NLWJC - Kagan

DPC - Box 029 - Folder 014

Health - Medicaid Provider Taxes

IMPACT OF A DISALLOWANCE

	TYPE OF VIOLATION	FEDERAL MEDICAID SPENDING FY1998 (in thousands)	ESTIMATED TAX LIABILITY1992-98 (in thousands)	TOTAL LIABILITY AS A PERCENTAGE OF FEDERAL SPENDING	ESTIMATED ANNUAL DISALLOWANCE (PERCENTAGE OF FED. SPENDING
ALABAMA	broad based	1,614,516	20,267	1%	0.42%
CONNECTICUT	broad based	1,416,467	545,648	39%	13%
FLORIDA	broad based	3,552,126	541,976	15%	5%
***HAWAII	broad based / hold harmless	293,029	21,394	7%	2%
*ILLINOIS	hold harmless	3,269,347	88,500	3%	1%
LOUISIANA	hold harmless	2,229,601	236,918	11%	4%
*MAINE	hold harmless	713,169	7,688	1%	0.36%
MASSACHUSETTS	broad based	2,753,280	846,872	31%	10%
*MISSOURI	hold harmless	1,994,323	1,366,555	69%	23%
NEW HAMPSHIRE	broad based	372,065	115,021	31%	10%
*NEVADA	broad based	258,365	27,606	11%	4%
**TENNESSEE	broad based / hold harmless	2,521,519	749446	30%	10%
*UTAH	broad based	491,962	14,126	3%	1%

Medicaid

÷3

Medicaid

Over 3 yrs

× 3

* Indicates States that are no longer collecting impermissible taxes

**Tennessee is no longer collecting taxes that violate the broad based and uniform provision, but is still collecting taxes that violate the hold harmless provision

**Hawaii is no longer collecting taxes that violate the hold harmless provision, but is still collecting taxes that violate the broad based and uniform provision

Health - Medicaid provider taxes

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February 26, 1999

MEMORANDUM TO JOHN PODESTA

FROM:

SUBJECT: MEDICAID PROVIDER TAXES AND DONATIONS ENFORCEMENT

In the absence of any direction from the White House, HHS is planning to take the first steps towards sanctioning those states that are apparently using illegal provider taxes and donations to help maximize Federal Medicaid matching dollars (and minimize state expenditures.) HHS has been threatening to take enforcement actions against states out of statutory compliance since the beginning of the Administration, but for a variety of reasons have not been very aggressive or successful in doing so. The tax liability associated with these States is estimated to be $4.6 billion retrospectively and they are expected to incur an additional $427 million annually for each year that we delay action. Because of the magnitude of this problem, as well as its implications for tobacco recoupment and state relations in general, we are seeking your guidance on this issue.

BACKGROUND

Provider Taxes and Donations in Medicaid. 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. The widespread use of these financing mechanisms contributed to the extraordinary increases in Federal Medicaid expenditures in the early 1990s. One report found that provider tax revenue rose from $400 million in six states in 1990 to $8.7 billion in 39 States in 1992. There was a similar increase in Federal Medicaid spending, which more than doubled between 1988 and 1992, with a staggering average annual rate of over 20 percent.

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

States' continued reliance on impermissible provider taxes and our enforcement record. Since the publication of the regulations, there have been several actions but no initiation of the

enforcement process. The Administration formally notified those states which appeared to be out of compliance that they were in danger of being audited in 1993 and 1996. The issue resurfaced in the Balanced Budget Act, which included a provision that legalized New York's provider tax. Because BBA singled out New York for special treatment and created an extremely troubling precedent, the President line-item vetoed this provision. Although the Supreme Court subsequently over-rode the line item veto, making New York's taxes permissible, there remain at least 15 states that are out of compliance with the provider tax and donation law.

Recognizing the difficulty of attempting to collect all the potential state liabilities, the Administration (in late 1997) urged the Congress to pass legislation to give HHS the authority, (which it does not now have), to forgive past Medicaid debts if the states came into prospective compliance. Because Congress was split between some Members wanting no legislation (because the good guy states believe that HCFA should be aggressively pursuing "crooks") and the "bad guy" states (who saw no reason to rock the boat with legislation that explicitly still requires them to come into full compliance), the Congress ended up taking no action. As a result, it appears that numerous states are still utilizing "bad" taxes and donations primarily because they have little to no fear that HCFA will enforce the law. Even if they do, most states still figure they can come to appeal to the White House or the Congress for relief.

