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M E M O R A N D U M

Summary of Federal Limitations on Provider-Specific Taxes and Historical Overview of the Kentucky Provider Tax

(Provided on behalf of Balanced Health Kentucky, Inc.)

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I. Federal law governing provider-specific taxes.

Congress recognized that a number of states, including Kentucky, had attempted to work around the federal requirement that states make contributions to the Medicaid program in order to obtain federal Medicaid matching funds by imposing "taxes" on healthcare providers and then effectively returning these same funds to these same providers, supplemented by the federal matching funds. To curb this practice, Congress enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234). This federal act permits states to impose any provider-specific taxes they wish. **However, revenue generated by impermissible healthcare related taxes received by a state or local government will be deducted from a state's expenditures for medical assistance before calculating the federal match.** The statutory limitations on healthcare related taxes are found at 42 U.S.C. § 1396b(w), and the accompanying regulations can be found at 42 C.F.R. Part 433.

Healthcare-related taxes must be "broad-based" and "uniform."

In order for tax revenues to be used to draw down federal Medicaid matching funds, a "**healthcare-related tax**" must be a "**broad-based health care related tax**." To be a "broad-based health care related tax", the tax must be (1) broad-based; (2) uniform; and (3) not hold providers harmless for the amount of tax paid.

"Healthcare-related tax" is defined 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. It includes taxes that are not limited to health care items or services but provide for different or unequal treatment for individuals or entities that are paying for or providing health care items or services.

A tax is "**broad-based**" if it is imposed on all non-Federal, nonpublic providers of a specified class of "**health care items or services**." (A tax cannot be limited to just Medicaid providers.) The term "**health care items or services**" is not defined by federal law (either the statute or its implementing regulations).

A tax is "**uniform**" if the same tax is imposed on all providers of a specified class of "health care items or services."

States cannot hold providers harmless for the cost of the provider taxes (i.e., they cannot guarantee that providers receive their money back). Federal regulations describe three tests (a positive correlation test, a Medicaid payment test and a guarantee test) that are applied to provider taxes to determine whether providers paying the tax are held harmless. Taxes that fail any of these tests are determined to have a hold harmless provision in violation of the law. Federal regulations create a safe harbor from the guarantee test for taxes where collections are six percent (6%) or less of net patient revenues.

Waivers of broad-based and uniform requirements

The Secretary of Health and Human Services is authorized to waive the broad-based and uniform requirements. In order to waive either requirement, a state must prove that the net impact of the tax is "generally redistributive" and the amount of the tax is not directly correlated to Medicaid payments. (Rural and sole community providers are expressly cited as allowable exemptions to both the broad-based and uniform requirements with Secretary approval.) The prohibition on hold harmless provisions cannot be waived.

Specified classes of health care items and services

For purposes of the "broad-based" and "uniform" requirements, federal law specifies **eighteen (18) classes** of health care items and services that each are considered to be a **separate class** for purposes of the broad-based and uniform requirements for taxes:

	Class	Authority/Basis
1	Inpatient hospital services	Federal statutory class 42 U.S.C. § 1396b(w)(7)(A)(i)
2	Outpatient hospital services	Federal statutory class 42 U.S.C. § 1396b(w)(7)(A)(ii)
3	Nursing-facility services	Federal statutory class 42 U.S.C. § 1396b(w)(7)(A)(iii)
4	ICF-MR	Federal statutory class 42 U.S.C. § 1396b(w)(7)(A)(iv)
5	Physicians' services	Federal statutory class 42 U.S.C. § 1396b(w)(7)(A)(v)
6	Licensed home-health-care-agency services	Federal statutory class 42 U.S.C. § 1396b(w)(7)(A)(vi)

	Class	Authority/Basis
7	Outpatient prescription drugs	Federal statutory class 42 U.S.C. § 1396b(w)(7)(A)(vii)
8	Services of managed care organizations	Federal statutory class 42 U.S.C. § 1396b(w)(7)(A)(viii)
9	Ambulatory surgical centers services	Federal regulatory class as to facility services (not surgical procedures) 42 C.F.R. § 433.56(a)(9)
10	Dental services	Federal regulatory class 42 C.F.R. § 433.56(a)(10)
11	Podiatric services	Federal regulatory class 42 C.F.R. § 433.56(a)(11)
12	Chiropractic services	Federal regulatory class 42 C.F.R. § 433.56(a)(12)
13	Optometric services	Federal regulatory class 42 C.F.R. § 433.56(a)(13)
14	Psychological services	Federal regulatory class 42 C.F.R. § 433.56(a)(14)
15	Therapeutic/therapist services	Federal regulatory class 42 C.F.R. § 433.56(a)(15)
16	Nursing services	Federal regulatory class 42 C.F.R. § 433.56(a)(16)
17	Other laboratory and x-ray services	Federal regulatory class 42 C.F.R. § 433.56(a)(17)
18	Emergency ambulance services	Federal regulatory class 42 C.F.R. § 433.56(a)(18)

Other classes of health care items and services

Federal law does not provide any guidance as to how to classify other "health care items or services" or providers of other "health care items or services" for purposes of these federal restrictions. Health care insurance premiums and HMO premiums are not considered to be payment for "health care items and services." See 42 C.F.R. § 433.55(e). Accordingly, taxes on health care insurance premiums and HMO premiums are not subject to these federal restrictions.

