

MEDICAID PROVIDER TAX AND DONATION ENFORCEMENT

March 11, 1999

HHS PLAN

PHASE ONE: ENFORCEMENT IN STATES THAT HAVE USED RECYCLING 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.**

POLICY OPTIONS

1. Proceed along the enforcement time frame suggested by HHS
2. Initiate intensive advocacy for legislation that provides the Secretary with more authority to negotiate with states who have outstanding bad taxes and request that HHS implement its enforcement activities more slowly
3. Ask HHS for a much more comprehensive review of the issue prior to initiating enforcement



HEALTH CARE FINANCING ADMINISTRATION

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ADDRESSEE'S FAX MACHINE NUMBER:**DATE:**

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REMARKS:



FYI

Tenn. may have to pay back millions in matching funds

By Paula Wade

The Commercial Appeal

Nashville Bureau

NASHVILLE - Tennessee has used an "impermissible tax" to fund its Medicaid nursing home program and could have to pay the federal government \$500 million or more, federal health officials say.

In a Sept. 1 letter to TennCare Director Brian Lapps, federal officials notified the state that Tennessee's \$2,600-per-bed nursing home tax, together with its system of \$2,600 grants to qualified non-Medicaid nursing home residents, is essentially a financial shell game to draw down federal matching funds illegally.

The Department of Health and Human Services (HHS) intends to send a team of auditors to determine how much the state must repay to the federal government, according to the letter from Sally Richardson, director of Medicaid and State Operations for HHS. Preliminary estimates by the state Comptroller's Office indicate the figure may be a budget-busting \$500 million or more.

✕ "It could be as much as \$800 million. Nobody really knows the number. . . ." said state Finance Commissioner John Ferguson. "If they went all the way back to 1991 and counted it all, we're talking \$1.2 billion."

A spokesman for the Health Care Financing Administration of HHS said the main purpose of the letter is to stop states' use of "impermissible taxes" to draw down more federal funds than the states are entitled to. If a return of funds is decided on, the spokesman said it would likely be arranged as a reduction in future federal matching funds over "an extended period of time. . . . No state would have to pay any kind of lump-sum payment."

The federal-vs.-state dispute over Tennessee's so-called Granny Grants program has been boiling off and on since 1991, when Congress passed a law specifying how states could tax medical services so that the proceeds could draw federal matching funds under the Medicaid program. The law specified that states couldn't levy the tax, draw down the federal matching funds and then use the much-enhanced proceeds to reimburse the taxpayers. As Richardson's letter phrases it, "the taxes

collected must not be returned to the taxpayers directly or indirectly."

Tennessee's \$2,600 nursing home bed tax is levied on all nursing home beds and is paid by the nursing homes. The Granny Grants are awarded to non-Medicaid nursing home patients, not to the homes themselves. Therefore, state officials have argued, the grants are not reimbursements to the nursing homes themselves, and thus not illegal.

"We're going to take a strong position that the program is correct. And as the letter pointed out, there are certain remedies (of appeal) all the way to the federal court, so it may be that by the time the next governor is about to finish his term it will all be settled," said Ferguson.

From 1992 to the current budget year, Tennessee will have collected \$802.7 million in nursing home bed taxes, drawing down federal matching funds totaling \$1.2 billion for the period, Ferguson's office confirmed. During that period, only a few people qualified for the Granny Grants, since most of the state's nursing home population is on Medicaid. The state has paid out only \$9 million in Granny Grants in the 1992-99 period, Ferguson said.

The HHS position is that the Granny Grants, which were designed to offset the bed tax for non-Medicaid patients, renders the entire nursing home bed tax impermissible.

* State officials are loath to get rid of the popular Granny Grants, but said federal officials may force it.

"The Granny Grant program has certainly been an important help for people who are not on Medicaid to afford to stay in a nursing home," said Comptroller John Morgan. "I would hope that the HCFA people would recognize that it's cheaper to both the federal and the state government to help keep people off Medicaid as long as possible."

Ferguson agreed. "The alternative could be that they'll tell us we have to discontinue the Granny Grants, but I wonder what politician in Washington would like to deliver that message to those people."

* The Granny Grants program was the brainchild of Ferguson's McWherter-era predecessor, David Manning, who won the support of the nursing home industry for the bed tax as a vehicle to draw down federal funds for Medicaid on a nearly two-to-one basis. In effect, the grants meant that non-Medicaid nursing home patients were repaid the amount of the tax that they'd paid through nursing home charges.

As Richardson points out in her letter, Congress passed the law in 1991 and HHS completed its regulations implementing it in 1993. "In 1994, HHS formally communicated its concerns regarding the licensed bed nursing facility tax to the state of Tennessee. . . . HHS again notified the state of Tennessee in 1995 of our belief that the licensed bed nursing facility tax was impermissible," she wrote.

States challenged the interpretation, so HHS reviewed its policy. In 1998, the Clinton administration proposed legislation that would allow HHS to negotiate repayment and that would give states incentives to end "impermissible taxes," but it didn't pass. Now, again, HHS is trying to enforce its interpretation of the law.

* "I called David Manning and told him about the letter, and he told me how fortunate I was only to have had one. . . . Apparently he had quite a few," said Ferguson.

15tcare.htm at www.gomemphis.com

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He said if HHS ultimately wins, he's hoping federal officials will settle for discontinuing the grant program without forcing the state to give the money back.

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HOME PAGE

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Pending Provider Tax Issues - State Summary

Hold Harmless States:

- We believe six States may (have) impose(d) provider tax programs that are possibly in violation of the hold harmless provision of the Act and for which there may exist an outstanding liability to HCFA. [HAWAII, ILLINOIS, *LOUISIANA, MAINE, MISSOURI, and *TENNESSEE]
- HCFA has had formal communication with five of those six States via letters in December of 1994 and July of 1995.¹ In these letters, HCFA indicated that we believed that the taxes may be bad.

States that Have Applied for Waivers:

- There are several States that have submitted formal requests for waiver of the broad based/uniform tax law for review. We believe that at least nine States will not be able to pass the generally redistributive waiver test for a particular provider tax program. [*ALABAMA, *CONNECTICUT, *FLORIDA, HAWAII, *MASSACHUSETTS, *NEW HAMPSHIRE, NEVADA, TENNESSEE, and UTAH]
- HCFA had formal communication with three of those nine States in December of 1994.² In these letters, HCFA indicated that we believed that the taxes may be bad. The remaining six States had some level of communication with HCFA regarding their waiver request prior to December 1994 and therefore, did not receive the December 1994 letter. In order to determine definitive waiver test results, HCFA believes additional information should be requested from all nine States.

* State continues to collect revenue from provider tax program at issue.

¹ HCFA became aware of the tax arrangement in MISSOURI after the release of the December 1994 letters.

² ALABAMA, HAWAII, and TENNESSEE received the December 1994 letters regarding the provider tax program at issue.

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Pending Provider Tax Issues - State Summary

Hold Harmless States:

- We believe the estimated aggregate Federal financial participation (FFP) associated with provider tax programs that are possibly in violation of the hold harmless provision of the Act is \$2,079,478,809 through the period ending September 30, 1998 [\$11,322,209, \$88,500,000, \$236,917,971, \$7,687,661, \$1,366,895,454, and \$368,495,514].
- The estimated aggregate FFP is based on Regional Office estimates for Federal fiscal year (FFY) 1993 and based on State reporting on the HCFA-form 64.11A for FFY 1994 through FFY 1998.
- The estimated annual FFP associated with the on-going provider tax programs at issue for FFY 1999 and thereafter is \$100.9 million

States that Have Applied for Waivers:

- We believe the estimated aggregate FFP associated with provider tax programs that will not be able to pass the generally redistributive waiver test is \$2,502,527,604 [\$20,256,720, \$545,647,653, \$541,975,688, \$10,072,653, \$846,872,109, \$115,021,289, \$27,605,684, \$380,950,000, and \$14,125,808].
- The estimated aggregate FFP is based on Regional Office estimates for Federal fiscal year (FFY) 1993 and based on State reporting on the HCFA-form 64.11A for FFY 1994 through FFY 1998.
- The estimated annual FFP associated with the on-going provider tax programs at issue for FFY 1999 and thereafter is \$325.8 million.

revenue
States

grant
award

going
forward



retrospective
as

[illegible]

REPORT DATE: FEBRUARY 26, 1999

* * * DOES NOT INCLUDE GRANT AWARD ADJUSTMENTS * * *

MEDICAL ASSISTANCE PAYMENTS AND ADMINISTRATIVE EXPENDITURES REPORT DATE: FEBRUARY 26, 1999
 TOTAL COMPUTABLE AND FEDERAL SHARE FOR FISCAL YEAR 1998

STATE: UTAH	
	MAP
TYPE OF SERVICE	FEDERAL SHARE
INPAT HOSP A	67,332,852
INPAT HOSP B	2,423,051
MENTAL HLTH A	6,219,041
MENTAL HLTH B	576,949
SKILL NURS.	62,904,766
ICF/MR: PUB	16,952,332
ICF/MR: PRI	14,950,068
PHYSICIAN	15,863,504
OUTPAT HOSP	13,004,287
PRESCRIBD DR	50,154,059
DRUG REB OFF NT	7,254,012
DRUG REB OFF ST	0
DENTAL SERV.	7,600,136
OTHER PRACT.	1,764,415
CLINIC	56,735,517
LAB AND RAD	212,276
HOME HEALTH	1,871,561
STERILIZATN.	299,553
ABORTION	0
EPSDT SCR	471,122
RURAL HEALTH	251,817
HLTH INS-A	375,027
HLTH INS-B	3,968,923
POV120-134 QUAL	0
POV135-175 QUAL	0
CO-INS-DED	4,409,315
MEDICAID-MCO	0
MEDICAID-PHP	0
GROUP HEALTH	113,993,810
MEDICAID-DED	1,190,904
HLTH INS-OTHR	0
HOME & COMM.	45,480,920
H&CB DIS-ELDRLY	0
COMM LIVING	0
ALL INCLUSIVE	0
PERSONAL CARE	313,130
TARGET CASE	6,193,459
PCCM	0
HOSPICE BEN.	557,374
EMRGNCY ALIENS	0
FED QUAL HLTH	1,921,510
OTHER CARE	9,130,989
CHIP-RELATD EXP	0
TOT CURR EXP	499,878,657
INCR CL (PR)	467,185
OTHER EXP.	0
COLLECT TPL	3,872,325
COLLECT PROBT	1,535,453
COLLECT F&A	1,466
COLLECT OTHR	2,174,903
COLLECT	0
DEC CL FED AUD	0
DEC CL OTHER	791,312
DEC CL	8,342
NET EXP REPT	491,962,041

