

# **HCFA** LEGISLATIVE SUMMARY

February 14, 1992

## THE MEDICAID VOLUNTARY CONTRIBUTION AND PROVIDER-SPECIFIC TAX AMENDMENTS OF 1991

On December 12, 1991, the President signed into law H.R. 3595, the Medicaid Voluntary Contribution and Provider-specific Tax Amendments of 1991 (P.L. 102-234). A description of these Medicaid provisions is attached.

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Attachment



**MEDICAID VOLUNTARY CONTRIBUTION AND PROVIDER-SPECIFIC TAX  
AMENDMENTS OF 1991  
(P.L. 102-234)**

**Sec. 1 Short Title**

The short title of the act is the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991". The provisions amend title XIX of the Social Security Act.

**Sec. 2 Prohibition on the use of Voluntary Contributions, and Limitation on the use of Provider-specific taxes to obtain Federal Financial Participation Under Medicaid**

Subsection (w) is added to section 1903 of the Social Security Act. In general, as of January 1, 1992, this subsection denies Federal matching funds for almost all donations from health care providers and limits Federal matching funds for health care related taxes. Certain transition provisions are provided for donation programs in effect on September 30, 1991, for State fiscal year (FY) 1992 and for health care related taxes in effect or enacted as of November 22, 1991.

The total amount of Federal matching funds for Medicaid medical assistance expenditures is reduced by the sum of any revenues received by the State (or unit of local government) during the fiscal year from impermissible provider-related donations and health care related taxes as described below.

- o Federal matching funds are not available for provider-related donations except for bona fide provider-related donations and for donations for outstationed eligibility workers.

Provider-related donations are any donations or other voluntary payments (in cash or in kind) made directly or indirectly to a State or unit of local government by a health care provider, an entity related to a health care provider, or an entity providing goods or services under the State plan and paid as administrative expenses.

Bona fide provider-related donations are donations that the Secretary of Health and Human Services determines have no direct or indirect relationship to payments made under this title. Regulations may be issued that more clearly define bona fide provider-related donations.

Donations for outstationed eligibility workers are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and outreach materials) of State or local agency personnel who are stationed at the entity to determine Medicaid eligibility

and to provide outreach services to eligible or potentially eligible individuals. Beginning in Federal FY 1993, these donations are limited to ten percent of a State's total administrative expenditures (Federal and State) for Medicaid during the fiscal year.

- o Federal matching funds are not available for revenues from health care related taxes except for broad-based health care related taxes.

Health care related taxes include taxes that are related to health care items or services or to the provision of such items or services. Taxes that are related to the authority to provide health care items or services or the payment for such items or services are also considered to be health care related taxes.

A tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers. A tax that is not limited to health care items or services but provides different treatment for individuals or entities that are providing or paying for such services is also considered a health care related tax.

Taxes that are uniformly imposed on all non-Federal, non-public providers in a class and all business of providers in that class are considered to be broad-based health care related taxes. A health care related tax may exempt Medicaid and/or Medicare providers, revenues, or receipts and still qualify as a broad-based health care related tax.

- o Classes of health care items and services

Each of the following is considered a separate class of health care items and services:

- + inpatient hospital services,
- + outpatient hospital services,
- + nursing facility services,
- + services of intermediate care facilities for the mentally retarded,
- + physicians' services
- + home health care services
- + outpatient prescription drug services, and
- + services of health maintenance organizations and health insuring organizations.

Other classes of health care items or services may be established by the Secretary in regulations.

- o A tax is considered to be uniformly imposed if:
  - + the amount of the tax is the same for every provider in the class (e.g., a licensing fee);
  - + the amount of the tax is the same for each bed of each provider in the class (e.g., a bed tax);
  - + the tax is imposed on all gross revenues or receipts (or net operating revenues) at the same rate for all providers in the class, or;
  - + the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.
  
- o A health care related tax is not considered to be uniformly imposed if the tax provides for any credits, exclusions, or deductions that return to providers all or a portion of the tax paid in a manner that:
  - + precludes the net impact of the tax from being generally redistributive;
  - + creates a direct correlation between the amount of the tax and Medicaid payments for items or services with respect to which the tax is imposed, or;
  - + provides for a hold harmless provision (described below).

The Secretary is to specify in regulations, types of credits, exclusions, and deductions that would not prevent a tax from being considered uniformly imposed.

- o Waiver for health care related taxes that are not broad-based and/or uniformly applied

A State may apply for a waiver requesting the Secretary to treat a tax as a broad-based health care related tax even though the tax does not meet the definition of a broad-based health care related tax. For example, a State may apply for a waiver if the tax does not apply to all health care items, services, or providers in a class; if the tax provides for a credit, deduction, or exclusion; or if the tax is otherwise not imposed uniformly.

