ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

A REVIEW OF HEALTH CARE PROVIDER TAXES AND THEIR POTENTIAL FISCAL IMPACT TO ARIZONA

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HEALTH CARE PROVIDER ASSESSMENTS

I. REPORTING REQUIREMENTS

Arizona Laws 2009, Third Special Session, Chapter 10, Section 29 requires the Arizona Health Care Cost Containment System (AHCCCS) to review and report on health care provider assessments to the President of the Senate, the Speaker of the House of Representatives and the Governor. Specifically, the AHCCCS Administration must:

- Analyze a variety of methods for provider assessments for federally matched programs;
- Examine the potential for enhanced revenue generated based on hospital patient stays;
- Review what has been done in other states; and
- Consider a distribution formula for all hospital providers.

II. SUMMARY

1. Medicaid is a federal/state partnership financed jointly by state and federal government. The federal government acknowledges as part of the established regulatory structure that states have a right to impose taxes on providers and insurers.

2. To ensure that states are not attempting to circumvent their obligations for paying the non-federal share of the cost of Medicaid, federal law requires that state provider taxes must be broad based, uniformly imposed, and cannot hold a provider harmless – that is, states may not create a mechanism for ensuring that the taxpayer is repaid for all or any portion of the cost of the tax, whether directly or indirectly.

3. There are three tests for determining whether taxpayers are held harmless: a positive correlation test, a Medicaid payment test, and a guarantee test. If any of these conditions are met, the tax program would be determined to have a hold harmless provision and the tax would be impermissible. The guarantee test is not violated if the taxes produce revenues that are less than or equal to 5.5% of the provider's net patient revenues.

4. The Centers for Medicare and Medicaid Services (CMS), AHCCCS' federal oversight agency, would need to review any provider tax prior to implementation. That process would include a review of the tax's impact on budget neutrality.

5. Currently, 44 states have some type of provider assessment. In 2009, 23 states taxed inpatient hospitals, 28 states taxed ICF/MR-DD, 35 taxed nursing facilities, and 16 taxed managed care organizations.

6. Arizona currently has a health insurer tax based on 2% of premium revenues. From 2003 through 2008, the premium tax on Arizona's Medicaid health insurers has generated $575 million. Increasing that tax by 1% would yield an additional $161 million, depending on which premiums were ultimately included.

7. Another form of provider assessment is a tax on a percentage of hospital or nursing facility revenues. A 1% tax on hospital net revenues would yield approximately $107 million. A 1% tax on net revenues from Arizona nursing facilities would yield approximately $10.8 million.

8. Also, a per-bed tax can be assessed on hospitals or nursing facilities. A $2,000 per bed/per year tax would generate about $25 million per year from hospitals and about $31.5 million per year from nursing facilities.

9. Any distribution formula that returns any portion of the revenues raised from the provider assessment would need to be approved by CMS and cannot violate federal requirements.

10. Any potential provider assessment legislation must address the following policy issues:

- What provider types should be assessed?
- At what level should they be assessed?
- How should the revenues generated by a tax be distributed?

III. GENERAL POLICY CONSIDERATIONS

The experience in other states suggests that provider taxes can serve as an important revenue stream, particularly during economic downturns when states experience significant increases in Medicaid enrollment. Different models analyzed in this paper show that Arizona could gain significant revenue from application of a new provider tax or expansion of the existing premium tax. However, before reviewing the details of how provider taxes work and what the benefits to Arizona might be in terms of enhanced revenue, it is important to consider certain policy objectives and administrative issues.

Listed below are only some of the issues that can be considered. This list offers some very broad concepts and is not intended to be all inclusive. Also, the concepts below are not mutually exclusive – i.e. provider assessments can share multiple goals, a variety of structures and include more than one provider type.

What is the timing of the provider assessment?

- Is this a permanent tax?
- Is this a temporary tax designed to provide an alternative revenue source during economic downturns?

How should the provider tax be structured?

- Will taxes be applied to gross or net revenues?
- What is the level at which a tax would be applied (in consideration of budget neutrality requirements)?
- Which provider type should be included in the tax – hospitals, nursing facilities, managed care organizations – or should more than one provider type be included?
- Will any provider type be exempted from the tax?

What would be the stated goal(s) of the provider tax?

- Reduce the General Fund liability for Medicaid program costs by a specified dollar amount? Establish, for instance, a dollar amount, enrollment threshold or percentage of the overall General Fund budget that policymakers believe the General Fund can sustain for the Medicaid program, and then use provider tax revenues to cover costs that go beyond the set threshold.
- Provide relief to the General Fund by using provider tax revenue to supplant funding for existing programs – e.g., KidsCare?
- Address provider workforce shortage issues by funding increased Graduate Medical Education programs?
- Increase or stabilize provider reimbursement rates – e.g., increase hospital inpatient or outpatient rates or avoid reducing hospital rates?
- Reduce uncompensated care costs by increasing Disproportionate Share Hospital payments?
- Establish a foundation for funding future coverage expansions that may be mandated through federal healthcare reform legislation?

How should the tax be administered?

- Who is the administering agency – AHCCCS, Arizona Department of Revenue, etc.?
- How will administrative costs be allocated?

Policymakers can choose among several types of provider assessments and select among various options for how best to use the enhanced revenue – reducing the State's General Fund liability for the Medicaid program, funding non-Medicaid programs, reducing uncompensated care, stabilizing or increasing provider reimbursement rates. Provider taxes can also be used as an alternate revenue source when the General Fund liability for the Medicaid program exceeds a certain threshold. Ultimately, it is a policy decision for the legislature and the Executive to determine the ways in which revenues raised by provider taxes can be used and redistributed and these different directions should be considered while weighing the options.

IV. FEDERAL RULES GOVERNING PROVIDER TAXES

A. General Background

Federal law permits states to collect revenues from specified categories of health care providers or services and use those revenues to fund various activities, including pay a portion of the state's share of the Medicaid program. Federal matching dollars can be used to raise provider rates, fund other costs of the Medicaid program or for other non-Medicaid purposes, including depositing the funds into the state's general treasury.

