



PROVIDER TAXES – A COMPREHENSIVE OVERVIEW

Provider taxes are a strategy that almost every state employs to help fund Medicaid programs while leveraging additional federal dollars. To control federal costs of the Medicaid program, there are certain limitations, restrictions, and other requirements that policy makers and health care providers must be aware of and take into consideration when contemplating the use of provider taxes to support Medicaid programs. Additionally, the type, amount, and use of provider taxes vary dramatically among states. This briefing will provide case studies of tax models used in different states as well as an overview of how provider taxes are being used to leverage Medicaid expansion in various states.

Key Points

General

- Provider taxes are defined as any fee, assessment, or mandatory payment where 85% of the burden falls upon health care providers.¹
- There are 19 classes of providers that may be taxed as identified by CMS.²

Requirements

- Provider taxes must meet three general requirements in order for the funds to be eligible to count as part of the state's Medicaid match. These three requirements are:³
 - 1) The tax must be broad based, meaning it must apply to all non-federal, non-public providers or services within that class;
 - 2) The tax must be uniform, meaning the same fee (amount, rate, percentage, etc.) must be applied to all providers or services within that class; and
 - 3) The tax cannot hold providers harmless, meaning it cannot guarantee that providers will be made financially whole through direct or indirectly means. However states can provide an indirect guarantee if the tax is 6% or less of net patient revenues within the class of providers or services being taxed.

Waivers

- States may apply to the Secretary of the Department of Health and Human Services (DHHS) for a waiver from the broad based and uniform requirements, but not the hold harmless requirement.
- In general, waivers must show that the proposed tax is generally distributive, that the tax is not directly correlated to Medicaid payments, and that it does not hold providers harmless. This is tested with specific formulas outlined in regulations.
- Establishing different thresholds or excluding rural access hospitals and sole community hospitals are specifically identified in statute as examples for which a waiver would be viewed favorably.⁴

Provider taxes are complex and require in depth analysis and modeling to avoid unintended negative consequences on the health care infrastructure.

Federal and State Funding for Medicaid

The Medicaid program is jointly financed by the federal government and state government. The amount the federal government pays is based on each state's Federal Medical Assistance Percentage (FMAP). The FMAP is calculated using a variety of different factors, but is largely based on a state's per capita income. The actual amount of federal assistance received by states is based on the FMAP and on reported Medicaid expenditures for both medical costs and administrative costs.

In order to receive federal funding for Medicaid, each state must provide matching funds to help pay for their portion of the program cost. In the late 1980s, states realized that they could leverage provider taxes to increase the federal funding they received for the program and to decrease state general funds as a portion of the state required match. They did this by taxing health care providers, collecting the taxes and putting them towards the state required match. The increased income from provider taxes resulted in an increase in state funding for the program, which in turn drew down additional federal funds. These funds were then passed back to providers through increased rates and supplemental payments above and beyond what providers had paid in taxes.

States were so successful in using provider taxes to leverage federal funds that, in an effort to contain Medicaid costs in the early 1990s, the federal government began regulating provider taxes in effect limiting a state's ability to use these funds in a way that qualifies for federal matching dollars. In order for funds generated by provider taxes to count as part of the state's match, the provider taxes must meet several requirements outlined and determined by the Center for Medicaid and Medicare Services (CMS). If CMS determines that a provider tax does not meet the requirements outlined in statute and regulation, then CMS will subtract the amount of ineligible provider tax dollars from the total state Medical assistance expenditures before calculating the federal match.⁵

In general, requirements for state matching funds include:

- At least 40% of matching funds must be state funds.⁶
- No more than 25% of a state's match can come from provider tax funds.⁷
- Up to 60% of a state's match can come from local government funds or Certified Public Expenditures (CPE).⁸ CPEs are the reported expenditures for Medicaid services performed by a hospital or provider that is owned by a local government entity. CPEs are reported to the state Medicaid program and added to the Medicaid expenditure total when calculating federal assistance. States can choose to pass all or a portion of the federal funds received for CPEs back to the local government entity.⁹

