alaska, Delaware, and Hawaii.

Nursing home taxes were the most popular type of provider tax, with 41 states using a nursing home tax. Hospital and ICF-MR/DD provider taxes were used by a majority of states, with hospital taxes in 39 states and ICF-MR/DD taxes in 34 states. In addition, 9 states had managed care taxes, and 12 states had other types of provider taxes.

Table A-1. State-by-State Provider Taxes, by Type, SFY2013

State	No Provider Tax	Type of Provider Tax				
		Hospital	ICF/MR- DD	Nursing Home	Managed Care	Other
Alabama		X		X		X
Alaska	X					
Arizona	X					
Arkansas		X	X	X		
California		X	X	X		
Colorado		X		X		
Connecticut		X	X	X		
Delaware				X		
District of Columbia		X	X	X	X	
Florida		X	X	X		
Georgia		X	X	X		
Hawaii		X		X		
Idaho		X	X	X		
Illinois		X	X	X		
Indiana		X	X	X		
Iowa		X	X	X		
Kansas		X		X		
Kentucky		X	X	X		X
Louisiana			X	X		X
Maine		X	X	X		X
Maryland		X	X	X	X	
Massachusetts		X		X		
Michigan		X		X		
Minnesota		X	X	X	X	X
Mississippi		X	X	X		X
Missouri		X	X	X		X
Montana		X	X	X		
Nebraska			X	X		

State	No Provider Tax	Type of Provider Tax				
		Hospital	ICF/MR- DD	Nursing Home	Managed Care	Other
Nevada				X		
New Hampshire		X		X		
New Jersey		X	X	X	X	X
New Mexico					X	
New York		X	X	X		X
North Carolina		X	X	X		
North Dakota			X			
Ohio		X	X	X		
Oklahoma		X	X	X		
Oregon		X		X		
Pennsylvania		X	X	X		X
Rhode Island		X		X	X	
South Carolina		X	X			
South Dakota			X			
Tennessee		X	X	X	X	
Texas			X		X	
Utah		X	X	X		
Vermont		X	X	X		X
Virginia			X			
Washington		X	X	X		
West Virginia		X	X	X		X
Wisconsin		X	X	X		
Wyoming				X		
Number of States	2	39	36	43	8	12

Source: Vernon K. Smith, Kathleen Gifford, Eileen Ellis et al., Medicaid Today; Preparing for Tomorrow A Look at State Medicaid Program Spending, Enrollment and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013, Kaiser Commission on Medicaid and the Uninsured, October 2012.

Notes: SFY = state fiscal year; ICF-MR/DD = Intermediate care facilities for individuals with mental retardation or developmental disabilities.

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