Survey of State Exec Experiences with Provider Fees - April 2012

State	Provider Fee? YES/NO	% of State Take	Cost % of Medicaid coverage before/after provider fee program		Current FMAP	FMAP When Implemented	Public facility participation?	Law directs use of state set-aside?	Law identifies funding amounts?	Sunset Law? If so, how often?	Uniform or Varied Rate	CMS approval time
			Before	After								
ARIZONA	Hospitals: NO Nursing homes: YES											
ARKANSAS	YES	3.5% of taxed amount or $1.6M	70% inpatient / 42% outpatient	95%	70% Feds		No	No	No	No	We vary the rate based upon UPL gap. Currently, rate is 1.5%.	10 months
COLORADO	YES	13% *	55%	70%	50%	68%	Yes	Limits to 3 primary purposes **	Does not identify funding amounts but specifies which programs and how to fund. ***	Yes. Sunsets in 2019. [implementation date not given]	Varied. ****	Approx. 9 months *****
DELAWARE	NO											
FLORIDA	YES											
GEORGIA	YES	Approx. 1/3 to finance Medicaid rate increase for hospitals; remaining 2/3 used for general Medical funding	85%	State hasn't released for 1st year; likely that it's close to 97% given that the tax finances a ~12% payment add-oin for Medicaid inpatient and outpatient services	66.16% Implementation date: July 1, 2010		Yes	Yes. *	Enabling legislation does not speak to funding amounts but the state's annual Appropriations Act shows the Provider Payments (Fee) as a revenue source in the program funding for the Medicaid and CHIP programs.	Yes. Sunsets on June 20, 2013. No provisions for continuation past this date.	Varies. CAH, State owned/operated and free standing, psychiatric hosp are exempt from paying the fee. Trauma hospitals pay 1.4% of their net patient revenue; others pay 1.45%.	June - Sept.

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IDAHO	YES	0% (some minor administrative costs are paid of of assessments.	77.5%	100%	70-30	71-29	For the extra assessments, yes, but prior to that and since 2002, the public hospitals leveraged the UPL gap by using IGT methodology and the entire amount of leverage federal dollars went directly to them.	N/A	N/A	Original law contained a sunset clause, but was removed because of our agreement with Medicaid on extra assessments. Additional assessment language sunsets on 7/1/12 and no additional sunset language has been added.	Uniform	9 months
ILLINOIS	YES	14%	75%	90%	50%	50%	Exempt but receive reimubursement benefit	Approx 40% of state share directed for use in the law; remainder assigned to General Revenue Funds.		Program designed with 5-yr life, but recently was extended by 1 year.	Uniform rate per bed day.	8 months
INDIANA	YES, pending approval	28.50%	40% before supp. Pymts	Medicare-equiv rates, roughly 85% of cost	Normally about 66.6% (w/o temp ARRA increase)	Not yet imple-mented	Yes	It specifies "Medicaid expense" as the use for the State's portion, but there are no specifics.		The enabling legislation authorizes the program for 2 years (we have a biennial budget process)	Not completely uniform but we met the requirements for the waiver.	First submitted 9/30/11. Still waiting for initial approval.
LOUSIANA	NO											
MAINE	YES	20% (Hospitals reimbursed in the aggregate 80% of the amount paid in tax so I think the answer is 20%)	Did not change after fee was implemented. Medicaid has historically covered about 75% of allowable cost and that amount is closer to 70% at this point given other budgeted reductions unrelated to the fee.		64.5%	Approx. 66%	No	The tax law provides that the tax money gets deposited in the general fund. The State budget each year then appropriates that money over to the general Medicaid account to fund Medicaid payments to all types of providers.		No, but the Legislature does need to appropriate the money during each two year budget cycle.	Uniform	3 months
MINNESOTA	YES	None								2019	2% comm. 1.56% Medicaid	
MONTANA	YES	None	70%	90%	3:1		County & district hospitals but not State fac.	No. All goes back to hospitals.		Not anymore, now permanent; but laws can change	Uniform	Don't remember, but not too long.
