

*Health Care -  
Medicaid  
Provider Tax*

October 9, 1997

**TO: DISTRIBUTION**  
**FROM: Chris Jennings and Jeanne Lambrew**  
**RE: MEDICAID PROVIDER TAX MATERIAL: EMBARGOED UNTIL 4PM**

Attached are the Department of Health and Human Services' materials for release this afternoon. This includes:

- DHHS Press Release
- Summary (for internal use)
- Fact sheet
- Questions and answers
- Letter being sent to State Medicaid Directors

The public documents will be presented at briefings of the Congressional committees of jurisdiction, the National Governors' Association, a meeting with the New York gubernatorial staff, and the New York delegation beginning at 4pm.

Given the sensitive nature of the material, these are close hold until 4pm.

Please call with questions.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Press Office  
Washington, DC 20201

**STATEMENT BY SALLY RICHARDSON  
DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS  
HEALTH CARE FINANCING ADMINISTRATION**

Thursday, October 9, 1997

*HCFA Center for Medicaid and State Operations Director Sally Richardson issued the following statement regarding today's policy clarification on state provider taxes used to obtain federal matching funds for Medicaid.*

We have a responsibility to make sure that state taxes collected from health care providers and then used to generate federal matching funds for Medicaid are levied in a way that is fair and equitable among all states. Permitting some states to use improper provider taxes to obtain federal funds threatens Medicaid's fiscal integrity and is unfair to states that play by the rules.

We are today clarifying policy on taxes collected from health care providers based on patient days or occupied beds. This action makes clear that certain taxes are acceptable in 10 states that have asked us for waivers. Because of the complexity of the law there are states that have other taxes that still require review.

Given the outstanding questions, we are today announcing our intention to work with Congress and the states to enact legislation that codifies the tests for whether a state provider tax is permissible. This legislation will also enhance the Secretary's authority to resolve current liabilities for states that come into full compliance with the law. We sincerely hope such legislation will expeditiously end the use of impermissible taxes. However, if such legislation is not passed by next August, HCFA will apply with full force the current policies.

We realize this is a big undertaking, and stand ready and willing to work with Congress and the states in this effort.

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## SUMMARY: MEDICAID PROVIDER TAXES

- **What is being released.** Today, the Department of Health and Human Services (DHHS) has sent a letter to State Medicaid Directors. This letter clarifies how DHHS will implement the law and regulations on states' use of health care-related taxes for their share of Medicaid. There will also be a notice in the Federal Register containing a correcting amendment to the regulation to make it consistent with Congressional intent.

The State Medicaid Director letter also includes an announcement of our support for legislation that (a) codifies current regulations that contain the tests to determine that a tax is permissible; and (b) would concentrate authority in the Department to resolve impermissible tax liabilities if a state comes into full compliance by ending the use of impermissible taxes. This legislative approach may more expeditiously end the use of impermissible taxes. If, however, by August 1998 no legislation is passed, the Secretary will move forward to complete the process already begun to apply with full force the current law.

- **Why action is needed?** States' use of impermissible provider taxes poses a major threat to Medicaid's fiscal integrity. During the late 1980s, health care provider tax programs were used to increase Federal Medicaid funding without using additional state resources. These schemes contributed to the doubling of Federal Medicaid spending between 1988 and 1992.

Today, a number of states continue to use potentially impermissible provider taxes. To maintain the integrity of the Medicaid program, we must be certain that the Federal Treasury is not impermissibly being tapped to underwrite costs that are the responsibilities of the states. To not do so would be unfair to those states (and their taxpayers) which are in compliance.

