Office of Legislative Research
Research Report
February 29, 2016
2016-R-0027

CONNECTICUT'S HOSPITAL TAX

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ISSUE

Provide an (1) overview of state health provider taxes and fees and (2) explanation of Connecticut's hospital tax and its relationship to hospital funding.

SUMMARY

Health provider taxes and fees are a mechanism states have used since the 1980s to help finance their Medicaid programs. States impose the taxes and fees on hospitals and various other health providers and, subject to federal Medicaid law requirements, use the revenue to draw down additional federal funds. In FY 13, all the states except Alaska levied one or more provider taxes or fees.

Connecticut's hospital tax is one of its three provider taxes and fees (the other two are resident user fees imposed on nursing homes and certain intermediate care facilities). The legislature enacted the tax in 2011 as part of the state's FY 12-13 biennial budget that increased state payments to hospitals (PA 11-6, §§ 145-149). In FY 12, hospitals paid $349.3 million in taxes and the state appropriated $399.5 million to hospitals in supplemental and other payments. This resulted in an additional $199.8 million in federal matching funds and a $50.4 million net gain to hospitals. Since then, the state has reduced the amount of supplemental payments it makes to hospitals each year. For FY 16, Connecticut hospitals expect to pay $556.2 million in provider taxes (before tax credits) and expect to receive $164.3 million in regular supplemental payments and small hospital pool supplemental payments.

In November 2015, the Connecticut Hospital Association petitioned the Department of Social Services (DSS) and Department of Revenue Services (DRS), seeking a declaratory ruling that the hospital tax is invalid on several grounds. The agencies are expected to rule on the petition later this year.

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STATE HEALTH PROVIDER TAXES AND FEES

Medicaid Funding

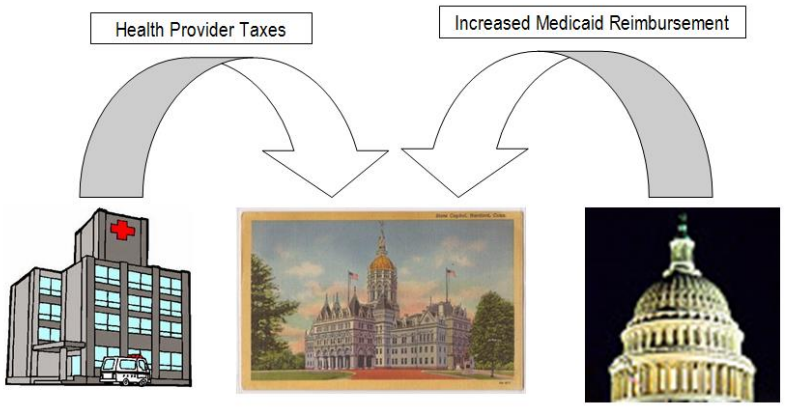
States tax hospitals, nursing homes, and other health care providers to obtain federal Medicaid funds, which reimburse them for a portion of the health care costs of elderly and low-income people and people with disabilities. The reimbursement (i.e., federal medical assistance percentage or FMAP) depends on a state's per capita income, and thus varies from state to state. In FY 16, the FMAP ranges from 50% to 74.17% (Henry J. Kaiser Family Foundation, *FMAP for Medicaid and Multiplier*).

States initially obtained federal reimbursement by spending state and local general funds. Under federal law, at least 40% of the state funds must come from state taxes, fees, and other sources, and up to 60% from local ones. In FY 12, 62.9% ($113.2 billion) of the total nonfederal share came from state sales, corporate, and personal income taxes, 15.5% ($27.9 billion) from local governments, 10.4% ($18.8 billion) from health provider taxes and fees, and 4.6% ($8.3 billion) from tobacco settlement and other funds (Government Accountability Office, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, July 2014).