NEVADA	Hospitals: NO LTC: YES				56.2%							

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NEW HAMPSHIRE	?											
NEW JERSEY					50 / 50							
NEW MEXICO	NO		Until 2010 we had 97% of cost. [Now] down to 75%		69.07%							
NEW YORK					50.00%		Yes			Yes. 3-31-14	0,35% or $375M + $27B on non-Medicare	Varied.
OHIO	YES	44.00%	82% not including DSH	We estimate 95% after supplemental payments	64% - just implemented		Yes	Funding is appropriated to Medicaid, but in no specific amount or direction within Medicaid		Yes. Every 2 years.	Uniform, excluding Medicare costs (our tax is a facility cost-based tax)	6 months
OKLAHOMA	YES	$30M (fixed amount, which is initially 20% of the assessment)	*"Error in reported information…checking."*		63.88%	63.88%	State: No Non-state government owned: Yes	Yes.	100% for Medicaid programs	Yes. Initial period was 4 years	Uniform	6 months
PA	YES	18% statewide. Also is a city-specific hosp. tax in Philly and the state and city receive approx. 30% of that revenue.	77%	89%	55.07%	63% (Certain non-DSH programs received an enhanced FMAP of approx 63% as a result of the ARRA)	Have no public general acute care hospitals. *	The state's share is used in the general fund.	No	Yes. Three years	Uniform	7 months
S. DAKOTA	NO				57%							

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TENNESSEE	YES	None. But assessment did cover non-hospital cuts such as physicians and opening the medically needy category.	67%	70.6% excluding DSH	65.85%	65.78%	NO. They provide CPE.	All must be used on Medicaid (TennCare) program.		Yes. Annual.	Uniform	4-5 weeks.
UTAH	YES	Flat $1 million of total assessment. Assessment increases each year based on growth in UPL.	Approx 88%	Believe it is near 90% but continue to refine that calculation.	70%	71%	No	$1 million kept by State. Has to be used for "Medicaid mandatory expenditures".		Yes. Sunsets July 1, 2013. This cycle was for 3 years.	Uniform	No one can recall.
VERMONT	YES	All fees and match go to hospitals and docs. *	unk	unk	unk	58%	n/a	Assessment method in statute. All fees and match go to hospitals and docs.		No.	Uniform	?
VIRGINIA	NO				50%							
WASHINGTON	YES	First two years: State received $70M and hospitals $120 M (63%). Now in court over next 2 years. Hospitals receive nothing and State gains $180M	75%	No increase	50%	Enhanced when created, 63% and 57%	No large publics. Small public CAH have a small fee, instituted so they could participate and lend political support	Not as intended. Unfortunately, our state cut rates granted under the tax program and these cuts are used to supplant other funding which would have gone to Medicaid hospital payments.		Yes. Once in 2013.	Vary. None for large publics, small amounts for CAH hospitals and regular amounts for the rest.	March to October.
WEST VIRGINIA	YES				72%							
WISCONSIN	YES	About 40%. Some goes to increase coverage	45%	65% net	62%	Same	All hospitals taxed same rate.	NO, but understood as part of "the deal"		NO, but revisited every two years as part of budget cycle	Uniform	Less than 6 months

State	COMMENTS
ARIZONA	We have no hospital provider tax in Arizona. We advocated for one last year as an alternative to the massive Medicaid custs our governor proposed, but due to an overwhelmingly conservative Legislature, lack of support from the governor, and aggressive lobbying by three AzHHA members who opposed the tax, we were unable to get it passed. We began this session with a revised provider fee proposal that would have directed the revenues to a charity care pool to offset the staggering uncompensated care our members are providing in the wake of our Medicaid cuts. However, again due to conservative opposition and lobbying by the few AzHHA members who are opposed to any type of hospital provider tax, we were unable to get traction. So we chose to withdraw the proposal and lobby for a straight-up rate increase for all hospitals, plus an increase in supplemental payments for small rural hospitals. We're still pushing that boulder up the hill as budget negotiations continue.
