HEALTH -
Provider Tax

Grievances
Costs, Culture of Disbelief

66539
65359

Jennings

· Disproportionate Share Hospitals
· used M'aid HMOS or direct pay providing (of M'care rates) → DSH exempt, help pay for un-compensated care — for limits
· states would use overpay to DSH to gen. fed matching
SCHEME: hosp submit inflated claims → state pays hosp. → to get extra fed $.
· we cracked down: limit how much pay DSH
limit state share
→ made all provider taxes illegal
· since, many states not comply: NY skipped a gi pattern, + Dem states (MO, LA, TN) — pts/US rates, restore
- warn '94, letter '96
· leg: we'll forgive past liability - got nowhere
→ HHS now take action. Podesta wants defer
~ Ltrs to states + threaten audit
~ avalanche of process: 1 year!
· OMB wants do it - good gov't
HHS ambivalent - some want done, some fear coverage cut.

FOR INTERNAL USE ONLY
Press Questions & Answers
Provider Tax Issue
July 14, 1999

1. Q. HHS has just sent letters to six states telling them they have to stop collecting taxes they use to support their Medicaid programs. What kind of taxes are they and why can't the states keep using them?

A. The letters that went out today are the latest step in a series of actions taken by both Congress and HHS to halt the use of impermissible taxes to support state Medicaid programs. Because Medicaid is a state/federal partnership, states must pay a share of the program's costs from general revenues which are then matched (generally at 50 percent or more) by the Federal government. State tax programs designed to replace general revenue and/or to artificially inflate the state's share and therefore the Federal share of Medicaid dollars, are unfair to other states that play by the rules and to Federal taxpayers.

States receiving letters today--Hawaii, Illinois, Louisiana, Maine, Missouri, and Tennessee--have all enacted a type of tax that allows the state to replace funds otherwise appropriated for Medicaid and/or inflate their Medicaid funds, which are then matched by the Federal government. The states do this by using receipts from these types of taxes on providers to obtain Federal match. The Federal matching funds are then returned to providers in the form of medical assistance payments, often increased to repay the provider(s) for part or all of the tax cost. This is called a "hold harmless" tax because the dollars collected from the provider are later returned to them in the form of medical assistance payments from the state. To allow these states to continue using impermissible taxes would be unfair to states that play by the rules.

2. Q. Why has HHS established different time frames for contacting the six states in question?

A. HHS is focused on ending the use of impermissible taxes. To that end, HHS will contact Louisiana and Tennessee within 15 days as, based on the information HHS has received, these two states have failed to discontinue either the tax or the associated grant program, or to modify the tax program to conform with the law. HHS believes these two states may **currently** be operating an impermissible tax and therefore HHS wants to begin the process of gathering information to determine the permissibility of these taxes as soon as possible.

In contrast, HHS will contact the other four states in question within 45 days as, based on the information HHS has received, these states have ultimately modified the tax programs in question to conform with the law. In other words, HHS believes that these four states may have operated an impermissible tax **in the past**, so the need to start gathering information is less urgent.

3. Q. Is HHS charging that these states were in collusion with hospitals and other health care providers to unfairly boost their Medicaid payments from the Federal government?

A. No. But, by levying a certain type of tax on certain health care providers, states effectively can replace state funds otherwise required to be contributed to the program for Medicaid, are then matched with Federal funds. The state does this not by using general revenues, but by using receipts from these types of taxes on providers. The Federal matching funds are then returned to providers in the form of medical assistance payments, and were often increased to repay the provider(s) for part or all of the tax cost. This is called a "hold harmless" tax because the dollars collected from the provider are later returned to them in various forms of payment from the state. To allow these states to continue using impermissible taxes would be unfair to states that play by the rules and to Federal taxpayers.

4. Q. If the states have to give up this revenue, and repay the Federal government large sums of money HHS says were collected illegally, will it threaten the viability of their Medicaid programs?

A. No. States will still operate Medicaid programs using permissible revenues. The letters we have sent today are to states we believe are claiming Federal funds in excess of the amount permitted by the Medicaid statute. Specifically, these states collect taxes that we believe include "hold harmless" provisions to replace state obligations and/or to artificially inflate the state's share while relieving the taxed health care providers of the tax burden. Now that the states have been notified of our belief that they have an impermissible tax, HHS regional office staff will conduct on site reviews and audits to determine how much money may have been raised from an impermissible tax.

