Medicaid Provider Taxes

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Summary

Provider-specific taxes have been used by many states over the last two decades to help pay for the costs of the Medicaid program. Such taxes are required to meet a number of federal laws and regulations, some of which have been in flux recently. This report provides background information on provider-specific taxes and describes recent legislative and administrative action on the tax programs, including a moratorium, in place until April 1, 2009, on the implementation of certain provisions of a recent administrative ruling. This moratorium was further extended to July 1, 2009, via the American Recovery and Reinvestment Act of 2009 (P.L. 111-5).

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States have the authority to establish taxes to fund various activities. Sometimes states establish taxes to fund specific purposes. Other times, taxes may be credited to the states' general treasury to be used for any state purpose. One type of tax that is commonly relied on by many states to fund a portion of their share of Medicaid program costs is a tax on health care providers. These taxes, called provider taxes, are required to comport with certain federal laws established by Congress in 1991 and modified in 2005 and 2006.

The 1991 law set rules for provider taxes and for two other Medicaid funding mechanisms to minimize state practices that were viewed as ways for states to circumvent their state/federal shared responsibility for funding the Medicaid program. Subsequent changes to federal law and to the administrative procedures governing the use of provider taxes have represented a continuing struggle between ensuring the shared financing responsibility for Medicaid while balancing states' rights and need to raise funds for state programs and Medicaid providers.[1] New rules issued in February of 2008 conform the administrative regulations to the legislative changes made by Congress in 2005 and 2006, as well as make other changes to the procedures for approving provider taxes. The rule changes became effective in April of 2008.

Medicaid Provider Tax Legislation

In 1991, Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234). This bill grappled with several Medicaid funding mechanisms that were sometimes used to circumvent the state/federal shared responsibility for funding the cost of the Medicaid program. Under these funding methods, states collect funds (through taxes or other means) from providers and pay the money back to those providers as Medicaid payments, while claiming the federal matching share of those payments. States were essentially "borrowing" their required state matching amounts from the providers. Once the state share was netted out, the federal matching funds claimed could be used to raise provider payment rates, to fund other portions of the Medicaid program, or for other non-Medicaid purposes. In some cases, provider groups initiated the process by approaching the state and requesting that one of the financing programs be implemented in exchange for improved payment rates funded by the federal matching amounts.

At the time that the 1991 law was deliberated, many of the provider taxes on the books specifically targeted only those providers that accepted Medicaid payments because those were the only providers for whom it would be routine and legal to pay back the borrowed funds through Medicaid payments. The 1991 law sought to address some of the mechanisms that allowed these arrangements to work.

With respect to provider-specific taxes, the 1991 law

- requires provider taxes be "broad based" and uniformly applied to all providers within specified classes of providers—in other words, states cannot limit the provider taxes only to Medicaid providers;

[1] U.S. Government Accountability Office, *State Medicaid Financing Practices*, HEHS-96-76R, date; *Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency*, GAO-07-214, April 30, 2007; *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*, GAO/HEHS-94-133, August 1, 1994.

- prohibits taxes that exceed 25% of the state (or non-federal) share of Medicaid expenditures; and
- prohibits states from a direct or indirect guarantee that providers receive their money back (or be "held harmless")

for the purpose of claiming federal matching payments. The specified classes of providers used to ensure that tax programs are "broad-based" are those that provide the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Nursing facility services (other than services of intermediate care facilities for the mentally retarded).
- Services of intermediate care facilities for the mentally retarded.
- Physicians' services.
- Home health care services.
- Outpatient prescription drugs.
- Services of Medicaid managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).[2]
- Other classifications of health care services as specified by the Secretary.[3]

Requiring that all providers within a class be taxed, as opposed to only Medicaid providers, dampened the ability of states to establish such taxes. The reason is that Medicaid providers could easily be held harmless by inflating Medicaid payments. Other providers could not be repaid so simply, and therefore would be more likely to oppose the imposition of such taxes.

Recent changes to law include a provision in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), which altered one of the specified classes of providers. The "Medicaid managed care organizations" class was changed to all "managed care organizations." The Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432) included a provision changing the rules exempting taxes from scrutiny of their hold harmless provisions. Those rule changes are described more fully below.

Regulations

Federal regulations further define the rules with which Medicaid provider taxes must comply. Most regulations have been in place since not long after the 1991 law was enacted.[4] Following the passage of TRHCA and DRA, the Center for Medicare and Medicaid services issued a new

[2] The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) modified this class of providers by changing "Medicaid managed care organizations" to all "managed care organizations." This change further broadened the group upon which a tax could be imposed, thereby reducing the potential for abusive tax programs.