- **Why now?** This review, which has been on-going at DHHS for many months, has drawn increased attention recently due to the line-item veto of a Medicaid provider tax provision in the Balanced Budget Act. Under this provision, all of New York's over 30 provider taxes would be deemed approved. The President vetoed this provision because it was too broad and singled out a single state for special treatment. However, he promised that DHHS would intensify its review of its interpretation of the law for New York and all states. Today's action is a result of this review.
- **Impact on New York.** One of New York's major concerns have been that Medicaid regulations have not grandfathered the State's "regional" tax. Given evidence of Congressional intent for this tax treatment, the Administration will publish a correcting amendment to the regulation in the Oct. 15 *Federal Register*. This action relieves New York of over \$1 billion of provider tax liability.

No final resolution on New York's other provider taxes has been reached. However, HCFA will be contacting New York and other states to gather further information on taxes.

- **Impact on other states.** 10 States will benefit from the clarification that the Department is providing today. States will be contacted with requests for additional information. It is our hope that all states and their representatives will work toward legislation that protects the Federal Treasury as well as treats States fairly as we move to ensure that all states are in compliance with the law (D.C., Alabama, Louisiana, Ohio, Mississippi, Montana, New York, South Carolina, Utah, Wisconsin).

## 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.

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 are 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 15, 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 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.

HEALTH CARE RELATED TAX QUESTIONS & ANSWERS

GENERAL QUESTIONS ABOUT PROCESS

**1.Q. What is HCFA's rationale for a change in some of its policies regarding these taxes?**

A. Since the original publication of 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.

**2.Q. HCFA could tomorrow begin enforcing the provider tax laws. Aren't you avoiding the hard decisions that you could make under current law by introducing legislation?**

A. Quite the opposite: we think that legislation could make enforcing the provider tax laws more efficient and timely. Given the complexity of the provider taxes and questions that states have about HCFA's interpretation, it could take years of costly audits, appeals and possible law suits to resolve each state's case. Legislation offers the opportunity to clarify the ways that a tax may be identified as permissible and concentrates the Department's authority to work with states to resolve their current liabilities if the states comes into full compliance as soon as possible.

**3.Q. Isn't HCFA just issuing these policy clarifications to provide cover for President Clinton's retreating on his use of the line-item veto of a special fix for New York's improper provider taxes in the Balanced Budget Act?**

A. No. HCFA has been reviewing provider tax policies for some time. The policy review described today was in the pipeline prior to the President's action but has received increased attention as a result of the line item veto. The item canceled by President Clinton would have given preferential treatment to New York by allowing that state to continue relying on potentially impermissible taxes to fund its share of the Medicaid program.

## FOR INTERNAL USE

**4.Q. Does HCFA's policy change resolve most of state provider taxes problems or are some still open to dispute?**

A. The policy changes affect some but not all of state provider tax concerns. After review of our interpretation of the law, we have clarified our interpretations of three types of taxes. First, we have determined that one of the types of taxes we questioned — those imposed on providers based on patient days or the occupied beds — are indeed uniform. In addition, we have determined that States do not need to submit a new waiver request for a tax under its existing waiver if there is a uniform change in the rate. Thirdly, HCFA has published in the *Federal Register* a correcting amendment to the uniformity test in the regulation lowering the threshold for allowable tax programs based on regional variations, enacted and in effect prior to November 24, 1992.

These policy clarifications and corrections will apply to all States, and we think that certain taxes in at least 10 States will immediately be considered permissible and require no further review (Alabama, District of Columbia, Louisiana, Ohio, Mississippi, Montana, New York, South Carolina, Utah, Wisconsin).

However, many issues remain unresolved. HCFA will attempt to resolve these issues through discussions with States and will support legislation to assist in these efforts. The Administration will support 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, it 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.

**5.Q. Many states have had waiver applications at HCFA for several years. Why has this action take so long?**

A. Reviewing the state waiver requests has taken longer than we would have liked. The evaluation of each waiver request is a lengthy and complicated process that often requires HCFA to seek additional information from states and for states to resubmit calculations that may have been done in error. Resolving some of these tax issues could involve lengthy litigation. That is why the Administration will support a legislative codification of what qualifies as a permissible tax.

