By Jeffrey D. Goetz and Ronald M. Winters[1]

Medicaid Provider Assessments: Regulatory Fee, or Priority Tax Debt?

Jeffrey D. Goetz
Dickinson Bradshaw Fowler & Hagen, PC
Des Moines, Iowa

Ronald M. Winters
Gibbins Advisors, LLC; Nashville, Tenn.

Jeffrey Goetz is a shareholder with Dickinson Bradshaw Fowler & Hagen, PC in Des Moines, Iowa. Ronald Winters is a co-founder and principal of Gibbins Advisors, LLC in Nashville, Tenn.

States across the nation employ a "provider assessment"[2] (also known as provider taxes or fees) to trigger a Medicaid "match" (a federal medical assistance percentage). These programs impose assessments on hospitals, nursing home providers and others under state law[3] to generate additional federal funds to reinvest into the state's Medicaid program to ultimately improve the quality of service.

An April 2025 MACPAC report indicated that "provider taxes and donations" reflected 17 percent of nonfederal funds for Medicaid payments in SFY 2018.[4] Estimates of total provider assessments nationally vary widely but appear likely to exceed $29 billion annually.[5] Throughout the past 20 years, the number of states using provider assessments has doubled,[6] and many states, such as Iowa, rely on them to maintain care standards despite increasing staffing costs.

The Importance of the Fee to the States

Federal Medicaid funds are provided to states based on how much they spend on Medicaid, conforming to the matching scheme.[7] Because a provider assessment, on paper, inflates the amount spent on Medicaid by the state, more federal funds are allocated to that state. Nearly every state has implemented some form of provider assessment, which allows the state to receive more federal Medicaid dollars.[8] For some states, including Iowa, this fee provides more than 30 percent of the total federal share of Medicaid funds.[9] The elimination of this fee would result in the loss of more than $80 billion in annual federal Medicaid funds across the nation.[10] For states that heavily rely on these funds, particularly southern states, this loss could be devastating.

Notwithstanding the foregoing, once again, discussions around cutting the use of provider assessment fees are swirling in Congress.[11] For more than 20 years, the federal government has tried to cut these fees from both sides of the aisle.[12] However, the stakes are higher for small, rural nursing homes that provide care to a higher portion of Medicaid recipient patients. In addition, nursing homes in Iowa deferred payment of these fees during the COVID-19 pandemic and, in some instances, during the post-pandemic recovery period.[13] Once deferred payment allowances ended, many nursing homes were unable to afford to resume the payments, resulting in increased bankruptcy filings.[14] Losing federal Medicaid funding by eliminating the provider assessment fee loophole or modifying the matching mechanism, in addition to the recent implementation of work requirements for Medicaid recipients, could put millions of Americans at risk of losing coverage.[15]

Given these assessments, importance once a health care provider winds up in bankruptcy, determining their priority for purposes of distribution is imperative. *In re Ridgecrest Healthcare Inc*.[16] and *Boston Regional v. Massachusetts Div. of Health*[17] analyzed these state assessments to determine whether they constituted a fee or a tax for purposes of the priority scheme. Both concluded that the assessment claims had a higher priority under the excise-tax provision in § 507 of the Bankruptcy

1 The authors thank Brennan B. Eddie, Abby Crabtree, Isaac Strohman and Maureen Wainwright for their assistance and contributions to this article.
2 In some instances, these are captioned a "provider tax," "quality assurance fee," "health care-related tax" or "bed tax."
3 "Medicaid Provider Taxes," RS22843, Cong. Rsch. Serv. 1-2 (Dec. 30, 2024), congress.gov/crs_external_products/RS/PDF/RS22843/RS22843.28.pdf (unless otherwise specified, all links in this article were last visited on June 24, 2025).
4 Holly Saltrelli & Chris Park, "Medicaid in Context: Payment and Financing," Medicaid and CHIP and Access Commission (MACPAC) (April 10, 2025), macpac.gov/wp-content/uploads/2025/04/02_April-Slides_Medicaid-in-Context-Payment-and-Financing.pdf.
5 *Id.*; Improving the Transparency of Medicaid and CHIP Financing (Chapter 1 of June 2024 Report to Congress on Medicaid and CHIP): "[I]n SFY 2018, MACPAC found that states reported only $29 billion in health care–related taxes on Form CMS-64.11 in MBES [Medicaid Budget and Expenditure System], but they reported $37 billion in health care–related taxes on GAO's survey."
6 "States with a Nursing Facility Provider Tax in Place," KFF (2024), kff.org/medicaid/state-indicator/states-with-a-nursing-facility-provider-tax-in-place.
7 Morgan Henderson, Leigh Goetschius & Alice Middleton, "What's the Impact of Eliminating Medicaid Provider Taxes?," Hilltop Inst. (May 6, 2025), hilltopinstitute.org/wp-content/uploads/publications/EliminatingProviderTaxes_6May2025.pdf.
8 *Id.*
9 *Id.*
10 *Id.*
11 Margot Sanger-Katz & Sarah Kliff, "GOP Targets a Medicaid Loophole Used by 49 States to Grab Federal Money," *New York Times* (May 6, 2025), nytimes.com/2025/05/06/upshot/medicaid-hospitals-republicans-cuts.html (subscription required to view article).
12 *Id.*
13 Clark Kauffman, "Bankrupt Nursing Home Says It Owes Iowa Taxpayers $1.1 Million," *Iowa Capital Dispatch* (Aug. 1, 2024), iowacapitaldispatch.com/2024/08/01/bankrupt-nursing-home-says-it-owes-iowa-taxpayers-1-1-million.
14 *See id.* (describing recent bankruptcy filings of Tabor Manor Care Center).
15 Elizabeth Zhang & Gideon Lukens, "Harsh Work Requirements in House Republican Bill Would Take Away Medicaid Coverage From Millions: State and Congressional District Estimates," Ctr. on Budget and Policy Priorities (May 13, 2025), cbpp.org/research/health/harsh-work-requirements-in-house-republican-bill-would-take-away-medicaid-coverage.
16 *See In re Ridgecrest Healthcare Inc.*, 601 B.R. 826, 830 (C.D. Cal. 2019).
17 *See Boston Reg'l v. Mass. Div. of Health*, 365 F.3d 51 (1st Cir. 2004).