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STATE:	CONNECTICUT				
	MAP	MAP		ADMIN	ADMIN
TYPE OF SERVICE	TOTAL COMPUTABLE	FEDERAL SHARE	TYPE OF EXPEND	TOTAL COMPUTABLE	FEDERAL SHARE
INPAT HOSP A	160,953,734	80,503,785	FAM PLANNING	0	0
INPAT HOSP B	266,862,863	133,431,433	DES DEV INHS	44,569	40,112
MENTAL HLTH A	25,409,149	12,704,576	DES DEV CNTR	182,032	163,029
MENTAL HLTH B	103,267,504	51,633,752	DES DEV DRUG	0	0
SKILL NURS.	854,539,736	427,269,869	SKILLED PROF	1,998,666	1,499,000
ICF/MR: PUB	158,298,409	79,149,205	MMIS OP INHS	0	0
ICF/MR: PRI	45,912,813	22,956,408	MMIS OP CNTR	23,855,881	17,891,910
PHYSICIAN	26,811,802	13,439,465	MECH SYS INHS	6,822,361	3,411,181
OUTPAT HOSP	47,009,272	23,558,273	MECH SYS CNTR	0	0
PRESCRIBD DR	187,408,248	93,856,821	PEER RVW ORG	1,593,613	1,195,210
DRUG REB OFF NT	32,128,587	16,064,294	JRD PTY LIAB	0	0
DRUG REB OFF ST	0	0	ASSGT RIGHTS	0	0
DENTAL SERV.	5,261,285	2,630,643	ISVS COSTS	0	0
OTHER PRACT.	31,491,559	15,758,101	NURSE AIDE	102,711	51,356
CLINIC	18,949,443	9,552,706	PREADMISSION	483	363
LAB AND RAD	3,822,824	1,912,415	RESIDENT RVW	98,927	74,195
HOME HEALTH	111,727,983	55,882,709	DRUG USE RVW	316,969	158,485
STERILIZATN.	159,612	135,556	DRUG IMPL COST	0	0
ABORTION	0	0	OUT ELIG WRKS	0	0
EPSDT SCR	540,613	285,497	TANF BASE	0	0
RURAL HEALTH	0	0	TANF-SEC-90	0	0
HLTH INS-A	0	0	TANF-SEC-75	0	0
HLTH INS-B	37,515,471	18,757,736	EXT QUAL.	0	0
POV120-134 QUAL	20,586	20,586	ENROLMNT BROKR	0	0
POV135-175 QUAL	15	15	OTHR FINANCL	53,663,281	26,831,642
CO-INS-DED	90,456,248	45,228,125	TOT CURR EXP	88,679,493	51,317,283
MEDICAID-MCO	377,994,674	188,997,337	INCR CL (PR)	5,946,679	3,244,414
MEDICAID-PHP	0	0	OTHER EXP.	0	0
GROUP HEALTH	0	0	COLLECT OTHR	0	0
MEDICAID-DED	0	0	COLLECT	0	0
HLTH INS-OTHR	0	0	DEC CL FED AUD	0	0
HOME & COMM.	297,990,792	148,998,110	DEC CL OTHER	391,056	246,891
H&CB DIS-ELDRLY	0	0	NET EXP REPT	94,232,116	54,314,806
COMM LIVING	0	0			
ALL INCLUSIVE	0	0			
PERSONAL CARE	0	0			
TARGET CASE	11,862,306	5,931,154			
PCCM	0	0			
HOSPICE BEN.	0	0			
EMRGNCY ALIENS	0	0			
FED QUAL HLTH	0	0			
OTHER CARE	63,272,544	31,792,578			
CHIP-RELATD EXP	0	0			
TOT CURR EXP	2,895,410,898	1,448,322,561			
INCR CL (PR)	74,624,563	37,325,274			
OTHER EXP.	0	0			
COLLECT TPL	11,046,308	5,523,156			
COLLECT PROBT	7,731,922	3,865,962			
COLLECT FRAA	2,331,549	1,165,776			
COLLECT OTHR	104,044,917	52,022,459			
COLLECT	0	0			
DEC CL FED AUD	0	0			
DEC CL OTHER	3,688,274	1,844,139			
DEC CL	9,518,731	4,759,366			
NET EXP REPT	2,831,673,760	1,416,466,977			

MEDICAL ASSISTANCE PAYMENTS AND ADMINISTRATIVE EXPENDITURES REPORT DATE: FEBRUARY 26, 1999
TOTAL COMPUTABLE AND FEDERAL SHARE FOR FISCAL YEAR 1998

STATE: LOUISIANA						
	MAP	MAP			ADMIN	ADMIN
TYPE OF SERVICE	TOTAL COMPUTABLE	FEDERAL SHARE		TYPE OF EXPEND	TOTAL COMPUTABLE	FEDERAL SHARE
INPAT HOSP A	558,532,554	391,920,912		FAM PLANNING	0	0
INPAT HOSP B	654,692,384	458,481,077		DES DEV INHS	0	0
MENTAL HLTH A	11,099,611	7,773,057		DES DEV CNTR	544,197	489,777
MENTAL HLTH B	83,569,366	58,523,627		DES DEV DRUG	0	0
SKILL NURS.	502,806,276	352,258,394		SKILLED PROF	2,042,777	1,532,083
ICF/MR: PUB	152,233,980	106,609,456		MMIS OP INHS	185,004	138,754
ICF/MR: PRI	171,680,864	120,232,905		MMIS OP CNTR	17,114,162	12,835,622
PHYSICIAN	206,835,816	145,637,002		MECH SYS INHS	27,428	13,714
OUTPAT HOSP	149,989,111	105,046,621		MECH SYS CNTR	0	0
PRESCRIBD DR	367,292,987	257,757,197		PEER RVW ORG	0	0
DRUG REB OFF NT	65,994,910	46,313,413		3RD PTY LIAB	0	0
DRUG REB OFF ST	0	0		ASSGT RIGHTS	0	0
DENTAL SERV.	17,951,656	12,571,666		ISVS COSTS	0	0
OTHER PRACT.	0	0		NURSE AIDE	0	0
CLINIC	44,730,408	31,333,343		PREADMISSION	17,455	13,091
LAB AND RAD	42,512,178	29,771,279		RESIDENT RVW	187,699	140,775
HOME HEALTH	22,123,632	15,493,279		DRUG USE RVW	0	0
STERILIZATN.	1,725,541	1,552,988		DRUG IMPL COST	0	0
ABORTION	0	0		OUT ELIG WRKS	0	0
EPSET SCR	23,249,779	16,281,820		TANF BASE	0	0
RURAL HEALTH	7,538,487	5,340,546		TANF-SEC-90	0	0
HLTH INS-A	20,232,104	14,168,542		TANF-SEC-75	0	0
HLTH INS-B	61,980,199	43,404,733		EXT QUAL.	0	0
FOV120-134 QUAL	67,233	67,233		ENROLMNT BROKR	575,791	287,896
FOV135-175 QUAL	0	0		OTHR FINANCL	77,944,470	38,972,236
CO-INS-DED	0	0		TOT CURR EXP	98,638,983	54,423,948
MEDICAID-MCO	0	0		INCR CL (PR)	14,681,309	9,678,137
MEDICAID-PHP	0	0		OTHER EXP.	0	0
GROUP HEALTH	180,736	126,570		COLLECT OTHR	0	0
MEDICAID-DED	0	0		COLLECT	0	0
HLTH INS-OTHR	0	0		DEC CL FED AUD	0	0
HOME & COMM.	67,003,813	46,922,770		DEC CL OTHER	14,237,084	8,518,037
H&CB DIS-ELDRLY	0	0		NET EXP REPT	99,083,208	55,584,048
COMM LIVING	0	0				
ALL INCLUSIVE	0	0				
PERSONAL CARE	0	0				
TARGET CASE	3,763,162	2,635,342				
PCOM	366,840	256,898				
HOSPICE BEN.	1,819,083	1,273,904				
EMRGNCY ALIENS	0	0				
FED QUAL HLTH	3,896,764	2,773,379				
OTHER CARE	88,331,693	61,858,685				
CHIP-RELATD EXP	0	0				
TOT CURR EXP	3,200,211,547	2,243,759,832				
INCR CL (PR)	106,055,985	86,069,983				
OTHER EXP.	34,480,432	24,869,982				
COLLECT TPL	16,614,413	12,613,607				
COLLECT PRCBT	10,590	7,507				
COLLECT F&A	1,396,829	1,018,026				
COLLECT OTHR	25,934,941	18,343,077				
COLLECT	28,136,465	19,703,966				
DEC CL FED AUD	0	0				
DEC CL OTHER	87,284,474	68,391,722				
DEC CL	6,976,969	5,020,425				
NET EXP REPT	3,174,392,783	2,229,601,117				

MEDICAL ASSISTANCE PAYMENTS AND ADMINISTRATIVE EXPENDITURES REPORT DATE: FEBRUARY 26, 1999
 TOTAL COMPUTABLE AND FEDERAL SHARE FOR FISCAL YEAR 1998

STATE: MASSACHUSETTS					
	MAP	MAP		ADMIN	ADMIN
TYPE OF SERVICE	TOTAL COMPUTABLE	FEDERAL SHARE	TYPE OF EXPEND	TOTAL COMPUTABLE	FEDERAL SHARE
INPAT HOSP A	614,812,606	307,640,346	FAM PLANNING	67,331	60,598
INPAT HOSP B	393,579,716	196,789,859	DES DEV INHS	0	0
MENTAL HLTH A	40,669,401	20,334,701	DES DEV CNTR	0	0
MENTAL HLTH B	103,700,000	51,850,000	DES DEV DRUG	0	0
SKILL NURS.	1,330,036,403	665,018,203	SKILLED PROF	5,467,847	4,100,886
ICE/MR: PUB	252,869,371	126,434,687	MMIS OP INHS	5,912,857	4,434,643
ICE/MR: PRI	0	0	MMIS OP CNTR	21,231,999	15,923,999
PHYSICIAN	198,265,981	99,498,124	MECH SYS INHS	0	0
OUTPAT HOSP	246,350,205	123,368,511	MECH SYS CNTR	0	0
PRESCRIBD DR	505,711,215	255,269,268	PEER RVW ORG	3,961,999	2,971,500
DRUG REB OFF NT	89,011,664	44,541,287	3RD PTY LIAB	68,086	34,044
DRUG REB OFF ST	0	0	ASSGT RIGHTS	33,768	16,885
DENTAL SERV.	53,628,267	26,814,135	ISVS COSTS	0	0
OTHER PRACT.	8,180,755	4,094,809	NURSE AIDE	0	0
CLINIC	128,584,554	64,916,461	PREADMISSION	700,425	525,319
LAB AND RAD	9,831,682	4,973,821	RESIDENT RVW	306,592	229,945
HOME HEALTH	91,614,651	45,807,412	DRUG USE RVW	570,014	285,007
STERILIZATN.	3,269,187	2,942,269	DRUG IMPL COST	0	0
ABORTION	0	0	OUT ELIG WRKS	0	0
EPSDT SCR	8,984,669	4,492,336	TANF BASE	702,357	632,121
RURAL HEALTH	0	0	TANF-SEC-90	1,720,955	1,548,860
HLTH INS-A	54,550,560	27,275,280	TANF-SEC-75	0	0
HLTH INS-B	74,382,770	37,191,386	EXT QUAL.	0	0
POV120-134 QUAL	0	0	ENROLMNT BROKR	0	0
POV135-175 QUAL	0	0	OTHR FINANCL	111,768,102	55,884,052
CO-INS-DED	0	0	TOT CURR EXP	152,512,332	86,647,859
MEDICAID-MCO	733,744,254	366,872,128	INCR CL (PR)	19,255,457	10,063,829
MEDICAID-PHP	389,989,621	194,994,812	OTHER EXP.	260,526	234,473
GROUP HEALTH	2,070,372	1,035,187	COLLECT OTHR	0	0
MEDICAID-DED	0	0	COLLECT	0	0
HLTH INS-OTHR	0	0	DEC CL FED AUD	0	0
HOME & COMM.	400,110,665	200,055,334	DEC CL OTHER	6,063,380	3,531,463
H&CB DIS-ELDRLY	0	0	NET EXP REPT	165,964,935	93,414,698
COMM LIVING	0	0			
ALL INCLUSIVE	0	0			
PERSONAL CARE	139,105,479	69,552,788			
TARGET CASE	188,165,066	94,082,534			
PCCM	0	0			
HOSPICE BEN.	8,053,232	4,026,617			
EMRGNCY ALIENS	481,750	481,750			
FED QUAL HLTH	0	0			
OTHER CARE	195,783,497	97,894,161			
CHIP-RELATD EXP	0	0			
TOT CURR EXP	6,087,514,265	3,049,165,632			
INCR CL (PR)	46,163,811	23,081,913			
OTHER EXP.	0	0			
COLLECT TPL	11,381,773	5,690,889			
COLLECT PROBT	20,137,674	10,068,838			
COLLECT F&A	16,317,853	8,158,928			
COLLECT OTHR	484,604,600	242,185,739			
COLLECT	0	0			
DEC CL FED AUD	0	0			
DEC CL OTHER	68,215,674	34,135,938			
DEC CL	37,453,927	18,726,965			
NET EXP REPT	5,495,566,575	2,753,280,248			