Provider Tax Definition & Requirements-

Provider taxes are defined as any "fee, assessment, or mandatory payment" for which 85% or more of the burden of the payment is shouldered by health care providers.¹⁰ Although often thought of as primarily a "hospital tax," there are 19 classes of health care providers that fall under this definition as outlined in federal regulations:¹¹

- 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;
- 5) Physician services;
- 6) Home health care services;
- 7) Outpatient prescription drugs;
- 8) Services of managed care organizations (including HMO & PPO);¹²

- 9) Ambulatory surgical center services (facility only, not procedures);
- 10) Dental services;
- 11) Podiatric services;
- 12) Chiropractic services;
- 13) Optometric/optician services;
- 14) Psychological services;
- 15) Therapist services (including PT, SLP, OT, respiratory therapy, audiological services, and rehabilitative specialist services);
- 16) Nursing services (including nurse midwives, nurse practitioners, and private duty nurses);
- 17) Laboratory and x-ray services in a licensed, free-standing laboratory or x-ray facility (excludes those provided in a physician's office, hospital inpatient outpatient department);
- 18) Emergency ambulance services; and
- 19) Other health care items or services not listed above on when the state has enacted a licensing or certification fee, subject to the broad based, uniformity, and hold harmless requirements.

CMS has established three thresholds that a provider tax must pass in order to be eligible for federal matching funds. These include: 1) the tax must be broad based; 2) the tax must be uniform; and 3) the tax must not hold providers harmless. In general, these three requirements are evaluated based on how a tax is applied to a class of providers or services and are calculated in aggregate. States may apply to the DHHS Secretary for waiver of the broad based and uniform requirements, however there is no allowable waiver for the hold harmless provision. The details and process associated with each requirement (where applicable) are described below. From 2008 through 2012, CMS approved broad based and/or uniform waivers in 29 states.¹³

1. Broad based requirement

This requirement states that a tax must be applied to “all services or items within a class including all non-federal or non-public providers within the class.”¹⁴ States can apply for a waiver from this requirement if they are seeking to impose a tax that excludes certain providers within a class as long as they can show that the tax is “generally redistributive in nature.”¹⁵

States are automatically granted a broad based waiver if the proposed tax is no more than \$1,000 annually per provider, or if the total amount of the tax is used to cover the cost of a licensing and certification program.¹⁶ To evaluate other proposed taxes for a broad based waiver, CMS applies a formula that divides the estimated amount of the tax if it were applied to all providers within that class by the estimated amount of the tax as applied to providers under the proposed waiver. If the result is 1 or higher, the waiver is automatically approved. If the result is between 0.90 and 1, CMS will review the waiver and will approve if the proposed tax only excludes or treats differently providers in the classes listed below:¹⁷

- Providers that provide no services or who do not charge for services in the state
- Rural hospitals
- Sole community hospitals
- Physicians practicing in medically underserved areas as defined by section 1302(7) of the Public Health Service Act
- Financially distressed hospitals only if:
 - 1) Such hospitals are defined by state law that is applied uniformly to hospitals around the state; and
 - 2) No more than 10% of hospitals are excluded from the tax
- Psychiatric hospitals
- Hospitals owned and operated by HMOs

2. Uniform requirement

An additional requirement for any provider tax is that it be uniformly imposed, meaning it is applied to all providers or services within that class and that it is applied to the same degree.¹⁸ Examples identified in regulation are listed below:

Example 1: If the tax is a bed tax, the same amount per bed must be applied to all providers within that class.

Example 2: If the tax is a certification fee, the fee must be the same for all providers within that class.

Example 3: If the tax is based on gross revenue receipts or net operating revenue, the tax rate must be the same for all providers within that class.

Specifically, in order to be uniform the tax must be “generally redistributive in nature,” just as with the broad based requirement, but the tax must also prove that provider revenues are not correlated with Medicaid payments at any point in time. Also, there is repeated and significant emphasis that any taxes providing credits, exclusions, or direct or indirect payment to providers would violate the uniformity clause and the hold harmless clause. Some states have developed methods to work around this clause that are discussed further in this paper.