5. Q. If HHS takes all this money back from the states, won't it threaten the health care benefits of millions of vulnerable low-income beneficiaries?

A. No. The Clinton Administration is committed to maintaining access to health care for all Medicaid enrollees and, in fact, the Federal government pays a significant share of the

costs for the program. The affected states will continue to operate Medicaid programs, but they will have to repay the Federal government the Federal funds generated from an impermissible tax. The administration would never take an action that would threaten the care being provided to this most vulnerable population--nor should states.

6. Q. How much money is at stake? Will the Federal government be willing to negotiate with the states about a pay-back plan? What happens now?

A. It is difficult to estimate at this point how much federal money ultimately may have been improperly paid to states. HHS staff will conduct audits in the states we believe to have collected an impermissible tax. If these audits find that improper payments were made, HHS will request a return of the funds. After this request, states may dispute any facts about circumstances or amounts. In any event, repayments would be made by reducing, by some amount, any future payments due to states over an extended period of time. No state would be forced to produce a lump-sum one-time payment. States can also appeal to the HHS Departmental Appeals Board and in Federal court.

7. Q. Are other states affected?

A. While all states must comply with the health care provider tax laws, these appear to be the only states found to have problems with the hold harmless prohibition of federal law. However, several other states have submitted requests to HHS to waive certain other portions of Federal tax law. Pending the outcome of those waiver decisions, it is possible that any one or all of those states could be liable for disallowances as well. It is clear, however, that the "hold harmless" provisions in the six states receiving letters today are not waivable.

Background:

Passage of the 1991 law was an attempt by Congress to tighten the fiscal integrity of the Medicaid program and to clamp down on states' use of financing schemes that generated federal matching funds without expending general state funds. Its general goal is to assure that the Federal government is paying its fair share of Medicaid costs--and no more. However, certain sections of the rules can be waived if the state can prove to the Secretary that the impact of the tax would not unfairly increase the cost to the Federal Medicaid program.

8. Q. What is an impermissible tax? What do "broad-based," "uniform" and "hold harmless" mean?

A. Impermissible health care taxes fall into three general categories: taxes imposed on groups not listed in the Federal statute or regulation (bad classes); taxes returned to the taxpayers (hold harmless); and taxes that fail the broad-based and/or uniformity waiver test. In general, a broad-based health care related tax is one that applies to all members of a class or category. For example, a state that imposes a tax on hospitals must tax all hospitals and cannot exclude certain subgroups such as psychiatric hospitals without applying for a waiver of the rules. Uniform health care related taxes are taxes that are levied at the same rate for all those in a particular group or class. For example,a state that taxes hospitals must tax them all at the same rate and can't tax public hospitals at a higher rate than private hospitals. Federal rules provide waiver tests states must meet for tax programs that do not meet the broad based and/or uniformity requirements.

9. Q. HHS could have taken this action years ago. This has been an issue since 1992, why has it taken HHS so long to act?

A. We wanted to be thorough and give states an opportunity to comply with the law Congress passed in 1991. HHS consulted extensively with states and worked closely with the National Governors' Association before publishing final regulations for this law in August 1993. In December 1994, HHS notified certain states about problems with impermissible provider taxes. In February 1995, the agency held a national conference on provider taxes and contacted states again in July of 1995 expressing its continued concern about this issue. While some states have terminated the use of questionable health care related taxes, others have not. In 1998 the administration offered a legislative resolution that would have codified the regulatory definitions and tests used to determine what constitutes a permissible tax. The bill also would have granted the Secretary greater authority to negotiate settlements with states. Congress, however, did not pass that bill and HHS must now take more definitive action to make sure states comply with the law.

10. Q. Didn't HHS have a similar problem with the state of New York? How did that get resolved?

A. New York levied certain health care provider taxes that HHS believed to be impermissible. However, the Balanced Budget Act of 1997 (BBA) included a provision that allowed New York to impose those taxes legally. President Clinton used his new line-item veto authority to strike that provision of the BBA, believing it to be unfair to

other states. However, a U.S. Supreme Court ruling struck down the presidential line-

item veto authority as unconstitutional. The result of that decision is that the taxes and fees covered by the New York tax provision in the BBA are now deemed permissible.