MEDICAL ASSISTANCE PAYMENTS AND ADMINISTRATIVE EXPENDITURES REPORT DATE: FEBRUARY 26, 1999
TOTAL COMPUTABLE AND FEDERAL SHARE FOR FISCAL YEAR 1998

STATE: MISSOURI						
	MAP	MAP		ADMIN	ADMIN	
TYPE OF SERVICE	TOTAL COMPUTABLE	FEDERAL SHARE	TYPE OF EXPEND	TOTAL COMPUTABLE	FEDERAL SHARE	
INPAT HOSP A	319,741,838	194,019,348	FAM PLANNING	0	0	0
INPAT HOSP B	467,025,524	283,391,088	DES DEV INHS	0	0	0
MENTAL HLTH A	7,893,057	4,789,587	DES DEV CNTR	0	0	0
MENTAL HLTH B	199,031,452	120,772,285	DES DEV DRUG	0	0	0
SKILL NURS	696,469,369	422,617,614	SKILLED PROF	1,502,960	1,127,221	0
ICF/MR: PUB	97,419,578	59,114,200	MMIS OP INHS	2,900,277	2,175,209	0
ICF/MR: PRI	48,743,612	29,577,746	MMIS OP CNTR	9,019,435	6,764,577	0
PHYSICIAN	49,997,054	30,838,140	MECH SYS INHS	0	0	0
OUTPAT HOSP	118,827,519	72,601,889	MECH SYS CNTR	0	0	0
PRESCRIBD DR	393,066,136	239,038,016	PEER RVW ORG	0	0	0
DRUG REB OFF NT	66,460,159	40,644,963	3RD PTY LIAB	0	0	0
DRUG REB OFF ST	0	0	ASSGT RIGHTS	0	0	0
DENTAL SERV.	9,064,249	5,500,187	ISV6 COSTS	0	0	0
OTHER PRACT.	5,677,369	3,445,028	NURSE AIDE	504,928	252,464	0
CLINIC	39,878,788	24,441,626	PREADMISSION	512,434	378,183	0
LAB AND RAD	6,177,876	3,754,133	RESIDENT RVW	21,513	15,686	0
HOME HEALTH	7,779,357	4,720,514	DRUG USE RVW	0	0	0
STERILIZATN.	3,521,118	2,685,124	DRUG IMPL COST	0	0	0
ABORTION	2,820	1,716	OUT ELIG WRKS	0	0	0
FPSDT SCR	65,617,217	39,816,528	TANF BASE	4,762,909	4,286,618	0
RURAL HEALTH	14,442,480	0,880,522	TANF-SEC-90	0	0	0
HLTH INS-A	2,635,781	1,599,391	TANF-SEC-75	0	0	0
HLTH INS-B	44,016,278	26,709,078	EXT QUAL.	0	0	0
POV120-134 QUAL	7,577	4,598	ENROLMNT BROKR	0	0	0
POV135-175 QUAL	0	0	OTHR FINANCL	102,218,167	51,109,084	0
CO-INS-DED	58,962,455	35,778,418	TOT CURR EXP	121,442,623	66,109,042	0
MEDICAID-MCO	342,256,318	207,681,135	INCR CL (PR)	336,010	302,409	0
MEDICAID-PHP	0	0	OTHER EXP.	0	0	0
GROUP HEALTH	730,891	443,504	COLLECT OTHR	0	0	0
MEDICAID-DED	4,844	2,940	COLLECT	0	0	0
HLTH INS-OTHR	347,376	210,788	DEC CL FED AUD	0	0	0
HOME & COMM.	218,279,751	132,452,153	DEC CL OTHER	336,010	168,005	0
H&CB DIS-ELDRLY	0	0	NET EXP REPT	121,442,623	66,243,446	0
COMM LIVING	0	0				
ALL INCLUSIVE	0	0				
PERSONAL CARE	91,636,182	55,604,835				
TARGET CASE	34,932,758	21,197,197				
PCCM	0	0				
HOSPICE BEN.	8,668,745	5,260,195				
EMRGNCY ALIENS	0	0				
FED QUAL HLTH	6,393,656	3,918,000				
OTHER CARE	27,701,231	16,809,108				
CHIP-RELATD EXP	0	0				
TOT CURR EXP	3,320,490,225	2,017,039,588				
INCR CL (PR)	3,036,661	1,032,072				
OTHER EXP.	0	0				
COLLECT TPL	14,971,041	9,084,428				
COLLECT PROBT	2,981,743	1,809,205				
COLLECT F&A	1,578,334	948,059				
COLLECT OTHR	9,591,606	5,813,461				
COLLECT	0	0				
DEC CL FED AUD	0	0				
DEC CL OTHER	8,844,465	5,333,571				
DEC CL	2,570,457	1,559,754				
NET EXP REPT	3,282,989,240	1,994,323,182				

MEDICAL ASSISTANCE PAYMENTS AND ADMINISTRATIVE EXPENDITURES REPORT DATE: FEBRUARY 26, 1999
TOTAL COMPUTABLE AND FEDERAL SHARE FOR FISCAL YEAR 1998

STATE: NEW HAMPSHIRE							
	MAP	MAP		ADMIN	ADMIN		
TYPE OF SERVICE	TOTAL COMPUTABLE	FEDERAL SHARE		TYPE OF EXPEND	TOTAL COMPUTABLE	FEDERAL SHARE	
INPAT HOSP A	35,939,570	17,970,270		FAM PLANNING	0	0	
INPAT HOSP B	103,411,171	51,705,586		DES DEV INHS	5,228	2,615	
MENTAL HLTH A	1,909,935	954,968		DES DEV CNTR	11,401	5,701	
MENTAL HLTH B	25,000,000	12,500,000		DES DEV DRUG	0	0	
SKILL NURS.	207,839,374	103,919,688		SKILLED PROF	1,014,508	760,882	
ICF/MR: PUB	1,502,299	751,150		MMIS OP INHS	0	0	
ICF/MR: PRI	0	0		MMIS OP CNTR	0	0	
PHYSICIAN	18,466,593	9,270,371		MECH SYS INHS	723,755	361,878	
OUTPAT HOSP	25,035,240	12,520,446		MECH SYS CNTR	6,597,496	3,298,749	
PRESCRIBD DR	54,686,543	27,495,428		PEER RVW ORG	91,233	60,425	
DRUG REB OFF NT	9,676,461	4,838,231		3RD PTY LIAB	0	0	
DRUG REB OFF ST	0	0		ASSGT RIGHTS	0	0	
DENTAL SERV.	4,496,502	2,248,252		ISVS COSTS	0	0	
OTHER PRAC.T.	6,879,982	3,440,435		NURSE AIDE	183,160	91,580	
CLINIC	82,647,320	41,382,947		PREADMISSION	181,468	136,102	
LAB AND RAD	869,161	444,124		RESIDENT RVW	0	0	
HOME HEALTH	3,865,705	1,932,893		DRUG USE RVW	0	0	
STERILIZATN.	1,075,345	967,811		DRUG IMPL COST	0	0	
ABORTION	31,403	15,702		OUT ELIG WRKS	12,843	6,422	
PRSDT SCR	1,006,436	503,678		TANF BASE	0	0	
RURAL HEALTH	3,484,345	1,748,829		TANF-SEC-90	28,530	25,677	
HLTH INS-A	383,665	191,833		TANF-SEC-75	0	0	
HLTH INS-B	2,945,057	1,472,530		EXT QUAL.	0	0	
POV120-134 QUAL	0	0		PNRLMNT BROKR	0	0	
POV135-175 QUAL	0	0		OTHR FINANCL	21,047,680	10,523,841	
CO-INS-DED	0	0		TOT CURR EXP	29,897,302	15,281,872	
MEDICAID-MCO	0	0		INCR CL (PR)	4,439,615	2,219,809	
MEDICAID-PHP	0	0		OTHER EXP.	0	0	
GROUP HEALTH	0	0		COLLECT OTHR	0	0	
MEDICAID-DED	0	0		COLLECT	0	0	
HLTH INS-OTHR	11,935,862	5,967,932		DEC CL FED AUD	0	0	
HOME & COMM.	103,118,138	51,559,070		DEC CL OTHER	3,900,984	1,950,493	
H&CB DIS-ELDRLY	11,948,502	5,974,252		NET EXP REPT	30,435,933	15,551,189	
COMM LIVING	0	0					
ALL INCLUSIVE	0	0					
PERSONAL CARE	2,294,653	1,147,327					
TARGET CASE	1,316,023	658,012					
PCCM	0	0					
HOSPICE BEN.	0	0					
EMRGNCY ALIENS	0	0					
FED QUAL HLTH	0	0					
OTHER CARE	65,731,543	32,867,025					
CHIP-RELATD EXP	0	0					
TOT CURR EXP	768,143,994	384,772,328					
INCR CL (PR)	2,536,486	1,268,244					
OTHER EXP.	0	0					
COLLECT TPL	3,184,740	1,592,152					
COLLECT PROBT	5,105,178	2,554,623					
COLLECT F&A	20,824	10,412					
COLLECT OTHR	2,319,232	1,159,616					
COLLECT	0	0					

MEDICAL ASSISTANCE PAYMENTS AND ADMINISTRATIVE EXPENDITURES REPORT DATE: FEBRUARY 26, 1999
TOTAL COMPUTABLE AND FEDERAL SHARE FOR FISCAL YEAR 1998