	Interestingly, Arizona's nursing home community was able to get the Legislature to pass a small provider tax for nursing homes this year. Their success -- which has surpassed their own expectations -- is a testiment to the united front they presesnted to the legislature, real fears about nursing homes closing (no one wants to see Grandma kicked out in the street in an election year), and the relatively small size of their tax. We don't know whether the governor will sign their bill.
	Having read all of [the] responses and given our recent and painful experiences, I remain convinced that a provider fee should be pursued only when the loaded gun of massive cuts is pointed squarely at your head. In my state, it deeply divided my membership and put us in the position of asking the most conservative Legislature in Arizona history to vote for something many lawmakers had signed a pledge not to do. We will recover, but progress is painful and slow. .....The wounds are still fresh..... Don't do it if you don't absolutely have to.
ARKANSAS	
COLORADO	* Out of a total fee of $632M, $465M is used to fund enhanced Medicaid, Indigent and uncompensated care payments that come directly back to hospitals; $105M is used to finance eligibility expansions in the Medicaid and Children's Health Insurance programs; $11M is used for the state's administrative expenses related to the program and the expansions and $72M is general fund relief, $56M of which is funneled back into Medicaid and $16M is used for the state's indigent care program. The $56M is a temporary funding, and legislation had to be passed with our support to make it happen.
	** Three primary purposes: Enhanced hospital payments, expansions to the Medicaid and children's health insurance programs and state Medicaid agency administrative expenses directly related to the provider fee.
	*** Specifies the following: Enhanced Medicaid payments to hospitals up to the Upper Payment Limit. Enhanced indigent care payments to hospitals up to cost. Medicaid eligibility expansions for parents from 60% FPL to 100%. Medicaid eligibility expansions for childless adults up to 100% of the FPL (a newly covered group). Medicaid buy-in program for the disabled up to 450% of the FPL (a new program). Children's Health Insurance program expansions form 205% of the FPL to 250%.
	**** The inpatient fee is based on patient days and the outpatient fee is based on a percentage of outpatient charges. Discounts are provided to certain high Medicaid and indigent care hospitals and to small rural hospitals. Also, managed care days are significantly disocunted compared to other days. Psych, rehab and LTC hospitals are exempt from paying the fee.
	***** The whole process from initial discussions through legislation and up to the point cash started flowing was 2 years.
DELAWARE	No provider tax. We beat a proposed one four years ago. Long term care has requested one for their members this year but prospects iffy. My board just voted to oppose long term care request.
FLORIDA	If you don't have one now, you are better off without one. No matter what deal you get this year, it is likely to deteriorate over time. Then, it will become a divisive issue among your hospitals.
GEORGIA	* The enabling statutory language: 33-8-179.4.(a) The department shall collect the provider payments imposed pursuant to Code Seciton 31-8-179.3. All revenues raised pursuant to this article shall be deposited into the segregated account. Such funds shall be dedicated and used for the sole purpose of obtaining federal financial participation for medical assistance payents to providers on behalf of Medicaid recipients pursuant to Article 7 of Chapter 4 of Title 49.

State	COMMENTS
IDAHO	Re % of cost: When our "assessment" law began in 2008, hospitals under 40 beds were receiving 92.5% of cost and hospitals over 40 beds were receiving about 77.5% which led to a UPL gap which was leveraged by the assessment dollars. The reimbursement rates didn't change until additional assessments were made to fund the state's match for Medicaid DSH and a fixed amount for trustee and benefits. In order to lessen the impact of the fixed amount assessment by spreading it out over time and to bring in more federal dollars sooner, reimbursement was increased to 101% for CAHs and 100% for all others. This deal cost the hospitals over $60M over time, but would have cost substantially more if we had not cut the deal with Medicaid. The fiscal year we are in is the last year for the extra assessments, but it should be noted that the reimbursement will remain at 101% and 100% respectively.
ILLINOIS	
INDIANA	
LOUSIANA	
MAINE	The money isn't worth the aggravation, trust me.