11. Q. Why should New York be able to impose these taxes legally while you're penalizing others for doing the same thing?

A. The Clinton administration did not support the provision of the BBA that allows New York to levy these taxes. Again, President Clinton used his line-item veto power for the first time on that provision. The Supreme Court later stripped him of that authority and the BBA provision stands. The court did not consider the merit of the New York case; rather, it only looked at the constitutionality of the line item veto. It is also noteworthy that the provider taxes deemed permissible by the BBA were believed by HHS to be in violation of waivable provisions of the law, while the states notified today have non-waivable provider taxes.

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FACT SHEET ON MEDICAID HEALTH CARE RELATED TAXES

Medicaid is a Federal-state cooperative program to furnish medical assistance to certain low-income individuals. The Medicaid statute sets broad parameters for state Medicaid plans, and provides for payment by the Secretary of a Federal share of the costs that states incur operating approved plans. States must commit funds in order to receive Federal financial participation (FFP). Certain sources of state funds have been in contention.

BACKGROUND

During the late 1980s, many states established new taxes that had the effect of increasing their Federal Medicaid funds without using additional state resources. Typically, a state would raise funds from health care providers (through provider taxes or "donations"), then pay back those providers through increased Medicaid payments. Since the Federal government pays at least half of Medicaid payments, the provider taxes or donations would be repaid in large part by Federal matching payments. Using this mechanism, the state was left with a net gain because it only had to repay part of the provider tax or donation it originally received.

The widespread use of these financing mechanisms contributed to the extraordinary increases in Federal Medicaid expenditures in the late 1980s and early 1990s. One report found that provider tax revenue rose from $400 million in 6 states in 1990 to $8.7 billion in 39 states in 1992. There was a similar increase in Federal Medicaid spending, which more than doubled between 1988 and 1992, with an average annual rate of over 20 percent. The number of people served by Medicaid did not rise nearly as quickly and could not have accounted for the total increase in spending. Unofficial reports have suggested that some states used the funds generated through this scheme for non-Medicaid purposes, such as building roads and stadiums.

In response to this unprecedented drain on the Federal Treasury, Congress passed "The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991" (Public Law 102-234). The first stand-alone piece of Medicaid legislation in the program's history, this law requires reduction in Federal Medicaid matching payments for states using revenue from health care-related taxes that are not broad based (i.e., applied to all providers in a definable group); uniform (i.e., same for all providers within the group); and are not part of a "hold harmless" arrangement (i.e., the taxes are not structured in such a way as to repay dollar-for-dollar the provider who was initially assessed). The law also limits Federal Medicaid matching payments to states that use

provider donations, except in very limited circumstances. In addition, the law introduced limits on how much states could pay hospitals through the disproportionate share hospital (DSH) program — the primary method by which states repaid taxes or donations to providers.

The final regulation for this law was published in 1993 following extensive consultation with the states. The regulation defined which taxes are permissible, the Department of Health and Human Services' (HHS) methodology for determining permissibility, and a process for requesting waiver approval of certain tax programs.

Since the regulation was implemented, HHS has continued to communicate with states — through letters, a national conference, and state contacts at the regional level — regarding provider tax policies. However, given the complexity of health care financing, some issues intended to be resolved by the 1991 law, the 1993 regulations, and subsequent HHS interpretations are still questioned by some states. This continuing disagreement led to a thorough review by HHS of its interpretations of these policies.

As a result of HHS's review of its interpretation of the provider tax law and regulations, a state Medicaid directors' letter was issued in October of 1997. In that letter HHS announced policy clarifications to its interpretation of the uniformity requirements of the law. These clarifications resulted in the determination that several states' taxes were permissible and required no further review. The letter also reminded states that they may suggest additional classes of providers to qualify as "broad based" and that they should submit quarterly revenue reports on their provider taxes and donations. Finally, in its effort to end the use of impermissible provider taxes, HHS promised to work with states to resolve Medicaid liabilities resulting from impermissible tax and donation programs.

To that end, HHS submitted legislation to Congress that would have facilitated that goal by codifying the tests used to determine what constitutes a permissible tax and granting the Secretary greater authority to negotiate settlements. When we announced that we would be seeking new legislation, we also announced that, if our legislation was not enacted, we would have no choice but to proceed with the enforcement process under current law. Our legislation was submitted to Congress last year but was not introduced or enacted. We must now proceed under current law.

