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Medicaid
Medicaid Provider Tax

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I. INTRODUCTION

There continues to be only limited activity in the area of provider taxes during 2018. Below are summaries of the few legislative actions.

II. FEDERAL ACTIONS

NEWS

States' Use of Provider Taxes Requires Increased Oversight

The U.S. Government Accountability Office (GAO) determined that healthcare provider taxes used to fund Medicaid warrant stricter oversight by the Centers for Medicare & Medicaid Services (CMS). It was estimated that healthcare providers paid $19 billion in provider taxes in fiscal year 2012, nearly double the amount in 2008.

The federal government is concerned about the cost-shifting effects of the provider taxes. The taxes are used as a way for states to avoid drawing from their general funds to support Medicaid. The states use the provider taxes as a way to increase Medicaid payments, thus leading to an increase in the amount the federal government has to pay.

For example, Illinois enacted a bed tax for nursing facilities. This bed tax led to a $220 million payment increase for nursing facilities which resulted in an estimated $110 million increase in federal matching funds and no increase in state general funds. The nursing facilities saw a net payment increase, after pay the taxes, of $105 million.

In 2010, California increased the existing provider tax imposed on skilled nursing facilities which resulted in an $80 million increase in federal matching payments for the state and a net payment increase of $69 million for skilled nursing facilities.

As a result of the increased provider taxes, the cost of financing Medicaid is being shifted from the states to the federal government and in turn benefiting the providers at the cost of the federal government. CMS is tasked with overseeing compliance with current limits and requirements on financing of the nonfederal share. The GAO recommended that CMS improve their data collection to ensure that states report accurate and complete data on all funding sources used to finance the nonfederal share of Medicaid payments. [FN1]

GAO Report Says Provider Tax is Shifting Medicaid Responsibility to Federal Government

The Government Accountability Office's (GAO) report on the challenges facing the Medicaid program found that the provider taxes are pushing more and more of the financial responsibility onto the federal government. According to federal law, states are required to “finance at least 40% of the nonfederal share of total Medicaid expenditures each year.” The provider tax is used to gain federal matching dollars to help offset the costs of Medicaid. GAO reports that in one year a state received an estimated “$110 million increase in federal matching funds” without increasing their share. GAO also reports that the Centers for Medicare and Medicaid Services (CMS) does not require states to report on the funds they use to finance Medicaid. It is GAO's recommendation that CMS obtain “improved data” on state financing of Medicaid. [FN2]

III. STATE ACTIONS

NEWS

Arizona's Hospital Fee Upheld

The Arizona Supreme Court unanimously upheld the fee on hospitals used to expand the state's Medicaid. The Supreme Court decision also affirmed “that the hospital assessment used to pay for the expansion is not a tax that requires a two-thirds legislative majority to impose. [FN3] ” The hospital assessment is not a tax because it is “not prescribed by formula, amount or limit.” [FN4]

Maricopa County Superior Court Judge Douglas Gerlach upheld the fee on hospitals. [FN5] The fee was established in 2013 by Arizona Health Care Cost Containment System, with the approval of then Governor Brewer and the support of the Arizona Hospital and Healthcare Association, as a way to fund Medicaid expansion following the enactment of the Affordable Care Act. [FN6] This decision was only made possible after the Arizona Supreme Court ruled that the case could move forward after hearing arguments on whether the lawmakers had standing to challenge the fee and Medicaid expansion. [FN7]

The state lawmakers argued that the Arizona Constitution requires that new taxes or tax increases require a two-thirds vote in both houses in order to take effect and that allowing the hospital tax would create a loophole in the law. However, the lawyer representing Governor Ducey argued that it is a fee and not a tax imposed on the hospitals because taxes are imposed across the board and only a small portion of hospitals are having the fee imposed upon them. [FN8]

The hospitals have reaffirmed that they are in favor of the fee as it has netted them additional payments that would not have been available. According to the Arizona Health Care Cost Containment System, the hospitals “received $488 million in payments for previously uninsured Medicaid beneficiaries” while only paying in $143 million. [FN9]

CMS Gives Arizona Approval to Assess Hospital Fees

In September of 2013, Arizona requested permission to tax hospitals for the purpose of gaining federal matching funds. Many of the hospitals agreed to the tax in the hope that it would help cover uncompensated care. However, short-term specialty hospitals, small psychiatric hospitals, rehabilitation facilities, state owned hospitals, and hospitals owned by a Native American tribe are exempt from the hospital assessment. [FN10]

Arizona Establishes Hospital Tax to Fund Medicaid Expansion

Associated Press reports Arizona Gov. Jan Brewer signed a bill which imposes a hospital tax to raise revenue to support Medicaid expansion. [FN11] AP reports Gov. Brewer is the first governor to propose a stand-alone hospital tax designed specifically to fund the Medicaid expansion. [FN12] The federal government caps the tax at 6 percent of hospital revenues. All but 11 states already use some form of hospital tax. Of the 39 with a tax already in place, nearly all have room to increase them to the 6 percent maximum.

City of Mesa to Impose “Access to Care” Tax

The Mesa City Council is seeking to keep Mesa hospitals from closing by implementing an “access to care” tax. The tax would require all hospital's in Mesa to “pay the city $461.91 for every patient they discharge through Dec. 31.” The money from the tax would be used to obtain matching funds from the federal Medicaid program. The federal Medicaid matching funds could bring in “reimbursement equal to twice the amount of the tax.” [FN13]

Phoenix Gets Federal Approval to Tax Local Hospitals

Associated Press reports that Phoenix received federal approval to tax local hospitals. [FN14] The tax will be used to increase the amount of federal dollars that Phoenix receives under the state's Medicaid program. AP reports that the tax “is expected to generate about $200 million in federal matching funds.”

Hospitals Ask Tucson City Council to Tax Them; Tucson Agrees, but Federal Government Says “No.”

Tucson hospitals have asked the city council to tax them to generate federal Medicaid matching funds. [FN15] The tax would be based on patient revenues and would have the potential to generate $70 million in federal Medicaid funds. This money would be used to offset the cost of uncompensated care to uninsured and low-income residents in Tucson.

Tucson City Council voted to tax 8 Tucson Hospitals in an effort to bring in an estimated $70 million in addition revenue. The U.S. Centers for Medicare & Medicaid Services denied Tucson's proposal. [FN16]

Phoenix Hospital Suit Targets Arizona Hospital Assessment

The Goldwater Institute filed a lawsuit to block the hospital assessment from going into effect in January 2014. Goldwater Institute argues that the hospital assessment “violated the separation-of-powers provision in the state Constitution by delegating its taxing authority to the director of the Arizona Health Care Cost Containment System.” [FN17] Arizona Governor Jan Brewer's administration argued that this is an assessment and not a tax and thus “didn't need a two-thirds vote.”

