

MAR 11 1994

Washington, D.C. 20201

Forward to Carol Rasco
3/11/94
CONFIDENTIAL *PA*

MEMORANDUM TO CAROL RASCO

From: Kevin Thurm *[Signature]*
Re: Hyde Amendment

DETERMINED TO BE AN *RW*
ADMINISTRATIVE MARKING
INITIALS: *Ry* DATE: 8/8/11

Attached is a memo detailing proposed next steps with respect to enforcement of the FY 1994 Hyde Amendment.

We would like to begin consultations by the middle of next week; please let me know if you have any questions or if you need any further information.



MAR 1 1994

~~CONFIDENTIAL~~
~~CONFIDENTIAL~~

Rw

MEMORANDUM FOR THE HONORABLE CAROL RASCO
ASSISTANT TO THE PRESIDENT FOR
DOMESTIC POLICY

In December, HCFA notified all states that their Medicaid programs must be made consistent with the current Hyde Amendment by March 31, 1994, or they would risk being determined out of compliance with federal law.¹ (A copy of that letter is at Tab 1.) March 31 is fast approaching. Most states -- including some with conflicting state laws -- have indicated a willingness to comply, but there are some which have not. This memorandum sets out how we propose to proceed.

1. The status of state compliance

There are two potential obstacles to a state matching the terms of the Hyde Amendment: (a) the state's Medicaid plan and (b) a state statute or constitutional provision.

(a) State Medicaid plans

The December 28 HCFA letter required all states to bring their Medicaid plans, which are on file in HHS regional offices, into compliance with the current Hyde Amendment. Some states, however, are silent in their Medicaid plans on the scope of their coverage of abortions. We do not require that a state specify the scope of coverage, so silence by itself is not a problem.

The problem arises in those situations in which either the plan states that coverage is more restrictive than the current Hyde; or, in states where, although the plan is silent, we are aware that state law limits coverage more restrictively.

¹Normally, states are expected to comply with a new law as soon as it takes effect. In this instance, HCFA extended the deadline to March 31 to give states one full quarter after receipt of the December 28 letter to bring their programs and plans into compliance. (Changes in state plans can be made retroactive to the first day of the quarter in which they are submitted.)

(b) State law

In states with a conflicting state law, some states have indicated to us that they recognize that federal law pre-empts in this situation, and that they intend to furnish the required services. Other states, however, have indicated either that their state legislatures may amend their state laws, so they are waiting for their current legislative sessions to conclude; or they have indicated that they intend not to comply. Attached at Tab 2 is a chart summarizing the status of state compliance as it appears to us today.²

(c) Projected results

We believe that on April 1, there will be one state that will, on the face of its state plan, be in non-compliance with no intent to comply: **New Hampshire**. There is no conflicting state statute or constitutional provision in New Hampshire, so there is no arguable legal impediment to compliance.

In addition, there are four states where the state plan is silent, but there is a conflicting state regulation (**Montana**) or a conflicting law that the state intends not to change and where the state legislature has been in session and has chosen not to act: **Utah, Indiana, and South Dakota**. In Montana, where the conflict exists in a regulation only, the regulation could be changed without any legislative action.

There are four and possibly five other states where we expect enforcement difficulties, but where the state legislatures are still in session or will be in session later this year and could amend state law to remove any asserted conflict: **Colorado, Kentucky, Louisiana, Michigan** and possibly **Arizona**.

Pennsylvania has objected to the December letter, but only on a narrow reporting issue. We are treating the issue of Pennsylvania's objections to the reporting waiver separately because there is no dispute with Pennsylvania over coverage of rape and incest abortions, nor is there a dispute over whether the state's reporting requirement is reasonable. That is, Pennsylvania already covers rape and incest abortions and has an acceptable reporting requirement. The only dispute concerns Governor Casey's refusal to agree that the reporting requirement would have to be waived in those instances in which a physician certifies that an individual woman could not, for medical reasons, comply with the reporting requirement. Pennsylvania is the only state which has objected on this basis.

²The chart categorizes states based on the terms of their current state plans and any relevant state laws, and incorporates the results of recent inquiries by HCFA staff to state Medicaid directors regarding their intentions to comply or not to comply with the new Hyde Amendment.

2. Medicaid compliance procedures

The regulations governing Medicaid hearings, 42 CFR §430.60 et. seq., outline a series of steps and procedural rules that apply when HCFA determines that "a State plan or State practice... is not in compliance with Federal requirements." The Administrator is required to notify the state, by mail and by publication in the Federal Register, of a hearing which is to be scheduled not fewer than 30, nor more than 60, days from the date of notice.

Both those regulations and the more detailed Medicaid Regional Office Manual favor attempts to resolve disputes through negotiation. Section 1102.4 of the manual directs the Assistant Regional Administrator to "make[] every effort to resolve a question of compliance by negotiations...." Negotiations are to be continued "only as long as there is a reasonable expectation of success....," not to exceed one year, to be terminated sooner if "there is sufficient indication of the absence of a good faith intent [by the State] to resolve the issue."

After a hearing occurs, the state has a right to appeal any adverse decision to the HHS Departmental Appeals Board. If the decision of the Appeals Board is adverse, the state can seek judicial review.

The scope of the remedy is somewhat discretionary. Once there has been a finding of noncompliance, the remedy can be either total withholding of future federal financial participation (FFP) until compliance is guaranteed, or withholding of FFP from the parts of the plan or practice affected by the noncompliance.

Thus, the Secretary has broad discretion, in the words of Gilbert and Sullivan, to make the punishment fit the crime. In this particular case, the Secretary would be able, after a finding of noncompliance, to terminate funding for the entire program, to withhold funding only for that portion of the program that pays for physician services, to withhold funding only for all abortion services, to withhold funding for obstetrical services, or to withhold funding for State administration on the theory that the noncompliance results from the failure of the State properly to administer the program.

These compliance steps inevitably will consume at least several months. We do not know whether Congress will re-enact the Hyde Amendment in its current form, or change it in some fashion in the FY 1995 budget (which in all likelihood would be before any enforcement action will have made its way through the administrative process). In any event, however, we will need to take action efficiently in order to communicate the message that the Department takes this issue seriously and will not accept open defiance by the states.

3. Proposed enforcement steps

(a) Consultation with states and other affected groups

We intend to schedule a meeting with representatives from the National Governors Association, the National Conference of State Legislatures, the American Public Welfare Association, and other affected groups to consult with them about our plans as soon as we get White House clearance to proceed. The Director of the Medicaid Bureau has drafted a letter to be sent to the states before March 31 providing an update and answering questions that we have received. (A copy is attached at Tab 3.) We will explain to the groups the information in the pre-March 31 letter and express our desire to work with states that are having difficulty coming into compliance but which share that goal.

(b) Pre-March 31 letter

We have received inquiries from approximately a dozen states seeking clarification of the December 28 letter to the states from the Director of the Medicaid Bureau. Some of these inquiries have concerned logistical matters, such as the form of certification required for payment. Some have sought a fuller explanation of the legal basis for the December letter. A few have questioned whether the agency intends to enforce compliance at all.

The proposed letter at Tab 3 responds to these inquiries. It will function as a public statement as well as a letter to specific states.

The letter includes two key points:

- * It stresses that "we are willing to work with those states that demonstrate their willingness to take the necessary steps to bring their programs into compliance with federal requirements in order to avoid any unnecessary disruption of ongoing programs."

- * It warns states that an individual woman's claim to benefits for the abortion of a pregnancy that results from rape or incest cannot be blocked by a contrary state law, according to a series of court holdings. It further states that these judicial holdings would apply regardless of the status of any proceedings between HHS and the state.

(c) Post-deadline actions

When the March 31 deadline passes, we will communicate with states depending on their status at that time.

For all states where the state plan, on its face, is out of compliance, we will ascertain whether there is a state law in conflict. As stated above, we expect that one state (New

Hampshire) will have a plan out of compliance without any state law or regulation contrary to the scope of the Hyde Amendment. In addition, we expect that one state (Montana) will be out of compliance based solely on a state regulation. Negotiations probably leading to enforcement proceedings against those states would be appropriate immediately. For states with a non-conforming state plan but state laws in conflict, we would write to ask them whether their state legislature had had the opportunity to amend its state law or whether the legislature was still in session. We would indicate that we will take no enforcement steps against a state so long as its legislature could act to remedy the situation. As stated above, we now expect that three states (Indiana, South Dakota and Utah) will be in this category, i.e. states whose legislatures will have adjourned without taking action to amend state law. Assuming that they respond to our letter in the manner that we now anticipate, negotiation and probably enforcement proceedings would then become appropriate.

For states where the state plan is silent, we would ask them to certify that they are providing services of the scope required by the Hyde Amendment. If they are not, we would make the same inquiry described above regarding state legislative sessions.

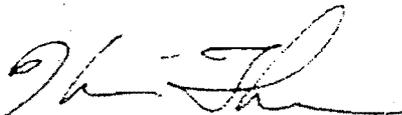
4. Litigation by advocates

Pro-choice advocacy groups have filed three lawsuits against states since the enactment of the current Hyde Amendment. The state constitutional provisions restricting use of state funds in Arkansas and Colorado were challenged in lawsuits filed in federal court in those states, and there is also a suit in Pennsylvania challenging both that state's second physician certification requirement for abortions needed to save the woman's life and the reporting requirement for rape and incest abortions. Dispositive motions have been filed in at least two of those cases, and we have no indication of when the judges might rule.

We expect that these groups will initiate additional lawsuits after the March 31 deadline passes, although we do not know where these suits are likely to be filed. Judicial rulings in some of these cases could precede the completion of Departmental enforcement actions.

5. Summary

Our plan is to proceed in a measured, fair fashion, allowing the states and their legislatures as much leeway as possible. We are committed to negotiating with states so long as there is a reasonable expectation that a particular state is genuinely seeking to comply. Once a state has clearly indicated that it will not comply, however, we would institute enforcement on a case-by-case basis.



Kevin Thurm



December 28, 1993

Dear State Medicaid Director:

The purpose of this letter is to notify you about a recent Congressionally enacted revision to the "Hyde Amendment" which affects the Medicaid program and to tell you how this revision in the law is to be implemented.

Effective October 1, 1993, as part of P.L. 103-112, the Health and Human Services Appropriation bill, Congress passed a revision of the Hyde Amendment pertaining to Federal funding of abortions under the Medicaid program. As enacted, the provision states:

None of the funds appropriated under this Act shall be expended for any abortion except when it is made known to the Federal entity or official to which funds are appropriated under this Act that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape or incest.

Thus, Federal funding (FFP) is now available for abortions performed to save the life of the mother or to terminate pregnancies resulting from rape or incest when the claim for such an abortion is paid by the State on or after October 1, 1993. Please note that it is the date that the State pays the claim and not the date of the service which determines the availability of FFP.

In order to implement this provision of the law, we are requesting that beginning with the first Quarterly Expenditure Report (HCFA-64) for fiscal year (FY) 1994 in January, States submit to the Health Care Financing Administration (HCFA) regional office (RO) a form certifying the number of abortions for which FFP is being claimed. The form should outline the number of abortions performed to save the life of the mother, the number performed for a pregnancy resulting from an act of rape, and the number performed for a pregnancy resulting from an act of incest. This certification should be submitted to the RO on a quarterly basis with the completed HCFA-64.

