

Medicaid Provider Test File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

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2474



Rubbin' Chris

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: GARY

To: Chris Jennings

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Phone: _____
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Number of Pages (Including Cover): _____

Comments:

As requested

Phase I - Draft Audit Reports for 5 States

Each of these States has imposed a provider tax in violation of the "hold harmless" requirements.

Hawaii

nursing facility tax with an income tax credit to private pay patients; *program no longer in operation*

Illinois

nursing facility tax with a grant payment to private pay patients; *program no longer in operation*

Maine

nursing facility tax with an income tax credit to private pay patients; *program no longer in operation*

Louisiana

nursing facility tax with a grant payment to private pay patients; *program may have been terminated in last State legislative session*

Tennessee

nursing facility tax with a grant payment to private pay patients; *program operational*

NOTE: We have not completed our evaluation of the hospital tax in the State of Missouri. Upon completion of that review, we anticipate issuing a draft audit report to Missouri.

Phase II - Request to Submit/Re-Submit Waiver Applications for 9 States

Each of these States has imposed a provider tax in violation of the "broad based" and/or "uniformity" requirements. While these statutory provisions are waivable, the States have yet to submit approvable waiver requests.

Alabama

tax imposed on only certain prescriptions; *program operational*

Connecticut

tax imposed on only certain hospitals and only certain hospital revenues; *program operational*

Florida

tax imposed on only certain nursing facilities; *program no longer in operation*

Hawaii

tax imposed on only certain hospitals; *program no longer in operation*

Massachusetts

tax imposed on only certain hospitals and only certain hospital revenues; *program operational*

Nevada

tax imposed on only certain hospitals and only certain hospital revenues; *program no longer in operation*

New Hampshire

tax imposed on only certain hospitals; *program operational*

New York

tax imposed on only certain hospitals and only certain hospital revenues; *program operational*

Utah

tax imposed on only certain hospitals and adjusted days; *program no longer in operation*

Medicaid Provider Taxes P14

PROVIDER TAXES AND DONATIONS NEXT STEPS

- SUMMARY OF MEETING WITH CBO
- DRAFT TIME LINE FOR PROCEEDING
- FRIENDLY LETTER
- RESPONSE TO FRIENDLY LETTER

Meeting with CBO Concerning Scoring of the Provider Tax Bill - John Klemm, Susan Hammersten (OL) and Cindy Smith (OMB) met with Jean Desa of CBO to discuss scoring of our bill. John Klemm laid out his reasons for not including potential disallowances in his baseline. CBO listened but said that they were on record as to how they scored the NY BBA provision, and that they understood John's reasoning but didn't necessarily agree with it. CBO raised the issue of the decision on the Line Item Veto authority and indicated that they believed it would increase the likelihood that HCFA would actually try to collect disallowances from States (hence raising their score of our bill). OMB asked CBO to consider scoring some savings for our bill since it demands that States end impermissible taxes in order to get a discount on past liabilities (in contrast to the NY BBA provision which forgave past liabilities and deemed the current 'bad' taxes 'good'). OMB pointed out that some States may not be able to replace impermissible funding with permissible funding on a dollar for dollar basis and therefore our bill might actually generate some small federal savings. Finally, CBO said that they couldn't really begin to discuss a score for our bill until they got some numbers from us regarding estimates of State liability.

DATE: July 15, 1998
NOTE TO: The Administrator
SUBJECT: HCFA's Review Plan for Impermissible Taxes and Donations
FROM: Acting Deputy Director, Office of Legislation

You have requested an update on HCFA's strategy for enforcement of the current provider tax and donation statute. Consistent with HCFA's October 1997 announcement to end the use of impermissible taxes and donations, beginning August 1, 1998 HCFA is prepared to enforce the statutory provisions of section 1903(w) of the Social Security Act. The proposed strategy includes a time line of the steps necessary to enforce the recovery of FFP attributable to impermissible provider taxes and donations and a chart identifying the estimated resources required within each Region.

The time line is arranged into three concurrent phases based on a grouping of states. States can be divided into three categories; a) States which we know have impermissible taxes and for which those taxes are not eligible for a waiver (i.e. 'hold harmless' or 'impermissible class' taxes), b) States that have potentially impermissible taxes for which waiver applications are pending, and c) the remainder of the States that reported the collection of provider donations, and/or other mandatory payments including licensing fees and user fees.¹

- A. Impermissible taxes - ineligible for waiver applications
HI, IL, IN, LA, ME, MN, MO, NY, TN²
- B. Potentially impermissible taxes - waiver applications pending decisions
AL, CT, FL, HI, MA, MN, NV, NH, TN, UT
- C. Permissibility undetermined - provider donations, licensing and user fees - no waivers pending
AL, CT, CO, FL, MD, MI, MN, MT, NV, NJ, NC, OH, OK, PA, SC, TX, UT, WV, WI, WY

¹ The State groupings are based on State reports from the HCFA-form 64.11A and the November 1997 information collection exercise. The preliminary number of States impacted by this strategy is 30.

² The impermissible tax programs in HI, IL, IN, and ME have been terminated.

The plan is to address the states with impermissible taxes first (category A), followed by the waiver states (category B), and then the donation/licensing fee states (category C). This time line assumes that the different steps involved in the process will be able to occur concurrently among the three phases (i.e. step three will be occurring in Phase A at the same time that step two is occurring in Phase B and step one is occurring in Phase C).

The chart identifies states with impermissible tax and/or donation programs, the estimated number of hours required to enforce, and the amount of travel expenses associated with that enforcement. Given that the resources were assessed for only one iteration of the entire process, this may not be possible. If that is true, the time needed to complete the process for all taxes and all states will be longer than is indicated in the chart.

Please let me know if you wish to discuss.

Bonnie Washington

HCFA's Review Plan for Impermissible Taxes and Donations

Steps	Time line Phase A	Time line Phase B	Time line Phase C
<p>August of 1998</p> <p>Step #1 Review in-house info on impermissible taxes <i>Tasks: [Central Office]</i></p> <ul style="list-style-type: none"> - Review HCFA-64.11 reports to identify states with impermissible taxes. - Assign states to groups based on type of tax, waiver status and reporting history. - Review federal statutes, regulations, and HCFA policy regarding taxes. 	<p>Day 1</p> <p>Day 9</p>	<p>N/A</p> <p>Completed during Phase A</p>	<p>N/A</p> <p>Completed during Phase A</p>
<p>August-October of 1998</p> <p>Step #2A Notify states with impermissible taxes <i>Tasks: [Central Office]</i></p> <ul style="list-style-type: none"> - Develop specific review plans for each state. - Send letters to states notifying them of our determination that they have an impermissible tax and outlining our timetable for action. <p>Step #2B Take Action on Pending Waiver Requests <i>Tasks: [Central Office]</i></p> <ul style="list-style-type: none"> - Send letter to States indicating we will begin making final waiver decisions (allow States 15 days to provide additional information) - Review incoming information from States - Deny or grant waiver request and notify State of our decision. - <i>Move to step 2A.³</i> <p>Step #2C Notify States of Potential Audits <i>Tasks: [Central Office]</i></p> <ul style="list-style-type: none"> - Send letter to States outlining our plan and inform them that, while we have no information that they have any impermissible taxes, we will be conducting audits on licensing fees, user fees, and donations. - <i>Move to Step 2A</i> 	<p>Day 10</p> <p>Day 15</p> <p>N/A</p> <p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>Day 45</p> <p>Day 50</p> <p>Day 15</p> <p>Day 50</p> <p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>Day 90</p> <p>Day 95</p> <p>N/A</p> <p>N/A</p> <p>Day 20</p> <p>Day 95</p>

³Even in cases where waiver applications are approved audits may still have to be conducted to determine the amount of penalty owed for the period prior to the waiver application.