Code, which means that they are paid before the general unsecured claims.

Boston Regional Six-Part Test

What differentiates an excise tax from a regulatory fee? This question has been considered at various points by many courts. In 2004, the First Circuit addressed[18] whether amounts owed by a debtor hospital to a state fund under Massachusetts law were considered an excise tax, thus receiving priority in *Boston Regional v. Massachusetts Div. of Health*'s bankruptcy. The court applied a six-factor test to determine whether exactions qualify as taxes:[19]

> (1) an involuntary pecuniary burden, regardless of name, laid upon individuals or property; (2) imposed by, or under authority of the legislature; (3) for public purposes, including the purposes of defraying expenses of government or undertakings authorized by it; (4) under the police or taxing power of the state ...; (5) whether the exaction is universally applied to all similarly situated entities; and (6) whether the granting of priority status to a governmental claimant would prejudice private creditors with like claims.[20]

Ultimately, the First Circuit concluded that provider fees constitute taxes and not fees. How does applying the *Boston Regional* requirements to provider fees help clear up the question as to whether they are taxes or fees?

The first factor depends on whether the fee is voluntary, which can be more complicated than it initially appears. Using Iowa as an example, a quality assurance assessment fee (QAAF) is imposed uniformly on all nursing facilities (with exceptions), indicating that it is involuntary.[21] However, the amount that a nursing home pays is determined on a per-day basis for only non-Medicaid patients and is different for each facility. Despite the foregoing because nursing homes could choose to serve more or fewer Medicaid patients, it could be argued that the individual facilities have control over how much they are required to pay, and in theory, they could pay nothing if the nursing home provided care exclusively to Medicaid patients.

Requirements two through four are likely more straightforward, but the fifth factor depends on the statute's language. For example, as previously mentioned, Iowa Code states that QAAFs "shall be imposed uniformly upon all nursing facilities," unless there is an exception under state law.[22] On its face, this appears to meet the fifth factor of being universally applied to all entities that are similarly situated. However, one argument against this factor is that a daily per-person fee for non-Medicaid patients under Iowa law is not applied in the same way that a fee based on percentage revenue is universally applied.

Finally, the sixth requirement of whether private creditors would be prejudiced will depend on the facts and circumstances of each case. Other creditors will most likely be prejudiced if the state gets the advantage of priority.

Ridgecrest Healthcare Five-Part Test

In *Ridgecrest Healthcare*, a skilled nursing home filed for bankruptcy. Shortly thereafter, the California Department of Health and Human Services (DHS) filed a proof of claim asserting a priority unsecured claim based on quality-assurance (QA) fees.[23] The U.S. Bankruptcy Court for the Central District of California held that the fees should be given priority because it operated as an excise tax.[24] The district court affirmed the bankruptcy court's holding on appeal.[25]

To determine whether California's QA fee operated as an excise tax, the court followed the Ninth Circuit's five-factor test, which differs slightly from the six-factor test utilized by the *Boston Regional* court.[26] The Ninth Circuit test considers whether:

> (1) the fee is an involuntary pecuniary burden, regardless of name, laid upon an individual or property; (2) the fee is imposed by or under the authority of the legislature; (3) the fee is for public purposes, including the purposes of defraying expenses of government or undertakings authorized by it; (4) the fee is imposed under the police or taxing power of the state; and (5) whether a private creditor similarly situated to the government can be hypothesized under the relevant statute.[27]