In order to be able to draw down federal financial participation, provider taxes must meet detailed requirements in federal law and regulation.[1] Broadly speaking, Congress established the federal requirements to address state attempts to circumvent their share of Medicaid program costs. Thus, federal law addresses the issue of states "borrowing" their share of the Medicaid cost from providers who subsequently were paid back their portion of the tax in the form of increased Medicaid payments, for which the state claimed federal matching dollars. Federal law also prohibits provider taxes from exceeding 25% of the state's share of Medicaid expenditures.[2]

B. Classes of Health Care Services and Providers Subject to Tax

Health care-related taxes are fees, assessments or other mandatory payments related to (1) health care items or services; (2) the provision of health care items or services or (3) the payment for health care items or services.[3] A tax will be considered to be related to health care items or services if at least 85% of the burden of the tax revenue falls on health care providers.[4]

Health care-related taxes can be applied to 19 specified classes of providers that provide health care items or services specifically listed in federal regulation. Some of those services include:

- Inpatient hospital services;
- Outpatient hospital services;
- Nursing facility services;
- Intermediate Care Facility services for the mentally retarded or developmentally disabled (ICF/MR-DD);
- Physician services;
- Home health care services;

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[1] Congress addressed concerns regarding various mechanisms for implementing provider taxes in 1991 through the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234), 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 for states electing to adopt provider taxes.

[2] 42 USC § 1396b(w)(5)(A).

[3] 42 CFR § 433.55.

[4] 42 CFR § 433.55(b).

- Outpatient prescription drugs; and
- Services of managed care organizations (including health maintenance organizations and preferred provider organizations).[5]

A tax of any particular class of service or provider of such service must apply uniformly to all items/services or providers within that class.[6] This rule prevents states from limiting provider taxes solely to Medicaid providers who can easily be held harmless through increased Medicaid payments.

C. Conditions for Imposing Provider Taxes

If the tax is not "health-care related" as defined above, then the State would not need to comply with the rules below. Otherwise, in order to be permissible under federal law, provider taxes must be:

- Broad based;
- Uniformly imposed; and
- Cannot violate the hold harmless provisions.

1. *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" and is imposed uniformly.[7]

2. *Uniformly Imposed*

Generally, a health care-related tax will be considered to be imposed uniformly if the tax is the same amount for every provider furnishing those items or services within the class.[8] 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.

Uniformity is not established where the tax (a) provides for credits or deductions that result in the return to providers of all, or a portion, of the tax paid and (b) results, directly or indirectly, in a tax that is not generally redistributive and the amount of the tax is directly correlated to payments under the Medicaid program. The uniformity requirement is also violated where the tax holds taxpayers harmless for the cost of the tax.[9]

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[5] 42 CFR § 433.56(a).
[6] 42 CFR § 433.56(b).
[7] 42 CFR § 433.68(c).
[8] 42 CFR § 433.68(d)(1).
[9] 42 CFR § 433.68(d)(2).

3. *Hold Harmless Provisions*

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." There are three tests for determining whether taxpayers are held harmless: a positive correlation test, a Medicaid payment test, and a guarantee test. If any of these conditions are met, the tax program would be determined to have a hold harmless provision and the tax would be impermissible. These three conditions are explained more fully below.

a. 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."[10] These payments may take various forms, such as tax credits or grants, and "direct or indirect" is interpreted broadly. CMS provides the following example:

> 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."[11]

The above cited example results in a hold harmless for the nursing home because there is a "reasonable expectation" that the grant monies going to the nursing home residents will be returned to the nursing home as increased fee payments.

Similarly, the hold harmless provisions would find a violation of the positive correlation test and the guarantee test where a payment is made to a taxpayer as long as the payment is from a source "controlled or directed by the state."[12] For instance, "States will not be permitted to recycle monies through third parties, by making payments to such third parties and requiring that the money be used to reimburse taxpayers for any portion of their health care related tax."[13]

[10] 42 CFR § 433.68(f)(1).
[11] 73 Fed. Reg. 9685, 9691 (Feb. 22, 2008).
[12] 73 Fed. Reg. 9685, 9694 (Feb. 22, 2008).
[13] *Id*.

b. 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.[14] 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. This test is designed to guard against effectively repaying taxpayers and protect the integrity of the development of sound Medicaid payment rates consistent with efficiency, economy and quality of care.[15]

c. Guarantee Test and Safe Harbor

A tax program will be 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.[16] Federal law creates a "safe harbor" from the prohibition against guaranteeing return of tax funds. If the taxes produce revenues that are less than or equal to 5.5% of the provider's net patient revenues, the tax is permissible under the guarantee test.[17]

4. *Waiver from Broad Based and Uniformity Requirements*

A state may be waived only from the broad-based and uniformity requirements if the tax program meets all of the following:

a. The net impact of the tax and any payments made to the provider is generally redistributive;
b. The amount of the tax is not directly correlated to Medicaid payments; and
c. The tax program does not fall within the hold harmless provisions.[18]

Federal regulations detail a statistical test that measures the degree to which the Medicaid program incurs a greater tax burden than if these requirements were met. There is no waiver of the hold harmless provisions.

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[14] 42 CFR § 433.68(f)(2).
[15] *See* 73 Fed. Reg. 9685, 9692-94 (Feb. 22, 2008).
[16] 42 CFR § 433.68(f)(3). "A direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax. An indirect guarantee is distinct from a direct guarantee in that such guarantee is initially measured by a percentage threshold that limits tax collection to 5.5 percent of patient revenue attributable to the assessed service. States collecting a tax in excess of 5.5 percent of assess patient service revenue must perform the second prong of the hold harmless test to demonstrate permissibility." 73 Fed. Reg. 9685, 9695 (Feb. 22, 2008). The second prong of the test is known as the 75/75 test, which will find a hold harmless to exist if 75% or more of the taxpayers in the class receive 75% or more in enhanced Medicaid payments or other state payments. 42 CFR § 433.68(f)(3)(i)(B).
[17] 42 CFR § 433.68(f)(3)(i)(A). The safe harbor percentage was changed from 6% to 5.5% for the period of January 1, 2008 through September 30, 2011, but will revert back to 6% after that period ends.
[18] 42 CFR § 433.72. *See also* 42 CFR § 433.68(e) for a definition of "generally redistributive."

D. Federal Review and the Role of Budget Neutrality

Any new provider tax that seeks to draw down federal Medicaid matching funds will have to be reviewed and approved by the Centers for Medicare and Medicaid Services (CMS). CMS serves as the federal oversight agency for the AHCCCS program. The timing of CMS review will depend on the complexity of the provider assessment, but can take anywhere from six months to over a year.

One of the issues CMS will review as part of any analysis regarding the imposition of a new provider tax is the impact any additional spending will have on the State's estimate for Budget Neutrality. Budget Neutrality is a requirement of the current 1115 waiver that governs the AHCCCS program. CMS mandated a spending cap as part of waiver negotiations resulting from the voter approved initiative Proposition 204 in 2000. From April 1, 2001 until September 30, 2006 the entire Acute Care program and Disproportionate Share Hospital payments had to be managed within a total spending limit.

