Health Care-Related Tax Study Report

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Submitted by: Pacific Health Policy Group

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EXECUTIVE SUMMARY

HEALTH CARE-RELATED TAX STUDY

A. Introduction

Federal law permits states to collect revenues or "health care-related taxes" from 19 specified classes of health care providers or services. Revenues collected from health care-related taxes can be used to raise provider rates, fund other costs of the Medicaid program or be used for other non-Medicaid purposes, such as depositing the funds into the state's general treasury. States must meet strict federal requirements when implementing health care-related taxes, including taxing all providers or services in a class (i.e., the tax cannot be limited to Medicaid providers only) and applying a methodology that is similar for all providers or services in that class (i.e., same rate or amount of tax is applied).

Currently, Vermont levies health care-related taxes on six of the permitted classes: inpatient and outpatient hospital, nursing facility, intermediate care facilities for the mentally retarded/developmentally disabled (ICF/MR-DD), home health and outpatient prescription drugs. Vermont Act 45 of 2011 granted authority to the Secretary of Administration to explore the functionality and practicality of establishing any health care-related tax currently not levied by the State. The State contracted with the Pacific Health Policy Group (PHPG) to evaluate the expansion of provider classes not currently levied in Vermont and propose recommendations for improving Vermont's existing provider taxes. PHPG is a national consulting firm specializing in the research, evaluation and reform of state Medicaid programs.

B. Methodology and Approach

This report summarizes PHPG's findings and presents recommendations for improving Vermont's provider tax system. PHPG's methodology and approach consisted of the following:

- *Collaboration with the Department of Vermont Health Access (DVHA)* – DVHA administers the existing provider assessments and developed proposed methodologies for implementing new taxes during the 2011 legislative session. PHPG met with State staff to obtain their opinions and any relevant documentation related to current tax implementation and proposed taxes.

- *Review of Other States' Practices* – PHPG identified states based on professional knowledge and surveyed the published literature to determine other states that implement one or

more health care-related taxes. PHPG obtained relevant documents related to these taxes, including statutes, regulations and reporting forms, through online resources and follow up contact directly with the states via telephone and email.

- *Discussions with Providers and Representatives* – PHPG met with various providers and their representatives to provide background on the purpose of the study; explain the federal requirements for health care-related taxes; provide information about Vermont's current taxes and methodological differences; and discuss options and solicit input about the current and potential new taxing methodologies.

- *Projection of Revenues and Implementation Considerations* – Based on discussions with State staff and provider groups, PHPG identified data sources to prepare estimates of projected patient revenues for all the provider/service classes and also identified key implementation considerations and activities. PHPG calculated or directly obtained historical tax base data from financial information submitted by providers to the State for the SFY 2012 assessments. For other permissible, but not currently taxed providers, PHPG utilized other verifiable State-specific and national data sources to estimate the historical tax base in lieu of actual financial information.

C. Overview of Other States' Health Care-Related Taxes

In recent years, states have increasingly relied on provider assessment revenues to fund their Medicaid programs. Currently, 46 states reported having some type of health care provider assessment. Although the total number of provider assessments in place has remained relatively constant, assessments on hospitals have seen the greatest increase: from 19 in SFY 2008 to 34 in 2011. To date, 38 states require nursing facilities to pay provider taxes, and 32 states assess taxes on ICF/MR-DD providers. At least 12 states assess managed care entities.

Only a handful of states levy taxes on the other federally-permissible classes of providers. Vermont is one of two states to assess home health care providers, and one of five states that tax outpatient prescription drugs dispensed or refilled by pharmacy providers. As outlined on the following page, seven states previously or currently tax the remaining provider classes and services.

Survey of States with Other Federally Permissible Health Care-Related Assessment Classes							
	Florida	Louisiana	Minnesota	Missouri	Rhode Island	West Virginia	Wisconsin
Physician Services			✓			X	
Ambulatory Surgical Center Services	X		✓		✓	✓	✓
Dental Services			✓			X	
Podiatric Services			✓			X	
Chiropractic Services			✓			X	
Optometric/ Optician Services			✓			X	
Psychological Services			✓			X	
Therapist Services			✓			X	
Nursing services			✓			X	
Laboratory/ X-ray Services	X		✓		✓	✓	
Emergency Ambulance Services		X	✓	✓		X	
Other Licensed Health Care Items or Services			✓				

Note: States that currently tax the provider classes are denoted by "✓"; although Minnesota still taxes these classes, the taxes are being phased out and will be eliminated in 2019. States that have eliminated, are not actively collecting or substantially modified their assessment programs are denoted by "X". Further detail is provided within the report and Appendix B.

In 2010, West Virginia eliminated most of its provider taxes as part of a decade-long phase down in anticipation of changes to the state's tax code as well as efficiency. Florida has considerably revised its assessment program in response to protracted legal challenges by providers, even though the tax was found to be constitutional. Louisiana has never enacted its statutory authority to collect taxes from medical transportation providers. While enacted in 2009, Missouri only has begun collecting its emergency ambulatory services tax as of SFY 2012. In December 2011, a bill was submitted to repeal Wisconsin's tax, raising issues of economic fairness, sustainability and lack of transparency**.**

Minnesota remains the only state that currently taxes all of these other classes. Revenues from Minnesota's taxes support the MinnesotaCare program which provides state-subsidized health care coverage for low-income individuals ineligible for Medicaid. However, the tax is being phased down and scheduled to sunset in anticipation that individuals under the MinnesotaCare program will be transferred into Medicaid per the Affordable Care Act.

D. Current Vermont Health Care-Related Assessments

Vermont first implemented health care-related assessments in 1991 for inpatient and outpatient hospital services, nursing homes and services of ICF/MRs. This program was expanded in 1999 to include home health care agencies and again in 2005 to include retail pharmaceutical prescriptions. The purpose of these assessments is to help provide the state share to leverage federal funds to support the State's Medicaid program without added expense to the State's general fund.

In SFY 2012, the existing assessments are expected to yield $129,674,332 in revenue for the State Health Care Resources Fund. When matched by federal funds, this represents a total of $307,722,667 to support the State's Medicaid program. Based on current assessment rates, PHPG estimates Vermont will raise over $137 million in revenues through the health care-related assessments in SFY 2013, an increase of approximately $8 million from the SFY 2012 revenues. PHPG also assessed the impact of increasing current assessment rates up to the maximum allowable under the federal safe harbor provision (i.e., 6 percent); this potentially would raise $40.4 million in additional revenues, the majority of which would be obtained from retail pharmacy providers.

Estimated Revenue from Current Assessments, SFY 2013

Provider Class	Projected Taxable Revenues	Current Assessment Rate	Projected Assessment Revenues under Current Rate	Maximum Potential Revenues (6.0% Rate)	Net Potential Additional Revenues
Hospital	$ 1,945,466,414	5.90%	$ 114,782,518	$ 116,727,985	$ 1,945,466
Nursing Homes	$ 279,280,500	6.00%	$ 16,756,830	$ 16,756,830	$ -
ICF/MR-DD	$ 1,338,789	5.90%	$ 78,989	$ 80,327	$ 1,339
Home Health	$ 131,377,439	3.90%	$ 5,123,720	$ 7,882,646	$ 2,758,926
Outpatient Pharmacy	$ 608,501,851	0.14%	$ 830,400	$ 36,510,111	$ 35,679,711
TOTAL			**$ 137,572,457**	**$ 177,957,900**	**$ 40,385,443**

During PHPG's meetings with each of the existing provider classes, none suggested that the State change the manner in which it administers the assessments (i.e., have another state department administer the assessments or require new forms to be completed). As such, this report does not recommend broad-based changes for the methodologies of the current

assessments levied in Vermont, since the methodologies are well-established. However, this report does identify several operational issues associated with the existing assessments and provides suggested solutions for the State to consider. In addition, the State should ensure that the department responsible for the assessments has the necessary resources to enable them to be administered efficiently and effectively.

In addition to these existing six health care-related assessments, beginning in 2007, the State imposed an assessment of 0.199 percent of all health insurance claims on health insurers to fund the State's Health Information Technology (HIT) Fund. Building off this assessment, as of October 1, 2011 the State required health insurers to pay an assessment of 0.80 percent of all health insurance claims paid for Vermont members to support the State Health Care Resources Fund. Federal guidance appears to suggest that a tax imposed only on health care insurance companies would be a health care-related tax.

New health care-related taxes do not require formal CMS approval unless they meet certain standards, which is not the case with these health care claims assessments. However, CMS encourages states to consult with them as new taxes are being contemplated to ensure that the taxes comply with federal standards. Should Vermont decide to increase the percentage of these health care claims assessments or implement new assessments, it is recommended that the State be cognizant of the 6 percent tax threshold and also consult CMS for technical guidance.

E. Potential New Vermont Health Care-Related Assessments

The following issues should be considered as Vermont explores whether to implement additional health care-related assessments:

- *Access to Care* – In each of the meetings that PHPG held with provider class representatives, concerns were raised about the impact new provider assessments would have on access to care for Vermonters. Providers from all groups raised similar concerns.

- *Federal Changes* – There is the possibility that future federal changes may reduce the amount of health care-related taxes that states can levy under the safe harbor provision from 6 percent to as low as 3 percent. If federal changes are to occur in the near future, Vermont could lose as much as half of the current assessment revenue used to support the State's Medicaid programs as well as revenues from any additional health care-related assessments. In addition, under the Affordable Care Act, states' Medicaid disproportionate share hospital (DSH) payments will be reduced quarterly beginning in 2014. States

identified as "low DSH states" will receive a smaller percentage reduction. It will be up to each state to determine the methodology for reducing its DSH payments.

- *Vermont Act 48* – Act 48 of 2011 sets up a framework for the development of a universal health care system, known as Green Mountain Care. The timeline for the transition from the current medical payment system to the single payer approach is six years from passage of the bill, assuming the State is able to obtain a waiver from the federal government in 2017. Financing plans for Green Mountain Care are required by statute to take into account the impact of various financing sources, including provider assessments.

Based on PHPG's estimates, the tax base for all other permissible classes for SFY 2013 totals approximately $973 million. The exhibit below contains projections of potential revenues if assessments are levied on each of the other permissible classes at various assessment rates. PHPG included a compliance/startup factor to account for the fact that the State most likely will not collect all potential revenues due to provider non-compliance and organizational learning as new administrative and oversight processes are implemented.

Potential Additional Revenues, Classes Not Currently Levied, SFY 2013 (Annualized)

Provider Class	Assessment Rate*	
	1.0%	6.0%
Physicians	$ 4,004,483	$ 24,026,896
Dentists	$ 2,277,186	$ 13,663,114
Specialty Therapists	$ 455,521	$ 2,733,126
Psychologists	$ 449,048	$ 2,694,287
Chiropractors	$ 320,996	$ 1,925,978
Nurses	$ 216,562	$ 1,299,371
Optometrists/Opticians	$ 290,676	$ 1,744,056
Podiatrists	$ 52,007	$ 312,043
Independent Lab/X-Ray	$ 93,994	$ 563,962
Emergency Ambulance Services	$ 140,127	$ 840,759
Ambulatory Surgical Centers	$ 17,454	$ 104,721
TOTAL	**$ 8,318,052**	**$ 49,908,315**

**Annualized revenues. Assumes only 85 percent of potential revenues collected in the first year (SFY 2013) due to compliance and other startup-related considerations.*

F. Implementation Tasks

If Vermont decides to move forward with proposing to implement additional or modify existing health care-related assessments, the State will need to consider factors in the following areas:

- *Policy Development* – This includes defining the taxed class, deciding on which State government entity should administer the new assessment(s), conferring with CMS and identifying oversight/monitoring processes.

- *Potential Impact on Section 1115 Waivers* – Vermont policy makers also should consider the potential impact of increasing existing or implementing new assessments on the State's two Section 1115 Medicaid Demonstration waivers, Choices for Care and Global Commitment to Health. Both Demonstrations operate under aggregate budget neutrality caps that limit total spending over the length of the Demonstrations. Although both Demonstrations have sufficient room for spending in the short term, if Vermont (in partnership with CMS) elects to continue to manage most of its Medicaid program under these Demonstrations for several years into the future, increases in program expenditures may potentially impact the waiver spending caps in the long term. As such, if new assessment revenues are used to increase provider payments or otherwise increase Medicaid expenditures, the State should closely analyze the impact of these increased expenditures on the waiver caps.

- *Administration* – To effectively administer the assessments, several functions should be considered, including: maintaining and routinely updating taxpayer lists; collecting data and calculating the assessments owed; notifying taxpayers; collecting the assessment; and on-going monitoring.

- *Staffing* – The State entity responsible for the assessment must have sufficient resources to administer the program, including a policy lead and operational staff in the areas of accounts receivable, auditing and legal support.

CHAPTER ONE

PROJECT OVERVIEW

A. Introduction

Federal law permits states to collect revenues or "health care-related taxes" from 19 specified classes of health care providers or services and use those revenues to fund various activities. Revenues collected from health care-related taxes can be used to raise provider rates, fund other costs of the Medicaid program or be used for other non-Medicaid purposes, such as depositing the funds into the state's general treasury. States must meet strict federal requirements when implementing health care-related taxes, including taxing all providers or services in a class (i.e., the tax cannot be limited to Medicaid providers only) and applying a methodology that is similar for all providers or services in that class (i.e., same rate or amount of tax is applied).

Currently, Vermont levies health care-related taxes on six of the permitted classes. Vermont Act 45 of 2011 granted authority to the Secretary of Administration to explore the functionality and practicality of establishing any health care-related tax currently not levied by the State. The State contracted with the Pacific Health Policy Group (PHPG) to evaluate the expansion of provider classes not currently levied in Vermont and propose recommendations for improving Vermont's existing provider taxes. PHPG is a national consulting firm specializing in the research, evaluation and reform of state Medicaid programs. This report summarizes PHPG's findings and presents recommendations for improving Vermont's provider tax system.

B. Methodology and Approach

The Department of Vermont Health Access (DVHA) has invaluable insights about the mechanisms used to implement the existing health care-related taxes. DVHA administers the existing provider assessments; in addition, during the 2011 legislative session, DVHA and other State staff developed proposed methodologies for implementing new taxes on dental services and managed care organizations. As such, upon project initiation, PHPG met with State staff to obtain their opinions and any relevant documentation related to current tax implementation and the proposals from earlier in 2011.

In order to inform the recommendations for Vermont, PHPG used professional knowledge and surveyed the published literature to determine other states that implement one or more health care-related taxes. PHPG obtained relevant documents related to these taxes, including

statutes, regulations and reporting forms, through online resources and follow up contact directly with the states via telephone and email.

Given Vermont's strong history of State-provider collaboration and the importance of such collaboration in developing a methodology that meets Vermont's needs, PHPG met with various providers and their representatives. A listing of these meetings and those in attendance is provided in Appendix A to this report. The meetings served as an opportunity to provide background on the purpose of the study; explain the federal requirements for health care-related taxes; provide information about Vermont's current taxes and methodological differences; and discuss options and solicit input about the current and potential new taxing methodologies.

Based on PHPG's discussions with State staff and provider groups, PHPG identified data sources to prepare estimates of projected patient revenues for all the provider/service classes as well as key implementation considerations and activities. To determine future tax revenues for classes currently taxed, PHPG calculated or directly obtained historical tax base data from financial information submitted by providers to the State for the SFY 2012 assessments. For other permissible, but not currently taxed providers, PHPG utilized other verifiable State-specific and national data sources to estimate the historical tax base in lieu of actual financial information.

C. Report Structure

Chapter Two describes the federal rules governing health care-related taxes, including the background of the regulations, taxable classes of providers and services, conditions for imposing such taxes and requirements for implementing provider taxes.

Chapter Three presents a national overview of state trends in provider taxes. This chapter discusses the most commonly taxed provider and service classes as well as those only a handful of states have implemented. In addition, PHPG provides a summary of the taxing methodologies used by states in administering their provider tax program.

Chapter Four discusses the provider taxes currently levied in Vermont, which include services provided by hospitals, nursing facilities and intermediate care facilities for the mentally retarded (ICF/MRs), home health and outpatient prescription drugs. This chapter explores assessment methodologies, revenues, collection mechanisms and identified implementation issues for Vermont's existing taxes.

Chapter Five provides suggested methodologies for, and the revenue impact of, implementing additional provider taxes in Vermont. Included in this discussion are policy considerations for any new provider taxes, such as the potential impact on access to care by provider/service class, possible federal changes and Vermont Act 48.

The report concludes with Chapter Six which provides suggestions for implementing taxes should Vermont decide to move forward. Factors to be considered by the State include policy development, potential impact on Vermont's Section 1115 Demonstration waivers, administration and staffing needs.

CHAPTER TWO

FEDERAL RULES GOVERNING HEALTH CARE-RELATED TAXES

A. Background

Prior to 1991, many states would collect funds from Medicaid providers in the form of taxes, donations, assessments or fees, and pay the money back to the same providers in the form of Medicaid payments, while claiming the federal matching share for those payments. Once the state share was netted out, the federal matching funds claimed could be used to raise provider payment rates, fund other portions of the Medicaid program or be used for other non-Medicaid purposes. In essence, states were using this mechanism to circumvent their share of Medicaid program costs.

To curb this practice, Congress passed the Medicaid Voluntary Contribution and Provider Specific Tax Amendments (P.L. 102-234) in 1991, amending Section 1903(w) of the Social Security Act (42 U.S.C § 1396b(w)). Those laws were later revised through the Tax Relief and Health Care Act of 2006 (P.L. 109-432). These laws, along with corresponding federal regulations (42 C.F.R. §§ 433.54 through 433.74), provide the authority and guidelines that states must follow in order to fund a portion of the state share of Medicaid program costs by assessing/taxing health care providers or services. The federal authority for health care-related taxes is the Centers for Medicare and Medicaid Services (CMS).

B. Description

Health care-related taxes are fees, assessments or other mandatory payments related to:[1,2]

(1) *Health care items or services* – Under this criterion, a tax is considered related to "health care items or services" if at least 85 percent of the burden of such tax falls on health care providers.[3] For example, if a tax is imposed at equal rates on physicians and attorneys, the tax would be considered health care-related under federal requirements if 85 percent of the tax burden falls on physicians;

(2) *Provision of, or authority to provide, health care items or services* – For example, this would include professional licensing fees required by the state; or

[1] 42 C.F.R. § 433.55.
[2] 57 Fed. Reg. 55118 (November 24, 1992).
[3] 42 C.F.R. § 433.55(b).

(3) *Payment for health care items or services* – For example, this would include taxes on payments made by health insurance plans for the provision of health care items or services.

A tax is considered to be health care-related if it is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different than the tax treatment provided to other individuals or entities.[4] In determining whether a tax applicable to health care providers is different from the treatment of other taxpayers, state credits and rebates also are taken into account.[5]

Health care-related taxes do not include the payment of a criminal or civil fine or penalty, unless the fine or penalty was imposed instead of a tax.[6] Federal regulations also stipulate that health care insurance premiums and health maintenance organization premiums paid by an individual or group to ensure coverage or enrollment are not considered payments for health care items and services for purposes of determining whether a health care-related tax exists.[7]

As described in Exhibit 2-1 on the following page, health care-related taxes can be applied to 19 specified classes of health care providers or services listed in federal regulation.[8] A tax on any particular class of service or provider of such service must apply uniformly to all items/services or providers within that class, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider.[9] This rule prevents states from limiting provider taxes solely to Medicaid providers who can easily be held harmless through increased Medicaid payments.

[4] 42 C.F.R. § 433.55(c).
[5] 57 Fed. Reg. 55118 (November 24, 1992).
[6] 42 C.F.R. § 433.55(d).
[7] 42 C.F.R. § 433.55(e).
[8] 42 C.F.R. § 433.56(a).
[9] 42 C.F.R. § 433.56(b).

Exhibit 2-1 – Taxable Classes of Health Care Providers and Services

- Inpatient hospital services*
- Outpatient hospital services*
- Nursing facility services*
- Intermediate care facility services for the mentally retarded or developmentally disabled (ICF/MR-DD)*
- Home health care services*
- Outpatient prescription drugs*
- Physician services
- Services of managed care organizations (including health maintenance organizations and preferred provider organizations)
- Ambulatory surgical center services, as described for purposes of the Medicare program in Section 1832(a)(2)(F)(i) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures
- Dental services
- Podiatric services
- Chiropractic services
- Optometric/optician services
- Psychological services
- Nursing services, defined to include all nursing services, including services of nurse midwives, nurse practitioners and private duty nurses
- Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services and rehabilitative specialist services
- Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department or hospital outpatient department
- Emergency ambulance services
- Other health care items or services not listed above on which the state has enacted a licensing or certification fee, subject to the following:
  (i) The fee must be broad based and uniform or the state must receive a waiver of these requirements;
  (ii) The payer of the fee cannot be held harmless; and
  (iii) The aggregate amount of the fee cannot exceed the state's estimated cost of operating the licensing or certification program

**Class currently assessed in Vermont, as of December 2011*

C. Conditions for Imposing Provider Taxes

In order to be permissible under federal law, any provider tax enacted by a state must be (1) broad based, (2) uniformly imposed and (3) cannot violate hold harmless provisions.[10]

Broad Based

A provider tax is considered to be broad based if the tax is imposed on at least all health care items or services in the class or providers of such items or services furnished by all non-federal, non-public providers in the state and is imposed uniformly.[11] In other words, states cannot limit the tax to Medicaid providers.