Current regulations at 42 CFR 441.203 and 441.206 require that before FFP can be made available, the State must obtain a signed physician's certification that, based on the professional judgment of the physician, the abortion was necessary because "the life of the mother would be endangered if the fetus were carried to term." Because the language of the current Hyde Amendment differs somewhat from its predecessors, the State must change the wording of the physician's certification to comport with the current statutory language. With regard to this portion of the Hyde Amendment, the new legislative language, "to save the life of the mother", has essentially the same meaning as the previous legislation.

As with all other mandatory medical services for which Federal funding is available, States are required to cover abortions that are medically necessary. By definition, abortions that are necessary to save the life of the mother are medically necessary. In addition, Congress this year added abortions for pregnancies resulting from rape and incest to the category of medically necessary abortions for which funding is provided. Based on the language of this year's Hyde Amendment and on the history of Congressional debate about the circumstances of victims of rape and incest, we believe that this change in the text of the Hyde Amendment signifies Congressional intent that abortions of pregnancies resulting from rape or incest are medically necessary in light of both medical and psychological health factors. Therefore, abortions resulting from rape or incest should be considered to fall within the scope of services that are medically necessary.

The definition of rape and incest should be determined in accordance with each State's own law. States may impose reasonable reporting or documentation requirements on recipients or providers, as may be necessary to assure themselves that an abortion was for the purpose of terminating a pregnancy caused by an act of rape or incest. States may not impose reporting or documentation requirements that deny or impede coverage for abortions where pregnancies result from rape or incest. To insure that reporting requirements do not prevent or impede coverage for covered abortions, any such reporting requirement must be waived and the procedure considered to be reimbursable if the treating physician certifies that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the requirement.

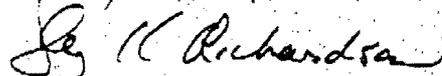
States which have State Plan language more restrictive than that provided for under the revised Hyde Amendment may qualify for Federal funding for the first quarter of FY 94 if they submit approvable State Plan language changes by December 31, 1993.

By March 31, 1994, all States must ensure that their State Plans do not contain language that precludes FFP for abortions that are performed to save the life of the mother or to terminate pregnancies resulting from rape or incest.

As you know, it is necessary for States to adhere to all conditions for Federal Medicaid funding. As part of its ongoing State assessment and audit programs, HCFA may include reviews of abortion claims, if necessary, to assure compliance with these conditions.

Please call my office if you have any questions about this matter.

Sincerely yours,



Sally K. Richardson
Director
Medicaid Bureau

cc: All Regional Administrators

CATEGORIES OF STATES FOR
HYDE AMENDMENT IMPLEMENTATION

**CATEGORIES OF STATES FOR HYDE AMENDMENT
IMPLEMENTATION**

1. No State law prohibits funding of rape & incest abortions--
State Plan or administrative provision prohibits such
funding.
 - a. State does not intend to comply or intent is unknown.

Montana* (Administrative Rule)
New Hampshire* (State Plan)
 - b. State will continue to fund with all State money, but
will not amend plan to conform with the new provisions.

Virginia
 - c. State intends to make necessary changes and comply.

Delaware
Guam
Iowa
Maine
Minnesota
Rhode Island

 2. State law, including constitutional provisions, prohibits
funding of R & I abortions.--No relevant State plan
provision.
 - a. State legislature will have adjourned prior to March
31. State intends to invoke State law and not comply.

Indiana*
South Dakota*
Utah*
 - b. State legislature will not have adjourned or met
prior to March 31. State intends to invoke State
law and not comply or intention is unknown.

Arizona
Arkansas
Colorado
Illinois
Michigan
Nebraska
North Dakota
Ohio
- * States most likely to be out of compliance on April 1
or soon there after.

c. State intends to comply without changing law.

Massachusetts
Missouri
Oklahoma

3. State law, including constitutional provisions, prohibits funding of R & I abortions--State Plan provision prohibits such funding.

a. State intends to invoke State law or intentions are unknown.

Kentucky
Louisiana

4. No State law prohibits funding of R & I abortions--No relevant State plan provision.

a. State intends to comply.

Alabama	New York
Alaska	North Carolina
California	Oregon
Connecticut	Puerto Rico
District of Columbia	South Carolina
Florida	Tennessee
Georgia	Texas
Hawaii	Vermont
Kansas	Virgin Islands
Maryland	Washington
Mississippi	West Virginia
Nevada	Wisconsin
New Jersey	Wyoming
New Mexico	

5. No State law prohibits funding of R & I abortions, but there are questions about reporting requirements.

Pennsylvania¹
Idaho

¹ State has a reporting requirement that it does not intend to waive.

6. Legislative calendars for States identified in 1, 2 and 3 above.

Arizona	January 10 - April 30
Arkansas	No regular legislative session in 1994
Colorado	January 12 - May 11
Illinois	January 12 - May 27
Indiana	January 5 - March 15 ²
Kentucky	January 4 - April 13
Louisiana	April 25 - June 8
Michigan	January 12 until end of year
Missouri	January 5 - May 15
North Dakota	No regular legislative session in 1994
Ohio	January 3 - May 31
Oklahoma	February 7 - May 7
South Dakota	January 11 - February 26 ³
Utah	January 17 - March 2

² Legislature has not acted and intends to adjourn early. Session ends March 4.

³ Regular session has ended will return March 15 to consider budget.

LETTER TO STATE MEDICAID
DIRECTORS PROVIDING GUIDANCE
TO STATES IN AREAS WHERE
QUESTIONS HAVE BEEN RAISED

DRAFT

Dear State Medicaid Director:

On December 28, 1993, I wrote to notify you about the congressionally enacted revision to the "Hyde Amendment" which governs federal funding of abortions. My letter described the requirements of the new law and explained how its provisions were to be implemented by states. Since that time, we have received a number of questions regarding implementation of the law. The purpose of this letter is to provide guidance to all states in the areas identified by those questions.

*Make advise log
watch*

We have been asked if the change in the language of the most recent "Hyde Amendment" signifies a change in what is meant by "to save the life of the mother". We do not believe that Congress intended any change in this category of abortion coverage. Therefore, states should continue to apply the same criteria in identifying these cases as were previously used. As before, a physician certification indicating that, on the basis of the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term, must be submitted to the state Medicaid agency. The certification must contain the name and address of the patient and must be signed by the physician. It is important to note that there are no exceptions to this certification requirement. A diagnosis code on the claim form may not be used in lieu of the above-described certification to document abortions performed to save the life of the mother.

With regard to the new provisions on abortions performed following rape or incest, HCFA will not require that any specific form(s) be used to document such cases. Each state is free to use any form or forms it chooses. Furthermore, HCFA will not require that any documentation be submitted to us for review prior to making payment for abortions resulting from rape or incest or those performed to save the life of the mother. However, we do expect that documentation of the circumstances of these cases will be maintained in the medical records or in the records of the agencies to which cases of rape or incest must be reported (if any).

Similarly, HCFA will not establish a time frame within which cases of rape or incest must be reported to a law enforcement or other agency. State law or policy should dictate when and to whom a rape or a case of incest must be reported. However, as noted in my December 28 letter, the state-established reporting requirements may not serve as an additional coverage requirement to deny or impede payment for abortions where pregnancies result from rape or incest.

DRAFT

The state must establish procedures which permit the reporting requirements to be waived, and the procedure reimbursed, if the treating physician certifies that, in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the reporting requirements.

We have also been asked whether states must claim FFP for the abortion services specified by the "Hyde Amendment". No state is compelled to claim FFP for abortion services. However, a state must provide abortion services to Medicaid recipients in accordance with the law even if the state chooses to claim no federal monies for those services.

A number of questions were raised concerning the circumstances under which states must amend their Title XIX state plans to conform to the law. States with plans that currently make no mention of abortion coverage need not amend their plans in any way. States with plans which do not provide for coverage of abortion services in accordance with the "Hyde Amendment" must modify those plans to bring them into conformance with the law by March 31, 1994.

We recognize the difficulties that some states face because of state laws that may conflict with the current Medicaid requirements. We are willing to work with those states that demonstrate their willingness to take the necessary steps to bring their programs into compliance with Federal requirements in order to avoid any unnecessary disruption of ongoing programs.

However, states that have non-conforming plans after March 31, 1994, and states that indicate they will rely on conflicting state law as a basis for their continuing noncompliance, will be subject to the compliance process applicable to all Title XIX mandates.

You should be aware that individuals participating in your Medicaid programs may claim entitlement to the federal benefits that are currently provided under that program, including payment for an abortion that results from an act of rape or incest. Federal courts that have considered this issue in the past have held that state law impediments cannot stand in the way of an individual's entitlement under a state's Medicaid program to medically necessary services, including abortions, for which federal funds are available. These holdings would apply regardless of the status of any proceedings between the Department and a state with respect to its conformity with current federal requirements.

DRAFT

I hope that this information is helpful to you in complying with the requirements of the law. Please call my office if you have any questions about this matter.

Sincerely yours,

Sally K. Richardson
Director
Medicaid Bureau

cc: All Regional Administrators

*I want to attend
to it as early as
possible. My
initial response to
the St. Louis
office is to
provide the
information to
the St. Louis
office as soon
as possible.*

**CATEGORIES OF STATES FOR HYDE AMENDMENT
IMPLEMENTATION**

1. No State law prohibits funding of rape & incest abortions--
State Plan or administrative provision prohibits such
funding.

Delaware*
Guam*
Iowa*
Maine*
Minnesota* *(US has reporting req. on rape)*
Montana (Administrative Rule)
New Hampshire (State Plan)
Rhode Island*
Virginia*

2. State law, including constitutional provisions, prohibits
funding of R & I abortions.--No relevant State plan
provision.

Arizona*
-Arkansas
Colorado
Illinois
-Indiana
Massachusetts*
Michigan
Missouri*
Nebraska
-North Dakota
Ohio
Oklahoma*
-South Dakota
-Utah

- * States which have indicated that they intend to fund
rape and incest abortions.

- 3. State law, including constitutional provisions, prohibits funding of R & I abortions--State Plan provision prohibits such funding.

Kentucky
Louisiana*

- 4. No State law prohibits funding of R & I abortions--No relevant State plan provision.

<p>Alabama* Alaska* California* Connecticut* District of Columbia* Florida* Georgia* Hawaii* Kansas* Maryland* Mississippi* Nevada* New Jersey* New Mexico*</p>	<p>New York* North Carolina* Oregon* Puerto Rico* South Carolina* Tennessee* Texas* Vermont* Virgin Islands* Washington* West Virginia* Wisconsin* Wyoming*</p>
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6325 Security Boulevard
Baltimore, MD 21207

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With regard to the new provisions on abortions performed following rape or incest, HCFA will not require that any specific form(s) be used to document such cases. Each State is free to use any form or forms it chooses. Furthermore, HCFA will not require that any documentation be submitted to us for review prior to making payment for abortions resulting from rape or incest or those performed to save the life of the mother. However, we do expect that documentation of the circumstances of these cases will be maintained in the medical records or in the records of the agencies to which cases of rape or incest must be reported (if any).

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DRAFT

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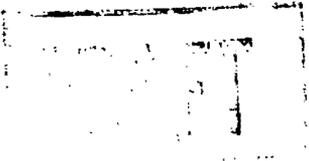
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You should be aware that individuals participating in your Medicaid programs may claim entitlement to the federal benefits that are currently provided under that program, including payment for an abortion that results from an act of rape or incest. Federal courts that have considered this issue in the past have held that State law impediments cannot stand in the way of an individual's entitlement under a State's Medicaid program to medically necessary services, including abortions, for which federal funds are available. These holdings would apply regardless of the status of any proceedings between the Department and a State with respect to its conformity with current federal requirements.



