

DRAFT
7-15-96

In December 1994, the Health Care Financing Administration (HCFA) notified Tennessee that the Federal government may disallow \$176 million from Federal Medicaid matching payments because the State's tax program violated Federal law. Although the potential disallowance remains a significant issue, no action has yet been taken on processing the disallowance at this time. The implementation of the disallowance and/or negotiations with the State are still under review by HCFA.

calls

by 2 pm

HCFE-type

- 1) 2 states (TN, state has imposed impermissible tax on nhs grant prog violate hold harmless in 1903(w)(4) HCFE determined the fed \$ & is preparing disallowance \$1,768,006,002

1. \$ gnt issue

2) who can't

3) is it a grant from Fed / State govts?

4) who's upset about

5) breakout of issues/groups on what order

6) what have we done

7) does state have ^{sol} post in plc dr

8) have we ~~been~~ ^{taken} position

9) who will get blamed (state/Feds)

cell 786
6643

THE WHITE HOUSE
WASHINGTON

7/11 w/ 7th St
major
hall
status, ambiguous
may not be
toward end of
year til HEFA
finalized course
of action

under review
- CS signif. ^{ISS} - likely will have
to address - but
CS still under

impl this dis
and/or neg w/ state

Tennessee Nursing Home Tax

Background:

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 established certain limitations on Federal financial participation under Medicaid when States receive funds from providers. The law establishes a definition of the types of health care related tax revenues that States are permitted to receive. In general, these taxes must be broad-based, apply to all health providers in a given class in a uniform manner, and not hold providers harmless from their tax costs.

Tennessee's Tax

Tennessee has a nursing home tax that is applied at a rate of \$2,600 for each licensed bed. This tax is applied to all nursing facilities, including facilities owned and operated by the State. The State indicated that there are no exclusions, deductions, or adjustments applied to the tax of any licensed facility different from any other such facility.

Simultaneous with the nursing home tax, the State enacted a grant assistance program for financial support for eligible individuals residing in licensed nursing homes. Individuals eligible for this assistance must not have their nursing home care paid for in whole or in part, by Federal, State, or combined Federal/State medical program.

HCFA Actions

HCFA believes the grant assistance program represents a direct repayment of the tax to non-Medicaid taxpayers. Consequently, the grant assistance program would violate the hold harmless provision of the 1991 Provider Tax legislation (Regulation -- 42 CFR 433.68 (f)(1)).

The last correspondence HCFA had with the State was a December 19, 1994 letter in which HCFA informed the State that its tax program violated the hold harmless provisions. Tennessee was one of seven States notified at that time. The disallowance is estimated to be approximately \$176 million.

No action has been taken on processing the disallowance at this time.

Potential Impacts

used in the administration of the licensing or certification program.

(d) *Uniformly imposed health care-related taxes.* A health care-related tax will be considered to be imposed uniformly even if it excludes Medicaid or Medicare payments (in whole or in part), or both; or, in the case of a health care-related tax based on revenues or receipts with respect to a class of items or services (or providers of items or services), if it excludes either Medicaid or Medicare revenues with respect to a class of items or services, or both. The exclusion of Medicaid revenues must be applied uniformly to all providers being taxed.

(1) A health care-related tax will be considered to be imposed uniformly if it meets any one of the following criteria:

(i) If the tax is a licensing fee or similar tax imposed on a class of health care services (or providers of those health care items or services), the tax is the same amount for every provider furnishing those items or services within the class.

(ii) If the tax is a licensing fee or similar tax imposed on a class of health care items or services (or providers of those items or services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of those items or services in the class.

(iii) If the tax is imposed on provider revenue or receipts with respect to a class of items or services (or providers of those health care items or services), the tax is imposed at a uniform rate for all services (or providers of those items or services) in the class on all the gross revenues or receipts, or on net operating revenues relating to the provision of all items or services in the State, unit, or jurisdiction. Net operating revenue means gross charges of facilities less any deducted amounts for bad debts, charity care, and payer discounts.

(iv) The tax is imposed on items or services on a basis other than those specified in paragraphs (d)(1) (i) through (iii) of this section, e.g., an admission tax, 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.

(2) A tax imposed with respect to a class of health care items or services will not be considered to be imposed uniformly if it meets either one of the following two criteria:

(i) The tax provides for credits, exclusions, or deductions which have as its purpose, or results in, the return to providers of all, or a portion, of the tax paid, and it results, directly or indirectly, in a tax program in which—

(A) The net impact of the tax and payments is not generally redistributive, as specified in paragraph (e) of this section; and

(B) The amount of the tax is directly correlated to payments under the Medicaid program.

(ii) The tax holds taxpayers harmless for the cost of the tax, as described in paragraph (f) of this section.

(3) If a tax does not meet the criteria specified in paragraphs (d)(1)(i) through (iv) of this section, but the State establishes that the tax is imposed uniformly in accordance with the procedures for a waiver specified in § 433.72, the tax will be treated as a uniform tax.

(e) *Generally redistributive.* A tax will be considered to be generally redistributive if it meets the requirements of this paragraph. If the State desires waiver of only the broad-based tax requirement, it must demonstrate compliance with paragraph (e)(1) of this section. If the State desires waiver of the uniform tax requirement, whether or not the tax is broad-based, it must demonstrate compliance with paragraph (e)(2) of this section.

(1) *Waiver of broad-based requirement only.* This test is applied on a per class basis to a tax that is imposed on all revenues but excludes certain providers. For example, a tax that is imposed on all revenues (including Medicare and Medicaid) but excludes teaching hospitals would have to meet this test. This test cannot be used when a State excludes any or all Medicaid revenue from its tax in addition to the exclusion of providers, since the test compares the proportion of Medicaid revenue being taxed under the proposed tax with the proportion of Medicaid reve-

nue being taxed under a broad-based tax.

(i) A State seeking waiver of the broad-based tax requirement only must demonstrate that its proposed tax plan meets the requirement that its plan is generally redistributive by:

(A) Calculating the proportion of the tax revenue applicable to Medicaid if the tax were broad based and applied to all providers or activities within the class (called P1);

(B) Calculating the proportion of the tax revenue applicable to Medicaid under the tax program for which the State seeks a waiver (called P2); and

(C) Calculating the value of P1/P2:

(i) If the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 1, HCFA will automatically approve the waiver request.

(ii) If a tax is enacted and in effect prior to August 13, 1993, and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.90, HCFA will review the waiver request. Such a waiver will be approved only if the following two criteria are met:

(A) The value of P1/P2 is at least 0.90; and

(B) The tax excludes or provides credits or deductions only to one or more of the following providers of items and services within the class to be taxed:

(1) Providers that furnish no services within the class in the State;

(2) Providers that do not charge for services within the class;

(3) Rural hospitals (defined as any hospital located outside of an urban area as defined in §412.62(f)(1)(ii) of this chapter);

(4) Sole community hospitals as defined in §412.92(a) of this chapter;

(5) Physicians practicing primarily in medically underserved areas as defined in section 1302(7) of the Public Health Service Act;

(6) Financially distressed hospitals if:

(i) A financially distressed hospital is defined by the State law;

(ii) The State law specifies reasonable standards for determining financially distressed hospitals, and these standards are applied uniformly to all hospitals in the State; and

(iii) No more than 10 percent of nonpublic hospitals in the State are exempt from the tax;

(7) Psychiatric hospitals; or

(8) Hospitals owned and operated by HMOs.

(iv) If a tax is enacted and in effect after August 13, 1993, and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.95, HCFA will review the waiver request. Such a waiver request will be approved only if the following two criteria are met:

(A) The value of P1/P2 is at least 0.95; and

(B) The tax complies with the provisions of §433.68(e)(1)(iii)(B).

(2) *Waiver of uniform tax requirement.* This test is applied on a per class basis to all taxes that are not uniform. This includes those taxes that are neither broad based (as specified in §433.68(c)) nor uniform (as specified in §433.68(d)).

(1) A State seeking waiver of the uniform tax requirement (whether or not the tax is broad based) must demonstrate that its proposed tax plan meets the requirement that its plan is generally redistributive by:

(A) Calculating, using ordinary least squares, the slope (designated as (B) (that is, the value of the x coefficient) of two linear regressions, in which the dependent variable is each provider's percentage share of the total tax paid by all taxpayers during a 12-month period, and the independent variable is the taxpayer's "Medicaid Statistic". The term "Medicaid Statistic" means the number of the provider's taxable units applicable to the Medicaid program during a 12-month period. If, for example, the State imposed a tax based on provider charges, the amount of a provider's Medicaid charges paid during a 12-month period would be its "Medicaid Statistic". If the tax were based on provider inpatient days, the number of the provider's Medicaid days during a 12-month period would be its "Medicaid Statistic". For the purpose of this test, it is not relevant that a tax program exempts Medicaid from the tax.

(B) Calculating the slope (designated as B1) of the linear regression, as described in paragraph (e)(2)(i) of this

section, for the S it were broad base

(C) Calculating as B2) of the line described in paragraph section, for the S proposed.