[3] A number of other classifications are described in the regulations at 42 CFR 433.56.

[4] The rules regarding provider taxes can be found at 42 CFR Part 433.

rule implementing several changes to comport with those laws, as well as making a number of other changes.

Hold Harmless

Regulations established in 1992 and 1993 describe three tests that are applied to a state's tax to determine whether taxpayers are held harmless: a positive correlation test, a Medicaid payment test, and a guarantee test. Taxes that fail any of those tests are determined to have a hold harmless provision in violation of the law.[5]

- A positive correlation test is used to determine whether a state or other unit of government imposing the tax provides directly or indirectly for a non-Medicaid payment to the taxpayers in an amount that is positively correlated to either the tax amount or the difference between their Medicaid payment and the tax amount.
- The Medicaid payment test is violated if all or any portion of the Medicaid payment to the taxpayer varies based *only* on the amount of the total tax payments.
- The guarantee test is violated if the state or other unit of government imposing the tax provides directly or indirectly for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

Safe Harbor

The administrative rules, however, waive the application of those hold harmless tests when the tax is applied at a rate that produces revenues that are less than or equal to between 5.5% and 6% of the revenue received by the taxpayer. This threshold has been referred to as a "safe harbor."

TRHCA changed the threshold under which tax programs could avoid being tested for violations of the hold harmless rule. The rule in effect before THRCA allowed for taxes on providers of 6% or less of their revenue to forego scrutiny of hold harmless provisions. THRCA changed the threshold so that for fiscal years beginning on or after January 1, 2008, through September 30, 2011, taxes at or below 5.5% of revenues could forego such scrutiny. After that period, the threshold would revert to 6% of revenues.

New Regulation

On February 22, 2008, HHS published a final rule: "Medicaid Program: Health Care Related Taxes"[6] in the *Federal Register*. The rule describes a number of changes to the Centers for Medicare and Medicaid's (CMS's) policies for reviewing health care-related taxes. Two of the changes implement provisions enacted in TRHCA and DRA, as described above. There are a number other changes proposed as well.

[5] The law also allows for states to apply for a waiver of the hold harmless requirements.

[6] Department of Health and Human Services, Centers for Medicare &Medicaid Services, "Medicaid Program; Health Care-Related Taxes," 73 *Federal Register* 9685, February 22, 2008.

The rule would make the following changes: (1) revise the threshold for determining if a tax program is required to undergo a test to determine whether a provider is being "held harmless" for the tax payment and clarify use of the term "revenues"; (2) clarify standards for determining the existence of a hold harmless arrangement; (3) codify one class of health care services permissible for establishing health care provider taxes; and (4) remove obsolete language. In addition, a few other notable changes are made, all of which are described in more detail below.

Revising the hold harmless threshold

In order to conform CMS regulations to the statutory changes made by THRCA, the new rule changes the threshold under which tax programs could avoid scrutiny of hold harmless provisions from 6% of a taxpayer's revenue to 5.5% for fiscal years beginning on or after January 1, 2008, through September 30, 2011. In addition, the regulation further specifies that the revenues against which the 5.5% threshold should be applied are "net operating revenues." The former regulation had not specified the type of revenues against which to apply the threshold test.

Permissible classes of services

As described above, DRA broadened one permissible class of services from the services of "*Medicaid* managed care organizations" to those of all managed care organizations. The regulation makes changes to conform with the DRA change. It further specifies that all services of MCOs, regardless of payer source, will be considered a permissible class of health care items or services for the purpose of the taxes. This is to reduce incentives for MCOs to reorganize to separate their business lines, thereby isolating Medicaid business, for the purpose of imposing Medicaid taxes only on the subsidiary of the MCO. The preamble of the proposed regulation notes that this practice was found to be occurring.[7]

Clarify standards for hold harmless tests

Several clarifications are made in the application of three tests to determine if a tax includes a prohibited hold harmless.

- Positive Correlation Test—One clarification involves the determination of whether a tax includes a direct or indirect non-Medicaid payment to the tax payers that is positively correlated to the tax amount or to the difference between the Medicaid payment and the tax amount. In the past, the use of the term "positively correlated" raised disagreements about allowable taxes. Tax programs disallowed by CMS were subsequently reinstated by an appeals board because the positive correlation test was not applied in a strict statistical manner. This regulation would allow a finding of a hold harmless for payments and taxes that are correlated even when there is not a strict correlation in a mathematical sense. This change would ensure that CMS is able to apply the positive correlation test in the broadest manner possible, allowing that a positive correlation can exist even if the correlation varies over time, the correlation changes, or if the payment to the taxpayer is conditional on the payment of the tax. The preamble of the proposed rule argues for the need for flexibility and subjectivity in the review of

[7] A proposed regulation with comment period was published on March 23, 2007, 72 *Federal Register* 13726.

tax arrangements and notes that it is impossible to anticipate all hold harmless plans that could be created.