I hope that this information is helpful to you in complying with the requirements of the law. Please call my office if you have any questions about this matter.

Sincerely yours,

Sally K. Richardson
Director
Medicaid Bureau

cc: All Regional Administrators

*John M...
6th Floor, E...ida*

**TALKING POINTS ON PENNSYLVANIA LAWSUIT ON REPORTING REQUIREMENTS
FOR MEDICAID-FUNDED ABORTIONS**

MARCH 18, 1994

On Wednesday, March 16, Pennsylvania Gov. Robert Casey and other state officials filed a lawsuit in U.S. District Court in Harrisburg, Pa., asking the court to overturn federal guidance on Medicaid funding of abortions. Pennsylvania claims that guidance is inconsistent with its requirement that victims of rape or incest must report the incident to law enforcement authorities prior to receiving a publicly funded abortion. The suit questions the directive contained in a Dec. 28, 1993, letter from Sally Richardson, the Health Care Financing Administration's Medicaid Director, informing all state Medicaid directors that a new federal law requires their programs to pay for abortions when pregnancies have resulted from rape or incest. The letter informed states of a new provision passed by Congress in October 1993.

**per Martha DiSario and Howard Coan/Press Office at HHS'
Health Care Financing Administration (202-690-6145)**

* HCFA is mystified by Pennsylvania's filing of this suit. At this time, HHS and the Administration cannot comment on the suit, but there are a number of inaccuracies in a three-page press release issued Wednesday by the Office of Pennsylvania Attorney General Ernest Preate Jr.

* Nothing in the December 28, 1993, HCFA letter to state Medicaid directors is inconsistent with Pennsylvania's current rape and incest reporting requirements. In fact, the letter states the states may impose such reasonable reporting requirements.

* The press release says HCFA has threatened to withhold at least some of the state's \$2.9 billion in annual Medicaid funding if the state does not comply. The letter contains no threat of any kind to withhold any dollars from Pennsylvania.

* The press release says the letter should have been issued as a regulation, with opportunity for the states to comment. In fact, the letter contained no new regulatory requirements. HCFA routinely advises all the states, as it did here, of changes in federal law, and HCFA routinely reviews states' compliance with federal requirements. The Dec. 28 letter merely informs the states of changes that Congress had made to abortion funding policy. HCFA is not aware of any compliance problems with the state of Pennsylvania over this issue.

#

Memorandum

Date FEB 1 1994

From Director
Medicaid Bureau

Subject Handling of Impermissible Provider Taxes Under
Medicaid

To The Administrator

ISSUE

We need to decide how to proceed with the potential disallowances of impermissible provider taxes under the Medicaid program.

BACKGROUND

With the help of the Regional Offices, we have surveyed the States to determine:

- 1) the number of States that have enacted provider tax programs subject to the new regulations;
- 2) which of these taxes appear to be problematic; and,
- 3) which of the taxes will need waivers in order to be permissible.

The results of the survey are shown in the attached tables. While we believe these charts are accurate based upon the information we have, we would caution that there may be some taxes that have not been identified. In addition, these charts were prepared based on a quick review of the tax programs. We still need to read each piece of State legislation to ensure this information is completely accurate. However, we believe the charts reasonably illustrate the number and size of the tax programs in each State.

In general, there are four requirements that a health care related tax must meet in order to be permissible. They are as follows:

1. it must tax a class of items and services listed in the statute or designated by the Secretary in regulations;
2. the tax must be broad-based; i.e., it must tax all of the items or services, or providers of those services, in a class;
3. the tax must be uniformly applied; (The statute lists three specific kinds of taxes that are uniform, and permits the Secretary to determine that other kinds of taxes are also uniform.) and,
4. a tax may not hold taxpayers harmless for their tax payments.

According to the statute and regulations, States are not permitted to hold providers harmless directly through guarantees or other explicit repayment arrangements. In addition, States are not permitted to hold providers harmless indirectly through Medicaid payments. HCFA will consider a hold harmless provision to exist if the tax is applied at a rate in excess of 6 percent of provider revenue and more than 75 percent of providers receive more than 75 percent of their tax costs through Medicaid rate increases and other State payments (75/75 test). The regulations allow States until September 13, 1993, to revise a tax in excess of 6 percent that could not meet the 75/75 test. If the tax was not modified, funds received by the State on/or after September 13, 1993, will be disallowed.

If a tax does not meet all four requirements listed above, the statute gives HCFA the authority to take a disallowance. Specifically, the State's total amount of Medicaid expenditures shall be reduced by the sum of any revenues received by the State during the fiscal year from impermissible provider taxes or donations, before any Federal matching funds are calculated.

TABLES

The following information relates to the 3 tables we have developed on State taxes at issue.

Table 1 -- Taxes Believed to be Impermissible.

This table indicates State tax programs, that on their face, appear to be in violation of the regulations. The table is divided into three parts.

Table 1-A Tax programs that tax classes of health care items and services not designated in the regulations [such as personal care services].

Some of these tax programs, such as the Arkansas home health agency tax, apply to both permissible and impermissible classes. In these cases, the amount of revenue collected and the amount of FFP to be disallowed reflect only the impermissible class.

Table 1-B Tax programs that contain features, such as grant programs or tax credits, that attempt to hold some of the taxpayers harmless for their tax payments.

Table 1-C Tax programs that were permissible only during the State's transition period, but for which the State received revenues after the transition period.

For each tax, we have indicated, where known, the amount of revenue collected under the tax through the end of Fiscal Year 93, and the amount that would be collected in the first quarter of Fiscal Year 94.

Tables 1-A, 1-B, and 1-C indicate that 8 States have enacted 16 tax programs in these categories. For Fiscal Year 93, these taxes produced revenues of \$507.359 million, that will result in approximately \$304.982 million in disallowances. For the first quarter of Fiscal Year 94, these taxes produced revenues of \$39.914 million, that will result in approximately \$25.182 million in disallowances. The tax revenue and disallowance amounts do not include four tax programs for which the revenue collected was not immediately available.

Table 2 -- Taxes That Need Waivers to be Approved.

Table 2-A Taxes that are not broad-based or uniform, and States will need to submit requests for waiver of these requirements.

In general, while we cannot predict with certainty which of these taxes would or would not meet the tests set out in the regulation, a tax that exempts providers with little or no Medicaid utilization or that does not meet the test for favorable presumption would not ordinarily meet the requirements for approval. In this vein, we would note that there are several tax programs (e.g., D.C. nursing home tax) that are unlikely to meet the tests for approval.

Table 2-B Tax programs that are not deemed by the statute to be uniform, but which States can ask the Secretary to deem as uniform.

The statute lists three specific kinds of tax bases that are deemed to be uniform. However, the statute permits States to ask the Secretary to review other kinds of taxes and deem them as uniform. While taxes on Table 2-B may ultimately require a waiver, States should be afforded the opportunity to demonstrate to the Secretary that these taxes are uniform in lieu of a formal waiver request.

Table 3 -- Taxes For Which Additional Information Is Needed.

Table 3 lists a number of tax programs for which there is insufficient information to make a judgement about their permissibility. For the most part, these taxes are recently enacted. We are contacting the States that have these taxes for more information.

RECOMMENDATION

I recommend that we proceed with the disallowances for several reasons. First, the statute that the donations and taxes regulations implement was enacted in 1991. We worked very closely with the States in developing the regulations and they had ample notice to correct impermissible taxes. If HCFA were now to defer taking action on the impermissible taxes, it would send a signal to the States and to Congress that we were not serious about enforcing these regulations. This could lead to more States "stretching the envelope" in developing provider taxes that are not allowable.

Second, as the tables indicate, there is a significant amount of FFP involved in the impermissible taxes, and the amount is growing. Deferral of action on recovery of these funds appears to be imprudent. As indicated in the list of taxes on impermissible classes and taxes with explicit hold harmless problems (Table 1), by the end of the first quarter of Fiscal Year 94, an additional \$25.182 million in disallowances would need to be recovered.

It would be the Medicaid Bureau's preference to handle the taxes in accordance with the following procedures:

- The Regional Administrators will notify, by letter, each State with an apparently impermissible tax. States would be invited to submit any justification they may have as to why the tax should be considered allowable.
- If the States cannot justify their questionable tax programs, the Regional Administrators will initiate disallowances, in keeping with their established process. The States will have the opportunity to follow the established appeals process with the Departmental Appeals Board, if they question HCFA's determination that the tax is impermissible. We will provide you with alerts before we take action on specific disallowances.
- We have drafted instructions for the States to use in submitting requests for waivers of the broad-based and uniform tax requirements. On November 16, 1993, we distributed these instructions to the States via a letter to the State Medicaid Directors.
- The Regional Offices will notify States we believe need waiver of the broad-based and uniform tax rules. These waiver applications will be reviewed by the Medicaid Bureau. When States do not qualify for waiver, any disallowances will be conducted through the established process.

I believe we should meet to more thoroughly discuss this matter.


Sally K. Richardson

Attachment

TAXES BELIEVED TO BE IMPERMISSIBLE

TABLE 1-A

STATE	DESCRIPTION OF TAX	IMPERMISSIBLE CLASS	TIME PERIOD	TOTAL TAX COLLECTED	FFP DISALLOW.
AR	Personal care services tax applied at a rate of 12.5% of personal care gross receipts. Expired 6/30/93.	Personal care services	4/1/92-9/30/93 10/1/93-12/31/93	\$6.4M \$0	\$4.76M \$0
	Home Health Agency services or personal care services tax, effective 2/1/93 applied at a rate of 1% of gross receipts.	Personal care services	2/1/93-9/30/93 10/1/93-12/31/93	\$38,000 \$14,000	\$28,275 \$10,424
	A tax, effective 2/1/93 applied at a rate of 1% of gross receipts on nursing facilities, ICFs/MR, residential treatment facilities, adult day care and other long-term care facilities. Effective 7/1/93 rate increases to 2.8%.	Residential treatment services and adult day care services	2/1/93-9/30/93 10/1/93-12/31/93	UNKNOWN UNKNOWN	UNKNOWN UNKNOWN
NY	Patient care services tax, effective 1/1/91 through 3/31/94 applied at a rate of .6% on gross receipts from all patient care services. This tax is imposed on the following entities: general hospitals, residential health care facilities (NF), diagnostic and treatment centers, certified home health agencies, long-term home health care programs, personal care providers, ICF/MR, mental retardation day treatment providers, mental retardation specialty and residential treatment facilities for children.	Personal care services, mental retardation day treatment services and mental retardation specialty hospital services	10/1/92-9/30/93 10/1/93-12/31/93	\$14.3M \$3.575M	\$7.15M \$.525M

STATE	DESCRIPTION OF TAX	IMPERMISSIBLE CLASS	TIME PERIOD	TOTAL TAX COLLECTED	FFP DISALLOW.
NY	ICF/MR tax, effective 4/1/92 through 3/31/93 applied at a rate of 2.4% of gross receipts from all patient care services. The tax is also imposed on mental retardation day treatment centers and mental retardation specialty hospitals.	Mental retardation day treatment services and mental retardation specialty hospital services	4/1/92-9/30/93 10/1/93-12/31/93	\$4.2M \$1.05M	\$2.1M \$.525M
	Laboratory fee is a flat fee, established annually by the State, and is charged uniformly to all free-standing clinical laboratories and laboratories within hospitals. The fee is based on laboratory's gross receipts, effective 4/1/64.	Laboratory services within a hospital	10/1/92-9/30/93 10/1/93-12/31/93	UNKNOWN UNKNOWN	UNKNOWN UNKNOWN
	An assessment of .3% of gross revenues for certified home health agencies and long-term home health care programs, effective 8/1/92 through 3/31/94.	Certain long-term home health care services	10/1/92-9/30/93 10/1/93-12/31/93	UNKNOWN UNKNOWN	UNKNOWN UNKNOWN