States applying for a waiver to the uniform requirement must also pass a test used to evaluate if there is any correlation between the receipt of Medicaid payments and the amount of provider taxes paid.¹⁹ To determine if this relationship exists, and to what extent it does exist if at all, CMS divides the slope of the linear regression if the state’s tax were broad based and uniform to the slope of the linear regression of the tax as proposed in the waiver. If the result is 1 or more, the waiver is automatically approved. If the result is between 0.90 and 1, the waiver may be approved only if it applies the tax in a non-uniform manner to the following providers (note this list is slightly different than the list of providers allowed under the broad based exclusion):²⁰

- Providers that provide no services or who do not charge for services in the state
- Rural hospitals
- Sole community hospitals
- Physicians practicing in medically underserved areas as defined by section 1302(7) of the Public Health Service Act.
- Financially distressed hospitals only if:
 - Such hospitals are defined by state law that is applied uniformly to hospitals around the state; and
 - No more than 10% of hospitals are excluded from the tax
- Psychiatric hospitals
- Providers or payers with varying tax rates based exclusively on region subject to certain requirements

3. Hold harmless requirement

This requirement essentially acts as a way to prohibit states from taxing providers, using those funds to pull down enhanced federal funding, and passing those dollars back to providers through direct or indirect means. There are no waivers to this requirement which CMS evaluates two ways:²¹

- 1) Does the tax use direct or indirect means to ensure the providers paying the tax are made financially whole through non-Medicaid payments; and
- 2) Does the amount providers receive from those payments positively correlate at any point in time to the amount the providers pay in taxes or the difference between their Medicaid

revenues and the amount they pay in taxes. The positive correlation still counts even if it is not constant over time.

Despite the lack of waiver for this requirement, there is an established “safe harbor” threshold that allows for a certain amount of flexibility. States can provide an indirect guarantee if the tax produces revenues less than 6% or more of the net patient revenue attributed to the class of health care providers or services being taxed.²² This safe harbor provision is currently set at 6%, but it is important to note that this has changed within the past decade falling to 5.5% from 2008 to 2011 before returning to 6%. There are ongoing discussions in Congress debating the impact and financial benefit to the federal government of lowering this threshold and at one point in the past few years President Obama’s budget proposed lowering the threshold to 3.5% as part of his administration’s effort to reduce the federal deficit.²³

To determine if there is a positive correlation or if the tax holds providers harmless, CMS applies a “two prong test:”

Prong 1: Does the tax create more revenue than 6% of the net patient revenue attributed to the class of health care providers or services being taxed?²⁴

Prong 2: If so, do 75% of the providers taxed recover 75% or more of their total costs back through enhanced Medicaid or other state payments?

According to a 2014 report by the GAO, all of the 63 taxes implemented between 2008 and 2012 as a percentage of net patient revenues were below the safe harbor threshold and would have passed the hold harmless test.²⁵ This is significant in understanding how some states are able to leverage provider taxes to fund expanded Medicaid programs, and in effect be “held harmless” despite the regulatory and statute provisions.

Provider Donations

Similar to provider taxes, provider donations have also come under scrutiny and both statute and regulations outline requirements that provider donations must meet in order for states to avoid reductions in federal matching funds. These requirements are:

- Provider donations can be cash, in-kind, direct or indirect services or payments to the state from a health care provider offering services under the state plan.²⁶
- Donations from individuals of \$5,000 or less annually are allowed.²⁷
- Donations from a health care provider/entity of \$50,000 annually or less are allowed.²⁸

Bona fide donations are donations for which providers are not held harmless. Specifically this means that there is no positive correlation at any time between provider donations and the amount of Medicaid payments the provider receives.