(ii) If the State Secretary's satisfaction of B1/B2 is at least 0.95, HCFA will review the waiver request. Such a waiver request will be approved only if the following two criteria are met:

(A) The value of

and

(B) The tax excludes its or deductions of the following providers of items and services within the class to be taxed:

(1) Providers that furnish no services within the class in the State;

(2) Providers that do not charge for services within the class;

(3) Rural hospitals (defined as any hospital located outside of an urban area as defined in §412.62(f)(1)(ii) of this chapter);

(4) Sole community hospitals as defined in §412.92(a) of this chapter;

(5) Physicians practicing primarily in medically underserved areas as defined in section 1302(7) of the Public Health Service Act;

(6) Financially distressed hospitals if:

(i) A financially distressed hospital is defined by the State law;

(ii) The State law specifies reasonable standards for determining financially distressed hospitals, and these standards are applied uniformly to all hospitals in the State; and

(iii) No more than 10 percent of nonpublic hospitals in the State are exempt from the tax;

(7) Psychiatric hospitals; or

(8) Hospitals owned and operated by HMOs.

(iv) If a tax is enacted and in effect after August 13, 1993, and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.95, HCFA will review the waiver request. Such a waiver request will be approved only if the following two criteria are met:

(A) The value of P1/P2 is at least 0.95; and

(B) The tax complies with the provisions of §433.68(e)(1)(iii)(B).

(2) *Waiver of uniform tax requirement.* This test is applied on a per class basis to all taxes that are not uniform. This includes those taxes that are neither broad based (as specified in §433.68(c)) nor uniform (as specified in §433.68(d)).

(1) A State seeking waiver of the uniform tax requirement (whether or not the tax is broad based) must demonstrate that its proposed tax plan meets the requirement that its plan is generally redistributive by:

(A) Calculating, using ordinary least squares, the slope (designated as (B) (that is, the value of the x coefficient) of two linear regressions, in which the dependent variable is each provider's percentage share of the total tax paid by all taxpayers during a 12-month period, and the independent variable is the taxpayer's "Medicaid Statistic". The term "Medicaid Statistic" means the number of the provider's taxable units applicable to the Medicaid program during a 12-month period. If, for example, the State imposed a tax based on provider charges, the amount of a provider's Medicaid charges paid during a 12-month period would be its "Medicaid Statistic". If the tax were based on provider inpatient days, the number of the provider's Medicaid days during a 12-month period would be its "Medicaid Statistic". For the purpose of this test, it is not relevant that a tax program exempts Medicaid from the tax.

(B) Calculating the slope (designated as B1) of the linear regression, as described in paragraph (e)(2)(i) of this

section, for the State's tax program, if it were broad based and uniform.

(C) Calculating the slope (designated as B2) of the linear regression, as described in paragraph (e)(2)(1) of this section, for the State's tax program, as proposed.

(i) If the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least 1, HCFA will automatically approve the waiver request.

(ii) If the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least 0.95, HCFA will review the waiver request. Such a waiver will be approved only if the following two criteria are met:

(A) The value of B1/B2 is at least 0.95; and

(B) The tax excludes or provides credits or deductions only to one or more of the following providers of items and services within the class to be taxed:

(1) Providers that furnish no services within the class in the State;

(2) Providers that do not charge for services within the class;

(3) Rural hospitals (defined as any hospital located outside of an urban area as defined in § 412.62(f)(1)(ii) of this chapter;

(4) Sole community hospitals as defined in § 412.92(a) of this chapter;

(5) Physicians practicing primarily in medically underserved areas as defined in section 1302(7) of the Public Health Service Act;

(6) Financially distressed hospitals if:

(i) A financially distressed hospital is defined by the State law;

(ii) The State law specifies reasonable standards for determining financially distressed hospitals, and these standards are applied uniformly to all hospitals in the State; and

(iii) No more than 10 percent of nonpublic hospitals in the State are exempt from the tax;

(7) Psychiatric hospitals; or

(8) Providers or payers with tax rates that vary based exclusively on regions, but only if the regional variations are coterminous with preexisting political (and not special purpose) boundaries. Taxes within each regional boundary must meet the broad-based and uniformity requirements as specified in paragraphs (c) and (d) of this section.

(iv) A B1/B2 value of 0.85 will be applied to taxes that vary based exclusively on regional variations, and enacted and in effect prior to November 24, 1992, to permit such variations.

(f) *Hold harmless.* A taxpayer will be considered to be held harmless under a tax program if any of the following conditions applies:

(1) The State (or other unit of government) imposing the tax provides directly or indirectly for a non-Medicaid payment to those providers or others paying the tax and the amount of the payment is positively correlated to either the amount of the tax or to the difference between the Medicaid payment and the total tax cost.

(2) All or any portion of the Medicaid payment to the taxpayer varies based only on the amount of the total tax payment.

(3) 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 all or a portion of the tax.

(i) An indirect guarantee will be determined to exist under a two prong "guarantee" test. This specific hold harmless test is effective September 13, 1993. In this instance, if the health care-related tax or taxes on each health care class are applied at a rate that produces revenues less than or equal to 6 percent of the revenues received by the taxpayer, the tax or taxes are permissible under this test. When the tax or taxes are applied at a rate that produces revenues in excess of 6 percent of the revenue received by the taxpayer, HCFA will consider a hold harmless provision to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments. The second prong of the hold harmless test is applied in the aggregate to all health care taxes applied to each class. If this standard is violated, the amount of tax revenue to be offset from medical assistance expenditures is the total amount of the taxpayers' revenues received by the State.

(ii) If, as of August 13, 1993, a State has enacted a tax in excess of 6 percent that does not meet the requirements in

paragraph (f)(3)(i) of this section, HCFA will not disallow funds received by the State resulting from the tax if the State modifies the tax to comply with this requirement by September 13, 1993. If, by September 13, 1993, the tax is not modified, funds received by States on or after September 13, 1993 will be disallowed.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43181, Aug. 13, 1993]

§433.70 Limitations on level of FFP for revenues from health care-related taxes after the transition period.

(a) *Limitations.* (1) Subsequent to the end of a State's transition period (as defined in §433.58(b)), and extending through September 30, 1995, the maximum amount of health care-related taxes specified in §433.68 that a State may receive during a State fiscal year (or portion thereof), without a reduction in FFP, is limited to—

(i) The greater of 25 percent or the State base percentage as described in §433.60(b); multiplied by

(ii) The State's share of total medical assistance expenditures for the State fiscal year, less all health care-related taxes other than those described in §433.68 that are deducted separately pursuant to paragraph (b) of this section.

(2) Beginning October 1, 1995, there is no limitation on the amount of health care-related taxes that a State may receive without a reduction in FFP, as long as the health care-related taxes meet the requirements specified in §433.68.

(b) *Calculation of FFP.* HCFA will deduct from a State's medical assistance expenditures, before calculating FFP, revenues from health care-related taxes that do not meet the requirements of §433.68 and any health care-related taxes in excess of the limits specified in paragraph (a)(1) of this section.

§433.72 Waiver provisions applicable to health care-related taxes.

(a) *Bases for requesting waiver.* (1) A State may submit to HCFA a request for a waiver if a health care-related tax does not meet any or all of the following:

(i) The tax does not meet the broad based criteria specified in §433.68(c); and/or

(ii) The tax is not imposed uniformly but meets the criteria specified in §433.68(d)(2) or (d)(3).

(2) When a tax that meets the criteria specified in paragraph (a)(1) of this section is imposed on more than one class of health care items or services, a separate waiver must be obtained for each class of health care items and services subject to the tax.

(b) *Waiver conditions.* In order for HCFA to approve a waiver request that would permit a State to receive tax revenue (within specified limitations) without a reduction in FFP, the State must demonstrate, to HCFA's satisfaction, that its tax program meets all of the following requirements:

(1) The net impact of the tax and any payments made to the provider by the State under the Medicaid program is generally redistributive, as described in §433.68(e);

(2) The amount of the tax is not directly correlated to Medicaid payments; and

(3) The tax program does not fall within the hold harmless provisions specified in §433.68(f).

(c) *Effective date.* A waiver will be effective:

(1) The date of enactment of the tax for programs in existence prior to August 13, 1993 or;

(2) For tax programs commencing on or after August 13, 1993, on the first day in the quarter in which the waiver is received by HCFA.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43182, Aug. 13, 1993]

§433.74 Reporting requirements.

(a) Beginning with the first quarter of Federal fiscal year 1993, each State must submit to HCFA quarterly summary information on the source and use of all provider-related donations (including all bona fide and presumed-to-be bona fide donations) received by the State or unit of local government, and health care-related taxes collected. Each State must also provide any additional information requested by the Secretary related to any other donations made by, or any taxes imposed on, health care providers. States' re-

ports must pre rate, and full c donation and ta itures.