CONCERNS ABOUT CERTAIN STATES' TAXES

The states receiving letters today have all imposed a specific type of tax program on providers of health care that appears to be impermissible under the Medicaid statute and

Federal regulations. The health care-related tax programs at issue in these states contain a financing scheme under which states access Federal Medicaid funds without committing state funds.

HHS will contact each state to schedule timely meetings to exchange information and discuss all issues relating to the tax program in question. HHS's goal in these meetings is to establish whether the tax(es) in question are impermissible and, if so, end their use.

THE WHITE HOUSE
WASHINGTON

To: Eric

From: Jeanne

Here's the back-up information as promised. I'll get the inside HHS story on timing of proposed

MEDICAID PROVIDER TAX AND DONATION ENFORCEMENT
March 11, 1999

HHS PLAN

PHASE ONE: ENFORCEMENT IN STATES THAT HAVE USED RECYLCLING SCHEMES

- **Notification of states suspected to have operated recycling schemes.** In mid March, HHS expects to notify states (Tennessee, Louisiana, Illinois, Missouri, Maine, and Hawaii) that they will be audited and subject to a disallowance if found to be out of compliance.

- **Audits of those states currently operating recycling schemes.** Immediately after these letters are sent, HHS will begin audits in Tennessee and Louisiana, the two states felt to be most seriously out of compliance.

- **Audits of those states who previously operated recycling schemes.** In late April, HHS is planning to begin auditing Illinois, Missouri, Maine, and Hawaii, who had similar taxing schemes, but now appear to be in compliance.

PHASE TWO: ENFORCEMENT IN STATES THAT HAVE TARGETED PROVIDER TAXES

- **Denial of waivers of the broad based and uniformity requirement.** At about the same time, HHS plans to inform Alabama, Connecticut, Florida, Hawaii, Massachusetts, New Hampshire, Nevada, Tennessee, and Utah their requests for a waiver of the statutory requirement that provider taxes be broad-based and uniform are denied.

- **Audit of states who have been or who are currently imposing targeted provider taxes.**

IMPACT OF A DISALLOWANCE

STATES IN VIOLATION OF BROAD BASED AND UNIFORM REQUIREMENT

	FEDERAL MATCH 1998	TAX LIABILITY 1992 - 1998	QUARTERLY DISALLOWANCE (OVER THREE YEARS)	QUARTERLY DISALLOWANCE (PERCENT OF MATCH)
AL	1,614,516,026	20,266,720	1,688,893	0.42%
CT	1,416,466,977	545,647,653	45,470,638	12.84%
FL	3,552,126,454	541,975,688	45,164,641	5.09%
HI	293,029,407	10,072,653	839,388	1.15%
MA	2,753,280,248	846,872,109	70,572,676	10.25%
NH	372,065,117	115,021,289	9,585,107	10.30%
NV	258,365,221	27,605,684	2,300,474	3.56%
TN	2,521,519,369	380,950,000	31,745,833	5.04%
UT	491,962,041	14,125,808	1,177,151	0.96%

STATES IN VIOLATION OF THE HOLD HARMLESS PROVISION

	FEDERAL MATCH 1998	TAX LIABILITY 1992 - 1998	QUARTERLY DISALLOWANCE OVER THREE YEARS	QUARTERLY DISALLOWANCE (PERCENT OF MATCH)
TN	2,521,519,369	368,495,514	30,707,960	4.87%
LA	2,229,601,117	236,917,971	19,743,164	3.54%
*IL	3,269,346,919	88,500,000	7,375,000	0.90%
*MO	1,994,323,182	1,366,555,454	113,879,621	22.84%
*HI	293,029,407	11,322,209	943,517	1.29%
*ME	713,168,665	7,687,661	640,638	0.36%