Uniformly Imposed

Generally, a health care-related tax is considered to be imposed uniformly if the tax is the same amount for every provider furnishing those items or services within the class.[12] For instance, if the tax is based on the number of hospital beds, then the amount of the tax must be the same for each bed of each hospital. If the tax is based on provider revenue, then the rate at which gross revenues or net operating revenues are taxed must be the same for all services (or providers of those services) in the class. The uniformity requirement also is violated where the tax holds taxpayers harmless for the cost of the tax.[13]

Hold Harmless

The hold harmless provisions were established to ensure that the tax paid by providers is not returned to them such that they are made whole or "held harmless."[14] In other words, states are prohibited from providing a direct or indirect guarantee that providers will receive their money back. There are three tests for determining whether taxpayers are held harmless: positive correlation test, Medicaid payment test and guarantee test. Taxes that fail any of these three tests are determined to have a hold harmless provision in violation of federal law. These three conditions are explained more fully on the next page.

[10] 42 C.F.R. § 433.68 (b).
[11] 42 C.F.R. § 433.68(c).
[12] 42 C.F.R. § 433.68(d)(1).
[13] 42 C.F.R. § 433.68(d)(2).
[14] 42 C.F.R. § 433.68(f).

Positive Correlation Test

The positive correlation test is met when the state makes a direct or indirect non-Medicaid payment to the taxpayer and the amount of the payment is "positively correlated to either the tax amount or to the difference between the Medicaid payment and the tax amount."[15] These payments may take various forms, such as tax credits or grants, and "direct or indirect" is interpreted broadly. CMS provides the following example:[16]

> A positive correlation would exist "where a state passes a tax on nursing home beds that a facility is permitted to pass on to its residents in the form of rate increases. If at or about the same time, the state passes a grant program that pays private pay residents of the nursing home an amount similar to the bed tax, the grant money would be available for use to compensate the nursing facility for the tax and a positive correlation would be found to exist between the tax and the grants. The correlation would not be destroyed by altering one variable over time and would not necessarily need to be measured in a statistical sense."

In the above example, the nursing home is held harmless from the impact of the tax because the grant monies going to the nursing home residents are returned to the nursing home as increased fee payments that are similar to the tax payment.

Medicaid Payment Test

The Medicaid payment test is met when all or any portion of the Medicaid payment to the taxpayer varies based only on the tax amount, including conditioning Medicaid payment on receipt of the tax amount.[17] States are permitted to use tax revenues to fund provider reimbursement for the provision of covered services. Reimbursement, however, cannot be based on the receipt of provider taxes.

Guarantee Test and Safe Harbor

A tax program is impermissible if it meets the guarantee test. This test is met when the state imposing the tax provides for any direct or indirect payment, offset or waiver that directly or indirectly guarantees to repay the taxpayer for all or any portion of the tax amount.[18] An indirect guarantee is determined to exist under a two-prong "guarantee" test. Taxes imposed

[15] 42 C.F.R. § 433.68(f)(1).
[16] 73 Fed. Reg. 9685, 9691 (Feb. 22, 2008).
[17] 42 C.F.R. § 433.68(f)(2).
[18] 42 C.F.R. § 433.68(f)(3).

on health care-related providers may not exceed 6 percent of the revenue received by the taxpayer unless the state makes a showing that, in the aggregate, 75 percent of taxpayers do not receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other state payments.

The Tax Relief and Health Care Act of 2006 (TRHCA)[19] changed the indirect hold harmless threshold under which tax programs could avoid being tested for hold harmless violations. For fiscal years beginning on or after January 1, 2008 and through September 30, 2011, taxes at or below 5.5 percent of revenues could forgo scrutiny of the hold harmless provisions. Beginning October 1, 2011, the threshold reverted to the 6 percent "safe harbor."

Possible Federal Changes Regarding Safe Harbor

In recent years, there have been a number of proposals at the federal level that would reduce the amount of health care-related taxes that states can levy under the safe harbor provision, thereby achieving savings at the federal level due to decreased requirement for federal share of states' Medicaid programs.[20] For example, the National Commission on Fiscal Responsibility and Reform (Bowles-Simpson) issued a series of deficit reduction proposals in November 2010, including a proposal to reduce taxes that states may levy on health care-related providers. The Congressional Budget Office's 2008 budget options publication included an option to lower the safe harbor threshold for provider taxes from 6 percent to 3 percent of revenues. President Obama's FY 2012 budget proposed to reduce the safe harbor threshold from 6 percent in 2014 to 3.5 percent from 2105 to 2017 and beyond. The President's Framework for Shared Prosperity and Shared Fiscal Responsibility released April 13, 2011 also would limit states' use of provider taxes. More recently, the failed Congressional Super-Committee's budget reduction efforts were purported to have included a reduction similar to that proposed by President Obama.

While none of these have actually been passed into law, it is a possibility that states should consider when depending on revenues from health care-related taxes to support their Medicaid programs.

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[19] Pub. L. 109-432.
[20] Kaiser Commission on the Uninsured, "Medicaid Financing Issues: Provider Taxes," (May 2011).

D. Federal Review of Health Care-Related Taxes

New health care-related taxes do not require formal CMS approval unless the amount of the tax is directly related to the provider reimbursement methodology under the State Plan, or if a state seeks a waiver from one or more of the requirements outlined in 42 C.F.R. § 433.68. However, CMS encourages states to consult with them as new taxes are being contemplated to ensure that the taxes comply with federal standards.[21] If CMS regards a health care-related tax as impermissible, following a formal or informal review, it may reduce federal matching to the extent of a state's receipt of tax revenues from the impermissible tax.[22]

For any health care-related tax program, states are required to report summary information to CMS on a quarterly basis, including supporting documentation of the legal basis for the program, as well as amount, source and use of taxes collected.[23] Vermont and CMS historically have a strong working relationship. It would be in the best interest of the State to notify CMS and solicit advice on the validity of any anticipated new health care-related taxes.

[21] Verbal communication with Richard McGreal, Associate Regional Administrator, Centers for Medicare and Medicaid Services, (December 13, 2011).
[22] 42 C.F.R. § 433.70(b).
[23] 42 C.F.R. § 433.74.

CHAPTER THREE

OVERVIEW OF OTHER STATES' HEALTH CARE-RELATED TAXES

A. Overview of State Trends

In recent years, states have increasingly relied on provider assessment revenues to fund their Medicaid programs. Currently, 46 states report having some type of health care provider assessment, an increase from 41 states in FY 2007.[24] The only states without these taxes are Alaska, Delaware, Hawaii and Wyoming.

Although the total number of provider assessments in place has remained relatively constant, assessments on hospitals have seen the greatest increase. The Kaiser Commission on Medicaid and the Uninsured reported assessments on hospitals increased from 19 in SFY 2008 to 34 in 2011.[25] During the 2011 legislative session, at least three states (Indiana, North Carolina and Oklahoma) enacted legislation to develop hospital assessment programs.

In addition to hospitals, other commonly taxed providers include nursing facilities and ICF/MR-DD providers. To date, 38 states require nursing facilities to pay provider taxes, and 32 states assess taxes on ICF/MR-DD providers. Additional states also are in the process of implementing assessments on facilities. Generally, implementing assessments on these three provider classes serve to benefit both the states and providers, given the number of Medicaid services provided and potential for federally-matched reimbursement for the services.

Exhibit 3-1 on the following page highlights the assessments currently levied by Vermont as well as the other states that have implemented these particular taxes. Contrary to hospital, nursing facility and ICF/MR-DD, taxes on home health care and outpatient prescription drugs are less frequently taxed. Vermont is one of two states to assess home health care providers, and one of five states that tax outpatient prescription drugs dispensed or refilled by pharmacy providers.[26,27]

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[24] NCSL, "Health Care Provider and Industry Taxes/Fees" (November 10, 2011), available at: http://www.ncsl.org/?tabid=14359. See also Kaiser Commission on Medicaid and the Uninsured, "Medicaid Financing Issues: Provider Taxes," (May 2011).

[25] Kaiser Commission on Medicaid and the Uninsured, "Medicaid Financing Issues: Provider Taxes," (May 2011).

[26] Louisiana is the only state that applies the assessment on both pharmacists and dispensing physicians. Further, Louisiana's assessment applies to any outpatient prescription dispensed filled or refilled in the state or shipped, mailed or delivered in any manner to the state. (See La. Rev. Stat. §§ 46:2622 and 46:2625 and L.A.C. 48:1:4001.)

[27] Washington applies a Business and Occupation gross receipts tax, which typically would not be considered a "health care-related tax." Additional detail regarding this taxing methodology is provided further in this report.

Exhibit 3-1 – National Overview of Health Care-Related Assessments

State	Hospitals	Nursing Facilities	ICF/MR-DDs	Home Health Care	Prescription Drugs	Any Provider Tax
Alabama	X	X			X	X
Alaska						
Arizona						X
Arkansas	X	X	X			X
California	X	X	X			X
Colorado	X	X	X			X
Connecticut		X				X
Delaware						
Florida	X	X	X			X
Georgia	X	X				X
Hawaii						
Idaho	X	X				X
Illinois	X	X	X			X
Indiana		X	X			X
Iowa	X	X	X			X
Kansas	X	X				X
Kentucky	X	X	X	X		X
Louisiana		X	X		X	X
Maine	X	X	X			X
Maryland	X	X	X			X
Massachusetts	X	X	X			X
Michigan	X	X				X
Minnesota	X	X	X			X
Mississippi	X	X	X			X
Missouri	X	X	X		X	X
Montana	X	X	X			X
Nebraska			X			X
Nevada		X				X
New Hampshire	X	X				X
New Jersey	X	X	X			X
New Mexico						X
New York	X	X				X
North Carolina		X	X			X
North Dakota			X			X
Ohio	X	X	X			X
Oklahoma		X				X
Oregon	X	X				X
Pennsylvania	X	X	X			X
Rhode Island	X	X				X
South Carolina	X		X			X
South Dakota			X			X
Tennessee	X	X	X			X
Texas			X			X
Utah	X	X	X			X
Vermont	X	X	X	X	X	X
Virginia	X		X			X
Washington	X	X	X		X†	X
West Virginia	X	X	X			X
Wisconsin	X	X	X			X
Wyoming						
Total	**34**	**38**	**32**	**2**	**5**	**46**

Information for this chart was compiled from multiple resources, including NCSL, Kaiser Family Foundation and research performed by PHPG.
†Note: Washington applies a Business and Occupation tax on the gross proceeds from sales of drugs, medicines, prescription lenses and other substances used for the diagnosis, cure, mitigation, treatment or prevention of disease or other ailments in humans. Additional detail regarding this taxing methodology is provided further in the report.

Federal regulations also permit states to tax services of managed care organizations, including health maintenance organizations (HMOs) and preferred provider organizations (PPOs). According to the National Conference of State Legislatures (NCSL), at least 12 states assess managed care entities.[28] This includes states that specifically tax managed care organization services or include these entities within a general tax on insurance companies. In most cases, the general insurance taxes are not a "health care-related tax" because the tax applies to multiple lines of businesses within the insurance industry.

Prior to passage of the Deficit Reduction Act of 2005,[29] taxes were limited to Medicaid managed care organizations. Subsequent enactment of federal regulations broadened the permissible class of services from services of Medicaid managed care organizations to those of all managed care organizations.[30]

Without clear guidance from CMS, this would suggest all services of MCOs could be considered a permissible class of health care items or services for purposes of the taxes. Managed care services may include care provided through a staff plan model, payment of claims or premiums collected. A managed care organization could be taxed on all these services, provided the aggregate total complies with the safe harbor threshold of 6 percent.

For example, Minnesota levies three distinct taxes on health maintenance organizations. The state applies its 2 percent gross revenue MinnesotaCare tax to staff model health plan companies.[31] Staff model health plans are a type of HMO where services are provided by employees of the health plan. Minnesota also levies a surcharge of 0.6 percent on all premium revenues of managed care plans and community integrated service networks.[32] HMOs, along with nonprofit health service plan corporations and community integrated service networks, are subject to a 1 percent tax on gross premiums as well.[33]

Several states have expanded or developed general taxing provisions on insurance claims and premiums to include managed care organizations. Generally, CMS does not consider a uniform tax on all types of insurance to be a "health care-related tax," provided the portion of health care services represents less than 85 percent of the burden of the tax revenue and equal

[28] NCSL, "Health Care Provider and Industry Taxes/Fees" (November 10, 2011), available at: http://www.ncsl.org/?tabid=14359.
[29] Pub. L. 109-171.
[30] 72 Fed. Reg. 13726 (March 23, 2007).
[31] Minn. Stat. § 295.50 *et seq*.
[32] Minn. Stat. § 256.9657.
[33] Minn. Stat. § 297I.05 *et seq.*

treatment is applied to all taxpayers.[34] In New Mexico, all insurance companies, including health insurers, must pay a premium tax of 3.003 percent of gross premiums.[35] In addition, health insurance plans must pay a surtax of 1 percent on gross health insurance premiums and membership and policy fees received. Recently, Michigan replaced its Medicaid MCO and prepaid inpatient health plans use tax with the Health Insurance Claims Assessment, which assesses a percentage of nearly all carriers' and third party administrators' claims.[36]

As summarized in Exhibits 3-2 and 3-3, only a handful of states levy taxes on the other 12 federally-permissible classes of providers and services. Only Minnesota currently taxes all the remaining provider classes. West Virginia eliminated most of its provider taxes in 2010. Among the 7 states that tax the other permissible entities, the most common classes are ambulatory surgical center services, laboratory and x-ray services and emergency ambulance services.

Exhibit 3-2 – Survey of States with Other Federally Permissible Health Care-Related Assessment Classes

	Florida	Louisiana	Minnesota	Missouri	Rhode Island	West Virginia	Wisconsin
Physician Services			✓			X	
Ambulatory Surgical Center Services	X		✓		✓	✓	✓
Dental Services			✓			X	
Podiatric Services			✓			X	
Chiropractic Services			✓			X	
Optometric/ Optician Services			✓			X	
Psychological Services			✓			X	
Therapist Services			✓			X	
Nursing services			✓			X	
Laboratory/ X-ray Services	X		✓		✓	✓	
Emergency Ambulance Services		X	✓	✓		X	
Other Licensed Health Care Items or Services			✓				

Note: States that currently tax the provider classes are denoted by "✓"; although Minnesota still taxes these classes, the taxes are being phased out and will be eliminated in 2019. States that have eliminated, are not actively collecting or substantially modified their assessment programs are denoted by "X". The specific taxes are described in further detail in this report and in Appendix B.

[34] State Medicaid Director Letter (June 21, 1995).
[35] N.M. Stat. § 59A-6-2.
[36] Michigan P.A. 142 of 2011. The assessment began January 1, 2012.

Exhibit 3-3 – Overview of States with Taxes on Other Permissible Classes Not Taxed by Vermont

State	Overview of Assessment Program	Taxed Provider/Service Classes
Florida	• Beginning in 1991, Florida imposed an annual assessment against certain health care entities licensed in the state, including ambulatory surgical centers, mobile surgical facilities, clinical laboratories and diagnostic imaging centers[37] • Assessments began at 1.5 percent of entities' net operating revenues but were reduced to 1 percent. Providers challenged the constitutionality of the assessment. Although the tax was found to be constitutional, the state stopped collecting the tax due to protracted legal challenges[38] • Subsequently, Florida implemented a new assessment program requiring all health care facilities subject to facility licensure to pay an annual fee based on the number of beds or a specified amount depending on the facility type[39] • Currently, ambulatory surgical centers, as well as diagnostic and clinical facilities, pay an annual fee of $150 • Funding from these annual fees support the local health councils	• Ambulatory Surgical Center Services • Laboratory/X-ray Services • Other entities currently taxed: hospitals, nursing facilities and ICF/MR-DDs
Louisiana	• State statute provides for the assessment of medical transportation providers, which are defined as: "any natural person, firm, corporation, partnership or other juridical person who is engaged in delivering transportation to or from a medical service and who is paid for such delivery"[40] • The assessment is $7.50 per medical service trip • Although this tax has been in statute since 1992, it has never been collected due to lack of support from providers	• Emergency Ambulance Services • Other entities currently taxed: nursing facilities, ICF/MR-DDs and pharmacy

[37] Fla. Stat. § 395.7015.
[38] Hameroff v. PMATF (911 So. 2d 827 (Fla. 1st DCA 2005)).
[39] Fla. Stat. § 408.033.
[40] La. Rev. Stat. §§ 46:2622 and 46:2625.

Exhibit 3-3 – Overview of States with Taxes on Other Permissible Classes Not Taxed by Vermont

State	Overview of Assessment Program	Taxed Provider/Service Classes
Minnesota	• Minnesota imposes a series of gross revenue taxes on various types of providers of health care goods and services[41] • Provider taxes apply to health care providers as well as non-licensed individuals who provide services that qualify for reimbursement under the state's Medicaid program; staff model health plan companies; ambulance services; opticians; sellers of hearing aids; hospitals; surgical centers; and wholesale drug distributors • Currently the tax rate is 2 percent of gross revenues derived from patient services • Collected revenues are used to pay for the MinnesotaCare program which provides state-subsidized health care coverage for low-income individuals ineligible for Medicaid • The MinnesotaCare Tax is being phased down and scheduled to sunset at the end of 2019. It is expected that when the Affordable Care Act is fully implemented, many of the individuals enrolled in MinnesotaCare will be transitioned to Medicaid which would eliminate the need for the tax	• Physician Services • Ambulatory Surgical Center Services • Dental Services • Podiatric Services • Chiropractic Services • Optometric/Optician Services • Psychological Services • Therapist Services • Nursing services • Laboratory/X-ray Services • Emergency Ambulance Services • Other Licensed Health Care Items or Services • Other entities also taxed: hospitals, nursing facilities, ICF/MR-DDs, wholesale drugs and managed care

[41] Minnesota Statute §295.52 *et seq*.

Exhibit 3-3 – Overview of States with Taxes on Other Permissible Classes Not Taxed by Vermont

State	Overview of Assessment Program	Taxed Provider/Service Classes
Missouri	• With the exception of ambulance services owned and operated by a state entity, each ground ambulance service provider is subject to the state's ambulance service reimbursement allowance tax[42] • Although imposed in 2009, collection began in SFY 2012 • Current allowance rate is 4.417 percent of gross receipts • Program has been extended from 2011 to 2015, along with the state's other provider taxes (i.e., hospital, nursing facility, ICF/MR and pharmacy)	• Emergency Ambulance Services • Other entities also taxed: hospitals, nursing facilities, ICF/MR-DDs and prescription drugs
Rhode Island	• Since 2007, Rhode Island has imposed a 2 percent assessment of net patient services revenue received by outpatient health care facilities (i.e., free standing ambulatory surgical centers, physician ambulatory surgery centers or podiatry ambulatory centers) and imaging service providers[43] • Although litigation was filed in 2007 challenging the constitutionality of these assessments, the Providence District Court ruled that the assessments did not violate due process or equal protection provisions of the U.S. and Rhode Island Constitutions[44]	• Ambulatory Surgical Center Services • Laboratory/X-ray Services • Other entities also taxed: hospitals, nursing facilities and managed care • Eliminated in 2009: ICF/MR-DDs

[42] Mo. Rev. Stat. § 19.800 *et seq*. and 13 C.S.R. 70-3.200.
[43] R.I. Gen. Laws § 44-64-1 *et seq*.
[44] Rhode Island Medical Imaging Inc. v. Sullivan (A.A. No. 08-185 (November 9, 2010)).

Exhibit 3-3 – Overview of States with Taxes on Other Permissible Classes Not Taxed by Vermont

State	Overview of Assessment Program	Taxed Provider/Service Classes
West Virginia	• West Virginia's Broad Based Health Care Related Tax program began in 1993 and taxed 16 classes of providers and services[45] • Taxes ranged from 1.75 percent to 5.5 percent of gross receipts, depending on the provider class • In 2001 anticipated changes to the state code regarding taxes, as well as efficiency, prompted the state's legislature to begin phasing out several of these taxes, with eventual elimination on June 30, 2010. The phase-out bill was sponsored by 33 out of 34 state senators • Today, the state still assesses ambulatory surgical centers, independent laboratory and x-ray services, inpatient and outpatient hospital services, ICF/MR-DDs and nursing facilities	• Ambulatory Surgical Center Services • Laboratory/X-ray Services • Other entities also taxed: hospitals, nursing facilities and ICF/MR-DDs • Eliminated in 2010: Physician Services, Dental Services, Podiatric Services, Chiropractic Services, Optometric/Optician Services, Psychological Services, Therapist Services, Nursing Services and Emergency Ambulance Services
Wisconsin	• Implemented in 2009, Wisconsin currently assesses ambulatory surgical centers at a rate of 4.68 percent of annual gross patient revenue[46] • In December 2011, Bill 408 was submitted to repeal this assessment • Proponents of Bill 408 raise the following issues: the tax is not good for employment or the economy, fairness, sustainability and transparency	• Ambulatory Surgical Center Services • Other entities also taxed: hospitals, nursing facilities and ICF/MR-DDs

[45] W. Va. Code § 11-27-1 *et seq.*
[46] Wis. Stat. § 146.98.