HHS and DoJ believe the current statute requires that they proceed with enforcement actions. HHS believes its lack of enforcement has undermined its credibility as an effective administrator of Medicaid. Moreover, DoJ believes that continued inaction leaves the Federal Government open to *qui tam* suits.

PROPOSED PLAN. Without any intervention from us, HHS plans to proceed with its enforcement plan. Under this plan, HHS will: (1) enforce the statute in those states that have used illegal taxes as part of recylcing schemes, beginning with those states that are currently out of compliance; and then (2) move on to those states that have collected taxes which illegally target specific groups of providers. In order to do so, it will first have to audit suspected states and, if necessary, the individual state would be penalized (most likely through subsequent reductions in Federal Medicaid payments). [This can be, and usually is, a long, drawn-out process. States have the ability to appeal Administration decisions and can -- and frequently do -- take us to court if they disagree with our ruling. They also have the right to retain the disputed funds until the end of the appeals process. As a consequence, these disputes routinely take years to resolve.]

PHASE ONE: ENFORCEMENT IN STATES THAT HAVE USED RECYLCLING SCHEMES

- **Notification of states suspected to have operated recylcling schemes.** In mid March, HHS expects to notify those states (Tennessee, Louisiana, Illinois, Missouri, Maine, and Hawaii) that have recylcled provider taxes in an effort to leverage more Federal funding that they will be audited and subject to a disallowance if found to be out of compliance.

- **Audits of those states currently operating recycling schemes.** Immediately after these

letters are sent, HHS will begin audits in Tennessee and Louisiana, the two States felt to be most seriously out of compliance. There is strong evidence that they are operating "granny grant" schemes, which cycle impermissible taxes through nursing homes; HHS estimates that these two states alone have collected $500 million in impermissible taxes since 1992. The prospective liability from these states is projected to be over $100 million a year.

- **Audits of those states who previously operated recylcing schemes.** In late April, HHS is planning to begin auditing Illinois, Missouri, Maine, and Hawaii, who had similar taxing schemes, but now appear to be in compliance. As mentioned above, without new statutory authority, HHS cannot forgive past actions that were illegal -- even if the states have moved aggressively to come into compliance. HHS estimates that these states have collected $1.6 billion in impermissible taxes since 1992.

PHASE TWO: ENFORCEMENT IN STATES THAT HAVE TARGETED PROVIDER TAXES

- **Denial of waivers of the broad based and uniformity requirement.** At about the same time, HHS plans to inform Alabama, Connecticut, Florida, Hawaii, Massachusetts, New Hampshire, Nevada, Tennessee, and Utah that because their waivers fail the statutory test, their requests for a waiver of the statutory requirement that provider taxes be broad-based and uniform are denied. Although Hawaii, Tennessee, Utah and Nevada have ended their tax programs, the remaining states have been collecting impermissible taxes while waiting for Federal approval of their waivers.

- **Audit of states who have been or who are currently imposing targeted provider taxes.** HHS plans to intiate audits of these States in late May and early June, beginning with those States that are currently out of compliance. HHS estimates that these states have collected approximately $2.5 billion in impermissible taxes since 1992, and will collect $326 million in 1999 and subsequent years.

In addition, HHS believes that almost every state in the nation has licencing fee schedules that violate the broad-based and uniform tax requirement. This primarily results because states do not consider such fees as "provider taxes" and thus subject to the restrictions. HHS currently has no time frame under which to audit these states and bring them into compliance, and no estimate of the amount that these states have collected in impermissible licencing fees. However, when and if it starts enforcement actions in this area, we can expect a very aggressive "push-back" from the National Governors' Association.

ISSUES

Given the amount of the money involved ($4.6 billion retrospectively and an additional $427 million annually), enforcing the provider tax and donation laws will be highly contentious. Some advocates and many Governors charge that recouping these funds through reduced Federal

Medicaid spending could cause states to cut back on Medicaid eligibility. Moreover, HHS anticipates a difficult, resource-intensive process once the initial letters are sent, with low prospects for recouping the money in the end. States, clearly, have opposed any effort to begin enforcement -- but have shown no interest in our legislative proposal to forgive retrospective liability in exchange for ending illegal practices.