* indicates States that are no longer collecting impermissible taxes

MEDICAID PROVIDER TAXES AND DONATIONS: ESTIMATED LIABILITY FOR POSSIBLE IMPERMISSABLE TAXES

	TYPE OF VIOLATION	FEDERAL MEDICAID SPENDING FY1998 (in thousands)	ESTIMATED TAX LIABILITY1992-98 (in thousands)	TOTAL LIABILITY AS A PERCENTAGE OF FEDERAL SPENDING	ESTIMATED ANNUAL DISALLOWANCE (PERCENTAGE OF FED. SPENDING
ALABAMA	broad based	1,614,516	20,267	1%	0.42%
CONNECTICUT	broad based	1,416,467	545,648	39%	13%
FLORIDA	broad based	3,552,126	541,976	15%	5%
**HAWAII	broad based / hold harmless	293,029	21,394	7%	2%
*ILLINOIS	hold harmless	3,269,347	88,500	3%	1%
LOUISIANA	hold harmless	2,229,601	236,918	11%	4%
*MAINE	hold harmless	713,169	7,688	1%	0.36%
MASSACHUSETTS	broad based	2,753,280	846,872	31%	10%
*MISSOURI	hold harmless	1,994,323	1,366,555	69%	23%
NEW HAMPSHIRE	broad based	372,065	115,021	31%	10%
NEVADA	broad based	258,365	27,606	11%	4%
TENNESSEE	broad based / hold harmless	2,521,519	749,446	30%	10%
UTAH	broad based	491,962	14,126	3%	1%

* Indicates States that are no longer collecting impermissible taxes

**Hawaii is no longer collecting taxes that violate the hold harmless provision, but is still collecting taxes that violate the broad based and uniform provision

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BACKGROUND

During the late 1980s, many states established new taxes that had the effect of increasing their Federal Medicaid funds without using additional state resources. Typically, a state would raise funds from health care providers (through provider taxes or "donations"), then pay back those providers through increased Medicaid payments. Since the Federal government pays at least half of Medicaid payments, the provider taxes or donations would be repaid in large part by Federal matching payments. Using this mechanism, the state was left with a net gain because it only had to repay part of the provider tax or donation it originally received.

The widespread use of these financing mechanisms contributed to the extraordinary increases in Federal Medicaid expenditures in the late 1980s and early 1990s. One report found that provider tax revenue rose from $400 million in 6 states in 1990 to $8.7 billion in 39 states in 1992. There was a similar increase in Federal Medicaid spending, which more than doubled between 1988 and 1992, with an average annual rate of over 20 percent. The number of people served by Medicaid did not rise nearly as quickly and could not have accounted for the total increase in spending. Unofficial reports have suggested that some states used the funds generated through this scheme for non-Medicaid purposes, such as building roads and stadiums.

In response to this unprecedented drain on the Federal Treasury, Congress passed "The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991" (Public Law 102-234). The first stand-alone piece of Medicaid legislation in the program's history, this law requires reduction in Federal Medicaid matching payments for states using revenue from health care-related taxes that are not broad based (i.e., applied to all providers in a definable group); uniform (i.e., same for all providers within the group); and are not part of a "hold harmless" arrangement (i.e., the taxes are not structured in such a way as to repay dollar-for-dollar the provider who was initially assessed). The law also limits Federal Medicaid matching payments to states that use

provider donations, except in very limited circumstances. In addition, the law introduced limits on how much states could pay hospitals through the disproportionate share hospital (DSH) program — the primary method by which states repaid taxes or donations to providers.

The final regulation for this law was published in 1993 following extensive consultation with the states. The regulation defined which taxes are permissible, the Department of Health and Human Services' (HHS) methodology for determining permissibility, and a process for requesting waiver approval of certain tax programs.

Since the regulation was implemented, HHS has continued to communicate with states — through letters, a national conference, and state contacts at the regional level — regarding provider tax policies. However, given the complexity of health care financing, some issues intended to be resolved by the 1991 law, the 1993 regulations, and subsequent HHS interpretations are still questioned by some states. This continuing disagreement led to a thorough review by HHS of its interpretations of these policies.

As a result of HHS's review of its interpretation of the provider tax law and regulations, a state Medicaid directors' letter was issued in October of 1997. In that letter HHS announced policy clarifications to its interpretation of the uniformity requirements of the law. These clarifications resulted in the determination that several states' taxes were permissible and required no further review. The letter also reminded states that they may suggest additional classes of providers to qualify as "broad based" and that they should submit quarterly revenue reports on their provider taxes and donations. Finally, in its effort to end the use of impermissible provider taxes, HHS promised to work with states to resolve Medicaid liabilities resulting from impermissible tax and donation programs.