(b) Each State primary informa graph (a) of this basis in accorda tablished by HC

(c) Each Sta readily reviewa documentation t description and nation and tax p as well as the sc nations received This informatio able to Federal r

(d) If a State fa reporting requir this section, fur be reduced by HCFA estimates sums raised by t grams as to whic ported properly, State complies w requirements. Defe ances of equival be imposed with r which the State properly. Unless by law, FFP for th be released when with all reporting

Subpart C—Me Processing Retrieval Sys

§433.110 Basis, pu bility.

(a) This subpart lowing sections of t

(1) Section 1903 which provides for penditures for the c or installation of processing and in systems and for the tain systems. Addi tions and HCFA pro menting these regu CFR part 74, 45 CFR and part 11, State and

(2) Section 1903(r) c (i) Requires reductio wise due a State unde



FAX COVER SHEET

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS

Number of Pages: 19

Date: 7-15-96

To:	From:
<i>Sandy Bullock-MX</i>	Don Johnson
Fax: <u>456-5542</u>	Fax: <u>202 690-8168</u>
Phone: <u>456-5586</u>	Phone: <u>202 690-7762</u>

REMARKS:

HEALTH CARE FINANCING ADMINISTRATION
 200 Independence Ave., SW
 Room 341-H, Humphrey Building
 Washington, DC 20201

PROGRAM SUMMARY

MEDICAID VOLUNTARY CONTRIBUTION AND PROVIDER
SPECIFIC TAX AMENDMENTS OF 1991

(PUBLIC LAW 102-234)

MEDICAID BUREAU
HEALTH CARE FINANCING ADMINISTRATION
March 5, 1992

INTRODUCTION

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Public Law 102-234, enacted December 12, 1991) amend provisions of Title XIX of the Social Security Act and establish new limitations on Federal Financial Participation (FFP) when States receive funds donated from providers and revenues generated by certain health care related taxes. The statute also establishes limits on the amount of payment adjustments to disproportionate share hospitals for which FFP is available.

In general, under the new law a reduction in FFP will occur if States receive donations made by, or on behalf of, health care providers. The law also establishes a definition of the types of health care related tax revenues States are permitted to receive, without reduction in FFP. Such taxes are broad-based taxes which apply to all health care providers in a given class in a uniform manner and which do not hold providers harmless for their tax costs. However, the law permits States which have, by specified dates prior to the enactment of this law, received provider donations and taxes which are not permitted by this law to continue to receive them for a limited time, without a reduction in FFP.

The provisions of the new law affecting taxes, donations and DSH payments apply to all 50 States and the District of Columbia, except Arizona, which operates its Medicaid Program under a waiver granted under section 1115 of the Social Security Act.

The law applies to donations from providers and related entities, and to health care related taxes. It does not affect the treatment of donations from other entities not related to providers and the receipt of revenues from generally applicable taxes. However, any revenues received by a State from the donations or taxes described in the Medicaid statute (Title XIX of the Social Security Act) are subject to its provisions, without regard to whether these funds were directly or indirectly received by the Medicaid Agency or some other department of the State or local government.

The new legislation directs HCFA to issue interim final regulations necessary to implement its provisions. These regulations will, of course, supersede this summary.

USE OF PROVIDER RELATED DONATIONS AND HEALTH CARE RELATED TAX REVENUES

GENERAL RULE

Effective January 1, 1992, before calculating the amount of Federal Financial Participation (FFP), certain revenues received by a State will be deducted from the State's expenditures for Medical Assistance. The revenues to be deducted are as follows:

1. Donations made by health care providers and entities related to providers (except for bona fide donations and, subject to a limitation, donations made by providers for the direct costs of outstationed eligibility workers),
2. Impermissible "Health Care Related Taxes", and,
3. Until October 1, 1995, "Permissible Health-Care Related Taxes" that exceed a specified limit.

The term "permissible health care related taxes" means those health care related taxes which are broad-based taxes uniformly applied to a class of health care items, services or providers, and which do not hold the provider harmless for the costs of the tax, or a tax program for which the Secretary has granted a waiver.

The term "impermissible health care related taxes" means a health care related tax that does not meet the requirements of a permissible tax.

This provision applies to revenues received by a State on or after January 1, 1992 (except for certain donations and taxes permitted under a transition period, which are subject to a limit). Revenues received by States prior to this date are not subject to these statutory provisions, even for expenditures funded by these revenues that are not made until after January 1, 1992.

SPECIAL RULES FOR TRANSITION PERIOD

Under certain circumstances, the new law permits States to use, without a reduction in FFP, revenues from provider donations and impermissible tax programs in effect before enactment of the new law, for a limited period of time, which is referred to as a "Transition Period." However, the law requires that, in order to be continued without a reduction in FFP, the tax and donation programs must meet specific requirements.

TRANSITION PERIOD -- For most States, the Transition Period extends until October 1, 1992. For other States, the Transition Period extends until January 1, 1993, or July 1, 1993. The criteria for determining the Transition Period are as follows:

- October 1, 1992 -- For States whose State fiscal years begin January 1 through July 1, and which are not eligible for the July 1, 1993, date.
- January 1, 1993 -- For States whose State fiscal years begin after July 1, and before January 1, and which are not eligible for the July 1, 1993 date.
- July 1, 1993 -- For States:
- a. which are not scheduled to have a regular legislative session in calendar year 1992, or
 - b. which are not scheduled to have a regular legislative session in calendar year 1993, or
 - c. which had enacted a provider-specific tax program on November 4, 1991.

Based on information supplied to HCFA by the National Council of State Legislatures, the Transition Period will expire on October 1, 1992, except for the following States:

Period Expires January 1, 1993:

Alabama
Michigan

Period Expires July 1, 1993:

Arkansas
Kentucky
Nevada
North Dakota
Montana
Oregon
Texas
West Virginia

USE OF DONATIONS DURING THE TRANSITION PERIOD -- After January 1, 1992, States may receive, without a reduction in FFP, revenues received from permissible donations (i.e., bona fide donations or donations for outstationed eligibility workers). In addition, States may receive, without a reduction in FFP, revenues from existing provider donation programs -- even though they do not meet the requirements of being "bona-fide" donations programs or are not for outstationed eligibility workers -- only during the State's transition period, and subject to the following rules:

1. The donation program must have been in effect or described in State plan amendments or related documents submitted to HCFA by September 30, 1991, and
2. The program must be applicable to the State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on September 30, 1991.

In implementing this provision, States must demonstrate through written documentary evidence submitted to HCFA that the above criteria are met. HCFA would consider as acceptable documentation such items as:

1. Reference to the donation program in a State plan amendment or related documents, including a response to a HCFA request for additional information,
2. State budget documents indicating the State's intention to continue to receive donations,
3. Written agreements with the parties donating the funds, or

4. Other written documentation that expresses the State's intention to receive donations during the period.

It is important to note that to be acceptable, the written documentary evidence must have been in existence on September 30, 1991.

The donations that may be received, without a reduction in FFP, by a State in Fiscal year 1992 (subject to the limitation imposed during the transition period) are those that the State can document that it intended to receive during that period. For any portion of State fiscal year 1993 that occurs during the transition period, the State may receive, without a reduction in FFP, the amount of donations that it received in the corresponding period in State fiscal year 1992, (including the five days after the end of that period).

USE OF TAXES IN THE TRANSITION PERIOD -- In general, States may, receive, without a reduction in FFP, during the transition period, revenues from tax programs that were in effect as of November 22, 1991, even though these taxes might not now meet the requirements for permissible health care related taxes. (These taxes are however, subject to the limitation imposed during the transition period.) In order to receive these revenues, without a reduction in FFP, the tax must have been in effect, or the legislation or regulations imposing the tax must have been enacted, or adopted, by November 22, 1991. States may only modify an existing tax program to extend the duration of the tax program, if it was scheduled to expire. Other modifications to State tax laws may be permitted only if the changes do not alter the rate of the tax or the base of the tax (e.g. the providers on which the tax is imposed) and do not otherwise increase the proceeds of the tax.

LIMIT ON AMOUNT OF DONATIONS AND TAXES DURING THE TRANSITION PERIOD

The amount of revenues States may use from provider donations and health care related taxes is subject to limitation. The limit for a State fiscal year is expressed as a percentage of the total non-Federal share of Medicaid Program expenditures in that fiscal year (including the State's Medicaid Program administrative costs), less the amount of provider-related donations (other than bona-fide donations or donations for outstationed eligibility workers), and impermissible taxes. The specific percentage to be applied for a State in any fiscal year is the greater of:

- a. 25 percent, or
- b. The State's "Base Percentage" which is calculated by dividing the amount of all provider donations and health care related taxes (whether or not they are permissible) estimated to be received in State fiscal year 1992, by the total non-Federal share of Medicaid Program expenditures (including administrative costs) in that fiscal year. The statute provides special rules for calculation of the amount of health care related taxes to be included in the numerator of the formula for taxes that were not in effect for the entire fiscal year, but were enacted as of November 22, 1991. In this case, the amount of revenues to be included would be estimated as if they were in effect for the entire fiscal year. The legislation requires HCFA to estimate the State Fiscal year 1992 non-Federal share of Medicaid expenditures based on the best available data in its possession as of December 12, 1991, the date of enactment of the law.