## FOR INTERNAL USE

**6.Q. Are some states getting a better deal than others? Can you say unequivocally that this policy is being applied fairly among all the states?**

A. Yes, we can say that no state is getting "a better deal" than another state. The HCFA policy has a national application and effect. For instance, all state hospital taxes that are based on the number of days that patients are in the hospital (occupied bed/or patient days) or only make a uniform change in the rate of a tax that is otherwise broad-based are now considered to be permissible taxes, to the extent these tax programs do not contain a hold harmless provision.

**7.Q. What is the White House's involvement in this issue?**

A. Medicaid enforcement actions are handled directly by the Department of Health and Human Services, and the Health Care Financing Administration (HCFA) in particular. As we do for all similar types of policy issues, the White House and the Office of Management and Budget have reviewed HCFA's policy interpretations. However, the White House has no direct involvement with compliance actions affecting specific states.

## NEW YORK QUESTIONS

**8.Q. The "correcting amendment" would change the generally redistributive waiver test threshold from 0.85 to 0.7. Is it true that this new number benefits only the State of New York? Is this another attempt by New York to get some sort of special fix? Why is HCFA so determined to give NY special treatment in the first place?**

A. While it is HCFA's understanding that the State of New York is the only State that has a tax program of this nature, the correcting amendment is not an attempt to give the State of New York preferential treatment. HCFA is simply bringing its regulation into compliance with the Congressional intent.

FOR INTERNAL USE

9.Q. **New York's Governor and Congressional Delegation have made it clear that no less than a "hold harmless" outcome (meaning the state owes no money to the Federal government) to the Administration's review of provider taxes would be acceptable. They may feel that HCFA's failure to give them a hold harmless will harm the State's Medicaid program. Don't you care about the hospitals and the poor people that the Medicaid program serves?**

A. First, the President's record of support for the Medicaid program is longstanding and clear. He fought long and hard to ensure that the program would not be block granted and that guarantee of health coverage for millions of Americans would be preserved.

Second, the announcement today makes clear that New York cannot be held liable for over \$1 billion in regional provider taxes that were previously in question. This is -- without question -- the largest provider tax that New York relied on, and today's action relieves the state of major budgetary concerns.

Third, the outstanding provider taxes still in question are just that -- still in question. HCFA will be contacting the State asking for more information if needed on some of its taxes. New York will have the opportunity to provide information to illustrate that their provider taxes are consistent with the law.

But let's be clear: to maintain the integrity of the Medicaid program and the confidence of the taxpayers who support it, we must be certain that the Federal Treasury is not impermissibly being tapped to underwrite costs that are the responsibility of the states. To not do so would damage the integrity of the Medicaid system and would be unfair to those other states (and the taxpayers who support them) which are in compliance

10.Q. **The Mayor's Office, the Governor's Office, the New York Hospital Association, and even Al Sharpton are threatening to sue the Federal Government over this provider tax issue. Do you have any response to these threats?**

A. They certainly have the right to sue, but we would hope that these parties would allow the Governor's office and the Health Care Financing Administration to work through either an administrative or legislative process that meets the Administration's criteria before they pursue a lengthy and potentially expensive legal response.

## FOR INTERNAL USE

**11.Q. What about the issue of the constitutionality of the line item veto and Senator Moynihan's indication that he supports a challenge of the President's veto?**

A. We believe that the President's line item veto power authority, which was authorized in statute by the Congress, would be upheld in any court challenge.

**12.Q. Doesn't your action leave New York \$500 million in hole? The state is claiming that you are still leaving them with a huge liability that will jeopardies their ability to run their Medicaid program.**

A. The amount of the provider tax dollars that may be out of compliance is unclear. It is true that HCFA does have questions about some of New York's provider taxes. The agency will request more information from the state about these taxes, and the state will have the opportunity to provide information to illustrate that their taxes are consistent with the law.