Arizona High Court to Hand Down Medicaid Expansion Ruling

AP Alerts, 11/17/2017, “Arizona high court to hand down Medicaid expansion ruling” The Arizona Supreme Court is set to release a decision on whether or not the Medicaid hospital fee is actually a tax which would require a 2/3 majority vote under the 1992 Constitutional amendment.

Arizona Supreme Court Upholds State's Medicaid Expansion

The Hill, November 17, 2017 “, in a unanimous decision, the Arizona Supreme Court stated that the Medicaid expansion is constitutional. The question before the court was whether or not the expansion was a tax and would therefore require a 2/3 majority vote in the legislature.

California Hospital Tax May Go to Reserve

California Healthline reports that the state budget proposed by California Gov. Jerry Brown extends the Hospital Quality Assurance fee, which is due to expire at the end of 2013. [FN18] The complicated fee structure was originally planned to gather about $2.8 billion from private hospitals over the 30-month life of the fee. Some of the money is used to tap federal matching money, which benefits both hospitals and the state.

The state estimates extending the fee would add $310 million to the state's general fund in fiscal year 2013-14. Private hospitals are urging the state to use the money on healthcare services rather than placing it into a general fund reserve. The extension must be approved by the Legislature in a separate bill from the budget.

Proposal Would Change Where Hospital Assessments are Held

Colorado hospitals pay a hospital tax that is intended to offset indigent care costs and to obtain matching dollars from the federal government. However, currently the revenue generated from the Colorado hospital tax is included in the general fund. Under Governor Hickenlooper's proposal, the hospital tax would be isolated in an enterprise fund and would be used to expand coverage for the uninsured. [FN19]

Governor's Budget Increases Hospital Tax

Connecticut Governor Malloy's budget plan calls for an increase to the hospital tax. The plan would increase the tax by $165.3 million. The hospitals would receive $96 million back in 2015 and all of the $165.3 million in during 2016 and 2017. [FN20]

Connecticut Hospitals Wary of Tax Raise

Governor Malloy and legislatures 2015-2016 budget calls for raising taxes on hospitals. The increased tax would result in $321 million in additional taxes on hospitals. The budget proposes using the funds to gain additional federal Medicaid assistance and giving it back to the hospitals. However, the hospitals don't believe that they will see a return on their tax. In 2011-2012, Connecticut imposed a $350 million tax on hospitals and initially the hospitals did receive payments, but gradually the payments have been reduced to $96 million per year. [FN21]

Connecticut Hospitals Challenge Tax

Twenty Connecticut hospitals petitioned the Centers for Medicare and Medicaid Services arguing that the state is operating an “illegal reimbursement scheme.” Connecticut established the hospital tax in 2011 as a way to get the state more federal money. The hospitals argue that the tax has continuously been increased but that the reimbursement to the hospitals is not being increased at the same rates. This fiscal year, the hospitals are expected to lose more than $400 million from the net on the tax and reimbursement. The hospitals ask CMS to prevent “any changes to the state's Medicaid plan that would reduce reimbursement rate to hospitals” and to “limit the amount of money from health care taxes that can be used for purposes other than health care.” [FN22]

Governor Withholds Millions in Supplemental Payments to Hospitals

Connecticut Governor Malloy asked the Department of Social Services to hold off making supplemental payments to hospitals. This action will result in nearly $140 million in lost payments to Connecticut hospitals. The reduction is going to leave hospitals with just $22 million in tax reimbursement payments this year, which is only 4% of what they paid. This tax cut is being used to offset a general deficit in Connecticut. The Connecticut Hospital Association argued that this action will adversely affect patients. [FN23]

Hospital's Want Hospital Tax Eliminated

Connecticut hospitals are seeking to have the hospital tax eliminated. The hospital tax was established in 2011 and updated in 2012. The hospitals claim that the tax now exceeds the amount they are being reimbursed. The hospitals are seeking to have the hospital tax phased out over a number of years. [FN24]

Hospital tax plan remains uncertain: Malloy wants lawsuit settled before deal done

The Bulletin (Norwich, CT), 10/01/2017, After discussions between hospitals and the State, hospitals have agreed with the changes to the provider tax. However, hospitals want this change to happen sooner rather than later, whereas the State wants to settle a pending lawsuit before the implementation of the change.

Deal on Budget Soon to be Reached

The Hartford Courant, published 10/11/2017, Speaker Touts Budge Progress Says Lawmakers Likely to Agree on Deal Soon STATE FINANCES, lawmakers have made strides towards a new budget that would increase the hospital provider tax from 6% to 8%. Although nothing has been signed, both parties are confident in their ability to make an agreement.

$41.3 Billion Plan Malloy Signs Most of Budget Bill Governor Vetoes Section on Hospital Tax

Hartford Courant, published 11/01/2017, the Governor of Connecticut has approved the new budget, however has vetoed the section which would raise the hospital tax from 6% to 8%. Senate Republican Leader Len Fasano expects legislators to return to Hartford to either re-work the hospital tax language or to over-rule the Governor's veto.

Florida Hospitals Split on Proposed Tax Increase

Governor Scott proposes raising the Public Medical Assistance Trust Fund (PMATF). The PMATF is a tax on hospitals' net revenues; it assesses a 1.5 percent tax on inpatient care and a 1 percent tax on outpatient care. Governor Scott plans to use the tax to fund Medicaid expansion and sought Florida's hospitals' opinions on the matter. The for-profit Hospital Corporation of Americas is in favor of raising the taxes on hospitals. [FN25] However, the Florida Hospital Association is opposed to the tax increase, but does believe that Medicaid should be expanded, just not at the hospitals' expense. [FN26]

Florida's 2011 Medicaid Reform Has “Tiering” Effect on Hospital Reimbursements

In 2011, Republicans initiated a Medicaid overhaul and included a provision to better distribute $1 billion in federal Medicaid matching funds. The provision intended to find a more equitable way to distribute the funds. However, hospitals are now seeing that the distributions are having a “tiering” effect. [FN27]

Miami-Dade hospitals will see a reduction in $218 million in Medicaid matching funds, $140 million of which will come from one hospital alone. These funds are going to be sent to other areas within the state. Thus, the funds that are raised in Miami-Dade County are being sent to other counties that did not raise their own funds.

The provision creates 3 tiers that will come into effect in July 2014. The first tier of funds goes to “children's hospitals, teaching hospital and rural hospitals that serve large numbers of Medicaid patients.” The second tier has two requirements for the hospitals, “they must be located in a county that raises healthcare funds, and more than 9 percent of their patients must be on Medicaid.” The third tier is for hospitals that do not meet the requirements of the first two tiers but who serve Medicaid patients.