<p>September-December of 1998 Step #3 - Conduct Audits <i>Tasks: [Regional Offices]</i></p> <ul style="list-style-type: none"> - Discuss tax programs with state officials. - Review state records. - Ascertain time periods when taxes were in effect. - Determine impact of impermissible taxes on FFP for FYs in question. 	<p>Day 30 Day 45</p>	<p>Day 85 Day 90</p>	<p>Day 120 Day 135</p>
<p>September of 1998 - February of 1999 Step #4 Prepare & issue draft audit reports <i>Tasks: [Regional Offices]</i></p> <ul style="list-style-type: none"> - Write letter that explains findings, shows FFP effect and requests return of improperly paid FFP. - Obtain OGC and CO concurrence with report and recommendations. - Issue report (letter) to state with 30-day response period. 	<p>Day 60 Day 90 Day 95</p>	<p>Day 105 Day 135 Day 140</p>	<p>Day 150 Day 180 Day 185</p>
<p>Beginning October 1, 1998 - Decision Point - Deferral of Current FFP Claims HCFA must decide if current claims for the quarter ending June 30, 1998 will be deferred. If claims are deferred and disallowed, states will not have the option of retaining funds during the appeal process. Will cause an immediate adverse fiscal impact.</p>			
<p>December of 1998 - June of 1999 Step #5 Prepare & issue final audit report <i>Tasks: [Regional Offices]</i></p> <ul style="list-style-type: none"> - Review state comments and make appropriate revisions to report. - Obtain OGC and CO concurrence with final report. - Issue report to state and request return of improperly claimed FFP. - Set deadline for return of FFP (normally 30 days). - If FFP is not returned, proceed with disallowance process. 	<p>Day 150 Day 180 Day 185 Day 215</p>	<p>Day 195 Day 225 Day 230 Day 260</p>	<p>Day 240 Day 270 Day 275 Day 305</p>
<p>December of 1998. - April of 1999 <i>Tasks: [Regional Offices]</i> Step #6 Disallowance Process</p> <ul style="list-style-type: none"> - Prepare draft disallowance letter. - Obtain OGC and CO clearance. - Issue disallowance letter to state.⁴ - If no appeal, recover FFP through grant award process. 	<p>Day 220</p>	<p>Day 265</p>	<p>Day 310</p>

⁴This is an appealable action, the State is usually given at least 30 days to respond to our disallowance letter.

April of 1998.....

Step #7 Appeal Process

Tasks:

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

Day 251

Day 296

Day 341

DRAFT

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
200 Independence Ave., SW
Washington, DC 20201

Dear Ms. DeParle:

I was very encouraged by the legislative proposal, the Medicaid Provider Tax and Donation Amendment of 1998, that your agency sent to Congress earlier this year. I am glad to see that HCFA has been taking action in pursuing its goal to end the use of impermissible provider taxes and donations. The continuing use of these taxes undermines the integrity of the Medicaid program and is unfair to States that operate in compliance with the law. It is unfortunate that more progress wasn't made in moving the bill forward during this legislative session.

If I recall correctly, last fall you announced that you would be working with States to develop this legislation. At that time you also made it clear that if, by August of this year, it did not look as if the bill would be enacted, you would have to proceed in your efforts to resolve this issue within the constraints of current law. I would like to know how HCFA intends to proceed, if Congress does not act on this legislation before the end of the session.

Specifically, I am interested in the agency's timetable for taking action in states that have impermissible tax programs, the list of states that will be involved, and the potential amounts of money at issue in each of those states. In addition, I would like to know more about what specific steps are necessary to complete the process of ending the taxes and recovering disallowed matching funds, what appeal rights if any the states will have, and how those appeals will affect the timeliness of the entire process.

While I feel that it would be unfortunate for the situation to be handled with the procedures available under current law rather than those outlined in your legislative proposal I understand your need to move forward in your efforts to end these impermissible taxes. I look forward to hearing from you.

****Please note that this represents the maximum amount of information that would be included in the letter. We will work to target the letter and tighten it up once we have received the incoming and everyone has had a chance to comment****

The Honorable _____
United States House of Representatives

Dear Congressman _____:

Thank you for your inquiry regarding HCFA's intended plan of action with respect to the continued use of impermissible health care related taxes and donations. Our goal is to end the use of these taxes and donations as quickly as possible. To that end we transmitted a bill, The Provider Tax and Donation Amendments of 1998, to Congress for consideration earlier this year. We began working on the bill in October of 1997. It was also at that time that we announced that if, by August of 1998, it did not appear that our bill would be enacted before the end of the 105th Congress, we would have no choice but to proceed on this matter within the constraints of current law.

You had asked us for some specific information regarding the steps necessary to end the use of impermissible taxes, and our time table for taking those actions. You had also asked for a list of the states that would be affected and the amounts of money at issue in each of those states. Finally, you wanted some information about the administrative appeals process and how that process might affect the length of time needed to resolve these issues.

Description of the Agency's Plan of Action

States will be divided into three groups. The Administration plans to address these groups in order. The first group will be made up of states with impermissible taxes that violate provisions of the statute that cannot be waived under our regulations. Examples of these kinds of taxes include taxing programs that hold the taxpayer harmless, using either direct or indirect repayment mechanisms, and tax programs that levy taxes on classes of health care services or providers that are not permitted under the statute or regulations.

There are two provisions of our tax laws that states can request be waived. These are the requirements that all health care related taxes be broad-based (i.e. the tax is levied on every provider or service within a defined class) and uniform (i.e. that every provider or service that is subject to the tax is taxed at the same rate). States that have requested waivers of these provisions must demonstrate that their taxes are generally redistributive and do not place an undo burden on Medicaid providers or service. Depending on a state's tax program structure, this demonstration is accomplished by calculating one of two numerical tests and producing a result that falls within a defined range of values.

Several states currently have waiver applications pending. HCFA must review those tax programs and act on the waiver requests. If HCFA determines that the tax programs do not meet the standards of the waiver tests, or that the tax is not eligible to receive a waiver, and therefore not in compliance with current law, we will proceed with the audit and disallowance process to recover the improperly paid federal funds.

The 1991 Provider Tax Law also covers the receipt of health care related donations and the imposition health care related licensing and user fees. Our regulations provide a presumption of permissibility for licensing fees that do not exceed \$1000 per individual per year and donations that do not exceed \$5,000 per individual provider or \$50,000 per health care organization or entity per year. Several States have reported receiving income from donations and/or other mandatory fees that fall both within and outside of these limits. Each of these mandatory fee programs and donation records would have to be reviewed and evaluated for compliance with tax and donation laws and regulations. Should any impermissible fees or donations be uncovered, we will proceed with the audit and disallowance process to recover the federal funds associated with these impermissible fees.

The steps necessary to determine the amounts of federal funding associated with the impermissible taxes, fees and donations are essentially the same for each of the three groups of states. Although the start dates will be staggered due to resource constraints, each of the three groups will be handled concurrently so that the entire process will have been completed in every state before August of 1999.

In August of this year we will begin notifying the states with impermissible taxes of our finding that the tax is impermissible. We will then design an audit and review plan for each state. Auditors from our regional offices should be conducting audits by September of this year in these states. The audits are necessary to determine the amounts of federal funds to be recovered from each state and should take between 30 and 60 days to complete.

Following the completion of the on-site audits, staff will write a draft audit report. This report will explain the findings of the audit, detail the amount of federal funds involved, and request the return of those funds. The draft audit reports will be issued to states between October and November of this year. States will have thirty (30) days to respond to these draft audit reports.

Preparation of the final audit reports will begin by November or December of this year. The final audit reports will incorporate state comments where appropriate. Once these final audit reports are issued, states will have 30 days in which to return the requested federal funds. If the state does not meet this deadline, HCFA will begin the formal disallowance process.

While the audits are being conducted in the first group of states, HCFA will be making the final decisions on the pending waiver applications from the second group of states. Audits in these states should be underway by mid-September of this year. Following the completion of the

audits in the those states, our auditors will be dispatched to the remaining states to begin the last round of audits by the end of October. The remainder of the steps will be completed in a similarly staggered fashion so that the entire process should be completed in each of the states by July of 1999.