B. Other Taxes Related to Health Care

Federal regulations limit the categories of health care providers upon which states may impose "health care-related taxes." However, states have explored the possibilities of imposing taxes on categories of providers that are not among those listed in federal statute and regulations. Notably, these have included home and community care providers, personal care providers, case management providers and behavioral health providers.[47]

States have added categories of providers not listed as permissible subjects of health care taxes through other tax provisions not subject to Medicaid's tax requirements. Generally, taxes are not subject to federal limitations if (1) more than 15 percent of the tax proceeds are collected from non-health care related taxpayers and (2) the treatment of taxpayers does not differ (i.e., a health care provider is not taxed at a different rate than a non-health care provider).

Exhibit 3-4 below highlights the practices of Washington, Maine and West Virginia, which tax providers of health care services not subject to Medicaid's tax requirements.

Exhibit 3-4 – Examples of Taxes Not Subject to Federal Medicaid Tax Provisions

State	Overview of Program	Included Health Care Entities
Washington	• Business and occupation (B&O) tax is a gross receipts tax calculated on the gross income from activities conducted by a business[48] • Tax rates vary by classification, including retailing, wholesaling, manufacturing and service/other activities • Generally, health care providers are assessed at the state's current rate for "services and other activities" – a rate of 1.8 percent of the gross income received from performing health care services • Distinct from the state's safety net assessments for hospitals, ICF/MR-DDs and nursing facilities	• Dentists and other health care providers licensed by the state • Optometrists, ophthalmologists and opticians • Hospitals, nursing homes, boarding homes, adult family homes and similar health care facilities • Prescription drugs, prosthetic and orthotic devices, ostomic items and medically prescribed oxygen • Medical and hospital service bureaus and associations and similar health care organizations
Maine	• Service Provider Tax applies to community support services for individuals with mental health diagnoses, mental retardation or Autism, as well as home support services and private non-medical institution services[49] • Tax also applies to cable and satellite television services, fabrication services, video media and equipment rental and telecommunication services • Tax rate is 5 percent of the value of services sold	• Community Support Services • Home Support Services • Private Non-medical Institution Services

[47] Covington and Burlington LLP, "States Advisory: Developments Relating to Taxes on Health Care Providers," (December 9, 2011).
[48] WAC 458-20-151.
[49] 36 M.R.S. §2551 *et seq*.

Exhibit 3-4 – Examples of Taxes Not Subject to Federal Medicaid Tax Provisions

State	Overview of Program	Included Health Care Entities
West Virginia	• West Virginia's Severance and Business Privilege Tax applies to persons providing behavioral health services • Behavioral health services are defined as "services provided for the care and treatment of persons with mental illness, mental retardation, developmental disabilities or alcohol or drug abuse problems in an inpatient, residential or outpatient setting"[50] • Tax also applies to persons exercising the privilege of engaging or continuing in the business of severing, extracting, reducing to possession and producing for sale, profit or commercial use coal, limestone or sandstone, or is in the business of furnishing certain health care services such as behavioral health • Tax is applied uniformly at a rate of 5 percent of the gross value of the natural resource produced or health care service provided	• Behavioral Health Service Providers

C. Summary of Taxing Methodologies for Provider Entities Other Than Hospitals, Nursing Facilities and ICF/MR-DDs

Definitions of providers often are defined by the types of services provided. Depending on who or what is being taxed, the tax may be based on gross or net operating revenues received from patient services or a flat fee applied to a defined quantity, such as the number of prescriptions filled.

Generally, gross revenues or receipts are defined as the total amount received or receivable for patient services. This takes into account payment from patients and third party payers as well as specific adjustments and allowances. For example, West Virginia defines gross receipts as follows:[51]

> Gross receipts means the amount received or receivable, whether in cash or in kind, from patients, third-party payers and others for physicians' services furnished by the provider, including retroactive adjustments under reimbursement agreements with third-party payers, without any deduction for any expenses of any kind, provided that accrual basis providers are allowed to reduce gross receipts by their contractual allowances, to the extent such allowances are included therein, and by bad debts, to the extent the amount of such bad debts was previously included in gross receipts upon which the tax was paid.

[50] W. Va. Code § 11-13A.
[51] W. Va. Code § 11-27-1 *et seq*.

Typically, net operating revenues include revenue related to patient services less deductions, which would include charity care, bad debt and contractual allowances. For example, Florida applied the following definition of net operating revenue to its former assessment on ambulatory surgical centers and diagnostic-imaging centers:[52]

> "Net operating revenue" means gross revenue less deductions from revenue. "Gross revenue" means the sum of daily service charges, ambulatory service charges, ancillary service charges, and other operating revenue, except revenues received for testing or analysis of samples received from outside the state or from product sales outside the state. "Deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts; contractual adjustments; uncompensated care; administrative courtesy, and policy discounts and adjustments; and other such revenue deductions, and includes the offset of restricted donations and grants for indigent care.

The taxes apply to revenues from patient services or care, which would include diagnostic, medical treatment and therapeutic services. Taxes exclude activities such as director fees for serving on a board of directors, testimony as an expert witness or court-related proceeding, conducting seminars or educating the general public or non-patient related consulting services. Sales of certain medical supplies may or may not be subject to provider taxes, depending on whether the item would be considered part of providing patient services.

As in Minnesota and West Virginia, gross receipts or revenue received for providing a health care service is taxed only one time, although more than one health care provider is involved. These states do not "pyramid" taxes when two or more health care providers are involved in the delivery of the care. For example, a patient is treated by a physician who is employed by a hospital. The hospital bills the patient and receives payment from the patient; the hospital then pays the physician for the services to the hospital. The gross receipts from the provision of the physician's services are included only in the gross receipts of the hospital and not in the gross receipts of the physician. In contrast, a physician who contracts with the hospital to provide patient services and bills the patient separately would be required to include this service in his or her gross revenues.

States often delegate the responsibility for collecting the tax to the department of revenue or tax. However, some states operate their provider assessment programs through their Medicaid

[52] Fla. Stat. § 395.7015.

agencies. Some states apply a hybrid approach that requires the Medicaid agency to set rates and notify providers, but require the tax department to collect and deposit the revenues.

Unlike hospitals, nursing facilities and ICF/MR-DDs which are subject to federal and state cost reporting requirements, other taxed providers submit a self-reported income form. Information obtained from a non-facility provider remains confidential from public disclosure through state-specific statutory protections.

Fees associated with the tax typically are submitted on a monthly or quarterly basis depending on the provider type. In rare instances, the fee is submitted annually. Notices often are sent directly to the provider as a reminder of an upcoming payment. Fees usually are submitted electronically; however, states do allow for submission via mail or phone. Although most states have monitoring systems in place to track timely payments, a few states reported that individual taxpayers have been known to evade payment due to a lack of state resources for monitoring submissions. Collected revenues are used to support states' Medicaid or low-income care funds, reimbursement allowances or other initiatives.

Exhibit 3-5 on the following page provides an overview of selected states' taxing methodologies for non-facility provider classes.

Exhibit 3-5 – Overview of Taxing Methodologies (Excludes Hospital, Nursing Facility and ICF/MR-DD)

	Florida	Minnesota	Missouri	Rhode Island	West Virginia	Wisconsin
Tax Definition	Percentage of annual net operating revenues*	Percentage of gross revenues	Percentage of gross receipts	Percentage of net patient services revenue	Percent of gross receipts	Percentage of annual gross patient revenue
Taxable Revenue	Gross revenue less deductions from revenue	Total amounts received in money or otherwise by provider for patient services	Revenue from Medicare, Medicaid, insurance and private payments received	Charges related to patient care service less charges attributable to charity care, bad debt expenses and contractual allowances	Amount received or receivable, whether in cash or in kind, from patients, third-party payers and others for services furnished by the provider, including certain adjustments/ allowances	Gross amount received on a cash basis by the provider from all patient services
Collection Responsibility	Agency for Health Care Administration	Department of Revenue	Department of Social Services	Department of Revenue	Tax Department	Department of Revenue
Reporting Manner	Self-reporting form	Self-reporting with an annual report filed to reconcile the estimated payments with the final liability	Self-reporting form	Self-reporting form signed by provider or authorized representative subject to penalties of perjury	Self-reporting form	Annual self-reporting survey of gross patient revenue, total patient charges, bad debt expense, charity care, payer discounts and payer
Assessment Frequency	Fee submitted quarterly	Fee submitted monthly or quarterly depending on provider type	Fee submitted annually	Fee submitted monthly	Fee submitted monthly	Fee submitted quarterly
Use of Funds	Deposited into Public Medical Assistance Fund	Support MinnesotaCare Program	Deposited into reimbursement allowance fund	Deposited into the General Fund	Deposited into the Medicaid State Share Fund	To collect federal match for medical assistance program

*Prior to termination of program and transition to flat annual fee used to support local health councils.

CHAPTER FOUR

CURRENT VERMONT HEALTH CARE-RELATED ASSESSMENTS

A. Overview

Chapter 19, subchapter 2 of Vermont Title 33, referred to as the "Health Care Improvement Program," establishes statutory authority for Vermont's health care-related assessments under the Department of Vermont Health Access (DVHA).[53]

Vermont first implemented health care-related assessments in 1991 for inpatient and outpatient hospitals services, nursing homes and services of intermediate care facilities for the mentally retarded (ICF/MRs). This program was expanded in 1999 to include home health care agencies and again in 2005 to include retail pharmaceutical prescriptions.

Vermont law stipulates that the funds be deposited in the State Health Care Resources Fund,[54,55] used in the state's health care program in such a way as to be eligible for federal financial participation,[56] and administered so as to maximize federal financial participation (FFP) and avoid disallowances of FFP.[57] As such, the purpose of these assessments is to help provide the state share to leverage federal funds to support the State's Medicaid program without added expense to the State's general fund. In addition, DVHA is prohibited from using more than one percent of the fees for administration of the assessments.[58]

The Vermont statutes also prohibit assessed providers from charging patients directly for the assessment, but it does allow them to treat it as "a cost of doing business for the purpose of determining rates and charges."[59]

These statutes have been amended several times to meet changing federal requirements and state resource needs. Most recently, during the SFY 2011 legislative session, the statutes related to hospitals, nursing facilities, ICF/MRs, and home health agencies were changed to

[53] 33 V.S.A. § 1950 - 1958.
[54] 33 V.S.A. § 1956.
[55] 33 V.S.A. § 1901d. The State Health Care Resources Fund is established in the treasury as a special fund to be a source of financing health care coverage for beneficiaries of the State's health care assistance programs under the Global Commitment to Health waiver approved by CMS under Section 1115 of the Social Security Act.
[56] 33 V.S.A. § 1950(a).
[57] 33 V.S.A. § 1950(b).
[58] 33 V.S.A. § 1952(b).
[59] 33 V.S.A. § 1952(d).

reflect the increase in the allowed safe harbor percentage that became effective October 1, 2011. In addition, the base data used to calculate the hospital assessment was changed from that available for the most recent full fiscal year for which data is available to the hospitals' most recent budgeted data for the assessed year, with a reconciliation process at the end of the fiscal year.

B. Assessment Methodologies and Revenue Projections

Exhibit 4-1 on the following pages summarizes the current statutory authorities, methodologies and revenues associated with each of Vermont's existing health care-related assessments. As indicated in Exhibit 4-1, the actual calculation methodology is different for each of the existing assessments, reflecting the State's long-standing value of working collaboratively with the relevant provider classes to implement the assessments in a manner that is acceptable and transparent for the providers, while also being administratively streamlined for both providers and the State.

While the calculation methodology differs for each assessment, the basic process used by DVHA to implement the assessments is somewhat similar for all of these classes except the pharmacy assessment. DVHA notifies each of the individual providers within each class of their estimated total annual assessment approximately two weeks prior to the beginning of the state fiscal year, followed by monthly invoices. Attachments to the annual notice include the formal assessment notice, individual worksheets which show the calculation of the assessment and the data used for the calculations. For the pharmacy assessment, at the end of each month, pharmacies complete a form declaring the number of prescriptions filled and refilled in the previous month and send the form and a check to DVHA for the amount owed.

In SFY 2012, the existing assessments are expected to yield $129,674,332 in revenue for the State Health Care Resources Fund. When matched by federal funds, this represents a total of $307,722,667 to support the State's Medicaid program.

Exhibit 4-1 – Existing Vermont Health Care-Related Taxes, as of December 2011

Health Care Provider	Methodology	SFY '12 Assessment Revenue	SFY '12 Estimated Gross Medicaid Expenditures

Hospitals
33 V.S.A. § 1953
	• 14 medical hospitals and 2 free-standing psychiatric facilities[60]
	• Licensed medical hospitals (Inpatient and Outpatient Services), as defined in Chapter 43 of Title 18[61]
	• Assessed 5.9% of net patient revenues (less chronic, skilled and swing bed revenues)[62]
	    o Vermont's two psychiatric facilities, as defined in 18 V.S.A. § 1902(1)(B) or (H), but excludes psychiatric units of general hospitals, are assessed 4.21 % of net patient revenues[63]
	• Assessment is based on the hospital budget information for the taxed year, available through BISCHA
	    o Psychiatric facilities' taxes are based on the most current information from the preceding fiscal year, as provided by the two hospitals to DVHA via an assessment worksheet
		$108,439,233
		
		84% of total assessment revenue
			$274,000,000[64]

Nursing Homes ***33 V.S.A. § 1954***	• 42 nursing homes, of which 39 accept Medicaid beneficiaries and 3 do not • Nursing homes are defined as a health care facility licensed under Chapter 71 of Title 33[65] • Assessed $4,919.93 per licensed bed (this is equivalent to 6% of net patient revenues) • Assessment for each licensed bed is prorated for the number of days during which the bed was actually licensed, based on information collected by AHS Division of Rate Setting	**$15,852,879** **12% of total assessment revenue**	**$116,030,498**

[60] Vermont's 2 free-standing psychiatric facilities are the Vermont State Hospital and Brattleboro Retreat. At the time of this report, the Vermont State Hospital is no longer operational due to Hurricane Irene.
[61] 33 V.S.A. § 1951(7).
[62] For SFY 2012, the hospital assessment and the ICF/MR assessments are a blended rate of 5.8 percent, representing 5.5 percent for July through September, and 5.9 percent for October through June. It will remain at 5.9 percent, unless legislative changes occur.
[63] 33 V.S.A. § 1953(a)(2).
[64] Represents in-state hospital inpatient and outpatient services, plus an estimate of Medicaid payments associated with in-state hospital owned practices, based on 40 percent of total estimated SFY 2012 Medicaid physician reimbursement.
[65] 33 V.S.A. § 1951(11).

Exhibit 4-1 – Existing Vermont Health Care-Related Taxes, as of December 2011

Health Care Provider	Methodology	SFY '12 Assessment Revenue	SFY '12 Estimated Gross Medicaid Expenditures
ICF/MR (Intermediate Care Facilities for Persons with Mental Retardation) ***33 V.S.A. § 1955***	• 1 ICF/MR • ICF/MR is defined as a facility which provides long-term health-related care to residents with mental retardation pursuant to subdivision 1902(a)(31) of the Social Security Act (42 U.S.C. § 1396a(a)(31))[66] • Assessed 5.9% of their total annual direct and indirect expense for the most recently settled ICF/MR audit, as reported to the Department of Disabilities, Aging and Independent Living (DAIL)[22]	**$75,682** **0.1% of total assessment revenue**	**$1,261,329**
Home Health ***33 V.S.A. § 1955a***	• 12 home health agencies, all of which serve Medicaid beneficiaries • Home health agency is defined as "an entity that has received a certificate of need from the state to provide home health services or is certified to provide services pursuant to 42 U.S.C. § 1395x(o)"[67] • Assessed 19.3% of net operating revenues from core home health care services,[68] excluding revenues for services provided under Title XVIII of the Social Security Act (i.e., Medicare). (This is equivalent to 3.9% of net patient revenues) • Assessment is based on the agency's most recent audited financial statements at the time of submission, which are provided to DVHA on or before December 1 of each year	**$4,506,538** **3.5% of total assessment revenue**	**$32,625,250**
Pharmacy ***33 V.S.A. § 1955b***	• 136 retail pharmacies licensed in the State[69] and approximately one-third are independent pharmacies • Pharmacy is defined as "a Vermont drug outlet licensed by the Vermont state board of pharmacy … in which prescription drugs are sold at retail"[70] • Assessed $0.10 for each prescription filled or refilled based on self-reported data provided to DVHA	**$800,000** **0.6% of total assessment revenue**	**$167,719,326**

[66] 33 V.S.A. § 1951(8).
[67] 33 V.S.A. § 1951(6).
[68] Core home health care services mean those medically-necessary skilled nursing, home health aide, therapeutic and personal care attendant services, provided exclusively in the home by the home health agency. Core home health services do not include private duty nursing, hospice, homemaker or physician services, or services provided under early periodic screening, diagnosis and treatment (EPSDT), traumatic brain injury (TBI), high technology programs or services provided for the terminally ill.
[69] Vermont Office of Professional regulation licensing database (December 15, 2011).
[70] 33 V.S.A. § 1951(13).

PHPG calculated or directly obtained historical tax base data from financial information (e.g., Medicare Cost Reports, audited financial statements, self-reported data) submitted by providers to DVHA for the SFY 2012 assessments. To project the tax base for SFY 2013, PHPG applied trend factors either obtained from the BISCHA 2009 Vermont Health Care Expenditures Analysis (VTHCEA) or CMS 2009 National Health Expenditures (NHE) dataset; if trend factors were available from both sources, PHPG applied the lesser of the two to ensure conservative estimates. PHPG assumed assessments for SFY 2013 would be based on revenues received by providers during SFY 2012. See Exhibit 4-2 below for detailed descriptions of the definitions, data sources, assumptions and other considerations used for developing these estimates.

Exhibit 4-2– Definitions and Data Sources, Classes Currently Levied

Provider Class	Definition of Taxable Revenue	Data Source: Baseline Taxable Revenues	Data Source: Trend Factor	Notes
Hospital (IP/OP)	Net patient revenue (gross revenue, less chronic care, skilled and swing bed revenue)	Actual DVHA Assessment Calculations (based on hospital reports to BISCHA)	2009 VTHCEA – Hospitals	
Nursing Home	Net patient revenue	Actual DVHA Assessment Calculations (based on bed count as of June 30, 2011)	2009 NHE – Nursing Care Facilities and Continuing Care Retirement Facilities	Per bed assessment considered equivalent to 6% of net patient revenue, per DVHA methodology
ICF/MR-DD	Total annual direct and indirect expense	Actual DVHA Assessment Calculations (based on DRS Adjusted Cost for the lasted Final Cost Report for the period ending June 30, 2009)	2009 NHE – Nursing Care Facilities and Continuing Care Retirement Facilities	
Home Health	Net patient revenue	Actual DVHA Assessment Calculations (based on prior year in Current Audited Financial Statement)	2009 VTHCEA – Home Health	19.3% of net operating revenue assumed equivalent to 3.9% of net patient revenue, per DVHA methodology
Pharmacy	Revenue from retail prescription sales, both fills and refills	2009 Verispan, L.L.C. (Henry J. Kaiser Family Foundation, State Health Facts Online)	2009 VTHCEA – Vision/DME	0.14% assessment rate equivalent to DVHA estimated assessments for SFY 2012 divided by Projected Taxable Revenues

Based on current assessment rates, PHPG estimates that Vermont will raise over $137 million in revenues through the health care-related assessments below, an increase of approximately $8 million from the 2012 revenues. PHPG also assessed the impact of increasing current assessment rates up to the maximum allowable under the federal safe harbor provision (i.e., 6 percent); this potentially would raise $40.4 million (29 percent) in additional revenues, the majority (88 percent) of which would be obtained from retail pharmacy providers (see Exhibit 4-3).

Exhibit 4-3 – Estimated Revenue from Current Assessments, SFY 2013

Provider Class	Projected Taxable Revenues	Current Assessment Rate	Projected Assessment Revenues under Current Rate	Maximum Potential Revenues (6.0% Rate)	Net Potential Additional Revenues
Hospital	$ 1,945,466,414	5.90%	$ 114,782,518	$ 116,727,985	$ 1,945,466
Nursing Homes	$ 279,280,500	6.00%	$ 16,756,830	$ 16,756,830	$ -
ICF/MR-DD	$ 1,338,789	5.90%	$ 78,989	$ 80,327	$ 1,339
Home Health	$ 131,377,439	3.90%	$ 5,123,720	$ 7,882,646	$ 2,758,926
Outpatient Pharmacy	$ 608,501,851	0.14%	$ 830,400	$ 36,510,111	$ 35,679,711
TOTAL			**$ 137,572,457**	**$ 177,957,900**	**$ 40,385,443**

C. Audits, Penalties and Appeals

Vermont law enables the State to conduct audits to determine that amounts received from health care providers are correct.[71] The Vermont law also provides for late payment penalty fees and the authority for DVHA to deduct assessment arrears and any late-payment penalties from Medicaid payment otherwise due to the provider.[72] The penalty allowed in statute for hospitals, nursing homes, ICF/MRs and home health agencies is at the discretion of the Commissioner, but cannot exceed $1,000 per payment due. For the pharmacy assessment, the late payment penalty is two percent of the assessment amount for each month it remains unpaid, but cannot exceed $500 for any one quarter.