Increasing Medicaid Matching Funds

States began to tax health care providers in the mid-1980s to increase their Medicaid matching funds (Figure 1) and use the additional revenue to "increase payments to the taxed providers as a means of incentivizing them for providing care to the Medicaid population," the Council of State Governments stated. Consequently, "most, but not all, providers will receive more in increased Medicaid payments than they paid in taxes, depending upon the amount of Medicaid services provided" (*Capitol Research,* "Provider Taxes: A Revenue Source for Health Care," June 2010).

Figure 1: Provider Taxes and Medicaid Funding Mechanism



States also use the revenue to expand their Medicaid programs. Some, like Colorado, use it to extend Medicaid coverage to parents and children, according to the Henry J. Kaiser Family Foundation ("Quick Take: Medicaid Provider Taxes and Federal Deficit Reduction Efforts," January 10, 2013).

"States were borrowing funds from Medicaid providers in order to draw down federal funds and increase Medicaid payment rates to providers that had paid taxes or donated funds," stated Congressional Research Service (CRS) health care financing analyst Alison Mitchell (*Medicaid Provider Taxes*, CRS, March 15, 2012).

Unlike other taxes, "provider tax mechanisms were politically viable for the states." But they also "became a point of contention between the federal government and the states." In 1991, Congress capped the amount of revenue states could draw from provider taxes to 25% of a state's Medicaid share and prohibited them from guaranteeing providers that they would receive their tax and fee payments back.

Congress also specified classes of providers states could tax, as shown in Table 1; prohibited them from imposing the tax on some class members and not others; and required states to tax all class members at the same rate.

Table 1: Health Provider Classes States May Tax for Medicaid Reimbursement

Inpatient hospital services	Outpatient prescription drugs	Optometric and optician services
Outpatient hospital services	Services of Medicaid managed care organizations	Psychological services
Nursing facility services	Ambulatory surgical centers	Therapist services
Services of intermediate care for people with intellectual disability	Dental services	Nursing services
Physician services	Podiatric services	Laboratory and x-ray services
Home health care services	Chiropractic services	

Source: Alison Mitchell, *Medicaid Provider Taxes*, CRS, March 15, 2012

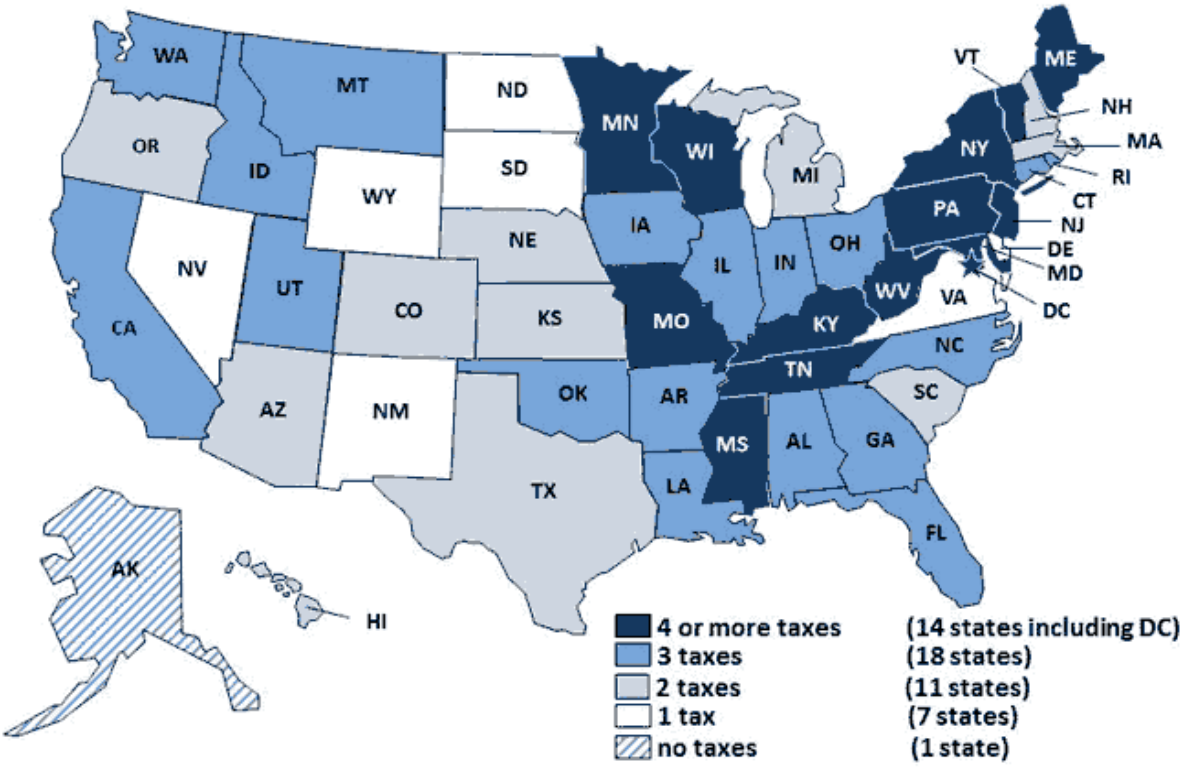
Congress allowed the Centers for Medicare and Medicaid Services (CMS), which oversees the Medicaid program, to waive these rules if the:

1. tax would generate proportionately more revenue from providers who serve relatively more Medicaid patients than those who do not and
2. amount of revenue it generates does not directly correlate with the Medicaid payments.

States Levying Provider Taxes and Fees

As Figure 2 shows, in FY 13, the District of Columbia and all the states except Alaska levied one or more provider taxes. The District of Columbia and 13 states including Maine, New Jersey, New York, and Vermont levied four or more taxes; 18, including Connecticut and Rhode Island, levied three; 12, including Massachusetts and New Hampshire, levied two; and six levied one.

Figure 2: Number of Provider Taxes by State, FY 13



Source: Kaiser Foundation, *Quick Take: Medicaid Provider Taxes and Federal Deficit*, January 10, 2013

As Table 2 shows, most states tax nursing homes (44), hospitals (39), and intermediate care facilities for people with intellectual disabilities (36). Nine tax Medicaid managed care organizations.

Table 2: State Health Care Provider Taxes and Fees by Provider Type

State	Provider Types				
	Hospitals	ICF-IDs*	Nursing Facilities	Medicaid Managed Care Organizations	Other
Alabama	X		X		X
Alaska					
Arizona			X	X	
Arkansas	X	X	X		
California	X	X	X		
Colorado	X		X		
Connecticut	X	X	X		
Delaware			X		
District of Columbia	X	X	X	X	
Florida	X	X	X		
Georgia	X	X	X		
Hawaii	X		X		
Idaho	X	X	X		
Illinois	X	X	X		
Indiana	X	X	X		
Iowa	X	X	X		
Kansas	X		X		
Kentucky	X	X	X		X
Louisiana		X	X		X
Maine	X	X	X		X
Maryland	X	X	X	X	
Massachusetts	X		X		
Michigan	X		X		
Minnesota	X	X	X	X	X
Mississippi	X	X	X		X
Missouri	X	X	X		X
Montana	X	X	X		
Nebraska		X	X		
Nevada			X		
New Hampshire	X		X		
New Jersey	X	X	X	X	X
New Mexico				X	
New York	X	X	X		X
North Carolina	X	X	X		
North Dakota		X			
Ohio	X	X	X		
Oklahoma	X	X	X		
Oregon	X		X		
Pennsylvania	X	X	X		X
Rhode Island	X		X	X	
South Carolina	X	X			
South Dakota		X			
Tennessee	X	X	X	X	
Texas		X		X	
Utah	X	X	X		
Vermont	X	X	X		X
Virginia		X			
Washington	X	X	X		
West Virginia	X	X	X		X
Wisconsin	X	X	X		X
Wyoming			X		

Note: * Intermediate Care Facilities for Persons with Intellectual Disabilities
Source: Henry J. Kaiser Family Foundation

CONNECTICUT'S HOSPITAL TAX

Connecticut's hospital tax applies to most health care facilities and institutions licensed by the Department of Public Health as short-term general hospitals (CGS §§ 12-263a to 12-263e). The legislature enacted the tax in 2011 as part of the state's FY 12-13 biennial budget (PA 11-6, §§ 145-149). The tax replaced the state's defunct hospital gross earnings tax that was first instituted in 1994 and eliminated in 2000.