Description of the Formal Disallowance and Appeals Processes

The disallowance process begins with HCFA issuing a formal disallowance letter to the state detailing which of the state funds were not eligible for federal matching funds and how much money is owed to the Federal government. It also outlines the procedure HCFA will use to recover the money by reducing the state's future Medicaid grant awards.

The issuance of the disallowance letter is an appealable action. The state is usually given 30 days to respond to the letter and file a formal appeal with the Departmental Appeals Board. Any state that loses its appeal to the DAB has the option to pursue the action within the (State/Federal) courts system. Should a state decide to pursue this option, the final resolution of the case could take a number of years.

States are permitted to retain the disputed funds during the appeals process. However, should the state ultimately lose its appeal, it is liable for payment of interest on those amounts from the date of the disallowance letter.

List of States and Amounts at Issue

HCFA does not have a comprehensive list of states with impermissible taxes. A total of thirty (30) states have reported income from provider taxes, fees, or donations to HCFA for which believes audits will be necessary. At a minimum, each of these states will be subject to a review of their tax and donation history since 1993. Over the last several weeks, HCFA staff have been reviewing documentation provided by States and dividing the states into the three groups for the first, second, and third round of audits.

The total amount of money at issue cannot be determined at this time and will not be known until all of the audits have been completed. While it is true that HCFA has attempted to estimate these numbers in the past, the reliability and usefulness of those estimates are severely limited at best. An on-site, detailed audit of State financial records is the only credible method for making these determinations.

Thank you again for your inquiry. I hope that we have provided you with a level of detail that clearly explains HCFA's plan of action. If you have any questions regarding the information this letter or about the taxes and donation issue in general please do not hesitate to contact _____ or myself.

Sincerely,

Nancy-Ann Min DeParle
Administrator

Provider Tax Issues

Purpose of Meeting: Update on status of health care provider tax issue

Note: Meeting called by Maria, not OMB, HHS or DPC/NEC; HHS not invited

Quick Review:

- Issue brought to the forefront last summer with line-item veto of NY's legislative grandfathering of an illegal provider tax
- Last September, we issued a clarifying reg and suggested that Congress adopt legislation to draw bright lines about which taxes are legal and illegal.
- In April, we sent model legislation to Congress with our recommended clarifications and encourage Congress to take up this legislation.
- Since there has been no action in Congress, we are planning a strategy for administrative actions.
- HCFA came over the brief NEC/DPC and OMB for the first time last Friday. We are working with them on this plan. So far, we think it looks OK but we have not thoroughly reviewed it yet.

DRAFT

Background on Provider Taxes. In 1991, Congress enacted Medicaid Voluntary Contribution and Provider-Specific Tax Amendments Act to curb the tremendous growth in the Medicaid Disproportionate Share Hospital Program (DSH). The growth resulted from states use of DSH payments and related special provider tax and donation financing mechanisms to effectively lower the state share of Medicaid. The 1991 law prohibited provider taxes and donations if the incidence of the tax falls disproportionately on the Medicaid program.

In spite of the legislation, HCFA believes that some states continue to levy impermissible taxes. However, the Administration never audited these states or taken a disallowance penalty. Thirty states reported income from provider taxes, fees, or donations to HCFA for which audits will be necessary. **HCFA's rough estimates suggest that revenue from impermissible taxes could total nearly \$5 billion.** Reliable estimates will not be available until HCFA audits the states.

Pending Legislation. State's use of impermissible taxes gained increased scrutiny in August 1997, when the President used his line item veto authority to cancel the BBA provision that would have permitted New York to levy impermissible taxes in the event HCFA attempted to enforce the law. In press statements following the veto, the Administration promised legislation to end the use of these taxes.

On April 2, 1998, HHS transmitted to the Congress new provider tax legislation designed to encourage states to comply with the 1991 law. The legislation provides the Secretary with greater authority negotiate favorable financial settlements with states for past non-compliance with the 1991 law. To qualify for a settlement, a state must end its impermissible taxes. The legislation also codifies existing regulations to underscore the intent of the 1991 provider tax and donation law.

In its transmittal letter, HHS informed Congress of its intention to enforce the existing law if legislation is not enacted by this August -- resulting in audits and disallowances. To date, Congress has not acted on the legislation.

Disallowance Process. A disallowance reduces future Federal contribution for the non-compliant state's Medicaid program. A disallowance action -- especially given the size of some state's impermissible tax liability -- could disrupt the state's Medicaid, waiver, and/or children's health programs.

Step One: Audits Before a disallowance, HCFA must perform a lengthy audit process to determine the amount of federal funds to be recovered from each state. Because of limited resources, HCFA plans to stagger the audits by prioritizing states who have most clearly violated the law:

- In August, HCFA will begin notifying the states with impermissible taxes and begin conducting audits in September (HI, IL, IN, LA, ME, MN, MO, NY, TN). These states' taxes are impermissible because they violated the "hold harmless" provision of the law.

DRAFT

- Concurrently, HCFA will review and, if necessary, begin audits for states that have submitted waivers for their taxes. (AL, CT, FL, HI, MA, MN, NV, NH, TN, UT).
- By the end of October, HCFA begin the audit process for states with questionable taxes and user fees. (AL, CT, CO, FL, MD, MI, MN, MT, NV, NJ, NC, OH, OK, PA, SC, TX, UT, WV, WI, WY). The last round of audits should be complete by the end October.

The initial audit may take up to 60 days, followed by a draft report and state comment period. Once a final audit report is issued to a state, the state 30 days to return the requested federal funds or HCFA begins a formal disallowance action. HCFA anticipates that the entire audit process will have been completed in every state before August, 1999.

Step Two: Disallowances The disallowance process begins with HCFA issuing a formal disallowance letter to the state detailing which funds are impermissible, how much money is owed to the Federal government, and how HCFA will recover the money by reducing the state's future Medicaid grant awards.

Step 3: Appeals The state may appeal the disallowance to the Departmental Appeals Board. The state may retain the disallowed funds through the appeals process. If the state loses the appeal, then it may pursue the action in court. Resolution of these court cases may take several years.

Next Steps. Before any action is taken, HCFA plans to brief Congress and the NGA on the process. Chris Jennings would like these briefings to take place as soon as possible. HCFA will try to meet with the NGA this Monday, and follow up the meeting with a more detailed letter. (See tabs A&B)

Attachments

- Tab A: HCFA's Draft Disallowance Process Letter for Congress/NGA
- Tab B: HCFA's Proposed Timeline for Disallowance Process
- Tab C: Summary of Administration's Provider Tax Legislation

Tab A

ACFA draft

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Health Care Financing Administration
200 Independence Ave., SW
Washington, DC 20201

Dear Ms. DeParle:

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If I recall correctly, last fall you announced that you would be working with States to develop this legislation. At that time you also made it clear that if, by August of this year, it did not look as if the bill would be enacted, you would have to proceed in your efforts to resolve this issue within the constraints of current law. I would like to know how HCFA intends to proceed, if Congress does not act on this legislation before the end of the session.

Specifically, I am interested in the agency's timetable for taking action in states that have impermissible tax programs, the list of states that will be involved, and the potential amounts of money at issue in each of those states. In addition, I would like to know more about what specific steps are necessary to complete the process of ending the taxes and recovering disallowed matching funds, what appeal rights if any the states will have, and how those appeals will affect the timeliness of the entire process.

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Dear Congressman _____:

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You had asked us for some specific information regarding the steps necessary to end the use of impermissible taxes, and our time table for taking those actions. You had also asked for a list of the states that would be affected and the amounts of money at issue in each of those states. Finally, you wanted some information about the administrative appeals process and how that process might affect the length of time needed to resolve these issues.

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audits in the those states, our auditors will be dispatched to the remaining states to begin the last round of audits by the end of October. The remainder of the steps will be completed in a similarly staggered fashion so that the entire process should be completed in each of the states by July of 1999.

Description of the Formal Disallowance and Appeals Processes

The disallowance process begins with HCFA issuing a formal disallowance letter to the state detailing which of the state funds were not eligible for federal matching funds and how much money is owed to the Federal government. It also outlines the procedure HCFA will use to recover the money by reducing the state's future Medicaid grant awards.