Bona fide donations from hospitals, FQHC, clinics, or similar provider classes are specifically allowed if they cover the costs of staff providing Medicaid eligibility determinations or redeterminations for the state at that facility.²⁹ These types of donations are limited to no more than 10% annually of the state’s Medicaid assistance administrative cost.³⁰ The donation must be a direct donation defined as costs for salaries, training, or fringe benefits for on-site or local agency support staff. Eligibility outreach costs may also be considered an allowable donation if those costs are prorated and calculated as a percentage of the state’s aggregate outreach cost. The cost of agency overhead and the space are specifically excluded as allowable bona fide donations.³¹

Reporting Requirements

Reporting requirements for both provider taxes and donations are outlined in regulations, however the requirements are rather vague. States are required to report provider taxes and donations on a quarterly basis in summary form.³² This information should include the source of tax or donation revenue and how the state is using these funds. Additionally the state is required to provide a legal basis for the donation or tax program.

The United States Government Accountability Office (GAO) has raised concerns that the current reporting system is not adequate and that CMS is not enforcing the existing reporting requirements.³³ CMS has indicated that they do not agree with the GAO assessment but will consider improving the reporting system at some point in the near future.

Process for Implementing Provider Taxes

Generally provider taxes are enacted by a state legislature through statute. The state then adds the proposed tax to their Medicaid state plan through a State Plan Amendment (SPA). During the SPA process CMS evaluates the taxes based on the requirements outlined above. In some states the fees are collected by provider association groups and are then passed along to the Medicaid program through an intergovernmental transfer.³⁴ In other cases, a state agency is responsible for collecting the taxes from each provider.

Provider Taxes that are not Regulated by CMS

Several states have implemented provider taxes that do not meet the definition in federal statute or regulation for provider taxes and thus are not subject to the requirements laid out by CMS. They have achieved this by making the taxable entities a mix of health care and non-health care providers so the total tax burden for health care providers is under the 85% threshold identified in statute. Specific examples are listed below:³⁵

- Washington enacted a business and occupation gross receipts tax. Health care providers, specifically hospitals are taxed based on their profit or non-profit status at 1.8% of gross revenue from health care activities.³⁶ Preferential tax rates are applied to other types of health care services such as room and domiciliary care to patients in an assisted living facility which is taxed at 0.27%.³⁷
- Maine taxed 5% of the value of mental health, intellectually disabled, and autistic home-support and institutional services along with cable and satellite television, fabrication services, video equipment and media rental, and telecommunication services.
- West Virginia enacted a 5% severance and business privilege tax on behavioral health services (inpatient, outpatient, residential) and the severing, extraction, and sale of commercial coal, limestone, or sandstone.

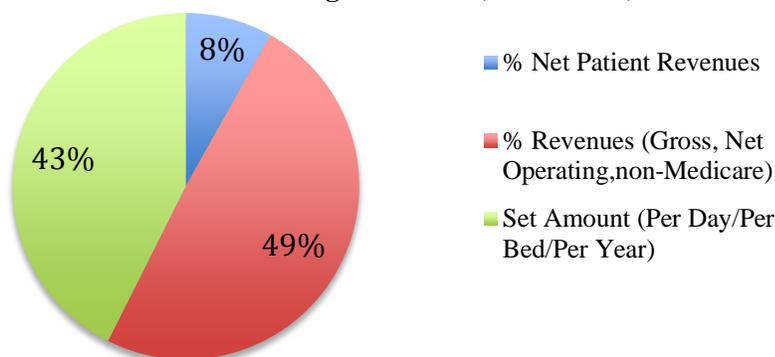
State Trends

According to the Kaiser Family Foundation in their annual state survey, 49 states reported assessing at least one provider tax with most states reporting multiple taxes. Alaska was the only state that had not implemented a provider tax, but Delaware, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Virginia, and Wyoming all reported assessing only one type of provider tax in 2015.³⁸ The other 41 states reported assessing two or more taxes on health care providers in 2015.