Given the relatively large revenue amounts to be collected from most of these assessments, the State may wish to consider revising some of the penalty amounts or formulas to be more

[71] 33 V.S.A. § 1957.
[72] 33 V.S.A. § 1952(f).

reflective of the amounts due. On the other hand, DVHA staff reported to PHPG that they do not have adequate resources to conduct audits of the payments, nor does the staff recall charging a late payment penalty fee on any provider.

Vermont law also sets forth an appeal process for the providers.[73] Under this appeals process, a provider has 20 days after DVHA notification of the annual assessment amount to submit a written request to DVHA for reconsideration, including the basis for the reconsideration. If requested, DVHA must hold a hearing within 20 days from the date on which the reconsideration request was received. On the basis of the evidence submitted to the department or presented at the hearing, the Department can reconsider and adjust the assessment.

The Department must provide written notice to the health care provider within 20 days of the hearing of the final determination of the amount it is required to pay based on any such adjustments. The law also provides for nonbinding arbitration with any health care provider dissatisfied with the Department's decision regarding the amount it is required to pay. In addition, any health care provider may appeal the decision of the Department as to the amount it is required to pay either before or after arbitration, to the superior court having jurisdiction over the health care provider.

D. Implementation Issues

One of the two purposes of this study is to "identify possible efficiencies and/or correct possible inconsistencies or problems with implementation" of existing Vermont assessments, and make suggestions for changes with a focus on "compliance with federal regulations, uniform approach to assessments, transparency in calculations, administrative ease in managing the assessments, and integrity and accuracy of base data used to calculate the assessments."

During the PHPG meetings with each of the existing provider classes, none suggested that the State change the manner in which it administers the assessments (i.e., have another State department administer the assessments, or require new forms to be completed). As such, this report does not recommend broad-based changes for the methodologies of the current assessments levied in Vermont, since the methodologies are well-established. However, the State should ensure that the department responsible for the assessments has the necessary

[73] 33 V.S.A. § 1958.

resources to enable them to be administered efficiently and effectively (see discussion on Administration of Existing and New Assessments and Staffing Needs in Chapter Six).

A number of specific implementation issues were identified during PHPG's meetings with the state and with providers. These issues are summarized in the following pages.

Hospitals

During PHPG's meetings with State staff, the Vermont Association of Hospitals and Health Systems (VAHHS) and a Springfield Hospital representative, the following five issues were identified:

(1) *Inclusion of Hospital-Owned Physician Practice Revenues* – Currently, DVHA includes revenue from hospital-owned physician practices as part of hospitals' net patient revenues when determining the assessment. VAHHS has raised the concern that the federally-permissible classes of providers and services are mutually exclusive, and therefore, physician practices (even those owned by hospitals) should not be included in hospital outpatient revenues.

(2) *FQHC Hospital Revenue Reporting* – Springfield Medical Care Systems (SMCS) is the parent system of Springfield Hospital and converted the Hospital's network of primary medical care practices to a network of federally qualified health centers (FQHCs). Springfield Hospital reports a "zero" in the physician clinic revenue line on BISHCA Report 5. DVHA asked whether physician clinic revenues associated with this organization should be reported.

(3) *Inclusion of Disproportionate Share Hospital (DSH) Payments in Assessment Calculations* – The DSH program is jointly funded by federal and state governments to provide additional revenues to hospitals that serve a disproportionate number of low-income patients (i.e., Medicaid and charity care). Vermont's hospital assessment is based on a percentage of net patient revenue (less chronic, skilled and swing bed revenues) as reported to BISCHA. As such, it is unclear whether the hospital assessment methodology should include DSH payments as part of hospital revenues, as an offset to bad debt and charity care deductions or not be included in the assessment calculation at all.

(4) *Lack of Consistency and Clarity Regarding Hospital Revenue Reporting* – An analysis by DVHA indicated that the net patient revenues reported to BISHCA on Report 5 do not necessarily equate to the net patient revenues submitted for some hospitals' Medicare Cost Reports (Worksheet G, line 3), even when taking into account the different definitions for the two submissions. Given the complexity of hospital revenues, there

may be confusion about what revenues should and should not be included in the hospital revenue reports to BISCHA.

(5) *Equity in Assessment Contributions* – Revenues from Vermont's hospital assessment yield approximately 84 percent of all provider assessment revenues. VAHHS and Springfield Hospital noted that, should Vermont enact new provider assessments, the organizations would expect the hospitals' relative percentage of contribution to be revisited.

A summary of Vermont's current practices along with key observations and suggested solutions to these issues are presented in Exhibit 4-4 beginning on the following page.

Exhibit 4-4 – Summary of Current Practices, Observations and Suggested Solutions for Issues Pertaining to Hospitals

Current Practices in Vermont	Key Observations	Suggested Solutions
(1) Inclusion of Hospital-Owned Physician Practice Revenues		
• Revenue from hospital-owned physician practices is included in the hospitals' outpatient revenues filed annually on BISHCA Report 5 (Net Patient Revenue by Payer) • DVHA includes this revenue as part of hospitals' net patient revenues as basis for assessment • Statutory language is unclear	• Federal regulations do not provide specific guidance on this issue; however, the Federal Register states: "while regulations specify classes that can be taxed, the regulations cannot interfere with the State's authority to impose taxes on one or more of the providers or prohibit a State from taxing a provider that would fall under two classes…"[74] • CMS guidance states: "If a State does not impose a separate tax on physician services, the inpatient hospital services performed by the physician should be subject to the tax. If, however, the State has a separate tax on physicians services, the State may include the inpatient hospital services performed by the physician under either inpatient hospital services or under physician services"[75] • State practices vary:[76] o AL: depends on what is included in hospitals' Medicare cost reports as hospitals may include revenue earned from their physician-owned practices as part of net patient revenue o CT: only net patient revenue from hospital's billings o MS: calculation is not required to be so specific, although any calculation would be made net of contractual allowances and other discounts o PA: does not include revenues earned from physician-owned practices as part of net patient revenue for tax	If NO new provider assessment on physicians: • Hospitals include revenue for hospital-owned practices in their revenue reports to BISHCA as part of hospital outpatient revenues for purposes of calculating their assessment, if the hospital-owned practices are: 1. Legal entities of the hospital organization, or 2. Included in Medicare Cost reports for Medicare reimbursement purposes. • Revise 33 V.S.A. § 1952(c) by deleting the reference to "physician's office practice" and add language in 33 V.S.A. § 1953(a)(1) to specifically include this revenue under the two above situations If THERE IS a new provider assessment on physicians (and other relevant classes): • Follow the above suggestions, and • Add language in the new statutory section for physician and other relevant practitioners to reference "services of (provider class) not otherwise taxed" to ensure an equitable interpretation of the law and avoid double taxation

[74] 58 Fed. Reg. 43156 (August 13, 1993).
[75] State Medicaid Director Letter (June 21, 1995).
[76] 2011 Provider Tax Inquiry to the National Association of Medicaid Directors Member States.

Current Practices in Vermont	Key Observations	Suggested Solutions
(2) Federally Qualified Health Center (FQHC) Hospital Revenue Reporting		
• Springfield Hospital, a critical access hospital, is the wholly-owned subsidiary of SMCS • SMCS is a 501(c)(3) non-profit FQHC	• SMD guidance states: "FQHCs are defined distinctly from physician services in section 1905(1)(2) of the Social Security Act and cannot be redefined by a state as a physician service"[77]	The parent company of Springfield Hospital is SMCS, which is a FQHC. As a subsidiary, Springfield does not own any physician practices. Therefore, Springfield would not be required to report FQHC physician revenues as part of its net patient revenues.
(3) Inclusion of Disproportionate Share Hospital (DSH) Payments in Assessment Calculations		
• Vermont's hospital assessments are based on percentage of net patient revenue (less chronic, skilled and swing bed revenues) as reported to BISHCA • BISCHA uniform reporting manual defines net patient revenues as "amount of funds the hospital will receive for the services rendered…after contractual allowances, commercial discounts, bad debts and free care are deducted from gross patient charges"	• Federal regulations do not refer to net patient revenues but define net operating revenues as gross charges of facilities less any deducted amounts for bad debt, charity care and payer discounts[78] • State practices vary:[79] ○ AL: net operating revenues is defined as gross charges less contractual allowances, but contractual could include bad debts, charity care, and be adjusted for DSH payments ○ GA: Net patient revenue means total gross patient revenue of a hospital less contractual adjustments, charity care, bad debt, Hill-Burton commitments and indigent care as defined and calculated in the department's annual hospital financial survey ○ OR: adjustments to net patient revenue include contractual adjustments, bed debts and charity care; also excluded are home health and physician services ○ PA: net operating revenue means net inpatient revenue – gross charges for facilities for inpatient services, less any deducted amounts for bad debt expense, charity care expense and contractual allowances as reported on the Medicare Cost Report for a specified year	Because DSH payments do not reflect billed services for patient care, do not include DSH payments as part of the net patient revenue for hospital assessment calculations. Because DSH payments are made by the state and federal governments to hospitals that serve a disproportionate number of low-income patients (i.e., Medicaid and charity care), these payments should be included as an offset to the deductions for charity care in the assessment calculations.

[77] State Medicaid Director Letter (June 21, 1995).
[78] 42 C.F.R. § 433.68(d)(1)(iii).
[79] 2011 Provider Tax Inquiry to the National Association of Medicaid Directors Member States.

Current Practices in Vermont	Key Observations	Suggested Solutions
(4) Lack of Consistency and Clarity Regarding Hospital Revenue Reporting		
• Net patient revenues are reported on both BISHCA Report 5 and Medicare Cost Reports (Worksheet G, line 3) • Different definitions are used for each report	• States produce hospital reporting guides to facilitate consistent completion of the cost reports; however, the level of detail varies	BISHCA and DVHA should jointly develop a clear set of reporting requirements for BISHCA Report 5 that will yield consistent revenue submissions across hospitals. This should be tied to the Medicare Cost Reports, and included in an Audit Guide given to Hospitals so they can assure that their audited statements include the details required for the assessment.
(5) Equity in Assessment Contributions		
• Revenues from the hospital assessment yield approximately 84 percent of all Vermont's provider assessment revenues	• Of the 46 states that levy provider taxes, 34 states tax hospitals whereas only 7 states tax providers not assessed by Vermont	If new assessments are enacted, the Administration and the General Assembly should review the relative contribution for each of the existing provider classes.

Nursing Homes

During PHPG's meetings with State staff and the Executive Director of the Vermont Health Care Association (VHCA), the following three issues were identified:

(1) *Communication with Corporate Entities* – DVHA indicated that some nursing homes are owned by corporate entities and do not receive the assessment notices in a timely manner since notices are sent to the nursing home administrator. This causes an additional administrative burden on DVHA staff and can result in delinquent payments.

(2) *Calculation Based on Licensed Beds* – According to VHCA's Executive Director, Vermont nursing homes have an average occupancy rate of 80 percent. This means that nursing homes pay the health care assessment on unfilled beds that are not generating any revenue. DVHA, however, noted that nursing homes are adding more private rooms which may result in more revenue from private payers or commercial insurance but does not result in additional assessment revenues for the State as the calculation is based on licensed beds.

(3) *Decreased Ability to Manage Financial Impact of Assessment* – VHCA's Executive Director noted that nursing homes used to be able to absorb the cost of the assessment through Medicare or private pay reimbursement. However, in October 2011, Medicare reduced nursing home rates by 11.1 percent. In addition, under federal health care reform, Medicare funding to Vermont nursing homes will be reduced by $27 million over the next few years. Nursing homes are paid based on costs that are at least two years old, creating little margin for inflationary factors. Nevertheless, VHCA and its members still are supportive of the provider assessment because it brings additional revenues to the State and supports Medicaid rates paid to nursing homes. If the existing Vermont inflationary factor for nursing home rates is not maintained or is decreased, VHCA members would not continue to support the assessment.

A summary of Vermont's current practices along with key observations and suggested solutions to these issues are presented in Exhibit 4-5 beginning on the following page.

Exhibit 4-5 – Summary of Current Practices, Observations and Suggested Solutions for Issues Pertaining to Nursing Homes

Current Practices in Vermont	Key Observations	Suggested Solutions
(1) Communication with Corporate Entities		
• DVHA sends assessment notices to nursing homes • Some nursing homes are owned by corporate entities which receive the notice rather than the nursing home itself	• Relying on internal re-routing of notices produces opportunities for delays and miscommunications	DVHA should work with the Division of Rate Setting to identify the appropriate staff in the Corporate Offices that should receive assessment notifications, and these staff should be copied on the notifications to the Nursing Home Administrators.
(2) Calculation Based on Licensed Beds		

• Vermont has 42 nursing homes, of which 39 are Medicaid nursing homes that average 65-70 percent Medicaid utilization
• Vermont assesses nursing homes on a per licensed bed basis (which is equivalent to 6 percent of net patient revenues), prorated for the number of days during which the bed was actually licensed
  ○ Nursing homes pay the health care assessment on unfilled licensed beds
  ○ Nursing homes are adding more private rooms which may result in more revenue but does not result in additional assessment revenues
	• It appears that there are several allowable bases for this tax, including licensed beds, all beds, occupied beds, patient days, and patient revenue, as long as the basis is uniformly imposed
	• CMS guidance states: The term "licensed or otherwise" refers to the "total number of beds that must be assessed for a tax to be considered uniformly imposed. The term 'or otherwise' has been defined to mean any existing beds in a facility that are otherwise unlicensed"[80]
	• CMS guidance states: federal regulations specify that a "health care related tax will be considered uniformly imposed if the tax is imposed on items or services on a basis other than those provided by statute, and the State establishes to the satisfaction of the Secretary that the amount of the tax is the same for each provider of such items or services in the class. We are clarifying that HCFA interprets 42 C.F.R. 433.68(d)(iv) to include health care related taxes on the occupied beds of a facility or the patient days of a facility…to the extent the rate of a health care related tax is the
		It is not clear that a change to the methodology would financially benefit the providers or the State. More analysis should be conducted before any changes to the existing methodology are considered.

[80] State Medicaid Director Letter (June 21, 1995).

Exhibit 4-5 – Summary of Current Practices, Observations and Suggested Solutions for Issues Pertaining to Nursing Homes

Current Practices in Vermont	Key Observations	Suggested Solutions
	same for each occupied bed or patient day and the tax is applied to all providers in the permissible class of services, a health care related tax program based on occupied beds or patient days will be considered uniformly applied"[81] • State practices vary: ○ FL: waiver for 3 Quality Assessment rate classes on a per-resident-day basis exclusive of Medicare days ○ ME: assessment is based on net operating revenues ○ MO: fee is based on per patient occupancy date which means the number of days that residents occupied the licensed beds ○ RI: tax is based on gross patient revenue received	
(3) Decreased Ability to Manage Financial Impact of Assessment		
• Tax revenues help to support nursing home reimbursement, but nursing homes are finically strained by Medicaid and private pay revenues	• VHCA's Executive Director reports that Medicare funding will be reduced by $27 million over the next few years	The Administration and General Assembly should understand the revenue sources and budgetary issues of nursing homes before making any changes to the inflationary factor or Medicaid rates.

[81] State Medicaid Director Letter (October 9, 1997).

Intermediate Care Facility Services for the Mentally Retarded or Developmentally Disabled (ICF/MR-DD)

PHPG met with State staff and the Executive Director of the Vermont Council for Developmental and Mental Health Services. No issues with the existing assessment were identified.

Home Health Agencies

During PHPG's meetings with State staff and the Executive Director of the Vermont Assembly of Home Health and Hospice Agencies (VAHHA), the following two issues were identified:

(1) *Multiple Fiscal Year End Dates and Use of Audited Financial Statements* – Not all home health agencies have the same fiscal year end dates. As such, DVHA must adjust the base for each agency to ensure that the assessments are calculated equitably. Further, re-statements on agencies' audited statements for prior years result in DVHA having to recalculate prior years' assessments and make necessary adjustments to the amount due for the current year.

(2) *Decreased Ability to Manage Financial Impact of Assessment* – The Executive Director of VAHHA noted that home health agencies used to be able to absorb the cost of the assessment through Medicare reimbursement. However, Medicare is reducing reimbursement rates to home health agencies. Moreover, Vermont reduced Medicaid rates to home health agencies by 2 percent in SFY 2008. The rates have not increased since then and have resulted in narrow operating budgets.

A summary of Vermont's current practices along with key observations and suggested solutions to these issues are presented in Exhibit 4-6 beginning on the following page.

Exhibit 4-6 – Summary of Current Practices, Observations and Suggested Solutions for Issues Pertaining to Home Health Agencies

Current Practices in Vermont	Key Observations	Suggested Solutions
(1) Multiple Fiscal Year End Dates and Use of Audited Financial Statements		
• Home health agencies have various fiscal year end dates • Assessments are based on home health agencies' most recent audited financial statements at the time of submission • Audited financial statements are submitted to DVHA on or before December 1 of each year	• Requires adjustments to align fiscal years	The only identified solution to this dilemma is for DVHA to change the methodology to be based on each agency's fiscal year. However, we believe this would add complexity rather than simplify the methodology, and therefore, we suggest that it remain the same.
(2) Decreased Ability to Manage Financial Impact of Assessment		
• Tax revenues help to support home health services reimbursement, but home health agencies are financially strained by Medicaid and private pay revenues	• VAHHA's Executive Director reports that home health agencies used to be able to absorb the cost of the assessment through Medicare reimbursement but anticipates challenges due to reduced reimbursement	As with all provider classes, the Administration and General Assembly should thoroughly understand the revenue sources and budgetary issues of home health agencies before making any changes to Medicaid reimbursement rates or health care assessment rates.

Pharmacy

During PHPG's meetings with State staff, and members of the Vermont Pharmacists Association and representatives, the following three issues were identified:

(1) *Ensuring All Vermont Retail Pharmacies Submit Payments* – DVHA noted that limited resources associated with the administration of the prescription drug assessment have resulted in the inability to closely monitor the status of pharmacies in Vermont that should pay this assessment fee. Given these limitations, DVHA does not send notifications about the assessment to newly licensed retail pharmacies. However, newly licensed pharmacies still submit their assessments without the notification. Without a routinely updated listing of pharmacies, DVHA also is unable to identify which pharmacies should submit assessment fees and appropriately follow-up with delinquent taxpayers or missing fee submissions.

(2) *Verification of Submitted Assessment Amounts* – Pharmacies self-report the number of filled prescriptions. Although the statute governing the assessment provides that pharmacies "shall provide supporting documentation to the commissioner of the total number of prescriptions filled and refilled in the previous month,"[82] DVHA does not have a mechanism in place to verify the accuracy of the information provided by taxpayers.

(3) *Assessed Amount* – The current assessment fee is $0.10 per prescription filled or refilled. Based on calculations performed by PHPG, this represents approximately 0.14 percent of pharmacy revenues. The current fee is significantly below the safe harbor threshold of 6 percent and could be raised. Pharmacists, however, reported additional financial burdens due to increased e-prescribing costs, increased Pharmacy Benefit Management claims processing fees, decreased private insurance dispensing fees and fewer Medicaid dispensing fees. The cumulative effect of these changes poses a challenge to independent pharmacies which are unable to spread the impact over multiple cost centers or states.

A summary of Vermont's current practices along with key observations and suggested solutions to these issues are presented in Exhibit 4-7 beginning on the following page.

[82] 33 V.S.A. § 1955b(b).

Exhibit 4-7 – Summary of Current Practices, Observations and Suggested Solutions for Issues Pertaining to Retail Pharmacies

Current Practices in Vermont	Key Observations	Suggested Solutions
(1) Ensuring All Vermont Retail Pharmacies Submit Payments		
• Providers are required to complete a Pharmacy Assessment Monthly Documentation Form • Newly licensed pharmacies are not notified by DVHA to comply with this requirement	• Inability to maintain current provider lists may result in missed revenue opportunities	Provide DVHA with the staff resources needed to monitor the licensed retail pharmacies in Vermont by routinely accessing the on-line database provided by the Vermont Office of Professional Regulation. • Using this on-line database, DVHA should routinely update their pharmacy list, delete those pharmacies no longer operating in Vermont and send assessment notifications to new retail pharmacies. • DVHA should use this list to identify pharmacies that are not submitting their assessment in a timely manner. Provide DVHA with the staff resources needed to follow-up on missing or delinquent fee submissions.
(2) Verification of Submitted Assessment Amounts		
• Providers are required to complete a Pharmacy Assessment Monthly Documentation Form that includes the number of prescriptions and refills • Information is self-reported	• Relying on self-reporting without verification may result in missed revenue opportunities • Vermont pharmacists noted that many providers use an automated electronic process to calculate the assessment owed, which also has the capacity to produce a list of all prescriptions filled • State practices vary: ○ AL: number of prescriptions dispensed are self-reported ○ LA: number of prescriptions dispensed are self-reported ○ MO: pharmacists submit an affidavit that includes, among other information, total pharmacy sales and gross receipts	Several options are available: • DVHA could require that pharmacies submit more detailed documentation that shows the number of prescriptions filled or refilled in the previous month. • DVHA could send an annual statement to pharmacies asking them to attest to the annual number of scripts filled, which can be used to validate against the monthly figures provided. • As a proxy, DVHA could run a report of total prescription claims paid by Medicaid to evaluate against the current figures reported (understanding that this report only captures Medicaid prescriptions). • DVHA could conduct annual audits on a randomly selected subset of retail pharmacy records to ensure the reporting information is accurate.