Georgia Hospitals Battle Over Bed Taxes

The Atlanta Journal-Constitution reported that Piedmont Healthcare and Children's Healthcare of Atlanta — two of Georgia's hospital power players –have been battling this fall over a law that taxes them and every healthcare system in the state. [FN28]

The two are at odds over the state's “bed tax” — a fee that Georgia hospitals pay to help prop up the state's Medicaid program. Hospitals pay the bed tax to the state, and the state sends the money back to them according to the level of Medicaid care they provide. The scheme has meant millions in revenue for Children's and millions in losses for Piedmont; that's because 55 percent of patients at Children's Healthcare are on Medicaid; at Piedmont Hospital in Buckhead, the total is less than 3 percent.

The hospital provider fee comes up for renewal in the next session of the Legislature. The central question: Should hospitals that don't see a heavy load of Medicaid patients help pay the costs of the hospitals that do?

Children's argues yes; Piedmont argues no — at least not as it's currently set up. And though they have been the most visible combatants on the issue, hospitals across Georgia stand to gain or lose millions depending on the outcome. In metro Atlanta, Grady Memorial Hospital and DeKalb Medical Center also see a windfall from the bed tax, but the fee acts as a financial drain on St. Joseph's, Emory University Hospital and Northside Hospital as well as Piedmont.

The Georgia Hospital Association is prodding hospitals to sign off on a compromise that will enable it to present a united front in favor of the fee to the Legislature. And though few legislators like the idea of renewing any tax, many believe the fee is too important to the state budget to do away with it.

In the 2011 fiscal year, the state collected $215 million in fees from hospitals, which brought in an additional $590 million in federal dollars for the Medicaid program, according to the Georgia Department of Community Health.

The General Assembly authorized the fee for three years, so it will phase out at the end of June unless the Legislature reauthorizes it.

Governor Signs Georgia Bed Tax Bill

The Atlanta Journal-Constitution reports Gov. Nathan Deal signed the hospital bed tax bill on February 13, averting a $700 million hole in the state's healthcare budget. [FN29]

The measure, Senate Bill 24, helps guarantee a stream of funding for the next four years for Medicaid, the government's health care program for the poor. The so-called “bed tax” requires hospitals to pay 1.45 percent of their net patient revenue. The state then uses

that money to draw roughly $450 million in federal matching dollars. Without the fee, hospitals would face Medicaid reimbursement cuts of 20 percent or more.

Anti-tax groups in Georgia and beyond have criticized the move, which was seen by some as an early Valentine's Day gift to lawmakers who were eager to avoid a vote on extending what some saw as a tax. Instead, the bill transfers the power to levy the fee from lawmakers to the state Department of Community Health.

Georgia Set for Bed Tax Debate

A major issue for the Georgia legislature this session is the hospital provider fee which is set to expire in 2017. Georgia receives “an estimated $280 million each year from its hospitals by levying a 1.45% tax on net profits [FN30] ” which is then used to drawn down federal matching funds. Hospitals with high amounts of Medicaid patients are in favor of keeping the tax. However, anti-tax activists with the Americans for Tax Reform are opposed to any tax increases.

Nursing Home Must Pay Bed Tax

In a 7-0 decision, the Illinois Supreme Court ruled that a nursing home must pay the bed tax even though it does not receive a benefit. Illinois requires every nursing home provider to pay a $1.50 fee for each licensed nursing bed and Eastern Star was sent a bill for failure to pay the tax dating back to 1993. [FN31] Eastern Star argued that they should not have to pay the bed tax because they do not accept any government funding or subsidies, including Medicaid. The State argued, and the Court agreed, that the purpose of the bed fee is not simply to fund Medicaid-related expenditures. The Court also stated that a taxpayer does not always receive a benefit from the tax paid. [FN32]

Judge Declines to Block Medicaid Managed-Care Transition

Iowa Hospital Association's request for an injunction against the state's plan to transition the Medicaid program to a private managed-care model was denied. The hospitals argued that the state's private-management plan would illegally use money from a trust fund set up with contributions from hospitals. The trust fund, which collects nearly $35 million annually from hospitals, is designed to obtain matching federal Medicaid dollars. Iowa Department of Human Services has indicated that it would funnel money from the trust fund to the managed-care companies. The trust fund is set up to exclusively give the money to ” ‘participating hospitals' and not other entities.” However, Judge Hanson wrote that the “controversy is not ripe and/or moot.” [FN33] The Centers for Medicare & Medicaid Services told the state that it must delay the transition until March 1 which gives the state time to bring its “statutes and regulations in compliance with the managed-care model.”

Maine to Delay Medicaid Payments to Hospitals

The Bangor Daily News reports that the Legislature's Appropriations Committee unanimously opposed the cuts to health and human services programs recommended by the administration. [FN34] Instead, the 13-member panel voted to delay Medicaid payments to hospitals form the current fiscal year to the next and found savings in other programs. The delay in paying $2.2 million in Medicaid hospital payments also delays $3.3 million in federal matching funds.

Massachusetts Budget Includes $250 Million Hospital Tax

Massachusetts lawmakers have approved a state budget that imposes a $250 million annual tax on hospitals over the next five years to fund the state's Medicaid managed-care plan. Massachusetts Governor Baker proposed to add the tax in January. However, initially his proposal did not have an end date and hospitals objected to the proposal. According to the budget, the allocated tax revenue will be reimbursed to the hospitals depending on the number of Medicaid patients they treat. [FN35]

Higher Than Expected Enrollment May Lead to Additional Hospital Tax

The Affordable Care Act led many states to expand eligibility for Medicaid and most of these states are seeing higher than expected turn out from the expansion. Michigan has enrolled more people in 16 months than the expected to enroll in the first 5 years of the expansion. [FN36] The states need to find a way to pay for the additional enrollees and one way to do that is having hospitals pay additional taxes. A few states have already established hospital taxes to help cover the cost of their Medicaid expansion and it is possible that more states could see this as beneficial. [FN37]

Michigan Requires Additional Tax to Fund Graduate Medical Education Training Programs

Hospitals will be required to pay an additional $93 million in provider taxes. The additional provider tax will be used to obtain federal matching dollars for the Medicaid program. The additional money will be used to help “preserve more than 5,200 medical residents and fellows at the teaching hospitals.” The hospitals are also being required to account for all the money that comes into their teaching hospitals, including money from Medicare, Medicaid, state general funds, and insurance payments. Hospitals that do not submit their accounting on time will have the graduate medical education funds withheld. [FN38]

Minnesota Legislature Will Need to Decide on Provider Taxes in 2019

Minnesota will need to decide whether to extend the state's 2% tax on medical providers which is slated to sunset at the end of 2019. The tax was originally passed in 1992 to pay for MinnesotaCare, a state-run healthcare program to provide coverage for working families. However, the tax has been used to for the medical assistance program and other healthcare needs as he federal funding for MinnesotaCare improved under the ACA. As a result, the legislature voted to repeal the tax in 2020. The current 2% tax generates $700 million in revenue. Governor “Walz and Democratic leaders want to renew the tax” while Republicans want to replace it with a “‘fee’ on claims processed by insurance companies and administrators of self-insurance plans.” [FN39]

New Hampshire to Tax More Services

Previously laboratory, ambulance and out-patient oncology services were exempt from the Medicaid Enhancement Tax. [FN40] Updated Department of Revenue Administration guidelines will now include revenues from those three areas in a hospitals' tax liability. The increase in the areas taxed is an attempt to offset the dropping MET revenues New Hampshire has seen over the past 3 years.