When the State had to renegotiate the waiver in 2006, the Budget Neutrality requirements were expanded to include Long Term Care. The Special Terms and Conditions of the waiver currently state that "if at the end of this Demonstration period the overall budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to CMS." AHCCCS has been able to maintain an overall positive Budget Neutrality variance. AHCCCS is currently projecting that the variance at the end of the current waiver period, which terminates on September 2011, will be a positive $129 million. It should be noted that these estimates are being made on over $60 billion in total spending. While a significant portion of that spending has already occurred, it is still an insignificant balance given the overall scope of the waiver. Additional details on this estimate have been provided at Appendix A to the report.

If a policy decision is made to pursue additional provider taxes, this will result in an increase in Medicaid spending. The current limited positive variance in Budget Neutrality will need to be incorporated into the potential level of provider tax that could be assessed. Given current projections, the impact on Medicaid spending should probably be limited to the current Budget Neutrality limits.

There are two additional items regarding Budget Neutrality that should be identified. The first is that since the current period ends on September 2011, AHCCCS is unsure how future obligations will be scored against Budget Neutrality. The second is that federal healthcare reform may significantly alter the type of Budget Neutrality requirements CMS may impose in future waiver discussions.

V. STATE SURVEY OF PROVIDER ASSESSMENTS

Provider assessments are an option for states needing to raise revenue. Currently, 44 states have some type of provider assessment. For Fiscal Year (FY) 2010, that number will be 45. A survey conducted for the Kaiser Commission on Medicaid and the Uninsured found that, as compared to FY 2008, an additional seven states are expected to have hospital taxes in FY 2010 and four more states added a tax on nursing facilities.[19] In addition, many states have increased the size of existing provider taxes. The Kaiser Commission state survey table is attached at Appendix B of this report.[20]

This report highlights four states – California, Colorado, Illinois and Oregon – and provides a brief overview of provider taxes in those states.

A. California

California currently has a provider tax on intermediate care facilities for the developmentally disabled and skilled nursing facilities (SNFs). The tax is assessed on aggregate net revenue but is not to exceed the safe harbor threshold.[21] Revenues are used to enhance federal financial participation in the Medi-Cal program, California's Medicaid program, to provide additional reimbursement or support facility quality improvement efforts.

In addition, California assesses a gross premium tax on insurers (generally defined as property insurance, life insurance, casualty insurance, some preferred provider organizations and some point of service plans). That tax is set at 2.35% of annual gross premiums and is in lieu of all other taxes and licenses upon insurers and their property.[22]

California also had in place a tax on its Medi-Cal managed care plans. The fee on managed care plans was set at 5.5% of revenues. The net increase in revenue was deposited into the state general fund and for 2008-09 was estimated at $238.8 million in Total Funds. The provider tax on Medicaid managed care plans was not in compliance with recent changes in federal law requiring provider fees to be broad based and uniformly imposed – that is the tax could not be levied only on managed care plans enrolled in the Medicaid program.

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[19] Vernon K. Smith, Ph.D., et al, Kaiser Family Foundation, *The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession; Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2009 and 2010*, 32-33 (September 2009).

[20] For additional state specific information, go to the National Conference of State Legislatures at http://www.ncsl.org/IssuesResearch/Health/HealthProviderandIndustryFeesandTaxes/tabid/14359/Default.aspx.

[21] For assessment on intermediate care facilities, *see* Cal Health & Saf. Code § 1324. to 1324.14 (2009); for assessment on SNFs *see* Cal Health & Saf. Code §§ 1324.20 to 1324.30 (2009). California has a waiver exempting some types of SNFs, such as continuing care retirement communities and SNFs operated by the state or another public entity.

[22] This tax is established in California's constitution, Section 28, Article XIII.

Due to its fiscal crisis, California was facing a near $200 million dollar shortfall in its Children's Health Insurance Program (CHIP), known as the Healthy Families program (KidsCare, in Arizona). That shortfall would have resulted in the disenrollment of about 600,000 children. To address the CHIP shortfall, California applied the gross premiums tax to Medi-Cal managed care plans.[23] Because the gross premiums tax is an existing tax on a broad group of insurers, the overwhelming majority of which are not health care insurers, it can be extended to Medi-Cal managed care plans without being considered a provider fee under federal law. Applying the tax was estimated to yield $97 million and was supported by the health plans. California can use revenues raised from the gross premiums tax as the source of state matching funds without having to meet the federal provider tax rules.

B. <u>Colorado</u>

On April 21, 2009, Governor Bill Ritter signed HB1293 into law. Pending CMS approval, this law established a provider fee on all hospital inpatient and outpatient services. Revenues generated from the fee are intended to: increase hospital reimbursement; reduce the number of uninsured through program expansions to medical assistance programs; and pay costs associated with administering the provider fee, together with the expansions.

In accordance with the legislation, the rate for the new fees shall be established by an Advisory and Oversight Board, consisting of thirteen members appointed by the Governor and confirmed by the State Senate. In conducting their fiscal analysis for the proposed legislation, the Colorado Legislative Council hypothesized that the Advisory and Oversight Board would levy the new fee at a rate of 3% of aggregate net revenue. Based on this rate, the Legislative Council staff estimated that the new hospital provider fee would generate $336.4 million in FY 2009-2010 and $389.5 million in FY 2010-2011. From this, Colorado would be eligible to receive up to $600 million in federal matching funds.

Currently, Colorado hospitals are reimbursed for Colorado Indigent Health Care Services at a rate of 90-92% of the Medicare rate for inpatients services and 72% for outpatient services. The legislation directs revenues from the provider fee to increase hospital reimbursements from the Colorado Indigent Care Program up to 100% of the hospitals' costs. The legislation also specifies that revenues shall be utilized to maximize inpatient and outpatient reimbursement up to the upper payment limit and pay for quality incentives for performing hospitals.

Under the legislation, eligibility for the Children's Basic Health Program will be increased from 205%-250% FPL. Income eligibility for parents with children would be increased from 60% to 100% FPL. In addition, new programs will be created that provide medical coverage to childless adults up to 100% FPL and provide for a Medicaid buy-in program for disabled individuals up to 450% FPL. Finally, the legislation

[23] *See* Assembly Bill 1422, approved by the Governor September 22, 2009.

includes provisions stipulating that if revenues from the provider fee are insufficient to fund these expansions, the Colorado Department of Health Care Policy and Financing is authorized to lower eligibility limits to meet funding levels. Implementation of the new provider fee is dependent on obtaining CMS approval of the overall tax program and a waiver from the broad based requirement.