Tax Rate and Base

The tax is based on a hospital's net patient revenue (defined as the amount of accrued payments a hospital earned for providing inpatient and outpatient services). The law allows the tax rate to be set up to the maximum allowed by federal law (6% as of October 1, 2011).

The rate is currently set at 6% of all net patient revenues. Prior to July 1, 2015, the tax rates were 5.5% of inpatient revenues and 3.83% of outpatient revenues. DSS sets the rate. By law, the DSS commissioner must determine the base year on which the tax will be assessed. Effective July 1, 2015, the base year for determining the tax was updated from 2009 to 2013 net patient revenues.

Hospitals Subject to the Tax

The tax applies to all short-term general hospitals except the Connecticut Children's Medical Center and John Dempsey Hospital. In addition to these two statutory exemptions, the law allows the DSS commissioner, in consultation with the Office of Policy and Management secretary and in accordance with federal law, to exempt hospitals from the outpatient revenue portion of the tax due to financial hardship. Currently, two hospitals are exempt from this portion of the tax – Milford Hospital and Windham Community Memorial Hospital.

Administration

Hospitals must file their hospital tax returns and pay the tax quarterly to DRS. Late filers are subject to a penalty of 10% of the tax due or $50, whichever is greater, plus interest of 1% per month.

Hospitals can reduce their tax liability by applying tax credits, up to a specified limit. (Urban and Industrial Sites Reinvestment tax credits are currently the only tax credits that may be used against the hospital tax.) The reduction was limited to 50.01% of hospital tax liability for the 2015 income year. It increased to 55% for the 2016 income year and increases by 5% each year until it reaches 70% in 2019.

Revenue

Table 3 shows the amount of hospital tax revenue the state collected from FYs 12 through 15.

Table 3: Hospital Tax Revenue, FYs 12-15

FY	*Revenue*
12	$349,277,587
13	347,294,200
14	321,208,807
15	300,060,728

Source: DRS annual reports

Challenge to the Tax

On November 30, 2015, the Connecticut Hospital Association and several of its members submitted petitions to DSS and DRS seeking a declaratory ruling that the hospital tax is invalid. The petitions asked for a ruling as to whether (1) the legislature unconstitutionally delegated to DSS the setting of the tax rate and base year, (2) the tax violates the equal protection clause of the federal constitution, and (3) DSS's implementation and administration of the tax is invalid under specified laws.

On January 29, 2016, DSS and DRS issued a letter to the petitioners, setting a proposed schedule of proceedings and requesting the petitioners to consent to an extension for a ruling until November 30, 2016. The letter states that if the petitioners do not consent to the extension, the agencies will issue their ruling by May 28, 2016.

CONNECTICUT'S PROVIDER FEES

In addition to the hospital tax, Connecticut imposes provider fees on nursing homes and intermediate care facilities for people with intellectual disabilities (ICF-IDs). The legislature established the nursing home fee in 2005 as part of the FY 06-07 budget act that also increased the Medicaid rates the state pays to nursing homes, ICF-IDs, and various other health care providers, contingent on the fee's implementation and the availability of federal Medicaid matching funds (PA 05-251). It established the ICF-ID fee in 2011 as part of the budget act that also established the hospital tax (PA 11-6).

The fees are resident user fees, calculated based on a rate DSS sets annually or biennially up to the maximum allowed by federal law. Nursing homes and intermediate care facilities remit the fees quarterly to DRS (CGS §§ 17b-320 to 17b-324 and 17b-340a to 17b-340b).