II. Historical overview of Kentucky Provider Taxes

A. 1990 – HICAP Hospital Assessments

The Kentucky Health Care Reform Act of 1990 established the Hospital Indigent Care Assurance Program ("HICAP"). The HICAP was a hospital indigent care program funded by

provider assessments on acute care hospitals (excluding inpatient psychiatric and rehabilitation facilities) and federal Medicaid matching funds. The HICAP was intended to serve as a disproportionate share (DSH) program under the SSA.

HICAP was funded by an annual assessment on all acute care hospitals (excluding inpatient psychiatric and rehabilitation facilities) and federal Medicaid matching funds. The Department for Medicaid Services calculated an assessment rate of 0.5% to 1.0% on all hospitals' costs for services to patients (based on Medicaid cost reports) that would generate the maximum amount that could be used to draw federal Medicaid matching funds. Hospitals remitted the assessments in quarterly installments which were deposited in the hospital indigent care trust fund (later renamed the Medicaid assessment revolving trust fund or "MART"), a special state fund. Of those assessments, $1 million was held in the fund as a contingency reserve.

The Department also determined an "indigent care factor" for each hospital. The factor was a percentage calculated as the hospital's total inpatient days covered by Medicaid in relation to the total number of such days of all hospitals' covered by Kentucky's Medicaid program. Each hospital was entitled to receive from the fund an amount equal to its indigent care factor multiplied by the total amount in the fund, including assessments plus federal Medicaid matching funds. These payments were in addition to the regular payments to hospitals under Kentucky's Medicaid program. The Department distributed the payments to each hospital quarterly within thirty days of the hospital's assessment payment.

The $1 million contingency reserve was used for "hold harmless" payments. If any hospital's assessment exceeded the amount it received from the fund, the Department was required to pay from the contingency reserve "an amount sufficient to bring the hospital's total payment under the program up to the assessment amount." Former KRS 205.575(7)(c). The hold harmless amount was later increased to include an additional $100,000.

The 1991 General Assembly later raised the cap on assessments to 5% and imposed assessments on nursing facilities, community health clinics, home health agencies, primary care centers, federally qualified health centers, mental hospitals, physicians, dentists, optometrists, pharmacies and any other providers qualified to participate in Kentucky's Medicaid program and receiving reimbursement based on cost. As with hospitals, these assessments were to be returned to providers and had a hold harmless regime.

Kentucky's HICAP assessments constituted a prohibited "hold harmless" provision under the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234).

B. H.B. 1 (1993) – Temporary Provider Tax: <u>Broad Tax</u>

Responding to the new federal restrictions, the Kentucky General Assembly enacted H.B. 1 (1993) which repealed HICAP and enacted the provider taxes. The stated intent of the bill was to tax "all health care items and services permitted to be taxed under federal law, except those classes that include any provider groups that are prohibited by state law from participating in the state medicaid program." H.B. 1 imposed the following new provider taxes:

1. Hospital Services and other Health Care Items or Services (2.5% of gross receipts tax): Impose a tax of 2.5% of gross revenues received by all "hospitals" for the provision of "health care items or services" or "hospital services." "Hospital" was defined to mean to mean an acute care, rehabilitation or psychiatric hospital licensee under KRS Chapter 216B. **"Health care items or services"** were defined as items or services against which the state is permitted to impose a provider tax pursuant to federal legislation or regulation. **"Hospital services"** was defined to mean all inpatient and outpatient services provided by a hospital, excluding the dispensing of prescription drugs on an outpatient basis by hospital pharmacies licensed separately. Hospital services did not include services provided by a noncontracted, university-operated hospital, or hospitals operated by the federal government, if necessary waivers were obtained by the Cabinet for Human Resources form the Health Care Financing Administration. **"Inpatient hospital services"** and **"outpatient hospital services"** were as defined by federal regulation pursuant to 42 U.S.C. § 1302.