During the transition period, the 25 percent limit (or if higher, the State base percentage) will limit the amount of revenues States may receive from provider donations and health care related taxes. This cap will apply to the sum of revenues received by States from:

1. provider donations, including permissible donations and donations eligible for use during the transition period, and
2. health care related taxes, including permissible taxes and impermissible taxes still eligible for use during the transition period.

Revenues received from these sources in excess of the 25 percent cap (or the State base percentage) will be deducted from Medicaid expenditures before FFP is calculated.

LIMIT ON AMOUNT OF TAXES PRIOR TO OCTOBER 1, 1995

Beginning on the day after the State's transition period has ended, and extending until October 1, 1995, revenues received from permissible taxes in excess of the 25 percent cap (or, if higher, the State base percentage) will be deducted. After October 1, 1995, there are no limitations on the amount of permissible taxes States may receive.

PROVIDER-RELATED DONATIONS

DEFINITION -- A provider-related donation is a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a State or unit of local government by a health care provider, an entity related to a health care provider, or an entity providing goods or services to the State for administration of the State's Medicaid plan.

Definition of Health Care Provider -- For purposes of determining whether a donation was made by a health care provider, the term "health care provider" is defined as the individual or entity that receives any payment for a health care item or service provided to a patient.

Entity Related to a Provider -- An individual or entity (i.e., an organization, corporation, association or partnership formed by or on behalf of a health care provider) would be considered to be related to a provider, if it:

1. is an organization or entity formed by, or on behalf of, health care providers,
2. is an organization or person with an ownership or control interest in the provider, as defined in section 1124(a)(3) of the Social Security Act,
3. is the employee, spouse, parent, child, or sibling of the provider, or of a person with an ownership or control interest in the provider, or
4. has a similar close relationship with the provider.

Permissible Donations -- States are permitted to receive, without a reduction in FFP, donations from persons and entities that are not health care providers, or entities not related to providers. (Donations made during the transition period are, however, subject to the 25 percent cap, or if greater, the State's base percentage). For example, donations made by the Robert Wood Johnson Foundation or other philanthropic institutions are permissible, as long as the donations are not made on behalf of health care providers or related entities. Moreover, States are permitted to use, without a reduction in FFP, provider donations in two circumstances, as follows:

1. Bona fide Donations -- States are permitted to use, without a reduction in FFP, donations from health care providers, persons or entities related to health care providers, or entities providing goods and services to the State for administration of the State's Medical Assistance Plan, when those donations are determined by HCFA to be bona fide. That is, the donation must have no relationship, whether direct or indirect, to Medicaid payments made to the provider or entity, to other providers furnishing the same class of items and services as the provider or entity, or to any related entity. States must receive approval from HCFA to use such donations, and must demonstrate that the requirements of this provision are met. Examples of donations for which approval may be given include those made by physicians or other professionals to a State University alumni fund.

HCFA may, by regulation, define certain classes of provider related donations as bona fide. Until these regulations are published, States will need to obtain explicit authorization from HCFA that specific donations (or kinds of donations) are "bona fide".

Note that the amounts permitted as bona fide donations would be included in the 25 percent cap, or if higher, the State base percentage.

2. Outstationed Eligibility Workers -- States are also permitted to use donations made by a hospital, clinic or similar entity for the direct cost of State or local agency personnel who are stationed at the facility to determine the eligibility of patients for Medicaid or to provide outreach services to eligible (or potentially eligible) Medicaid patients. Included in the term "direct costs" would be the costs of salaries and fringe benefits for the outstationed workers and the costs of pamphlets and materials distributed by the outstationed workers at that site. Other costs, such as State agency overhead costs and the cost of advertising campaigns, as well as the costs of provider employees or space are not allowable for this purpose.

Effective October 1, 1992, the statute provides that donations for outstationed eligibility workers are subject to a limitation. Such donations may not exceed 10 percent of a State's Medicaid administrative costs (Federal and State), exclusive

of the costs of family planning activities. Donations in excess of this limit will be offset from Medical Assistance expenditures prior to calculation of FFP.

Note that the amounts permitted as donations for outstationed eligibility workers would be included in the 25 percent cap, or if higher, the State base percentage.

HEALTH CARE RELATED TAXES

General Provisions -- Revenues from broad-based health care related taxes that are applied uniformly to providers, and which do not hold providers harmless for the costs of the tax, may be received by States without a reduction in FFP. Revenues from other health care related taxes are deducted from Medical Assistance expenditures before FFP is calculated.

Health Care Related Tax -- A health care related tax is any licensing fee, assessment or other mandatory payment which is related to health care items or services, or to the provision of, the authority to provide, or payment for the health care items or services. A tax would be considered to relate to health care items or services if at least 85 percent of the burden of the tax falls on health care providers. A tax would also be considered to be health care related, even if it is not limited to health care items or services, if the treatment of individuals or entities providing or paying for those health care items or services is different than the treatment it provides to others. The term "tax" does not include a criminal or civil fine or penalty, unless the fine or penalty was imposed instead of a tax.

Broad-Based Taxes -- In order for a health care related tax to be considered to be "broad-based", it must:

1. be imposed at least on all items or services in the class furnished by all non-Federal non-public providers in the State, or all non-Federal non-public providers in a class. If imposed by a unit of local government, the tax must extend to all items, services or providers (or to all within a class) in the area over which the unit of government has jurisdiction, and
2. be imposed uniformly.

Classes of Health Care Items, Services and Providers -- The statute defines classes of health care items, services and providers as:

1. Inpatient Hospital
2. Outpatient Hospital
3. Nursing Facilities
4. Intermediate Care Facilities for the Mentally Retarded
5. Physicians
6. Home Health
7. Outpatient Prescription Drugs
8. HMOs and other Prepaid Entities

HCFA may establish other service and provider classes by regulation.

Uniformly-Imposed Taxes -- A tax is considered to be uniformly imposed if it meets any one of the following criteria:

1. If the tax is a licensing fee or similar tax imposed on a class of health care items or services, or providers of those health care items or services, the tax must be the same amount for every provider providing those items or services within the class.
2. If the tax is a licensing fee or similar tax imposed on a class of health care items or services, or providers of those items or services, on the basis of the number of beds in the provider, the amount of the tax must be the same for each bed of each provider in the class.
3. If the tax is imposed on provider revenues or receipts with respect to a class of items or services or providers of those health care items or services, the tax must be imposed at a uniform rate for all items and services, and providers of those items or services in the class on all the gross revenues or receipts, or on net operating revenues.

If a State's tax program does not meet one of these criteria, the State must establish, to the satisfaction of HCFA, that the tax is imposed uniformly.

In the case of physicians' services, a tax that is applied at a flat rate, such as a licensing fee, must apply to all physicians in the class. In the case of a tax based on gross charges or receipts, the tax must apply to all

physicians who generate charges. Physicians in an employment relationship, such as provider-based physicians or physicians employed by an HMO, could be excluded from the class of providers to whom the tax program must be applicable, to the extent that the employment relationship is considered their full-time practice. Any charges generated by these physicians in a part-time practice, for example would be taxable.

Credits, Exclusions or Deductions -- A tax will not be considered to be imposed uniformly, if it meets either one of the following two criteria:

1. A tax is not uniform if it provides for any credits, exclusions or deductions which result in the return to providers of all, or a portion, of the tax paid and, if it results, directly or indirectly, in a tax program
 - a. in which the net impact of the tax and payments is not generally redistributive, and
 - b. in which the amount of the tax is directly correlated to payments under the Medicaid Program.
2. a tax will not be considered to be uniform if it holds providers harmless for the cost of the tax.

A tax will, however, be considered to be uniform, even if it excludes Medicaid or Medicare revenues, or in the case of a licensing fee, excludes Medicaid or Medicare providers.

Waivers -- A State may submit to HCFA a request that a tax program be considered a broad-based tax, even if it:

1. does not apply to all health care items or services in a class, or to all providers of such items or services,
2. provides for credits, exclusions or deductions,
3. does not meet the requirements for a uniformly applied tax, or
4. otherwise does not meet the requirements for a permissible tax.

For example, a State might wish to enact a program which exempts rural hospitals, sole community providers, or other hospitals from a tax program applicable to hospital gross revenues. In order for such a request to be approved, the State must demonstrate that its program meets both of the following requirements:

1. The net impact of the tax and any payments made to the providers by the State under the Medicaid program is generally redistributive in nature.
2. The amount of the tax is not directly correlated to Medicaid payments.

States need not obtain HCFA's approval prior to the enactment of a tax program which incorporates credits, deductions, or exclusions, or which does not meet the requirements for a broad-based, uniform tax. However, a State would be subject to a reduction in FFP if HCFA subsequently determines that the tax program does not meet the statutory requirements.