Hospitals and New Hampshire disagree over what revenue is taxable. New Hampshire contents that all services “that Medicaid reimburses should be taxed whether Medicaid, an insurance company or an individual pays for the services.” Hospitals content that “only the Medicaid payments are taxable.” Many hospitals and the NH Hospital Association are likely to appeal the new guidelines.

New Hampshire and Hospitals Disagree on Medicaid Taxes

New Hampshire argues that “all services a hospital provides that is Medicaid reimbursable should be taxed” regardless of payment source while the hospitals argue that “only the Medicaid payments are taxable.” [FN41] Ten of New Hampshire's largest hospitals sued New Hampshire over the constitutionality of the Medicaid Enhancement Tax (MET).

The MET revenues have dropped from $200 million annually to $185 million because the large New Hampshire hospitals are continuing to reduce their tax liability. Currently the MET taxes hospitals at 5.5 percent which is nearly double the average rate assessed by other states.

Special Commission Recommends New Hampshire MET Be Collected Quarterly

A New Hampshire commission studying the Medicaid Enhancement Tax (MET) recommends that the MET be assessed quarterly. Currently the MET is assessed once during the year in October which creates cash flow problems for the hospitals. The special commission was unable to come up with any other recommendations but did make several suggestions “that ranged from eliminating the tax to removing two specialty rehabilitation hospitals from being subject to the tax.” [FN42]

3 Hospitals Sue New Hampshire over Medicaid Enhancement Tax

On February 10, 20134, three hospitals sued the New Hampshire seeking to have the Medicaid Enhancement Tax declared unconstitutional. The hospitals claim that the MET is unfair because it does not tax doctors, offices, and clinics that provide similar services. New Hampshire says that the hospitals are taxed because they “receive higher Medicaid payments for the same service.” [FN43]

New Hampshire MET Ruled Unconstitutional

Superior Court Judge Kenneth R. McHugh ruled that the New Hampshire Medicaid Enhancement Tax (MET) on hospitals is unconstitutional. Judge McHugh ruled that the “MET created an ‘unconstitutional classification of taxpayers,’ and that hospitals cannot be separated from other similar businesses for purposes of taxation.” [FN44] Judge McHugh also ordered New Hampshire to refund $1.4 million that the hospital paid during 2010-11 assessment period. A similar case is under review in Hillsborough County Superior Court. It is likely that both cases will be repealed as millions of dollars are on the line.

The hospitals argued that the MET treats hospitals differently from other healthcare providers that provide the same services. Judge Mangones agreed writing that “the Met imposes a tax on hospitals simply because they are hospitals, not based on the nature of the services they provide.” [FN45] It is likely that both cases will be appealed to the New Hampshire Supreme Court as the State could lose nearly $200 million in revenue.

New Hampshire Plan Would Reduce Medicaid Enhancement Tax

The Concord Monitor reports that a New Hampshire Senate plan approved May 6 would reduce the rate of the Medicaid Enhancement Tax and return a greater share of the revenue back to hospitals. [FN46] The plan is an attempt to address recent court challenges to the tax from hospitals following New Hampshire's decision in 2011 to stop reimbursing hospitals for the tax as allowed under federal law.

Under the plan, the rate of the tax would be lowered by 0.25 percent each year for the next four years. The rate is currently 5.5 percent. The changes would become effective July 1, 2015 and future Legislatures would have to determine whether to continue phasing out the tax.

New Hampshire Legislators Agree on Hospital Tax Settlement

Associated Press reports New Hampshire House and Senate negotiators agreed on May 31 on legislation to implement a settlement with almost all New Hampshire hospitals over Medicaid rates and a tax on hospital revenues that were found unconstitutional. [FN47]

Gov. Maggie Hassan announced the settlement with 25 of the state's 26 hospitals on May 30. St. Joseph Hospital in Nashua is the only hospital that did not agree. St. Joseph Hospital has sued the state over the tax.

Under the settlement, hospitals will get more money for the care they provide in exchange for dropping a lawsuit over rates and the constitutionality of the hospital tax. The tax rate will also drop from 5.5 percent assessed on net patient revenues to 5.45 percent in 2016 and to 5.4 percent in 2017. Depending on the total cost of uncompensated care, the rate could drop to 5.25 percent in 2018.

New Jersey Governor Seeks to "Freeze" Taxes on Hospitals

Governor Chris Christies announced that he will seek to "freeze" taxes on hospitals for the next two years in order to avert potential litigation between towns and their local hospitals. [FN48] The proposal would "freeze" taxes until a new commission is able to find a solution to the issue. Many towns are seeking to sue their local nonprofit hospitals in lieu of property taxes. Last year the legislature passed a bill that would have imposed a $2.50 per day hospital bed fee and the fee would increase at 2% per year to adjust for inflation. However, Christie declined to sign the bill and it expired.

New Mexico Hospitals Propose Tax

The hospital industry proposed a 1% tax for two years to go towards a dedicated Medicaid Trust Fund. The proposed 1% would generate an estimated $52 million and the money would go towards Medicaid instead of into the state's general fund. Hospitals are opposed to a similar tax that would raise an estimated $100 million in revenue because it was earmarked for the general fund instead of being used to help pay for the costs of Medicaid. [FN49]

Ohio to End Medicaid Sales Tax

Ohio has been charging taxes on services provided through Medicaid managed-care organizations which resulted in matching federal funds coming back to the managed-care organizations and the state. However, the Centers for Medicare & Medicaid Services said that applying the tax only to managed-care companies dealing with Medicaid was not allowed. Starting July 1, 2017, Ohio will no longer be allowed to charge the Medicaid sales tax which gives the legislature a few months to come up with the missing funds. [FN50]

Wastebook Mocks Provider Taxes

Oklahoma Republican Senator Tom Coburn used his annual Wastebook to highlight Medicaid provider taxes. According to the Wastebook 2014, the reimbursement on provider taxes costs the federal government "$4-5 billion annually." [FN51]

Oregon Given Approval to Levy Provider Tax

The federal government authorized Oregon to levy a provider tax that was authorized by the Oregon Legislature in 2003. The provider tax "will be levied at a rate of 6% of revenue" and "every dollar that is used for Medicaid-paid nursing-facility care will leverage $1.50 in federal matching funds." [FN52] It is thought that the provider tax will generate $56 million in revenue for the state.

Oregon House Approves Hospital and Nursing Home Tax Increase

The Associated Press reports that the Oregon House voted to extend the hospital tax for two more years and the nursing home tax until 2020. [FN53] However, Senate Republicans are threatening to block the tax.