HOSPITAL FUNDING

When Connecticut began taxing hospitals in FY 12, it also provided them with supplemental payments, which, in the first year, exceeded the amount of the tax in the aggregate (see Connecticut State Budget FY 12 & FY 13 Biennium, p. 60). Since then, the amount of supplemental payments has declined. In 2015, the legislature created a small hospital pool distribution to provide additional payments to six hospitals. Below, we describe these payments and the federal requirements the state must meet in making them.

Hospital Taxes and Payments for Connecticut Hospitals

For FY 16, Connecticut hospitals expect to pay $556,242,279 in provider taxes and expect to receive (1) $150,210,909 in regular supplemental payments and (2) $14,100,002 in small hospital pool supplemental payments. Table 4 shows the distribution of provider taxes and payments and their net impact by hospital.

Table 4: Expected FY 16 Hospital Provider Taxes and Supplemental Payments

Hospital	FY 16 Estimated Provider Tax to be paid by Hospitals	Supplemental Payments to Hospitals	Small Hospital Pool Distribution	FY 16 Estimated Combined Payments to Hospitals	FY 16 Net Impact to Hospitals
BACKUS	($16,498,739)	$3,971,852	$0	$3,971,852	**($12,526,886)**
BRIDGEPORT	(25,801,946)	15,098,085	0	15,098,085	**(10,703,861)**
BRISTOL	(7,577,413)	2,276,805	2,917,675	5,194,480	**(2,382,932)**
CT CHILDRENS	0	0	0	0	**0**
DANBURY / NEW MILFORD	(35,075,330)	6,201,889	0	6,201,889	**(28,873,441)**
DAY KIMBALL	(6,236,120)	1,630,421	2,777,203	4,407,624	**(1,828,496)**
DEMPSEY	0	0	0	0	**0**
GREENWICH	(19,470,014)	850,626	0	850,626	**(18,619,388)**
GRIFFIN	(7,585,885)	1,404,745	3,315,317	4,720,063	**(2,865,822)**
HARTFORD	(56,389,526)	16,948,293	0	16,948,293	**(39,441,233)**
HOSP. CENTRAL CT	(21,662,085)	8,006,928	0	8,006,928	**(13,655,157)**
HUNGERFORD	(7,050,959)	1,710,151	2,051,467	3,761,618	**(3,289,341)**
JOHNSON	(3,458,624)	654,000	2,301,469	2,955,469	**(503,155)**
LAWRENCE & MEM	(18,206,811)	5,418,841	0	5,418,841	**(12,787,970)**
MANCHESTER	(10,372,141)	3,898,349	0	3,898,349	**(6,473,792)**

Table 4 (continued)

Hospital	FY 16 Estimated Provider Tax to be paid by Hospitals	Supplemental Payments to Hospitals	Small Hospital Pool Distribution	FY 16 Estimated Combined Payments to Hospitals	FY 16 Net Impact to Hospitals
MIDDLESEX	(21,101,283)	3,228,841	0	3,228,841	**(17,872,442)**
MIDSTATE	(13,492,924)	4,690,702	0	4,690,702	**(8,802,223)**
MILFORD	(2,059,239)	396,174	736,870	1,133,044	**(926,196)**
NORWALK	(20,159,380)	5,260,188	0	5,260,188	**(14,899,192)**
ROCKVILLE	(4,203,327)	730,861	0	730,861	**(3,472,466)**
ST FRANCIS	(39,500,666)	16,948,293	0	16,948,293	**(22,552,372)**
ST MARYS	(12,698,985)	7,348,197	0	7,348,197	**(5,350,788)**
ST VINCENTS	(24,312,732)	11,531,832	0	11,531,832	**(12,780,900)**
SHARON	(3,158,481)	277,801	0	277,801	**(2,880,680)**
STAMFORD	(28,685,948)	6,445,404	0	6,445,404	**(22,240,544)**
WATERBURY	(12,424,863)	6,940,660	0	6,940,660	**(5,484,203)**
WINDHAM	(2,174,287)	1,392,679	0	1,392,679	**(781,608)**
YALE / ST RAPHAEL	(136,884,572)	16,948,293	0	16,948,293	**(119,936,279)**
TOTAL	**($556,242,279)**	**$150,210,909**	**$14,100,002**	**$164,310,911**	**($391,931,367)**