Hold Harmless Provisions -- In general, tax programs that have the effect of holding providers harmless for the costs of the tax may not qualify as permissible taxes. A tax program incorporates a hold harmless provision if any of the following applies:

1. The State (or other unit of government) imposing the tax provides directly or indirectly for a non-Medicaid payment to those providers or others paying the tax and the amount of the payment is positively correlated to either the amount of the tax or to the difference between the enhanced Medicaid payment and the tax cost.
2. All or any portion of the Medicaid payment to the provider paying the tax varies based only on the amount of the tax payment.
3. The State (or local government) imposing the tax provides, directly or indirectly, for any payment, offset or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

There is no provision in the statute which precludes States from using revenues from permissible health-care related taxes to fund general rate increases under the Medicaid program or to use the need to fund such increases as the basis for State legislation.

LIMITS ON PAYMENTS TO DISPROPORTIONATE SHARE
HOSPITALS (DSH)

INTRODUCTION

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Public Law 102-234) contain provisions which restrict aggregate Medicaid payments to disproportionate share hospitals (DSHs). Prior to enactment of this legislation, no limits on these payments could be imposed by HCFA.

Under P.L. 102-234, limits will be imposed on DSH payments. One limit is applicable to the period from January 1, 1992 through September 30, 1992. A new limit goes into effect on October 1, 1992.

The first DSH limit is, in effect, a moratorium on new DSH plans, until October 1, 1992. The statute specifies that States may not receive FFP for DSH payments unless the payments were made in accordance with a State plan in effect or to plan amendments submitted prior to certain dates and which meet certain other requirements.

The second DSH limit, effective October 1, 1992, establishes both national and State limits on DSH payments. The national limit is established at 12 percent of total Medicaid program expenditures. The State limit is similarly set at 12 percent of a State's Medicaid expenditures. States with DSH payments above the 12 percent limit will not be able to increase aggregate DSH payments. States with DSH payments below the limit will be permitted to increase payments to the extent their Medicaid programs grow and to the extent National DSH payments do not exceed the 12 percent limit. The annual DSH limit for each State is calculated prospectively, before the beginning of the Federal fiscal year.

LIMIT APPLICABLE FROM 1/1/92 - 9/30/92

During this period, Federal Financial Participation is available for DSH payments only if made in accordance with:

- a. A State Plan in effect by September 30, 1991,
- b. A State Plan amendment submitted to HCFA by September 30, 1991,

- c. A State plan amendment submitted to HCFA between October 1, 1991 and November 26, 1991, as well as subsequent modifications of that amendment, only if the modifications either (1) bring the amendment into compliance with the requirements of P.L. 102-234, including modifications which limit the disproportionate share hospitals to which it applies to those with Medicaid or low-income utilization rates at or above the statewide arithmetic mean, and/or (2) change the designations of disproportionate share hospitals to include more hospitals with Medicaid or low-income utilization rates at or above the statewide arithmetic mean. The legislative history of the underlying statutory provision reveals that it was designed for use only in the circumstances described above; or
- d. A payment methodology established and in effect as of September 30, 1991, or in accordance with State law enacted or regulations adopted as of that date.

Since the new provision acts as a limit on FFP, States may not revise plan amendments to increase the payments to DSHs, or to increase the number of facilities qualifying for DSH adjustments, other than as permitted above. States may, however, amend their payment plans as may be necessary to pay DSHs the minimum payment adjustment described in section 1923(c)(1) of the Act, which provides for a payment adjustment based on the Medicare formula. States may revise DSH amendments as may be necessary, subject to the above limitations, to respond to a HCFA request for additional information.

State plan amendments regarding DSH payments which do not meet the above criteria, may not be approved for any period from January 1, 1992 through September 30, 1992. States may however, amend plans during this period to reduce the number of facilities qualifying for DSH payments or to reduce DSH payment adjustments.

LIMIT APPLICABLE 10/1/92

For Federal Fiscal years beginning on or after October 1, 1992, the new statute imposes a new National payment limit on aggregate DSH payments. This cap is implemented by designating, for each State, a specific amount of DSH payments, called the "State DSH Allotment," above which FFP will not be available.

NATIONAL DSH ALLOTMENT OR CAP -- The national cap for DSH payments in any Federal fiscal year is 12 percent of expenditures for Medical Assistance (i.e. not including administrative costs) during that year. Prior to the beginning of each Federal fiscal year (beginning Federal Fiscal Year 1993), HCFA will estimate and publish a projection of the National DSH Payment Limit and each State's DSH allotment for that year.

STATE DSH ALLOTMENT -- Each State's DSH allotment under the national payment limit is calculated using the State's "base allotment," that is, the greater of:

- a. its allowable DSH payments during the Federal fiscal year 1992 (beginning on October 1, 1991), or
- b. \$1 Million.

In calculating the DSH payments during Federal fiscal year 1992, HCFA will derive these amounts from payment plans which meet the requirements for FFP during the period from January 1, 1992 through September 30, 1992. These plans are as follows:

- a. A State Plan in effect by September 30, 1991,
- b. A State Plan amendment submitted to HCFA by September 30, 1991,
- c. A State plan amendment submitted to HCFA between October 1, 1991 and November 26, 1991, as well as subsequent modifications of that amendment, only if the modifications either (1) bring the amendment into compliance with the requirements of P.L. 102-234, including modifications which limit the disproportionate share hospitals to which it applies to those with Medicaid or low-income utilization rates at or above the statewide arithmetic mean, and/or (2) change the designations of disproportionate share hospitals to include more hospitals with Medicaid or low-income utilization rates at or above the statewide arithmetic mean. The legislative history of the underlying statutory provision reveals that it was designed for use only in the circumstances described above; or
- d. A payment methodology established and in effect as of September 30, 1991, or in accordance with State law enacted or regulations adopted as of that date; or

- e. the minimum required to meet the requirements of section 1923(c)(1) of the Social Security Act.

This calculation will have the effect of removing, for purposes of calculating the State base allotment, any payments made under plans effective October 1, 1991 or later, which are not eligible for FFP after January 1, 1992.

HCFA will calculate for each State the percentage of total Medical Assistance payments, (i.e. not to include administrative costs) during Fiscal Year 92 which were DSH payment adjustments. HCFA will classify a State as a "High-DSH" State if, in Fiscal Year 92, its DSH adjustments exceeded 12 percent of Medical Assistance payments. If its DSH payments were 12 percent or less, the State will be considered a "Low-DSH" State.

STATE DSH ALLOTMENT FOR HIGH-DSH STATES

For a State with a base-year allotment in excess of 12 percent of Medical Assistance payments, the dollar amount of DSH payments in any fiscal year may not exceed the dollar amount of payments made in Fiscal Year 92, until the year in which those payments, expressed as a percentage of Medical Assistance payments, equals 12 percent or less.

STATE DSH ALLOTMENT FOR LOW-DSH STATES

For a State with a base year allotment of 12 percent or less, the allotment in any subsequent fiscal year will be calculated by HCFA by increasing the prior year's DSH allotment by:

- a. a growth factor, and
- b. a supplemental amount.

No State's DSH allotment will be less than the minimum payment adjustment necessary to meet the requirements of section 1923(c)(1) of the Social Security Act, which provides for a payment adjustment to DSHs, based on the Medicare formula. No State (other than High-DSH States) can have a DSH allotment in excess of 12 percent of Medical Assistance payments.

GROWTH FACTOR

The growth factor for a State in a year is equal to the product of:

- a. the projected percentage increase in total State Medicaid program service expenditures relative to the corresponding amount in the previous year, and
- b. the prior year DSH allotment.

If there is no growth in State Medicaid expenditures over those in the previous year, there is no growth amount.

SUPPLEMENTAL AMOUNT

The supplemental amount is the State's share of a pool, which represents growth in DSH spending authority which High-DSH States are not permitted to use. The Redistribution Pool is calculated by HCFA by subtracting from the projected national DSH cap (12 percent of projected medical assistance payments) the following:

- a. the base allotments for all High-DSH States,
- b. the previous year's DSH allotments for all Low-DSH States,
- c. the growth amounts for all Low-DSH States, and
- d. any additional amounts necessary for a State to meet the minimum payment requirements of section 1923(c)(1) of the Act.

A low-DSH State's share of the redistribution pool is calculated based on the State's relative share of total Medical Assistance expenditures projected to be made by low-DSH States. In no event will a State receive a supplemental amount that would result in its DSH allotment exceeding 12 percent of projected Medical Assistance payments. Any amounts not allocated to States because of this limitation will be allocated to other low-DSH States in accordance with their share of Medical Assistance payments. The difference between a High-DSH State's actual DSH payments and its base allotment is not reallocated to Low-DSH States.

The individual State DSH limits will be published by HCFA prior to each Federal Fiscal Year.

STUDY OF DSH PAYMENT ADJUSTMENTS

The new law directs the Prospective Payment Assessment Commission to submit a report, not later than January 1, 1994 on the study to be conducted concerning :

- (1) the desirability and feasibility of establishing maximum and minimum Medicaid DSH payments, and
- (2) appropriate criteria for the designation of Medicaid DSHs.