The measure, House Bill 2216, increases the hospital tax 1 percentage point to 5.3 percent. The bill would extend the nursing home tax until 2020 and would remove 25 nursing homes' exempt status. The hospital tax brings in an estimated "$745 million" which is returned to the hospitals, but also "generates $1.3 billion in federal matching funds that help pay for the Oregon Health Plan."

Pennsylvania Tax on Medicaid MCOs Called into Question

The Office of Inspector General (OIG) released a report on Pennsylvania's Medicaid managed care organization (MCO) gross receipts tax in late May. The OIG found that the MCO gross receipts tax "appears to be a health care-related tax that is impermissible for Medicaid funding." Specific issues with the tax include that it:

• Is not broad based and does not apply to all MCOs, and

• Holds the Medicaid MCOs harmless as taxpaying entities.

The OIG recommended that the Centers for Medicare and Medicaid Services determine whether the tax on Medicaid MCOs is an impermissible healthcare-related tax and, if so:

• Offset the $1.7 billion in Gross Receipt Tax revenue from Pennsylvania's Medicaid expenditures, and

• Clarify its policy concerning permissible healthcare-related taxes for all states.

CMS agreed to clarify its policy. However, CMS did not agree that a disallowance was warranted until there is clarification of its interpretation of the healthcare-related tax requirements.

The full report is available at: https://oig.hhs.gov/oas/reports/region3/31300201.pdf.

Tennessee Governor Seeks to Expand Hospital Assessment Fee in Order to Expand Medicaid

Hospitals voluntarily came up with a plan in 2007 to establish an assessment fee. The hospital assessment fee currently stands at 4.52 percent of a hospital's gross patient revenue. Tennessee uses the hospital assessment fee to pay for its share of Medicaid, which is approximately 35 percent state funded. [FN54]

The Governor has stated that “the Insure Tennessee program will end” without the hospitals assessment fee. However, not everyone agrees that the hospital assessment is the way to go. United States Senator Corker, in 2013, tried to outlaw the practice of using provider taxes, bed taxes, and hospital assessments. Senators within Tennessee are citing that bill as a reason for not wanting to expand the hospital assessment fee. [FN55]

Vermont Governor Proposes Expanding Provider Tax

Vermont Governor Peter Shumlin proposed expanding a tax on health care providers in his 2017 budget proposal. “Currently, only hospitals and the doctors they employ and nursing homes are subject to the 6% assessment.” [FN56] The budget proposal would expand the assessment to additional health care providers but at a less amount of 2.35%. This would net the state an additional $17 million in revenue and would be matched by federal funds.

Hospitals Seek Assessment

Despite the hospitals push for a provider assessment, Virginia seems unlikely to expand Medicaid or other coverage to uninsured. Three private hospitals would like the provider assessment to be instituted because it would bring in more federal Medicaid money to help them pay for uncompensated care. Senator McWaters has proposed an assessment of 6 percent. However, other hospitals and representatives would like to see a study on provider assessments before the state imposes it on them. [FN57]

If the state were to impose an assessment of 2%, it is estimated that the hospitals would pay $250 million which would then be matched by federal funding. A 4% assessment would double that amount to $500 million. If the state was able to get the 4% assessment rate it would trigger a windfall under the Affordable Care Act's full Medicaid expansion and result in an estimated $2.7 billion in federal funding. [FN58]

Virginia Legislature Eliminated Hospital Tax from the Budget

The Virginia Legislature eliminated the hospital tax, proposed by Virginia Governor McAuliffe and supported by the public [FN59] , from the budget. [FN60] The hospital tax was set at 3% on hospital revenue and would have helped fund Virginia's share of the federal healthcare program.

Measure 101 Up for Vote

Oregonians will vote on Measure 101 on Tuesday, January 23, 2018. In 2017, the Legislature passed 2017 OR H.B. 2391 (NS) imposing a 0.7 percent tax on certain hospitals and 1.5 percent tax on certain health providers in order “to generate $1.3 billion in state and federal money” [FN61] and allow for the expansion of Medicaid. The measure asks voters to approve or reject the assessment. If the measure passes, the assessments will be approved, subject to approve by CMS. If the measure fails, the assessments will either be rejected, or delayed until approved by CMS. The measure is supported by Democrats, healthcare providers, hospitals, and insurers.

Oregon Voters Approve Measure 101

On Tuesday, January 23, 62% of Oregon voters approved Measure 101. Measure 101 asked voters to approve or reject a .7% tax on certain hospitals and a 1.5% tax on health insurers. The approved tax “will raise $210 million to $320 million in taxes on Oregon's largest hospitals and many health insurance policies by 2019.” [FN62] The Yes vote ensures that Oregon is able to pay for its Medicaid costs after expanding their coverage but seeing a reduction in reimbursements.

Oregon discusses changes to Provider Tax

The Oregonian (Portland, OR), “Bipartisan success from the past; partisan bias in the present”, discusses the wish of Rep. Julie Parrish to remove the provider tax and instead shift the cost of Medicaid to the consumers.

Virginia Hospitals Want Hospital Assessment

Former Governor Terry McAuliffe proposed adding a provider assessment on net patient review in the state budget in order to expand Medicaid coverage. The budget calls for an initial assessment of .5% on the net patient revenue and then would increase the following year to 1.4%. The Virginia Hospital & Healthcare Association is in favor of the assessment but not if it is in the budget. The Association does not want the assessment placed in the budget for fear that the money gained from the assessment would be mixed in with other state revenue instead of going directly to the hospitals. The Association wants the assessment to be placed in legislation outside of the budget to “ensure that any money generated by the tax is used only to help hospitals cover the costs of uncompensated care, bolster struggling hospitals in rural areas and help pay for graduate medical education.” [FN63]

CMS Approves New Virginia Hospital Tax

The Centers for Medicare and Medicaid Services approved Virginia's use of a new hospital tax to fund the state's share of Medicaid expansion. The new assessments are expected to raise $590 million over the next two years. The hospitals will be taxed a percentage of their net patient revenues. The tax will be used to obtain federal matching funds. This will allow the reimbursement rates paid to hospitals for Medicaid services to increase to 88% up from 71%. [FN64]

RECENT LEGISLATIVE ACTIVITY

Alabama

2019 AL H.B. 176 (NS), adopted May 28, 2019, amends AL ST § 40-26B-71 (Assessment), AL ST § 40-26B-73 (Hospital Assessment Account), AL ST § 40-26B-77.1 (Intergovernmental transfers to the Medicaid Agency), AL ST § 40-26B-79 (Inpatient Medicaid base payments), AL ST § 40-26B-80 (Outpatient Medicaid base payments), AL ST § 40-26B-81 (Medicaid hospital access payments), AL ST § 40-26B-82 (Effectiveness and cessation), AL ST § 40-26B-84 (Federal medical assistance percentage), and AL ST § 40-26B-85 (Eligibility and benefit expansions) extending the private hospital assessment and Medicaid funding program for fiscal years 2020, 2021, and 2020. The amendment is effective October 1, 2019.