STATE	DESCRIPTION OF TAX	HOLD HARMLESS/GRANT	TIME PERIOD	TOTAL TAX COLLECTED	FFP DISALLOW.
FL	Nursing facility tax applied at a rate of \$1.50 per patient day. Excludes comprehensive care centers. Hold harmless existed 7/1/92-5/1/93. Expired 5/1/93.	Tax program contained an explicit guarantee of repayment to the taxpayer.	7/1/92-9/30/93	\$26.9M	\$14.8M
			10/1/93-12/31/93	\$0	\$0
HI	Long-term care tax applied at a rate of 6% of long-term care revenues. Includes an income tax credit to private pay patients, effective 10/1/93.	Income tax credit guarantees repayment of part of the tax through a non-Medicaid payment.	NA	\$0	\$0
			10/1/93-12/31/93	\$.875M	\$.4375M
IL	Nursing facility tax applied at a rate of \$1 per occupied bed. Nursing facility prohibited from billing or passing it on to any resident or third party payor. Proceeds from this tax used to establish a grant program. Designed to offset \$6.30 tax paid by private pay patients. Excludes sole community providers. Expired 6/30/93.	Grant program established to offset \$6.30 NF tax guarantees repayment of part of the tax through a non-Medicaid payment.	7/1/92-6/30/93	\$30.633M	\$15.32M
			7/1/93-9/30/93	?	?
			10/1/93-12/31/93	\$0	\$0
	Nursing facility tax applied at a rate of \$6.30 per occupied bed. Excludes Cook County and sole community long-term care providers. Expired 6/30/93.	Tax is offset through grant program established above.	7/1/92-6/30/93	\$192.988M	\$96.5M
			7/1/93-9/30/93	?	?
			10/1/93-12/31/93	\$0	\$0
LA	Nursing facility tax applied at a rate of \$10 per occupied bed. The tax is then passed on to the patient through increased nursing facility rates. Long-Term Care Assistance Program. Effective 7/1/93 rate decreases to \$3.68 per bed.	Grant program established to offset \$10 NF tax guarantees repayment of part of the tax through a non-Medicaid payment.	7/1/92-9/30/93	\$120M	\$88.5M
			10/1/93-12/31/93	\$10.5M	\$7.7M

STATE	DESCRIPTION OF TAX	HOLD HARMLESS/GRANT	TIME PERIOD	TOTAL TAX COLLECTED	FFP DISALLOW.
NV	Hospital tax applied at the following rates: not less than 1%, nor more than 7%, on the operating costs of a hospital; not less than 1%, nor more than 4%, on the billed charges of a hospital; not more than 100% of the State share of the amount of the Medicaid payment made to a hospital for services provided to inpatients; or any combination of the above three rates with the exception that the total amount of the tax must not exceed the amount that would be generated by a tax at the maximum rate allowed by the first two rates, whichever is greater. The amount paid to a hospital must at least equal the amount of the tax imposed that was paid by the hospital in the preceding month, plus \$100,000 in each fiscal year, effective 7/1/93.	Tax program contains an explicit guarantee of repayment to the taxpayer.	7/1/93-9/30/93 10/1/93-12/31/93	UNKNOWN UNKNOWN	UNKNOWN UNKNOWN
TN	Nursing facility tax of \$2600 annually on licensed beds in all nursing facilities in the State. The nursing facility passes the cost of the tax to the patient. Grant Assistance Program provides for a payment to certain private pay patients.	Grant program established to offset \$2600 NF tax guarantees repayment of part of the tax through a non-Medicaid payment.	7/1/92-9/30/93 10/1/93-12/31/93	\$108.8M \$23.9M	\$73.52M \$15.98M
UT	An assessment on hospitals, hospital based ASCs and freestanding ASCs. Excludes hospitals owned by HMOs, Utah State hospital and rural hospitals.	Income tax deduction guarantees repayment of part of the tax through a non-Medicaid payment.	? 10/1/93-12/31/93	? ?	? ?

STATE	DESCRIPTION OF TAX	IMPERMISSIBLE CLASS	TIME PERIOD	TOTAL TAX COLLECTED	FFP DISALLOW.
AR	Excise tax equal to 15% of the State's share of Medicaid costs on all health care providers. Expired 6/30/93, however, State received collections in 7/93 and 8/93.	?	7/1/93-9/30/93 10/1/93-12/31/93	\$2.1M \$0	\$1.56M \$0
	A tax applied at a rate of 50% of the State's share of payments for personal care services provided to residents of residential care facilities. Expired 6/30/93, however, State received collections past 7/1/93.	Personal care services	7/1/93-9/30/93 10/1/93-12/31/93	\$1M \$0	\$.744M \$0
	Total Reduction in FFP Pre 10/1/93 =	\$304,982,000			
	Total Reduction in FFP 1st Qtr. FFY 94 =	\$25,182,000			

GROUP 1

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
AL	A \$.10 surcharge on each prescription filled or refilled with a retail price of \$3.00 or more.	YES	1/1/93-9/30/93 10/1/93-12/31/93	\$3.1M \$1M	\$2.215M \$712,200
CT	Hospital payment tax applied at a rate of 8.5%, excluding psychiatric and chronic hospitals.	YES	1/1/92-9/30/93 10/1/93-12/31/93	\$518.661M UNKNOWN	\$259.33M UNKNOWN
	Effective 5/24/93, rate decreased to 2.5%.	YES	5/24/93-9/30/93 10/1/93-12/31/93	{INC.ABOVE} UNKNOWN	{INC.ABOVE} UNKNOWN
	Effective 5/24/93, new class hospital added to sales tax at 6% but tax rate treated differently than other classes.	YES	5/24/93-9/30/93 10/1/93-12/31/93	{INC.ABOVE} UNKNOWN	{INC.ABOVE} UNKNOWN
DC	Nursing home tax applied at a rate of \$11.86 per patient day. Excludes continuing care retirement communities.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$8.66M \$2.165M	\$4.33M \$1.0825M
HI	Hospital tax applied at a rate of 4% of hospital revenues, effective 1/1/94.	YES	NA	NA	NA
IL	Hospital tax applied at a rate of 2.5% of adjusted gross revenue, excluding sole community providers and Cook County hospitals. Expired 6/30/93.	YES	7/1/92-6/30/93 7/1/93-9/30/93 10/1/93-12/31/93	\$254.180M ? NA	\$127.09M ? NA

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
IL	Hospital tax, effective 7/1/93 applied at a rate of 1.88% of adjusted gross revenue, excluding sole community providers and Cook County hospitals. Payment due 9/30/93.	YES	7/1/93-9/30/93 10/1/93-12/31/93	\$0 \$65.3125M	\$0 \$32.656M
IN	Hospital tax that applies to hospitals in cities with specified populations, with a rate set somewhere between 1% and 32% of a provider's taxable income. This tax has not yet been implemented, but would be retroactive to 10/1/92 upon approval of SPA 92-24. Not yet collected.	YES	10/1/92-9/30/93 10/1/93-12/31/93	(\$19.272M) ?	(\$12.18M) ?
	Hospital tax, effective 7/1/93 that replaces above hospital tax. Revises rate to up to 50%.	YES	7/1/93-9/30/93 10/1/93-12/31/93	\$0 \$6.424M	\$0 \$4.08M
	ICF/MR tax applied at a rate of up to 5% of gross residential services revenue, including community residential facilities for the developmentally disabled (certified ICFs/MR), effective 10/1/93.	YES	7/1/93-9/30/93 10/1/93-12/31/93	\$0 \$8.655M	\$0 \$5.495M
KY	A tax applied at a rate of 15% of gross Medicaid revenues for physicians, dentists, optometrists, and mental health providers. Bad class expired 6/30/93.	YES	7/1/93-9/30/93 NA	\$100,000 \$60,000	\$71,690 \$42,546
	Hospital tax, effective 7/1/93 applied at a rate of 2.5% of gross revenues.	YES	7/1/93-9/30/93	\$29M	\$20.79M
MA	Hospital tax applied at a rate of 6.95% of acute care hospital revenue.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$254.182M \$34.7M	\$127.091M \$17.35M

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
MN	Minnesota Care tax program, effective 1/1/93 applied at a rate of 2% of gross revenue for hospitals and ambulatory surgical centers.	YES	1/1/93-9/30/93	\$21.7M	\$11.92M
			10/1/93-12/31/93	\$16.375M	\$8.949M
	Hospital tax applied at a rate of 1.4% of net patient revenue, excluding Medicare and HMOs. Effective 7/1/93 rate increases to 1.56%.	YES	7/1/92-9/30/93	\$27.57M	\$15.144M
			10/1/93-12/31/93	\$8.42M	\$4.6M
MO	Hospital tax, effective 10/1/92 applied at a rate that is set annually by the Department of Social Services. Excludes Shriners hospital.	YES	10/1/92-9/30/93	\$410.567M	\$247.4M
			10/1/93-12/31/93	\$190.827M	\$115.72M
NH	Hospital tax applied to general and rehabilitative hospitals at a rate not to exceed 6%, effective 7/1/93. Excludes psychiatric hospitals.	YES	7/1/93-9/30/93	\$0	\$0
			10/1/93-12/31/93	\$87.172M	\$40.586M
NY	General hospital tax, effective 1/1/91 through 12/31/93 applied at a rate of 1% of gross revenue received for inpatient hospital services. Excludes psychiatric and specialty hospitals.(Also next 4)	YES	10/1/92-9/30/93	\$143.3M	\$71.65M
			10/1/93-12/31/93	\$35.8M	\$17.9M
	General hospital tax, effective 1/1/91 through 12/31/93 averages 5.48% Statewide on hospital rates for all non-Medicare and non-Medicaid payers.	YES	10/1/92-9/30/93	\$551.6M	\$275.8M
			10/1/93-12/31/93	\$137.9M	\$68.95M
	General hospital tax, effective 1/1/91 through 12/31/93 applied at a rate of .23% on hospital rates for all non-Medicare and non-Medicaid payers.	YES	10/1/92-9/30/93	\$22.3M	\$11.15M
			10/1/93-12/31/93	\$5.6M	\$2.8M

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
NY	General hospital tax, effective 1/1/91 through 12/31/93 applied at a rate of .235% on hospital rates for all non-Medicare and non-Medicaid payers.	YES	10/1/92-9/30/93	\$23.7M	\$11.85M
			10/1/93-12/31/93	\$5.9M	\$2.95M
	General hospital tax, effective 1/1/91 through 12/31/93 applied at a rate of .1% of gross receipts received from all patient care services.	YES	10/1/92-9/30/93	\$18.9M	\$9.45M
			10/1/93-12/31/93	\$4.7M	\$2.35M
	Patient care services tax, effective 1/1/91 through 3/31/94 applied at a rate of .6% on gross receipts from all patient care services. This tax is imposed on the following entities: general hospitals, residential health care facilities (NF), diagnostic and treatment centers, certified home health agencies, long-term home health care programs, personal care providers, ICF/MR, mental retardation day treatment providers, mental retardation specialty and residential treatment facilities for children.	YES	10/1/92-9/30/93	\$156.2M	\$78.1M
			10/1/93-12/31/93	\$39.025M	\$19.513M
	Residential health care facility tax (NF), effective 4/1/92 through 3/31/94 applied at a rate of 1.2% of gross receipts from all patient care services.	YES	4/1/92-9/30/93	\$62.6M	\$31.3M
			10/1/93-12/31/93	\$15.6M	\$7.8M
	ICF/MR tax, effective 4/1/92 through 3/31/93 applied at a rate of 2.4% of gross receipts from all patient care services. The tax is also imposed on mental retardation day treatment centers and mental retardation specialty hospitals.	YES	4/1/92-9/30/93	\$10.8M	\$5.4M
			10/1/93-12/31/93	\$2.65M	\$1.325M