ALTERNATE DSH LIMIT

P.L. 102-234 also provides for a legislative option to establish an alternative DSH limit. As of January 1, 1996, if legislation is enacted to establish such a limit, States will have the option of adhering to this alternative DSH limit instead of the 12 percent DSH limit.

Should such an alternative DSH limit be enacted, any State opting for this new limit on DSH payment adjustments could only designate a hospital as DSH if the hospital meets at least one of the following requirements:

- + the hospital's Medicaid inpatient utilization is at or above the average rate for all hospitals in the State,
- + the hospital's low-income utilization rate is at or above the average rate for all hospitals in the State,
- + the hospital's Medicaid inpatient days are equal to at least 1 percent of the total number of Medicaid inpatient days for all hospitals in the State, or
- + the hospital meets other requirements specified by the Secretary taking into account the special circumstances of children's hospitals, rural hospitals, and sole community hospitals.

REPORTING REQUIREMENTS

The new law specifies that, at the end of the Fiscal Year, each State is required to submit to the Secretary annual information on provider donations received, health care taxes collected, the aggregate amount of DSH payments and the amount of DSH payments to individual facilities. This reporting provision is effective for Federal Fiscal Year 1993.



FAX COVER SHEET

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REMARKS:

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

Experience in TennCare

- **What is TennCare?** In 1994, under a 1115 waiver granted by you, Tennessee converted its Medicaid program to a managed care program for virtually every one of its Medicaid recipients and also opened enrollment to all uninsured people in the state. It subsidized premiums for the uninsured, on a sliding scale basis, all the way up to 400 percent of poverty. (For example, families just above poverty paid \$25 a month; families at 400 percent of poverty paid \$366 a month; families above 400 percent of poverty paid \$462 a month; and uninsurables — families who have extremely sick individuals — paid \$562 a month). Due to a number of factors (explained below), enrollment of the uninsured ended after one year. However, the state plans to re-open enrollment to uninsured children in April 1997.
- **History of Tennessee's Waiver.** The idea for TennCare came from a need to avert a financial crisis facing Tennessee combined with a desire to expand coverage to the uninsured. In 1993, Tennessee and other states with large Medicaid disproportionate share hospital (DSH) programs were about to have their DSH funding limited by recently enacted laws. Tennessee's DSH spending was nearly 20 percent of the state's total Medicaid spending in 1992, among the highest in the nation. Governor McWherter, his Commissioner of Finance, and a small staff put together a plan that would capture the DSH funding through a "demonstration" or 1115 waiver program in which the state would use that money to expand coverage.

In May 1993, Governor McWherter gained approval of a plan from the state legislature and set about the task of getting it Federally approved and implemented by January 1994, when the state legislature reconvened. During the summer and fall of 1993, he negotiated with the Administration and was granted the waiver in November; by January 1, 1994, the demonstration began.

- **Rapid Expansion in 1994.** In early 1994, TennCare not only switched virtually all of its Medicaid recipients to managed care, it increased its enrollment by nearly 50 percent to cover an additional 400,000 previously uninsured people. By January 1995, when Governor Sundquist took office, TennCare enrollment was at its peak of 1,259,895. This included about 450,000 previously uninsured people. The increase in the number of the uninsured pushed Tennessee's coverage numbers ahead of most states and ALL southern states in the nation; although statistics vary, the state was covering over 90 percent of its population — an impressive achievement by any measure.

However, the first year was marked by several problems. Many providers rebelled against the "cram down" policy in which the state would not contract with providers for state employees if the providers did not also treat TennCare patients. Additionally, both Medicaid and uninsured people were confused over how to enroll and had difficulty in determining whether their providers were in their network. Finally, there were reports of serious fraudulent marketing practices by managed health care health plans. Specifically, prisoners were illegally enrolled; homeless shelters were targeted to sign up people who would never receive services; young healthy white males were enrolled while anyone who looked ill was avoided; and people who were already covered by Medicaid were told they would lose their Medicaid if they didn't sign up for a particular new managed care plan.

• **Reduced TennCare enrollment in 1995 and 1996.** Due to first year implementation problems and state budget pressures, Governor Sundquist closed enrollment of new uninsured applicants (except for "uninsurables"), increased premiums and collection efforts, and implemented more stringent eligibility verification. As a result, there were 78,500 fewer enrollees as of December, 1995. In August of 1996, the TennCare Bureau announced that it would cut tens of thousands of additional names from the rolls, saying that it lacked current addresses and the enrollees failed to respond to mail inquiries about their eligibility. At the same time, Blue Cross, which covers nearly 50 percent of TennCare enrollees, announced that it would freeze enrollment of TennCare recipients. As a result of these reductions in enrollment, there were 1,148,148 people enrolled in TennCare, as of February 11, 1997.

SAM
a/c/sk

• **Other challenges facing TennCare.** The provider community has consistently raised major quality, access, and payment concerns about TennCare. They threatened not to serve TennCare patients, but (other than a brief time of protest) most physicians are still serving the beneficiaries. The public hospitals who used to receive large DSH payments, like the "Med" in Memphis, have had a particularly hard time sustaining economic viability. However, with some financial and oversight assistance from the Federal Government, these problems and the marketing abuses outlined above, seem to be being addressed over time. For example, the state has commissioned a detailed study of access, cost and utilization to improve the operation of the program. Probably the most concerning development has been a recent rise in the infant mortality rate. This rate has not increased since 1987 and it happens to coincide with a time in which TennCare is covering over half of the state's live births.

• **Expanding to kids in 1997.** On January 13, 1997, the Governor announced that, for the first time in two years, enrollment in TennCare would be opened. It would extend coverage to poor children between 14 and 18, and would allow families with higher incomes to buy their children into TennCare. Governor Sundquist believes that they will be able to enroll 51,000 more children.

Part of the reason for this initiative is the managed care plans' concerns about the risk selection without re-opening enrollment. According to John Ferguson, State Finance Commissioner, "the addition of uninsured enrollees is needed for the health of the program" since TennCare "has lost the healthier ones whose premiums help pay for the care of others." Tony Garr, head of the advocacy group, Tennessee Health Care Campaign, confirms this more pragmatic rationale: "opening enrollment is the only option for the state. They need to do it to preserve the integrity of the program...."

• **Does TennCare serve as a model for other states to expand coverage?** Given the experiences in this program, the jury is still out as to whether TennCare is a model program for other states to emulate. It is a major accomplishment that 450,000 Tennessee residents who would otherwise have been uninsured have benefited from this program. And, even though the number of uninsured has been increasing in recent years, there are at least 300,000 more people insured than there were prior to the implementation of TennCare. However, as mentioned above, there are persisting challenges, particularly in terms of risk selection and quality. Most importantly, however, because of the unique disproportionate share financing arrangement the Administration provided to Tennessee, the TennCare model would be extremely difficult to replicate in other states.

• **Why is TennCare difficult to replicate?** First, there are only a handful of states (NH and MO among them) that have enough DSH dollars and political will to divert that money from public hospitals toward new coverage. Second, the low-DSH Governors -- who represent the vast majority of the country -- would oppose such an approach both because they would not benefit and because they believe that those who would only could do so because they "gamed" the system in the first place. Third, DSH money available is being reduced in our balanced budget proposal; it is now contributing about \$15 billion of our total \$22 billion in gross Medicaid savings. Unfortunately, a reduction in DSH savings would require an increase in savings from the unpopular per capita cap.

• **Lessons of TennCare:**

First, rapid movement from fee-for-service coverage to managed care achieves savings that can be invested back into coverage expansions. Unfortunately the savings may not be sustainable for long periods of time (TennCare plan premiums have seen some notable increases); moreover, since most states are already moving rapidly toward a greater use of managed care, future savings will be limited. Having said this, as we provide states with easier access to managed care (through the elimination of managed care waivers), we should strongly encourage them to reinvest their savings into coverage expansions.

Second, outside financing sources (TennCare used their DSH dollars) will be necessary to have any major expansion of coverage. Your budget explicitly recognizes this point by reinvesting about \$18 billion in support of increased access to insurance.

Third, Governors will likely learn that it is extremely difficult to successfully exchange constraint in provider reimbursement for coverage expansion without utilizing a McWherter-type model that rushes the proposal through the legislative process. Unfortunately, providers are now better prepared to oppose this strategy specifically because of the TennCare experience.

Fourth, the downside of legislative successes like TennCare is that they almost inevitably produce implementation problems (as has been the case in Tennessee) that are extremely challenging. Quality and access issues frequently arise because of rapid and confusing changes in the delivery system. Additionally, providers who oppose the changes are quick to point out — in the most public ways possible — any real and/or perceived problems.

Finally, the TennCare experience supports the idea that efforts to significantly expand new coverage must be done in a way that covers the healthy as well as unhealthy populations to guard against adverse selection. The problem in a predominantly voluntary program is that it is extremely difficult to entice healthy uninsured people to join without high subsidies. This argues for carefully designed approaches to incremental reform. Expanding coverage to a group like kids, for example, might be a way to both limit the Federal dollars and get healthy people enrolled, since many parents want to cover their children regardless of their health.