Connecticut

• 2019 CT H.B. 7424 (NS), adopted June 26, 2019, amends CT ST § 12-263q (Tax on net revenue from provision of inpatient hospital services and outpatient hospital services. Exemption request and approval) updating the taxes on net revenues on hospital's inpatient and outpatient services. The amendment is effective June 26, 2019.

• 2019 CT S.B. 1131 (NS), amended/substituted May 20, 2019, would amend CT ST § 12-263i (Tax on ambulatory surgical center gross receipts. Exemptions. Penalty. Recording of revenue) to update definitions, provide that the quarterly tax will be imposed at a rate of 6% of the net revenue of each ambulatory surgical center, and to add an allowable credit against the tax imposed. Also, would require the Commissioner of Social Services to seek approval from the Centers for Medicare and Medicare Services to exempt from the tax imposed.

District of Columbia

2019 DC L.B. 209 (NS), adopted July 22, 2019, amends DC CODE § 44-664.01 (Definitions), DC CODE § 44-664.03 (Hospital Provider Fee), DC CODE § 44-664.04 (Applicability of Fees), DC CODE § 44-664.05 (Medicaid Outpatient Hospital Access Payments), DC CODE § 44-664.06 (Quarterly Notice and Collection), and DC CODE § 44-664.09 (Sunset) to authorize the District to continue to charge a fee on each hospital's outpatient gross patient revenue, to be deposited in the Hospital Provider Fee Fund and to extend the sunset date from September 30, 2019 to September 30, 2029. The bill would also authorize the District to continue to charge a fee on the inpatient new patient revenue of each hospital, to be deposited in the Hospital Fund and extend the sunset date from September 30, 2019 to September 30, 2029. The bill is effective July 22, 2019.

Florida

• 2019 FL H.B. 7053 (NS), amended/substituted April 5, 2019, would amend FL ST § 395.701 (Annual assessments on net operating revenues for inpatient and outpatient services to fund public medical assistance; administrative fines for failure to pay assessments when due; exemption) and FL ST § 395.7015 (Annual assessment on health care entities) updating terminology to use “tax” instead of “assessment.”

• 2019 FL S.B. 4 (NS), adopted April 3, 2019, amends FL ST § 409.9083 (Quality assessment on privately operated intermediate care facilities for the developmentally disabled; exemptions; purpose; federal approval required; remedies) to remove obsolete language. The amendment is effective July 6, 2019.

Georgia

2019 GA H.B. 321 (NS), adopted April 25, 2019, amends GA ST § 31-8-179.6 (Repeal of article) extending the repeal date of the Hospital Medicaid Financing Program Act to June 30, 2025. The amendment is effective April 25, 2019.

Idaho

2019 ID H.B. 299 (NS), introduced April 3, 2019, would amend ID ST § 56-1404 (Assessments) to clarify that for private in-state hospitals, the assessments calculated pursuant to subsections (2) and (3) of this section shall not be greater than the maximum federal allowable tax percentage provided in 42 CFR 433.68 of the assessment base. The bill would also provide that of this assessment, forty-five percent (45%) may be used to meeting the requirements of this chapter, and fifty-five percent (55%) may be used to funding the expansion of Medicaid eligibility pursuant to section 56-267, Idaho Code. Provided, however, the Medicaid eligibility expansion portion of the hospital assessment under this section may not exceed forty-five percent (45%) of the state's share of Medicaid eligibility expansion costs. The bill would also provide that assessments must be made after application of the funds received from the Medicaid

expansion dedicated fund established in section 57-810, Idaho Code, as necessary to fund Medicaid eligibility expansion, subject to the limitations of this subsection.

Illinois

• 2019 IN H.B. 1001 (NS), adopted April 29, 2019, adopts IN ST 12-15-16-7.5 to provide definitions, specify conditions that apply to a Medicaid disproportionate share hospital payment order (DSH payment order), and requiring the hospital assessment fee committee (committee) to prepare a DSH payment order and submit the DSH payment order to the office of the secretary of family and social services (office of the secretary). The bill also amends IN ST 12-15-16-7 (Medicaid disproportionate share payment eligibility) to make this section subject to IN ST 12-15-16-7.5. The bill is effective April 29, 2019.

• 2019 IL S.B. 1321 (NS), adopted August 5, 2019, amends IL ST CH 305 § 5/5A-4 (Payment of assessment; penalty) clarifying that the assessments are due and payable in monthly installments on the 17th State business day of each month, instead of the 14th. The amendment is effective August 5, 2019.

• 2019 IL S.B. 1814 (NS), adopted June 5, 2019, would amend IL ST CH 305 § 5/5A-2 (Assessment) providing that the annual assessment on inpatient services on each hospital will be increased in 2021. The amendment is effective upon becoming law.

Indiana

2019 IN H.B. 1001 (NS), adopted April 29, 2019, adopts IN ST 12-15-16-7.5 providing definitions, specify conditions that apply to a Medicaid disproportionate share hospital payment order (DSH payment order), and requiring the hospital assessment fee committee (committee) to prepare a DSH payment order and submit the DSH payment order to the office of the secretary of family and social services (office of the secretary). The bill also amends IN ST 12-15-16-7 (Medicaid disproportionate share payment eligibility) to make this section subject to IN ST 12-15-16-7.5. The bill is effective April 29, 2019.

Kentucky

2019 KY H.B. 320 (NS), adopted March 26, 2019, establishes hospital rate improvement programs that require hospitals to pay an assessment into a fund to be used as state matching dollars for federal funds, establish formulas for collection of the assessments and for making supplemental payments to hospitals, condition the program upon federal approval, and create the hospital Medicaid assessment fund to be administered by the Department for Medicaid Services. The bill is effective June 26, 2019.

Maine

2019 ME H.P. 349 (NS), introduced January 29m 2019, would amend ME ST T. 36 § 2552 (Tax Imposed) to remove the 6% tax imposed on the value of community support services for persons with mental health diagnoses, community support services for persons with intellectual disabilities or autism, home support services, and group residential services for persons with brain injuries.

Michigan

• 2019 MI H.B. 4830 (NS), engrossed November 6, 2019, would amend MI ST 333.20161 (Fee and assessment schedule; health facility and agency licenses and certificates of need; use of funds; quality assurance assessment) to require that beginning November 1, 2020, and by November 1 of each year thereafter, the Department send a notification to each ambulance operation that will be assessed the quality assurance assessment authorized under this subsection during the year in which the notification is sent.

• 2019 MI H.B. 4861 (NS), introduced August 29, 2019, would amend MI ST 333.20161 (Fee and assessment schedule; health facility and agency licenses and certificates of need; use of funds; quality assurance assessment) extending the fees and assessments on health facilities to October 1, 2022.