Exhibit 4-7 – Summary of Current Practices, Observations and Suggested Solutions for Issues Pertaining to Retail Pharmacies

Current Practices in Vermont	Key Observations	Suggested Solutions
(3) Assessed Amount		
• Each Vermont retail pharmacy is assessed $0.10 for each prescription filled or refilled	• Federal regulations provide for a safe harbor provision of 6 percent beginning October 1, 2011[83] • State practices vary: ○ AL: $0.10 per prescription on all prescriptions filled/refilled by a pharmaceutical services provider ○ LA: $0.10 per out-patient prescription dispensed in the state or shipped, mailed or delivered in any manner to the state by a pharmacist or dispensing physician ○ MO: beginning January 1, 2010, tax rate is a uniform effective rate of 1.82 percent, with an aggregate quarterly adjustment, not to exceed 0.5 percent, of gross retail prescription receipts (the maximum rate is set at 5 percent)	If examining the pharmacy assessment amount, the State should consider the other fees already paid by Vermont pharmacies and the potential impact on their financial viability.

[83] 42 C.F.R. § 433.68 and Pub. L. 109-432.

E. Health Insurance Claims Assessment

Beginning in 2007 the State imposed an assessment on health insurers to fund the State's Health Information Technology (HIT) Fund.[84] Under this assessment, health insurers are required to pay 0.199 percent of all health insurance claims paid by the health insurer for its Vermont members. The statute defines "health insurer" as follows:[85]

> Any person who offers, issues, renews, or administers a health insurance policy, contract, or other health benefit plan in this state and includes third-party administrators or pharmacy benefit managers who provide administrative services only for a health benefit plan offering coverage in this state. The term does not include a third-party administrator or pharmacy benefit manager to the extent that a health insurer has paid the fee which would otherwise be imposed in connection with health care claims administered by the third-party administrator or pharmacy benefit manager. The term also does not include a health insurer with a monthly average of fewer than 200 Vermont insured lives.

The term health insurance excludes Medicaid, VHAP or any other State health care assistance program financed through a federal program, as well as policies issued for specified disease, accident, injury, hospital indemnity, dental care, long-term care, disability income or other limited benefit health insurance policies.

During the 2011 legislative session, Governor Shumlin's SFY 2012 Budget proposed implementing new health care-related taxes on dental services and services of managed care organizations; however, these were not authorized. Instead the State chose to impose a new Health Care Claims Assessment on health insurers[86] to build off of the existing, similar assessment for the State's HIT Fund. Beginning October 1, 2011, health insurers are required to pay 0.80 percent of all health insurance claims paid for Vermont members. Revenues are collected for the State Health Care Resources Fund. The terms "health insurer" and "health insurance" are defined the same as the HIT reinvestment fee, with the exception that dental care policies are included under the new assessment.

Federal regulations specify "services of managed care organizations (including health maintenance organizations, preferred provider organizations)" as a permissible class. The

[84] 8 V.S.A. § 4089k.
[85] 8 V.S.A. § 4089k.
[86] 8 V.S.A. § 4089l.

Health Care Financing Administration (now CMS) provided further guidance for taxes on health insurance companies in a June 21, 1995 State Medicaid Director Letter:

> Q: Is a tax on insurance companies, including health care insurance companies, for the premiums it collects considered a health care related tax?
>
> A: If it is a uniform tax on all types of insurance (life, auto, etc.) and the portion of health care services represents less than 85% of the burden of the tax revenue and the tax provides equal treatment of all taxpayers, it is not considered a health care related tax. However, if the tax is only imposed on premiums collected by health care insurance companies, it is a health care related tax.

Federal guidance appears to suggest that a tax imposed only on health care insurance companies would be a health care-related tax. It is unclear whether Vermont's health insurance claims assessments would be considered a "health care-related provider tax" subject to federal Medicaid rules. Should the State decide to implement additional taxes or increase current rates, it is recommended that the State be cognizant of the 6 percent tax threshold and consult CMS for technical guidance.

CHAPTER FIVE

POTENTIAL NEW VERMONT HEALTH CARE-RELATED ASSESSMENTS

A. Overview

The federal regulations allow states to choose whether to tax the revenues of providers who provide the services within each permissible class or to tax the revenues associated with all services (as defined by the state) provided within the class, regardless of provider type. Vermont's current assessments are based on provider type. All of the health care-related taxes administered by other states also base their assessment on services within a defined provider class. As such, PHPG recommends that Vermont levy any new health care-related assessments on the net health service revenue of specific providers who are licensed in Vermont.

Exhibit 5-1 below and on the following page lists the permissible provider classes not currently levied in Vermont, the suggested Vermont definition and the number of providers licensed in each class statewide. PHPG evaluated the percent of Vermont Medicaid revenues for each class, which ranged from 2.4 to 25 percent in 2010. These percentages are significantly lower than some of the larger classes currently taxed (e.g., 32 percent for hospitals).

Exhibit 5-1 – Possible New Classes for Vermont Health Care-Related Assessments

Class of Health Care Services and Providers Allowed Under Federal Regulations (42 C.F.R. § 433.56)	Suggested Vermont Definition	Number of Licensed Providers[1,2]
Physician Services	VT Licensed Doctors of Medicine (26 V.S.A. § 1311) VT Licensed Doctors of Osteopathy (26 V.S.A. § 1750) VT Licensed Physician Assistants (26 V.S.A. § 1732) VT Licensed Naturopathic Physicians (26 V.S.A. § 4121)	4,078
Ambulatory Surgical Center Services, as described for Medicare in §1832(a)(2)(F)(i) of the SSA. Defined to include facility services only and not surgical procedures	Ambulatory Surgical Centers (18 V.S.A § 9432)	1
Dental Services	VT Licensed Dentists (26 V.S.A. § 721)	470
Podiatric Services	VT Licensed Podiatrists (26 V.S.A. § 321)	35
Chiropractic Services	VT Licensed Chiropractors (26 V.S.A. § 521(4))	248
Optometric/Optician Services	VT Licensed Optometrists (26 V.S.A. § 1703; 26 V.S.A. § 2651) VT Licensed Opticians (26 V.S.A. § 2651)	225
Psychological Services	VT Licensed Psychologists, Doctorate (26 V.S.A. § 3001) VT Licensed Psychologist, Master (26 V.S.A. § 3001) VT Licensed Clinical Social Workers (26 V.S.A. § 3201) VT Licensed Mental Health Counselors (26 V.S.A. § 3261) VT Certified Psychoanalysts (26 V.S.A. § 4051) VT Licensed Drug and Alcohol Counselors (33 V.S.A. § 801)	2,828

Exhibit 5-1 – Possible New Classes for Vermont Health Care-Related Assessments

Class of Health Care Services and Providers Allowed Under Federal Regulations (42 C.F.R. § 433.56)	Suggested Vermont Definition	Number of Licensed Providers[1,2]
Therapist Services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services and rehabilitative specialist services	VT Licensed Physical Therapists (26 V.S.A. § 2081) VT Licensed Physical Therapy Assistant (26 V.S.A. § 2081) VT Licensed Occupational Therapists (26 V.S.A. § 3351) VT Licensed Occupational Therapy Assistant (26 V.S.A. § 3351) VT Licensed Audiologists (26 V.S.A. § 4451) VT Licensed Speech Pathologists (26 V.S.A. § 4451) VT Licensed Respiratory Care Practitioners (26 V.S.A. § 4701)	2,568
Nursing Services, defined to include all nursing services, including services of nurse midwives, nurse practitioners and private duty nurses	VT Registered Nurses (26 V.S.A. § 1572) VT Licensed Practical Nurses (26 V.S.A. § 1572) VT Advanced Practice Registered Nurse (26 V.S.A. § 1572)	20,013
Laboratory and X-ray Services, defined as services provided in a licensed free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department or hospital outpatient department	*Laboratories* – CMS Clinical Laboratory Improvement Amendments (CLIA) Certified as an Independent Laboratory *X-ray* – Registered with Department of Health, Radiological Health Division Taxable revenues to include revenues generated by services provided at facilities located in Vermont.	3 6
Emergency Ambulance Services	Licensed Emergency Ambulance Providers (24 V.S.A. § 2651)	90[3]
Managed Care Organizations (MCOs), including health maintenance organizations, preferred provider organizations	During the 2011 Vermont legislative session, the explicit decision was made to impose a new Health Care Claims Assessment on claims paid by health insurers for their Vermont members rather than a more limited assessment on MCOs. As such, this Report does not provide any further analyses regarding assessments on MCOs.	N/A
Other health care items or services not listed above on which the State has enacted licensing or certification fees, subject to (i) broad based and uniform fee or approved waiver; (ii) payer of fee cannot be held harmless; and (iii) aggregate amount of fee cannot exceed State's estimated cost of operating the licensing/certification program	The following other VT health care providers are licensed: • Acupuncturists • Dieticians • Hearing Aid Dispensers • Midwives • Nursing Home Administrators • Radiological Technicians Vermont currently charges a provider fee to help offset the cost of operating the licensing/certification program. Therefore, it would not be fruitful to pursue new assessments in this category.	N/A

[1] Only active licenses, excluding students/interns/trainees and temporary/emergency licenses; information obtained from Vermont's state licensing authorities (i.e., Office of Professional Regulation, Department of Health, Department of Education).

[2] Not all of these licensed providers are providing direct patient care, as some may hold administrative, teaching, consulting or other such full-time positions.

[3] Provider count includes services operated by municipalities.

The remainder of this chapter discusses the policy considerations and revenue impact of any potential new health care-related assessments in Vermont.

B. Policy Considerations

Policy considerations in three areas should be considered when implementing additional health care-related assessment:

(1) Access to Care
(2) Federal Changes
(3) Vermont Act 48

Potential Impact on Access to Care

In each of the meetings that PHPG held with provider class representatives, concerns were raised about the impact new provider assessments would have on access to care for Vermonters. Providers from all groups raised similar concerns. Exhibit 5-2 below highlights the issues raised by providers during these meetings.

Exhibit 5-2 – Access to Care Concerns Raised by Providers

Provider Groups	Concerns
Physician Services	• Vermont Medical Society (VMS) passed a resolution on October 29, 2011 opposing a Medicaid Tax on Physicians' Net Revenue "due to the devastating impact such a tax would have on the state's ability to attract and retain physicians and the resulting decrease in patients' access to care in the face of current and worsening shortages"[87] • Additional support cited by VMS includes: ○ Already low reimbursement rates received by Vermont providers ○ Stigma associated with tax would detract new physicians ○ Financial and administrative strain on small, independent providers ○ Inability to balance bill patients to make up for lost revenue from tax ▪ State statute prohibits assessed providers from charging patients directly for the tax but allows for treating tax as a cost of doing business for the purposes of determining rates and charges; further, State guidance prohibits balance billing by providers who contract with private insurers[88] and by providers who bill for Medicare[89] and Medicaid[90] ○ Practices' patient insurance coverage mixes make increased Medicaid reimbursement an inadequate strategy for alleviating any new tax burden on physicians

[87] See http://www.vtmd.org/sites/default/files/files/2011%20Provider%20Tax.pdf.

Exhibit 5-2 – Access to Care Concerns Raised by Providers

Provider Groups	Concerns
Dentists	• The 2011 Vermont legislative session actively considered an assessment on dental services, however, this did not pass • The Vermont Dental Society expressed strong opposition to the proposed assessment and future assessments, citing the following reasons: o Vermont's dentists are aging and recruitment is challenging; a new tax would exacerbate this problem and cause border dentists to stop serving Vermonters o Payer mix is different than other provider types (49 percent of dental care is paid out of pocket by patients, 40 percent is paid by commercial insurance and 11 percent is paid by Medicaid) o Concerns about equity if dentists are assessed and not other professions that provide dental services (e.g., orthodontists and oral surgeons)
Optometrists, Opticians and Chiropractors	• Unlike many of the other provider classes, revenue is often limited by the fact that commercial insurance offers these services as a special rider through discounted plans, with reimbursement on par or less than Medicaid • Insurers, including Medicaid, are reducing the scope of treatment codes covered • Reimbursement rates and net margins are relatively low • A new assessment may result in practice closures or inability to recruit new providers
Psychologists, Mental Health Workers, Social Workers and Alcohol Counselors	• Mental health professionals are aging – the average age of psychologists nationally is 52 and average age of Vermont social workers is approximately 60 • Mental health professionals are reimbursed lower by commercial insurers • Many providers work in multiple settings to make ends meet (e.g., small private practice, mental health agency, teaching, etc.) • Private practitioners are moving towards only treating self-payers on a sliding scale
Therapists	• The Vermont Chapter of the American Physical Therapy Association submitted written concerns noting the following: o Physical therapists in private practice have experienced declining rates, with an average payment decrease of $110 to $88 in the past five years o Additional financial constraints will force providers out of business: "Many physical therapists in Vermont are also small business owners, and a loss of these small businesses will reduce access to health care in our rural communities as well as impact our economy on a local and statewide scale"

[88] BISHCA Rule 09-03.
[89] 33 V.S.A. § 6501.
[90] See http://www.vtmedicaid.com/Downloads/manuals/ProvManual%2011-1-2011.pdf, page 25, Section 1.2.17.

Exhibit 5-2 – Access to Care Concerns Raised by Providers

Provider Groups	Concerns
Ambulance Services	• 87 of 90 licensed ambulance services providers in Vermont are provided by not-for-profit entities or are operated by municipalities, and more than half are staffed by volunteers • All but one entity bills insurance; providers can only bill if they actually provide a transport • Some ambulance services are supported by taxes from the local town(s) they serve • Representatives expressed significant concern that an assessment would cause these municipalities to increase local taxes to make up for the assessment and/or would cause the smaller, mostly voluntary, providers to close
Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Critical Access Hospitals (CAHs), Vermont Coalition of Clinics for the Uninsured (VCCU), Planned Parenthood Clinics, Area Health Education Centers (AHECs), Rural Primary Care Practices	• Bi-State Primary Care Association represents organizations which employ many providers that may be subject to one or more of the new assessments * • Bi-State expressed the following concerns: o Represented organizations are the primary safety net for Vermont's health care system, in that they serve one in four Vermonters, and have very low operating margins o New assessments will "have a negative impact on practices' ability to provide primary care services and uncompensated care to their patients" o Further, the assessments "undermine the primary aim of Act 48 which is to provide quality, accessible health care to all Vermonters" * *Note: "FQHC services" are recognized as a unique Medicaid category of service that is not recognized as a permissible taxable class; however, it is unclear whether revenues derived from services recognized as a permissible class (e.g., physician services) could be assessed.*

Federal Changes

There is the possibility that future federal changes may reduce the amount of health care-related taxes that states can levy under the safe harbor provision. This threshold is currently at 6 percent of net operating revenues. Federal proposals have included reducing the threshold to as low as 3 percent.

Most of Vermont's existing assessments are at or very close to the current 6 percent threshold. If federal changes are to occur in the near future, Vermont could lose as much as half of the current assessment revenue used to support the State's Medicaid programs. Further, this potential change in the allowed threshold should be taken into consideration should Vermont choose to implement one or more new health care-related assessments.

Changes to Vermont's assessment on hospitals should consider the impact of the Affordable Care Act on disproportionate share hospital (DSH) payments. Under the Affordable Care Act, state Medicaid DSH payments will be reduced quarterly beginning in 2014. The Secretary of Health and Human Services is provided discretion in choosing the methodology to implement these reductions, with some limitations. States identified as "low DSH states" will receive a smaller percentage reduction. Cuts are allocated to each state's Medicaid program, but it will be up to each state to determine the methodology for reducing their DSH payments to hospitals.

Vermont Act 48 of 2011

Act 48 of 2011 ("An Act Relating to a Universal and Unified Health System") sets up a framework for the development of a universal health care system, known as Green Mountain Care. The timeline for the transition from the current medical payment system to the single payer approach is six years from passage of the bill, assuming the State is able to obtain a waiver from the federal government in 2017.

Section 9 of Act 48 requires the Secretary of Administration or designee to recommend two financing plans to the committees of jurisdiction by January 15, 2013. One plan will recommend financing amounts and mechanisms for Vermont's Health Benefit Exchange. The second financing plan will recommend the amounts and mechanisms for financing Green Mountain Care. Both plans are required to address the following aspects of financing, as provided in Section 9(b):

(1) All financing sources, including adjustments to the income tax, a payroll tax, consumption taxes, provider assessments required under 33 V.S.A. Chapter 19, the employer assessment required by 21 V.S.A. Chapter 25, other new or existing taxes and additional options as determined by the Secretary;

(2) Impacts of the various financing sources, including levels of deductibility of any tax or assessment system contemplated and consistency with the principles of equity expressed in 18 V.S.A. § 9371;

(3) Issues involving federal law taxation;

(4) Impacts of tax system changes:

  (A) On individuals, households, businesses, public sector entities and the nonprofit community, including the circumstances under which a particular tax change may result in the potential for double payments, such as premiums and tax obligations;

  (B) Over time, on changing revenue needs; and

(C) For a transitional period, while the tax system and health care cost structure are changing;

(5) Growth in health care spending relative to needs and capacity to pay;

(6) Anticipated federal funds that may be used for health services and how to maximize the amount of federal funding available for this purpose;

(7) The amounts required to maintain existing State insurance benefit requirements and other appropriate considerations in order to determine the State contribution toward federal premium tax credits available in the Vermont Health Benefit Exchange pursuant to the Affordable Care Act;

(8) Additional funds needed to support recruitment and retention programs for high-quality health care professionals in order to address the shortage of primary care professionals and other specialty care professionals in this State;

(9) Additional funds needed to provide coverage for the uninsured who are eligible for Medicaid, Dr. Dynasaur and the Vermont Health Benefit Exchange in 2014;

(10) Funding mechanisms to ensure that operations of both the Vermont Health Benefit Exchange and Green Mountain Care are self-sustaining;

(11) How to maximize the flow of federal funds to the State for Medicare and paying or supplementing the cost-sharing requirements on their behalf;

(12) The use of financial or other incentives to encourage health lifestyles and patient self-management for individuals enrolled in Green Mountain Care;

(13) Preserving retirement health benefits while enabling retirees to participate in Green Mountain Care;

(14) The implications of Green Mountain Care on funds set aside to pay for future retiree health benefits; and

(15) Changes in federal health funding through reduced payments to health care professionals or through limitations or restrictions on the availability of grant funding or federal matching funds available to states through the Medicaid program.

As described above, the status of Vermont's health care-related taxes, and possible changes to them, will be considered during the development of the two plans due in January 2013.

In addition, Act 48 calls for the Green Mountain Care Board to approve a new Green Mountain Care benefit package to be available to Vermonters once federal waivers from certain provisions of the Affordable Care Act are obtained (in 2017 or later). The Green Mountain Care benefits must include primary care, preventive care, chronic care, acute episodic care and hospital services and are to include at least the same covered services as those included in the benefit package in effect for the lowest cost Catamount Health Plan offered on January 1, 2011. The Board can consider whether to include dental, vision and hearing benefits in the Green

Mountain Care benefit package.[91] Providers requested that if an assessment is levied on a particular class, the State should ensure that the service provided by that class be included in the Green Mountain Care benefit package.

C. Projected Revenues

For permissible provider classes not currently levied in Vermont, PHPG utilized other verifiable State-specific and national data sources to estimate the historical tax base in lieu of actual financial information. Our primary source of data was the 2009 Vermont Health Care Expenditure Analysis (VTHCEA), an annual report issued by the Banking, Insurance, Securities and Health Care Administration (BISHCA), which utilizes a combination of Vermont-specific and national health expenditure data to project expenditures by service type and payer.[92] The 2009 VTHCEA provides projections through calendar year 2013 for following classes: physician services, dental services, specialty therapists, nursing services, psychological services, chiropractor services and podiatry.[93]

For the remaining classes (i.e., nursing services, ambulatory surgical centers, emergency ambulance services, independent lab/x-ray providers and optometrists/opticians), PHPG utilized a combination of Medicaid claims, U.S. Economic Census and VHCURES data to estimate the baseline tax base.[94] Similar to the methodology for classes currently levied, PHPG applied trend factors obtained from either the VTHCEA or NHE; if trend factors were available from both sources, PHPG applied the lesser of the two to ensure conservative estimates. PHPG assumed SFY 2013 assessment revenues would be based on revenues received by providers during SFY 2012. See Exhibit 5-3 on the following page for detailed descriptions of the definitions, data sources, assumptions and other considerations used for developing these estimates.

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[91] 33 V.S.A. § 1825.

[92] PHPG used data from the Provider Analysis, as expenditures for services received by Vermont residents out of state would not be included in the tax base.

[93] Specialty therapists, nursing services, psychological services, chiropractor services and podiatry are categorized as "other professional" services in VTHCEA. While actual 2009 expenditures were provided for each class, projections were provided only for the category as a whole. PHPG applied the category's "average annual change" rate to actual 2009 expenditures in VTHCEA to obtain class-specific projections for 2013.