The issuance of the disallowance letter is an appealable action. The state is usually given 30 days to respond to the letter and file a formal appeal with the Departmental Appeals Board. Any state that loses its appeal to the DAB has the option to pursue the action within the (State/Federal) courts system. Should a state decide to pursue this option, the final resolution of the case could take a number of years.

States are permitted to retain the disputed funds during the appeals process. However, should the state ultimately lose its appeal, it is liable for payment of interest on those amounts from the date of the disallowance letter.

List of States and Amounts at Issue

HCFA does not have a comprehensive list of states with impermissible taxes. A total of thirty (30) states have reported income from provider taxes, fees, or donations to HCFA for which believes audits will be necessary. At a minimum, each of these states will be subject to a review of their tax and donation history since 1993. Over the last several weeks, HCFA staff have been reviewing documentation provided by States and dividing the states into the three groups for the first, second, and third round of audits.

The total amount of money at issue cannot be determined at this time and will not be known until all of the audits have been completed. While it is true that HCFA has attempted to estimate these numbers in the past, the reliability and usefulness of those estimates are severely limited at best. An on-site, detailed audit of State financial records is the only credible method for making these determinations.

Page 4

Thank you again for your inquiry. I hope that we have provided you with a level of detail that clearly explains HCFA's plan of action. If you have any questions regarding the information this letter or about the taxes and donation issue in general please do not hesitate to contact _____ or myself.

Sincerely,

Nancy-Ann Min Deparle
Administrator

Tab B

DATE: July 15, 1998

NOTE TO: The Administrator

SUBJECT: HCFA's Review Plan for Impermissible Taxes and Donations

FROM: Acting Deputy Director, Office of Legislation

You have requested an update on HCFA's strategy for enforcement of the current provider tax and donation statute. Consistent with HCFA's October 1997 announcement to end the use of impermissible taxes and donations, beginning August 1, 1998, HCFA is prepared to enforce the statutory provisions of section 1903(w) of the Social Security Act. The proposed strategy includes a time line of the steps necessary to enforce the recovery of PDP attributable to impermissible provider taxes and donations and a chart identifying the estimated resources required within each Region.

The time line is arranged into three concurrent phases based on a grouping of states. States can be divided into three categories; a) States which we know have impermissible taxes and for which those taxes are not eligible for a waiver (i.e. 'hold harmless' or 'impermissible class' taxes), b) States that have potentially impermissible taxes for which waiver applications are pending, and c) the remainder of the States that reported the collection of provider donations, and/or other mandatory payments including licensing fees and user fees.¹

- A. Impermissible taxes - ineligible for waiver applications
HI, IL, IN, LA, ME, MN, MO, NY, TN²
- B. Potentially impermissible taxes - waiver applications pending decisions
AL, CT, FL, HI, MA, MN, NV, NH, TN, UT
- C. Permissibility undetermined - provider donations, licensing and user fees - no waivers pending
AL, CT, CO, FL, MD, MI, MN, MT, NV, NJ, NC, OH, OK, PA, SC, TX, UT, WV, WI, WY

¹ The State groupings are based on State reports from the HCFA-form 64.11A and the November 1997 information collection exercise. The preliminary number of States impacted by this strategy is 30.

² The impermissible tax programs in HI, IL, IN, and MI have been terminated.

Page 2

The plan is to address the states with impermissible taxes first (category A), followed by the waiver states (category B), and then the donation/licensing fee states (category C). This time line assumes that the different steps involved in the process will be able to occur concurrently among the three phases (i.e. step three will be occurring in Phase A at the same time that step two is occurring in Phase B and step one is occurring in Phase C).

The chart identifies states with impermissible tax and/or donation programs, the estimated number of hours required to enforce, and the amount of travel expenses associated with that enforcement. Given that the resources were assessed for only one iteration of the entire process, this may not be possible. If that is true, the time needed to complete the process for all taxes and all states will be longer than is indicated in the chart.

Please let me know if you wish to discuss.

Bonnie Washington

HCFA's Review Plan for Impermissible Taxes and Donations

Steps	Time line Phase A	Time line Phase B	Time line Phase C
<p>August of 1998</p> <p>Step #1 Review in-house info on impermissible taxes <i>Tasks: [Central Office]</i></p> <ul style="list-style-type: none"> - Review HCFA-64.11 reports to identify states with impermissible taxes. - Assign states to groups based on type of tax, waiver status and reporting history. - Review federal statutes, regulations, and HCFA policy regarding taxes. 	<p>Day 1</p> <p>Day 9</p>	<p>N/A</p> <p>Completed during Phase A</p>	<p>N/A</p> <p>Completed during Phase A</p>
<p>August-October of 1998</p> <p>Step #2A Notify states with impermissible taxes <i>Tasks: [Central Office]</i></p> <ul style="list-style-type: none"> - Develop specific review plans for each state. - Send letters to states notifying them of our determination that they have an impermissible tax and outlining our timetable for action. <p>Step #2B Take Action on Pending Waiver Requests <i>Tasks: [Central Office]</i></p> <ul style="list-style-type: none"> - Send letter to States indicating we will begin making final waiver decisions (allow States 15 days to provide additional information) - Review incoming information from States - Deny or grant waiver request and notify State of our decision. - Move to step 2A <p>Step #2C Notify States of Potential Audits <i>Tasks: [Central Office]</i></p> <ul style="list-style-type: none"> - Send letter to States outlining our plan and inform them that, while we have no information that they have any impermissible taxes, we will be conducting audits on licensing fees, user fees, and donations. - Move to Step 2A 	<p>Day 10</p> <p>Day 15</p> <p>N/A</p> <p>N/A</p> <p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>Day 45</p> <p>Day 50</p> <p>Day 15</p> <p>Day 50</p> <p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>Day 90</p> <p>Day 95</p> <p>N/A</p> <p>N/A</p> <p>Day 20</p> <p>Day 95</p>

Even in cases where waiver applications are approved audits may still have to be conducted to determine the amount of penalty owed for the period prior to the waiver application.

<p>September-December of 1998 Step #3 - Conduct Audits <i>Tasks: [Regional Offices]</i></p> <ul style="list-style-type: none"> - Discuss tax programs with state officials. - Review state records. - Ascertain time periods when taxes were in effect. - Determine impact of impermissible taxes on FFP for FYs in question. 	<p>1</p> <p>Day 30</p> <p>Day 45</p>	<p>Day 85</p> <p>Day 90</p>	<p>Day 120</p> <p>Day 135</p>
<p>September of 1998 - February of 1999 Step #4 Prepare & issue draft audit reports <i>Tasks: [Regional Offices]</i></p> <ul style="list-style-type: none"> - Write letter that explains findings, shows FFP effect and requests return of improperly paid FFP. - Obtain OGC and CO concurrence with report and recommendations. - Issue report (letter) to state with 30-day response period. 	<p>Day 60</p> <p>Day 90</p> <p>Day 95</p>	<p>Day 105</p> <p>Day 135</p> <p>Day 140</p>	<p>Day 150</p> <p>Day 180</p> <p>Day 185</p>
<p>Beginning October 1, 1998 - Decision Point - Deferral of Current FFP Claims HCFA must decide if current claims for the quarter ending June 30, 1998 will be deferred. If claims are deferred and disallowed, states will not have the option of retaining funds during the appeal process. Will cause an immediate adverse fiscal impact.</p>			
<p>December of 1998 - June of 1999 Step #5 Prepare & issue final audit report <i>Tasks: [Regional Offices]</i></p> <ul style="list-style-type: none"> - Review state comments and make appropriate revisions to report. - Obtain OGC and CO concurrence with final report. - Issue report to state and request return of improperly claimed FFP. - Set deadline for return of FFP (normally 30 days). - If FFP is not returned, proceed with disallowance process. 	<p>Day 150</p> <p>Day 180</p> <p>Day 185</p> <p>Day 215</p>	<p>Day 195</p> <p>Day 225</p> <p>Day 230</p> <p>Day 260</p>	<p>Day 240</p> <p>Day 270</p> <p>Day 275</p> <p>Day 305</p>
<p>December of 1998 - April of 1999 <i>Tasks: [Regional Offices]</i> Step #6 Disallowance Process</p> <ul style="list-style-type: none"> - Prepare draft disallowance letter. - Obtain OGC and CO clearance. - Issue disallowance letter to state.⁴ - If no appeal, recover FFP through grant award process. 	<p>Day 220</p>	<p>Day 265</p>	<p>Day 310</p>

⁴ This is an appealable action, the State is usually given at least 30 days to respond to our disallowance letter.