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
NY	HMO tax, effective 7/1/92 through 12/31/93 applied at a rate up to 9% of inpatient hospital reimbursement rates for HMOs.	YES	7/1/92-9/30/93	\$16.9M	\$8.45M
			10/1/93-12/31/93	\$10.7M	\$5.35M
	Commercial insurance tax, effective 4/1/92 through 3/31/93 applied at a rate of 11% on inpatient reimbursement rates for commercial insured.	YES	4/1/92-9/30/93	\$35.2M	\$17.6M
			10/1/93-12/31/93	\$0	\$0
	A charge/fee of \$.50 per triplicate prescription form. This form is used by certain providers dispensing certain controlled substances, effective 4/1/76.	YES	10/1/92-9/30/93	\$1.7M	\$850,000
			10/1/93-12/31/93	\$.4M	\$200,000
	Narcotics dispensing fee applied at a rate from \$50 to \$600 charged against dispensers of controlled substances, including general hospitals and nursing homes, effective 4/1/89.	YES	10/1/92-9/30/93	\$.3M	\$150,000
			10/1/93-12/31/93	\$75,000	\$37,500
	Application fee of \$1,000 for CON submission, plus an additional fee of .4% of project cost for projects going before the State Hospital Review and Planning Council, effective 4/1/89.	YES	10/1/92-9/30/93	\$8.1M	\$4.05M
			10/1/93-12/31/93	\$2M	\$1M
	Mortgage development fee of .9%, and mortgage operational fee of .2% of the mortgage loan amount charged against eligible hospital and nursing home borrowers, effective 5/19/72.	YES	10/1/92-9/30/93	\$5.8M	\$2.9M
			10/1/93-12/31/93	\$1.4M	\$700,000

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
NY	Statewide Planning and Research Cooperative System (SPARCS) fee is a flat fee established annually by the State, and is charged uniformly to all general hospitals, effective 1/1/86. There is a maximum cap of .1% of total costs.	YES	10/1/92-9/30/93	\$2.7M	\$1.35M
			10/1/93-12/31/93	\$.7M	\$350,000
	Mortgage closing fee and mortgage re-financing fee of .9% of mortgage closing and .5% of mortgage refinancing, of both Federally aided mortgage loans and loans through the New York State Dormitory Authority, applied to health care facilities, effective 4/1/89.	YES	10/1/92-9/30/93	\$4.5M	\$2.25M
			10/1/93-12/31/93	\$1.1M	\$550,000
TN	A tax, effective 7/1/92 applied at a rate of 6.75% of gross charges on all hospitals, psychiatric hospitals, ambulatory surgical centers, and certain non-health care related entities.	YES	7/1/92-9/30/93	\$465M	\$314.2M
			10/1/93-12/31/93	\$99.4M	\$66.75M

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
UT	A tax on hospitals and ASCs, excluding HMO owned, rural, and Utah State hospitals. The assessment shall be based upon a quarterly rate times the number of adjusted inpatient days for the hospital; or for ASCs, a quarterly rate times the number of patient encounters for the facility. This quarterly rate shall be set at a rate that will generate revenues for the partial calendar quarter of May and June 1993 in the amount of \$1.5M. For FY 1993-94 in the amount of \$8.8M and for FY 1994-94 in an amount not to exceed \$10.2M.	YES	5/1/93-9/30/93	\$3.7M	\$2.79M
10/1/93-12/31/93			\$2.2M	\$1.64M	
VT	Hospital tax applied at a rate of 2% of audited gross patient revenues.	YES	7/1/93-9/30/93	\$2.15M	\$1.29M
			10/1/93-12/31/93	\$2.15M	\$1.28
	ICF/MR annual assessment of 6% of total annual direct/indirect expenses for the most recently settled audit.	YES	7/1/93-9/30/93	\$275,000	\$164,670
10/1/93-12/31/93			\$275,000	\$163,763	

TAXES WHICH NEED WAIVERS TO BE APPROVED

TABLE 2-B

GROUP 2

STATE	DESCRIPTION OF TAX	UNIFORMITY WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
AL	Hospital tax applied at a rate of \$25 per patient day divided by Medicare case mix for discharges. Expired 3/31/93. Excludes hospitals providing rehabilitation treatment.	YES	1/1/93-3/31/93 NA	\$10.5M NA	\$7.5M NA
DC	Hospital tax applied at a rate of 1.5% of each hospital's net patient services revenue, excluding net Medicaid revenue.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$19.8M \$4.95M	\$9.9M \$2.475M
	ICF/MR tax applied at a rate of \$15.29 per patient day.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$3.76M \$.94M	\$1.8M \$470,000
IL	Nursing facility tax applied at a rate of \$1.50 per licensed bed day, effective 7/1/93.	YES	7/1/93-9/30/93 10/1/93-12/31/93	\$13.75M 413.75M	\$6.875M \$6.875M
LA	ICF/MR tax, effective 7/1/92 applied at a rate of \$30 per occupied bed per day. Effective 7/1/93 rate decreases to \$8.74 per occupied bed day.	YES	7/1/92-9/30/93 10/1/93-12/31/93	\$61M \$5M	\$44.9M \$3.67M
MN	Nursing facility tax applied at a rate of \$535 per licensed bed. Effective 7/1/93 rate increases to \$620 per licensed bed.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$21.280M \$6.795M	\$11.69M \$3.71M

STATE	DESCRIPTION OF TAX	UNIFORMITY WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
MS	Nursing facility and ICF/MR tax applied at a rate not to exceed \$2 per occupied bed per day. Tax is currently \$1 per occupied bed day.	YES	1/1/92-9/30/93	\$6.9M	\$5.45M
			10/1/93-12/31/93	\$1.5M	\$1.18M
MT	Nursing facility tax, effective 7/1/91 applied at a rate of \$1 per patient day in FY 1992 and \$2 per patient day in FY 1993 to all Medicare, Medicaid and other third party beds, excluding private pay. Effective 7/1/93 \$2 tax applies to all beds through 6/30/95.	YES	7/1/93-9/30/93	\$2.9M	\$2.06M
			10/1/93-12/31/93	\$2.9M	\$2.07M
OH	ICF/MR tax applied at a rate of \$8.05 per bed day franchise permit fee.	YES	7/1/93-9/30/93	\$0	\$0
			10/1/93-12/31/93	?	?
	Nursing facility tax, effective 7/1/93 applied at a rate of \$1 per nursing home bed day franchise permit fee.	YES	7/1/93-9/30/93	\$0	\$0
			10/1/93-12/31/93	\$7.493M	\$4.558M
SC	Hospital tax, effective 1/1/92 revising an old tax by establishing the basis of the tax as the number of patient days from the prior year attributed to SC residents, excluding Medicaid patient days, adjusted by the hospital's ratio of total net to gross revenue. Hospital tax revenue (total for in-State and out-of-State providers) must total \$21.5M per SFY.	YES	7/1/92-9/30/93	\$21.5M	\$15.325M
			10/1/93-12/31/93	\$5.375M	\$3.821M
	ICF/MR tax, effective 7/1/93 applied at a rate of \$5 per patient day.	YES	7/1/93-9/30/93	\$3.81M	\$2.716M
			10/1/93-12/31/93	\$3.81M	\$2.708M

STATE	DESCRIPTION OF TAX	UNIFORMITY WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
UT	Nursing facility and ICF/MR tax imposes a \$1 per patient day surcharge, adjusted annually for inflation.	YES	10/1/92-9/30/93	\$615,000	\$463,034
			10/1/93-12/31/93	\$615,000	\$457,253
VT	Nursing home tax applied at a rate of \$725 per licensed bed, effective 7/1/92.	YES	7/1/92-9/30/93	\$3.375M	\$2.021M
			10/1/93-12/31/93	\$675,000	\$401,963
WI	Nursing facility tax applied at a rate of \$32 per month on occupied beds.	YES	7/1/92-9/30/93	\$20.448M	\$12.35M
			10/1/93-12/31/93	\$4.121M	\$2.5M
	ICF/MR tax imposes a \$68 monthly charge on occupied ICF/MR beds. Effective 7/1/93 rate increases to \$97. Effective 7/1/94 rate increases to \$100.	YES	7/1/92-9/30/93	\$2.788M	\$1.68M
			10/1/93-12/31/93	\$744,900	\$450,441

TAXES FOR WHICH ADDITIONAL INFORMATION
IS NEEDED

TABLE 3

STATE	DESCRIPTION OF TAX	BAD CLASS	WAIVER NEEDED	HOLD HARM	GRANT	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
GA	Ambulatory tax based on the number of emergency ambulances and providers. Fixed licensing fee for each provider; variable fee based on the number of ambulances per provider.	?	?	?	NO	7/1/93-9/30/93	UNKNOWN	UNKNOWN
						10/1/93-12/31/93	UNKNOWN	UNKNOWN
KY	Hospital tax, effective 7/1/93 applied at a rate of 2.5% of gross revenues.	?	?	?	NO	7/1/93-9/30/93	\$29M	\$20.79M
						10/1/93-12/31/93	\$43.5M	\$30.846M
	A tax, effective 7/1/93 applied at a rate of 2% of gross revenues on all nursing facilities, ICFs/MR, home health services, HMO services, physician services and any other specific health care items or services permitted under Federal regulations.	?	?	NO	NO	7/1/93-9/30/93	\$8.9M	\$6.38M
						10/1/93-12/31/93	\$13.3M	\$9.43M
ME	Nursing home tax applied at a rate of 7% of gross receipts.	NO	NO	?	NO	7/1/93-9/30/93	\$5.25M	\$3.245M
						10/1/93-12/31/93	\$5.25M	\$3.253M
NE	Physicians tax, effective 8/1/93 applied at a rate of \$400.	NO	NO	?	NO	8/1/93-9/30/93	\$208,333	\$127,750
						10/1/93-12/31/93	\$312,500	\$193,688
	Hospital Authority levies taxes. Effective 8/1/93.	?	?	?	?	8/1/93-9/30/93	\$2.851M	\$1.748M
						10/1/93-12/31/93	\$4.365M	\$2.705M

STATE	DESCRIPTION OF TAX	BAD CLASS	WAIVER NEEDED	HOLD HARM	GRANT	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
WA	ICF/MR tax applied at a rate of 6% of gross patient revenue, effective 7/1/93.	NO	NO	?	NO	7/1/93-9/30/93	\$2.707M	\$1.489M
						10/1/93-12/31/93	\$2.707M	\$1.468M
	Hospital tax, effective 7/1/93 applied at a rate of .75% of gross patient (inpatient and outpatient) revenues.	NO	NO	?	NO	7/1/93-9/30/93	\$2.6M	\$1.431M
						10/1/93-12/31/93	\$3.9M	\$2.116M
	ICF/MR tax applied at a rate of 6% of gross patient revenue, effective 9/13/93.	NO	NO	?	NO	9/13/93-9/30/93	\$500,000	\$275,100
						10/1/93-12/31/93	\$2.707M	\$1.47M
WI	Some percentage assessment.?	?	?	?	?	?	?	?

MAR 23 1994

To: John M.