[94] PHPG utilized VHCURES data provided in the 2010 Vermont Healthcare Utilization and Expenditure Report.

Exhibit 5-3 – Definitions and Data Sources, Classes NOT Currently Levied

Provider Class	Definition of Taxable Revenue	Data Source: Baseline Taxable Revenues	Data Source: Trend Factor	Notes
Physicians	Net patient revenue	2009 VTHCEA; SFY 2010 Medicaid claims	2009 NHE – Physician and Clinical Services	Excludes expenditures associated with hospital-owned physician practices; APRN, FQHC and RHC expenditures excluded based on ratio of categories of service to physician payments in Medicaid claims data*
Dentists	Revenue from dental services	2009 VTHCEA; SFY 2010 Medicaid claims	2009 NHE – Dental Services	VTHCEA data includes oral surgery services in this category
Specialty Therapists	Total revenue	2009 VTHCEA	2009 NHE – Other Professional Services	
Psychologists	Total revenue	2009 VTHCEA	2009 NHE – Other Professional Services	
Chiropractors	Total revenue	2009 VTHCEA	2009 NHE – Other Professional Services	
Nurses	Total revenue	SFY 2010 Medicaid claims; VHCURES; Henry J. Kaiser Family Foundation, State Health Facts Online	2009 NHE – Physician and Clinical Services/ Nursing Care Facilities and Continuing Care Retirement Facilities	Medicaid payments for APRNs and LNs extrapolated based on total Medicaid payments as percent of total statewide health expenditures. Trend factor is a weighted average, blending growth rates of APRN and LN expenditures
Optometrists/ Opticians	Patient care revenue, including sale of optical goods	2007 U.S. Economic Census	2009 VTHCEA – Vision/DME	Includes retail sale of optical goods
Podiatrists	Total revenue	2009 VTHCEA	2009 NHE – Other Professional Services	
Independent Lab/X-ray	Patient care revenue	2007 U.S. Economic Census; SFY 2010 Medicaid claims	2009 NHE – All Expenditures	Statewide expenditures adjusted to exclude out-of-state providers based on ratio of Medicaid payments for in- to out-of-state providers
Emergency Ambulance Services	Patient care revenue, emergency transport, surface ambulance	2007 U.S. Economic Census; SFY 2010 Medicaid claims	2009 NHE – Hospital Care	Includes revenue for all providers but may be overstated as some are operated by municipalities
Ambulatory Surgical Centers	Total revenue	2009 VTHCEA; VHCURES; Henry J. Kaiser Family Foundation, State Health Facts Online	2009 NHE – All Expenditures	Expenditures for privately insured (age 0-64) extrapolated as percent of total statewide health expenditures

**It is unclear whether physician services provided within FQHCs would be subject to the assessment.*

Based on PHPG estimates, taxable revenues from permissible classes not already assessed will total approximately $973 million in SFY 2013. The exhibits on the following pages contain projections of potential revenues if assessments were to be levied on each of the classes above at various rates.

Exhibits 5-4 and 5-5 demonstrate the effect on potential revenues should implementation of new assessments be delayed until October 1, 2012 (to account for alignment with the federal fiscal year and other legislative or administrative considerations). Also presented are the potential short-term limitations on revenue collections due to anticipated non-compliance and other startup-related factors.

Exhibit 5-4 below presents estimated annualized revenues for SFY 2013 (i.e., with an implementation date of July 1, 2012). PHPG included a compliance/startup factor of 85 percent to account for anticipated provider non-compliance and potential organizational learning curve as new administrative and oversight processes are implemented. Revenues could range from $8.3 to $50 million, based on the assessment rate.

Exhibit 5-4 – Potential Additional Revenues, Classes Not Currently Levied, SFY 2013 (Annualized)

Provider Class	Projected Taxable Revenues	Compliance/ Startup Factor	Assessment Rate					
			1.0%	2.0%	3.0%	4.0%	5.0%	6.0%
Physicians	$ 471,115,615	85%	$ 4,004,483	$ 8,008,965	$ 12,013,448	$ 16,017,931	$ 20,022,414	$ 24,026,896
Dentists	$ 267,904,196	85%	$ 2,277,186	$ 4,554,371	$ 6,831,557	$ 9,108,743	$ 11,385,928	$ 13,663,114
Specialty Therapists	$ 53,590,715	85%	$ 455,521	$ 911,042	$ 1,366,563	$ 1,822,084	$ 2,277,605	$ 2,733,126
Psychologists	$ 52,829,166	85%	$ 449,048	$ 898,096	$ 1,347,144	$ 1,796,192	$ 2,245,240	$ 2,694,287
Chiropractors	$ 37,764,266	85%	$ 320,996	$ 641,993	$ 962,989	$ 1,283,985	$ 1,604,981	$ 1,925,978
Nurses	$ 25,477,863	85%	$ 216,562	$ 433,124	$ 649,686	$ 866,247	$ 1,082,809	$ 1,299,371
Optometrists/Opticians	$ 34,197,176	85%	$ 290,676	$ 581,352	$ 872,028	$ 1,162,704	$ 1,453,380	$ 1,744,056
Podiatrists	$ 6,118,485	85%	$ 52,007	$ 104,014	$ 156,021	$ 208,028	$ 260,036	$ 312,043
Independent Lab/X-Ray	$ 11,058,087	85%	$ 93,994	$ 187,987	$ 281,981	$ 375,975	$ 469,969	$ 563,962
Emergency Ambulance Services	$ 16,485,479	85%	$ 140,127	$ 280,253	$ 420,380	$ 560,506	$ 700,633	$ 840,759
Ambulatory Surgical Centers	$ 2,053,360	85%	$ 17,454	$ 34,907	$ 52,361	$ 69,814	$ 87,268	$ 104,721
TOTAL			**$ 8,318,052**	**$ 16,636,105**	**$ 24,954,157**	**$ 33,272,210**	**$ 41,590,262**	**$ 49,908,315**

Exhibit 5-5 below presents estimated revenues for SFY 2013, based on an implementation date of October 1, 2012. Revenues could range from $6.2 to $37 million, based on the assessment rate.

Exhibit 5-5 – Potential Additional Revenues, Classes Not Currently Levied, SFY 2013 (October 1, 2012 Start)

Provider Class	Projected Taxable Revenues	Compliance/ Startup Factor	Assessment Rate					
			1.0%	2.0%	3.0%	4.0%	5.0%	6.0%
Physicians	$ 353,336,711	85%	$ 3,003,362	$ 6,006,724	$ 9,010,086	$ 12,013,448	$ 15,016,810	$ 18,020,172
Dentists	$ 200,928,147	85%	$ 1,707,889	$ 3,415,778	$ 5,123,668	$ 6,831,557	$ 8,539,446	$ 10,247,335
Specialty Therapists	$ 40,193,036	85%	$ 341,641	$ 683,282	$ 1,024,922	$ 1,366,563	$ 1,708,204	$ 2,049,845
Psychologists	$ 39,621,875	85%	$ 336,786	$ 673,572	$ 1,010,358	$ 1,347,144	$ 1,683,930	$ 2,020,716
Chiropractors	$ 28,323,199	85%	$ 240,747	$ 481,494	$ 722,242	$ 962,989	$ 1,203,736	$ 1,444,483
Nurses	$ 19,108,397	85%	$ 162,421	$ 324,843	$ 487,264	$ 649,686	$ 812,107	$ 974,528
Optometrists/Opticians	$ 25,647,882	85%	$ 218,007	$ 436,014	$ 654,021	$ 872,028	$ 1,090,035	$ 1,308,042
Podiatrists	$ 4,588,864	85%	$ 39,005	$ 78,011	$ 117,016	$ 156,021	$ 195,027	$ 234,032
Independent Lab/X-Ray	$ 8,293,565	85%	$ 70,495	$ 140,991	$ 211,486	$ 281,981	$ 352,477	$ 422,972
Emergency Ambulance Services	$ 12,364,110	85%	$ 105,095	$ 210,190	$ 315,285	$ 420,380	$ 525,475	$ 630,570
Ambulatory Surgical Centers	$ 1,540,020	85%	$ 13,090	$ 26,180	$ 39,271	$ 52,361	$ 65,451	$ 78,541
TOTAL			**$ 6,238,539**	**$ 12,477,079**	**$ 18,715,618**	**$ 24,954,157**	**$ 31,192,697**	**$ 37,431,236**

Exhibit 5-6 below presents estimated revenues for SFY 2014, based on a full year of collections. PHPG included a compliance/startup factor of 95 percent, representing greater provider compliance and more complete implementation of administrative and oversight processes. Revenues could range from $9.6 to $57 million, based on the assessment rate.

Exhibit 5-6 – Potential Additional Revenues, Classes Not Currently Levied, SFY 2014

Provider Class	Projected Taxable Revenues	Compliance/ Startup Factor	Assessment Rate					
			1.0%	2.0%	3.0%	4.0%	5.0%	6.0%
Physicians	$ 482,422,390	95%	$ 4,583,013	$ 9,166,025	$ 13,749,038	$ 18,332,051	$ 22,915,064	$ 27,498,076
Dentists	$ 274,333,896	95%	$ 2,606,172	$ 5,212,344	$ 7,818,516	$ 10,424,688	$ 13,030,860	$ 15,637,032
Specialty Therapists	$ 56,270,250	95%	$ 534,567	$ 1,069,135	$ 1,603,702	$ 2,138,270	$ 2,672,837	$ 3,207,404
Psychologists	$ 55,470,624	95%	$ 526,971	$ 1,053,942	$ 1,580,913	$ 2,107,884	$ 2,634,855	$ 3,161,826
Chiropractors	$ 39,652,479	95%	$ 376,699	$ 753,397	$ 1,130,096	$ 1,506,794	$ 1,883,493	$ 2,260,191
Nurses	$ 26,323,350	95%	$ 250,072	$ 500,144	$ 750,215	$ 1,000,287	$ 1,250,359	$ 1,500,431
Optometrists/Opticians	$ 35,565,063	95%	$ 337,868	$ 675,736	$ 1,013,604	$ 1,351,472	$ 1,689,340	$ 2,027,209
Podiatrists	$ 6,424,409	95%	$ 61,032	$ 122,064	$ 183,096	$ 244,128	$ 305,159	$ 366,191
Independent Lab/X-Ray	$ 11,533,585	95%	$ 109,569	$ 219,138	$ 328,707	$ 438,276	$ 547,845	$ 657,414
Emergency Ambulance Services	$ 17,293,268	95%	$ 164,286	$ 328,572	$ 492,858	$ 657,144	$ 821,430	$ 985,716
Ambulatory Surgical Centers	$ 2,141,655	95%	$ 20,346	$ 40,691	$ 61,037	$ 81,383	$ 101,729	$ 122,074
TOTAL			**$ 9,570,594**	**$ 19,141,188**	**$ 28,711,783**	**$ 38,282,377**	**$ 47,852,971**	**$ 57,423,565**

Note: Projected taxable revenues estimated using same trend factors as SFY 2013 estimates. VTHCEA does not include estimates for 2014, and NHE projections are inflated due to Affordable Care Act implementation.

CHAPTER SIX

IMPLEMENTATION TASKS

A. Overview

If Vermont decides to move forward with proposing to implement additional or modify existing health care-related assessments, the State will need to consider factors in the following areas:

- *Policy Development* – This includes defining the taxed class, deciding on which State government entity should administer the new assessment(s), conferring with CMS and identifying oversight/monitoring processes.

- *Administration* – To effectively administer the assessments, several functions should be considered, including: maintaining and routinely updating taxpayer lists; collecting data and calculating the assessments owed; notifying taxpayers; collecting the assessment; and on-going monitoring.

- *Staffing* – The State entity responsible for the assessment must have sufficient resources to administer the program, including a policy lead and operational staff.

B. Policy Development

Exhibit 6-1 on the following page outlines the key policy considerations for developing additional health care-related assessments. The following suggestions were informed by the findings from other states as presented in this report's National Overview, as well as PHPG's knowledge of Vermont state government and the State's health care environment. As with any proposed legislative action, it is recommended that the State complete a thorough legal review of proposed class definitions and calculation methodologies before actual proposed implementation.

These factors will assist the State in drafting a statement or outline of the taxes it seeks to implement. Although no formal approval process is required, the State should notify CMS of its intent to implement additional assessments. Including CMS in the development would allow Vermont to obtain the necessary technical assistance and guidance early in the process. Mechanisms also should be in place to complete any federally-mandated revenue reporting requirements.

These policy considerations also serve to assist the State in developing proposed statutory language for legislative review and approval.

Exhibit 6-1 – Key Policy Considerations for Implementing New Vermont Assessments

Task	Overview of Key Policy Considerations[95]
(1) Define Tax Basis	• Percentage of annual net health service revenues
(2) Define Taxed Entity	• Licensed Provider, as defined in Vermont statutes and listed in Exhibit 5-1, if the provider directly receives patient revenues, or the organization that is the recipient of revenues as a result of the providers' services
(3) Define Taxable Revenue	• Health Services – Act 48 of 2011 added the following definition to 18 V.S.A. § 9373: "Health service means any treatment or procedure delivered by a health care professional to maintain an individual's physical or mental health or to diagnose or treat an individual's physical or mental health condition, including services ordered by a health care professional, chronic care management, preventive care, wellness services, and medically necessary services to assist in activities of daily living" • Net health service revenue – Gross annual charges related to health services less charges attributable to bad debt, charity care, contractual allowances and other payer discounts • Exempt revenue already assessed in another class (i.e., hospitals, nursing facilities, home health agencies, ICF/MRs, ambulatory surgical centers, free-standing laboratory and x-ray facilities)
(4) Establish Reporting Regulations	• Self-reporting form signed by provider or authorized representative subject to penalties of perjury • Availability of the following documentation upon audit: amounts reported in filed report from audited financial statements, federal income tax returns, physician orders, patient bills or records of actual receipts
a. Reporting Frequency	• Annual form that declares the amount of health service revenues for the preceding calendar year, submitted no later than April of each year

[95] Due to the nature of their definitions, the assessment methodology for licensed providers will differ from the methodology for Managed Care Organizations (MCOs). If the latter is pursued by Vermont, the State should use the existing methodology for the Health Care Claims Assessment: assess each MCO a specified percentage of all health insurance claims paid by the MCO /HMO for its Vermont members in the previous fiscal year ending June 30, paid in quarterly installments. Data for the assessment base is provided through the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES).

Exhibit 6-1 – Key Policy Considerations for Implementing New Vermont Assessments

Task	Overview of Key Policy Considerations[95]
b. Confidentiality of Reporting	• Define in new statutes as confidential, pursuant to 1 V.S.A. § 317(c)(1) or 1 V.S.A. § 317(c)(6)[96] • Comply with necessary federal and state cost reporting provisions where applicable
(5) Determine Assessment Frequency	• Fee submitted quarterly to minimize administrative burden (and consider changing monthly assessment of existing fees to align with new assessment schedule) OR • Fee submitted monthly to align with existing assessment payment schedule, maximize state cash flow and identify providers that are late before the over-due amount is large
(6) Develop Provider Notification Methodology	• Provide notification to all assessed provider classes of annual assessment amounts at least one month prior to the beginning of the State fiscal year • Send notifications one month prior to the due date of quarterly provider assessment payments
(7) Establish Late Penalty Policy	• Either use current penalty structure in Vermont statute or revise the penalty structure to be more reflective of the amounts due. If continuing with the current statutory penalty structure, the penalties would be as follows: ○ For facilities (i.e., Ambulatory Care Services, Labs and X-Ray Facilities), penalty amount at the discretion of the Commissioner, but cannot exceed $1,000 per payment due ○ For providers, penalty is two percent of the assessment amount for each payment period it remains unpaid, but cannot exceed $500 for any one quarter
(8) Develop Audit and Oversight System	• Maintain statutory authority in 33 V.S.A. § 1957 to perform audits on provider submissions
(9) Develop Appeals Process	• Use the appeals process as described in 33 V.S.A. § 1958 for existing assessments
(10) Identify Collection Responsibility	• Department of Vermont Health Access or Department of Taxes
(11) Determine How Funds Will Be Used	• Deposited into Health Care Resource Fund

[96] (c) The following public records are exempt from public inspection and copying:

(1) Records which by law are designated confidential or by a similar term.

(6) A tax return and related documents, correspondence and certain types of substantiating forms which include the same type of information as in the tax return itself filed with or maintained by the Vermont Department of Taxes or submitted by a person to any public agency in connection with agency business.

C. Potential Impact on Section 1115 Waivers

Vermont policy makers also should consider the potential impact of increasing existing or implementing new assessments on the State's two Section 1115 Medicaid Demonstration waivers, Choices for Care and Global Commitment to Health. Both Demonstrations operate under aggregate budget neutrality caps that limit total spending over the length of the Demonstrations. Although both Demonstrations have sufficient room for spending in the short term, if Vermont (in partnership with CMS) elects to continue to manage most of its Medicaid program under these Demonstrations for several years into the future, increases in program expenditures may potentially impact the waiver spending caps in the long term. As such, if new assessment revenues are used to increase provider payments or otherwise increase Medicaid expenditures, the State should closely analyze the impact of these increased expenditures on the waiver caps.

D. Administration of Existing and New Assessments

Exhibit 6-2 below outlines the tasks necessary to effectively administer any health care-related assessments.

Exhibit 6-2 – Key Administrative Considerations for Existing and New Assessments

Task	Overview of Key Administrative Considerations
(1) Maintain Current Provider List	• Obtain and routinely update lists of providers eligible for assessment from State entities responsible for professional licensing/registration
(2) Collect Data to Calculate Assessment Owed	• Obtain audited information from State entities that have this information (i.e., BISHCA, Rate Setting, DAIL) • Develop forms to be completed by providers who are required to self-report • Provide written guides for calculating and reporting revenue and fees • Assure confidentiality of submitted revenue data for providers not subject to federal and state cost reporting requirements
(3) Collect Assessments	• Match eligible list with payments received
(4) Send Notifications to Taxpayers	• Send annual notices to providers regarding the assessment owed for the coming fiscal year • Send monthly/quarterly statements/notices as reminders of upcoming payment

Exhibit 6-2 – Key Administrative Considerations for Existing and New Assessments

Task	Overview of Key Administrative Considerations
(5) Maintain Open Lines of Communication with Taxpayers	• Answer provider questions about the methodology or calculation • Develop policy guidance and information bulletins
(6) Establish Accounts Receivable Process	• Establish and maintain an accounts receivable process for receiving and logging payments • Separate staff involved with receiving and logging fee payments • Use a functioning accounting system that can handle billing and accounts receivable that may interface with the State's Vision System
(7) Perform Ongoing Monitoring	• Audit payment submissions to ensure the amount paid is amount owed
(8) Manage Appeals Process	• Manage the assessment appeals process
(9) Analyze Impact of Federal and State Changes	• Perform ongoing analysis of revenue impacts from any proposed changes to the assessments both at the federal and state levels
(10) Maintain Open Lines of Communication with CMS	• Coordinate with CMS on any issues related to assessment construction or administration

E. Staffing Needs

The State entity responsible for the assessment must have sufficient resources to administer the program, including provider notification and tracking, assessment collection, penalty management and auditing.[97] PHPG suggests the following staff resources to adequately administer the assessment program:

- *Program Manager* – Dedicated management level position to oversee the entire assessment program, including interfacing with the Administration and the Legislature

- *Accounts Receivable Staff* – At least one FTE per 750 providers assessed (i.e., the number of providers that will be submitting assessment payments)

- *Audit Staff* – At least one FTE per 10 classes assessed

- *Legal Support* – Allows for ongoing review of compliance with federal and state requirements

[97] It should be noted that the department responsible for implementing the assessments is prohibited in Vermont statute from using more than one percent of the fees for administration of the assessments.

DVHA does have an assigned Assistant Attorney General that provides legal support for the Department, including issues regarding health care-related assessments. In the SFY 2012 Budget Adjustment Act, DVHA requested four FTEs for the Data and Reimbursement Unit. Three of these requested positions will provide the enhanced support needed for implementation of several of the State's health care reform initiatives. The fourth position will support DSH and provider assessment calculations.[98]

Currently, DVHA does not have any dedicated resources to administer the provider assessments levied in Vermont. DVHA does not have an accounts receivable position, there is no identified resource to conduct assessment audits, nor is there a part-time or full-time dedicated management position for administering the provider assessments. Rather, these functions are included in the duties of staff with many other responsibilities. There is no locus of accountability for managing health care-related assessments. If new assessments are implemented, the staffing pattern to support the program should be substantially increased.

[98] See http://dvha.vermont.gov/budget-legislative/sfy12-baa-12-15-11.pdf.