<p><i>April of 1998.....</i> Step #7 Appeal Process <i>Tasks:</i> - If state appeals to DAB, state may retain funds during appeal but is at risk for interest from the date of disallowance if appeal is unsuccessful.</p>	Day 251	Day 296	Day 341
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DUPLICATE

Tab C



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 2, 1998

The Honorable Albert Gore, Jr.
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

Enclosed for the consideration of the Congress is the Administration's draft bill, the "Medicaid Provider Tax and Donation Amendments of 1998".

Our goal is to end the use of impermissible provider taxes and donations. To that end, we have spent the last several months working with States to identify changes to the existing legislation that would make administration of tax programs less burdensome and give States stronger incentives to end the use of impermissible tax and donation programs. This bill is the culmination of those efforts.

The bill would amend the Medicaid statute (title XIX of the Social Security Act) to strengthen and clarify the provisions that define impermissible provider taxes and donations and to reduce record-keeping burdens on States. In addition, the bill would concentrate in the Department time-limited authority to work with States to resolve current tax liabilities in return for States eliminating impermissible tax and donation programs. Key features of the bill are outlined below. The provisions of the bill are described in greater detail in the enclosed section-by-section summary.

The bill would (1) provide that a tax consisting of a licensing fee or similar charge will not be treated as an impermissible tax if (A) the revenues from the tax are only used for administration of the program for which they are collected, and (B) the State Governor (or other official specified by the Secretary) provides

Page 2 - The Honorable Albert Gore, Jr.

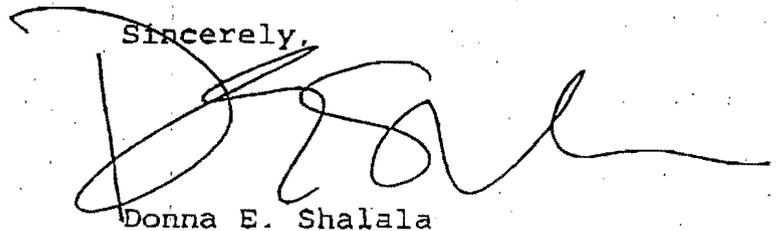
appropriate certification; (2) in the case of States that act quickly to eliminate all impermissible tax and donation programs in effect prior to enactment, require the Secretary to adjust the amount of the penalty that would otherwise be taken with respect to certain revenues raised from such programs; (3) clarify the manner in which a State must perform the "generally redistributive" test when it seeks a waiver from the Secretary for taxes that are not broad-based and uniform, and add a provision that would allow States to aggregate classes when performing such test; and (4) expand the list of classes of items and services on which a broad-based tax may be imposed, and specify the criteria to be used by the Secretary in establishing additional permissible classes.

This draft bill affects a program that is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. The Office of Management and Budget's scoring estimate of the draft bill is zero.

We urge the Congress to give the draft bill its prompt and favorable consideration.

The Office of Management and Budget has advised that there is no objection to the submission of this legislative proposal to the Congress, and that its enactment would be in accord with the program of the President.

Sincerely,



Donna E. Shalala

Enclosure

"Medicaid Provider Tax and Donation Amendments of 1998"

Section-by-section Summary

(Except as otherwise indicated, this bill amends provisions of the Social Security Act. References to the "Secretary" are to the Secretary of Health and Human Services.)

SEC. 2. HEALTH CARE LICENSING FEES.

Section 2 makes various amendments to provisions of 1903(w) that specify the types of health care related taxes that will be treated as "impermissible taxes" for purposes of determining whether a State will be subject to a disallowance of medical assistance expenditures eligible for Federal matching payments. These amendments provide that a tax consisting of a licensing fee or similar charge will not be subject to a disallowance if (1) the total amount of revenue raised by the State from such tax will be used in the administration of the licensing program for which the charge was assessed or for regulation of the entities subject to the charge, and the State maintains on file a certification by the Governor (or other official specified by the Secretary) to that effect; and (2) the tax does not contain a hold-harmless provision.

The bill also provides that if the Secretary finds that the State has used any revenue from a tax described above for purposes other than those described in a certification, the Governor (or other certifying official) is subject to a civil monetary penalty of not to exceed \$10,000. The bill specifies the administrative procedures that will apply if the Secretary imposes a civil monetary penalty pursuant to this authority.

SEC. 3. SECRETARY'S AUTHORITY TO ADJUST CERTAIN AMOUNTS OWED BY STATES.

Section 3 amends section 1903(w)(1)(A) (which requires that the amount of State medical assistance expenditures eligible for Federal matching payments be reduced by the amount of State revenues from certain impermissible taxes and donations (the "standard reduction") and adds new subparagraphs (H) and (I) to section 1903(w)(1). The amendments require the Secretary to reduce the amount of the standard reduction attributable to

revenues from impermissible tax or donation programs in effect prior to the date of enactment of the bill if the State eliminates all such impermissible programs within two years of enactment of the bill. The Secretary is not authorized to adjust the amount of the standard reduction for revenues (1) received more than one year after the enactment of the bill; or (2) from impermissible tax or donation programs initiated after the enactment of the bill.

The bill requires the Secretary to determine an appropriate adjustment percentage within a range that varies depending on the date by which the State eliminates all such past tax or donation programs (the "compliance date"). For a State with a compliance date that is (1) within one year after the enactment of the bill, the range is 20 to 60 percent of the standard reduction; and (2) more than one year, but less than two years, after such enactment, the range is 50 to 80 percent of the standard reduction.

In determining the appropriate percentage within the ranges described above, the Secretary is required to consider the following factors: (1) whether the tax or donation program is permissible under the bill; (2) whether the tax or donation program was initiated prior to the enactment of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991; (3) the number of years the impermissible tax or donation program was in effect; and (4) whether the State cooperated with the Secretary after the enactment of the bill by informing the Secretary of all impermissible tax or donation programs, providing the Secretary with all information necessary for the evaluation of such programs, and expeditiously eliminating such programs.

The bill authorizes the Secretary to take adjusted reductions against States over a five year period. The Secretary is required to take a minimum of 20 percent of a State's reduction amount per fiscal year, unless the State agrees to allow the Secretary to take the remaining balance in fewer than five years.

SEC. 4. GENERALLY REDISTRIBUTIVE WAIVER TEST.

Section 4 amends section 1903(w)(3)(E) (the "waiver"

authority under which a tax that does not otherwise meet the requirements for treatment as a broad-based and uniform tax will be so treated if the Secretary finds that it is generally redistributive and does not include a hold-harmless provision). The amendments clarify that a tax cannot be considered generally redistributive unless the burden it places on the Medicaid program is no greater than the burden that would be placed on the Medicaid program by a tax that is broad-based and uniform.

The amendments also prescribe elements of the method for performing the calculation to determine whether a proposed tax is generally redistributive. Specifically, a State must compare (A) the revenues that would be raised if the State were to tax all health care items, services, or providers within the class or classes that the State proposes to tax (including all Medicare and Medicaid revenues and receipts), with (B) the revenues that would be raised from only those items, services, or providers that are subject to the proposed tax.

Finally, the amendments add a new provision that allows a State that seeks to impose a tax on more than one class of health care items, services, or providers to consider in the aggregate the net impact of the tax on all such classes when performing the generally redistributive test.

SEC. 5. ADDITIONAL PERMISSIBLE HEALTH CARE CLASSES.

