NLWJC - Kagan

DPC - Box 029 - Folder 012

Health - Medicaid Cap

Health - medicaid

October 3, 1997

MEMORANDUM TO THE CHIEF OF STAFF

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

FROM: Chris Jennings

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

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

BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DRAFT: Provider Tax State Letters, October 8, 1997

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

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

Permissible

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

Impermissible

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

More Information Needed

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

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

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

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

Health - medicaid cap

Emily Bromberg
04/08/97 06:34:34 PM

Record Type: Record

To: Christopher C. Jennings/OPD/EOP, Nancy A. Min/OMB/EOP, Bruce N. Reed/OPD/EOP, Elena Kagan/OPD/EOP

cc: John L. Hilley/WHO/EOP, Jacob J. Lew/OMB/EOP, Gene B. Sperling/OPD/EOP, Jill M. Blickstein/OMB/EOP

Subject: govs and medicaid

The NGA has sent a letter requesting a POTUS meeting with the Medicaid Task Force (Miller, Chiles, Dean, Leavitt, Voinivich, Thompson) for late April or early May. It is clear from conversations with Ray, Executive Director of NGA, (who says he's calling Jack and Chris) and from the dems that the purpose of the meeting is to make clear to the POTUS their opposition to the per capita cap and to reiterate that they will not support children's health inititative unless we drop the cap. Ray is prettty worked up as are the dems. They say they've heard from committee staffers that for us the cap and disproportionate share cuts are not negotiable and must haves in the budget talks. .

Any advice on a response? The Govs plan to meet with the leadership on the Hill as well. Even the dems are saying this is a huge fight for them--and they are saying that our plan forces them to reduce benefits and cuts kids off.

File Health - Medicaid caps

EXECUTIVE OFFICE OF THE PRESIDENT

13-Jan-1997 02:29pm

TO: (See Below)

FROM: Christopher C. Jennings
Domestic Policy Council

SUBJECT: Pear article on Medicaid

Robert Pear just called. He is doing an article on Medicaid and where we are going to end up re savings and per capita cap/DSH policy. (Melissa S. told me last week that he was fishing around the Department for info).

He did not mention any savings number, nor even ask me to give him one. However, he seems to be doing an article that focuses on the per capita cap issue and the negative response the Hill Democrats and the advocates group have to reports that we are maintaining our past policy. I said I could neither confirm or deny that was the case. I did say that our past policy had a combination of savings from a per capita cap and DSH savings, and that we always say that our next policy will start with a review of our last budget. He said it did not matter because he has it on "good authority from other Administration sources" that we are maintaining our per cpaita cap proposal.

He also was fishing for a story about how Donna Shalala was the only Administration rep who opposed the per capita cap, but that her views were shoved aside by the White House. I did not play into that game.

I do not think there is anything we can do on this one. In the end, it might not end up being so bad for us. However, I thought I should give you all a heads up. I am always concerned whenever Robert is about to write a story.

cj

Distribution:

TO: Gene B. Sperling
TO: Bruce N. Reed
TO: John L. Hilley
TO: Michael McCurry
TO: Lorraine McHugh
TO: Barry Toiv
TO: Nancy-Ann E. Min

MEMORANDUM

January 30, 1997

TO: Erskine Bowles
Bruce Reed
Marcia Hale

FROM: Chris Jennings

RE: Medicaid and the governors

Attached are two documents in preparation for your upcoming discussions on Medicaid with the governors. The first document responds to the governors' concerns about the per capita cap as reported in today's article in the *New York Times*. The second document provides brief background on the Medicaid per capita cap and talking points to incorporate into your remarks to the governors when referencing Medicaid.

I hope this information is helpful. Please call me if you have any questions.

cc: Elena Kagan
Sylvia Matthews
Vicki Radd
Jason Goldberg

Talking Points/Q&A to Respond to Governors' Opposition to the President's Medicaid Proposal

Q: The Governors are joining advocates and providers in strongly opposing your per capita cap and significant savings in the Medicaid program. Aren't you concerned that support for your proposal seems to be waning?

A: There is no news here. Both sides are taking consistent and expected positions going into an important discussion about balancing the budget.

The Governors are once again taking the position that they would like maximum flexibility in administering their programs and would prefer not to have Federal budget constraints on the program if we are going to maintain the Medicaid's guarantee of coverage. This is not new.

The President, for the third year in a row, is proposing significant flexibility provisions for the States. In return, he is also proposing that the Federal Treasury be protected against excessive cost increases in the future. Again, this is not new.

The only thing that has changed is that the President's budget recognizes that growth in the Medicaid program has declined and as such will include much more modest savings than previous balanced budget initiatives.

We look forward to working with the Governors to craft appropriate and much overdue flexibility provisions to enable us to not only constrain costs but hopefully to expand health insurance coverage.

DRAFT

TALKING POINTS FOR DGA/NGA

I. Background

During the upcoming FY1998 budget debate (and the upcoming NGA conference), the Governors will return to their traditional role of advocating for significant flexibility in administering the Medicaid program combined with an aversion to any Federal fiscal constraints over the program. They have a longstanding policy of opposition to any cap (such as a per capita cap) on programmatic expenditures in combination with the retention of a Federal entitlement. They believe that such an approach leaves them holding the bag for guaranteed benefits and coverage. (The Democratic Governors now take the position that they only supported a per capita cap when it was the only realistic alternative to a block grant).

While some Governors will support the concept of additional savings from disproportionate share spending (DSH), their support generally dwindles when they conclude that such proposals would have significant impact on their state. Moreover, they strongly believe that the Medicaid program has made a significant contribution to deficit reduction that mitigates any need for any major savings to be taken from Medicaid in the upcoming budget debate.

II. Suggested Talking Points

- I fully recognize that you all have been extremely successful in constraining growth in your Medicaid programs. I hope you believe that the Federal government has become more your partner rather than your adversary in helping you get control over your programs.

- I have watched many states expand coverage, reduce infant mortality coverage, and make their programs much more efficient. These are achievements for which we can all be proud.

- We must make sure that our successes are maintained and enhanced in the years to come. While you all know that my upcoming balanced budget proposal will include provisions (a per capita cap and reductions in disproportionate share payments) to ensure that the Federal Treasury is not exposed to excessive increases in growth rates in future years.

- However, I want you to know that my budget will reflect the significant achievements you have made in this area. As such, savings from the Medicaid program will be modest.

DRAFT

- I know more than most, that our goal in achieving constraints in Medicaid cannot be realized without providing you much greater flexibility to administer your programs.

- This means that we must work together with the Congress to pass initiatives which would:

  -- repeal the Boren Amendment,

  -- repeal the cost-based reimbursement requirements for health centers,

  -- eliminate the burdensome Federal waiver process for implementing managed care options, and

  -- allow home and community care initiatives without a Federal waiver.

- And finally, as we work together to moderate the growth of the Medicaid program, I also want to work with you to expand coverage, particularly to children. Today, we have three million children who are eligible, but are not receiving, Medicaid. I want to work collaboratively to expand coverage not only to this population but to also children above poverty and Americans who are in-between jobs.

- None of these endeavors can be successful without your help. I look forward to building on our mutual successes and learning from your individual successes as we take steps together to improve the health care system for all Americans.