## POLICY QUESTIONS

**13.Q. How will you make sure vulnerable people are not hurt, or kicked off Medicaid rolls if the federal government recoups its overpayments from states?**

A. The Administration's record of protecting Medicaid and the people it serves is well documented. One of the major reasons why the President vetoed the 1995 Republican budget bill was its intent to dramatically reduce its Medicaid funding and eliminate the guarantee of health care to low income and disabled Americans. It would not support policies that disadvantage Medicaid beneficiaries. It is, however, HCFA's responsibility to run this program in a way that is fair and consistent across all states. Such management will increase the public's confidence in the Federal oversight of the Medicaid program.

**FOR INTERNAL USE**

**14.Q. What is impermissible about provider taxes? What does "broad based and uniform" mean?**

A. Impermissible health care related taxes fall into three general categories: taxes imposed on groups not listed in the 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 recognized class or category. Uniform health care related taxes mean a tax which is levied at the same rate for all those in a particular group or class. A "hold harmless" means that the taxes are returned to the taxpayer at the expense of the Federal government.

**15.Q. How much in total does the Federal government expect to recover?**

A. Recovery is not HCFA's primary goal; it is to end the use of impermissible taxes. There is no precise estimate of how much money is at stake since audits must be performed to determine the exact amount of revenue collected from impermissible health care related taxes. However, based on initial estimates through March 1997, HCFA estimates the total amount of impermissible taxes to be between \$2 and \$4 billion.

ALL STATES - GENERAL POLICY LETTER

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 ~~bro~~ad based~~ed~~ and ~~un~~iform~~ed~~ 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 end their use.

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 predominantly 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

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.

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

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Jennings

THE PRESIDENT HAS SEEN  
10-10-97

Health Care -  
Medicaid  
Provider Tax

THE WHITE HOUSE  
WASHINGTON  
October 9, 1997

MEMORANDUM TO THE PRESIDENT

cc: Vice President, Erskine Bowles, Bruce Reed, Gene Sperling  
FROM: Chris Jennings  
RE: NEW YORK AND THE PROVIDER TAX ISSUE

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

BACKGROUND

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

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

**States' continued reliance on impermissible provider taxes and our enforcement record.**

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

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

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

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

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

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

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

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

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

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

## SUMMARY: MEDICAID PROVIDER TAXES

- **What is being released.** Today, the Department of Health and Human Services (DHHS) has sent a letter to State Medicaid Directors. This letter clarifies how DHHS will implement the law and regulations on states' use of health care-related taxes for their share of Medicaid. There will also be a notice in the Federal Register containing a correcting amendment to the regulation to make it consistent with Congressional intent.

The State Medicaid Director letter also includes an announcement of our support for legislation that (a) codifies current regulations that contain the tests to determine that a tax is permissible; and (b) would concentrate authority in the Department to resolve impermissible tax liabilities if a state comes into full compliance by ending the use of impermissible taxes. This legislative approach may more expeditiously end the use of impermissible taxes. If, however, by August 1998 no legislation is passed, the Secretary will move forward to complete the process already begun to apply with full force the current law.

- **Why action is needed?** States' use of impermissible provider taxes poses a major threat to Medicaid's fiscal integrity. During the late 1980s, health care provider tax programs were used to increase Federal Medicaid funding without using additional state resources. These schemes contributed to the doubling of Federal Medicaid spending between 1988 and 1992.

Today, a number of states continue to use potentially impermissible provider taxes. To maintain the integrity of the Medicaid program, we must be certain that the Federal Treasury is not impermissibly being tapped to underwrite costs that are the responsibilities of the states. To not do so would be unfair to those states (and their taxpayers) which are in compliance.