However, OMB, DOJ, and HHS have repeatedly expressed concern over this lingering problem. The lack of enforcement of this law will lead states to believe that we do not have the political will to enforce this -- or any other -- Medicaid law. HHS also believes that to delay enforcement further would undermine the authority of the Secretary, since HHS has been informing States of its readiness to enforce the 1991 law for some time. In addition, our reluctance to act here could have a direct bearing on the tobacco recoupment debate. States could understandably conclude that our poor Medicaid provider tax enforcement record would suggest that they not take us seriously on the tobacco recoupment issue. In other words, why should the states fear us on tobacco recoupment when we have not enforced impermissible Medicaid provider taxes in the last 6 years?

POLICY OPTIONS

OPTION ONE: Proceed along the enforcement time frame suggested by HHS. Under this option, HHS will continue to advocate for legislation providing the Secretary with the authority to forgive past Medicaid debts if the states came into prospective compliance.

Pros:

- Provides HHS with the necessary authority to enforce the statute as planned.
- Protects HHS from the criticism that they are unable to effectively administer the Medicaid program and promotes our effectiveness as an enforcement agency.
- Places the level of pressure on states that is necessary to pass legislation providing HHS with the authority to strike acceptable tax liability settlements with states.
- Non-enforcement is currently construed as tacit approval of these impermissible taxes.
- Makes the threat of tobacco recoupment more credible.

Cons:

- Assures multiple and frequent confrontations with states over outstanding provider tax liabilities.
- Highlights the fact that the Administration has failed to enforce the statute for 6 years and exposes us to the charge that states had little reason to believe that they were out of compliance.
- If fully enforced, some States may be placed in financial jeopardy which may undermine the level or scope of services offered to Medicaid beneficiaries.
- When the HCFA actuary and CBO are presented with tangible evidence (such as the issuance of a disallowance letter) that HHS will recoup funds, they are likely to score a percentage of the savings from the recoupment on our baseline, based on the individual

state circumstances. These savings will then have to be offset in any legislation that provides more flexibility in settlements to States.

- Because the likelihood of legislation on this front is slim, we will be put in the difficult position of disallowing funds for past tax liability that we would have waived if we had the authority.

OPTION TWO: Initiate intensive advocacy for legislation that provides the Secretary with more authority to negotiate with states who have outstanding bad taxes and request that HHS implement its enforcement activities more slowly.

Pros:

- Helps shift some of the blame for the Administration's enforcement record onto Capitol Hill by resending the legislative language and publicly calling on Congress to help.
- Avoids an immediate confrontation with States who have outstanding tax liability.

Cons:

- Any legislation will not be seen as credible, given our history on this issue, and almost inevitably stagnate in Congress if pursued independent of outside enforcement pressure from HHS.
- Advocating for legislation will open us up to individual states being "fixed" in a piecemeal fashion, similar to the relief that New York received in the BBA.
- If pursued independent from outside enforcement pressure from HHS, states which are not seriously out of compliance will resent that others are allowed to continue their current recycling schemes. This will be reflected in the committees of jurisdiction.
- CBO currently assumes that we are recouping a percentage of the funds associated with impermissible taxes in their baseline and would score legislation that forgave all retrospective tax liability as a cost.

OPTION THREE: Ask HHS for a much more comprehensive review of the issue prior to initiating enforcement.

Recognizing the difficulties of enforcement and the likelihood of limited success, one option would be to hold back on dedicating resources to this activity until we have an even better understanding of the scope and degree of the problem. Such an action would be consistent with the OMB Medicaid baseline, which assumes no recoupment savings in its current projections.

Pros:

- Avoids a major confrontation with the states at a time when we are also dealing with the issue of tobacco recoupment.
- Avoids a long shot battle to obtain necessary authority to sign off on settlements with states, which will inevitably require the expenditure of a good deal of political capital.
- Because of our past history and lack of enforcement, our failure to recoup funds from states that are out of compliance is currently not scoring on our baseline. Although

recoupment has the potential to help the baseline, failing to recoup these funds will not hurt it.

Cons:

- This undermines our present and future credibility when enforcing state violations of the Medicaid statute and sends a poor signal to our career staff charged with enforcement.
- Although the likelihood of an individual filing a *qui tam* suit is slim, it is theoretically possible that an individual with independent knowledge of a State recycling scheme could file a suit under the False Claims Act. No one has ever attempted to file a qui tam suit to recoup impermissible provider taxes.

RECOMMENDATIONS

HHS, OMB and DOJ favor the first option of initiating the enforcement process on provider taxes and donations -- although there is a willingness to simultaneously pursue the second option.