STATE: NEVADA					
	MAP	MAP		ADMIN	ADMIN
TYPE OF SERVICE	TOTAL COMPUTABLE	FEDERAL SHARE	TYPE OF EXPEND	TOTAL COMPUTABLE	FEDERAL SHARE
INPAT HOSP A	115,078,353	57,581,571	FAM PLANNING	0	0
INPAT HOSP B	73,559,997	36,779,999	DES DEV INHS	0	0
MENTAL HLTH A	11,338,986	5,669,494	DES DEV CNTR	0	0
MENTAL HLTH B	0	0	DES DEV DRUG	0	0
SKILL NURS.	70,245,071	35,122,537	SKILLED PROF	2,639,159	1,979,370
ICF/MR: PUB	17,327,739	8,663,870	MMIS OP INHS	0	0
ICF/MR: PRI	8,120,811	4,060,407	MMIS OP CNTR	0	0
PHYSICIAN	39,394,469	19,796,883	MECH SYS INHS	218,677	109,688
OUTPAT HOSP	22,985,891	11,636,605	MECH SYS CNTR	0	0
PRESCRIBD DR	32,440,069	16,266,340	FEER RVW ORG	1,470,518	1,102,888
DRUG REB OFF NT	5,143,136	2,587,923	3RD PTY LIAB	0	0
DRUG REB OFF ST	0	0	ASSGT RIGHTS	0	0
DENTAL SERV.	12,359,579	6,179,790	ISVS COSTS	0	0
OTHER PRACT.	4,899,371	2,454,395	NURSE AIDE	118,407	59,204
CLINIC	2,552,513	1,793,879	PREADMTSSION	89,644	67,233
LAB AND RAD	1,197,402	598,842	RESIDENT RVW	104,580	78,436
HOME HEALTH	7,354,125	3,679,337	DRUG USE RVW	52,884	26,444
STERILIZATN.	1,073,688	966,319	DRUG IMPL COST	0	0
ABORTION	0	0	OUT ELIG WRKS	100,710	50,356
EPSDT SCR	3,889,168	1,958,460	TANF BASE	0	0
RURAL HEALTH	889,610	447,424	TANF-SEC-90	0	0
HLTH INS-A	3,897,224	1,948,613	TANF-SEC-75	0	0
HLTH INS-B	8,546,198	4,273,100	EXT QUAL.	0	0
POV120-134 QUAL	0	0	ENROLMNT BROKR	0	0
POV135-175 QUAL	0	0	OTHR FINANCL	24,621,165	12,310,584
CO-INS-DED	0	0	TOT CURR EXP	29,415,744	15,784,203
MEDICAID-MCO	22,691,787	11,504,621	INCR CL (PR)	0	0
MEDICAID-PHP	0	0	OTHER EXP.	2,984,092	1,677,250
GROUP HEALTH	38,656	19,329	COLLECT OTHR	0	0
MEDICAID-DED	0	0	COLLECT	0	0
HLTH INS-OTHR	0	0	DEC CL FED AUD	0	0
HOME & COMM.	11,868,161	5,934,081	DEC CL OTHER	3,150,829	1,824,969
H&CB DIS-ELDRLY	0	0	NET EXP REPT	29,249,007	15,636,484
COMM LIVING	0	0			
ALL INCLUSIVE	0	0			
PERSONAL CARE	2,025,840	1,012,922			
TARGET CASE	0	0			
PCCM	15,310,777	8,154,852			
HOSPICE BEN.	259,542	129,771			
EMRGNCY ALIENS	0	0			
FED QUAL HLTH	0	0			
OTHER CARE	43,588,301	21,813,056			
CHIP-RELATD EXP	0	0			
TOT CURR EXP	527,790,192	265,858,574			
INCR CL (PR)	8,956	4,480			
OTHER EXP.	458,149	416,403			
COLLECT TPL	371,177	185,590			
COLLECT PROBT	949,945	474,974			
COLLECT F&A	250,027	125,014			
COLLECT OTHR	77,839	38,920			
COLLECT	99,168	49,586			
DEC CL FED AUD	0	0			
DEC CL OTHER	13,660,510	6,968,814			
DEC CL	142,675	71,338			
NET EXP REPT	512,705,956	258,365,221			

MEDICAL ASSISTANCE PAYMENTS AND ADMINISTRATIVE EXPENDITURES REPORT DATE: FEBRUARY 26, 1999
 TOTAL COMPUTABLE AND FEDERAL SHARE FOR FISCAL YEAR 1998

STATE: TENNESSEE					
	MAP	MAP		ADMIN	ADMIN
TYPE OF SERVICE	TOTAL COMPUTABLE	FEDERAL SHARE	TYPE OF EXPEND	TOTAL COMPUTABLE	FEDERAL SHARE
INPAT HOSP A	295,266,324	187,080,742	FAM PLANNING	0	0
INPAT HOSP B	0	0	DES DEV INHS	0	0
MENTAL HLTH A	584,862	370,568	DES DEV CNTR	0	0
MENTAL HLTH B	0	0	DES DEV DRUG	0	0
SKILL NURS.	706,182,082	447,436,968	SKILLED PROF	1,557,253	1,167,940
ICF/MR: PUB	187,836,424	119,013,158	MMIS OP INHS	15,959,319	11,969,490
ICF/MR: PRI	55,783,554	35,344,460	MMIS OP CNTR	0	0
PHYSICIAN	20,810,346	13,185,435	MECH SYS INHS	0	0
OUTPAT HOSP	14,150,088	8,965,496	MECH SYS CNTR	0	0
PRESCRIBD DR	29,538,580	18,715,645	PEER RVW ORG	0	0
DRUG REB OFF NT	840	532	3RD PTY LIAB	46,533	23,267
DRUG REB OFF ST	0	0	ASSGT RIGHTS	17,919	8,960
DENTAL SERV.	32,683	20,708	ISVS COSTS	0	0
OTHER PRACT.	3,578,828	2,267,545	NURSE AIDE	564,030	282,016
CLINIC	15,368,809	9,737,677	PREADMISSION	0	0
LAB AND RAD	2,375,511	1,505,123	RESIDENT RVW	0	0
HOME HEALTH	415,361	263,173	DRUG USE RVW	0	0
STERILIZATN.	0	0	DRUG IMPL COST	0	0
ABORTION	0	0	OUT ELIG WRKS	0	0
EPSDT SCR	0	0	TANF BASE	0	0
RURAL HEALTH	404,245	256,129	TANF-SEC-90	0	0
HLTH INS-A	28,826,154	18,264,251	TANF-SEC-75	0	0
HLTH INS-B	93,465,272	59,219,596	EXT QUAL.	2,554,054	1,915,541
POV120-134 QUAL	0	0	ENROLMNT BROKR	0	0
POV135-175 QUAL	0	0	OTHR FINANCL	47,606,466	23,803,234
CO-INS-DED	0	0	TOT CURR EXP	68,305,574	39,170,448
MEDICAID-MCO	2,109,798,880	1,336,768,570	INCR CL (PR)	54,350,146	27,551,105
MEDICAID-PHP	0	0	OTHER EXP.	536,447	270,277
GROUP HEALTH	0	0	COLLECT OTHR	0	0
MEDICAID-DED	0	0	COLLECT	0	0
HLTH INS-OTHR	0	0	DEC CL FED AUD	0	0
HOME & COMM.	86,147,127	54,582,820	DEC CL OTHER	24,026	12,013
H&CB DIS-ELDRLY	0	0	NET EXP REPT	123,168,141	66,979,817
COMM LIVING	0	0			
ALL INCLUSIVE	0	0			
PERSONAL CARE	0	0			
TARGET CASE	90,107,740	57,092,264			
PCCM	0	0			
HOSPICE BEN.	572	362			
EMRGNCY ALIENS	0	0			
FED QUAL HLTH	0	0			
OTHER CARE	17,401,517	11,025,601			
CHIP-RELATD EXP	0	0			
TOT CURR EXP	3,758,074,119	2,381,115,759			
INCR CL (PR)	219,303,961	143,379,335			
OTHER EXP.	60,210,421	39,383,240			
COLLECT TPL	798,734	528,430			
COLLECT PROBT	533,937	352,106			
COLLECT F&A	1,315,195	903,866			
COLLECT OTHR	1,862,847	1,209,336			
COLLECT	3,749,817	2,375,885			
DEC CL FED AUD	0	0			
DEC CL OTHER	62,489,694	41,102,080			
DEC CL	-6,491,063	-4,112,738			
NET EXP REPT	3,973,329,340	2,521,519,369			

MEDICAL ASSISTANCE PAYMENTS AND ADMINISTRATIVE EXPENDITURES REPORT DATE: FEBRUARY 26, 1999
 TOTAL COMPUTABLE AND FEDERAL SHARE FOR FISCAL YEAR 1998

STATE: UTAH					
	MAP	MAP		ADMIN	ADMIN
TYPE OF SERVICE	TOTAL COMPUTABLE	FEDERAL SHARE	TYPE OF EXPEND	TOTAL COMPUTABLE	FEDERAL SHARE
INPAT HOSP A	92,770,531	67,332,852	FAM PLANNING	0	0
INPAT HOSP B	3,338,456	2,423,051	DES DEV INHS	538,532	484,679
MENTAL HLTH A	8,568,532	6,219,041	DES DEV CNTR	0	0
MENTAL HLTH B	794,916	576,949	DES DEV DRUG	16,223	14,601
SKILL NURS.	86,669,560	62,904,766	SKILLED PROF	2,586,344	1,939,758
ICF/MR: PUB	23,356,753	16,952,332	MMIS OP INHS	8,906,959	6,680,220
ICF/MR: PRI	20,598,053	14,950,068	MMIS OP CNTR	1,222,910	917,182
PHYSICIAN	21,851,519	15,865,504	MECH SYS INHS	0	0
OUTPAT HOSP	17,387,932	13,004,287	MECH SYS CNTR	0	0
PRESCRIBD DR	69,029,101	50,154,059	PEER RVW ORG	0	0
DRUG REB OFF NT	9,988,037	7,254,012	3RD PTY LIAB	0	0
DRUG REB OFF ST	0	0	ASSET RIGHTS	0	0
DENTAL SERV.	10,471,391	7,600,136	ISVS COSTS	0	0
OTHER PRACT.	2,430,993	1,764,415	NURSE AIDE	124,915	62,458
CLINIC	78,169,630	56,735,517	PREADMISSION	0	0
LAB AND RAD	292,471	212,276	RESIDENT RVW	0	0
HOME HEALTH	2,578,619	1,871,561	DRUG USE RVW	0	0
STERILIZATN.	332,836	299,553	DRUG IMPL COST	0	0
ABORTION	0	0	OUT ELIG WRKS	2,307,946	1,151,474
EPSDT SCR	649,107	471,122	TANF BASE	0	0
RURAL HEALTH	346,951	251,817	TANF-SEC-90	0	0
HLTH INS-A	516,707	375,027	TANF-SEC-75	0	0
HLTH INS-B	5,468,346	3,968,925	EXT QUAL.	0	0
POV120-134 QUAL	0	0	ENROLLMNT BROKR	0	0
POV135-175 QUAL	0	0	OTHR FINANCL	36,884,206	18,442,103
CO-INS-DED	6,075,111	4,409,315	TOT CURR EXP	52,583,035	29,692,475
MEDICAID-MCO	0	0	INCR CL (PR)	71,270	35,635
MEDICAID-PHP	0	0	OTHER EXP.	0	0
GROUP HEALTH	157,059,533	113,993,810	COLLECT OTHR	0	0
MEDICAID-DED	1,640,815	1,190,904	COLLECT	0	0
HLTH INS-OTHR	0	0	DEC CL FED AUD	0	0
HOME & COMM.	62,663,159	45,480,920	DEC CL OTHER	0	0
H&CB DIS-ELDRLY	0	0	NET EXP REPT	52,654,305	29,728,110
COMM LIVING	0	0			
ALL INCLUSIVE	0	0			
PERSONAL CARE	431,427	313,130			
TARGET CASE	8,533,286	6,193,459			
PCCM	0	0			
HOSPICE BEN.	767,945	557,374			
EMRGNCY ALIENS	0	0			
FED QUAL HLTH	2,647,436	1,921,510			
OTHER CARE	12,377,229	9,130,989			
CHIP-RELATD EXP	0	0			
TOT CURR EXP	687,830,308	499,878,657			
INCR CL (PR)	638,154	467,185			
OTHER EXP.	0	0			
COLLECT TPL	5,335,251	3,872,325			
COLLECT PROBT	2,115,533	1,535,453			
COLLECT F&A	2,020	1,466			
COLLECT OTHR	2,996,560	2,174,903			
COLLECT	0	0			
DEC CL FED AUD	0	0			
DEC CL OTHER	1,074,302	791,312			
DEC CL	11,431	8,342			
NET EXP REPT	676,933,365	491,962,041			

Date: _____

FAX



Health Division



Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To:

Fax:

Dewash

From:

Cindy

AB

Number of Pages (excluding cover):

Subject:

Voice Numbers:

Health Division (Front Office)	202/395-4922
Health & Human Services Unit	202/395-4925
Health Programs & Services Branch	202/395-4926
Health Financing Branch	202/395-4930

Fax Numbers:

Health Division (Front Office)	202/395-3910
Health Division (Room 7001)	202/395-7840
Health Division (Room 7002)	202/395-5648



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington D.C. 20201 - 0001

557
CC: BC
MM
HFB Medicaid

Dear State Medicaid Director:

We are writing to inform you of several policy interpretations which the Health Care Financing Administration (HCFA) has recently adopted. These interpretations relate to the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. No. 102-234 § 2(a) (codified at section 1903(w) of the Social Security Act (the Act)), and related regulations, and were adopted as part of a review of HCFA's policies in the area of provider taxes.