The Secretary shall approve a waiver if the State establishes to the Secretary's satisfaction that: (1) the net impact of the tax and associated Medicaid expenditures is generally redistributive in nature, and (2) the amount of the tax is not directly correlated to Medicaid payments for items or services with respect to which the tax is imposed.

o **Health care related taxes and hold harmless provisions**

Federal matching funds are not available for revenues from broad-based health care related taxes if there is a hold harmless provision with respect to the tax. A hold harmless provision is determined to be in effect if any of the following applies:

- + The State or unit of government provides (directly or indirectly) for a payment (other than a Medicaid payment) to taxpayers and the amount of the payment is positively correlated either to the amount of the tax or to the difference between the amount of the tax and the amount of Medicaid payments.
- + All or any portion of Medicaid payments to the taxpayer varies based only upon the amount of the total tax paid.
- + The State or other unit of local government provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

The State or unit of local government is not prevented from using revenues from broad-based health related taxes to reimburse health care providers for Medicaid expenditures, i.e., to increase Medicaid payment rates across the board. State and local governments are also not precluded from relying on such Medicaid reimbursement to justify or explain the tax in the legislative process.

o **Limits on the State share from health care related tax revenues**

For State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, Federal matching funds are not available for revenues from broad-based health care related taxes to the extent the amount of such revenues exceeds the greater of: 1) 25 percent of the non-Federal share of Medicaid program expenditures during a fiscal year, or 2) the State base percentage.

In calculating the 25 percent of the non-Federal share, total Medicaid program expenditures (including administrative expenditures) in a fiscal year are reduced by any revenues received by the State or unit of local government from provider-related donations, health care related taxes that are not broad based, and broad based health care related taxes when there is a hold harmless provision in effect. Bona fide provider-related donations, donations for outstationed eligibility workers, and broad based health care related tax revenues (where there is no

hold harmless provision in effect) are not deducted from Medicaid program expenditures before calculating the 25 percent of the non-Federal share.

The State base percentage is calculated by first adding the total amount of revenues from health care related taxes (whether or not broad based) and the amount of provider-related donations (whether or not bona fide) projected to be collected in State FY 1992.

- + The amount of revenues from health care related taxes shall be determined by the Secretary based on only those taxes that were in effect or enacted as of November 22, 1991, and only at the same rate and base that was in effect on that date. If a tax is not in effect throughout State FY 1992 (or if the rate or base of a tax is increased during such fiscal year), the Secretary shall project the amount to be collected as if the tax (or increase) were in effect during the entire State fiscal year.
- + The amount of provider related donations shall be determined by the Secretary based on donation programs in effect on September 30, 1991, and applicable to State FY 1992 as demonstrated by State plans amendments, written agreements, State budget documents, or other documentary evidence in existence as of September 30, 1991.
- + A State's base percentage is calculated by first summing the tax and donation revenues for State FY 1992 and then dividing this sum by the non-Federal share of total Medicaid program expenditures (including administrative expenditures) during State FY 1992. The amount of the expenditures under the State plan shall be determined by the Secretary based on the best data available as of December 12, 1991.

**o Expiration Dates for Grandfather Provisions**

The restriction on Federal matching funds for provider related donations and health care related taxes do not apply to certain "grandfathered" donation and tax programs during FY 1992 and, in some cases, during all or part of FY 1993.

- + The grandfather provisions expire on October 1, 1992 for States with a State fiscal year beginning on or before July 1. This applies to the vast majority of States.
- + The grandfather provisions for States with fiscal years beginning after July 1 expire on January 1, 1993.

+ Regardless of when their fiscal year ends, States without a regularly scheduled legislative session in 1992 or 1993, and States with a provider-specific tax enacted on November 4, 1991 are eligible to receive Federal matching funds for grandfathered donation and tax programs until July 1, 1993.

o **Grandfathered donation and tax programs**

Donations received prior to the expiration of a State's grandfather provisions, (for most States, October 1, 1992), are eligible for Federal matching if the donations are received under a donation program that was in effect, or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992. States may demonstrate that their donations are applicable to State FY 1992 through State plan amendments, written agreements, State budget documents, or other documentary evidence in existence on September 30, 1991.

In States that remain eligible for Federal matching funds for donations into State FY 1993, the total amount of donations cannot exceed the total amount of donations received in the corresponding period (or not later than 5 days after the end of the period) of the State fiscal year 1992.