Section 5 amends section 1903(w)(7)(A) (which specifies the classes of items or services on which a broad-based tax may be imposed). First, the bill adds as permissible classes (1) health insurance coverage; and (2) every health care item or service within a State. Second, in order to clarify the conditions under which the Secretary may establish an additional class, the bill adds language from the preamble to the final provider tax and donation regulation published on August 13, 1993, specifying that the additional class must meet the following criteria: (1) no more than 50 percent of the gross revenues or receipts of the class may be derived from Medicaid; (2) no more than 80 percent of such revenues or receipts may be derived from Medicaid, the Children's Health Insurance Program, Medicare, and any other Federal health care program; (3) the class is a designated category for purposes of State licensing or Federal regulation or taxation, is included as a type of health care provider under

Medicare or Medicaid, or is otherwise clearly identifiable; and
(4) the class is not unique to a State.

For 3:30 Meeting - I don't know why sending a letter Not AN OPTION

Medicaid Provider Tax File

DRAFT

OPTIONS FOR PROCEEDING ON PROVIDER TAX AND DONATION LEGISLATION

Issue: The Administration's tax and donation legislation will not be enacted before August recess. We are not planning to proceed with audits until later in the fall. What action should be taken to move this issue forward?

Background: Last October HCFA sent out a letter to all State Medicaid Directors announcing our intention to seek legislation to resolve State tax and donation liabilities. In that letter, we said that if our legislation had not been enacted by August of 1998, we would have no choice but to move forward using the full force of current law. We submitted our legislation to Congress on April 2, 1998.

The Administration's bill was not well received by either the committee staff or the NGA. The potential scoring of the bill was a major concern. Since no progress had been made on the legislation, staff began planning to initiate audits in August.

We met with the White House to discuss our strategy and time line for proceeding with audits in August. Following the meeting, we were informed that we should not proceed with the audits until sometime late in the fall. They also suggested that HCFA send a letter to the authorizing committees highlighting the importance of our legislation and asking them to move it forward.

We have been considering what options, other than sending a letter to the Hill, might be available for moving forward.

OPTION 1: Have high level White House officials work to get the proposed legislative language attached to a vehicle that would be passed before the end of the session (e.g. appropriations bill). The package would include instructions for directed score keeping.

The Department's goal is to resolve all retrospective tax and donation liabilities and get all States to come into full compliance with the law. This option will allow the Department to move forward with a commitment to fully enforce the law and take any future disallowances on a timely basis. The language would include the same kind of conditional limited amnesty for States that come into full compliance. Since the scoring of the bill is such a sensitive issue, this option may be difficult to implement.

Scoring

The biggest hurdle to getting our legislation enacted was the prospect of a large score and having to find sufficient offsets. CBO scores this kind of legislation by taking an estimate of the total amount of the potential disallowances and using a certain percentage of that number as the score.

The percentage represents CBO's estimate of the likelihood that HCFA would have taken action to collect the money. In scoring the New York BBA provision, CBO estimated that there was only a 10% likelihood that HCFA would have recovered the money. CBO has indicated that due to the exercise of the Line Item Veto authority and the Supreme Court's subsequent decision that it is unconstitutional, they have raised their estimate of HCFA's willingness to take action. CBO has mentioned a score as high as 33% of the total amount owed. Any public action that the Department takes toward initiating audits and disallowances is likely to raise this percentage.

Directed Scoring

Within a spending bill, it is possible for Congress to disregard CBO's score of a bill thereby altering the offsets required to pass the bill under the BEA (Budget Enforcement Act). Under this approach, the Budget Committees on both sides add language to a bill indicated that the committee is changing the CBO score. The committees may then "direct" the score to be at the level they feel is appropriate (for example, OMB's score or a score of zero.)

On the House side, several congressional committees would have to work in tandem for this to be successful. Generally, the Budget Committee will only make such a scoring change if the authorizing and appropriating committees approve. The change in score is then implemented by a special rule. On the Senate side, this approach would be more difficult. In many instances, provisions in bills that alter or violate provisions of the BEA (such as directed scoring) are subject to a point of order where any Senator could object to the language. If such an objection is raised, a super majority (60 votes) would be required to keep the bill's proposed language altering the BEA requirements.

Pros

- Achieves our stated goals.
- Helps facilitate passage of our bill.

Cons

- Political process could be complicated requiring a substantial commitment of time and effort from high level officials.
- Directed score keeping is subject to a point of order in the Senate -- if it is raised, the bill would have to pass by 60 votes.
- Directed score keeping is controversial. Such actions would generally be opposed by the Administration.

OPTION 2: Work quietly with low-level discussions with committee staff to push the bill. If these discussions are unsuccessful, proceed with audits in November or December.

Under this option we would continue to have discussions with committee staff encouraging

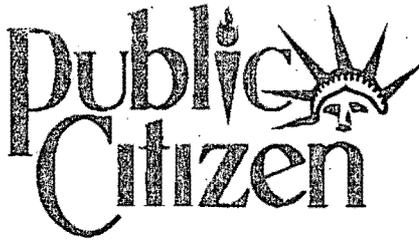
them to take up our bill and letting them know that we are dedicated to moving forward in November if they don't. We would need a firm commitment from the Administration that we would be allowed to proceed with audits in November and December. This option basically represents a short delay in our August deadline. Although we would continue to work toward getting the legislation passed, our efforts are unlikely to be successful without a significant push from the White House.

Pros

- Does not require the Department to get a significant commitment of time and effort from high level White House officials.
- Allows the Department to continue to work throughout the remainder of the session to get the bill passed.
- Delaying the initiation of the audits until December means that we may only have to commit one or two months worth of resources to them before a new Congress begins. The new Congress may have the time and the motivation (due to the on-going audits) to pass legislation that would resolve the issue before we are too far into the process.

Cons

- Talks with committee staff will probably be unsuccessful.
- May commit us to conducting audits which will commit us to taking disallowances with the limited flexibility available under current law unless new legislation is passed.
- Requires that we get a FIRM commitment from the White House that will we be allowed to proceed with the audits in November or December.



File
Medical
Malpractice

Buyers Up • Congress Watch • Critical Mass • Global Trade Watch • Health Research Group • Litigation Group
Joan Claybrook, President

October 7, 1997

Contact: Joan Mulhern (202) 546 4996 ex.384
Joanne Doroshov (202) 546 4996 ex. 315
Brian Dooley (202) 588 7703

**STATEMENT OF FRANK CLEMENTE
Director, Public Citizen's Congress Watch**

On the Medical Malpractice Provisions in the D.C. Appropriations Bill

We are here today because once again a member of Congress wants to impose his personal priorities on the residents of the District of Columbia. Charles Taylor of Brevard, North Carolina, wants to turn us into guinea pigs. He seeks to shred our strong laws that protect us from physicians and hospitals who often maim and sometimes kill because they are careless or outright incompetent. His hometown constituents wouldn't put up with being guinea pigs. And we won't either.

He seeks to impose the most Draconian restrictions on the legal rights of people injured or killed by medical malpractice of any state in the nation. His proposal is unfair. It is discriminatory. It is life threatening. And it must be stopped.

This bill not only limits the liability of medical professionals and medical facilities. It also limits the liability of manufacturers of defective medical devices. Even health insurance companies that deny benefits in bad faith would be protected by the Taylor bill.

No matter how you cut it -- this legislation discriminates. It hurts women more than men. It hurts children more than adults. It hurts lower-income people more than the well-to-do. And it hurts minorities more than white Americans. By capping non-economic damages at \$250,000 for harm such as lost child-bearing ability, disfigurement or loss of sight, well-paid working male adults will be better able to get just compensation for their injuries than others who suffer just as much from medical malpractice. And it will have a particularly discriminatory impact on women who don't work outside the home, children, the elderly and the poor, whose damages tend to be non-economic in nature.

The bill's cap on punitive damages will dramatically reduce the ability of D.C.'s civil justice system to deter future wrongdoing by negligent doctors or manufacturers of defective drugs and devices. Punitive damages are awarded by juries to punish wrongdoers for egregious misconduct.