• 2019 MI S.B. 444 (NS), adopted October 2, 2019 amends MI ST 333.20161 (Fee and assessment schedule; health facility and agency licenses and certificates of need; use of funds; quality assurance assessment) extending the fees and assessments on health facilities to October 1, 2023. The amendment is effective October 2, 2019.

Missouri

• 2019 MO S.B. 29 (NS), adopted July 11, 2019, amends MO ST 633.401 (Definitions--assessment imposed, formula--rates of payment--fund created, use of moneys--record-keeping requirements--report--appeal process--rulemaking authority--expiration date) extending the assessment on intermediate care facility for the intellectually disabled to September 30, 2020. The amendment is effective August 28, 2019.

• 2019 MO S.B. 548 (NS), prefiled December 1, 2019, would amend MO ST 633.401 (Definitions--assessment imposed, formula--rates of payment--fund created, use of moneys--record-keeping requirements--report--appeal process-- rulemaking authority--expiration date) extending the assessment on intermediate care facility for the intellectually disabled to September 30, 2021.

Minnesota

• 2019 MN H.F. 5 (NS), adopted May 30, 2019, amends MN ST § 295.52 (Taxes imposed) reducing the tax imposed on the gross revenue for hospitals, surgical centers, health care providers, and wholesale drug distributors to 1.8% down from 2%. The amendment is effective for gross revenues received after December 31, 2019. The amendment is effective May 31, 2019.

• 2019 MN H.F. 2125 (NS), engrossed May 1, 2019, would amend MN ST § 295.53 (Exemptions; special rules) to update the payments that are exempted from the gross revenues subject to hospital, surgical center, or health care provider taxes under MN ST § 295.50 to MN ST § 295.59.

Montana

2019 MT H.B. 658 (NS), adopted May 9, 2019, establishes the Montana HELP ACT special review account to allow outpatient hospital utilization fees to be deposited into the fund to the credit of the Department. The bill also amends MT ST 15-66-101 (Definitions), MT ST 15-66-102 (Utilization fees--for inpatient bed days--hospital outpatient revenue), MT ST 15-66-103 (Relation to other taxes and fees), MT ST 15-66-201 (Reporting and collection of fee), MT ST 15-66-202 (Audit--records), MT ST 15-66-203 (Periods of limitation), MT ST 15-66-204 (Penalty and interest for delinquent fees-- waiver), and MT ST 15-66-205 (Estimated fee on failure to file) to update definitions, add a utilization fee in the amount of .825% of hospital outpatient review, and change the filing date to March 31. These sections are effective July 1, 2019.

New Mexico

• 2019 NM S.B. 246 (NS), adopted March 14, 2019, would create the Health Care Quality Surcharge Act to impose a temporary surcharge on certain health care facilities, to require that the revenue from the surcharge be used to reimburse a portion of the surcharge as a Medicaid-allowable cost, and to increase Medicaid provider reimbursement rates.

• 2019 NM H.B. 396 (NS), introduced January 28, 2019, would amend NM ST § 7-9-73 (Deduction; gross receipts; governmental gross receipts; sale of prosthetic devices), NM ST § 7-9-73.2 (Deduction; gross receipts tax and governmental gross receipts; prescription drugs; oxygen), NM ST § 7-9-73.3 (Deduction; gross receipts and governmental gross receipts; durable medical equipment; medical supplies), NM ST § 7-9-77.1 (Deduction; gross receipts; certain medical and health care services), M ST § 7-9-93 (Deduction; gross receipts; certain receipts for services provided by health care practitioner), NM ST § 7-9-96.1 (Credit; state sales tax; receipts of certain hospitals), NM ST § 7-9-96.2 (Credit; state sales tax; unpaid charges for services provided in a hospital), NM ST § 7-20C-2 (Definitions), NM ST § 7-20C-3 (Local hospital sales tax; authority to impose; ordinance requirements), NM ST § 7-20E-12.1 (County hospital emergency sales tax; authority to impose; use of proceeds), NM ST § 7-20E-13 (Special county hospital sales tax; authority to impose; ordinance requirements), NM ST § 7-20E-14 (Special county hospital sales tax; use of proceeds), NM ST § 7-20E-18 (County health care sales tax; authority to impose rate) to update terminology to use “sales tax” instead of “gross receipts tax.”

• 2019 NM S.B. 358 (NS), introduced January 25, 2019, would repeal NM ST § 7-9-73 (Deduction; gross receipts; governmental gross receipts; sale of prosthetic devices), NM ST § 7-9-73.2 (Deduction; gross receipts tax and governmental gross receipts; prescription drugs; oxygen), NM ST § 7-9-73.3 (Deduction; gross receipts and governmental gross receipts; durable medical equipment; medical supplies), NM ST § 7-9-77.1 (Deduction; gross receipts; certain medical and health care services), M ST § 7-9-93 (Deduction; gross receipts; certain receipts for services provided by health care practitioner), NM ST § 7-9-96.1 (Credit; state sales tax; receipts of certain hospitals), NM ST § 7-9-96.2 (Credit; state sales tax; unpaid charges for services provided in a hospital), NM ST § 7-20C-2 (Definitions), NM ST § 7-20C-3 (Local hospital sales tax; authority to impose; ordinance requirements), NM ST § 7-20E-12.1 (County hospital emergency sales tax; authority to impose; use of proceeds), NM ST § 7-20E-13 (Special county hospital sales tax; authority to impose; ordinance requirements), NM ST § 7-20E-14 (Special county hospital sales tax; use of proceeds), NM ST § 7-20E-18 (County health care sales tax; authority to impose rate).

New York

• 2019 NY A.B. 2007 (NS), amended/substituted March 11, 2019, and 2019 NY S.B. 1507 (NS), amended/substituted March 12, 2019, would amend NY PUB HEALTH § 2807-d (Hospital assessments) to provide that for all gross receipts received on or after April 1, 2019 through March 31, 2024 will be assessed at 6%.

• 2019 NY S.B. 1507 (NS), adopted April 12, 2019, amends NY PUB HEALTH § 2807-d (Hospital assessments) providing that the tax on gross receipts received on or after April 1, 2019 through March 31, 2021 will be assessed at 6%. The amendment is effective April 1, 2019.