C. Illinois

In December of 2008, Governor Blagojevich signed Senate Bill 2857. Under this agreement between Illinois and the federal government, the Illinois Department of Healthcare and Family Services (HFS) will distribute $1.55 billion in Medicaid payments to hospitals from the Hospital Provider Fund. From this distribution, the federal government sends Illinois $777 million in matching funds. The state then collects $907 million in taxes from hospitals. Through this process, hospitals gain $655 million in increased funding. The General Assembly has included SB 2857 in the FY09 budget.

Illinois has previously received federal approval for two similar hospital assessment plans bringing nearly $2.3 billion in federal dollars to Illinois.

HFS will distribute the money to hospitals during the course of the year in 12 equal payments. The amount of money a hospital receives is based on the various services it provides to Medicaid patients. Additional funding recognizes hospitals for obstetrical, psychiatric and rehabilitative services, and capital costs.

The amount of money that each hospital receives is the same for the period of the assessment, which allows hospitals to plan for their cash flow from the program each year. SB 2857 codifies a five year plan, which will be effective after being approved by CMS.

D. Oregon

Provider taxes allow Oregon to secure federal matching funds to finance Oregon's Medicaid program and support payments to hospitals and Managed Care Organizations (MCOs). Four new taxes – (1) Hospital tax; (2) Long Term Care Facility tax; (3) Managed Care organization; and (4) Tax on Programs for All-Inclusive Care for Elderly Persons – were first created by the Oregon Legislature in 2003. In the 2007-2009 bienniums, Oregon is expected to collect $215 million in provider taxes from hospitals and Managed Care Organizations (MCOs) to generate another $343 million in federal matching funds. After the tax is assessed and collected, the monies are matched with $1.66 in federal Medicaid funds.

The Director of the Department of Human Services determines the rate on each hospital subject to the tax, not to exceed the 3% cap limit of net revenue of each hospital. Oregon received a CMS waiver from the "broad based" requirement to exclude certain hospitals

(mostly smaller, rural hospitals with less than 50 beds), hospitals operated by the U.S. Department of Veterans' Affairs, and pediatric specialty hospitals that provide free care to children.

In 2004, Oregon received federal approval to tax certain nursing facility patient days per bed. The assessment equals the rate times the number of patient days at the long term care facility for a calendar quarter also established by the Director. The Veterans' home, nursing facilities with Medicaid utilization of 85% or more and nursing facility patient days in Continuing Care Retirement Communities are excluded.

There is a proposal to expand provider taxes to draw down additional federal matching funds. Examples of the expansion would be to raise the cap limit on hospital taxes to 4%. In addition, Oregon recently expanded its MCO tax to include all commercial insurers; previously, the tax was limited to Medicaid MCOs.[24]

VI. APPLYING DIFFERENT PROVIDER ASSESSMENTS IN ARIZONA

A. Existing Provider Taxes in Arizona

Arizona currently has a health insurer tax based on 2% of premium revenues. Originally, AHCCCS managed care plans were not included in that tax. However, to ensure the tax was broad based, Arizona statutes were amended in 2003 and the premium tax was applied to AHCCCS health plans.[25] From 2003 through 2008, the premium tax on Arizona's AHCCCS health insurers generated over $575 million of which $390 million was federal matching dollars. The table at Appendix C provides additional detail.

B. Analysis of Different Provider Assessments for Federally Matched Programs

Policy-makers have different methods or options of provider assessments that will result in varying revenue collection amounts. Examples include: a tax on a percentage of hospital or nursing facility revenues; a per-bed tax that can be assessed on hospitals or nursing facilities; or expanding the health care insurer premium tax.[26] These methods are discussed in more detail below and their revenue enhancing potential for Arizona is outlined in Appendix D.

1. *Tax on Revenues for Hospitals and Nursing Facilities*

A tax on gross revenues would assess a tax based on a percentage of a facility's gross revenues. The recently approved tax in Illinois is a 2.5% tax on gross revenues for inpatient and outpatient services. One benefit of using gross revenues is that the data is

[24] House Bill 2116, 75th OREGON LEGISLATIVE ASSEMBLY, 2009 Regular Session.
[25] A.R.S. §§ 36-2905 and 36-2944.01.
[26] In addition, the existing premium tax on non-health care insurers can be increased and used as state match for the Medicaid program that would also yield federal matching dollars.

easily attainable; it is the total of a hospital's billed charges before any contracts or allowances. A tax on gross revenues could minimize the incentive for hospital charge-master inflation.

Alternatively the tax could be assessed on net revenues. This would take into account and adjust for discounts provided to payers. These amounts are also reported by hospitals.

As there is currently no process for collecting hospital taxes, the administration of such a tax, if legislated, would have to be described in rule, documented in policy, staffed and resourced. It is expected that this process could take twelve to fifteen months. Revenues from such an assessment could be unpredictable. However, considering Arizona's increasing population and medical cost trends, revenues should rise from year to year.

As a benchmark, a 1% tax on hospital net revenues would yield approximately $107 million. A tax on 1% of hospital gross revenues is projected to generate approximately $199 million. For nursing facilities, a 1% tax on net revenues would generate approximately $10.8 million while a 1% tax on gross revenues would yield approximately $13 million. Additional revenue detail and comparisons can be found at Appendix D for hospitals and nursing facilities.

Any provider tax in excess of 5.5% of provider revenues is subject to additional regulations and testing by CMS. Implementation of either a tax on gross revenues or a tax on beds would need methodology that would cap a provider's tax at 5.5% of revenue.

2. *Bed Tax on Hospitals and Nursing Facilities*

A "bed tax" imposes a provider assessment based on the number of beds licensed within a facility. There are approximately 13,500 licensed hospital beds in Arizona and 15,800 licensed nursing facility beds. The number of licensed beds is reported to the Arizona Department of Health Services.

Revenues from such a tax would be relatively easy to predict. Hospitals and nursing facilities do not regularly change the number of beds in their hospital licensing data. New hospitals and nursing facilities and their licensing capacities are usually known in advance.

Regarding hospitals, a bed tax would be a tax on the inpatient portion of hospital operations. This tax would disregard all of the services that are provided by hospitals in outpatient settings. As inpatient services have a slower growth curve than outpatient services, this methodology misses a large part of growing services for hospitals. A benefit to this methodology, however, is that Critical Access Hospitals, which by design become more tertiary hospitals with an emphasis on outpatient services, would be less affected by a bed tax. Arizona's Critical Access Hospitals have smaller budgets and more vulnerable bottom lines than most of the other hospitals.