But this bill caps punitive damages at \$250,000, or two times compensatory damages,

Ralph Nader, Founder

1600 20th Street NW • Washington, DC 20009-1001 • (202) 588-1000

reducing the incentive for hospitals and physicians to exercise the utmost caution. This is particularly absurd given that a 1993 Public Citizen study, "Comparing State Medical Boards," showed that D.C. has one of the worst doctor discipline records in the country -- ranked 45th nationwide. And it protects the misbehavior of the biggest companies or hospitals.

Even worse, the bill completely absolves from punitive damages companies that manufacture defective drugs or medical devices that had the stamp of approval of the Food and Drug Administration. There are many harmful FDA-approved products that have caused medical disasters in the past. This bill should be renamed the Wrongdoers Protection Act, as it would let off scot-free companies that manufacture such products that maim or kill.

It will also be very harmful to women, many of whom suffer each year from sex-related offenses by physicians. According to a Public Citizen study released this year, approximately four of every 10 physicians disciplined for sex-related offenses continue to practice medicine because of overly-lenient actions by regulatory agencies.

There is an epidemic of medical malpractice in this country. It causes 80,000 deaths each year and takes an enormous financial toll -- as much as \$60 billion a year. The costs of medical malpractice insurance are estimated to be only around \$4 billion in a \$1 trillion health care economy. That's why this measure won't reduce health care costs. It will only serve to restrict the rights of medical malpractice victims to hold doctors and hospitals and medical device companies accountable. It will lead to less deterrence, to more injuries, to more uncompensated victims, and to greater overall costs to taxpayers.

Members of Congress enjoy the best health care in the world -- delivered to them at taxpayer expense in the confines of Maryland's Bethesda Naval Hospital or in their home town. As they sit in the comfort of their plush Capitol Hill offices they should remember that tomorrow Congress is not about to experiment with taking away the legal rights of its own members. Only the rights of average citizens are quashed.

The growing concern over the quality of health care in this country demands that Congress reject such brutal health liability restrictions as are contained in the D.C. Appropriations. Congress should focus instead on enacting measures to increase patient safety in Washington, such as beefing up the underfunded and understaffed Board of Medicine, rather than enacting laws that decrease the liability of doctors and other dangerous health care providers, drug companies and medical device manufacturers.

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HEALTH CARE LIABILITY RESTRICTIONS IN THE HOUSE D.C. APPROPRIATIONS BILL -- AMONG THE CRUELEST IN THE COUNTRY

The House Appropriations Committee has targeted the District of Columbia with some of the cruelest liability restrictions in the country. The House D.C. Appropriations bill would severely weaken the legal rights of all D.C. consumers who are injured by malpracticing doctors, manufacturers of defective medical products, and even health insurance companies that deny insurance benefits in bad faith. No state in the country has enacted such Draconian and discriminatory measures.

These provisions will not reduce the costs of health care or medical malpractice insurance. They will be detrimental to efforts to improve the quality of health care, and will penalize some of the most vulnerable members of our community -- the sick and the injured. They would also dramatically reduce the ability of the civil justice system to deter future wrongdoing that threatens consumers' health and safety. Less deterrence will lead to more injuries, more uncompensated victims and greater overall costs to taxpayers.

Among the most damaging provisions are:

- ◆ **Cap on non-economic damages at \$250,000 and elimination of joint and several liability for non-economic damages.** Awards for non-economic loss (injuries such as lost child-bearing ability, disfigurement, and loss of sight) compensate for the human suffering accompanying injuries caused by medical malpractice. An arbitrary cap on such damages would be devastating to those who suffer most. Moreover, the bill makes an unfair distinction between economic damages (e.g. medical expenses and lost wages) and non-economic damages. By limiting non-economic damages, this legislation makes a value judgment that high wage-earners are more deserving of compensation than are low-wage workers, seniors, children and women who work in the home.
- ◆ **Cap on punitive damage awards at \$250,000 or three times the amount of economic loss, whichever is greater.** In recent times the media has reported on doctors amputating the wrong leg; removing the wrong breast; removing a healthy lung; and killing a patient by negligently administering a lethal dose of a cancer-fighting drug. In these kinds of cases, the availability of punitive damages should not be restricted. Moreover, 68% of punitive damage awards in medical malpractice cases are awarded to women, most often in cases of sexual misconduct by health care providers. According to a Public Citizen study "Physicians Disciplined for Sex-Related Offenses," released this June, approximately four of every 10 physicians disciplined for sex-related offenses continue to practice medicine because of overly-lenient actions by regulatory agencies. Without adequate regulatory enforcement, the availability of adequate punitive damages is critical to holding such doctors accountable.

- ◆ **Prohibiting punitive damages in cases involving drugs or medical devices that are approved by the Food and Drug Administration.** Prohibiting punitive damage based on the excuse that the FDA has approved the product could be disastrous for D.C. consumers. FDA pre-market approval and standards set by the agency are minimum safety standards. At most, they establish an acceptable current level of safety, and may only establish a lower safety floor bred by many concessions to powerful lobbies. Manufacturers can discover product dangers after a drug or device is marketed and resist modification or recall without being guilty of withholding or misrepresenting information. This provision could protect manufacturers of some of the most notorious FDA-approved products which have wreaked havoc on consumers, such as defective pacemakers and heart valves that have led to hundreds of deaths and injuries.

- ◆ **Periodic payments for future losses over \$50,000.** This provision is tantamount to enacting a "payment plan for wrongdoers." Periodic payments penalize over time victims who are hit soon after an injury with large medical costs and those who must make adjustments in transportation and housing. In addition, because these payments are not adjusted for inflation, they rapidly pay for fewer needs of the innocent victim as time goes on.

These provisions will do nothing to address the problem of health care costs in the District. Medical malpractice insurance costs make up a minuscule part of overall health care costs. For example, in 1991, total health care costs in the United States were about \$750 billion; medical malpractice premiums that year were about \$4.8 billion, or .6 percent of total health care costs. Moreover, according to a recent study by former Federal Insurance Administrator and Texas Insurance Commissioner Robert Hunter of the Consumer Federation of America, over the last 10 years, medical malpractice premiums, when calculated in constant dollars, have fallen from \$9.5 billion to \$6.4 billion -- a 31% drop in cost relative to general medical costs.

Rather than limiting victims' rights, Congress should consider instead reforms to reduce medical malpractice and improve the quality of health care in the District. According to Public Citizen, the board which licenses doctors in D.C. has one of the worst records for disciplining malpracticing doctors. Better doctor discipline is essential to reducing the incidence of medical negligence. In addition, reform of the insurance industry would ensure sensible underwriting and thereby lower costs in the health care system. Insurance companies should charge rates based on a physician's experience, so that the small number of doctors responsible for the most malpractice would pay higher premiums, and the majority of good doctors would pay less.

Approximately 80,000 deaths occur annually due to doctor negligence in the country -- more than twice the number of motor vehicle occupants killed each year. With the growing concern over health care quality in this country, Congress should enact measures to increase patient safety in Washington, DC, not, as this bill would do, decrease the liability of dangerous health care providers, drug companies and medical device manufacturers.

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CONGRESS IS THREATENING D.C. RESIDENTS' HEALTH

The District of Columbia is not immune to medical disasters. In fact, a 1993 Public Citizen Book, Comparing State Medical Boards, found that D.C. had one of the country's lowest rates of disciplining doctors, ranked 45th compared with the 50 states. The medical liability caps proposed in the D.C. Appropriations bill will further reduce accountability of doctors and hospitals, endangering the health and safety of the District's most vulnerable residents. The District has enough medical horror stories without giving doctors, hospitals and insurers immunity from people who are injured by negligence.