2. Nursing facility services; intermediate care facility services for the mentally retarded; physician services; home health care services; HMO services; and any other specific health care items or services that federal legislation or regulation permits the state to tax (as specified by state administrative regulation)(2.0% of gross receipts tax): Imposed a provider tax of 2.0% of the gross revenues received by each "provider" for the provision of health care items or services, excluding gross revenues received for dispensing outpatient prescription drugs (subject to the prescription tax below). Taxable providers included individuals or entities but excluded facilities operated by the federal government.

3. Pharmacies/Prescriptions ($0.25 per prescription tax): Imposed a provider tax on in-state pharmacies and out-of-state pharmacies doing business in Kentucky of $0.25 per prescription upon outpatient prescription drugs for which delivery is taken in this state.

4. Other taxes to be included by regulation: Authorized the Secretary for the Cabinet for Human Resources to add additional classes of health care providers to the list of those already subject to the tax if additional classes are later added to those specified by federal law.

No passthrough of the tax: Providers, including pharmacies, were prohibited from passing these taxes on to the recipient of the taxable items or services. Pharmacies were authorized to pass the prescription tax on to insurers, HMOs and non-profit hospital, medical-surgical, dental and health service corporations.

Charitable providers exempted: "Charitable hospitals" and "charitable providers" were from these taxes. Charitable hospitals and providers were defined to mean any hospital or provider which did not charge its patients for health care items or services, and which did not seek or accept Medicare, Medicaid, or other financial support from the federal government or any state government.

The Secretary of the Cabinet for Human Resources was required to annually review the provider tax rates and revenues generated thereby and adjust tax rates upward or downward as necessary to ensure full federal financial participation in Kentucky's Medicaid program, subject to a maximum rate of 6% of gross revenues and $0.35 per prescription.

H.B. 1 provided that the new taxes it levied would expire the earlier of 90 days after the last day of any special session of the General Assembly addressing the issue of health care reform, or 90 days after the last day of the 1994 regular session.

C. H.B. 250 (1994) – Current Provider Tax: Narrow Tax

H.B. 250 (1994) repealed and replaced H.B. 1 (1993) with a new provider tax regime that still exists today. The class of taxable providers under H.B. 250 was not coextensive with federal law, instead taxing on a special subclass of the healthcare industry. H.B. 250 imposed the following provider taxes:

1. Hospitals (2.5% of gross receipts tax): Imposed a tax on "providers" of 2.5% of the gross revenues received for the provision of hospital services, excluding revenues from dispensing outpatient prescription drugs separately subject to tax (discussed below). **"Provider"** was defined to mean any person receiving gross revenues for the provision of "health care items or services" in Kentucky, excluding any facility operated by the federal government. **"Hospital services"** were defined to mean all "inpatient and outpatient services" provided by a "hospital", excluding services provided by a noncontracted university-operated hospital or any freestanding psychiatric hospital, if necessary waivers were obtained from HCFA, or hospitals operated by the federal government. **"Hospital"** was defined to mean an acute care, rehabilitation, or psychiatric hospital licensed under KRS Chapter 216B. **"Inpatient hospital services"** and **"outpatient hospital services"** was as defined in federal regulations.

2. Other providers (2% of gross receipts tax): Imposed a tax on "providers" of 2% of the "gross revenues" received for the provision of the following services:

- Nursing facility services;
- Intermediate care facility services for the mentally retarded;
- Physician services;
- Licensed home health care services; and
- HMO services.

Revenues from dispensing outpatient prescription drugs were exempt if separately subject to the provider tax on outpatient prescription drugs (discussed below). This 2% tax, as opposed to the 2.5% tax levied by KRS 142.303, was to apply to freestanding psychiatric hospitals if necessary waivers were obtained from HCFA. A waiver was also need for the HMO tax. According to the Kentucky Department of Revenue ("KDOR"), neither waiver was obtained.

3. Prescription drugs ($0.25 per prescription tax): Imposed a tax on pharmacies and other "providers" (as defined above) "dispensing" or delivering in a suitable container outpatient prescription drugs within the state are subject to a provider tax of $0.25 per prescription. **"Dispensing"** is defined to mean to deliver one or more doses of a prescription drug for use by a patient or other individual entitled to receive the prescription drug.

H.B. 250 (1994) continued to exempt "charitable providers" from these taxes.

D. 1996 Repeal of the Provider Tax on Physician Services (eff. July 1, 1999).

In response to intense lobbying efforts by physicians, the 1996 General Assembly repealed the provider tax on physician services effective June 30, 1999. The tax rate was phased down over a three year period – 1.5% beginning August 1, 1996; 1% beginning July 1, 1997; 0.5% beginning July 1, 1998; and no tax beginning July 1, 1999.

E. 1998 Repeal of the Provider Tax on Prescription Drugs (eff. July 1, 1999).

The 1998 General Assembly repealed the provider tax on prescription drugs beginning July 1, 1999.