The most popular type of tax was a tax on nursing facilities (44 states), followed by hospital services (38 states), and intermediate care facilities (37 states). Among states that tax additional services beyond hospital, intermediate, and nursing facilities, the most common taxes were on ambulatory surgical center services, laboratory and x-ray services and emergency ambulance services.³⁹

States have been creative with the way that they implement taxes. Some examples of provider taxes include licensing fees, bed taxes, a tax per hospital admission, a tax per hospital discharge, a tax on gross revenue, a tax on net revenue, prescription taxes, etc.⁴⁰

Type of Provider Taxes Among All States (2008 - 2012)



A recent report from the GAO highlights the increasing reliance of state Medicaid funding through provider taxes. According to their report, the amount of provider taxes funding Medicaid programs across the US increased from \$10 billion in 2008 to around \$19 billion by 2012 and increases were largely seen in provider taxes on inpatient hospitals and nursing homes.⁴¹ Specifically, in 2008 there were 117 provider taxes implemented in 42 states, and by 2012 that increased to 159 provider taxes implemented across 47 states. This represents a 36% increase over the 5-year period and a net increase of 42 taxes.⁴²

Increasingly, states have turned to provider and local government funds in order to finance the non-federal portion of supplemental payments. In 2012, seven states reported relying exclusively on provider taxes and local government funds for the non-federal portion of their Disproportionate Share Hospital (DSH) match.⁴³ Seven other states used a mix of provider taxes and local funding to provide their portion of matching funds for supplemental non-DSH payments.⁴⁴ Notably, Idaho and Nevada made both lists and reported funding all of their supplemental payments, DSH and non-DSH, with 100% provider taxes and local government funds. From 2009 through 2010, Idaho eliminated the use of state general funds for supplemental payments by increasing or establishing new taxes for inpatient and outpatient hospital services and nursing homes.⁴⁵ This increase in provider taxes and local government funding made Idaho the state with the largest increase in provider taxes in the U.S. during that time period. While Idaho is at one end of the spectrum of choices states have made in funding their Medicaid programs, the overall 5-year trend has been an increase in taxes on provider and services.

Just as every Medicaid program is unique to each state, so is their provider tax structure. Summarized below are some notable models/elements of provider taxes in a variety of states.

Kansas

Assesses a 1.83% tax on hospital net inpatient operating revenue and a flat rate of \$1,950 per nursing home bed. State statute dictates that at least 80% of the revenues from the hospital tax must be redistributed to hospital providers, and 20% is redistributed to physicians. Additionally all of the revenue from the nursing home tax must be used to improve quality of health care in those facilities including offsetting nursing home rate reductions and covering the cost of the assessment.⁴⁶ Critical access hospitals, teaching hospitals and public hospitals are exempted and state legislation specifies that the cost of the tax may not be passed onto consumers.

Minnesota

This state has enacted some of the widest variety of provider taxes among all of the states with a focus on using provider taxes to fund public health programs for those who were uninsured and previously ineligible for Medicaid under a health plan called MinnesotaCare. MinnesotaCare was funded through the creation of the Health Care Access fund. This fund was made up of state taxes totaling 2% of hospital, surgical centers, health care providers, and wholesale drug distributor's gross revenues.⁴⁷ While the fund was created with the intention of funding MinnesotaCare, during challenging budget times provider tax funds were actually used to balance the state budget and were not fully put towards supporting health care programs. As a result of a combination of advocacy by provider associations and the expansion of Medicaid to uninsured, childless adults, the state decided to slowly phase out the provider taxes with the intention of eliminating them by 2019.⁴⁸

Washington

Aside from the Business and Occupation Tax described on page 8, the State of Washington implemented a hospital assessment to support safety net services in 2010 when the state was facing a budget shortfall.⁴⁹ The assessment was intended to pull down matching federal funds which would then be passed onto hospitals through increased rates with a small portion (\$50 million) being put towards the general fund. A year later, the legislature reversed course reducing Medicaid rates and directing \$110 million in Safety Net Assessment funds to the general fund. This in turn reduced the state's federal match for Medicaid and resulted in an estimated \$260 million impact. This disproportionately impacted Prospective Payment System (PPS) hospitals in the state as they ended up paying more in taxes than they were receiving. Critical access hospitals, public hospitals, and psychiatric hospitals were not impacted as deeply by the changes.