Source: Office of Fiscal Analysis

Federal Law on Supplemental Payments

Federal Medicaid law requires states to reimburse health care providers at a rate that ensures efficiency and economy (42 U.S.C. § 1396a(30)(A)). While states have some discretion in how they construct their payments, the Upper Payment Limit (UPL), as specified in federal regulations, limits payments to hospitals and certain other institutional providers by prohibiting federal matching funds for payments in excess of a total based on what Medicare would pay for comparable services. Because the regulations allow federal matching payments up to the UPL, some states make supplemental payments to hospitals based on the difference between the state's regular Medicaid payments for hospital services and the UPL. In other words, states are able to make supplemental payments to hospitals because their regular Medicaid payments, in aggregate, are less than the UPL.

States have some discretion over how they distribute supplemental payments to individual facilities. They may use supplemental payments, and receive matching federal funds, to offset provider taxes or compensate for budget-driven cuts to base payment rates. When combined with a provider tax, the supplemental payments must be redistributive in order to receive federal matching funds (i.e., a hospital cannot generally receive in payments what it paid in provider taxes) (42 C.F.R. 433.74). According to the Medicaid and CHIP Payment and Access Commission

(MACPAC), in 2014, this type of supplemental payment accounted for more than 20% of total Medicaid fee-for-service hospital payments nationally and over 50% in some states.

The amount of the federal match for supplemental payments is a blended rate, generally between the state's regular FMAP and an enhanced FMAP for certain payments under the federal Affordable Care Act. Connecticut's regular FMAP is 50% and the enhanced FMAP under the Affordable Care Act can be up to 100%, but will decline to 90% by 2020. Connecticut's blended rate for supplemental payments in FY 16 is approximately 66% (e.g., if a hospital receives $1,000,000 in supplemental payments, the federal government pays roughly $660,000 (66%), while the cost to the state is $340,000 (34%)).

Connecticut's State Plan Amendments for Supplemental Payments

Generally, states must specify how they intend to distribute supplemental payments through amendments to their state Medicaid plans. The state plan amendments (SPAs) must be submitted to the federal CMS for approval. Though states can distribute payments before SPAs are approved, if CMS does not approve a SPA, the state must make corrective payments.

To implement its supplemental payments to hospitals for the latter half of FY 16, DSS submitted a SPA establishing the distribution of payments. According to the SPA, most short-term general hospitals are eligible for payments. Each hospital's share of the supplemental pool is that hospital's proportional share of the total Medicaid inpatient revenues of all eligible hospitals in the aggregate. Medicaid inpatient revenues are payments for Medicaid inpatient hospital services provided in federal FY 13 to each hospital up to $50 million per year per hospital (no hospital is expected to receive the maximum).

PA 15-5, June Special Session, § 382 allows the DSS commissioner, within available appropriations, to establish another inpatient pool for certain hospitals (i.e., the small hospital pool). Under the SPA submitted by DSS, hospitals eligible for these payments are short-term general acute care hospitals that (1) have no more than 180 licensed beds and (2) are not merged or affiliated with any other hospital. Each eligible hospital's share of this small hospital pool is the hospital's proportional share of total Medicaid inpatient revenues of all eligible hospitals in aggregate for federal FY 14. According to the SPA, DSS will reevaluate eligibility for payments quarterly. Hospitals become ineligible if they merge or affiliate with other hospitals or if they increase their licensed beds over 180. If a hospital becomes ineligible, its allocated funds lapse and are not distributed to any other hospitals.

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