- **Why now?** This review, which has been on-going at DHHS for many months, has drawn increased attention recently due to the line-item veto of a Medicaid provider tax provision in the Balanced Budget Act. Under this provision, all of New York's over 30 provider taxes would be deemed approved. The President vetoed this provision because it was too broad and singled out a single state for special treatment. However, he promised that DHHS would intensify its review of its interpretation of the law for New York and all states. Today's action is a result of this review.
- **Impact on New York.** One of New York's major concerns have been that Medicaid regulations have not grandfathered the State's "regional" tax. Given evidence of Congressional intent for this tax treatment, the Administration will publish a correcting amendment to the regulation in the Oct. 15 *Federal Register*. This action relieves New York of over \$1 billion of provider tax liability.

No final resolution on New York's other provider taxes has been reached. However, HCFA will be contacting New York and other states to gather further information on taxes.

- **Impact on other states.** 10 States will benefit from the clarification that the Department is providing today. States will be contacted with requests for additional information. It is our hope that all states and their representatives will work toward legislation that protects the Federal Treasury as well as treats States fairly as we move to ensure that all states are in compliance with the law (D.C., Alabama, Louisiana, Ohio, Mississippi, Montana, New York, South Carolina, Utah, Wisconsin).

October 3, 1997

**MEMORANDUM TO THE CHIEF OF STAFF**

**cc:** Sylvia Matthews, John Podesta, Bruce Reed, Gene Sperling, Frank Raines, Rahm Emanuel, John Hilley, Mickey Ibarra, Jack Lew, and Josh Gotbaum

**FROM:** Chris Jennings

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

On Monday, we (DPC, OMB and HHS) will brief you on the status of our Medicaid provider tax enforcement plans for New York and other states who may be out of compliance with current law and regulations. As you well know, this issue is extremely controversial. Therefore, it is critically important that we have Administration-wide agreement and understanding on how we will announce our position on outstanding provider taxes and on how we will subsequently negotiate with affected states. This memo provides you with background information to help prepare you for the Monday briefing.

**BACKGROUND**

**Financing scheme.** During the late 1980s, many states established financing schemes that had the effect of increasing their Federal Medicaid funds without using additional state resources. Typically, states would raise funds from health care providers (through provider taxes or "donations"), then pay back those providers through increased Medicaid payments. Since the Federal government pays at least half of Medicaid payments, the provider taxes or donations would be repaid in large part by Federal matching payments. Using this mechanism, the state was left with a net gain because it only had to repay part of the provider tax or donation it originally received. This led to an unprecedented drain on the Federal Treasury — the major reason why Federal Medicaid costs more than doubled between 1988 and 1992.

**The law and regulatory interpretation of the law.** Because provider taxes and donations were effectively siphoning off potentially billions of dollars from the Federal Treasury, the Congress limited states' use of these schemes in a bill enacted by President Bush in 1991. It is important to note that the subsequent regulatory interpretation of these limits -- the very regulations that we are now planning to enforce -- was negotiated with the states and the National Governors' Association in 1993.

**States' continued reliance on impermissible provider taxes and our enforcement record.**

Despite the new law and the regulations, many states continued to use provider taxes that at least appeared to be out of compliance. To date, these possibly impermissible taxes total an estimated \$2 to 4 billion and, in the future, will cost billions more. In response, HCFA issued letters and discussed its concerns about certain taxes with states, but -- for a variety of reasons -- never took any final action (called a "disallowance"). Unfortunately, this has meant that a number of states have continued using these taxes, believing that HCFA might never enforce the law, or that if they did, they could seek recourse through the White House or the Congress. (In fact, since we do not have a good track record on enforcement, budget examiners at CBO and in the Administration have already written off Federal revenue raised through these provider taxes; this is important to know since it means we could waive past "abuses" retrospectively and it might not be scored as a cost.)

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

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

**Review of provider taxes in New York and other states.** In August, we began a review of the options to address provider taxes in New York and other states. At the time, we well knew that this action would force us to finally attempt to move to enforce laws against provider taxes in all 36 states that may be out of compliance. We also knew that we had to take this position to support our justification for the line-item veto that no individual state be singled out for special treatment.