The Washington State Hospital Association filed a lawsuit in 2011 and, in an effort to avoid a contentious legal battle, the hospital association and the legislature crafted a provider tax structure that is currently in place.⁵⁰ Under this structure the state established a dedicated fund within the treasury called the Safety Net Assessment Fund.⁵¹ The stated legislative intent is that as Medicaid expansion brings additional federal dollars to the state health care system to cover individuals in the safety net, the need for this assessment will decrease. Beginning in state fiscal year 2016, the assessment program will be phased out ending entirely in 2019.⁵² Additionally, the legislation contains stipulations that protect hospitals from having the fund be misused or diverted as they were in the past.⁵³

- The state cannot pull more than \$100 million per year from the assessment fund to put towards general fund spending in the Medicaid program.
- The bulk of the funds must be used to help hospitals support vulnerable patients.
- Any dollars remaining in the fund in 2019 must be distributed back to the hospitals.
- Hospitals engage in a contract with the state Health Care Authority each biennium to ensure there are no additional legislative changes to the supplemental payments, rates, assessments, DSH payments, capitation payments, or other financial arrangements outline in statute.⁵⁴

Hospitals agreed to accept 2009 Medicaid rate levels for inpatient and outpatient services for both Fee for Service (FFS) and Managed Care (MC).⁵⁵ For PPS hospitals, the assessment is based on a flat rate per non-Medicare inpatient bed day up to a set limit of 54,000 bed days per year.⁵⁶ Once that threshold is reached, any additional bed patient days are assessed at a lower rate. Overall, the assessment rate is higher for PPS hospitals than for critical access hospitals, psychiatric hospitals, and rehabilitation hospitals.

In turn, hospitals receive direct quarterly supplemental payments from the state for inpatient and outpatient FFS Medicaid services. The quarterly payments are based on a set amount fixed in statute for fiscal years 2014 and 2015 per hospital class. Should the combination of Medicaid revenues and additional supplemental payments exceed the Upper Limit (UL), the supplemental payments must be reduced until they are within the UL threshold. The remaining funds will be paid to Medicaid Managed Care organizations.⁵⁷

Notably, the statute also includes a provision requiring hospitals to treat the assessment as part of their operating overhead and restricts them from passing on these costs to consumers and third-party payers through increased charges.⁵⁸

Arizona

In 2013 Arizona established a hospital assessment intended to cover the state's portion of the cost to expand Medicaid coverage to non-disabled, childless adults with incomes between 100% and 133% of the Federal Poverty Level (FPL) along with restoring funding for a program called Prop 204 which provided coverage for childless adults with incomes 100% FPL or less.⁵⁹ Rather than the Legislature developing the assessment, Governor Brewer directed the Director of the Arizona Health Care Cost Containment System (AHCCS) to develop an assessment model not codified in statute in order to retain flexibility.⁶⁰

Ultimately the assessment model was supported by the Arizona Hospital and Healthcare Association (AHHA) because of a shared understanding that the assessment would be designed in such a way that no hospital would experience financial harm.⁶¹ In order to achieve this, the assessment model uses a variety of exemptions and variable rates to ensure the assessment does not harm different hospital models. In a move similar to that of Washington state, legislation was crafted that specifically prohibits hospitals from passing on the cost of the assessment to consumers.

The assessment itself is at the heart of a legal challenge to Arizona's decision to expand Medicaid. Arizona requires that state taxes be approved by a two-thirds majority rather than a simple majority. Governor Brewer's administration determined the assessment was not a tax, and the enabling legislation for the hospital assessment was passed with a simple majority, however that is now being challenged in the court system.⁶²

Indiana

In order to maintain his commitment to not use taxpayer funds to support Medicaid expansion, Governor Pence worked with the hospital association to develop a funding mechanism that uses tobacco tax revenues and increases an existing provider tax to cover the state's portion of the cost to expand Medicaid.⁶³ Specifically, Indiana's expansion model uses a tax on acute and private psychiatric hospitals that was established in 2011 with proposed increases taking effect as the federal funding match for the expansion population begins to drop in 2017. The hospital tax will provide \$959 million of the estimated \$1.6 billion state required match while revenue from a tobacco tax increase will cover the additional \$640 million.