DRAFT

THE TENNESSEE MEDICAID WAIVER (TENNCARE)
A Background Paper

SUMMARY

On the face of it, the idea of (a) increasing enrollment by 50%, (b) contracting with managed care plans with their associated administrative and profit margin costs, and (c) capping Federal contributions at the before-waiver level is counter-intuitive provided that some reasonable assumptions are made about savings under managed care (conventionally thought to be 3-8%).

In summary,

- o Tennessee repealed a hospital tax, and under-funded TennCare at the outset. Combined with a 50% increase in participants, apparently serious financing stresses remain unresolved.
- o To hold onto the approximately \$750 million in Federal funds that had been matching those hospital tax-financed State Medicaid expenditures, the State proposed and DHHS agreed it would recognize other "contributions" as State share of Medicaid costs. But none represented new cash investments.
- o Low capitation and provider payment rates, and loss of long-standing indigent care and other payments to hospitals are some of the financing results that continue to retard maturation of the program and create political stresses. Early start-up chaos has subsided, and about 400,000 formerly uninsured Tennesseans have received insurance coverage through TennCare.
- o The State has been to HCFA looking for additional financial help. It is considering some combination of seeking a Federal block grant at 1993 levels (including illegal tax income), reinterpreting the waiver agreement in order to claim additional Federal funding, and finding non-tax means of bringing additional state funds into TennCare.

TENNESSEE BEFORE THE WAIVER --BACKGROUND

Tennessee is a relatively poor state:

- o their Federal Medicaid matching rate, based on a measure of poverty, has ranged from 69.64 in 1989 to 66.52 in 1994 (in the latter year, 14 states had higher Federal match rates -- i.e., are, by this standard, poorer);

- o in 1991, 15.5 percent of the population had family incomes below the poverty level; by 1993, this had increased to 19.6 percent (7 states have higher percentages);
- o in terms of total taxable resources, Tennessee in 1993 was ranked 36th among states (it had experienced a 9.6% growth over 1991).

During the early late 1980s and early 1990s, Tennessee, like other states, experienced a significant growth in Medicaid enrollment. This was due in part to the recession and in part to requirements to enroll more pregnant women and children.

- o During the period 1988-93, the number of beneficiaries in Tennessee grew by about 89% (an average annual rate of 13.6%) compared to a nationwide increase of 47% (8.1% per year).
- o In 1993, Tennessee had a rate of beneficiaries per 1,000 state residents that was 5th highest in the nation.

Their Medicaid provider payment levels have been similar to Medicare levels, and were only slightly below the national average for all state Medicaid programs.

During this same period, average annual growth in Medicaid expenditures per beneficiary (excluding disproportionate share payments) was 3.3% in Tennessee compared to a national average growth of 7.6%.

Legislation in 1986 and 1987 gave states additional flexibility in raising funds to finance their Medicaid programs. States exploited that mechanism by levying taxes on and accepting donations from hospitals and nursing homes; the States then returned those funds to the institutions in the form of "disproportionate share" (DSH) Medicaid "expenditures" and claimed Federal matching funds. This effectively increased the Federal matching rate.

In 1989-90, Tennessee raised \$85 million of the State share of Medicaid program funding through taxes, fees and donations; by the 1992-93 program year, those special funds had increased to \$541 million. By including these DSH funds, Tennessee's average annual expenditure per beneficiary in the period 1988-93 grew at 6.4% (national 10.6%), nearly twice Tennessee's without-DSH expenditure increase of 3.3%.

The centerpiece of Tennessee's special funding was a hospital tax which, in the 18 months between July 1, 1992 and its repeal on December 31, 1993, yielded

\$565 million. When the State returned those tax proceeds to the hospitals under the heading of Medicaid "disproportionate share" payments, this generated 67% Federal matching funds of approximately \$376 million. This effectively raised the Federal matching percentage. Both this tax and a nursing home tax (which generates about \$85 million in annual revenues and about \$57 million in Federal matching funds) have now been challenged by HCFA to have been unlawful.

With the special hospital tax scheduled to "sunset" in June of 1994, and little political likelihood of extension, Tennessee was faced with the annual loss of about \$376 million in Federal matching funds.

FINANCING THE TENNESSEE WAIVER -- AS PROPOSED, AS APPROVED

Initially, Tennessee proposed that the Federal Government approve an 1115 waiver that amounted to a block grant: even though Tennessee would withdraw \$376 million (the repealed tax), the Federal Government would pay at previous levels, and the effective Federal matching rate would be increased from the statutory 67% to over 80%. This was rejected. The State then began a search for any spending that the Federal Government could be persuaded to recognize as "State share" and to match with Federal funds.

Perhaps the most creative state share "contribution," was a projected \$572 million (over 5 years) in "certified public expenditures." Public hospitals would serve TennCare beneficiaries, managed care plans would be permitted to underpay hospitals' costs by an estimated \$326 per eligible, and that amount would be termed a "public expenditure" eligible for Federal matching. Furthermore, although the State would be making some payments from special pools to the hospitals to meet some of their uncompensated care costs (e.g., for persons considered "TennCare-eligible but not enrolled", the State argued that the Federal Government should disregard those State payments and match hospitals' gross uncompensated care rather than net. When HCFA insisted on matching only net uncompensated care, the State told hospitals that Washington had "changed the rules" necessitating a halt to State payments from special pools.

Other State-share contributions approved for Federal matching were

- o some \$457 million (over 5 years) in "patient revenues" of which the majority would be premium payments by some TennCare enrollees; instead of flowing directly to the managed care plans in which they were enrolled, these premiums would be captured by the State and then dispensed to the plans so Washington would recognize the payments as State expenditures, hence federally matchable;

- o certain payments for TennCare enrollees in Institutions for Mental Diseases (mainly State mental hospitals) not generally matchable; (these were to include persons already residing in IMDs when the waiver began, not only persons admitted during the period of the waiver);
- o about \$251 million (5 years) in local government indigent health services expenditures for TennCare eligibles and enrollees (including payments to private hospitals in Knox and Davidson Counties).

The State also proposed that HCFA match \$188 million in State payments for public health and mental health services (including State funds required to match certain PHS grants); this was later withdrawn.

FINANCING IN TENNESSEE TODAY -- FACTS AND EFFECTS

Under TennCare, approximately 400,000 Tennesseans who had previously been uninsured are now covered. The managed care industry, which prior to TennCare had enrolled only about 140,000 people in Tennessee, has now grown to cover nearly all 1.2 million TennCare enrollees. These are considerable accomplishments in the space of 15 months.

However, three factors -- two financial and the one political -- combine to produce a tense and unstable condition for TennCare today.

The first was the State's method of calculating the capitation rate that Managed Care Plans would be paid for each enrollee. The basic capitation rate was set by calculating a Medicaid historical fee-for-service per-capita equivalent amount -- \$1,641. From this was deducted \$335 in expected charity care from providers (in effect, holding onto hospitals' cost shift to private payers); \$28 in local indigent care funds the plans were expected to benefit from; and \$48 in patient coinsurance and deductible payments. This left a net capitation to plans of \$1,230 (raised last July to \$1,275). The low MCO capitation has resulted in low payments to physicians who contract with managed care plans, and to other providers participating in the MCOs' provider networks.

The second was the December 31 discontinuation by the State of payments to hospitals from an "unallocated funds pool." HCFA agreed to recognize State expenditures up to the Federal cap. Amounts in the pool represented the difference between the Federal funding cap for the year and aggregate amounts the State was paying to managed care plans as capitation. For the first six months between January 1 and June 30, 1994, these unallocated funds were estimated at

\$175 million, and were paid for medical education, uncompensated care payments to essential providers, extra payments to high-Medicaid caseload hospitals, and extra payments to MCOs for the first 30 days of care to TennCare beneficiaries (pent-up demand).

As enrollment increased, and as the State had to send increasing amounts of funds to managed care plans as capitation payments, the State had decreasing amounts available for these pool payments. In late December, when enrollments reached about 1.2 million and the State realized it could afford to enroll no more people and closed enrollments, the State informed the hospitals that no more pool payments were available. At least one hospital, the Regional Medical Center in Memphis ("The Med") is going through rapid and sharp cutbacks.

The third was the political arm-twisting by the State to force physicians to participate in TennCare. To avoid contention and compromise, the State did not engage Tennessee physicians in a dialogue over this plan. Blue Cross/Blue Shield (which has about 40% of TennCare enrollees) told the physicians participating in its managed care plan for State employees that if they wanted to continue in the state employees program, they would have to agree to participate in the TennCare program at TennCare payment rates. Without this requirement (called the "cram down" in Tennessee), the program would have been unlikely to be able to attract enough physicians at low payment levels to operate the program. (In fact, Governor Sundquist, who campaigned on a promise to eliminate this "cram down" requirement, has had to renege on that promise.) The Tennessee Medical Association sued the State (unsuccessfully) over this issue. This participation requirement, and the Governor's failure to eliminate it, have left a reservoir of ill-will in the physician community and, despite assurances to the contrary by TennCare officials, it is apparently difficult to obtain TennCare services in some specialties. There are said to be significant pressures from hospital and physician organizations to pare back eligibility and/or benefits to free up more funding for higher per-service payment levels to health care providers.