As you know, the Medicaid Voluntary Contribution and Provider Specific Tax Amendments were enacted to limit Federal financial participation (FFP) in States' medical assistance expenditures when the States receive funds from, among other sources, impermissible health care related taxes. Under the Act, States may continue to receive FFP with respect to "broad based" and "uniform" health care related taxes. According to section 1903(w)(3)(B), a broad based health care related tax means a health care related tax which is imposed with respect to a permissible class of items or services on all providers in that class. In addition, under section 1903(w)(3)(C) of the Act, a uniform health care related tax means a tax which is imposed with respect to a permissible class of items or services at the same rate for all providers. For those taxes which are not broad based or uniform, the Secretary may grant waivers if she finds that the taxes in question are "generally redistributive," pursuant to section 1903(w)(3)(E) of the Act.

In this letter, we first clarify HCFA's interpretation of the requirement that health care related taxes be applied uniformly. Second, we clarify that, when the Secretary has granted a waiver with regard to a health care related tax because she has concluded that the tax is generally redistributive, a later uniform change in the rate of tax will not require the State to submit a new waiver request. Third, we are reminding States of their opportunity to propose additional classes of providers, items, or services which the Secretary may consider including as permissible classes. Fourth, we are reminding States that all provider related donation revenue and health care related tax revenue, which includes licensing fee revenue, must be reported to HCFA on the HCFA-form 64.11A. Lastly, we commit to working with States to consider ways, including legislation, to expedite the identification of impermissible taxes and their use.

Page 2 - State Medicaid Director

First, with regard to the requirement that health care related taxes be uniformly imposed, the implementing Federal regulation at 42 C.F.R. § 433.68(d)(iv) specifies that a health care related tax will be considered uniformly imposed if the tax is imposed on items or services on a basis other than those provided by statute, and the State establishes to the satisfaction of the Secretary that the amount of the tax is the same for each provider of such items or services in the class. We are clarifying that HCFA interprets 42 C.F.R. § 433.68(d)(iv) to include health care related taxes on the occupied beds of a facility or the patient days of a facility. HCFA has concluded that, to the extent the rate of a health care related tax is the same for each occupied bed or patient day and the tax is applied to all providers in the permissible class of services, a health care related tax program based on occupied beds or patient days will be considered uniformly applied. Previously, HCFA had interpreted the Act to require that the tax be applied to all beds or all days to be considered uniform.

Second, where States have sought and obtained waivers for existing health care related tax programs, HCFA is clarifying that a uniform change in the rate of tax will not require a new waiver. To the extent a State makes no other revisions to an existing health care-related tax program (e.g., modifications to provider or revenue exclusions), HCFA would not view a uniform change in the tax rate as a new health care related tax program.

Third, section 1903(w)(7)(A)(ix) of the Act states that the Secretary may establish, by regulation, classes of health care items and services, other than those listed by statute. The implementing regulation, at 42 C.F.R. § 433.56 specifies 10 additional permissible classes of items and services. In addition, the preamble to the implementing regulation indicates that the Secretary will consider adding additional classes if States can demonstrate the need for additional designations and that any proposed class meets the following criteria: 1) the revenue of the class is not pre-dominantly from Medicaid and Medicare (not more than 50 percent from Medicaid and not more than 80 percent from Medicaid, Medicare, and other Federal programs combined); 2) the class is clearly identifiable, for example, by designation through State licensing programs, recognition for Federal statutory purposes, or inclusion as a provider in State plans; and 3) the class is nationally recognized rather than unique to a State. This is a reminder and an invitation to States that they may identify additional classes.

Fourth, section 1903(w)(7)(F) of the Act defines the term "tax" to include any licensing fee, assessment, or other mandatory payment. Therefore, any licensing fee applied to the items or services listed by statute and/or regulation must comply with the

Page 3 - State Medicaid Director

law. Furthermore, section 42 C.F.R. 433.56(a)(19) requires that for health care items or services not listed by regulation on which the State has enacted a licensing fee or certification fee, the fee must be broad based, uniform, not contain a hold harmless provision, and the aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program. Section 42 C.F.R. 433.68(c)(3) states that waivers from the uniform and broad based requirements will automatically be granted in cases of variations in licensing and certification fees for providers if the amount of such fee is not more than \$1,000 annually per provider and the total amount raised by the State from the fees is used in the administration of the licensing or certification program. This is a reminder to States that any licensing or certification fee imposed on providers of health care items or services is considered a health care related tax.

Furthermore, section 1903(d)(6)(A) of the Act requires that States include in their quarterly expenditure reports, information related to provider-related donations and health care-related taxes. This is a reminder to report all provider-related donation revenue and health care-related tax revenue on the HCFA-form 64.11A

The Administration remains committed to ending the use of impermissible taxes. Failure to end their use undermines the integrity of the Medicaid program and would be unfair to those States that are in compliance as well as to the taxpayers who pay for the program.

HCFA will continue to apply the current provider tax laws. As a part of this process, HCFA will have discussions with States individually to understand their existing provider taxes and, where necessary, to develop better compliance plans that recognize the challenges that States may face.

The Administration's goal is to end the use of impermissible taxes as soon as possible. To achieve rapid and full State compliance, it is willing to work with States to resolve impermissible tax liabilities. The Administration believes that this will be facilitated by legislation that codifies the tests to determine that a tax is permissible and concentrates in the Department greater authority to work with States to resolve current tax liabilities in return for States coming into full compliance. In the development of this legislation, the Administration will work with States, the National Governors' Association, and Congress to address the concerns States have raised with respect to current law. If, however, legislation is not enacted by August 1998, the Secretary will move forward to complete the process already begun to apply with full force the current law.

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If you have any questions concerning these policy clarifications,
please contact your regional office.

Sincerely,

Sally K. Richardson
Director
Center for Medicaid and State
Operations

cc: All Regional Administrators

All HCFA Associate Regional Administrators
Division of Medicaid and State Operations

Lee Partridge
American Public Welfare Association

Joy Wilson
National Conference of State Legislatures

Jennifer Baxendell
National Governors' Association

TOTAL P.05

Tennessee \$3.7 billion total 97; 2.4 billion
\$3.1 billion; 2.1 billion
\$3.3 billion; 2.2 billion federal
\$2.7 billion; 1.8 federal
\$2.6 billion total; 1.8 billion federal

current offenders Tennessee and Louisiana

- STATES IN VIOLATION OF THE BROAD BASED AND UNIFORM REQUIREMENTS

Alabama, Connecticut, Florida, Hawaii, Massachusetts, New Hampshire, Nevada, Tennessee, and Utah

current offenders Alabama, Connecticut, Florida, Massachusetts, New Hampshire

FINALF~1

	Alabama	Connecticut	Florida	Hawaii	Illinois	Louisiana	Maine
TOTAL COMPUTABLE							
1992	1,540,751,580	2,291,403,170	4,220,592,322	359,755,115	4,410,769,568	3,385,003,054	751,389,665
1993	2,073,620,737	2,657,831,942	5,952,966,970				
1994	1,816,998,698	2,882,998,699	6,641,167,952				
1995	1,983,455,807	2,568,029,742	6,207,240,363				
1996	2,080,804,300	2,666,598,607	5,971,407,087				
1997	2,241,428,774	2,778,466,722	6,481,733,518				
FEDERAL SHARE							
1992	1,119,027,057	1,151,570,289	2,311,690,418	190,557,252	2,223,352,241	2,534,190,069	467,875,073
1993	1,445,960,749	1,333,854,797	3,320,941,160				
1994	1,579,580,509	1,430,682,612	3,701,918,090				
1995	1,394,059,169	1,290,553,556	3,491,021,609				
1996	1,449,687,397	1,339,566,414	3,329,548,887				
1997	1,555,179,318	1,391,631,785	3,615,568,320				

Massachusetts	Missouri	New Hampshire	Nevada	Tennessee	Utah
4,141,202,993	2,364,207,776	1,117,942,060	377,631,682	2,405,460,984	444,970,979
4,739,573,231		703,105,147	404,405,669		505,732,800
5,186,111,156		783,553,169	519,189,526		698,761,297
5,221,488,271		855,229,022	472,309,350		590,159,353
4,756,645,142		707,400,672	492,521,162		646,954,075
5,065,875,292		765,692,598	500,844,617		663,013,526
2,080,217,055	1,440,118,971	561,004,824	190,615,744	1,641,435,510	330,847,262
2,387,948,801		353,867,442	217,204,595		375,762,150
2,614,016,681		395,819,747	263,435,084		492,072,424
2,548,305,412		382,679,692	238,628,277		427,232,163
2,391,315,782		354,954,434	249,525,004		466,201,255
2,547,304,603		385,138,324	253,551,581		471,894,464

MEDICAID EXPENDITURES							
TOTAL MEDICAID EXPENDITURES 1992 - 1997		\$166 billion					
TOTAL TAX LIABILITY 1992-1997		\$4.6 billion					
TAX LIABILITY AS A PERCENTAGE OF EXPENDITURES		2.70%					
STATES IN VIOLATION OF BROAD BASED AND UNIFORM REQUIREMENT							
STATE MEDICAID EXPENDITURES							
	AL	CT	FL	HI	MA	NH	NV
1992	1,540,751,580	2,291,403,170	4,220,592,322	359,755,115	4,141,202,993	1,117,942,060	377,631,682
1993	2,073,620,737	2,657,831,942	5,952,966,970	386,000,000	4,739,573,231	703,105,147	404,405,669
1994	1,816,998,698	2,882,998,699	6,641,167,952	457,000,000	5,186,111,156	783,553,169	519,189,526
1995	1,983,455,807	2,568,029,742	6,207,240,363	724,000,000	5,221,488,271	855,229,022	472,309,350
1996	2,080,804,300	2,666,598,607	5,971,407,087	628,000,000	4,756,645,142	707,400,672	492,521,162
1997	2,241,428,774	2,778,466,722	6,481,733,518	580,000,000	5,065,875,292	765,692,598	500,844,617
TOTAL 1992-97	11,737,059,896	15,845,328,882	35,475,108,212	3,134,755,115	29,110,896,085	4,932,922,668	2,766,902,006
TOTAL LIABILITY 1992-9	20,266,720	545,647,653	541,975,688	10,072,653	846,872,109	115,021,289	27,605,684
	0.17%	3.44%	1.53%	0.32%	2.91%	2.33%	1.00%
1992-1997 EXPENDITURES FOR ALL 9 STATES				124,358,025,878			
1992-1997 TAX LIABILITY FOR ALL 9 STATES				2,500,000,000			
TAX LIABILITY AS A PERCENTAGE OF EXPENDITURES				2.01%			
1992-1997 EXPENDITURES FOR 5 STATES OUT OF COMPLIANCE				97,101,315,743			
1992-1997 TAX LIABILITY FOR 5 STATES OUT OF COMPLIANCE				2,069,783,459			
TAX LIABILITY AS A PERCENTAGE OF EXPENDITURES				2.13%			