To that end, HHS submitted legislation to Congress that would have facilitated that goal by codifying the tests used to determine what constitutes a permissible tax and granting the Secretary greater authority to negotiate settlements. When we announced that we would be seeking new legislation, we also announced that, if our legislation was not enacted, we would have no choice but to proceed with the enforcement process under current law. Our legislation was submitted to Congress last year but was not introduced or enacted. We must now proceed under current law.

CONCERNS ABOUT CERTAIN STATES' TAXES

The states receiving letters today have all imposed a specific type of tax program on providers of health care that appears to be impermissible under the Medicaid statute and

Federal regulations. The health care-related tax programs at issue in these states contain a financing scheme under which states access Federal Medicaid funds without committing state funds.

HHS will contact each state to schedule timely meetings to exchange information and discuss all issues relating to the tax program in question. HHS's goal in these meetings is to establish whether the tax(es) in question are impermissible and, if so, end their use.

PRESS/EXTERNAL FACT SHEET
August 1999

MEDICAID AND HEALTH-CARE RELATED TAXES

Overview: Today the Department of Health and Human Services (HHS) notified six states--Hawaii, Illinois, Louisiana, Maine, Missouri, and Tennessee--that they imposed certain taxes on health care providers that may be impermissible under Medicaid law. The letters that went out today are the latest step in a series of actions taken by both Congress and HHS to halt the use of impermissible taxes to support state Medicaid programs. This notice is based on information currently available to HHS. Depending on the outcomes of the individual audits in the states receiving these letters, each of the states could be liable for repayment of the Federal matching funds collected using revenue from these impermissible tax programs.

Responding to rapid increases in Federal Medicaid outlays, Congress passed a law in 1991 which penalized states that impose certain kinds of taxes on health care related revenues and health care providers termed "impermissible taxes." Since that time, HHS has worked with states and provided technical assistance concerning provisions in the Medicaid tax law and proper sources of funding for state Medicaid programs. In spite of these efforts, the agency believes some states are still collecting impermissible taxes. To allow these states to continue collecting these taxes would be unfair to states that play by the rules.

Background

The Medicaid program is funded by both the Federal and state governments in order to provide medical assistance to people with low incomes. States use general state revenue to provide care, and that money is then matched by the Federal government. HHS believes that the taxes at issue in these states all increase the states' Federal matching funds without the state spending its fair share of its own money to generate those funds. By levying special taxes on certain health care providers and "recycling" the dollars through state treasuries, states can inflate the Medicaid matching funds and enhance the amount they get from the Federal government. States also can use revenue from these special taxes, in place of regularly appropriated funds, to attract Federal matching funds. Once they have received the Federal funds, all or a portion of the original amount of the tax is returned to the provider that paid the tax. These taxes are commonly referred to as "hold harmless" taxes because the state eventually repays all or most of the tax back to the health care provider, thus holding the provider harmless for the tax liability.

These "hold harmless" arrangements are impermissible under the 1991 Medicaid tax law.

HHS will contact each of the states believed to have "hold harmless" taxes and will begin gathering information to help determine whether they have been using impermissible

taxes. States that may currently be operating an impermissible tax will be contacted within 15 days (Louisiana and Tennessee), and the other four states that may have operated an impermissible tax in the past will be contacted within 45 days (Hawaii, Illinois, Maine, and Missouri). If it is found that a state collected impermissible taxes, Medicaid will audit the state's financial records and ask it to repay any Federal matching funds that were paid inappropriately. Recoupment of Federal Medicaid dollars is generally accomplished by withholding a portion of future Medicaid payments to that state. States can appeal a request for repayment to the Departmental Appeals Board (DAB) and then to a Federal court of the DAB decision is unfavorable.