- Cynthia Wichelman, 38, has just *two years to live* because a doctor failed to detect her breast cancer. Early in 1990, she went to a specialist at Georgetown University Medical Center after detecting lumps on one breast. The doctor did a biopsy on one lump and found it to be benign. However, the doctor failed to biopsy another suspicious lump. Concerned, Wichelman returned to the Center in January 1991, *but the doctor failed to order an ultrasound or mammogram*. Two months later, she saw another Center doctor, who told her to return in a year. In October 1991, Wichelman went to a non-Center doctor who biopsied the area and *diagnosed her with breast cancer*. *By that point, the cancer had spread to her lungs.* (National Law Journal, 8/4/97).
- In December 1993, Patricia Lawson underwent the *amputation of her right ring finger* at George Washington University Medical Center after the Center's doctors diagnosed a growth on it as cancerous. It was later discovered that the growth wasn't malignant and that Lawson *never had cancer*. (Legal Times, 7/22/96).
- Costella Prince Thompson, a 53-year-old District teacher, died after undergoing surgery on her arm in 1992. Complaining of a sore throat, chills and vomiting, Thompson returned to the medical center a week after the operation. She was examined by an assistant, who prescribed medicine and bed rest. *She died the next day*. An autopsy revealed *massive internal complications from her surgery that were completely missed by the assistant*. (Washington Post, 8/7/95).
- In October 1991, D. C. resident Lilia Reyes, 44, complained to her physician of abdominal pains, bleeding and other problems. Her doctor did not refer Reyes' for a sigmoidoscopy, a normal test for colon cancer, and instead diagnosed her problem as irritable bowel syndrome. In August 1992 when Reyes underwent emergency surgery for a blocked colon, she was then diagnosed with colon cancer. *Her life expectancy is greatly shortened as a result of the earlier misdiagnosis*. (Washington Post, 8/7/95).
- District resident Damon Briggs, 19, has cerebral palsy and *is confined to a wheelchair for the rest of his life because doctors at Columbia Hospital for Women botched his difficult birth*. (Washington Times, 2/6/92).
- In December 1986, Julie Surland arrived at the Washington Hospital Center for an abortion. While performing the procedure, *the doctor failed to detect a one-inch gash that he had made in Surland's uterus*, and discharged her upon completion. Almost immediately, Surland began to suffer massive internal bleeding and was in critical condition. *Rendered "surgically menopausal" at age 19, Surland is permanently unable to bear another child*. (Washington Post, 12/19/89).

Improving medical care in D.C. should be a top priority of Congress. Instead, the House Appropriations Committee is trying to ram through a measure that would arbitrarily restrict District residents' rights to hold bad doctors, hospitals and insurance companies accountable for the harm they cause.

BACKGROUND ON DISTRICT OF COLUMBIA PATIENTS INJURED BY MEDICAL MALPRACTICE

MARK SCOTT

Mark Scott, now seven years old, will never be able to walk, talk or take care of himself. Mark is catastrophically brain damaged as the result of medical malpractice.

Mark was born February 26, 1990, at the Greater Southeast Community Hospital in Washington, D.C. During the course of Mary Scott's pregnancy, her doctor determined that she was a high-risk patient who required close monitoring. When Mary Scott began to experience labor pains, her private attending physician was contacted by telephone. He advised Mary to report to the hospital.

The hospital's notes show that Mary arrived at the labor and delivery suite at 8:05 a.m. on February 26. Between 8:05 a.m. and 4 p.m. -- when Mary's doctor came to the hospital -- no medical doctor saw, consulted, examined or had any contact with her, despite the fact she was a high-risk patient. The only people who came into contact with Mary Scott were nurses. When the doctor finally arrived, the decision was made to perform a caesarean section for "fetal distress and cephalopelvic disproportion." In other words, Mary's pelvis was too small and her doctor anticipated a difficult delivery. Notwithstanding the decision to go to delivery because of "fetal distress," Mark Scott was not born until 6:37 p.m.

After birth, Mark was severely compromised and depressed and had aspirated meconium (a condition that occurs when a baby has a bowel movement in utero and inhales this toxin.) As a result of this botched -- and clearly negligent -- delivery, he suffers from seizure disorder, cerebral palsy and mental and motor retardation. At age seven, Mark cannot talk, walk or feed himself. He has no self-help skills. However, he is aware of his environment and enjoys stimulation. The Scotts' medical malpractice lawsuit against the hospital and health care providers settled out of court.

If the bill was law, children like Mark Scott could get only nominal payments for pain and suffering. Their families would be able to recover medical expenses but, if he lives to age 60, Mark could only recover about \$4,000 per year for losing the chance to live a normal life.

CYNTHIA PADDOCK

In 1990, Cynthia Paddock of Washington, D.C., was studying for a career in international affairs when she developed the medical condition known as hydrocephalus. This condition is accompanied by an abnormal increase in the amount of spinal fluid within the cranial cavity.

Cynthia went to a D.C. hospital for what was to be a fairly routine procedure, the placement of a shunt to drain the excess fluid. Patients who have shunts generally can lead normal, active lives. However, after the surgery Cynthia developed intracranial bleeding while in the intensive care unit. The hospital staff negligently failed to recognize symptoms of the bleeding for an extremely long period, and as a result Ms. Paddock was severely -- and permanently -- injured.

Ms. Paddock underwent emergency surgery to repair the hemorrhage. After the surgery she was completely incapacitated, like a baby. Only after months of rehabilitation did she regain her ability to speak and walk, albeit with a limp and cane and partial, permanent paralysis.

Now 34, Ms. Paddock also has permanent neurological injuries as a result of this negligence.

Her ability to understand, think and remember has been permanently damaged. She knows that her anticipated career will never happen. She no longer is able to participate in the recreational activities that she once did. She knows that her normal life was taken away from her because of the medical industry's negligence. Cynthia brought a lawsuit, which was settled, against the negligent health care providers to hold them accountable.

If this bill had been law when Cynthia filed her case, she could have recovered no more than \$7,150 per year for her pain and suffering (assuming she lives until about age 70).

EVONNE BARBER

In 1992, Evonne Barber lived and worked in Washington, D.C. She enjoyed trips with her husband and family and was active at work, traveling to conferences and meetings. Because of medical malpractice, Ms. Barber is now a double amputee, unable to work or enjoy many of the activities she used to share with her family and colleagues.

Ms. Barber went to a physician in Washington, D.C. with complaints of leg pain. Following some tests, including an aortogram, the doctor determined that Ms. Barber had problems with her circulation. Surgery was performed to implant prosthetic grafts to improve her circulation. After the surgery, complications arose. Ms. Barber had to be hospitalized more than once for infections where the grafts were placed. Ms. Barber's doctor failed to recognize the seriousness of the infection and did not remove the grafts quickly enough. As a result, Ms. Barber's legs became severely infected. She was forced to have her right leg amputated above the knee and her left leg amputated below the knee.

The bill caps punitive damages at \$250,000 or three times economic losses. This means Evonne Barber could not ask a jury to assess more than \$250,000 in punitives no matter how careless the jury found the defendants in causing her tragic amputations. A jury could not award more even if it believed that more than \$250,000 was needed to punish the defendants and deter them from making the same mistake in the future.

KALIL WRIGHT

Kalil Wright, now four, was born in August 1993 at the Columbia Hospital for Women in Washington, D.C. Kalil's mother, Tonya, received regular prenatal care and had an uncomplicated pregnancy with Kalil, her first and only child.

After Tonya's due date passed, she was admitted to the hospital to induce labor. The nursing notes documented adverse signs on a fetal monitor, but they did not respond quickly enough. In addition, the attending physician was not told quickly enough that there were warning signals from the fetal monitor. When Tonya's doctor finally was notified, she recognized that a caesarean section was necessary. However, the doctor did not arrive at the hospital until it was too late to deliver Kalil without his suffering severe brain damage from a loss of oxygen.

Kalil is a beautiful and active boy, but is unable to speak or dress himself or do any of the activities that a normal 4-year-old boy might do. He suffers from severe mental retardation, which was caused by the health care providers' negligence. Kalil will need constant care all of his life. But just as importantly, he has been deprived forever of his chance to lead a normal life.

If the bill was law, children like Kalil could get only nominal payments for pain and suffering. Their families would be able to recover medical expenses but, if he lives to age 60, Kalil could only recover about \$4,000 per year for losing the chance to live a normal life.