Today, Medicaid pays nearly half of all nursing home care nationwide. In Arizona, AHCCCS pays 61% of all nursing facility bed days. While AHCCCS pays the majority of nursing facility bed days, many Arizonans are private pay – 13% of Arizona's nursing facility patients pay their own way. Consequently, a bed tax on nursing facilities is more likely to be passed along to private pay residents than in the hospital setting.

Because a bed tax is not currently in operation, resources would need to be allocated for its administration. The timing and resources required to implement a bed tax would be similar to that of operating a tax on gross revenue described above taking twelve to fifteen months to implement.

As an example of potential revenue, a $2,000 per bed/per year tax would generate about $25 million (this is the number of licensed beds above times $2000 per bed) per year from hospitals and about $31.5 million per year from nursing facilities, for combined revenues of $56.5 million. A bed tax assessment on nursing facilities yields a larger percentage of federal participation because Medicaid is a larger percentage of state nursing facility bed days.

Any provider tax in excess of 5.5% of provider revenues is subject to additional regulations and testing by CMS. Implementation of either a tax on gross revenues or a tax on beds would need methodology that would cap a provider's tax at 5.5% of revenue.

3. *Premium Tax*

There are several components of the Premium Tax in Arizona. In addition to the 2% premium levied on both commercial and Medicaid health insurance companies, current law also taxes life insurance and property and casualty at a 2% rate.

Due to the economy, several of these components are predicted to decrease over the next couple of years. In FY 2010, these components are anticipated to generate $322.5 million with the Medicaid premium representing just under half of the tax levied. (See Appendix C.)

Because this tax is already in existence, there would be minimal administrative cost for implementing a modest increase in the taxable percentage. A 1% increase would yield approximately $161 million with roughly $78 million in increased Medicaid insurance premiums. The State Match of roughly $26 million would need to be appropriated and deducted from the overall increase. These estimates assume that items currently over the 2% rate, like vehicle premiums, are not adjusted upward. Additionally, since health related items represent roughly 73% of the overall tax, an adjustment should require minimal CMS input and review.

C. Consider a Distribution Formula for All Hospital Providers

Any redistribution formula of a provider tax is a policy decision for the legislature and the Executive. Providers may expect a portion of any new assessment be returned to them in some form. This return on the provider's investment serves to stabilize provider rates and offers some security for the overall healthcare delivery system, which has benefits beyond merely the Medicaid program. However, any redistribution formula must be in line with the regulatory framework that has been established by Congress and CMS.

The State cannot simply distribute funds to the providers. The tax amount also cannot be returned to providers in the form of credits, grants or exclusions that have the effect of holding the taxpayer harmless. Federal guidelines also mandate that provider taxes must be levied equally across an industry. A tax on hospital beds or gross revenues, for instance, cannot be levied solely on hospitals that serve a high percentage of Medicaid patients. Rather, a tax on hospitals would have to meet the federal requirements detailed above. Certainly one of the major issues associated with a provider tax or assessment is the varying impact on facilities due to payer mix. Appendix E has been included to provide an approximation of the net revenues by hospital and the percent of Medicaid bed days.

The redistribution methodology is further complicated by the fact that AHCCCS cannot make any payments to providers directly outside of a managed care plan payment, except supplemental payments provided to hospitals, as in Disproportionate Share Hospital or Graduate Medical Education (GME) payments. This is different from what some other states are able to do that have larger fee-for-service populations.

If policymakers make the decision to use funding generated by a tax to enhance payments to providers, there are opportunities within the current reimbursement structure. The tax revenues could be matched with federal Medicaid funds and used to cover increased inpatient per diem rates to account for recent rate freezes. The funding could be dedicated to programs like GME or used to expand GME to cover Indirect Medical Education costs. If Nursing Facilities were taxed and a decision was made to use the funds to support this provider type, the funding could be used to increase rates for this provider group as well.

Accordingly, CMS would review any redistribution methodology on a case-by-case basis.

VII. CONCLUSION

The federal government acknowledges states' right to impose taxes on providers and insurers, and provides federal financial participation for those provider assessments through the Medicaid program. To ensure that states are not attempting to circumvent their obligations for paying the non-federal share of the cost of Medicaid, federal law places strict requirements on state provider taxes – must be broad based, uniformly imposed, and cannot hold a provider harmless.

Other states offer examples as to how a provider tax could be applied in Arizona. State surveys suggest that provider taxes can serve as an important revenue stream, particularly during economic downturns when states experience significant increases in Medicaid enrollment. Different models analyzed in this paper show that Arizona could gain significant revenue from application of a new provider tax or expansion of the existing premium tax.

Ultimately, it is a policy decision for the legislature and the Executive to determine the ways in which revenues raised by provider taxes can be used and redistributed. Policymakers can choose among several types of provider assessments and select among various options for how best to use the enhanced revenue – reducing the State's General Fund liability for the Medicaid program, funding non-Medicaid programs, reducing uncompensated care, stabilizing or increasing provider reimbursement rates. Provider taxes can also be used as an alternate revenue source when the General Fund liability for the Medicaid program exceeds a certain threshold. Likewise, there are various different methods for redistributing provider tax dollars. Regardless, any policy decisions made by Arizona policymakers will have to be reviewed by CMS.

APPENDIX A: BUDGET NEUTRALITY SUMMARY

Arizona Health Care Cost Containment System
Budget Neutrality Status by Fiscal Year
Total Funds
SEPTEMBER 2009 REBASE MODEL (RATE ADJUSTED)