F. 2004 and 2005

1. Levy of Bed Taxes on Nursing Facility Services (eff. July 1, 2004).

The 2004 and 2005 General Assemblies repealed the 2% gross receipts tax on nursing facilities and replaced it with a number of bed taxes on "nursing facility services." **"Nursing facility services"** was defined to mean services provided by a licensed skilled-care facility, nursing facility, nursing home, or intermediate-care facility, excluding services provided by intermediate-care facilities for the mentally retarded and services provided through licensed personal care beds. The taxes were imposed as follows:

Non-hospital based nursing facilities: Imposed a single assessment on nursing facilities that are provided at a non-hospital based facility with total bed capacity of 60 or fewer beds of a maximum of 1% of the average daily revenue per patient bed applied to actual non-Medicare patient bed days.

Hospital based nursing facilities: Imposed a tax on nursing facilities provided at a hospital-based nursing facility of a maximum of 2% of the average daily revenue per patient bed applied to actual non-Medicare patient bed days.

Other nursing facilities: Imposed a tax of a maximum of 6% of the average daily revenue per patient bed applied to actual non-Medicare patient bed days by each nursing facility.

These tax rates are to be adjusted by the Department for Medicaid Services annually subject to the statutory maximums. State veterans' nursing homes were excepted from these additional taxes. These taxes were levied to fund additional reimbursements for nursing facility services. These taxes were contingent upon obtaining the necessary waiver from HCFA. According to the KDOR, the necessary waivers were obtained.

2. Levy of Taxes on Intermediate Care Facility Services for the Mentally Retarded and Services Provided Through the Supports for Community Living Waiver Program (eff. July 1, 2004)

The 2005 General Assembly imposed a tax of 5.5% on gross receipts received by each provider of for the provision of intermediate care facility services for the mentally retarded and the provision of services through, or identical to those provided under, the Supports for Community Living Waiver Program. These taxes were contingent upon obtaining the necessary waiver from HCFA. According to the KDOR, the necessary waivers were obtained.

G. 2005 Additional Tax Levied on MCOs.

The 2005 General Assembly imposed a tax of 5.5% of gross revenues from services provided by Medicaid managed care organizations. This tax was contingent upon obtaining the necessary waiver from HCFA which was granted.

As amended in 1997, 42 U.S.C. § 1396b(w)(7)(A)(viii) identified as a class of health care items and services for purposes of state healthcare taxation services of Medicaid managed care organizations. Congress further amended this class in 2005 amended 42 U.S.C. § 1396b(w)(7)(A)(viii) to change the permissible taxable class to all managed care organizations. To comply with this change, Kentucky ceased collecting the tax on Medicaid managed care organizations as of September 30, 2009.

H. 2006 Hospital Provider Tax Capped.

The 2006 General Assembly included a provision in the 2006-2008 Executive Branch Budget that provided for the 2006-2008 biennium that that hospital provider tax collections in for the 2005-06 state fiscal year shall not be less than $180 million. The provision also provided that hospitals shall pay as provider tax for each of the 2006-07 and 2007-08 state fiscal years the amount of provider tax they paid in the 2005-06 fiscal year.

The 2007 General Assembly later codified this regime, amending KRS 142.303 to provide that hospitals in operation in the 2005-06 state fiscal year would continue to pay tax in future years only on their 2005-06 gross revenues. Hospitals not in operation in the 2005-06 state fiscal year remained subject to tax of 2.5% of their gross revenues received.

I. Kentucky Provider Tax Revenue By Class (FY 2017)

For its fiscal year ended June 30, 2017, Kentucky collected approximately $296 million in provider taxes from the following classes of providers of healthcare items and services:

	Class	Taxes Paid	% of Total
1	Hospitals (inpatient and outpatient hospital services)	$182,021,080	61%
2	Nursing-facility services	$80,786,694	27%
3	Supports for Community Living	$16,753,443	6%
4	ICF-MR	$8,463,045	3%
5	Licensed home-health-care-agency services	$8,198,558	3%
6	Physicians' services	$0	0%
7	Outpatient prescription drugs	$0	0%
8	Services of managed care organizations	$0	0%
9	Ambulatory surgical centers services	$0	0%
10	Dental services	$0	0%
11	Podiatric services	$0	0%
12	Chiropractic services	$0	0%
13	Optometric services	$0	0%
14	Psychological services	$0	0%
15	Therapeutic/therapist services	$0	0%
16	Nursing services	$0	0%
17	Other laboratory and x-ray services	$0	0%
18	Emergency ambulance services	$0	0%
	Total:	**$296,222,820**	**100%**

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