**Wednesday's actions.** We believe that our discussion with New York next Wednesday about their provider tax status necessitates that we concurrently release similar information to every other potentially affected state. Three types of actions resulting from this comprehensive review will be announced. First, HCFA will clarify its interpretation of the law and correct the regulation affecting one of the largest New York provider taxes. These policy clarifications will provide relief to 10 states, the largest amount (over \$1 billion) going to New York.

Second, HCFA will issue letters to 9 other states notifying them that one or several of their taxes may be impermissible. Two more states, New York and Louisiana, will also receive this news, but it will be in a letter that also provides some good news about other provider taxes in their states. HCFA will immediately contact these states to begin discussions. The letters do not contain final decisions nor are they legally binding; however, they tell these states that, without further information, HCFA could conduct an audit.

Third, HCFA will ask another 17 states for more information on one or more of their provider taxes, to assess if they are permissible. (Nine other states who are in one of the top two categories will get similar requests.) For these states, we simply do not have sufficient information to determine the legality of at least some of their taxes. As we discuss this issue with these states, however, we will also make certain they are aware that they may be eligible for waivers that make their taxes permissible and/or that the provision of additional information may well clarify the legality of their taxes. [NOTE: All states affected are listed in the attached document; dollar amounts are not listed because we will not know them until/unless the states are audited.]

**Discussions and negotiations.** The follow up to these letters will be, we hope, immediate discussions between HCFA and the states. Our primary goal is to protect the Federal Treasury prospectively. We may have to trade getting only a fraction of the retrospective disallowed taxes in return for expeditious agreements to prevent future use of impermissible taxes. However, the Department of Justice, which must approve all settlements, has not yet decided how it will evaluate these settlements. This information is crucial to HCFA's ability to negotiate with states in good faith.

**Implications.** Very few of the states who receive notices will be pleased. For example, although HCFA is relieving approximately two-thirds of New York's past impermissible tax claims (worth over \$1 billion), there is still at least \$500 million in taxes that HCFA probably cannot consider legal. The New York delegation has already put us on notice that nothing less than a "hold harmless" solution is acceptable. They define this as meaning that they want us to waive all current taxes both retrospectively and prospectively; in other words, they want the provisions we line-item vetoed.

Those states most displeased will be the 10 others receiving letters that say that we believe that one or more of their provider taxes clearly appear to be out of compliance. They are: Hawaii, Illinois, Indiana, Louisiana, Maine, Massachusetts, Minnesota, Missouri, Nevada, and Tennessee. Governor Carnahan, who met with Jack Lew recently to discuss Medicaid issues, made it clear that he considers his taxes legal and will go to court if necessary. There is no question that Missouri has the largest problem — they could owe nearly \$1 billion.

Another complication is that we anticipate that many of these states will appeal to you or the President to over-ride these preliminary or subsequent decisions. Since this is an enforcement action, we all need to be extremely careful about intervening. We must ensure that you and others who might be talking with Governors are well briefed on the issues, arguments and process.

Finally, some states will inevitably seek legislative solutions, like New York's balanced budget provision. While we probably should not encourage this action (for the same reasons that we vetoed the New York provision), we also should not foreclose the possibility that some type of comprehensive legislative clarification could be helpful as we aim to end the practice of illegitimately using provider taxes.

**Roll-out strategy.** Obviously, our rationale and process for explaining our enforcement actions is crucial. DPC/NEC and OMB are working with HHS and HCFA to ensure that we have an effective roll-out. This will include how we provide information to the Congress, the states, interested providers and unions, experts who will validate our enforcement action and influence elite media coverage, and -- of course -- a carefully orchestrated New York strategy.

We will provide more details of the roll-out on Monday. We thought providing you this information first, however, would facilitate a more efficient discussion of this issue and how we are going to deal with it.

**DRAFT: Provider Tax State Letters, October 8, 1997**

Thirty-six states in total will receive letters. Since most states have multiple health care-related provider taxes, these letters contain multiple findings about one or more of these taxes.