Expenditure Limit Calculation	Actual 2001 (2Q)	Actual 2002	Actual 2003	Actual 2004	Actual 2005	Actual 2006	Actual 2007	Actual 2008	Estimate 2009	Estimate 2010	Estimate 2011	Total
State Plan Member Months												
TANF	2,482,841	6,241,119	7,586,711	8,167,819	8,796,624	8,692,780	8,679,111	9,162,186	10,242,268	11,600,616	12,179,562	93,831,637
SSI	541,681	1,178,612	1,288,308	1,407,575	1,515,553	1,537,497	1,543,098	1,574,664	1,587,197	1,607,270	1,642,169	15,423,624
EPD	-	-	-	-	-	-	299,341	311,870	325,476	335,302	352,598	1,624,587
DD	-	-	-	-	-	-	227,232	242,334	258,326	273,618	288,874	1,290,383
Combined	3,024,522	7,419,731	8,875,019	9,575,394	10,312,177	10,230,277	10,748,782	11,291,054	12,413,267	13,816,806	14,463,203	112,170,232
Waiver PMPM												
TANF	250.23	273.98	300.00	328.48	359.67	393.19	421.27	451.60	484.12	518.98	556.35	420.13
SSI	473.25	505.81	540.60	577.80	617.55	607.59	632.50	678.04	726.86	779.19	835.29	651.84
EPD	-	-	-	-	-	-	3,409.91	3,655.42	3,918.61	4,200.75	4,503.20	3,959.46
DD	-	-	-	-	-	-	3,516.33	3,769.51	4,040.91	4,331.86	4,643.75	4,094.21
Weighted	290.17	310.81	334.93	365.13	397.57	425.41	600.25	842.86	679.23	714.11	765.88	545.51
Waiver Expenditure Limit												
TANF	621,270,500	1,709,970,300	2,276,008,900	2,683,000,800	3,163,916,500	3,417,921,300	3,656,249,100	4,137,643,200	4,958,486,800	6,020,487,700	6,776,099,200	39,421,054,300
SSI	256,346,400	596,148,100	696,465,200	813,294,300	935,930,900	934,166,100	976,009,400	1,067,685,300	1,153,670,400	1,252,368,500	1,371,887,400	10,053,774,000
EPD	-	-	-	-	-	-	1,020,725,900	1,140,015,900	1,275,412,000	1,408,520,400	1,587,820,500	6,432,494,700
DD	-	-	-	-	-	-	799,022,700	913,480,400	1,043,871,500	1,185,275,000	1,341,456,600	5,283,106,200
Total	877,618,900	2,306,118,400	2,972,474,100	3,496,295,100	4,099,847,400	4,352,067,400	6,452,007,100	7,258,824,800	8,431,440,700	9,866,651,600	11,077,063,700	61,190,429,200
DSH Allotment	115,473,000	132,371,100	122,252,800	141,792,200	141,392,700	142,384,900	143,477,400	143,477,400	154,574,700	158,487,300	150,167,600	1,545,851,100
Total Waiver Expenditure Limit	993,091,900	2,438,489,500	3,094,726,900	3,638,087,300	4,241,240,100	4,494,472,300	6,595,484,500	7,402,302,200	8,586,015,400	10,025,138,900	11,227,231,300	62,736,280,300
Expenditures												
TANF/SOBRA	539,713,900	1,400,586,800	1,651,659,300	1,898,380,000	2,183,970,000	2,361,254,300	2,541,218,400	2,890,767,900	3,418,628,700	3,747,205,100	4,126,341,900	26,759,726,300
SSI	259,586,600	594,348,700	659,647,800	830,513,600	968,005,700	1,002,527,300	1,054,762,900	1,162,452,800	1,223,683,000	1,270,514,500	1,375,129,800	10,401,172,700
TWG	110,078,000	415,799,400	543,440,700	622,410,400	834,523,500	1,060,636,700	1,100,212,400	1,359,842,900	1,745,377,200	2,501,572,700	2,808,004,200	13,102,098,100
EPD	-	-	-	-	-	-	1,025,034,600	1,107,412,500	1,264,935,900	1,281,850,700	1,402,290,200	6,081,523,900
DD	-	-	-	-	-	-	784,569,000	869,190,200	941,043,600	1,010,001,900	1,119,977,600	4,724,782,500
Expenditure Subtotal	909,378,500	2,410,734,900	2,854,747,800	3,351,304,000	3,986,499,200	4,424,618,300	6,505,797,300	7,389,686,300	8,593,668,400	9,811,144,900	10,831,743,900	61,069,303,500
DSH	114,929,600	130,303,800	122,243,000	141,792,200	141,392,700	136,354,400	143,477,300	141,543,300	154,574,700	158,487,300	150,167,600	1,537,265,900
Total Expenditures	1,024,308,100	2,541,038,700	2,976,990,600	3,493,098,200	4,127,891,900	4,562,972,700	6,649,274,600	7,531,209,600	8,748,243,100	9,969,632,200	10,961,911,500	62,606,569,400
Expenditure PMPMs												
TANF/SOBRA	217.38	224.41	217.70	232.42	248.27	271.63	292.80	315.51	333.78	323.02	338.79	
SSI	479.22	504.28	512.03	590.03	638.71	652.05	683.54	738.22	770.97	790.48	837.39	
TWG	901.93	683.94	624.56	673.85	609.22	733.73	798.68	854.50	908.72	910.05	960.54	
EPD	-	-	-	-	-	-	3,424.30	3,550.88	3,886.42	3,822.97	3,977.02	
DD	-	-	-	-	-	-	3,452.72	3,586.74	3,642.86	3,891.28	3,877.05	
Budget Neutrality Variance	(31,216,200)	(102,549,200)	117,736,100	144,991,100	113,348,200	(68,500,400)	(53,790,100)	(128,907,400)	(162,227,700)	55,506,700	245,319,800	**129,710,900**
Cummulative Variance		(133,765,400)	(16,029,300)	128,961,800	242,310,000	173,809,600	120,019,500	(8,887,900)	(171,115,600)	(115,608,900)	129,710,900	
Variance by WG												
TANF/SOBRA	81,556,600	309,383,500	624,349,600	784,820,600	979,946,500	1,056,667,000	1,115,030,700	1,246,875,300	1,539,858,100	2,273,282,600	2,649,757,300	12,661,328,000
SSI	(3,238,200)	1,799,400	36,817,400	(17,219,300)	(32,074,800)	(68,361,200)	(78,753,500)	(94,767,500)	(70,012,600)	(18,146,000)	(3,442,400)	(347,396,700)
TWG	(110,078,000)	(415,799,400)	(543,440,700)	(622,410,400)	(834,523,500)	(1,060,836,700)	(1,100,212,400)	(1,359,842,900)	(1,745,377,200)	(2,501,572,700)	(2,808,004,200)	(13,102,098,100)
EPD	-	-	-	-	-	-	(4,308,700)	32,603,400	10,476,100	128,669,700	185,530,300	350,970,800
DD	-	-	-	-	-	-	14,453,700	44,290,200	102,827,900	175,273,100	221,478,600	558,323,700
DSH	543,400	2,067,300	9,800	-	-	4,030,500	100	1,934,100	-	-	-	8,585,200
	(31,216,200)	(102,549,200)	117,736,100	144,991,100	113,348,200	(68,500,400)	(53,790,100)	(128,907,400)	(162,227,700)	55,506,700	245,319,800	129,710,900
Exp PMPM Change												
TANF/SOBRA		3.2%	-3.0%	6.8%	6.8%	9.4%	7.6%	7.8%	5.8%	-3.2%	4.9%	
SSI		5.2%	1.5%	15.2%	8.3%	2.1%	4.8%	8.0%	4.4%	2.5%	5.9%	
TWG		-24.2%	-8.7%	7.9%	-9.6%	20.4%	8.9%	7.0%	6.3%	0.1%	5.5%	
EPD								3.7%	9.4%	-1.6%	4.0%	
DD								3.9%	1.6%	1.3%	5.0%	