North Carolina

2019 NC H.B. 588 (NS), introduced April 4, 2019, and 2019 NC S.B. 452 (NS), introduced April 2, 2019, would amend the Hospital Provider Assessment Act. It includes the following sections: NC ST § 108A-121 (Definitions) to update definitions; NC ST § 108A-122 (Assessment) to clarify that assessments are due on the first business day of each quarter and to update terminology to use “supplemental assessment” and “base assessment” instead of “equity assessment” and “UPL assessment”; NC ST § 108A-123

(Assessment amount) to establish the supplemental assessment and base assessment rates; NC ST § 108A-123.1 (Coverage gap assessment) to establish an additional assessment to be imposed on all hospitals and provide requirements for calculation and notice, appeal, and adjustment requirements; NC ST § 108A-124 (Use of assessment proceeds) to clarify that the payments may be used to fund payments to hospitals made directly by the Department and to fund a portion of capitation payments to Prepaid Health Plans attributable to hospital care and to fund the nonfederal share of any expenditures associated with expanding Medicaid coverage to individuals at or below one hundred thirty-eight (138%) of the federal poverty level and to fund the nonfederal share of Graduate Medical Education payments; NC ST § 108A-126 (Approval of assessment program) to clarify that the initial assessment retroactive to the effective date of the State plan amender or waiver; NC ST § 108A-127 (Repeal) to clarify that the authority to impose an assessment is repealed in the event that CMS revokes approval of any portion of the waiver authorizing the payments; and NC ST § 108A-128 (Payment for providers formerly subject to this Article) to update terminology and provide that percentage must be calculated by dividing the amount of the State's annual Medicaid payment by the total amount collected under the base assessment program authorized by this Article.

Ohio

2019 OH H.B. 166 (NS), adopted July 18, 2019, amends OH ST § 5168.06 (Assessments on hospitals) updating terminology to use “United States Centers for Medicare and Medicaid Services” instead of the “Health Care Financing Administration of the United States Department of Health and Human Services.” The amendment is effective October 17, 2019.

and outpatient services. The amendment is effective June 26, 2019.

Oklahoma

• 2019 OK H.B. 1013 (NS), introduced February 4, 2019, would amend OK ST T. 56 § 2002 (Nursing Facilities Quality of Care Fee) increasing ombudsmen staff employed by the Department of Human Services and directing payment of accrued monies to implement and maintain certain counseling services.

• 2019 OK H.B. 1089 (NS), adopted April 16, 2019, amends OK ST T. 63 § 3241.3 (Hospital assessment--Exceptions--Fees--Promulgation of rules) extending the supplemental hospital offset payment program fee termination through December 31, 2025. The amendment is effective November 1, 2019.

• 2019 OK H.B. 1278 (NS), adopted May 15, 2019, amends OK ST T. 56 § 2004 (Home based quality assurance assessment) providing that beginning November 1, 2019, any reductions in planned services must comply with the following: (1) all reductions in planned services shall be applied prospectively with the new plan year and not changed retroactively; (2) the updated algorithms shall not affect any prior authorized service; and (3) any new participant through the ADvantage Waiver program shall receive a minimum of two hundred units of case management services to allow for the development of two plans within the same year. The amendment is effective November 1, 2019.

• 2019 OK H.B. 1902 (NS), engrossed March 12, 2019, would amend OK ST T. 56 § 2002 (Nursing Facilities Quality of Care Fee) to increase the number of ombudsmen employed by the Department of Human Services and to add a $3 per patient per day quality assurance component.

• 2019 OK H.B. 2341 (NS), adopted May 28, would amend OK ST T. 56 § 2002 (Nursing Facilities Quality of Care Fee) would update terminology to use “individuals with intellectual disability (ICFs/IID)” instead of “mentally retarded.” The amendment is effective November 1, 2019.

• 2019 OK S.B. 280 (NS), adopted May 28, 2019, amends OK ST T. 56 § 2002 (Nursing Facilities Quality of Care Fee) adding and modifying allowable expenses and updating terms and statutory language. The amendment is effective October 1, 2019.

• 2019 OK S.B. 890 (NS), amended/substituted April 10, 2019, would amend OK ST T. 56 § 2002 (Nursing Facilities Quality of Care Fee) to update terminology to use “intermediate care facilities for the intellectually disable (ICF/IID)” instead of “intermediate care facilities for the mentally retarded (ICFs/MR).”

Pennsylvania

• 2019 PA H.B. 33 (NS), adopted June 28, 2019, amends PA ST 62 P.S. § 801-E (Definitions) updating the definition for “assessment,” “general acute care hospital,” and “hospital” and providing the definition for “net patient revenue.” The bill would also amend PA ST 62 P.S. § 801-G (Definitions) to update the definition for “net patient revenue” and “net outpatient revenue.” The bill also amends PA ST 62 P.S. § 802-E (Authorization), PA ST 62 P.S. § 804-E (Administration), PA ST 62 P.S. § 805-E (No hold harmless), PA ST 62 P.S. § 807-E (Tax exemption), and PA ST 62 P.S. § 808-E (Time period). The bill is effective July 1, 2019.

• 2019 PA S.B. 695 (NS), adopted June 28, 2019, would amend PA ST 62 P.S. § 807-A (Assessment Amount and Timing), PA ST 62 P.S. § 810-A (Remedies), and PA ST 62 P.S. § 813-A (Repayment), and PA ST 62 P.S. § 815-A (Time periods) updating the amount and timing of assessment due for each nursing facility. Adding a penalty for failing to pay the assessment within 60 days. Clarifying that a nursing facility is guaranteed a repayment of its assessment. Extending the assessment to June 30, 2022. The bill is effective June 28, 2019.

Texas

2019 TX S.B. 2286 (NS), adopted June 10, 2019, adopts TX HEALTH & S § 292C(County Health Care Provider Participation Program in Certain Counties with Hospital District Bordering Oklahoma) allowing the County to assess and collect mandatory payments from hospitals to generate revenue to be used to provide the nonfederal share of a Medicaid supplemental payment program.

Vermont

2019 VT S.B. 27 (NS), engrossed February 22, 2019, would maintain the provider tax assessed on home health agencies by extending the sunset to July 1, 2021.

Washington

2019 WA H.B. 1553 (NS), introduced January 24, 2019, and 2019 WA S.B. 5517 (NS), introduced January 23, 2019, would, beginning July 1, 2020, impose a quality assurance fee for each ambulance transport provided by each ambulance transport provider. The fee would be paid quarterly and calculated annually.

West Virginia

2019 WV H.B. 2405 (NS), adopted March 27, 2019, repeals WV ST § 11-26 (Health Care Provider Medicaid Tax), amend WV ST § 11-27-3 (Definitions), and adopts WV ST § 11-27-10a (Imposition of tax on managed care organizations) to impose provide taxes on managed care organizations, establish tax rates, and require federal approval of tax. The bill is effective June 7, 2019.

RECENT REGULATORY ACTIVITY

Iowa

2019 IA REG TEXT 516877 (NS), filed April 1, 2019, amends IA ADC 441-36.6(249L) (Assessment) increasing the nursing facility assessment to $2.45 up from $1.36 for nursing facilities with 46 or fewer licensed beds, nursing facilities designated as continuing care retirement centers (CCRCs), and nursing facilities with annual Iowa Medicaid patient days of at least 21,000. Also increasing the quality assurance assessment rate add-on to $15 up from $10. The rule is effective July 1, 2019.

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