CURRENT TENNCARE FINANCING PROBLEMS

Tennessee was supposed to collect \$98 million in premiums from upper-income enrollees last year; instead, it collected \$12 million. In order to finance program costs to have been covered by the \$86 million in missing premiums, and to earn the approximately \$57 million in Federal matching funds, the State must make up the loss.

HCFA is seeking to recover Federal payments made in 1993 related to the now-unacceptable hospital tax (\$381 million). And an illegal nursing home tax of \$2,600 per bed (which the state repays to the institutions) has led to steps by HCFA to recover \$120 million for the 1993 year, with the expectation of similar recoveries for 1994.

The State has now approached HCFA for extra matching for local government payments to their public hospitals. Although HCFA already matches the value of charity care discounts below costs for care which public hospitals give to TennCare eligibles and enrollees (considered a "certified public expenditure"), Tennessee now wants to claim local appropriations of about \$43 million which counties pay to those same hospitals (a public hospital revenue, not an expenditure) to offset the costs of such uncompensated care.

Former and current State officials recently visited Washington to press for a block grant (in part, they said, so they "wouldn't have to keep jumping through hoops to come up with the State share.") Discouraged over the level of funding likely to be available to them under a block grant, however, they appear to have fallen back on trying to squeeze more Federal funds out of the current arrangement (see preceding paragraph) while conceding that there is probably a need for a 5-10% hike in capitation rates this year.

PROGRAM UNCERTAINTIES

Departmental officials who recently visited Tennessee were left with a number of uncertainties. They could not determine

- (1) whether there is beneficiary underutilization of the system; if so, what the volume and its trends might be, and whether it is purposeful as consequence of State and/or MCO plan-erected barriers (due to underfinancing) or incidental and a natural -- and temporary -- consequence of shifting a population into an unfamiliar arrangement;
- (2) how much real care management is occurring and how much is simply discounted fee-for-service (five of the 12 plans are PPOs which will not be required to have gatekeepers until year 3);
- (3) the financial stability of managed care plans - whether capitation payments are sufficient to permit profits by MCOs and to underwrite plan-to-provider contract rates adequate to keep providers in the program (State-sponsored audits are under way);

- (4) whether payment delays are about what would be considered normal, or might be indicators that some MCOs are performing poorly, purposefully delaying payments for cash flow reasons, or this is evidence of underlying problems in the overall levels or structure of financing;
- (5) the ratio of operational problems to total plan performance; whether early performance complaints (access, enrollment, referrals, information) are largely behind the plans, or there continue to be significant design errors and implementation problems that are not being recognized or overcome.

HYPOTHESES: HOW DID THEY MAKE IT WORK?

Program impact and performance data is not yet available. Assertions and anecdotes are inconsistent and ambiguous. But the essential conundrum remains: on the face of it, the idea of (a) increasing enrollment by 50% and (b) capping Federal contributions at the before-waiver level is counter-intuitive providing that reasonable assumptions are made about savings under managed care.

The following hypotheses suggest a framework within which to consider what may be happening.

Hypotheses #1: Tennessee's Medicaid program was so financially robust before the waiver that the program can now be adequately financed on a tight per capita fiscal diet.

The evidence to support this hypothesis might include pre-waiver per capita costs well above what would be expected (embodying some mix of high utilization and high prices). In fact, per beneficiary costs in Tennessee in 1993, were below the national average (\$2,946 vs. \$3,895), and slightly above the average for the states in their east south central region (\$2,892). Tennessee's Medicaid payment rates in 1993 were calculated by PhysPRC in 1993 to be at 1.05 - 1.17 of national fees; for example, their fee for total obstetrical care and vaginal delivery was \$1,100 compared to a national Medicaid median of \$1,051; and an office visit for a new patient was \$40 compared to the national Medicaid median of \$36.

When considered by class of service, Tennessee's acute care expenditures per beneficiary were \$1,683 compared to \$1,637 in their region and \$1,993 nationally. In long-term care spending per elderly beneficiary, Tennessee spent \$4,244 compared to \$3,878 by states in their region and \$6,907 nationally.

The foregoing does not suggest that, when compared to other states, Tennessee's Medicaid program was far going into the demonstration.

Hypothesis #2: Tennessee's program is working and sustainable, but for reasons we don't understand.

The least visible funding in the Tennessee system is amounts hospitals garner from surcharging private payors and cost-shifting to subsidize TennCare eligibles and enrollees. Part of such funds (the gap between costs and payments they receive from health plans) is visible because hospitals account for it in order that the state might claim the Federal match for that difference as "certified public expenditures." But the Federal 2/3 match leaves 1/3 unfunded. In fact, it may be that the hospitals are raising greater amounts for cross-subsidies than is apparent, and these will be able to compensate for low TennCare hospital rates for an extended period. (Since public hospitals have less of a privately insured client base, they have greater difficulty obtaining funds for cross-subsidies.)

In addition, it is possible that new enrollees under TennCare may, on average, be healthier than the average Medicaid population; many appear to be in low-wage working families. Conceptually, persons with chronic medical problems that left them unable to work, and children with ongoing problems are likely to have been enrolled under Medicaid prior to TennCare. If this turns out, upon empirical analysis, to be correct, their average costs would be lower than those of categorically eligible Medicaid population upon whose costs capitation rates were established.

There have been anecdotal reports that hospitalization rates per 1000 program beneficiaries are down significantly which could save substantial amounts if true. On the other hand, it could represent lack of access; a visiting Federal group heard reports that the second-largest HMO has been unable to conclude a contract with hospitals in one region of the state (including a large city), and the inconvenience faced by going outside of the region could dampen utilization temporarily.

Hypothesis #3: That TennCare is unsustainable without infusion of additional funding.

Empirical information on program effects is not yet available, and qualitative reports are ambiguous. Some hospitals and other providers are declining to continue to participate, but it is not known how generalizable that is. Discussions with a very few beneficiaries indicated some continued mechanical problems (like being

switched from plan to plan with no notice or reason), and difficulties with referrals and drug formularies.

A number of program elements may have, in the first year, masked the tenuousness of the program's financing foundation. First, the Federal payment cap did not take into account the phase-in of new beneficiaries through the first year. Given the early start-up confusion and the time it would take to enroll people and for them to begin to use health services, it is more likely that an appropriate capitation estimate for the first year would be about one-half the annual rate for the first year. In the second year, the average costs are more likely to nearly approximate ongoing costs.

Second, managed care organizations were frantically busy in the first year building their referral networks -- primary care physicians, referral specialists, hospital, etc. The very incompleteness of those networks probably held down costs, a factor much less likely to have effect in the next (and first full) year of operation.

Third, beneficiary sign-up with managed care plans, linkage with a primary care provider, transportation arrangements and other problems is likely to have had two effects: first, some -- perhaps many -- may have under-used needed services because they couldn't find access or gave up in frustration. Second, many went to their former care providers at least some of which went ahead and provided a service anyway hoping that reimbursements could later somehow be obtained from one of the managed care plans; some of those reimbursements probably did not happen. This chaos (and any savings that may have accrued to the State and the plans) is not likely to be repeated.

Fourth, plan payments to providers are widely reported to have been slow. There may even be some significant backlog of physician and hospital payments by some of the managed care plans which matured State monitoring will cause to be paid; this will increase retroactive first-year costs, and (unless repeated) will not mask second year costs.

Perhaps the strongest indication of the precariousness of current TennCare funding comes from Washington visits by former-Governor McWherter and the former director of Finance and Administration Manning seeking additional funding. Their concerns are outlined by Tennessee press reports in which Robert Corker, current Director of Finance and Administration, testifying before the legislature's TennCare Oversight Committee, is reported as indicating a TennCare financing shortage in the area of \$200 million.

The outlook for TennCare is ambiguous. On one hand, the managed care delivery

networks should begin to mature during the coming year, with real case management beginning to replace what, in many cases now, is reported to be essentially discounted fee-for-service care. Quality oversight by the State will begin to reinforce expectations that preventive and primary services in doctors' offices will replace episodic acute care in hospital emergency rooms. An increase in capitation payments should ease financing pressures, perhaps drawing additional specialist physicians into the program easing access pressures.

On the other hand, serious risks remain. Provider disenchantment could continue to build into further litigation, and more physicians could leave the program as well as some hospitals that are least dependent on Medicaid funding. There continues to be talk that at least one of the managed care plans may not be able to continue (although Blue Cross/Blue Shield may offer replacement coverage). The Tennessee legislature may continue to under-fund the program in which case the State will continue to have difficulty making enough qualifying Medicaid expenditures to attract Federal matching funds.