APPENDIX B: KAISER FAMILY FOUNDATION STATE SURVEY

Provider Taxes in Place in the 60 States and District of Columbia FY 2009 and FY 2010

States	Hospitals		ICFIMR-DD		Nursing Facilities		Managed Care Organizations		"Other"		Any Provider Tax	
	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010
Alabama		x			x	x			x	x	x	X
Alaska												
Arizona							X	x			x	x
Arkansas		X		X	X	X					X	X
California			x	x	x	x	x				x	x
Colorado												
Connecticut												
Delaware												
District of Columbia												
Florida												
Georgia					x	x	x		x		x	X
Hawaii												
Idaho	x	x				x					x	X
Illinois	X	x	x	x	x	x					x	x
Indiana			x	x	x	x					x	X
Iowa												
Kansas												
Kentucky												
Louisiana												
Maine												
Maryland	X	x	x	x	x	x	x	x	x	x	x	x
Massachusetts	x	x			x	x					x	x
Michigan	x	x			x	x	x				x	x
Minnesota	X	x	x	x	x	x	x	x			x	X
Mississippi	x	x	x	x	x	x					x	x
Missouri												
Montana												
• Nebraska												
Nevada												
New Hampshire												
New Jersey			x	x	x	x	x	x			x	X
New Mexico							X	x	x	x	x	X
New York	X	X			X	X			X	X	X	X
North Carolina			X	x	x	x					x	X
North Dakota			x	x							x	x
. Ohio :												
OklahOma												
Oregon												
Pennsylvania												
Rhode Island												
South Carolina	x	x	x	x							x	X
South Dakota			X	x							x	X
Tennessee			x	x	x	x	x	x			x	x
Texas			x	x			x	x			x	X
Utah			x	x	x	x					x	x
Vermont												
Virginia												
. Washington												
West Virginia												
Wisconsin												
Wyoming												
Total	23	26	28	31	35	37	16	11	10	11	45	45

*Kentucky, Minnesota, Missouri, New York & Vermont all reported multiple "other' provider tax in both 2009 and 2010

APPENDIX C: ARIZONA HEALTH INSURANCE PREMIUM TAX REVENUE

Arizona Health Insurance Premium Tax (IPT) Revenue

Calendar Year	2003	2004	2005	2006	2007	2008	2009 est	2010 est
Revenue Source								
1 Medicaid IPT	$21,032,400	$92,650,410	$102,683,996	$108,316,346	$116,858,738	$133,774,628	$144,095,534	$156,487,000
FMAP	70.21%	68.72%	67.32%	66.84%	66.40%	68.57%	75.00%	75.00%
Federal	$14,766,848	$63,667,445	$69,131,847	$72,403,781	$77,591,207	$91,733,763	$108,071,651	$117,365,250
State	$6,265,552	$28,982,966	$33,552,149	$35,912,565	$39.267,531	$42.040,865	$36,023,884	$39,121,750
2 Non-Medicaid IPT	$75.285.428	$78,087,905	$75,799,689	$81.016,768	$86.497,515	$83,860,662	$78,800,000	$75,700,000
TOTAL	**$96.317.828**	**$170.738.315**	**$178.483.684**	**$189.333.113**	**$203.356.253**	**$217.635.290**	**$222.895.534**	**$232.187.000**

1 Data Source -AHCCCS, DHCM Finance and Reinsurance
2 Data Source -Insurance Premium Tax Forecast prepared by Department of Insurance

Additional IPT Assessment Estimates

Category	Current Assessment	FY 2010 Estimate	Additional1%
Life Insurance	2.00%	$37,500,000	$18.750,000
Accidental and Health	2.00%	$78,800,000	$39,400,000
AHCCCS Plans	2.00%	$156,500,000	$78,250,000
Other Property and Casualty	2.00%	$49,700,000	$24,850,000
Totals		**$322.500.000**	**$161.250.000**
Percent of Tax Health Related		73%	

Data Source -FY 10 est. based on Insurance Premium Tax Forecast prepared by Department of Insurance

APPENDIX D: POTENTIAL REVENUE FROM PROVIDER ASSESSMENT

AZ Potential Revenue from Provider Assessment

		Est First Year Total State Revenue
Hospital		
Tax on Net Revenues		
	0.25%	$26,750,000
	1.00%	$107,000,000
Bed Tax		
	$1,000/ bed	$12,541,000
	$2,000/ bed	$25,082,000
	$3,000/ bed	$37,623,000
Nursing Facility		
Tax on Net Revenues		
	1.00%	$10,811,275
	2.00%	$21,622,549
	5.00%	$32,433,824
Bed Tax		
	$1,000/ bed	$15,788,000
	$2,000/ bed	$31,576,000
	$3,000/ bed	$47,364,000

Hospital Net Revenues and bed count from most recently filed Medicare Cost Report. Nursing Facility Net Revenues and bed count from 2008 Universal Accounting Reports. Where no reports (MCR or UAR) were filed, data is not included.