Between 1988 and 1992, Federal Medicaid spending more than doubled without a commensurate rise in enrollment. This spike (sudden rise) prompted a close look by the Federal government. Because of the drain on the Federal Treasury, Congress in 1991 passed the "Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991," the first piece of stand-alone Medicaid legislation in the program's history. This law set out strict conditions that states must meet in order to use taxes levied on health care providers as part of their state share for Medicaid matching funds. The taxes must be broad based (applied to all members of a definable provider group; for example, all hospitals, not just psychiatric hospitals); uniform (the same tax rate/amount for all providers within the group); and not contain a "hold harmless" arrangement (where the funds are returned to the provider in some form). In addition, the only permissible classes of provider taxes are those that are listed in the Federal statute or regulation. Otherwise, these taxes are termed "bad classes." After much consultation with states and the National Governors' Association, a final regulation for this law was published in 1993. The rule laid out a process for states to request waivers of certain provisions for tax programs that are not broad based and/or uniform. The "hold harmless" provisions cannot be waived.

While HHS has no authority to force states to eliminate or modify tax programs that violate the Medicaid statutes, the agency is required to recoup those Federal funds that were paid based on a state's collection and use of an impermissible tax(es). Since publication of the 1993 regulation, HHS has taken several actions to remind states of the law's requirements. In 1994 and 1995, HHS notified several states that they had potentially impermissible taxes and has continued to work with states informally in order to end the use of these taxes. Several states have stopped imposing these taxes as a result of these contacts, although they may still owe repayments for periods when the taxes were in effect.

In October 1997, the Clinton Administration announced it would seek legislation giving states new incentives to end the use of impermissible taxes. HHS also surveyed state Medicaid agencies so as to further identify and end these taxes, and it encouraged states to provide suggestions for legislation that would help resolve this matter. In April 1998, in yet another attempt to address this problem, the Clinton Administration asked Congress to provide further incentives for states to comply with the 1991 law and to give the Secretary greater authority to negotiate with states over repayment amounts and schedules. However, that legislation was not enacted, and HHS is now taking further action to make sure states comply with existing laws.

October 9, 1997

MEMORANDUM TO THE PRESIDENT

cc: Vice President, Erskine Bowles, Bruce Reed, Gene Sperling

FROM: Chris Jennings

RE: **NEW YORK AND THE PROVIDER TAX ISSUE**

Today, DHHS announced the results of its policy review of Medicaid provider taxes and its policy changes regarding New York. In brief, they announced (1) policy clarifications that clarify that certain provider taxes previously in question, including New York's regional tax, are permissible; and (2) support for legislation that expedites identifying impermissible taxes and ending their use. This is the culmination of an intensive process that involved HHS, OMB, DPC/NEC, Legislative and Intergovernmental Affairs, the Office of the Vice President and other senior staff.

BACKGROUND

Financing scheme and the law limiting it. During the late 1980s, many States established financing schemes that had the effect of increasing their Federal Medicaid funds without using additional State resources. Typically, States would raise funds from health care providers (through provider taxes or "donations"), then pay back those providers through increased Medicaid payments. Since the Federal government pays at least half of Medicaid payments, the provider taxes or donations would be repaid in large part by Federal matching payments. Using this mechanism, the State was left with a net gain because it only had to repay part of the provider tax or donation it originally received.

Because provider taxes and donations were effectively siphoning off potentially billions of dollars from the Federal Treasury, the Congress limited states' use of these schemes in a bill enacted by President Bush in 1991. The subsequent regulatory interpretation of these limits was, as you know, negotiated with the states and the National Governors' Association in 1993.

States' continued reliance on impermissible provider taxes and our enforcement record. Despite the new law and the regulations, many states continued to use provider taxes that at least appeared to be out of compliance. To date, these possibly impermissible taxes total an estimated $2 to 4 billion and, in the future, could cost billions more. In response, HCFA issued letters and discussed its concerns about certain taxes with states, but -- for a variety of reasons -- never took any final action. Unfortunately, this has meant that a number of states continue using these taxes, believing that HCFA might never enforce the law, or that if they did, they could seek recourse through the White House or the Congress.

The New York provision in the balanced budget. To ensure that New York would never be vulnerable to Medicaid provider tax enforcement actions, Senator Moynihan and Senator D'Amato successfully added a provision to the Balanced Budget Act to exempt all of its provider taxes (it has dozens), both retrospectively and prospectively, from disallowances. Both in writing and orally we repeatedly objected to this provision. Moreover, we provided alternative statutory language that would have forgiven about $1 billion. As you know, however, the Senators (through their staff) rejected our offer and insisted on their original provisions.