In return for the assessment, the hospitals will benefit by avoiding rate reductions and increased reimbursement for physician services from around 55% of Medicare rates to 75%.⁶⁴ Additionally, some of the assessment funds will be used to establish a trust fund to cover administrative costs for the program. Indiana also established a Hospital Assessment Fund board that oversees the formula used to determine the assessment. The board is made up of two members from the hospital association and two appointees from the state.⁶⁵

Considerations for Provider Taxes in Alaska

Should Alaska providers and policy makers engage in the discussion of enacting a provider tax or assessment, some considerations are listed below:

- 1) Ensure that the tax is not misappropriated by future legislatures as much as possible. With Alaska's constitutional prohibition against dedicated funds, it may be appropriate to consider taking Washington's approach and having a state agency contract with hospitals and using the contract terms to protect against misappropriation.
- 2) Can tribal health providers be included in a provider tax structure? This is an important issue that would need to be resolved early in the process. A discussion on what providers are included in a tax structure is a critical question.
- 3) Ensure that supplemental payments to hospitals or other provider classes are not in excess of the upper payment limit and develop a plan to manage any excess payments in advance.
- 4) Consider establishing a board made up of state agency representatives and hospital association or provider representatives to manage the assessment process on an annual or biennial basis.
- 5) Consider the staff time necessary to manage the tasks associated with an assessment. Specifically staff would be needed to manage the quarterly reporting requirements, the collection of the assessment, and the development of any waivers.
- 6) Ensure providers are not financially harmed by an assessment. This would require a balance of the following:
 - Staying under the 6% safe harbor threshold;
 - Ensuring that supplemental payments to make hospitals whole do not exceed Medicaid upper payment limit; and
 - Providing variable tax rates or exemptions for critical access hospitals and/or sole community hospitals.
- 7) States typically require outside expertise to assist in the development of a provider tax through modeling the impact of rates and types of taxes (e.g. bed, revenue, discharge, etc.) on different providers. Arriving at a methodology that will meet the needs of diverse providers and fulfill complex CMS requirements makes consultant support critical.

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- ¹ 42 C.F.R. § 433.55
- ² 42 C.F.R. § 433.56
- ³ 42 C.F.R. § 433.68
- ⁴ Social Security Act § 1903 (w)(3), 42 U.S.C. § 1396b
- ⁵ 42 C.F.R. § 433.57
- ⁶ 42 C.F.R. § 433.53
- ⁷ Social Security Act § 1903(w)(5), 42 U.S.C. § 1396b
- ⁸ United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. Retrieved from <http://www.gao.gov/assets/670/665077.pdf>
- ⁹ Ibid.
- ¹⁰ 42 C.F.R. § 433.55
- ¹¹ 42 C.F.R. § 433.56
- ¹² Health insurance and HMO premiums are not considered a provider tax and are specifically excluded per 42 CFR § 433.55.
- ¹³ United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. Retrieved from <http://www.gao.gov/assets/670/665077.pdf>
- ¹⁴ 42 C.F.R. § 433.68
- ¹⁵ Ibid.
- ¹⁶ Ibid.
- ¹⁷ Ibid.
- ¹⁸ Ibid.
- ¹⁹ 42 CFR § 433.68
- ²⁰ Ibid.
- ²¹ Ibid.
- ²² 42 CFR § 433.68
- ²³ Kaiser Commission on Medicaid and the Uninsured. (2013). *Quick Take: Medicaid Provider Taxes and Federal Deficit Reduction Efforts*. Retrieved from <http://kff.org/medicaid/fact-sheet/medicaid-provider-taxes-and-federal-deficit-reduction-efforts-2/>
- ²⁴ 42 CFR § 433.68
- ²⁵ United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. Retrieved from <http://www.gao.gov/assets/670/665077.pdf>
- ²⁶ Social Security Act § 1903 (w)(2), 42 U.S.C. § 1396b
- ²⁷ 42 CFR § 433.55
- ²⁸ 42 CFR § 433.55
- ²⁹ 42 CFR § 433.66
- ³⁰ 42 CFR § 433.67
- ³¹ 42 CFR § 433.66
- ³² 42 CFR § 433.74
- ³³ United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. Retrieved from <http://www.gao.gov/assets/670/665077.pdf>
- ³⁴ Boothe, A. & Kim, S. (2014). Medicaid Provider Fees Explained. American Action Forum. Retrieved from <http://americanactionforum.org/insights/medicaid-provider-fees-explained>
- ³⁵ Pacific Health Policy Group. (2012). *Health Care-Related Tax Study Report [Prepared for the Department of Vermont Health Access]*. Retrieved from <http://dvha.vermont.gov/budget-legislative/2health-care-related-tax-study-report-01-12-12.pdf>
- ³⁶ State of Washington Department of Revenue. (n.d.). *Business and Occupation (B&O) Tax Classification Definitions*. Retrieved from http://dor.wa.gov/Content/FileAndPayTaxes/BeforeIFile/Def_TxClassBandO.aspx#0135
- ³⁷ WAC § 458-20-168
- ³⁸ Kaiser Family Foundation. (2014). *State Health Facts: Medicaid Provider Taxes*. Retrieved from <http://kff.org/medicaid/state-indicator/medicaid-provider-taxes-in-place/>
- ³⁹ Pacific Health Policy Group. (2012)