PROVIDER TAXES AND DONATIONS

Total Medicaid expenditures, including DSH, services, and administration for FY 1997: \$166 billion

Federal share for FY 1997: \$94 billion

Since 1992

FY 96 153 billion fed share 87 billion

fy 95 \$152 billion fed share 85 billion

fy 94 \$138 billion fed share 79 billion

FY 93 \$126 billion fed share 73 billion

- STATES IN VIOLATION OF THE HOLD HARMLESS

Tennessee, Louisiana, Illinois, Missouri, Maine, and Hawaii

Illinois \$7 billion for 97; \$4 billion

96 \$6 billion and \$3 billion

95 \$6 billion total \$3 billion federal

94 \$5.1 billion total \$2.6 billion

93 \$4.9 billion total \$2.4 billion federal

Hawaii \$580 million for 97; federal 291 million

\$628 million; \$314 million federal share

\$724 million; 323 million

\$457 million total; 229 million federal

\$386 million and \$194 million federal

Louisiana \$3.1 billion total 97; 2.5 billion federal

\$3 billion; 2.5 billion 96

\$4.1 billion; \$3 billion

\$4.2 billion total 3.1 billion federal

\$3.9 billion total; 2.9 billion federal

Maine \$1.1 billion total 97; federal 694 million

\$970 million; 615 million federal

\$921 million; \$583 federal

\$910 million; \$563 federal

\$828 million; \$510 federal

Missouri \$3.2 billion total 97; 1.9 billion

\$2.9 billion total; 1.8 billion fed share

\$2.7 billion; 1.6 billion federal

\$2.5 billion total; \$1.5 billion federal

\$2.3 billion total; 1.4 billion federal

Total exp
total liability
@ liability

• Cost of the intervention

• # total # states

broken out among
categories of states
==

1. GAO studies over
last 3 or 4

1. what happens if we
don't do this

(QTEM suits legal
vulnerability to
not enforcing

aware of anyone
that's suggested this
as

get reading from
lead on VP's
position on
these options

lay out in 1991
how bad this
was —

magnitude of
what we've done

status that
we not seriously
out of compliance

will resent that
others are
allowed to
continue scam
be reflected
in Court
in his fiction
but is good
apples

CBD scoring

because of past
history & lack
of enforcement,
our own actuaries
are not scoring.
Although recap.
doesn't help
baseline,
not doesn't hurt
it.

had we enforced,
govt would have
more \$ &

credibility as
law-enforcement
agency would
be in question
last years so
how enforcement
fair approval.

Sylvia	David	Kevin
Dan	Sally	Rich
Fred	Kathy	NAMD
Elena	Jane	Harriet

2 states w/ hold harmless schemes
granny tax cycled thru nursing homes

together ① letter to all 6 < 4 not gov 1st
NY & IN resolved 2 we're coming

4 even though they've stopped; disallowances

Elena: go after? David explains audit

NAMD process takes years, b/c of state
appeals.

② pending waiver requests AL, DC, HI,
IL, IN, KY, LA, MN, MS, MT, OH,
SC, TN, VT, WI

want waiver of uniform/broadbased
requirement.

if we approved all waivers & no offset
of costs b/c we're already in
baseline? Dan: no.
no PAYGO offset

if we came to agreement w them
it would already be in baseline?
+ that already one \$ →

pass legislation; that will cost
how much? HHS has no estimate
CBO doesn't have magnitude
HCFA scored as 0.

HCFA: no disallowance, then no cost

waivers are all prospective → licensing fees
even if we get to endpoint
can't get retroactive waiver

magnitude -

6 states largest % of \$s
don't know waiver State magnitude

what's the consequence of doing nothing?
Kevin says not an option; we have
to enforce law; what is press?

QTEM lawsuits?

4107865647 David
David Cade owes us paper

12/91 effective
1/92
regs amended
in 1/93

- ① 6 States
30-45 days
auditors immediately to 2
4 RO auditors coming soon

CAVEAT: When we see legal analysis, States
may drop out

2 States (timeline) go back to 92 for
effective date; you get disallowed
for tax on a gross basis, not net
take 2 months

write back w/ audit findings & say
we are taking a disallowance

source that's bad; not the use

HCFA 64

(200) LA } 500 million
(300) TN }

90 IL
over 13 MD
8 ME
12 HI } ~~400 million~~

time frame
will be roughly
the same

these 6 all are hold harmless
(state has taxes \$ & returned to
provider)

exclude from taxable income amt
of tax you paid

\$100,000

10% 10,000

taxed on a lesser

unsure if there's more: we haven't
gone out actively to review States

80-90 from now 40-50 after
letters out from 4 States

waivers; bad waivers 15 States
broad based & uniformity

regression analysis test;

this rule applies to licensing fees
all states have this problem;
not a lot of \$, but it adds up.

reg mandatory payments; give
presumption if licensing fee
is below a certain

unclear as to whether they are
going to actively go after States

small amt of \$ but adds up.

won't collect until 2 years down,
or more

rule is taxes $\neq$ DONATIONS

rules put pretty tight reins on it
b/c of DSH; providers are interested
in CHIP

how ~~do~~ do we rule out
who is provider related?

working w/in HHS to clarify foundations
to make it work.

PROVIDER TAXES AND DONATIONS

^{allow it to continue to}
The Department of Health and Human Services is planning to begin a systematic audit of States that it believes to be out of compliance with current statute governing appropriate provider taxes and donations. The tax liability associated with these States is estimated to be over \$4 billion.

The issue of provider taxes and donations received public attention in August 1997, when the President used his line item veto authority to cancel the BBA provision that would have ~~permitted~~ ^{singled out} New York to levy impermissible taxes. The provider tax issue remains highly controversial and complex, and its resolution has implications for the Medicaid program, 1115 waivers, and the new CHIP program. ^{higher} ^{endowment} ^{Reduced state subsidies, the issue}

BACKGROUND

Provider Taxes and Donations in Medicaid

^{stat} ^{reflecting} ^{impact} ^{on} ^{subsidy}
In 1991, Congress enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments Act to curb the tremendous growth in the Medicaid Disproportionate Share Hospital Program (DSH). The growth resulted from States' use of DSH payments and related financing mechanisms such as provider taxes and donations to effectively lower the state share of Medicaid spending. The 1991 provider tax law allowed provider taxes and donations only if:

- The taxes do not *hold taxpayers harmless* for all or a portion of the tax. This provision prevents States from using "recycling" schemes to leverage more Federal Medicaid funds.
- The taxes are *broad-based* in that the tax is imposed on at least all health care items or services in the class and the taxes are *uniformly* imposed if the fee, percent, or per bed tax does not vary across a given class of providers. These provisions prevent the incidence of the tax from falling disproportionately on Medicaid providers.

^{Talk about} ^{last year} ^{legislation}
In spite of the 1991 legislation, ~~HHS believes~~ ^{current to} a number of states still rely on these impermissible taxes to finance a portion of their Medicaid programs. The Administration has never officially audited these states or taken a disallowance penalty. ^{notified} ^{states} ^{for} ⁹⁷ ^{the}

^{As a consequence, how to believe we will}
Proposed Enforcement Strategy ^{ever enforce...}

Although HHS is still pursuing legislation that provides the Secretary with authority to forgive past tax liability in return for States' prospective compliance with the 1991 law, it has developed a strategy to enforce the current law retroactive to the date of enactment. ^{How many} ^{stay open (may be} ^{out of compliance) it}
~~This means that HHS~~
will be auditing and potentially penalizing States which have ~~recently begun to comply with the~~ ^{of advised / approved} 1991 law, as well as those States which are still out of compliance.

^(or more until ready)
^{Justice/HMO advised}
^{as that we must}
^{enforce or will be vulnerable}
^{to question state & lose credibility}

Ensuring Compliance with the Hold Harmless Provision

Targeting States Currently Out of Compliance. By early to mid March, HHS ~~will~~ send auditors to Tennessee and Louisiana to examine their provider tax provisions. These States are suspected of operating "granny grant" schemes, which cycle impermissible taxes through nursing homes. HHS estimates that together, these States have collected approximately \$500 million in impermissible taxes since 1992.

Targeting States That Have Recently Come Into Compliance. In early to mid March, HHS ~~will~~ send letters to the States of Illinois, Missouri, Maine, and Hawaii, informing them of the Department's intention to send auditors in the near future to examine their provider tax provisions. Although these States are currently in compliance, they previously operated recycling schemes which violated the hold harmless provision of the statute. HHS estimates that together, these States have collected over a billion dollars in impermissible taxes since 1992.

Ensuring Compliance with the Broad-Based and Uniform Provision

Targeting States with Impermissible Hospital Taxes. In mid to late May, HHS will inform the States of Alabama, Connecticut, Florida, Hawaii, Massachusetts, New Hampshire, Nevada, Tennessee, and Utah, that their requests for a waiver of the statutory requirement that provider taxes be broad-based and uniform are denied. Although Hawaii and Nevada have terminated their impermissible tax programs, the majority of these States have been collecting impermissible taxes while waiting for Federal approval of their waivers. HHS estimates that together, these States have collected approximately \$2.5 billion in impermissible taxes since 1992. HHS plans to begin auditing these States in ____.

Targeting States With Impermissible Licensing Fees. Although there are 9 States that have acknowledged that they may be in violation of the requirement that provider taxes be broad-based and uniform, HHS believes that almost every State in the nation has licensing fee schedules that violate this requirement. They currently have no timeframe under which to audit these States and bring them into compliance, and no estimate of the amount that these States have collected in impermissible licensing fees.

It is important to note that the current statute requires that the entire amount of the tax or donation be disallowed, regardless of how the funds were spent. This means that even if a State only spent a fraction of the funds from the impermissible tax on its Medicaid program, the Administration would recoup the entire amount that the State collected.

Although HHS expects to be able to complete their audits and formally notify States about the amount of money HCFA is disallowing by midsummer, the actual recoupment process is expected to take years, as States have the option to keep the funds in question during the Departmental appeals process.

is preparing for

why these
7 laws?
must clearly
out of
compliance?
largest
ambush
potentially
used!

why punish
good states
before
bad guys

POLICY OPTIONS

OPTION ONE: Proceed along the enforcement time frame suggested by HHS.

Pros:

- Provides HHS with the necessary authority to enforce the statute as planned.
- Protects HHS from the criticism that they are unable to effectively administer the Medicaid program.
- Places the level of pressure on States that is necessary to pass legislation providing HHS with the authority to strike acceptable tax liability settlements with States.

Cons:

- Assures multiple and frequent confrontations with States over outstanding provider tax liabilities.
- Highlights the fact that the Administration has failed to enforce the statute for 8 years and exposes us to the charge that States had little reason to believe that they were out of compliance.
- If fully enforced, some States may be placed in financial jeopardy which may undermine the level or scope of services offered to Medicaid beneficiaries.
- The moment HHS notifies States that they are subject to a disallowance, CBO assumes the savings from the recoupment on our baseline. These savings will then have to be offset in any legislation that provides more flexibility in settlements to States.

OPTION TWO: Initiate intensive advocacy for legislation that provides the Secretary with more authority to negotiate with States who have outstanding bad taxes.

Legislation would provide HHS with the flexibility to expedite closure on these outstanding tax liabilities. This could be a strategy that is independent of or part of option one. If independent, it would slow our enforcement of the statute.

