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RESEARCH SUMMARY

MEDICAID PROVIDER TAXES
The Gimmick That Exposes Flaws with Medicaid's Financing

Medicaid's complex federal-state financing structure has long created perverse incentives that discourage efficient care. Key to the problem is the federal government's uncapped reimbursement of state Medicaid expenditures, which encourages states to artificially inflate their Medicaid spending. Such schemes have significantly increased over the past several years and they likely add tens of billions in generally low-value Medicaid spending each year.

A new study from the Mercatus Center at George Mason University examines states' use of accounting schemes to inflate federal Medicaid reimbursements. The study focuses on the largest of the current schemes, provider taxes. These are assessments states levy on healthcare providers, often accompanied by the explicit or implicit guarantee of increased Medicaid payments to those same providers, financed from the federal matching funds. The study provides an economic and political analysis of these taxes and other strategies that states have employed to maximize federal Medicaid reimbursements, and recommends reforms. It contains an appendix with a case study of Arizona, which shows how the state imposed provider taxes to pay for Medicaid expansion.

To read this study in its entirety and learn more about the author, Mercatus senior research fellow Brian C. Blase, please see "Medicaid Provider Taxes: The Gimmick That Exposes Flaws with Medicaid's Financing."

KEY POINTS

- States employ various strategies to artificially inflate their Medicaid spending in order to maximize the federal reimbursement. The largest of these is healthcare provider taxes.
- Currently, 49 states partially fund their Medicaid program with provider taxes. Although provider tax revenue is generally underreported, states reported nearly $22 billion raised through provider taxes in fiscal year (FY) 2015—more than double the inflation-adjusted amount raised in FY 2008.

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- The Bush and Obama administrations, the Bowles-Simpson Commission, and research institutes across the political spectrum have voiced support for reducing or eliminating provider taxes.
- But past efforts to limit provider taxes have backfired by prompting alternative strategies to artificially increase Medicaid spending, such as intergovernmental transfers (IGTs), which have similar properties to provider taxes and are nearly as large a problem.
- State strategies that shift a larger share of program financing to the federal government increase overall Medicaid spending—a problem that will grow as Medicaid's enrollment rapidly escalates. The Congressional Budget Office estimates that federal Medicaid spending will nearly double over the next decade, partly because of the Affordable Care Act. Medicaid's financing structure encourages states to direct spending toward Medicaid—already the largest budget item for states—at the expense of other public priorities.
- Beyond increasing overall Medicaid costs, the program's financing structure also tilts federal dollars toward states that employ the shrewdest gimmicks rather than toward states with greater amounts of poverty.
- Successful reform must change incentives. Transitioning Medicaid to a fixed-payment system would shift states' incentives away from maximizing federal reimbursements and toward maximizing value, and would make provider taxes and other similar schemes obsolete.

BACKGROUND

Though Medicaid is administered by states, it is heavily subsidized by the federal government at a rate inversely related to each state's per capita income. Historically, the average reimbursement has been 57 percent.

While states must provide a specified benefits package for particular populations, they have significant discretion over how Medicaid funds are spent. This, combined with the uncapped federal reimbursement, provides state policymakers with ample opportunity to artificially inflate Medicaid spending to bring additional federal tax dollars into their states.

GAMING THE SYSTEM

Provider taxes represent the most prevalent accounting gimmick that states use to take advantage of the uncapped federal reimbursement. Under provider tax schemes, healthcare providers are given increased Medicaid payments in exchange for paying higher taxes. Such arrangements increase states' Medicaid expenditures—but only on paper. They do not require additional funding from the states' tax base. They do, however, spur the federal government to reimburse its statutorily required share of the artificial spending increase.

States share the benefits of provider tax programs by paying out more in provider Medicaid payments than they take in through the taxes, generally leaving providers with large profits that motivate industry support. For instance, the Government Accountability Office reported that nursing homes in Illinois received a $220 million Medicaid payment increase in exchange for paying $115 million in taxes—a profit of more than $100 million.

Arizona's experience is another example of why healthcare providers support provider taxes. According to Arizona's Medicaid agency, "The Administration expects to return millions more in SFY [state fiscal year] 2016 in incremental payments for hospital services than will be collected through the assessment." In a court case regarding the tax, Arizona's Superior Court confirmed that the provider taxes were not really a tax because the assessments directly benefited the hospitals they targeted.

The use of provider taxes is growing: in 2015, states reported provider tax revenue more than double the inflation-adjusted amount they reported seven years earlier. Both the number of states with provider taxes and the tax rates have increased, contributing to a growing federal share of Medicaid expenditures. In 2015, the federal share of Medicaid expenditures was 63 percent, far higher than the historical federal share of 57 percent. Inflation-adjusted federal Medicaid spending is up 59 percent since 2008 (see table 1).

Table 1. Growth in Provider Taxes and Medicaid Spending

Category	FY 2008	FY 2015	Increase	% increase
Provider tax revenue	$10.7 bn	$21.9 bn	$11.2 bn	105%
State Medicaid spending	$167.0 bn	$205.6 bn	$38.6 bn	23%
Federal Medicaid spending	$220.4 bn	$350 bn*	$129.6 bn	59%
Total Medicaid spending	$387.4 bn	$555.6 bn	$168.2 bn	43%
Federal share of spending	57%	63%*	6%	11%

* These figures are estimates from the Congressional Budget Office, *The Budget and Economic Outlook: 2016 to 2026*, January 25, 2016.

Note: The 2008 amounts have been adjusted for inflation and are shown in 2015 dollars.

Sources: Congressional Budget Office, *The Budget and Economic Outlook: 2016 to 2026*, January 25, 2016; Government Accountability Office, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection* (GAO Report 14-627, July 2014); Department of Health and Human Services, *2010 Actuarial Report on the Financial Outlook for Medicaid*; John Hagg, "Examining Medicaid and CHIP's Federal Medical Assistance Percentage" (Testimony before the House Committee on Energy and Commerce: Subcommittee on Health, Department of Health and Human Services, Office of Inspector General, February 10, 2016).

OTHER STRATEGIES

Provider taxes are just one of the strategies states have developed to maximize federal Medicaid reimbursements. Another is provider donation programs, which allowed providers to donate to state or local governments in the expectation that those donations would be returned with a bonus in the form of supplemental Medicaid payments.

In response to a crackdown on provider taxes and donations in 1991, many states began employing IGTs, which involve issuing large supplemental Medicaid payments to state and local government

healthcare providers. These public providers first transfer money to the state government. The state then sends that money back to the provider under the guise of Medicaid payments, with the federal government sending the state its share of the payment delivered to the provider. IGTs are still common, and provide nearly as much revenue as provider taxes, with more than $18 billion raised in 2012.

POLICY RECOMMENDATION

Policymakers and academics across the political spectrum have suggested limiting or eliminating provider taxes. While this would be a positive step, it would ignore what has historically been a cat-and-mouse game between the federal government and the states. As long as the federal government provides an uncapped reimbursement of state Medicaid expenditures, states will find ways to generate artificial spending.

Successful reform must change the incentives for state policymakers. One way to do this would be to transition Medicaid from an uncapped reimbursement model to a defined contribution model, in which the federal government provides some type of fixed payments to states. This would shift state decision makers' incentives from maximizing Medicaid spending to getting the best deal for their Medicaid dollars.