APPENDIX A
PHPG MEETINGS WITH PROVIDER REPRESENTATIVES

Appendix A: PHPG Meetings with Provider Representatives

Health Care Provider Class	Meeting Date	Attendees
Hospital Services	Nov. 18	Mike Del Trecco, Vermont Association of Hospitals and Health Systems Bea Grause, Vermont Association of Hospitals and Health Systems Lucy Garrand, Downs, Rachland and Martin for Springfield Hospital
Nursing Facility Services	Nov. 16	Laura Pelosi, Vermont Health Care Association
ICF/MR Services	Nov. 18	Julie Tessler, Vermont Council for Developmental and Mental Health Services
Home Health Care Services	Nov. 16	Peter Cobb, Vermont Assembly of Home Health and Hospice Agencies
Outpatient Prescription Drugs	Nov. 21	Theo Kennedy, Otis and Brooks, P.C. Rich Harvie, Vermont Pharmacists Association Marty Irons, Vermont Pharmacists Association Anthony Otis, Otis and Brooks, P.C. Bill Shouldice, Shouldice and Associates Heather Shouldice, Shouldice and Associates
Physician Services	Nov. 22	Paul Harrington, Vermont Medical Society Madeleine Mongan, Vermont Medical Society
Managed Care Organization Services	Nov. 17	Jeanne Kennedy, CIGNA Bill Little, MVP Health Care Heidi Tringe, MacLean, Meehan and Rice, LLC for MVP Health Care Leigh Tofferi, BCBS-VT
Ambulatory Surgical Center Services	N/A	PHPG was unable to schedule a meeting with this provider class
Dental Services	Nov. 23	Elizabeth Cote, Vermont State Dental Society Paul Kenworthy, Dentist Joyce Hottenstein, Dentist George “Spin” Richardson, Dentist Peter Taylor, Vermont State Dental Society Jonathan Wolff, Primmer Piper Eggleston and Cramer
Podiatric Services	N/A	PHPG was unable to schedule a meeting with this provider class
Chiropractic Services	Nov. 21	Theo Kennedy, Otis and Brooks, P.C. James McDaniel, Vermont Chiropractic Association Anthony Otis, Otis and Brooks, P.C. Bill Shouldice, Shouldice and Associates Heather Shouldice, Shouldice and Associates Daniel Woodcoch, Woodcoch Family Chiropractic
Optometrist/ Optician Services	Nov. 21	Steve St.Marie, Vermont Optometric Association Karena Shippee, Vermont Optometric Association

Appendix A: PHPG Meetings with Provider Representatives

Health Care Provider Class	Meeting Date	Attendees
Psychological Services	Nov. 16	Alex Forbes, Vermont Psychological Association
	Nov. 18	Julie Tessler, Vermont Council for Developmental and Mental Health Services
	Nov. 21	Rick Barnett, Vermont Psychological Association Rosanna Lak, Vermont Psychological Association
	Nov. 23	Rilla Murray, National Association of Social Workers- Vermont Chapter
Therapist Services	Nov. 17	Julie Adams, Vermont Chapter – American Physical Therapy Association Becky Basiliere, Physical Therapist Leslie Bell, Vermont Chapter – American Physical Therapy Association Mike Dee, Physical Therapist Karlene Gentley, Physical Therapist Louise Lynch, Physical Therapist Susan Mason, DVHA Clinical Consultant
Nursing Services	Nov. 17	Lynne Dapice, Vermont State Nurses Association Jennifer Laurent, Vermont Nurse Practitioner Association
Free-standing Laboratory and X-Ray Services	N/A	PHPG was unable to schedule a meeting with this provider class
Emergency Ambulance Services	Nov. 30	Jim Finger, Vermont Ambulance Association
	Dec. 15	Chris Bell, Vermont Department of Health Emergency Medical Services
Bi-State Primary Care Association[99]	Nov. 18 and Dec. 15	Susan Barrett, Bi-State Primary Care Association Kevin Kelley, Community Health Center of Lamoille Valley Lori Real, Bi-State Primary Care Association Grant Whitmer, Community Health Center of the Rutland Region

[99] Bi-State Primary Care Association represents Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Critical Access Hospitals (CAHs), The VT Coalition of Clinics for the Uninsured (VCCU, free clinic programs), Planned Parenthood Clinics, Area Health Education Centers (AHECs) and rural primary care practices. These organizations employ many providers that could be subject to one or more of the new assessments.

APPENDIX B
STATE SUMMARIES

Physician Services

Physician Services	States		
	Minnesota	Washington	West Virginia
Taxed Entity	**Health Care Provider**	Other Health Care Providers (***Physicians***)	**Providers of Physician Services**
Amount of Tax	A tax equal to **2 percent of gross revenues** is imposed on each health care provider	Health care providers are subject to the service and other activities Business and Occupation (B&O) tax rate of **1.8 percent** on their **gross income** from performing health care services	Prior to program termination June 30, 2010, tax was **0.2 percent of gross receipts** derived by taxpayer rendering physicians' services in the state
Definition Taxed Provider/Service	"Person" whose health care occupation is regulated or required to be regulated by the state furnishing any or all of the following goods or services directly to a patient or consumer: **medical**, **surgical**…	Health care provider is a person who is **licensed** under the provisions of Title 18 **to provide health care services** to humans in the ordinary course of business or practice of a profession	Physicians' services are limited to those services furnished by a physician within the **scope of the practice of medicine or osteopathy** whether furnished in the physician's office, recipient's home, hospital, skilled nursing facility or any other location. Physicians' services include those professional services directly furnished by a physician in the scope of his or her employment by a hospital. Other services rendered in conjunction with hospital-employed physicians' services are not considered physicians' services, provided that hospitals that own and operate freestanding physician offices or primary care clinics in office buildings or other locations separate and apart from a hospital whereby employed physicians provide services ordinarily provided by physicians in a freestanding physician's office may class all revenue from such services as physicians' services…
Definition of Taxed Revenue	Gross revenues: **total amounts received** in money or otherwise by a health care provider for **patient services**	Gross income: includes any separate charge for drugs, medicines and other substance administered or provided to a patient as part of the **health care services delivered** to patient	Gross receipts: **amount received** or receivable, whether in cash or in kind, from patients, third-party payers and others for **physicians' services furnished** by the provider…
Collection Responsibility	**Department of Revenue**	**Department of Revenue**	**Tax Department**

Physician Services	States		
	Minnesota	Washington	West Virginia
Reporting Manner	**Self-reporting**; quarterly estimated payments submitted	Registration with the Department; tax **reported** and paid on excise tax return	**Self-reporting**; taxes submitted monthly
Confidentiality of Reporting	**Unknown**	**Confidential**	**Confidential**
Use of Funds	**MinnesotaCare Program**	Fund **various programs** within the state	**Medicaid State Share Fund**
Program Dates	1992-Dec. 31, 2019	Continuous	1993-June 30, 2010
Reason for Program Discontinuation	Once the **Affordable Care Act** is implemented, the state believes that many individuals in MinnesotaCare will qualify for Medicaid which comes with additional federal funding capabilities. Beginning December 1, 2011, and following each year, tax will phase down if certain budget criteria met	N/A	Tax initial rate of 2 percent and phased out between 2001 and 2010 as a result of **changes in the interpretation of the code and efficiency**
Statutory/Administrative Authority	Minn. Stat. § 295.50 *et seq*.	WAC 458-20-151, 458-20-224; RCW 82.32.330	W. Va. Code § 11-27-1 *et seq*. (particularly § 11-27-16)

Ambulatory Surgical Center Services

Ambulatory Surgical Center Services	States				
	Florida	Minnesota	Rhode Island	West Virginia	Wisconsin
Taxed Entity	Health care facilities (i.e., **ambulatory surgical centers**)	**Surgical Centers**	**Outpatient Health Care Facility**	**Ambulatory Surgical Center**	**Ambulatory Surgical Center**
Amount of Tax	Prior to stopping collection, assessment was **1 percent of annual net operating revenues**	**2 percent of gross revenues**	**2 percent of net patient services revenue**	**1.75 percent of gross receipts**	**4.38 percent of annual gross patient revenue**
Definition Taxed Provider/Service	Facility that primarily **provides elective surgical care**, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and is not part of a hospital…	Freestanding facility organized for the specific purpose of providing **elective outpatient surgery** for pre-examined, pre-diagnosed, low-risk patients. Admissions are limited to procedures which utilize local or general anesthesia and which do not require overnight inpatient care…	An outpatient health care facility means a person or governmental unit that is **licensed to establish, maintain and operate a free standing ambulatory surgery center or physician ambulatory surgery center or a podiatry ambulatory center**	Ambulatory surgical center services means those services of an ambulatory surgical center as defined in **§1832(a)(2)(F)(1) of the Social Security Act**	Ambulatory surgical center means a facility that meets the requirements of **42 C.F.R. §416.2**
Definition of Taxed Revenue	Net operating revenue: **gross revenue less deductions from revenue**. Deductions from revenue are reductions from gross revenue resulting from inability to collect payment of charges	Gross revenues: **total amounts received** in money or otherwise by a surgical center for **patient services**	Net patient services revenue: **charges related to patient care service less charges attributable to charity care, bad debt expenses and contractual allowances**	Gross receipts: **amount received** or receivable, whether in cash or in kind, from patients, third-party payers and others for **ambulatory surgical center services** furnished by the provider	Gross patient revenue: **gross amount received** on a cash basis by the provider from **all patient services**
Collection Responsibility	**Agency for Health Care Administration**	**Department of Revenue**	**Department of Revenue**	**Tax Department**	**Department of Revenue**

Ambulatory Surgical Center Services	States				
	Florida	Minnesota	Rhode Island	West Virginia	Wisconsin
Reporting Manner	**Self-reporting**; tax submitted quarterly	**Self-reporting**; monthly estimated payments	**Self-reporting** form signed and subject to penalties of perjury; payments submitted monthly	**Self-reporting**; taxes submitted monthly	Annual **self-reporting** survey; payments are submitted for quarterly estimated payments
Confidentiality of Reporting	**Subject to federal and state cost reporting requirements**	**Unknown**	**Unknown**	**Confidential**	**Confidential**
Use of Funds	**Public Medical Assistance Fund**	**MinnesotaCare Program**	**General Fund**	**Medicaid State Share Fund**	**Medical Assistance Trust Fund**
Program Dates	1991-2005	1992-Dec. 31, 2019	2007-	1993-	2009-
Reason for Program Discontinuation	Began at 1.5 percent and amended to 1. Although the tax was found to be constitutional, the state stopped collecting the tax due to protracted legal challenges (Hameroff v. PMATF (911 So. 2d 827 (Fla. 1st DCA 2005)). Facilities instead pay an annual fee (see below)	Once the **Affordable Care Act** is implemented, the state believes that many individuals in MinnesotaCare will qualify for Medicaid which comes with additional federal funding capabilities. Beginning December 1, 2011, and following each year, tax will phase down if certain budget criteria met	Note: Litigation was filed in 2007, but tax ruled by the Providence District Court to not violate due process or equal protection provisions of the U.S. and Rhode Island Constitutions (Rhode Island Medical Imaging Inc. v. Sullivan, A.A. No. 08-185 (November 9, 2010))	N/A	In December 2011 Bill 408 was introduced and referred to committee review to repeal this tax by July 1, 2013. Proponents of Bill 408 raise issues that the tax is not good for employment/economy, fairness, sustainability and transparency
Statutory/Administrative Authority	Fla. Stat. §395.7015; F.A.C. §59B-6.022	Minn. Stat. § 295.50 *et seq*.	R.I. Gen. Laws § 44-64-1 *et seq*.	W. Va. Code § 11-27-1 *et seq.* (particularly § 11-27-4)	Wis. Stat. § 146.98
Additional Related Assessments	Fla. Stat. §408.033 requires ambulatory surgical centers to pay an annual fee of $150 to support local health councils				

Dental Services

Dental Services	States		
	Minnesota	Washington	West Virginia
Taxed Entity	**Health Care Provider**	**Dentists (and other health care providers)**	**Providers of Dental Services**
Amount of Tax	A tax equal to **2 percent of gross revenues** is imposed on each health care provider	Dentists are subject to the service and other activities Business and Occupation (B&O) tax rate of **1.8 percent** on their **gross income** from performing dental services	Prior to program termination June 30, 2010, tax was **0.175 percent of gross receipts** derived by taxpayer from furnishing dental services in the state
Definition Taxed Provider/Service	"Person" whose health care occupation is regulated or required to be regulated by the state furnishing any or all of the following goods or services directly to a patient or consumer:…**surgical**…**dental**…	Health care provider is a person who is **licensed** under the provisions of Title 18 **to provide health care services** to humans in the ordinary course of business or practice of a profession	Person entitled to **practice dentistry or dental surgery**
Definition of Taxed Revenue	Gross revenues: **total amounts received** in money or otherwise by a health care provider for **patient services**	Gross income: includes any separate charge for drugs, medicines and other substance administered or provided to a patient as part of the **dental services delivered** to patient	Gross receipts: **amount received** or receivable, whether in cash or in kind, from patients, third-party payers and others for **dental services** furnished by the provider...
Collection Responsibility	**Department of Revenue**	**Department of Revenue**	**Tax Department**
Reporting Manner	**Self-reporting**; quarterly estimated payments submitted	Registration with the Department; tax **reported** and paid on excise tax return	**Self-reporting**; taxes submitted monthly
Confidentiality of Reporting	**Unknown**	**Confidential**	**Confidential**
Use of Funds	**MinnesotaCare Program**	Fund **various programs** within the state	**Medicaid State Share Fund**
Program Dates	1992-Dec. 31, 2019	Continuous	1993-June 30, 2010
Reason for Program Discontinuation	Once the **Affordable Care Act** is implemented, the state believes that many individuals in MinnesotaCare will qualify for Medicaid which comes with additional federal funding capabilities. Beginning December 1, 2011, and following each year, tax will phase down if certain budget criteria met	N/A	Tax initial rate of 1.75 percent and phased out between 2001 and 2010 as a result of **changes in the interpretation of the code and efficiency**
Statutory/Administrative Authority	Minn. Stat. § 295.50 *et seq*.	WAC 458-20-151, 458-20-224; RCW 82.32.33	W. Va. Code § 11-27-1 *et seq*. (particularly § 11-27-6)

Podiatric Services

Podiatric Services	States		
	Minnesota	Washington	West Virginia
Taxed Entity	**Health Care Provider**	Other Health Care Providers (***Podiatric Medicine and Surgery***)	**Providers of Podiatry Services**
Amount of Tax	A tax equal to **2 percent of gross revenues** is imposed on each health care provider	Health care providers are subject to the service and other activities Business and Occupation (B&O) tax rate of **1.8 percent** on their **gross income** from performing health care services	Prior to program termination June 30, 2010, tax was **0.175 percent of gross receipts** derived by taxpayer from furnishing podiatric services in the state
Definition Taxed Provider/Service	"Person" whose health care occupation is regulated or required to be regulated by the state furnishing any or all of the following goods or services directly to a patient or consumer: **medical**, surgical…	Health care provider is a person who is **licensed** under the provisions of Title 18 **to provide health care services** to humans in the ordinary course of business or practice of a profession	Person entitled to **render podiatry services**
Definition of Taxed Revenue	Gross revenues: **total amounts received** in money or otherwise by a health care provider for patient services	Gross income: includes any separate charge for drugs, medicines and other substance administered or provided to a patient as part of the **health care services delivered** to patient	Gross receipts: **amount received** or receivable, whether in cash or in kind, from patients, third-party payers and others for **podiatry services furnished** by the provider…
Collection Responsibility	**Department of Revenue**	**Department of Revenue**	**Tax Department**
Reporting Manner	**Self-reporting**; quarterly estimated payments submitted	Registration with the Department; tax **reported** and paid on excise tax return	**Self-reporting**; taxes submitted monthly
Confidentiality of Reporting	**Unknown**	**Confidential**	**Confidential**
Use of Funds	**MinnesotaCare Program**	Fund **various programs** within the state	**Medicaid State Share Fund**
Program Dates	1992-Dec. 31, 2019	Continuous	1993-June 30, 2010
Reason for Program Discontinuation	Once the **Affordable Care Act** is implemented, the state believes that many individuals in MinnesotaCare will qualify for Medicaid which comes with additional federal funding capabilities. Beginning December 1, 2011, and following each year, tax will phase down if certain budget criteria met	N/A	Tax initial rate of 1.75 percent and phased out between 2001 and 2010 as a result of **changes in the interpretation of the code and efficiency**
Statutory/Administrative Authority	Minn. Stat. § 295.50 *et seq*.	WAC 458-20-151, 458-20-224; RCW 82.32.33	W. Va. Code § 11-27-1 *et seq*. (particularly § 11-27-17)

Chiropractic Services

Chiropractic Services	States		
	Minnesota	Washington	West Virginia
Taxed Entity	**Health Care Provider**	Other Health Care Providers (***Chiropractic Services***)	**Providers of Chiropractic Services**
Amount of Tax	A tax equal to **2 percent of gross revenues** is imposed on each health care provider	Health care providers are subject to the service and other activities Business and Occupation (B&O) tax rate of **1.8 percent** on their **gross income** from performing health care services	Prior to program termination June 30, 2010, tax was **0.175 percent of gross receipts** derived by taxpayer from furnishing chiropractic services in the state
Definition Taxed Provider/Service	Person whose health care occupation is regulated or required to be regulated by the state furnishing any or all of the following goods or services directly to a patient or consumer: **medical**, surgical…	Health care provider is a person who is **licensed** under the provisions of Title 18 **to provide health care services** to humans in the ordinary course of business or practice of a profession	Person entitled to **render chiropractic services**
Definition of Taxed Revenue	Gross revenues: **total amounts received** in money or otherwise by a health care provider for **patient services**	Gross income: includes any separate charge for drugs, medicines and other substance administered or provided to a patient as part of **health care services delivered** to patient	Gross receipts means: **amount received or receivable**, whether in cash or in kind, from patients, third-party payers and others for **chiropractic services** furnished by the provider…
Collection Responsibility	**Department of Revenue**	**Department of Revenue**	**Tax Department**
Reporting Manner	**Self-reporting**; quarterly estimated payments submitted	Registration with the Department; the tax is **reported** and paid on excise tax return	**Self-reporting**; taxes submitted monthly
Confidentiality of Reporting	**Unknown**	**Confidential**	**Confidential**
Use of Funds	**MinnesotaCare Program**	Fund **various programs** within the state	**Medicaid State Share Fund**
Program Dates	1992-Dec. 31, 2019	Continuous	1993-June 30, 2010
Reason for Program Discontinuation	Once the **Affordable Care Act** is implemented, the state believes that many individuals in MinnesotaCare will qualify for Medicaid which comes with additional federal funding capabilities. Beginning December 1, 2011, and following each year, tax will phase down if certain budget criteria met	N/A	Tax initial rate of 1.75 percent and phased out between 2001 and 2010 as a result of **changes in the interpretation of the code and efficiency**
Statutory/Administrative Authority	Minn. Stat. § 295.50 *et seq*.	WAC 458-20-151, 458-20-224; RCW 82.32.330	W. Va. Code § 11-27-1 *et seq*. (particularly § 11-27-5)

Optometric/Optician Services

Optometric/Optician Services	States		
	Minnesota	Washington	West Virginia
Taxed Entity	**Health Care Provider**	**Optometrists, Ophthalmologists and Opticians**	**Providers of Opticians' Services and Providers of Optometric Services**
Amount of Tax	A tax equal to **2 percent of gross revenues** is imposed on each health care provider	Optometrists, ophthalmologists and opticians are subject to the service and other activities B&O tax rate of **1.8 percent** on their **gross income** from providing professional services	Prior to program termination June 30, 2010, tax was **0.175 percent of gross receipts** derived by taxpayer from furnishing optician/optometric services in the state
Definition Taxed Provider/Service	Person whose health care occupation is regulated or required to be regulated by the state furnishing any or all of the following goods or services directly to a patient or consumer:…**optical**, **visual**…	Health care provider is a person who is **licensed** under the provisions of Title 18 **to provide health care services** to humans in the ordinary course of business or practice of a profession	Person entitled to **furnish optician/optometric services**
Definition of Taxed Revenue	Gross revenues: **total amounts received** in money or otherwise by a health care provider for **patient services**	Gross revenues: **total amounts received** in money or otherwise by the provider for **professional services**	Gross receipts: **amount received** or receivable, whether in cash or in kind, from patients, third-party payers and others for **optician or optometric services** furnished by the provider…
Collection Responsibility	**Department of Revenue**	**Department of Revenue**	**Tax Department**
Reporting Manner	**Self-reporting**; quarterly estimated payments submitted	Registration with the Department; the tax is r**eported** and paid on excise tax return	**Self-reporting**; taxes submitted monthly
Confidentiality of Reporting	**Unknown**	**Confidential**	**Confidential**
Use of Funds	**MinnesotaCare Program**	Fund **various programs** within the state	**Medicaid State Share Fund**
Start Date	1992-Dec. 31, 2019	Continuous	1993-June 30, 2010
Reason for Program Discontinuation	Once the **Affordable Care Act** is implemented, the state believes that many individuals in MinnesotaCare will qualify for Medicaid which comes with additional federal funding capabilities. Beginning December 1, 2011, and following each year, tax will phase down if certain budget criteria met	N/A	Tax initial rate of 1.75 percent and phased out between 2001 and 2010 as a result of **changes in the interpretation of the code and efficiency**
Statutory/Administrative Authority	Minn. Stat. § 295.50 *et seq*.	WAC 458-20-150, 458-20-224; RCW 82.32.330	W. Va. Code § 11-27-1 *et seq*. (particularly § 11-27-13 and § 11-27-14)