Pros:

- Helps shift some of the blame for the Administration's timid enforcement record onto Capitol Hill by calling on Congress to pass legislation.
- Avoids an immediate confrontation with States who have outstanding tax liability.

Cons:

- Any legislation will almost inevitably stagnate in Congress if pursued independent of outside enforcement pressure from HHS.
- Advocating for legislation will open us up to individual States being "fixed" in a piecemeal fashion, similar to the relief that New York received in the BBA.

OPTION THREE: Requesting that HHS delay enforcement of the statute.

Recognizing the difficulties of enforcement and the likelihood of limited success, one option would be to hold back on dedicating resources to this activity and in effect, accepting that we will not recoup these outstanding liabilities. Such an action would be consistent with how the actuaries have already projected our activities in this area, as they are scoring no baseline recoupment savings in their current projections.

Pros:

- Avoids a major confrontation with the States at a time when we are also dealing with the issue of tobacco recoupment.
- Avoids a long shot battle to obtain necessary authority to sign off on settlements with States, which will inevitably require the expenditure of a good deal of political capital.

Cons:

- This undermines our present and future credibility when enforcing State violations of the Medicaid statute and sends a poor signal to our career staff charged with enforcement.
- Exposes us to Q-TEM suits. (7)

Strong opposition to HHS & Justice

Date: _____

FAX



Health Division



Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To:

Devorah

Fax:

From:

Cyndhia S.

Number of Pages (excluding cover):

6555 7

Subject:

Voice Numbers:

Health Division (Front Office)	202/395-4922
Health & Human Services Unit	202/395-4925
Health Programs & Services Branch	202/395-4926
Health Financing Branch	202/395-4930

Fax Numbers:

Health Division (Front Office)	202/395-3910
Health Division (Room 7001)	202/395-7840
Health Division (Room 7002)	202/395-5648

10/09/97 THU 14:28 FAX 202 456 5581

DOMESTIC POLICY COL

005

FACT SHEET ON MEDICAID HEALTH CARE-RELATED TAXES
October 9, 1997

Medicaid, enacted in 1965, is a Federally-guaranteed health insurance program for certain low-income individuals, primarily pregnant women, children, the elderly and the disabled. It is a state/Federal partnership where the Federal government sets broad eligibility standards and pays states a portion of their Medicaid costs. States must commit funds in order to receive Federal financial participation (FFP). The source of certain State funds has been contentious, as described below.

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, 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 realized a net gain because it had to repay only 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 by nearly so much.

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 permits States to use revenue from health care-related taxes to claim Federal Medicaid matching payments only to the extent that these taxes are 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 devised to repay dollar-for-dollar the provider who was initially assessed). The law also precluded States from using 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 way that States repaid their provider taxes or donations.

The final regulation for this law was published in 1993 after extensive consultation with the States and the National Governors' Association. The regulation defined which taxes are permissible, HCFA's methodology for determining permissibility of taxes, and a process for requesting waiver approval for tax programs that are either not broad based and/or uniform.

10/09/97 THU 14:29 FAX 202 456 5581

DOMESTIC POLICY COL

0006

Since the regulation, HCFA has communicated with States — through letters, a national conference, and State contacts at the regional level — about the 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 HCFA interpretations are still questioned by some States. This has led to a review by HCFA of its interpretations of these policies.

POLICY CLARIFICATIONS

Today, the results of HCFA's review of its interpretation of the provider tax law and regulations is being described in a State Medicaid Directors' letter and a *Federal Register* notice. HCFA has determined that several changes in its implementation of the Medicaid provider tax provisions are appropriate, as described in today's letter to State Medicaid Directors (dated October 9, 1997). First, HCFA will clarify its interpretation of taxes that are considered uniform. It will permit taxes on occupied beds or patient days to be considered uniform (previously, only taxes on all beds and all days were considered uniform). Second, the letter states that States do not need to submit a new waiver request for a tax subject to an existing waiver if there is a uniform change in the tax rate. The letter also reminds States that they may suggest additional classes of providers to qualify as "broad based" and that they should submit quarterly reports on their provider taxes and donations. These clarifications have resulted in the determination that certain taxes in 10 States are permissible and require no further review.

In addition, HCFA will publish in the October 10, 1997 *Federal Register* a correcting amendment to the provider tax regulation regarding its interpretation of the uniformity test. It corrects the threshold for allowable tax programs based on regional variations, enacted and in effect prior to November 24, 1992. The correction is to conform the regulation to HCFA and Congress's intent to recognize such taxes as generally redistributive.

PLANS FOR ENDING THE USE OF IMPERMISSIBLE TAXES

In its effort to apply the law and end the use of impermissible provider taxes, HCFA will open discussions with the States individually to understand better their specific provider taxes and their issues resulting from the current law.

The Administration's goal is to end the use of impermissible taxes as soon as possible. To this achieve rapid and full compliance, it is willing to work with States to resolve impermissible tax liabilities. The Administration believes that this will be facilitated by legislation that codifies the tests to determine that a tax is permissible and concentrates in the Department greater authority to work with States to resolve impermissible tax liabilities in return for States coming into full compliance. In the development of this legislation, the Administration will work with States, the National Governors' Association, and Congress to address the concerns States have raised with respect to current law. If, however, legislation is not enacted by August 1998, the Secretary will move forward to complete the process already begun to apply with full force the current law.

It is our hope that States will be responsive and cooperative so we can resolve these issues in a mutually satisfactory way.

IMPACT OF A DISALLOWANCESTATES 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 ESTIMATED TAX SPENDING FY1998 (in thousands)	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



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

Mr. Thomas D. Collins, Director
Department of Health and Hospitals
1201 Capitol Access Road
Baton Rouge, Louisiana 70802

Dear Mr. Collins:

In 1991, responding to rapid increases in Federal Medicaid outlays, Congress enacted legislation penalizing States that impose certain kinds of taxes on health care items, services or providers, termed "impermissible taxes." Since then, the Department of Health and Human Services (HHS) has worked with States and provided technical assistance to enable States to avoid penalties. Despite these efforts, HHS believes that the State of Louisiana may still be collecting an impermissible tax and unfairly increasing Federal matching funds.

In order to protect the Federal investment in the Medicaid program, HHS must ensure that States run their programs in compliance with Medicaid law. 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 providers for payment by the Secretary of a Federal share of the costs that States incur operating approved plans. Both partners must pay their fair share of funds into the program. Impermissible taxes, however, may operate to shift some of a State's responsibility for a State Medicaid program to the Federal government.

A representative from HHS will contact you within the next 15 days to discuss a tax imposed on nursing facilities in the State of Louisiana. As expressed in previous communications with your office, HHS believes that the tax imposed on the occupied bed days of nursing facilities, in conjunction with the grant paid by the State to private pay patients of such facilities, is impermissible under the Federal Medicaid statute. Through the combined arrangement of the tax program and the grant program, the State of Louisiana has caused Federal taxpayers in other States to shoulder more than their fair share for Medicaid spending in Louisiana.

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Background On 1991 Law

Medicaid is a cooperative Federal-State program under which States are responsible for expenditures to provide medical services to eligible individuals. The Federal government then pays the State a share of those expenditures (known as Federal matching funds). In the late 1980s and the early 1990s, Federal Medicaid spending more than doubled without a similar rise in enrollment. Because of the drain on the Federal Treasury caused by this increase, 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 to use taxes levied on health care services, items or providers as payment for medical assistance expenditures that qualify for Federal matching funds. Under that law, State taxes must:

- Be Broad-Based - - A tax must apply to all providers of a particular type of health care service. For example, a tax must apply to all hospitals, not just psychiatric hospitals;
- Be Uniform - - All providers of a particular service must be taxed at the same rate; and
- Avoid "hold harmless" Arrangements -- The taxes collected must not be returned to the taxpayers directly or indirectly.

The prohibition on "hold harmless" taxes is the most relevant for this letter. By levying special taxes on certain health care providers and passing the dollars through state treasuries, states can increase 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 claim 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. The "hold harmless" arrangements are impermissible under the 1991 Medicaid tax law.

HHS's Work With States

Since the passage of the 1991 law, HHS has worked with States and provided technical assistance concerning the Medicaid rules about health care-related taxes. A final regulation implementing this law was published in 1993. The regulation contained the

Page 3 - Mr. Thomas D. Collins, Director

criteria to determine whether a tax was permissible, HHS's interpretation of those criteria, and the process for States to request waiver approval of tax programs that are not broad based and/or uniform. It is important to note, however, that the law does not allow "hold harmless" provisions to be waived.

HHS followed up on the regulation by continuing to communicate with States regarding provider tax policies through letters, a national conference, and meeting with State officials. In 1994, HHS formally communicated its concerns regarding the occupied bed day nursing facility tax to the State of Louisiana. After reviewing information provided by the State of Louisiana, HHS again notified the State of Louisiana in 1995 of our belief that the occupied bed day nursing facility tax was impermissible.

Given the complexity of health care financing, some States questioned the HHS policy and regulations. These questions led to a thorough review by HHS of our policies. As a result of this review, HHS also issued a State Medicaid Directors letter in 1997. In that letter, HHS announced certain policy clarifications and reminded States of their obligation to operate their Medicaid programs in accordance with the law. 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 programs.

In October 1997, the Clinton Administration announced it would seek legislation giving States new incentives to end the use of impermissible taxes. At that time, HHS surveyed State Medicaid agencies to further identify and end these taxes. HHS also encouraged States to provide suggestions for legislation that would help resolve this matter. In April 1998, the Administration submitted proposed legislation, asking 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. Although HHS continues to support the legislative proposal and believes that provisions contained within it form the basis for a timely and fair resolution to this issue, we must proceed with enforcing the provisions of the 1991 amendments using the procedures available under current law.

Louisiana's Status

The State of Louisiana currently imposes a per bed, per day tax on each occupied bed of nursing facilities. HHS believes the structure of this tax includes a provision for a grant program that was established to offset the cost of the nursing facility tax. Based on the information HHS has received to date, it is our belief that the grant program

Page 4 - Mr. Thomas D. Collins, Director

associated with this nursing facility tax program violates the "hold harmless" provisions contained in section 1903(w)(4)(A) and (C) of the Social Security Act (the Act).

Section 1903(w)(4)(A) of the Act specifies that a "hold harmless" provision exists when the State or other unit of local government imposing the tax provides (directly or indirectly) for a payment (other than under Title XIX) to taxpayers, and the amount of such payment is positively correlated to either the amount of such tax, or to the difference between the amount of the tax and the amount of the payment under the State plan.

Section 1903(w)(4)(C) of the Act specifies that a "hold harmless" provision exists when the State or other unit of local government imposing the tax provides (directly or indirectly) for any payment, offset or waiver that guarantees to hold taxpayers harmless for any portion of the cost of the tax.

In the case of the Louisiana nursing facility occupied bed day tax, HHS believes that the information provided to date demonstrates that the State has combined a tax program and a grant program to ensure that the Federal government shoulders more than its share of the aggregate costs of the State's Medicaid program. This tax is imposed on nursing facilities, which then pass along the cost of the tax by increasing the rates to private pay patients. The State subsequently returns a portion of the revenue raised from the tax using grants that go only to private pay (non-Medicaid) patients and uses the remainder as the State's share of Medicaid payments/increases. The end result is that taxpayers in other States ultimately pay more than their share of Louisiana's Medicaid expenditures and the putative taxpayer, in this case the nursing facility, is held harmless for the cost of the tax.

only 4 States
Conclusion

which ended impermissible taxes -
Based on the information HHS has received, it is our understanding that Louisiana has failed to discontinue either the tax or the associated grant program, or to modify the tax program to conform with the law. As a result of our information, HHS believes, ~~however~~, that Louisiana is operating an impermissible tax under Federal law and regulation. If this is confirmed, HHS will conduct an audit of the State's finances in order to determine the amount of Federal matching funds associated with the tax that were paid in error.