MINNESOTA	I would agree with Bruce and others that it might be best not to go there. We have both a broad provider tax of 2% on non-Medicare revenues that is on all providers and we also have a 1.56% Medicaid surcharge that was enacted about 10 years ago to bolster hospital payments/avoid cuts. The 2% provider tax, which was enacted in 1992, goes into a separate fund known as the Health Care Access Fund (HCAF) and the bulk of the funds are used for MinnesotaCare, an insurance program for low income folks not otherwise eligible for Medicaid. Surpluses in the HCAF have been diverted to the general fund from time to time over the past twenty years (about $400 million at latest count), and there is a continuing stream of attempts to use some of the funds for other programs. The 2% provider tax is set to sunset entirely in 2019 and to begin ratcheting down to progressively lower levels beginning in 2014, based on the availability of surplus dollars in the HCAF. The sunset and reduction is contingent on the federal health care law being upheld by the Supreme Court, since the expanded Medicaid program would fund the coverage currently provided under MinnesotaCare up to 133% of poverty. We are trying to kick the habit but our way out is pretty foggy right now. Both the provider tax and the Medicaid surcharge generate considerable conflict within the association on a regular basis.
MONTANA	
NEVADA	We have opposed the last two legislative sessions successfully. Nevada has had a provider tax for nursing home industry in place for 10 years and it backfired on them. They have been fighting to change the last several legislative sessions. Nevada is currently looking at a UPL program but that is turning into a big fight between our members. The State wants a significant peice of any benefit from this program if it goes forward which they promise to put back into Medicaid rates. We really believe that! Our experience has been [that] they use any net gain to maintain current funding levels not to enhance rates so they can free up general fund monies for other state budget issues. Currently hospitals are receiving on average 53% of cost.

State	COMMENTS
NEW HAMPSHIRE	I would like to associate myself with the statement from the gentleman from Florida…to quote a favorite movie, "Run Forrest, run!"
NEW JERSEY	We defeated a significant bed tax on hospitals that would have raised about $400-plus million and divert a significant portion to the State's General Fund (that was in 2006). We do have a 0.53 percent tax on hospital gross revenues. It was imposed in 1992 and capped at taking $40 million from industry. That $40M goes to our FQHCs for uncomp care. A couple of years ago the .53% tax was uncapped and it now generates over $95 million. The first $40 million goes to FQHCs and the rest is put up for fed match and all returned to hospital industry. We have a nursing home bed tax too and that has been eroded over time so that way too much of it goes to our State and not enough to the nursing home industry.
NEW MEXICO	We've been consumed with analyzing the impact of a proposed Medicaid redesign that will move the program from about 75% now to 100% managed care. With no Medicaid FFS left, that means we will have no basis left for calculating our UPL which generates $300 million/year for hospitals. So we are moving toward uncompensated care and DSRIP pools a la CA and TX. All of our current matching funds come from county indigent funds. One possibility for the non-federal share may be a county-specific local option tax and we are aggressively trying to identify state and county program costs that can be counted as CPE. We have no provider tax. Members have always been divided on it. The for-profit systems would welcome it. Our large non -profit system abhors taxes of any type. We've had favorable Medicaid payments. ..... Nursing homes begged to be taxed last year and new R governor refused.
NEW YORK	New York State has instituted a number of provider taxes on various providers including hospitals, nursing homes, diagnostic and treatment centers, home care and personal care providers. The state's share of Medicaid spending is legislatively capped at $15.3B, $15.9B, and $16.6B in states fiscal years 2011-12, 2012-13 and 2013-14 respectively. The collections from provider taxes are somewhat fungible and have been used to offset potential cuts to the Medicaid program and to supplement funding for various health initiatives including subsidies for children and family purchase of health insurance, Indigent Care pool, (Medicaid DSH), etc..