From: Sally

This is the level of analysis that can be gleaned from the information we have on provider taxes at this point. To obtain more is to ask the state to calculate the tax revenue from and Medicaid payments to each individual provider covered in addition to an estimate of the tax revenue from and payments which would be in place if the tax were broad-based. The fact that this is not an easy job is probably why most states have not yet requested their waivers.

Once we have that information, a formula calculation is done on the ratio between revenue and payments for the whole and for the taxed class. The exercise demonstrates the redistributive nature of the tax.

This is probably more than you wanted to know about the situation overall and less than you wanted about states individually.

cc: Tom Gustafson
Richard Chambers

03-23-94 10:07AM FROM HCFA MEDICAID BUR

P03

*Sally -
Per your request.
Bill
3/22*

From: QB10 --HCFACOM
To: QB60 --HCFADOM Richardson, Sally

Date and time 03/22/94 15:08:29

From: BILL HICKMAN
Subject: Taxes Needing Waivers

This is in response to your telephone request that we identify those States which are likely to submit successful provider tax waiver requests. We tried approaching this by looking for the negative, i.e. which States look like a pretty sure bet not to be able to put together the necessary numerical justifications to obtain a waiver. As you can see from Bernie's note, none of the States stands out as a sure waiver denial situation. Therefore, our conclusion is that they all have a reasonable chance of getting a waiver, but we won't know for sure until we see the actual numbers from them so we can confirm the numerical tests built into the donations-and taxes regulation.

*** Forwarding note from QB32 --HCFACOM 03/22/94 14:51 ***
To: QB10 --HCFADOM Hickman, Bill

From: BERNIE TRUFFER
Subject: Taxes Needing Waivers

You asked that we review the State provider tax programs in Attachments 2A and 2B of the February 1, memo to the Administrator on Handling of Impermissible Taxes. In particular, you asked that we identify, to the extent we could, which of these tax programs would likely result in successful applications.

However, as you know, the regulations implementing the waiver provisions require States to demonstrate that their taxes are "generally redistributive" by completion of one of two specific numerical tests. Each of these tests measures the degree to which a tax that is not broad-based or uniform shifts the burden of the tax to those providers with higher than average Medicaid use. Put another way, those taxes that exempt providers with below average Medicaid use will not likely qualify for waiver.

To comply with your request, we examined the taxes listed in the attachments to determine if we could identify any that would not likely be approved, because of exempting low Medicaid providers. After reviewing these tax programs, we could not conclude that any of them jumped out as being certain disapprovals. However, at the same time, we are reluctant to label the others as "likely approvals" since we can't really determine whether they qualify until the States submit the numbers, or until we verify that these taxes do not contain hold harmless or other features that would render them impermissible.

I would think that all the taxes we listed in the attachments have a reasonable chance of approvals.

cc: EF01 --HCFADOM Abato, Rozann

From Director
Medicaid Bureau

Subject Handling of Impermissible Provider Taxes under
Medicaid

To The Administrator

ISSUE

We need to decide how to proceed with the potential disallowances of impermissible provider taxes under the Medicaid program.

BACKGROUND

With the help of the Regional Offices, we have surveyed the States to determine:

- 1) The number of States that have enacted provider tax programs subject to the new regulations,
- 2) Which of these taxes appear to be problems, and
- 3) Which of the taxes will need waivers in order to be permissible.

The results of the survey are shown in the attached tables. While we believe these charts are accurate based upon the information we have, we would caution that there may be some taxes that we have not identified. In addition, these charts were prepared based on a quick review of the tax programs. We still need to read each piece of State legislation to ensure this information is completely accurate. However, we believe the charts reasonably illustrate the number and size of the tax programs being used by the States.

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In general, there are four requirements which a health care related tax must meet in order to be permissible; i.e.,

1. It must tax a class of items and services listed in the statute or designated by the Secretary in regulations,
2. The tax must be broad-based; i.e., it must tax all of the items or services, or providers of those services, in a class,
3. The tax must be uniformly applied, (The statute lists three specific kinds of taxes that are uniform, and permits the Secretary to determine that other kinds of taxes are also uniform.)
4. A tax may not hold taxpayers harmless for their tax payments.

According to the statute and regulations, States are not permitted to hold providers harmless directly through guarantees or other explicit kinds of repayment arrangements. In addition, States are not permitted to hold providers harmless indirectly through Medicaid payments. HCFA will consider a hold harmless provision to exist if the tax is applied at a rate in excess of 6 percent of provider revenue and more than 75 percent of providers receive more than 75 percent of their tax costs through Medicaid rate increases and other State payments (75/75 test). The regulation allowed States until September 13, 1993, to revise a tax in excess of 6 percent that could not meet the 75/75 test. If the tax was not modified, funds received by the State on/or after September 13, 1993, will be disallowed.

TABLES

The following information relates to the 3 tables we have developed on State taxes at issue.

Table 1 -- Taxes Believed to be Impermissible.

This table indicates which State tax programs, on their face, appear to be in violation of the regulations. The table is divided into three parts.

Table 1-A Tax programs which tax classes of health care items and services (such as personal care services) not designated in the regulations.

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Some of these tax programs, such as the Arkansas home health agency tax, apply to both permissible and impermissible classes. In these cases, the amount of revenue collected and the amount of FFP to be disallowed reflect only the impermissible class.

Table 1-B Tax programs which contain features, such as grant programs or tax credits, that attempt to hold some of the taxpayers harmless for their tax payments.

Table 1-C Tax programs which were permissible only during the State's transition period, but for which the State received revenues after the transition period.

For each tax, we have indicated, where known, the amount of revenue collected under the tax through the end of Fiscal Year 93, and the amount that would be collected in the first quarter of Fiscal Year 94.

Tables 1-A, 1-B, and 1-C indicate that 8 States have enacted 16 tax programs in this category. For Fiscal Year 93, these taxes produce revenues of \$507.359 million, which will result in approximately \$304.982 million in disallowances. For the first quarter of Fiscal Year 94, these taxes produce revenues of \$39.914 million, which will result in approximately \$25.182 million in disallowances. The tax revenue and disallowance amounts do not include four tax programs for which the revenue collected was not immediately available.

Table 2 -- Taxes Which Need Waivers to be Approved.

Table 2-A Taxes which are not broad-based or uniform, and States will need to submit requests for waiver of these requirements.

In general, while we cannot predict with certainty which of these taxes would or would not meet the tests set out in the regulation, a tax which exempts providers with little or no Medicaid utilization or which does not meet the test for favorable presumption would not ordinarily meet the requirements for approval. In this vein, we would note that there are several tax programs (e.g., D.C. nursing home tax) that are unlikely to meet the tests for approval.

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Table 2-B Tax programs that are not deemed by the statute to be uniform, but which States can ask the Secretary to deem as uniform.

The statute lists three specific kinds of tax bases that are deemed to be uniform. However, the statute permits States to ask the Secretary to review other kinds of taxes and deem them as uniform. While taxes on Table 2-B may ultimately require a waiver, States should be afforded the opportunity to demonstrate to the Secretary that these taxes are uniform in lieu of a formal waiver request.

Table 3 -- Taxes For Which Additional Information Is Needed.

Table 3 lists a number of tax programs for which we do not have sufficient information to make a judgement about their permissibility. For the most part, these taxes are recently enacted. We are contacting the States which have these taxes for more information.

RECOMMENDATION

I recommend that we proceed with the disallowances for several reasons. First, the statute that the donations and taxes rules implement was enacted in 1991. We worked very closely with the States in developing the rules and they had ample notice to correct impermissible taxes. If HCFA were now to defer taking action on the impermissible taxes, it would send a signal to the States that HCFA was not serious about enforcing these rules. This could lead to more States "stretching the envelope" in developing provider taxes that are not allowable.

Second, as the tables indicate, there is a significant amount of FFP involved in the impermissible taxes and the amount is growing. Deferral of action on recovery of these funds seems imprudent. As indicated in the list of taxes on impermissible classes and taxes with explicit hold harmless problems (Table 1), by the end of the first quarter of Fiscal Year 94, an additional \$25.182 million in disallowances would need to be recovered.

It would be the Medicaid Bureau's preference to handle the taxes in accordance with the following procedures:

- We propose to have the Regional Administrators notify, by letter, each State with an apparently impermissible tax. States would be invited to submit any justification that they might have as to why the tax should be considered allowable.

03-09-94 04:06PM FROM HCFA MEDICAID BUR

P05

Page 5 - The Administrator

- If the States cannot justify their questionable tax programs, the Regional Offices will initiate disallowances, in keeping with their usual process. The States will have the usual appeals process with the Departmental Appeals Board, if they question HCFA's determination that the tax is impermissible. We will provide you with alerts before we take action on specific disallowances.
- We have prepared instructions for the States to use in submitting requests for waivers of the broad-based and uniform tax requirements. On November 16, 1993, we distributed these instructions to the States via a letter to the State Medicaid Directors.
- States which HCFA believes need waiver of the broad-based and uniform tax rules will be similarly notified by the Regional Offices. These waiver applications will be reviewed by Medicaid Bureau staff. Should States not qualify for waiver, any disallowances will be conducted through the usual process.

I believe we should meet to discuss this matter.

15
Sally K. Richardson

Attachment

TAXES BELIEVED TO BE IMPERMISSIBLE

TABLE 1-A

STATE	DESCRIPTION OF TAX	IMPERMISSIBLE CLASS	TIME PERIOD	TOTAL TAX COLLECTED	FFP DISALLOW.
AR	Personal care services tax applied at a rate of 12.5% of personal care gross receipts. Expired 6/30/93.	Personal care services	4/1/92-8/30/93	\$6.4M	\$4.76M
			10/1/93-12/31/93	\$0	\$0
	Home Health Agency services or personal care services tax, effective 2/1/93 applied at a rate of 1% of gross receipts.	Personal care services	2/1/93-8/30/93	\$38,000	\$28,275
			10/1/93-12/31/93	\$14,000	\$10,424
NY	A tax, effective 2/1/93 applied at a rate of 1% of gross receipts on nursing facilities, ICFs/MR, residential treatment facilities, adult day care and other long-term care facilities. Effective 7/1/93 rate increases to 2.8%.	Residential treatment services and adult day care services	2/1/93-9/30/93	UNKNOWN	UNKNOWN
			10/1/93-12/31/93	UNKNOWN	UNKNOWN
NY	Patient care services tax, effective 1/1/91 through 3/31/94 applied at a rate of .6% on gross receipts from all patient care services. This tax is imposed on the following entities: general hospitals, residential health care facilities (NH), diagnostic and treatment centers, certified home health agencies, long-term home health care programs, personal care providers, ICF/MR, mental retardation day treatment providers, mental retardation specialty and residential treatment facilities for children.	Personal care services, mental retardation day treatment services and mental retardation specialty hospital services	10/1/92-9/30/93	\$14.3M	\$7.15M
			10/1/93-12/31/93	\$3.575M	\$.525M

STATE	DESCRIPTION OF TAX	PERMISSIBLE CLASS	TIME PERIOD	TOTAL TAX COLLECTED	DISALLOW
NY	ICF/MR tax, effective 4/1/92 through 3/31/93 applied at a rate of 2.4% of gross receipts from all patient care services. The tax is also imposed on mental retardation day treatment centers and mental retardation specialty hospitals.	Mental retardation day treatment services and mental retardation specialty hospital services	4/1/92-9/30/93 10/1/93-12/31/93	\$4.2M \$1.05M	\$2.1M \$.525M
	Laboratory fee is a flat fee, established annually by the State, and is charged uniformly to all free-standing clinical laboratories and laboratories within hospitals. The fee is based on laboratory's gross receipts, effective 4/1/84.	Laboratory services within a hospital	10/1/92-9/30/93 10/1/93-12/31/93	UNKNOWN UNKNOWN	UNKNOWN UNKNOWN
	An assessment of 3% of gross revenues for certified home health agencies and long-term home health care programs, effective 8/1/92 through 3/31/94.	Certain long-term home health care services	10/1/92-9/30/93 10/1/93-12/31/93	UNKNOWN UNKNOWN	UNKNOWN UNKNOWN