To help us confirm the possible permissibility of the tax in question and how much money was raised with this tax, HHS will contact you within 15 days to begin gathering

Page 5 - Mr. Thomas D. Collins, Director

necessary information. If it is found that the provider tax is impermissible under the 1991 Medicaid law, an audit of the State's financial records will be conducted and the State will be asked to repay the Federal matching funds that were paid as a result of the impermissible tax.

Under the HHS disallowance procedures, recoupment of Federal Medicaid dollars is generally accomplished by withholding a portion of future Medicaid payments to the State owing the repayment. States can appeal a request for repayment to the Departmental Appeals Board and then to a Federal district court. Should recoupment become necessary, HHS will provide information regarding the details involved in the disallowance process.

This letter is not intended to reflect any determination on any other health care-related tax program(s) in your State. HHS will address other health care tax programs, if necessary, in subsequent communications.

Our goal is to work together with you, keeping in mind your State's concerns and our obligations under the law, to ensure that all States are treated fairly in the distribution of Federal matching funds that help provide health care to millions of Americans with low incomes. I firmly believe that only a joint effort can bring a smooth resolution to this matter.

Sincerely,

Sally K. Richardson
Director
Center for Medicaid and State Operations

DRAFT PROVIDER TAX ROLL OUT

Necessary Paper

- Master Talk Points for Briefings (Internal) CMSO/Baltimore w/ HCFA/IGA and Press Office
- Talk Points for Calls to Congress, Governor's Staff (Internal) HCFA/IGA w/ Press Office and CMSO/Baltimore
- Press Qs and As (Internal) HCFA Press Office
- Comprehensive Qs and As (Internal) CMSO/Baltimore
- Letters to States (Public) CMSO/Baltimore
- Press Fact Sheet (Public) HCFA Press Office
- Internal Fact Sheet (Internal) CMSO/Baltimore

Three/Four Weeks Out

- Place Master Talk Points, both sets of Qs and As, both sets of letters (initial six States and waiver letters) to the States, and both Fact Sheets (Internal and Press) are put into materials into clearance.

Two/Three Weeks Out

- Receive clearance back any final comments on Master Talk Points, both sets Qs and As, the six letters to states, and both Fact Sheets.
- Using cleared Master Talk Points, HCFA/IGA to begin drafting talk points for Congress, Governor's offices, and RDs.
- Using cleared Master Talk Points, CMSO/Baltimore to begin drafting HCFA/RO talk points.
- Talking points for Congress, the governors offices and regions are submitted to HCFA Press Office for clearance by noon (in coordination with OASPA).
- Briefing for the Deputy Secretary and/or Secretary (if needed).

- Talk points for Congressional, Governor's staff, and ROs cleared by COB. Finalize all paper for internal and external use; Re-clear paper as needed.

Five Days Before Roll-out

- Invite HCFA RAs to RA/RD briefing. (*HCFA/IGA and OS/IGA*)
- Put letters to waiver States into clearance.

Four Days Before Roll-out

- Brief RDs and HCFA RAs. (*HCFA/IGA and OS/IGA*)
- Begin work on roll-out materials for the second waive of letters, the waiver States. The rollout for the waiver States is planned for the second week after rollout of initial six States.

Three Days Before Roll-out

- Early Afternoon: Invite Hill staff (committees and appropriate state delegations) and State Groups (NGA, NASMD, NCSL) to briefings in the afternoon on the day of roll-out. (*ASL, HCFA/OL, OS/IGA and HCFA/IGA*).

Day Of Roll-out

8:00am Early Morning:

- Final roll out paper circulated to appropriate IGA, ASL, HCFA/OL, and HCFA staff. (*HCFA/IGA*)

9:00am Calls to Medicaid Directors staff begin

- Sally Richardson with HCFA/IGA calls Medicaid Directors (individually) in the six States.

10:00am Simultaneously and prior to briefings:

- ROs call and fax letters to States.
- Calls and faxes to Delegation staff from appropriate States. *(HCFA/OL)*
- Calls and faxes to Committee Staff. *(ASL)*
- Calls from senior member of the Department to key Members of Congress: Porter, Gephardt, Breaux. *(ASL)*
- Calls and faxes to Chief of Staffs and Governors D.C. Health Reps of the six States. *(OS/IGA and HCFA/IGA)*
- Calls and faxes to NGA, NASMD, and NCSL notifying them of the specific States. *(OS/IGA and HCFA/IGA)*
- RDs to make appropriate calls within each State as designated.
- Release letters and Press Fact Sheet to Press in Washington (National, 6 States) and to capital press in States.

Early Afternoon Back-to-back briefings--Scheduling dependent on Thursday Afternoon Calls:

- NGA, NCSL, and State Medicaid Directors staff at NGA offices
- Authorizing Committee Staff *(ASL, HCFA/OL, CMSO and OS/IGA)*
- House and Senate Delegation Staff *(ASL, HCFA/OL, CMSO)*

Afternoon Press Briefings

- Conference call/briefing with relevant reporters. *(HCFA Press Office w/ CMSO)*

Day After Rollout

- Conduct Comprehensive Briefing with ARAs on the audit strategy.
- *If necessary:* Conduct briefing with remaining state health reps. and NGA staff, NCSL, and Medicaid Directors Association Washington staff at Hall of the States. *(OS/IGA, HCFA/IGA, CMSO)*

Briefing Team

Andy Hyman
Sally Richardson
Rich Tarplin

David Cade
Jane Horvath
Jim Frizzera

Don Johnson
Lloyd Bishop
Peter Harbage

Utah - shows the steps, updating the time line.

HCFA's Review Plan for Impermissible Taxes and Donations

Steps	Time line Phase A	Time line Phase B
February-March of 1999 Step #1 Review in-house info on impermissible taxes Tasks: [Central Office] - Review HCFA-64.11 reports to identify estimated impermissible tax revenue for each state. - Review federal statutes, regulations, and HCFA policy regarding hold harmless taxes and pending waiver requests with HHS/HCFA tax team and the Office of the General Counsel (OGC).	Day 1 - Day 45	N/A Completed during Phase A
March-May of 1999 Step #2A Notify states with impermissible taxes Tasks: [Central Office] - Develop specific review plans for each state. - Send letters to states notifying them of our determination that they have an impermissible tax and that they will be audited by their Regional Office regarding audit action.¹	Day 46 Day 51	N/A N/A
Step #2B Take Action on Pending Waiver Requests Tasks: [Central Office] - Develop specific review plans for each State. - Send letters to States notifying them of our determination that they have an impermissible tax and giving States 30 days to provide additional information. Also inform States that if after 30 days HCFA has not received a response, audit action will begin.² - Review incoming information from States		Day 51 Day 81 Day 111

¹Roll-out to the Hill and State organizations necessary prior to release of letters to States.

²Roll-out to the Hill and State organizations necessary prior to release of letters to States.

April-June of 1999 Step #3 - Conduct Audits <i>Tasks: [Regional Offices]</i> - Discuss tax programs with state officials. - Review state records. - Ascertain time periods when taxes were in effect. - Determine impact of impermissible taxes on FFP for FYs in question.	Day 66 Day 81	Day 136 Day 141
May-August of 1999 Step #4 Prepare & issue draft audit reports <i>Tasks: [Regional Offices]</i> - Write letter that explains findings, shows FFP effect and requests return of improperly paid FFP. - Obtain OGC and CO concurrence with report and recommendations. - Issue report (letter) to state with 30-day response period.	Day 96 Day 126 Day 131	Day 156 Day 186 Day 191
Beginning June 1, 1999 - Decision Point on Status of Current FFP Claims HCFA must decide if current claims for the quarter ending June 30, 1999 will be deferred. If claims are deferred and disallowed, states will not have the option of retaining funds during the appeal process. Will cause an immediate adverse fiscal impact.		
August-December of 1999 Step #5 Prepare & issue final audit report <i>Tasks: [Regional Offices]</i> - Review state comments and make appropriate revisions to report. - Obtain OGC and CO concurrence with final report. - Issue report to state and request return of improperly claimed FFP. - Set deadline for return of FFP (normally 30 days). - If FFP is not returned, proceed with disallowance process.	Day 186 Day 216 Day 221 Day 251	Day 246 Day 276 Day 281 Day 311
October-December of 1999 <i>Tasks: [Regional Offices]</i> Step #6 Disallowance Process - Prepare draft disallowance letter. - Obtain OGC and CO clearance. - Issue disallowance letter to state.³ - If no appeal, recover FFP through grant award process.	Day 256	Day 316

³This is an appealable action, the State is usually given at least 30 days to respond to our disallowance letter.

November of 1999-January of 2000.....

Step #7 Appeal Process

Tasks:

- If state appeals to DAB, state may retain funds during appeal but is at risk for interest from the date of disallowance if appeal is unsuccessful.

Day 287

Day 347

DRAFT

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-

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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.

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

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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 if 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.

Master Talking Points - Provider Taxes

- Good morning/afternoon, I am calling to discuss the Department of Health and Human Services' (HHS) plan of action with respect to the use of impermissible health care related taxes and donations, to fund the Medicaid program.
- HHS's goal is to end the use of impermissible taxes as soon as possible.
- To achieve rapid and full State compliance, HHS announced its willingness to work with states to resolve impermissible tax and donation liabilities through new legislation.
- At the same time, we also announced that if our bill was not enacted during the 105th Congress, we would have no choice but to proceed on this matter within the constraints of current law.
- We transmitted our bill, The Provider Tax and Donation Amendments of 1998, to Congress for their consideration last year (April 2, 1998).
- It is unfortunate that more progress was not made in moving the bill forward during the legislative session of the last Congress.
- At this point, we must proceed to the next step in the process of ending the use of impermissible taxes using the tools available under current law.
- Today, HHS will notify six (6) States in writing about a particular provider tax program that HCFA believes is impermissible in each State (Hawaii, Illinois, Louisiana, Maine, Missouri, Tennessee).
- Two (2) States that continue to operate a tax program that HHS believes is impermissible will be informed of the immediate need to audit the revenues collected from those sources (Louisiana and Tennessee). These states will be contacted within 15 days by regional office staff.
- This notice will serve as the initial step taken by HHS in reducing future Medicaid grant awards in order to recoup improperly paid Federal financial participation.
- The four (4) remaining States will be informed that a future audit will be scheduled to determine revenues derived from an impermissible tax program imposed for some period of time subsequent to the States' statutory transition deadline. These

states will be contacted within 45 days by regional office staff.

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- Although these letters are “pre-disallowance” letters, their purpose is to communicate HHS’s position with respect to these States’ provider taxes.
- Beginning October 1999, HHS will send auditors to the two (2) States with impermissible provider tax programs that are still in effect. This audit process will take approximately 3 months.
- In October 1999, HHS will also begin scheduling audits for the remaining four (4) States that imposed impermissible provider tax programs.
- By December 1999, HHS will begin the “formal” disallowance process in State where this is required. Some or all of the six (6) States will be sent formal disallowance notices for the impermissible provider tax programs. States will have 30 days from receipt of the disallowance letter to appeal.
- Within the next 60 days, HHS will be making final determinations on the permissibility of tax programs in States which have submitted waiver applications. Pending the outcome of those determinations, HHS will proceed with enforcement actions where appropriate.