⁴⁰ Kaiser Family Foundation. (2014).

⁴¹ United States Government Accountability Office. (2014). *Medicaid Financing: States Increased Reliance on Funds From Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. Retrieved from <http://www.gao.gov/assets/670/665077.pdf>

⁴² Ibid.

⁴³ Ibid. The seven states are Colorado, Florida, Idaho, Mississippi, Nevada, South Carolina, and Tennessee.

⁴⁴ Ibid. The seven states are Alabama, Idaho, Illinois, Nebraska, Nevada, North Carolina, and Wyoming.

⁴⁵ Ibid.

⁴⁶ Kansas Health Institute. (2014). *Kansas Medicaid: Beyond the Basics*. Retrieved from <http://media.khi.org/news/documents/2014/06/04/MedicaidSupplementREVISED.pdf>

⁴⁷ Minn. Stat. § 295.52

⁴⁸ Minnesota Medical Association. (n.d.). *Provider/Sick Tax*. Retrieved from <http://www.mnmed.org/Advocacy/Key-Issues/Sick-Tax>

⁴⁹ Washington State Hospital Association. (2014). Questions and Answers About the Safety Net Assessment Lawsuit. Retrieved from <http://www.wsha.org/LawsuitFAQ.cfm>

⁵⁰ Ibid.

⁵¹ Wash. Rev. Code § 74.60

⁵² Wash. Rev. Code § 74.60

⁵³ Wash. Rev. Code § 74.60

⁵⁴ Wash. Rev. Code § 74.60.160

⁵⁵ Wash. Rev. Code § 74.60.020

⁵⁶ Wash. Rev. Code § 74.60.030

⁵⁷ Wash. Rev. Code § 74.60.120

⁵⁸ Wash. Rev. Code § 74.60.070

⁵⁹ Hospital Assessment. (n.d.)

⁶⁰ Arizona Hospital and Healthcare Association. (2014). *Implementing the Hospital Assessment: Ensuring Fairness and No Financial Harm [Issue Paper]*.

⁶¹ Arizona Hospital and Healthcare Association. (2014). *Implementing the Hospital Assessment: Ensuring Fairness and No Financial Harm [Issue Paper]*.

⁶² Williams, T. & Rojas, R. (31 Dec. 2014). Arizona Supreme Court Allows Challenges to State's Medicaid Expansion. *New York Times*. Retrieved from <http://www.nytimes.com/2015/01/01/us/politics/arizona-supreme-court-allows-challenge-to-states-medicaid-expansion.html? r=0>

⁶³ Daly, R. (2015). *Indiana Hospitals Help Fund Medicaid Expansion*. Healthcare Financial Management Association. Retrieved from <https://www.hfma.org/Content.aspx?id=27903>

⁶⁴ Ibid.

⁶⁵ Indiana Family and Social Services Administration. (n.d.). *Healthy Indiana Plan 2.0*. Retrieved from http://www.in.gov/fssa/hip/files/HIP_2_0_Roadshow_DM_FINAL.pdf