- The Medicaid Payment Test—Under the Medicaid payment test, a hold harmless arrangement exists if all or any portion of a Medicaid payment varies based only on the amount of the tax payment. The new rule adds a clarification to allow for a finding that a Medicaid payment varies based on the tax payment when a payment *is conditional* on the tax payment. The preamble of the proposed rule states that because Medicaid payments are required, by statute, to be based on efficiency, economy, and quality of care, payments conditioned *solely* on the payment of a tax are considered to be in violation of that law.
- The Guarantee Test—Under the existing regulation, tax arrangements that include a direct or indirect guarantee that holds taxpayers harmless for any portion of their tax costs are considered to be in violation of the hold harmless prohibition. The new rule further specifies that the hold harmless rule is violated if a tax arrangement includes a direct or indirect guarantee of a direct or indirect payment of any portion of their tax costs.

The new rule includes a number of other changes, as well:

- It removes all references to transition periods that expired in the early 1990s.
- It standardizes the terminology used for referring to the tax amount and the payment amount across all of the hold harmless tests. The purpose of this change seems to be twofold—to reduce confusion raised by using slightly different terms in different places for the same thing, and to utilize terms that are sufficiently broad to allow for the maximum amount of flexibility for the agency in applying the hold harmless tests.
- It makes parallel changes to the provisions implementing the hold harmless prohibition for bona fide provider donations.

In early 2008, HHS estimated that the imposition of the rule would reduce federal Medicaid outlays by $0.4 billion over the five-year period beginning in 2008. At that time, the Congressional Budget Office estimated the impact to be a reduction in federal outlays of $0.6 billion over the same period.[8] States, however, in responding to a 2008 survey conducted by the staff of the House Committee on Oversight and Government Reform, estimated their loss of federal Medicaid funds to be over $5 billion for the period, an amount more than 10 times the HHS and CBO estimates.[9]

Opposition to the Rule

Opposition to the rule was expressed in a letter from the American Public Human Services Association and the National Association of State Medicaid Directors to the Acting Administrator

[8] See Congressional Budget Office, *Medicare, Medicaid and SCHIP Administrative Actions Reflected in CBO's Baseline*, February 29, 2008. Since the implementation of this rule has been delayed, these cost estimates would need to be adjusted for the time difference.

[9] *The Administration's Medicaid Regulations: State-by-State Impacts*, prepared for Chairman Henry Waxman by the Majority Staff, U.S. House of Representatives, Committee on Oversight and Government Reform, March 2008.

of CMS.[10] The letter raised concerns that the rule reduces consistency and clarity, that its changes exceed the Secretary's authority, and that it would impede a state's ability to condition Medicaid reimbursements on payment of required taxes. Other concerns about specific provisions were raised, as well.

Based on their survey of state Medicaid Directors, the majority staff of the House Committee on Oversight and Government Reform concluded that the fiscal and programmatic impacts of CMS's recent regulatory changes—including the provider tax regulation—are far more extensive than has been understood and warn against making such changes without fully understanding the impact on Medicaid programs and beneficiaries. Their results echo the objections of governors and hospital associations expressing the concern that the Administration's recent rule changes would have a significant impact on Medicaid financing that could potentially harm access to Medicaid services for Medicaid beneficiaries.

Finally, Congress has taken action as well. As part of H.R. 2642, The Supplemental Appropriations Act of 2008 (the War Supplemental), signed into law on June 30, 2008, a moratorium is placed on much of the final regulation until April 1, 2009. That law halts the implementation of all provisions of the rule, except for those enacted as part of TRHCA and DRA (described above). This moratorium was further extended to July 1, 2009, via the the American Recovery and Reinvestment Act of 2009 (P.L. 111-5). The Congressional Budget Office and the Joint Committee on Taxation estimate that the moratorium on the provider taxes rule (and two other final rules regarding case management services and school-based services), along with a new moratorium on a final rule for outpatient hospital services, and a Sense of the Congress that the Secretary should not promulgate final rules regarding cost limits for public providers, graduate medical education, and rehabilitative services will cost $105 million in FY2009.[11] Separate cost estimates for the provisions affecting each individual regulation were not provided.

[10] Letter addressed to Leslie Norwalk, Acting Administrator of CMS, dated May 22, 2007.

[11] The Congressional Budget Office and the Joint Committee on Taxation, *Estimate of Division B of H.R. 1 (ERN09560.LC, February 12, 2009)*, February 12, 2009.

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