<u>States:</u>		<u>Type of Findings</u>
Only permissible tax	6	] 10 permissible
Permissible tax & more information needed	2	
Permissible tax, impermissible tax & more information needed	2	] 11 impermissible
Only possible impermissible tax	3	
Possible impermissible tax & more information needed	6	
Only more information needed	17	27 more information
<b>TOTAL</b>	<b>36 states</b>	<b>48 types of findings</b>

**Permissible**

- (1) Policy revision: Change regional tax
- (2) Policy revision: No longer need waiver for uniformity test (occupied beds / patient days).
- (3) Policy revision: No longer need waiver for uniformity test (uniform change in tax rate).

**Impermissible**

- (4) Tax program appears to not be **broad based** (impermissible class of providers).
- (5) Tax program appears to not be **uniform** (fails generally redistributive waiver test).
- (6) Tax program appears to fail **hold harmless rule**.

**More Information Needed**

- (7) Tax program waiver requires more information.
- (8) Licensing / user fees require more information.

State	Permissible	Possibly Impermissible	More Information Needed
Alabama	✓ (2)		✓ (7)
Arkansas			✓ (7, 8)
Connecticut			✓ (7, 8)
District of Columbia	✓ (2)		
Florida			✓ (7, 8)
Georgia			✓ (7, 8)
Hawaii		✓ (6)	✓ (7)
Illinois		✓ (6)	✓ (8)
Indiana		✓ (6)	
Iowa			✓ (8)
Kansas			✓ (8)

State	Permissible	Possibly Impermissible	More Information Needed
Kentucky			✓ (7, 8)
Louisiana	✓ (2)	✓ (6)	✓ (8)
Maine		✓ (6)	
Massachusetts		✓ (5)	
Michigan			✓ (8)
Minnesota		✓ (4)	✓ (7)
Mississippi	✓ (2)		
Missouri		✓ (6)	✓ (8)
Montana	✓ (2)		
Nebraska			✓ (7, 8)
Nevada		✓ (5)	✓ (8)
New Hampshire			✓ (8)
New York	✓ (1,3)	✓ (4, 5)	✓ (7, 8)
Ohio	✓ (3)		
Oklahoma			✓ (7, 8)
Oregon			✓ (7, 8)
Pennsylvania			✓ (8)
Rhode Island			✓ (7, 8)
South Carolina	✓ (2)		
Tennessee		✓ (6)	✓ (7, 8)
Texas			✓ (7, 8)
Utah	✓ (2)		✓ (7)
Vermont			✓ (8)
Washington			✓ (7, 8)
Wisconsin	✓ (2)		
<b>TOTAL: 36 STATES*</b>	<b>10</b>	<b>11</b>	<b>27</b>

\* NOTE: 12 states have more than one type of finding (e.g., both a permissible tax and one that needs more information) so that there are more findings (48) than there are states receiving letters (36).

## Briefing: Medicaid Provider Taxes

October 6, 1997

### 1. Brief historical review

Medicaid growth in the early 1980s; 1991 Congressional / Bush Admin response

The Balanced Budget Act, the line-item veto and enforcement follow-up

### 2. HCFA's review produces three general categories of provider tax (in 22 states):

- A. Permissible taxes: 10 states
- B. Potentially impermissible taxes: 9 states, plus 2 that also have a permissible tax
- C. Additional information requested: 3 states, plus 6 that also have permissible and/or potentially impermissible taxes

### 3. Difficult issues

### 4. Process

Implementation of normal compliance process

Negotiations

Law suits and/or legislative recourse

### 5. Release and roll-out strategy

Congress, States, other interested parties' briefings

Information Package:

- HCFA press release
- 1-page summary
- Fact Sheet
- Questions and answers (internal)
- State summary (internal)
- State Medicaid Directors letter
- *Federal Register* notice
- State-specific letters