	The provider taxes on hospitals include: a 0.35% inpatient and outpatient gross receipts tax (approx. $170M), 1% inpatient assessment (approx.$370M) and a $30 million dollar quality contribution assessed on inpatient obstetric services. In addition, there is also a surcharge on inpatient and outpatient cash receipts based on payer (excluding Medicare) on hospitals and diagnostic and treatment centers (approx. $2.7B). Many of these provider taxes are decades old and in the case of the gross receipts tax and surcharge have been assessed at different rates over time. Both voluntary and public hospitals are subject to these provider taxes.
	Some of these provider taxes are set to sunset with NYS's Health Care Reform Act (our payment system essentially) on March 31, 2014. NYS current FMAP is 50%. All of the hospital provider taxes above where first affective when NYS FMAP was 50% . The time it took for CMS approval for the implementation of these provider taxes varied. Almost all of them were controversial in their initiation and in subsequent redistributive iterations over time. Unfortunately, at this point without them we would have widespread policy and delivery chaos. Recovering from the potential unconstitutionality of the ACA would be a walk in the park compared to the implosion of the payment system here should the provider taxes in NYS significantly shrink.
OHIO	
OKLAHOMA	
PA	* Hospitals that are exempt from the statewide hospital assessment include state-owned psychiatric hospitals, private psychiatric facilites, long term acute hospitals and federally designated CAHs.
S. DAKOTA	We have always been opposed although there are some members that from time to time become enamored with the proposal. As so many states have shown, the amount of funding left for the hospitals tends to slip away relatively quickly, either to other parts of the budget or other Medicaid provider groups. Hopsitals' percent of costs covered is approximately 70%.

State	COMMENTS
TENNESSEE	
UTAH	
VERMONT	*Our assessment comes back entirely to us and employed docs either in the form of rate increases and a DSH payment. None of the assessment goes to other parts of Medicaid or our general fund.
	Originally implemented in 1992 but has changed a lot in last five years. We are in the FL and NH camps, recognizing…that if these taxes went entirely away, our hospital and physician payments would be annihilated. Since HI is obviously funding you currently without yet relying on taxes, I would resist the temptation. If not, eventually you and your staff will be spending a lot of time on formulas, hold harmelss analyses and ugly member "fairness" issues.
VIRGINIA	
WASHINGTON	I would be a lot more cautious about a provider tax if we could do it again. We are using it to support rates rather than a supplemental payment program and it is much too complicated. It would be a lot easier if hospitals just got a fixed sum of money. On top of that, the legislature raided our tax plan and took a large amount of the anticipated increase after the first year. It hasn't turned out as anticipated, to put it mildly.
WEST VIRGINIA	West Virginia has a base provider tax for all private hospitals at 2.5% of gross patient revenue (net of adjustments as specified in WV law) that has been in place for several years. Our tax goes to the state tax department, it is then transferred to Medicaid and then Medicaid uses the tax funds to generate federal match funds which are utilized to operate the Medicaid program with all provider types. There is not any money taken off the top, etc. Physicians were included in the provider tax, but due to an uproar by them several years ago, they were phased out over a 10 year period that ended in 2010. Nursing homes pay a tax of 5.5%
	We are currently in the process (pending) with CMS of implementing a UPL program for our privately owned PPS hospitals. It is a tax of 0.88% of gross patient revenue (net of adjustments similar to the general provider tax) that will be paid for a two year period (will be retroactive to July 1, 2011) and will run through June 30, 2013. The state will pay our hospitals the entire net tax benefit over the two years via eight quarterly payments. The tax is paid only on fee-for-service day, and Medicaid managed care is excluded.
	The UPL State Plan Amendment was submitted to CMS in September 2011; we received questions from CMS before the 90 day deadline; we submitted our responses in early January; and we received one more question related to our calculations late March.
	We are dependent on [it]; we don't like it, but we depend on it. And we know it is likely to be short-lived or reduced significantly.
WISCONSIN	Our program has worked well for 4 years but concur with skepticism regarding sustainability, as institutional memory fades quickly and new issues emerge….And maintaining integrity of payouts will likely be threatened by move toward managed care.