TABLE 1-B

STATE	DESCRIPTION OF TAX	HOLD NAME/ESS/FRONT	TIME PERIOD	TOTAL TAX COLLECTED	FFP D/SALLOW
FL	Nursing facility tax applied at a rate of \$1.50 per patient day. Excludes comprehensive care centers. Hold harmless existed 7/1/82-5/1/83. Expired 5/1/83.	Tax program contained an explicit guarantee of repayment to the taxpayer.	7/1/82-6/30/83 10/1/83-12/31/83	\$28.9M 90	\$14.8M 90
HI	Long-term care tax applied at a rate of 6% of long-term care revenues. Includes an income tax credit to private pay patients, effective 10/1/93	Income tax credit guarantees repayment of part of the tax through a non-Medicare payment.	NA 10/1/83-12/31/83	\$0 \$8.75M	\$0 \$4.375M
IL	Nursing facility tax applied at a rate of \$1 per occupied bed. Nursing facility prohibited from billing or passing it on to any resident or third party payer. Proceeds from this tax used to establish a grant program. Designed to offset \$6.30 tax paid by private pay patients. Excludes sole community providers. Expired 6/30/93.	Grant program established to offset \$6.30 NF tax guarantees repayment of part of the tax through a non-Medicare payment.	7/1/82-6/30/83 7/1/83-9/30/83 10/1/83-12/31/83	\$30.633M ? \$0	\$15.32M ? \$0
IA	Nursing facility tax applied at a rate of \$6.30 per occupied bed. Excludes Cook County and sole community long-term care providers. Expired 6/30/83.	Tax is offset through grant program established above.	7/1/82-6/30/83 7/1/83-9/30/83 10/1/83-12/31/83	\$182.988M ? \$0	\$98.5M ? \$0
LA	Nursing facility tax applied at a rate of \$10 per occupied bed. The tax is then passed on to the patient through increased nursing facility rates. Long Term Care Assistance Program. The rate 7/1/83 rate decreases to \$3.60 per day.	Grant program established to offset \$10 NF tax guarantees repayment of part of the tax through a non-Medicare payment.	7/1/82-6/30/83 10/1/83-12/31/83	\$120M \$10.5M	\$88.5M \$7.7M

STATE	DESCRIPTION OF TAX	HOLD HARMLESS/GRANT	TIME PERIOD	TOTAL TAX COLLECTED	FFP DISALLOW.
NV	Hospital tax applied at the following rates: not less than 1%, nor more than 7%, on the operating costs of a hospital; not less than 1%, nor more than 4%, on the billed charges of a hospital; not more than 100% of the State share of the amount of the Medicaid payment made to a hospital for services provided to inpatients; or any combination of the above three rates with the exception that the total amount of the tax must not exceed the amount that would be generated by a tax at the maximum rate allowed by the first two rates, whichever is greater. The amount paid to a hospital must at least equal the amount of the tax imposed that was paid by the hospital in the preceding month, plus \$100,000 in each fiscal year, effective 7/1/93.	Tax program contains an explicit guarantee of repayment to the taxpayer.	7/1/93-9/30/93 10/1/93-12/31/93	UNKNOWN UNKNOWN	UNKNOWN UNKNOWN
TN	Nursing facility tax of \$2600 annually on licensed beds in all nursing facilities in the State. The nursing facility passes the cost of the tax to the patient. Grant Assistance Program provides for a payment to certain private pay patients.	Grant program established to offset \$2600 NF tax guarantees repayment of part of the tax through a non-Medicaid payment.	7/1/92-9/30/93 10/1/93-12/31/93	\$108.8M \$23.9M	\$73.52M \$15.98M
UT	An assessment on hospitals, hospital based ASCs and freestanding ASCs. Excludes hospitals owned by HMOs, Utah State hospital and rural hospitals.	Income tax deduction guarantees repayment of part of the tax through a non-Medicaid payment.	? 10/1/93-12/31/93	? ?	? ?

TAXES COLLECTED AFTER TRANSITION

TABLE 1-C

STATE	DESCRIPTION OF TAX	IMPERMISSIBLE CLASS	TIME PERIOD	TOTAL TAX COLLECTED	FFP DIALLOW.
-------	--------------------	---------------------	-------------	---------------------	--------------

AR

Excise tax equal to 15% of the State's share of Medicaid costs on all health care providers. Expired 6/30/93, however, State received collections in 7/93 and 8/93.

?
7/1/93-9/30/93 \$2.1M \$1.56M
10/1/93-12/31/93 \$0 \$0

A tax applied at a rate of 50% of the State's share of payments for personal care services provided to residents of residential care facilities. Expired 6/30/93, however, State received collections past 7/1/93.

Personal care services
7/1/93-9/30/93 \$1M \$.744M
10/1/93-12/31/93 \$0 \$0

Total Reduction in FFP Pre 10/1/93 = \$304,982,000

Total Reduction in FFP 1st Qtr. FFY 94 = \$25,182,000

TAXES WHICH NEED WAIVERS TO BE APPROVED

TABLE 2-A

GROUP 1

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
AL	A \$.10 surcharge on each prescription filled or refilled with a retail price of \$3.00 or more.	YES	1/1/93-9/30/93 10/1/93-12/31/93	\$3.1M \$1M	\$2.215M \$712,200
CT	Hospital payment tax applied at a rate of 8.5%, excluding psychiatric and chronic hospitals.	YES	1/1/92-9/30/93 10/1/93-12/31/93	\$518.661M UNKNOWN	\$259.33M UNKNOWN
	Effective 5/24/93, rate decreased to 2.5%.	YES	5/24/93-9/30/93 10/1/93-12/31/93	{INC.ABOVE} UNKNOWN	{INC.ABOVE} UNKNOWN
	Effective 5/24/93, new class hospital added to sales tax at 6% but tax rate treated differently than other classes.	YES	5/24/93-9/30/93 10/1/93-12/31/93	{INC.ABOVE} UNKNOWN	{INC.ABOVE} UNKNOWN
DC	Nursing home tax applied at a rate of \$11.86 per patient day. Excludes continuing care retirement communities.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$8.66M \$2.165M	\$4.33M \$1.0825M
HI	Hospital tax applied at a rate of 4% of hospital revenues, effective 1/1/94.	YES	NA	NA	NA
IL	Hospital tax applied at a rate of 2.5% of adjusted gross revenue, excluding sole community providers and Cook County hospitals. Expired 6/30/93.	YES	7/1/92-6/30/93 7/1/93-9/30/93 10/1/93-12/31/93	\$254.180M ? NA	\$127.09M ? NA

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
IL	Hospital tax, effective 7/1/93 applied at a rate of 1.88% of adjusted gross revenue, excluding sole community providers and Cook County hospitals. Payment due 9/30/93.	YES	7/1/93-9/30/93 10/1/93-12/31/93	\$0 \$65.3125M	\$0 \$32.656M
IN	Hospital tax that applies to hospitals in cities with specified populations, with a rate set somewhere between 1% and 32% of a provider's taxable income. This tax has not yet been implemented, but would be retroactive to 10/1/92 upon approval of SPA 92-24. Not yet collected.	YES	10/1/92-9/30/93 10/1/93-12/31/93	(\$19.272M) ?	(\$12.18M) ?
	Hospital tax, effective 7/1/93 that replaces above hospital tax. Revises rate to up to 50%.	YES	7/1/93-9/30/93 10/1/93-12/31/93	\$0 \$6.424M	\$0 \$4.08M
	ICF/MR tax applied at a rate of up to 5% of gross residential services revenue, including community residential facilities for the developmentally disabled (certified ICFs/MR), effective 10/1/93.	YES	7/1/93-9/30/93 10/1/93-12/31/93	\$0 \$8.655M	\$0 \$5.495M
KY	A tax applied at a rate of 15% of gross Medicaid revenues for physicians, dentists, optometrists, and mental health providers. Bad class expired 6/30/93.	YES	7/1/93-9/30/93 NA	\$100,000 \$80,000	\$71,690 \$42,546
	Hospital tax, effective 7/1/93 applied at a rate of 2.5% of gross revenues.	YES	7/1/93-9/30/93	\$29M	\$20.79M
MA	Hospital tax applied at a rate of 6.95% of acute care hospital revenue.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$254.182M \$34.7M	\$127.091M \$17.35M

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
MN	Minnesota Care tax program, effective 1/1/93 applied at a rate of 2% of gross revenue for hospitals and ambulatory surgical centers.	YES	1/1/93-9/30/93	\$21.7M	\$11.92M
			10/1/93-12/31/93	\$18.375M	\$8.948M
MN	Hospital tax applied at a rate of 1.4% of net patient revenue, excluding Medicare and HMOs. Effective 7/1/93 rate increases to 1.58%.	YES	7/1/92-9/30/93	\$27.57M	\$15.144M
			10/1/93-12/31/93	\$8.42M	\$4.6M
MO	Hospital tax, effective 10/1/92 applied at a rate that is set annually by the Department of Social Services. Excludes Shriners hospital.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$410.567M \$190.827M	\$247.4M \$115.72M
NH	Hospital tax applied to general and rehabilitative hospitals at a rate not to exceed 6%, effective 7/1/93. Excludes psychiatric hospitals.	YES	7/1/93-9/30/93 10/1/93-12/31/93	\$0 \$87.172M	\$0 \$40.586M
NY	General hospital tax, effective 1/1/91 through 12/31/93 applied at a rate of 1% of gross revenue received for inpatient hospital services. Excludes psychiatric and specialty hospitals.(Also next 4)	YES	10/1/92-9/30/93	\$143.3M	\$71.65M
			10/1/93-12/31/93	\$35.8M	\$17.9M
	General hospital tax, effective 1/1/91 through 12/31/93 averages 5.48% Statewide on hospital rates for all non-Medicare and non-Medicaid payers.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$551.6M \$137.9M	\$275.8M \$68.95M
NY	General hospital tax, effective 1/1/91 through 12/31/93 applied at a rate of .23% on hospital rates for all non-Medicare and non-Medicaid payers.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$22.3M \$5.6M	\$11.15M \$2.8M

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
NY	General hospital tax, effective 1/1/91 through 12/31/93 applied at a rate of .235% on hospital rates for all non-Medicare and non-Medicaid payers.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$23.7M \$5.9M	\$11.85M \$2.95M
	General hospital tax, effective 1/1/91 through 12/31/93 applied at a rate of .1% of gross receipts received from all patient care services.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$18.9M \$4.7M	\$9.45M \$2.35M
	Patient care services tax, effective 1/1/91 through 3/31/94 applied at a rate of .6% on gross receipts from all patient care services. This tax is imposed on the following entities: general hospitals, residential health care facilities (NF), diagnostic and treatment centers, certified home health agencies, long-term home health care programs, personal care providers, ICF/MR, mental retardation day treatment providers, mental retardation specialty and residential treatment facilities for children.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$156.2M \$39.025M	\$78.1M \$19.513M
	Residential health care facility tax (NF), effective 4/1/92 through 3/31/94 applied at a rate of 1.2% of gross receipts from all patient care services.	YES	4/1/92-9/30/93 10/1/93-12/31/93	\$62.6M \$15.6M	\$31.3M \$7.8M
	ICF/MR tax, effective 4/1/92 through 3/31/93 applied at a rate of 2.4% of gross receipts from all patient care services. The tax is also imposed on mental retardation day treatment centers and mental retardation specialty hospitals.	YES	4/1/92-9/30/93 10/1/93-12/31/93	\$10.8M \$2.65M	\$5.4M \$1.325M