In its analysis of the first factor, the court held that a fee is an involuntary pecuniary burden if the entity charged with the fee did not contract to pay the fee.[28] As QA fees were imposed on all operators of skilled-nursing facilities, not just those nursing facilities that were licensed to engage in specialized activities,[29] the court rejected the argument that skilled-nursing facilities "volunteer to pay QA fees by obtaining a license to run a skilled-nursing facility."[30]

There was no dispute regarding the second factor.[31] The QA fees were imposed by the California legislature by Assembly Bill 1629,[32] which is codified in California's Health and Safety Code.[33]

To determine whether QA fees were imposed for a public purpose according to the third factor, the court looked to the purpose behind the legislation. In doing so, the court found that the relevant Code section stated that QA funds "shall be available to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and to support facility quality improvement efforts in, licensed skilled nursing facilities."[34] The court interpreted

18 *Boston Reg'l v. Mass. Div. of Health*, 365 F.3d 51, 57 (1st Cir. 2004).
19 *Id.* at 64-65.
20 *Id.*
21 *See* Iowa Code § 249L.3(1)(c).
22 *Id.*
23 *In re Ridgecrest Healthcare Inc.*, 571 B.R. 838, 840 (C.D. Cal. 2017).
24 *Id.* at 845.
25 *Id.* at 830 (C.D. Cal. 2019).
26 *Id.* at 841 (C.D. Cal. 2017); *Boston Reg'l v. Mass. Div. of Health*, 365 F.3d 51 (1st Cir. 2004).
27 *In re Ridgecrest Healthcare Inc.*, 571 B.R. at 841.
28 *Id.* at 842.
29 *Id.*
30 *Id.*
31 *Id.* at 843.
32 *Id.*
33 *Id.*
34 *Id.* (quoting Cal. Health & Safety Code § 1324.25).

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this language to demonstrate support for a broad public purpose (*i.e.*, support for California's Medicaid program).

In its analysis of the fourth factor, the court found that QA fees were regulatory, and were imposed under California's policing power.[35] In addition, the court noted that even if QA fees were not regulatory, they would still have been found to be imposed under California's taxing power.[36] The court characterized QA fees as "flat fee[s] based on revenues from housing all patients," thus finding that there was "no hypothetical private creditor who would charge the Debtor a flat fee based on the number of patients the Debtor had each day."[37]

As with California QA fees discussed in *Ridgecrest* and Massachusetts fees discussed in *Boston Regional*, the Iowa QAAF was meant to determine each nursing home's share for the purpose of drawing additional federal matching funds.[38] As in California and Massachusetts, Iowa's law similarly uses the per-bed/per-patient charge, which is uniform among all nursing facilities, and was enacted to "receive federal matching funds (or federal financial participation) pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, *et seq*. (also known as the Medicaid Act)." Iowa Code Chapter 249L specifically states that "the quality assurance assessment shall be implemented as a broad-based health care-related tax as defined in 42 U.S.C. § 1396b(w)(3)(B)." Such a claim under Iowa's QAAF would likely meet the six-factor requirement described in *Boston Regional* for the purposes of priority determination. While not conclusive, Iowa's law similarity and purpose behind imposing QAAF is indicative that the state's claim would be considered an excise tax.

Tax or Fee?

When a nursing home facility is going through bankruptcy, the way that a state's provider assessments are categorized makes a difference. Determining whether the provider tax is considered an excise tax or a regulatory fee might seem like a tedious exercise, but this distinction has important implications for creditors in the bankruptcy waterfall because, if characterized as a tax, the state's claim will be considered a priority before payment to a general unsecured creditor. In addition to the more obvious impact to equity-holders, treatment of the provider assessment as a tax might adversely impact vendors, secured lenders and landlords (and patients/residents and employees if a facility shutters), as well as have ripple effects.

Under § 507 of the Bankruptcy Code, certain government taxes are given priority, including excise taxes.[39] If a provider assessment is an excise tax, it receives priority during bankruptcy proceedings. Ultimately, the question of whether a provider assessment constitutes an excise tax or a regulatory fee depends on state law, but the distinction is critical in determining priority during bankruptcy.

Conclusion

It is important to look at the language of the applicable state statute. For example, in the Iowa statute authorizing QA fees for nursing homes, the QA fee is referred to as a "tax." For example, § 249L.3 of the Iowa Code explicitly states, "The quality assurance assessment shall be implemented as a broad-based health care-related *tax*."[40] In addition, courts have helped to provide a distinction between a tax and a regulatory fee to determine priority. As such, practitioners must look to the language of the relevant state statute, along with related tests set forth in applicable case law. abi

35 *Id.* at 844.
36 *Id.*
37 *Id.*
38 *See Boston Reg'l*, 365 F.3d at 64-65; *see also Ridgecrest Healthcare*, 601 B.R. at 830; *see also* Mikki Stier, "Nursing Facilities Quality Assurance Assessment Fee Usage Report," Iowa Dep't of Human Servs. (2019), www.legis.iowa.gov/docs/publications/DF/1023381.pdf.

39 11 U.S.C. § 507(a)(7).
40 Emphasis added.

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