Line-item veto and New York's reaction. In announcing the line-time veto on August 11, we raised concerns about the cost and ramifications of singling out as permissible one state's provider taxes. Although our actions were generally viewed as responsible and defensible by those who know the program and/or who are budget experts, the same clearly cannot be said of New York's political establishment. The Governor's office, the New York Congressional delegation, the Mayor, providers and unions reacted strongly and negatively to the veto. Among a host of complaints, they charged that they were singled out and were never made aware that this provision could be subject to the line-tem veto. Most recently they have criticized us for our delay in getting back to them and our willingness to support fixes for the other two vetoed provisions without addressing their problem.

TODAY'S ACTIONS. The line-item veto of New York's special provider tax waiver provision accelerated a review process of these tax policies that was already underway at DHHS. This process has yielded two results. First, HCFA is issuing a set of policy clarifications in a letter to State Medicaid Directors. This letter clarifies how DHHS will implement the law and regulations on states' use of health care-related taxes for their share of Medicaid; this letter will be viewed as good news for at least nine states. HCFA also released a notice in the Federal Register containing a correcting amendment to the regulation to make it consistent with Congressional intent; this will make New York's regional tax permissible.

The State Medicaid Director's letter also includes an announcement of our support for legislation that (a) lays out in statute how to identify impermissible taxes; and (b) would provide enhanced authority to the Secretary **to forgive up to the entire amount of individual states' current liabilities if they come into full compliance with the law for future financing**. If, however, by a date certain -- August 1998 -- no legislation is passed, HCFA will aggressively enforce its current policies. (Attached is a one-page summary of our actions today.)

Need for legislation. The Administration's goal in these actions is to work with the states to end the impermissible use of provider taxes. Given the staggering size of the liabilities for some states, we agree that this is best accomplished through negotiation. Specifically, we are interested in trading reductions in some or all of states' retrospective liabilities for discontinued use of such taxes in the future. However, the administrative process that HCFA has at its disposal offers many opportunities for states to continue to stall (as they have done in the past). More importantly, final settlements must be approved by the Department of Justice which may take a hard line in terms of recouping retrospective liabilities. This could force states to look for a legislative "rifle shots" to fix their particular problem, or to go to court.

Consequently, we think that the best way to bring states to the negotiations is through reliance on a legislative strategy. By strengthening the Secretary's ability to negotiate, we avoid the uncertainty inherent in an ordinary administrative process. By stating what type of legislation we would support, we get ahead of the rifle shots and possibly prevent them, as well as to get the Congress invested (albeit reluctantly) in developing a mutual solution to the provider tax mess. And by offering to clarify our ways of identifying impermissible taxes, we may engage states that have concerns about our interpretation, thus possibly preventing suits. These incentives are reinforced by threat of a deadline for passage of such legislation (August 1998) that triggers an aggressive enforcement action by HCFA.

Reaction from New York. Today's briefing of both Governor Pataki's staff and the New York Congressional delegation seemed to go quite well. They appreciated the resolution on the states' regional tax and seemed to accept that our legislation approach was much preferable to an immediate administrative enforcement action. We explained to them that the law and our current regulations would have forced us to publicly state that some of their provider taxes appear to be impermissible. Having said this, they certainly would have preferred an action that retrospectively and prospectively forgiven any potential liability; in other words, they want the provisions we line-item vetoed. As such, as of this writing, it is unclear what public posture either the Governor or the Congressional delegation will take.

Reaction from other states. Although nine other states benefit from the new policy clarifications, it is news of our support for legislation that caught the states' attention at our NGA briefing. The dozen or so states that have widely used provider taxes appeared to view this positively. It is these states that we want to engage in discussion and eventually negotiations. However, it was unclear whether the remaining states that either ended their provider tax use or who never used them to begin with viewed our action as too conciliatory. We communicated to all the states that we have not -- and will not -- change our opposition to the use of provider taxes. We simply stated that we are looking for the most effective way to end all states' reliance on impermissible taxes.

Next steps. HCFA plans on immediately reaching out to the states to obtain updated information about the status of state provider taxes. There will probably be Congressional interest in knowing how we plan on pursuing our legislative strategy. John Hilley believes that we should have an Administration bill, but that we should not introduce it until we have had sufficient time to achieve more investment in the details of the bill from the Congress and the states. We will keep you apprised of developments.