APPENDIX E: POTENTIAL ASSESSMENT FOR ARIZONA HOSPITALS

Potential Assessment for Arizona Hospitals

Hospital Name	Net Revenue	beds	%AHCCCS beddays	1% Net Revenue Tax
ST. JOSEPH S HOSPITAL & MED CTR	$780,966,040	743	49%	$7,809,660
MAYO CLINIC HOSPITAL	$638,774,110	196	3yo	$6,387,741
BANNER GOOD SAMARITAN MEDICAL CENTER	$545,950,000	626	27%	$5,459,500
UNIVERSITY MEDICAL CENTER	$473,997,000	365	'41%	$4,739,970
BANNER DESERT MEDICAL CENTER	$463,705,194	600	30%	$4,637,052
TUCSON MEDICAL CENTER	$381,444,501	625	40%	$3,814,445
PHOENIX CHILDREN S HOSPITAL	$373,885,668	290	54%	$3,738,857
SCOTTSDALE HEALTHCARE - SHEA	$345,396,414	311	10%	$3,453,964
BANNER THUNDERBIRD	$331,769,186	372	27%	$3,317,692
SCOTTSDALE HEALTHCARE - OSBORN	$326,846,494	310	20%	$3,268,465
FLAGSTAFF MEDICAL CENTER	$315,671,676	242	34%	$3,156,717
MARICOPA MEDICAL CENTER	$282,043,906	586	61%	$2,820,439
CHANDLER REGIONAL HOSPITAL	$272,270,282	147	24%	$2,722,703
SUN HEALTH BOSWELL HOSPITAL	$271,481,644	430	9%	$2,714,818
BANNER BAYWOOD MEDICAL CENTER	$258,572,669	242	20%	$2,585,727
YUMA REGIONAL MEDICAL CENTER	$243,056,922	277	30%	$2,430,569
NORTHWEST MEDICAL CENTER	$233,934,398	278	17%	$2,339,344
JOHN C. LINCOLN HOSPT-NORTH MOUNTAIN	$226,062,267	262	30%	$2,260,623
CARONDELET ST MARY S HOSPITAL	$224,599,896	301	21%	$2,245,999
CARONDELET ST. JOSEPH HOSPITAL	$217,005,948	409	31%	$2,170,059
BANNER ESTRELLA MEDICAL CENTER	$179,333,955	208	34%	$1,793,340
BANNER DEL E WEBB HOSPITAL	$172,320,326	228	11%	$1,723,203
KINGMAN REGIONAL MEDICAL CENTER	$165,942,240	215	28%	$1,659,422
MERCY GILBERT MEDIAL CENTER	$159,338,703	88	5%	$1,593,387
JOHN C. LINCOLN HOSPT-DEER VALLEY	$155,427,508	127	26%	$1,554,275
YAVAPAI REGIONAL MEDICAL CENTER	$148,347,972	135	20%	$1,483,480
ST. LUKE S MEDICAL CENTER	$142,642,883	85	28%	$1,426,429
WESTERN ARIZONA REGIONAL MEDICAL CEN	$122,675,061	139	19%	$1,226,751
HAVASU REGIONAL MEDICAL CENTER	$121,445,363	119	16%	$1,214,454
VERDE VALLEY MEDICAL CENTER	$118,013,536	99	23%	$1,180,135
BANNER BAYWOOD HEART HOSPITAL	$107,909,886	60	9%	$1,079,099
PHOENIX BAPTIST HOSPITAL	$107,781,862	216	51%	$1,077,819
ARROWHEAD COMMUNITY HOSPITAL	$101,635,888	115	33%	$1,016,359
CASA GRANDE REGIONAL MEDICAL CENTER	$96,515,599	127	35%	$965,156
MARYVALE HOSPITAL MEDICAL CENTER	$91,103,141	232	65%	$911,031
PARADISE VALLEY HOSPITAL	$89,084,676	128	31%	$890,847
SIERRA VISTA REGIONAL HEALTH CENTER	$88,910,470	82	29%	$889,105
WEST VALLEY HOSPITAL	$84,837,374	157	37%	$848,374
ARIZONA HEART HOSPITAL	$84,268,304	59	7%	$842,683
MOUNTAIN VISTA MEDICAL CENTER	$84,057,709	178	13%	$840,577
MESA GENERAL HOSPITAL	$82,160,341	78	44%	$821,603
NAVAPACHE REGIONAL MED. CTR.	$79,188,405	66	38%	$791,884
NORTHWEST MEDICAL CENTER ORO VALLEY	$85,589,874	96	17%	$655,899
GILBERT HOSPITAL	$60,696,562	6	17%	$606,966
TUCSON HEART HOSPITAL	$56,371,673	80	12%	$563,717
TEMPE ST. LUKES HOSPITAL	$52,267,257	109	27%	$522,673
PAYSON REGIONAL MED CTR	$51,574,112	44	22%	$515,741
THE UNIVERSITY PHYSICIANS HOSPITAL	$49,437,107	190	36%	$494,371
VALLEY VIEW MEDICAL CENTER	$46,808,413	60	9%	$468,084
MT. GRAHAM REGIONAL MEDICAL CENTER	$42,712,302	59	36%	$427,123
KINDRED HOSPITAL - PHOENIX	$34,410,581	58	12%	$344,106
ST. LUKE S BEHAVIORAL HEALTH	$32,441,330	225	17%	$324,413
SSH -ARIZONA INC.	$29,491,726	29	9%	$294,917
ARIZONA ORTHOPEDIC SURGICAL HOSPITAL	$29,402,859	27	2%	$294,029
COBRE VALLEY COMMUNITY HOSPITAL	$28,736,035	49	41%	$287,360
BANNER GATEWAY MEDICAL CENTER	$25,833,141	176	34%	$258,331
CARONDELET HOLY CROSS HOSPITAL	$23,829,795	31	54%	$238,298
SOUTHERN ARIZONA REHAB HOSPITAL	$21,287,017	60	9%	$212,870
HS REHAB INSTITUTE OF TUCSON	$20,964,087	80	12%	$209,641
LITTLE COLORADO (WINSLOW)	$20,420,925	34	58%	$204,209
ARIZONA SPINE AND JOINT HOSPITAL	$18,388,555	18	1%	$183,886
SURGICAL SPECIALTY HOSPITAL OF ARIZ°	$17,574,048	33	10%	$175,740
VALLEY OF THE SUN REHAB CENTER	$17,260,310	60	9%	$172,603
HEALTHSOUTH SCOTTSDALE REHAB HOSPITA	$16,683,392	46	5%	$166,834
KINDRED HOSPITAL - TUCSON	$15,990,396	51	12%	$159,904
PAGE HOSPITAL	$15,597,405	25	64%	$155,974
SSH - PHOENIX	$14,608,339	48	11%	$146,083
LA PAZ REGIONAL HOSPITAL	$14,113,407	39	18%	$141,134
PROMISE HOSPITAL OF PHOENIX INC.	$12,759,633	40	22%	$127,596
YUMA AZ REHAB	$12,608,090	41	5%	$126,081
SAGE MEMORIAL HOSPITAL	$12,248,941	45	50%	$122,489
COPPER QUEEN COMM. HOSP.	$12,132,831	13	24%	$121,328
N. COCHISE COMM. HOSPITAL	$11,664,723	24	21%	$116,647
MOUNTAIN VALLEY REGIONAL REHAB	$11,519,404	40	12%	$115,194
WHITE MOUNTAIN REGIONAL MEDICAL CTR	$11,121,783	16	25%	$111,218
CORNERSTONE HOSP OF SE ARIZONA	$10,725,980	34	14%	$107,260
BENSON HOSPITAL	$9,377,468	22	20%	$93,775
TOTAL	810.717.024.918	12,541	21%	$107.170.249

Data for evaluation of methodology only; hospitals where revenue or utilization data was not available are not Included in this report.
Estimates are a proxy based on most recently filed Medicare Cost Reports