Psychological Services

Psychological Services	States		
	Minnesota	Washington	West Virginia
Taxed Entity	**Health Care Provider**	Other Health Care Providers (***psychologists, counselors, mental health counselors, marriage and family therapists and social workers***)	**Providers of Psychological Services**
Amount of Tax	A tax equal to **2 percent of gross revenues** is imposed on each health care provider	Health care providers are subject to the service and other activities Business and Occupation (B&O) tax rate of **1.8 percent** on their **gross income** from performing health care services	Prior to program termination June 30, 2010, tax was **0.175 percent of gross receipts** derived by taxpayer from furnishing psychological services in the state
Definition Taxed Provider/Service	Person whose health care occupation is regulated or required to be regulated by the state furnishing any or all of the following goods or services directly to a patient or consumer: …**diagnostic**… **financial resources and community resources**. They include treatment of **psychological dysfunctions** caused by environmental and interpersonal factors (Revenue Notice #94-14 (mod.)). Various types of services provided by social workers that are subject tax, including psychosocial services provided in the diagnosis, treatment or prevention of a mental condition; diagnostic services that use diagnostic tools to ascertain whether the individual has a mental disorder, impairment, behavior or condition which leads to a diagnosis of conditions; and therapeutic services provided in response to a diagnosis of a mental condition. Tax applies to LGSW, LICS and LICSW who provide "patient services" as defined by statute and Revenue Notice #97-10 (mod.)	Health care provider is a person who is **licensed** under the provisions of Title 18 **to provide health care services** to humans in the ordinary course of business or practice of a profession	Person entitled to **render psychological services**. (Note: the practice of psychology is limited holders of a doctor of philosophy degree or its equivalent or a master's degree in psychology from an accredited institution of higher learning, with adequate course study)

Psychological Services	States		
	Minnesota	**Washington**	**West Virginia**
Definition of Taxed Revenue	Gross revenues: **total amounts received** in money or otherwise by a health care provider for **patient services**	Gross income: includes any separate charge for drugs, medicines and other substance administered or provided to a patient as part of **health care services delivered** to patient	Gross receipts: **amount received** or receivable, whether in cash or in kind, from patients, third-party payers and others for **psychological services** furnished by the provider…
Exclusions/Exceptions	All payments for **community support programs** (i.e., programs designed to help adults with serious and persistent mental illness function and remain in the community) and family community support programs (i.e., programs designed to help children with severe emotional disturbances to function and remain with the child's family in the community) are excluded from gross revenues for patient services and need not be reported for the MinnesotaCare tax (Revenue Notice #06-13)	N/A	N/A
Collection Responsibility	**Department of Revenue**	**Department of Revenue**	**Tax Department**
Reporting Manner	**Self-reporting**; quarterly estimated payments submitted	Registration with the Department; the tax is **reported** and paid on excise tax return	**Self-reporting**; taxes submitted monthly
Confidentiality of Reporting	**Unknown**	**Confidential**	**Confidential**
Use of Funds	**MinnesotaCare Program**	Fund **various programs** within the state	**Medicaid State Share Fund**
Program Dates	1992-Dec. 31, 2019	Continuous	1993-June 30, 2010
Reason for Program Discontinuation	Once the **Affordable Care Act** is implemented, the state believes that many individuals in MinnesotaCare will qualify for Medicaid which comes with additional federal funding capabilities. Beginning December 1, 2011, and following each year, tax will phase down if certain budget criteria met	N/A	Tax initial rate of 1.75 percent and phased out between 2001 and 2010 as a result of **changes in the interpretation of the code and efficiency**
Statutory/Administrative Authority	Minn. Stat. § 295.50 *et seq*.	WAC 458-20-151, 458-20-224; RCW 82.32.330	W. Va. Code § 11-27-1 *et seq*. (particularly § 11-27-18)

Therapist Services

Therapist Services	States		
	Minnesota	Washington	West Virginia
Taxed Entity	**Health Care Provider**	Other Health Care Providers (***PT, OT, hearing/speech and respiratory care***)	**Providers of Therapists' Services**
Amount of Tax	A tax equal to **2 percent of gross revenues** is imposed on each health care provider	Dentists and other health care providers are subject to the service and other activities Business and Occupation (B&O) tax rate of **1.8 percent** on their **gross income** from performing health care services	Prior to program termination June 30, 2010, tax was **0.175 percent of gross receipts** derived by taxpayer from furnishing therapist services in the state
Definition Taxed Provider/Service	Person whose health care occupation is regulated or required to be regulated by the state furnishing any or all of the following goods or services directly to a patient or consumer:…**therapeutic**	Health care provider is a person who is **licensed** under the provisions of Title 18 **to provide health care services** to humans in the ordinary course of business or practice of a profession	Person entitled to render **therapists' services**
Definition of Taxed Revenue	Gross revenues: **total amounts received** in money or otherwise by a health care provider for **patient services**	Gross income: includes any separate charge for drugs, medicines and other substance administered or provided to a patient as part of **health care services delivered** to patient	Gross receipts: **amount received** or receivable, whether in cash or in kind, from patients, third-party payers and others for **therapists' services** furnished by the provider…
Collection Responsibility	**Department of Revenue**	**Department of Revenue**	**Tax Department**
Reporting Manner	**Self-reporting**; quarterly estimated payments submitted	Registration with the Department; the tax is **reported** and paid on excise tax return	**Self-reporting**; taxes submitted monthly
Confidentiality of Reporting	**Unknown**	**Confidential**	**Confidential**
Use of Funds	**MinnesotaCare Program**	Fund **various programs** within the state	**Medicaid State Share Fund**
Program Dates	1992-Dec. 31, 2019	Continuous	1993-June 30, 2010
Reason for Program Discontinuation	Once the **Affordable Care Act** is implemented, the state believes that many individuals in MinnesotaCare will qualify for Medicaid which comes with additional federal funding capabilities. Beginning December 1, 2011, tax will phase down if certain budget criteria met	N/A	Tax initial rate of 1.75 percent and phased out between 2001 and 2010 as a result of **changes in the interpretation of the code and efficiency**
Statutory/Administrative Authority	Minn. Stat. § 295.50 *et seq*.	WAC 458-20-151, 458-20-224; RCW 82.32.330	W. Va. Code § 11-27-1 *et seq*. (particularly § 11-27-19)

Nursing Services

Nursing Services	States		
	Minnesota	Washington	West Virginia
Taxed Entity	**Health Care Provider**	Other Health Care Providers (***Nursing Care***)	**Providers of Nursing Services**
Amount of Tax	A tax equal to **2 percent of gross revenues** is imposed on each health care provider	Health care providers are subject to the service and other activities Business and Occupation (B&O) tax rate of **1.8 percent** on their **gross income** from performing health care services	Prior to program termination June 30, 2010, tax was **0.175 percent of gross receipts** derived by taxpayer from furnishing nursing services in the state
Definition Taxed Provider/Service	Person whose health care occupation is regulated or required to be regulated by the state furnishing any or all of the following goods or services directly to a patient or consumer: …**nursing services**…	Health care provider is a person who is **licensed** under the provisions of Title 18 **to provide health care services** to humans in the ordinary course of business or practice of a profession	Person entitled to **render nursing services**
Definition of Taxed Revenue	Gross revenues: **total amounts received** in money or otherwise by a health care provider **for patient services**	Gross income: includes any separate charge for drugs, medicines and other substance administered or provided to a patient as part of **health care services delivered** to the patient	Gross receipts: **amount received** or receivable, whether in cash or in kind, from patients, third-party payers and others for **nursing services** furnished by the provider…
Collection Responsibility	**Department of Revenue**	**Department of Revenue**	**Tax Department**
Reporting Manner	**Self-reporting**; quarterly estimated payments submitted	Registration with the Department; the tax is **reported** and paid on excise tax return	**Self-reporting**; taxes submitted monthly
Confidentiality of Reporting	**Unknown**	**Confidential**	**Confidential**
Use of Funds	**MinnesotaCare Program**	Fund **various programs** within the state	**Medicaid State Share Fund**
Program Dates	1992-Dec. 31, 2019	Continuous	1993-June 30, 2010
Reason for Program Discontinuation	Once the **Affordable Care Act** is implemented, the state believes that many individuals in MinnesotaCare will qualify for Medicaid which comes with additional federal funding capabilities. Beginning December 1, 2011, and following each year, tax will phase down if certain budget criteria met	N/A	Tax initial rate of 1.75 percent and phased out between 2001 and 2010 as a result of **changes in the interpretation of the code and efficiency**
Statutory/Administrative Authority	Minn. Stat. § 295.50 *et seq*.	WAC 458-20-151, 458-20-224; RCW 82.32.330	W. Va. Code § 11-27-1 *et seq*. (particularly § 11-27-12)

Laboratory and X-ray Services

Laboratory and X-ray Services	States			
	Florida	Minnesota	Rhode Island	West Virginia
Taxed Entity	Health care facilities (i.e., **clinical laboratories and diagnostic-imaging centers**)	**Health Care Provider**	**Imaging Services**	**Providers of Independent Laboratory or X-ray Services**
Amount of Tax	Prior to stopping collection, assessment was **1 percent of annual net operating revenues**	**2 percent of gross revenues**	**2 percent of net patient revenue**	**5 percent of gross receipts**
Definition Taxed Provider/Service	Clinical laboratories provide information or materials for use in the **diagnosis, prevention or treatment of a disease or identification or assessment** of a medical or physical condition…Diagnostic-imaging centers are freestanding outpatient facilities that provide specialized services for the identification or determination of a disease…	A person whose health care occupation is regulated or required to be regulated by the state furnishing any or all of the following goods or services directly to a patient or consumer:…**laboratory, diagnostic**… Independent laboratory services are subject to the tax as provided in Revenue Notice #94-03 (mod.)	A provider is any "person" who furnishes **imaging services** for the purposes of patient diagnosis, assessment or treatment	Independent laboratory or X-ray services means those **services provided in a licensed, free standing laboratory or X-ray facility**
Definition of Taxed Revenue	Net operating revenue: **gross revenue less deductions from revenue**. Deductions from revenue are reductions from gross revenue resulting from inability to collect payment of charges	Gross revenues: **total amounts** received in money for **patient services**	Net patient services revenue: **charges related to patient care services less charges attributable to charity care, bad debt expenses and contractual allowances**	Gross receipts: **amount received** or receivable, whether in cash or in kind, from patients, third-party payers and others for **independent laboratory or X-ray services** furnished by the provider…

Laboratory and X-ray Services	States			
	Florida	**Minnesota**	**Rhode Island**	**West Virginia**
Exclusions/Exceptions	Excludes any hospital laboratory; clinical laboratory operated by the state; clinical laboratories with 501(c)(3) status and receives 70 percent or more of its gross revenues from services to charity/Medicaid; tissue bank; and wholly owned and operated by 6 or fewer physicians and practice in same group	Excludes hospitals	Excludes any person licensed as a hospital or a rehabilitation hospital center or a not-for-profit organization ambulatory care facility. Also excluded are providers who do not perform more than 200 radiological procedures per month. Further, this surcharge does not apply to any person subject to the Outpatient Health Care Facility Surcharge or any person licensed in the state as a dentist or a podiatrist or veterinarian	Excludes hospitals
Collection Responsibility	**Agency for Health Care Administration**	**Department of Revenue**	**Department of Revenue**	**Tax Department**
Reporting Manner	**Self-reporting**; tax submitted quarterly	**Self-reporting**; quarterly estimated payments submitted	**Self-reporting** form signed and subject to penalties of perjury; payments are submitted monthly	**Self-reporting**; taxes submitted monthly
Confidentiality of Reporting	**Subject to federal and state cost reporting requirements**	**Unknown**	**Unknown**	**Confidential**
Use of Funds	**Public Medical Assistance Fund**	**MinnesotaCare Program**	**General Fund**	**Medicaid State Share Fund**
Program Dates	1991-2005	1992-Dec. 31, 2019	2007-	1993-

Laboratory and X-ray Services	States			
	Florida	Minnesota	Rhode Island	West Virginia
Reason for Program Discontinuation	Began at 1.5 percent and amended to 1. Although the tax was found to be constitutional, the state stopped collecting the tax due to protracted legal challenges (Hameroff v. PMATF (911 So. 2d 827 (Fla. 1st DCA 2005)). Facilities instead pay an annual fee (see below)	Once the **Affordable Care Act** is implemented, the state believes that many individuals in MinnesotaCare will qualify for Medicaid which comes with additional federal funding capabilities. Beginning December 1, 2011, tax will phase down if certain budget criteria met	Litigation was filed in 2007, but ruled by the Providence District Court to not violate due process or equal protection provisions of the U.S. and Rhode Island Constitutions (Rhode Island Medical Imaging Inc. v. Sullivan, A.A. No. 08-185 (November 9, 2010))	N/A
Statutory/Administrative Authority	Fla. Stat. §395.7015; F.A.C. §59B-6.022	Minn. Stat. § 295.50 *et seq*.	R.I. Gen. Laws § 44-65-1 *et seq*.	W. Va. Code § 11-27-1 *et seq.* (particularly § 11-27-8)
Additional Related Assessments	Fla. Stat. §408.033 requires these facilities to pay an annual fee of $150 to support local health councils			

Emergency Ambulance Services

Emergency Ambulance Services	States			
	Louisiana	Minnesota	Missouri	West Virginia
Taxed Entity	**Medical Transportation Providers**	**Health Care Provider**	**Ground Emergency Ambulance Service**	**Providers of Emergency Ambulance Service**
Amount of Tax	**$7.50 per medical service trip** for medical transportation providers	**2 percent of gross revenues**	Ambulance Service Reimbursement Allowance Rate is **4.417 percent of gross receipts**	Prior to program termination June 30, 2010, tax was **0.2 percent of gross receipts**
Definition Taxed Provider/Service	A medical transportation provider is any natural person, firm, corporation, partnership or other juridical person who is engaged in **delivering transportation to or from a medical service and who is paid for such delivery**	An ambulance service required to be **licensed**	Ambulance is specially designed, staffed or equipped or operated for transportation of **persons who require the presence of medical equipment being used on such individuals**, but does not include regular transportation of persons who are disabled, handicapped, normally using a wheelchair, or otherwise not acutely ill, or emergency vehicles used within airports	Emergency ambulance service means the **transportation** by ambulance, and the **emergency medical services** rendered at the site of pickup and en route, of a patient to or from a place where medical, hospital or clinical service is normally available
Definition of Taxed Revenue	Definition unavailable	Gross revenues: **total amounts received** in money or otherwise for **patient services**	Gross receipts: **emergency ambulance revenue from Medicare, Medicaid, insurance and private payments received** by a licensed ambulance service	Gross receipts: **amount received** or receivable, whether in cash or in kind, from patients, third-party payers and others for **emergency ambulance service** furnished by the provider…
Exclusions/Exceptions	N/A	N/A	Excludes ambulance service owned and operated by the board of curators or any department of the state	N/A
Collection Responsibility	N/A	**Department of Revenue**	**Department of Social Services**	**Tax Department**
Reporting Manner	N/A	**Self-reporting**; quarterly estimated payments submitted	**Self-reported**; taxes submitted annually	**Self-reporting**; taxes submitted monthly
Confidentiality of Reporting	N/A	**Unknown**	**Confidential**	**Confidential**

Emergency Ambulance Services	States			
	Louisiana	Minnesota	Missouri	West Virginia
Use of Funds	N/A	**MinnesotaCare Program**	Funds are deposited in the **Ambulance Service Reimbursement Allowance Fund** for the sole purposes of providing payments to ambulance services	**Medicaid State Share Fund**
Program Dates	The program has never been implemented	1992-December 31, 2019	Program was imposed in 2009 but collection did not begin until June 9, 2011 because MO HealthNet corresponded and provided information to CMS several times before CMS approved the tax	1993
Reason for Program Discontinuation	Lack of support from providers	Once the **Affordable Care Act** is implemented, the state believes that many individuals in MinnesotaCare will qualify for Medicaid which comes with additional federal funding capabilities. Beginning December 1, 2011, tax will phase down if certain budget criteria met	Extended from 2011 to September 30, 2015	Tax initial rate of 5.5 percent and phased out between 2001 and 2010 as a result of **changes in the interpretation of the code and efficiency**
Statutory/Administrative Authority	La. Rev. Stat. §§ 46:2622 and 46:2625	Minn. Stat. § 295.50 *et seq*.	Mo. Rev. Stat. § 19.800 *et seq*.; 13 CSR 70-3.200	W. Va. Code § 11-27-1 *et seq.* (in particularly § 11-27-7)

Services of Managed Care Organizations

Managed Care Organizations	States				
	Michigan	Minnesota	Minnesota	Minnesota	New Mexico
Taxed Entity	Certain Insurance Carriers, **HMO**, Nonprofit Health Care Corporation, Nonprofit Dental Care Corporation, Specialty Prepaid Health Plan, Group Health Plan Sponsor	**Health Care Provider** (staff model health plan companies)	**HMO** and Community Integrated Service Networks	**HMO**, Nonprofit Health Service Plan Corporations and Community Integrated Service Networks	**Insurer that Transacts Health Insurance**
Amount of Tax	**1 percent of paid claims** of covered carrier, third party administrator or self-insured entity	A tax equal to **2 percent of gross revenues** is imposed on each health care provider	Surcharge equal **to 0.6 percent of the total premium revenues**	Tax is equal to **1 percent of gross premiums less return premiums** on all direct business received in CY	Premium surtax of **1 percent of gross health insurance premiums and membership and policy fees**
Definition Taxed Provider/Service	Tax applies to certain **insurance carriers, third party administrators and self-insured entities** that **pay health insurance claims** for Michigan residents for health-related services performed in the state	A health care provider means a staff model health plan company which **employs one or more types of health care provider to deliver health care services to the health plan company's enrollees**	HMO means a **health maintenance organization licensed and operating** under Minnesota law	HMO is a nonprofit corporation or a local governmental unit which provides **comprehensive health maintenance services or arranges for the provision** of these services, to enrollees on the basis of a fixed prepaid sum	Includes HMO – any person who undertakes to **provide or arrange for delivery of basic health care services to enrollees on prepaid basis**, except for enrollee responsibility for copayments or deductibles

Managed Care Organizations	States				
	Michigan	Minnesota	Minnesota	Minnesota	New Mexico
Definition of Taxed Revenue	Paid claims: **actual payments, net of recoveries, made to health and medical services provider or reimbursed to an individual by a carrier, third party administrator or excess loss carrier**. Certain paid claims and plans are exempt including specified accident-only plans, disability income, long-term care, auto and worker's compensation, supplemental liability insurance, state and federal government programs	Gross revenues: **total amounts received** in money or otherwise by a health care provider for **patient services**	Premium revenue: recognized on **prepaid basis from individuals and groups for provision of specified range of health services** (except federal Employee Health Benefit Program premiums); **Medicare wraparound subscriber premiums**; **Medicare revenue**; **medical assistance revenue**	Gross premiums: **total premiums paid by policyholders and applicants** of policies	Applies to **gross health insurance premiums and membership and policy fees** received by plan on hospital and medical expense incurred insurance or contracts; **nonprofit health care service plan contracts**, excluding dental or vision only contracts; and **health maintenance organization subscriber contracts** covering health risks**, less all return health insurance premiums**, including dividends paid or credited to policy/contract holders and health insurance premiums received for reinsurance on New Mexico risks. Taxes exclude state or federal insurance contracts and federal HMO payments
Collection Responsibility	**Department of Treasury**	**Department of Revenue**	**Department of Human Services**	**Department of Revenue**	**Insurance Division**
Reporting Manner	**Self-reporting**; quarterly payments	**Self-reporting**; quarterly estimated payments submitted	**Self-reporting**; monthly payments	**Self-reporting**; quarterly payments	**Self-reporting**; quarterly payments
Confidentiality of Reporting	**Unknown**	**Unknown**	**Unknown**	**Unknown**	**Unknown**

Managed Care Organizations	States				
	Michigan	Minnesota	Minnesota	Minnesota	New Mexico
Use of Funds	**Health Insurance Claims Assessment Fund**	**MinnesotaCare Program**	**MinnesotaCare Program and Medical Assistance Program**	**General Fund**	**Insurance Department Suspense Fund and Insurance Operations Fund**
Program Date	Jan. 1, 2012-Jan. 1, 2014	1992-Dec. 31, 2019	2007-	2000-	1984-
Reason for Program Discontinuation	**Affordable Care Act**	Once the **Affordable Care Act** is implemented, the state believes that many individuals in MinnesotaCare will qualify for Medicaid which comes with additional federal funding capabilities. Beginning December 1, 2011, and following each year, tax will phase down if certain budget criteria met	N/A	N/A	N/A
Statutory/Administrative Authority	P.L. 142 of 2011; MCL §550.1732 and §550.1733	Minn. Stat. § 295.50 *et seq*.	Minn. Stat. § 256.9657 *et seq*.; Minnesota Administrative Rules § 9510.2000 *et seq*.	Minn. Stat. § 297I.01 *et seq*.	N.M. Stat. § 59A-6-2
Additional Related Assessments	Eliminates the Use Tax assessed against specific insurance carriers that provide Medicaid benefits				All insurance companies pay a premium tax of 3.003 percent of gross premiums and membership and policy fees (N.M. Stat. § 59A-6-2)