Impermissible taxes are health care related taxes that would otherwise not be eligible for Federal matching funds under this legislation. Tax revenues received from impermissible taxes prior to a State's effective date, (for most States, October 1, 1992), are eligible for Federal matching funds if the tax was in effect as of November 22, 1991. The grandfathered status of tax revenues also applies if the legislation or regulations imposing these taxes were enacted or adopted as of that date. The grandfather status only applies to the tax rate and base that was in effect or enacted as of November 22, 1991.

o **Additional limits on grandfathered donations and taxes**

For FY 1992 and FY 1993, the total amount of donations and taxes permitted under the grandfather provisions in each fiscal year cannot exceed the 25 percent limit of the non-Federal share (as defined earlier in this document) minus the total amount of revenues from permissible broad based health care related taxes received in that year. For States with a State base percentage over 25 percent, the total amount of donations and taxes permitted under the grandfather provisions cannot exceed the State base percentage minus the total amount of revenues from broad based health care related taxes received in that year.

o **Federal matching funds for intergovernmental transfers**

HHS may not restrict States' use of funds derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the State share of Medicaid unless the transferred funds are derived from donations or taxes that would not otherwise be recognized for Federal matching purposes. This applies whether or not the unit of government transferring the money is also a health care provider. Transferred funds not restricted by this subsection shall not be considered a provider-related donation or a health care related tax.

o **Miscellaneous definitions**

**Health care provider** - an individual that receives payments for the provision of health care items or services. An entity is considered to be related to a provider if the entity:

- + is an organization, association, corporation, or partnership formed by or on behalf of health care providers,
- + is a person with an ownership or control interest in the provider,
- + is the employee, spouse, parent, child, or sibling of the provider (or of a person with an ownership or control interest in the provider), or
- + has a similar close relationship to the provider (as defined in regulations).

**State** - the 50 States and the District of Columbia, except for any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Social Security Act.

**State fiscal year** - with respect to a specified calendar year, the State fiscal year ending in that calendar year.

**Tax** - any licensing fee, assessment, or other mandatory payment; this does not include payment of a criminal or civil fine or penalty except for those imposed instead of a fee, assessment, or other mandatory payment.

**Unit of local government** - a city, county, special purpose district, or other governmental unit in the State.

### Conforming Amendments

Section 1903(i)(10), as inserted by section 4701(b)(2)(B) of OBRA 1990, relates to Federal matching funds for payments attributable to provider-specific taxes. This subsection is deleted.

Section 1902(t) limits the Secretary's authority to deny Federal matching funds for expenditures attributable to taxes (whether or not of general applicability). This section is amended by striking reference to 1903(i)(10) and by changing the description of taxes to apply only to protect Federal matching funds for taxes of general applicability.

### Effective Date

These amendments take effect January 1, 1992, without regard to whether or not regulations have been promulgated.

Except as specifically provided in this new section, the Secretary shall not disallow any claim prior to the effective dates or otherwise withhold Federal matching funds because: (1) the source of the non-Federal share is a tax imposed on, or a donation received from, a health care provider, or (2) because the amount of any donation or tax proceeds must be credited against the amount of the expenditure.

The interim final rule on the State share of financial participation promulgated on October 31, 1991, is nullified and of no effect. No part of this interim final rule shall be effective except for parts promulgated after December 12, 1991 and consistent with this section and the amendments made by this section.

## **Sec. 3 Restrictions on Aggregate Payments for Disproportionate Share Hospitals**

### Repeal of Prohibition of Upper Payment Limit for Disproportionate Share Hospitals

The prohibition on an upper payment limit for disproportionate share hospitals (DSH) is deleted from 1902(h).

### Limitation on Aggregate Payment Adjustments

Subsection (f) is added to section 1923. As of January 1, 1992, this subsection denies Federal matching funds for DSH payments in excess of certain limits.

- o National aggregate DSH payments are limited to 12 percent of total national expenditures for medical assistance under all State plans during a fiscal year. Medicaid expenditures for medical assistance do not include administrative expenditures.
- o Before the beginning of the fiscal year, the Secretary shall estimate and publish the national DSH payment limit and each State's allotment within that DSH limit.
- o **Transition provisions**

For FY 1992, Federal matching for DSH payment adjustments in each State are limited to payments in accordance with:

- + State plans in effect or amendments submitted by September 30, 1991;
- + State plans in effect or amendments submitted by November 26, 1991, or modifications thereof, if the amendment designates only DSH with a Medicaid or low-income utilization percentage at or above the Statewide arithmetic mean; or
- + a payment methodology that was established and in effect on September 30, 1991, or in accordance with legislation or regulations enacted or adopted as of September 30, 1991.