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
NY	HMO tax, effective 7/1/92 through 12/31/93 applied at a rate up to 9% of inpatient hospital reimbursement rates for HMOs.	YES	7/1/92-9/30/93 10/1/93-12/31/93	\$16.9M \$10.7M	\$8.45M \$5.35M
	Commercial insurance tax, effective 4/1/92 through 3/31/93 applied at a rate of 11% on inpatient reimbursement rates for commercial insured.	YES	4/1/92-9/30/93 10/1/93-12/31/93	\$35.2M \$0	\$17.6M \$0
	A charge/fee of \$.50 per triplicate prescription form. This form is used by certain providers dispensing certain controlled substances, effective 4/1/76.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$1.7M \$.4M	\$850,000 \$200,000
	Narcotics dispensing fee applied at a rate from \$50 to \$600 charged against dispensers of controlled substances, including general hospitals and nursing homes, effective 4/1/89.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$.3M \$75,000	\$150,000 \$37,500
	Application fee of \$1,000 for CON submission, plus an additional fee of .4% of project cost for projects going before the State Hospital Review and Planning Council, effective 4/1/89.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$8.1M \$2M	\$4.05M \$1M
	Mortgage development fee of .9%, and mortgage operational fee of .2% of the mortgage loan amount charged against eligible hospital and nursing home borrowers, effective 5/19/72.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$5.8M \$1.4M	\$2.9M \$700,000

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
NY	Statewide Planning and Research Cooperative System (SPARCS) fee is a flat fee established annually by the State, and is charged uniformly to all general hospitals, effective 1/1/86. There is a maximum cap of .1% of total costs.	YES	10/1/92-9/30/93	\$2.7M	\$1.35M
			10/1/93-12/31/93	\$.7M	\$350,000
	Mortgage closing fee and mortgage re-financing fee of .9% of mortgage closing and .5% of mortgage refinancing, of both Federally aided mortgage loans and loans through the New York State Dormitory Authority, applied to health care facilities, effective 4/1/89.	YES	10/1/92-9/30/93	\$4.5M	\$2.25M
			10/1/93-12/31/93	\$1.1M	\$550,000
TN	A tax, effective 7/1/92 applied at a rate of 6.75% of gross charges on all hospitals, psychiatric hospitals, ambulatory surgical centers, and certain non-health care related entities.	YES	7/1/92-9/30/93	\$465M	\$314.2M
			10/1/93-12/31/93	\$99.4M	\$66.75M

STATE	DESCRIPTION OF TAX	BROAD BASED/UNIFORM WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
UT	A tax on hospitals and ASCs, excluding HMO owned, rural, and Utah State hospitals. The assessment shall be based upon a quarterly rate times the number of adjusted inpatient days for the hospital; or for ASCs, a quarterly rate times the number of patient encounters for the facility. This quarterly rate shall be set at a rate that will generate revenues for the partial calendar quarter of May and June 1993 in the amount of \$1.5M. For FY 1993-94 in the amount of \$8.8M and for FY 1994-94 in an amount not to exceed \$10.2M.	YES	5/1/93-9/30/93	\$3.7M	\$2.79M
			10/1/93-12/31/93	\$2.2M	\$1.64M
VT	Hospital tax applied at a rate of 2% of audited gross patient revenues.	YES	7/1/93-9/30/93	\$2.15M	\$1.29M
			10/1/93-12/31/93	\$2.15M	\$1.28
	ICF/MR annual assessment of 6% of total annual direct/indirect expenses for the most recently settled audit.	YES	7/1/93-9/30/93	\$275,000	\$164,670
			10/1/93-12/31/93	\$275,000	\$163,763

TAXES WHICH NEED WAIVERS TO BE APPROVED

TABLE 2-B

GROUP 2

STATE	DESCRIPTION OF TAX	UNIFORMITY WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
AL	Hospital tax applied at a rate of \$25 per patient day divided by Medicare case mix for discharges. Expired 3/31/93. Excludes hospitals providing rehabilitation treatment.	YES	1/1/93-3/31/93 NA	\$10.5M NA	\$7.5M NA
DC	Hospital tax applied at a rate of 1.5% of each hospital's net patient services revenue, excluding net Medicaid revenue.	YES	10/1/92-8/30/93 10/1/93-12/31/93	\$19.8M \$4.95M	\$9.9M \$2.475M
	ICF/MR tax applied at a rate of \$15.29 per patient day.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$3.76M \$.94M	\$1.8M \$470,000
IL	Nursing facility tax applied at a rate of \$1.50 per licensed bed day, effective 7/1/93.	YES	7/1/93-9/30/93 10/1/93-12/31/93	\$13.75M 413.75M	\$6.875M \$6.875M
LA	ICF/MR tax, effective 7/1/92 applied at a rate of \$30 per occupied bed per day. Effective 7/1/93 rate decreases to \$8.74 per occupied bed day.	YES	7/1/92-9/30/93 10/1/93-12/31/93	\$61M \$5M	\$44.9M \$3.67M
MN	Nursing facility tax applied at a rate of \$535 per licensed bed. Effective 7/1/93 rate increases to \$620 per licensed bed.	YES	10/1/92-9/30/93 10/1/93-12/31/93	\$21.280M \$6.795M	\$11.68M \$3.71M

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STATE	DESCRIPTION OF TAX	UNIFORMITY WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
MS	Nursing facility and ICF/MR tax applied at a rate not to exceed \$2 per occupied bed per day. Tax is currently \$1 per occupied bed day.	YES	1/1/92-9/30/93	\$6.9M	\$5.45M
			10/1/93-12/31/93	\$1.5M	\$1.18M
MT	Nursing facility tax, effective 7/1/91 applied at a rate of \$1 per patient day in FY 1992 and \$2 per patient day in FY 1993 to all Medicare, Medicaid and other third party beds, excluding private pay. Effective 7/1/93 \$2 tax applies to all beds through 6/30/95.	YES	7/1/93-9/30/93	\$2.9M	\$2.06M
			10/1/93-12/31/93	\$2.9M	\$2.07M
OH	ICF/MR tax applied at a rate of \$8.05 per bed day franchise permit fee.	YES	7/1/93-9/30/93	\$0	\$0
			10/1/93-12/31/93	?	?
OH	Nursing facility tax, effective 7/1/93 applied at a rate of \$1 per nursing home bed day franchise permit fee.	YES	7/1/93-9/30/93	\$0	\$0
			10/1/93-12/31/93	\$7.493M	\$4.558M
SC	Hospital tax, effective 1/1/92 revising an old tax by establishing the basis of the tax as the number of patient days from the prior year attributed to SC residents, excluding Medicaid patient days, adjusted by the hospital's ratio of total net to gross revenue. Hospital tax revenue (total for in-State and out-of-State providers) must total \$21.5M per SFY.	YES	7/1/92-9/30/93	\$21.5M	\$15.325M
			10/1/93-12/31/93	\$5.975M	\$3.821M
SC	ICF/MR tax, effective 7/1/93 applied at a rate of \$5 per patient day.	YES	7/1/93-9/30/93	\$3.81M	\$2.716M
			10/1/93-12/31/93	\$3.81M	\$2.708M

STATE	DESCRIPTION OF TAX	UNIFORMITY WAIVER NEEDED	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
UT	Nursing facility and ICF/MR tax imposes a \$1 per patient day surcharge, adjusted annually for inflation.	YES	10/1/92-9/30/93	\$615,000	\$463,034
			10/1/93-12/31/93	\$615,000	\$457,253
VT	Nursing home tax applied at a rate of \$725 per licensed bed, effective 7/1/92.	YES	7/1/92-9/30/93	\$3.375M	\$2.021M
			10/1/93-12/31/93	\$675,000	\$401,963
WI	Nursing facility tax applied at a rate of \$32 per month on occupied beds.	YES	7/1/92-9/30/93	\$20.448M	\$12.35M
			10/1/93-12/31/93	\$4.121M	\$2.5M
	ICF/MR tax imposes a \$68 monthly charge on occupied ICF/MR beds. Effective 7/1/93 rate increases to \$97. Effective 7/1/94 rate increases to \$100.	YES	7/1/92-9/30/93	\$2.788M	\$1.68M
			10/1/93-12/31/93	\$744,900	\$450,441

TAXES FOR WHICH ADDITIONAL INFORMATION
IS NEEDED

TABLE 3

STATE	DESCRIPTION OF TAX	BAD CLASS	WAIVER NEEDED	HOLD HARM	GRANT	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
GA	Ambulatory tax based on the number of emergency ambulances and providers. Fixed licensing fee for each provider; variable fee based on the number of ambulances per provider.	?	?	?	NO	7/1/93-9/30/93 10/1/93-12/31/93	UNKNOWN UNKNOWN	UNKNOWN UNKNOWN
KY	Hospital tax, effective 7/1/93 applied at a rate of 2.5% of gross revenues.	?	?	?	NO	7/1/93-9/30/93 10/1/93-12/31/93	\$29M \$43.511	\$20.79M \$30.846M
	A tax, effective 7/1/93 applied at a rate of 2% of gross revenues on all nursing facilities, ICFs/MR, home health services, HMO services, physician services and any other specific health care items or services permitted under Federal regulations.	?	?	NO	NO	7/1/93-9/30/93 10/1/93-12/31/93	\$8.9M \$13.311	\$6.38M \$9.43M
ME	Nursing home tax applied at a rate of 7% of gross receipts.	NO	NO	?	NO	7/1/93-9/30/93 10/1/93-12/31/93	\$5.2511 \$5.2511	\$3.245M \$3.253M
NE	Physicians tax, effective 8/1/93 applied at a rate of \$400.	NO	NO	?	NO	8/1/93-9/30/93 10/1/93-12/31/93	\$208,343 \$312,510	\$127,750 \$193,688
	Hospital Authority levies taxes. Effective 8/1/93.	?	?	?	?	8/1/93-9/30/93 10/1/93-12/31/93	\$2.851M \$4.385M	\$1.748M \$2.705M

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STATE	DESCRIPTION OF TAX	BAD CLASS	WAIVER NEEDED	HOLD HARM	GRANT	TIME PERIOD	TOTAL TAX COLLECTED	POTENTIAL FFP DISALLOWANCE
WA	ICF/MR tax applied at a rate of 6% of gross patient revenue, effective 7/1/93.	NO	NO	?	NO	7/1/93-9/30/93 10/1/93-12/31/93	\$2.707M \$2.707M	\$1.489M \$1.468M
	Hospital tax, effective 7/1/93 applied at a rate of .75% of gross patient (inpatient and outpatient) revenues.	NO	NO	?	NO	7/1/93-9/30/93 10/1/93-12/31/93	\$2.6M \$3.9M	\$1.431M \$2.116M
	ICF/MR tax applied at a rate of 6% of gross patient revenue, effective 9/13/93.	NO	NO	?	NO	9/13/93-9/30/93 10/1/93-12/31/93	\$500,000 \$2.707M	\$275,100 \$1.47M
	Some percentage assessment?	?	?	?	?	?	?	?