However, in no case shall the State DSH limit be less than the minimum DSH adjustments required in section 1923(c)(1).

- o For FY 1993 and later, Federal matching will not be available for DSH payments in a fiscal year excess of a State's DSH allotment for that year. A State DSH allotment for a fiscal year shall not exceed 12 percent of Medicaid expenditures for medical assistance, except in a high DSH State where the allotment shall equal the State base allotment.

The State base allotment is the total amount of DSH payment adjustments eligible for Federal matching during FY 1992 or \$ 1 million, whichever is greater.

States that have DSH payment adjustments above 12 percent of their total Medicaid expenditures for medical assistance in a fiscal year are referred to as high DSH States. These States will only receive Federal matching funds for DSH expenditures up to the dollar amount of their State base allotment.

States with DSH payments below 12 percent of total Medicaid expenditures for medical assistance in FY 1992 are not high DSH States and will be allowed to increase their State base allotment relative to two factors. These States will be allotted a State growth factor and a State supplemental amount in addition to their previous year's DSH allotment.

The State growth factor for each State is the percentage growth in State Medicaid expenditures (described in section 1903(a)) between the previous and the current fiscal years.

The State supplemental amount for each state is determined in a two step process. First, the total amount of the residual funds to be distributed to the States is determined. Second, the DSH pool is divided up among eligible States.

- + The DSH pool is equal to 12 percent of total, national Medicaid expenditures for medical assistance for a Federal fiscal year less the total of: all State DSH allotments for the previous fiscal year, all State growth amounts for States that are not high DSH States, and any DSH payments the Secretary estimates will be made to States due to minimum requirements for DSH payment adjustments.
- + The pool is distributed to all States that are not high DSH States. Each State is allocated the lesser of:
  - 1) the fraction of the residual pool equal to the ratio of that State's Medicaid expenditures for medical assistance divided by Medicaid expenditures for medical assistance in all States other than high DSH States, or;
  - 2) the amount that would raise the State DSH allotment to 12 percent of the State Medicaid expenditures for medical assistance.
- o As of January 1, 1996, if legislation is enacted to establish a limit on DSH payment adjustments, States will have the option of adhering to this new DSH limit and to requirements for designating hospitals as DSH instead of the 12 percent DSH limit.

Should such a limit be enacted, any State opting for this new limit on DSH payment adjustments could only designate a hospital as DSH if the hospital meets at least one of the following requirements:

- + the hospital's Medicaid inpatient utilization is at or above the average rate for all hospitals in the State,
- + the hospital's low-income utilization rate is at or above the average rate for all hospitals in the State,

- + the hospital's Medicaid inpatient days are equal to at least 1 percent of the total number of Medicaid inpatient days for all hospitals in the State, or
- + the hospital meets other requirements specified by the Secretary taking into account the special circumstances of children's hospitals, rural hospitals, and sole community hospitals.

#### Limits on Authority to Restrict DSH Designations

The Secretary may not restrict a State's authority to designate hospitals as DSH. This restriction does not affect the Secretary's authority to reduce payments if the Secretary determines that, as a result of such designations, the State has in effect a hold harmless provision for a broad-based health care related tax.

#### Study of DSH Payment Adjustments

The Prospective Payment Assessment Commission shall submit a report not later than January 1, 1994, on a study to be conducted concerning: (1) the feasibility and desirability of establishing maximum and minimum Medicaid DSH payments, and (2) appropriate criteria for the designation of Medicaid DSH.

#### Effective Date

These amendments shall take effect January 1, 1992.

The DSH proposed rule published on October 31, 1991, is withdrawn and cancelled. No part of this proposed rule shall be effective except for parts promulgated after December 12, 1991, and consistent with this section.

#### **Sec. 4 Reporting Requirements**

At the end of the fiscal year, each State is required to report annual information on: provider-related donations received; health care related taxes collected; the aggregate amount of DSH payments; and the amount of DSH payments to individual facilities.

This reporting provision is effective for Federal fiscal year 1993.

## Sec. 5 Interim Final Regulations

The Secretary shall issue regulations necessary to implement this Act and the amendments made by this Act. These regulations may be issued on an interim final or other basis.

However, other than regulatory changes necessary to implement this Act, the Secretary may not issue any interim final regulation that changes the treatment of public funds as a source of State share of Medicaid. The Secretary may issue interim final regulations to deny Federal matching funds for public funds that are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under the new section, 1903(w).

The Secretary shall consult with the States before issuing any regulations under this Act.