9/25/91 Conference Call

Tom Scully
Governor Voinovich
Governor McKernan
Governor Hunt
Governor Edgar

NACO
NEVADA ASSOCIATION OF COUNTIES
308 NORTH CURRY STREET, SUITE 205 • CARSON CITY, NEVADA 89703 (702) 883-7863

November 7, 1991

THE CHIEF of STAFF
has seen

Richard Bryan
U.S. Senate
364 Russell Senate Building
Washington, DC 20510

Dear Senator Bryan:

The Nevada Association of Counties urges you to cosponsor S.1886, the Medicaid Moratorium Amendments of 1991. Immediate legislative action is needed to stop the Health Care Financing Administration's efforts to terminate state funding sources for the program.

The October 31 Federal Register clarification does not show any willingness to compromise on voluntary contributions or provider taxes. With the exception of direct county appropriations to state Medicaid programs, long-standing intergovernmental transfers are also under scrutiny. If the regulations stand, the impact on services will be devastating.

S. 1886 represents a reasonable and appropriate response to this critical issue. It continues intergovernmental transfers and places a September 30, 1992 moratorium on regulations affecting contributions or taxes. By February 3, 1992, the Secretary of Health and Human Services would be required to submit to Congress the proposed regulations limiting these funding mechanisms. These provisions allow states and counties to continue to serve Medicaid-eligible women, children and the elderly while recognizing that some changes will be necessary before October 1992.

I urge you to cosponsor the legislation. Without action by Congress, counties, states and beneficiaries will be hurt. I look forward to discussing this issue in person with you next week during my visit to Washington, D.C.

Sincerely,

Robert S. Hadfield
Executive Director

RSH/mb

cc: National Association of Counties
Governor John H. Sununu, White House
Debra Anderson, White House

NACO
NEVADA ASSOCIATION OF COUNTIES
308 NORTH CURRY STREET, SUITE 205 • CARSON CITY, NEVADA 89703 (702) 883-7863

November 7, 1991

Harry Reid
U.S. Senate
Washington, DC 20510

Dear Senator Reid:

The Nevada Association of Counties urges you to cosponsor S.1886, the Medicaid Moratorium Amendments of 1991. Immediate legislative action is needed to stop the Health Care Financing Administration's efforts to terminate state funding sources for the program.

The October 31 Federal Register clarification does not show any willingness to compromise on voluntary contributions or provider taxes. With the exception of direct county appropriations to state Medicaid programs, long-standing intergovernmental transfers are also under scrutiny. If the regulations stand, the impact on services will be devastating.

S. 1886 represents a reasonable and appropriate response to this critical issue. It continues intergovernmental transfers and places a September 30, 1992 moratorium on regulations affecting contributions or taxes. By February 3, 1992, the Secretary of Health and Human Services would be required to submit to Congress the proposed regulations limiting these funding mechanisms. These provisions allow states and counties to continue to serve Medicaid-eligible women, children and the elderly while recognizing that some changes will be necessary before October 1992.

I urge you to cosponsor the legislation. Without action by Congress, counties, states and beneficiaries will be hurt. I look forward to discussing this issue in person with you next week during my visit to Washington, D.C.

Sincerely,

Robert S. Hadfield
Executive Director

RSH/mb

cc: National Association of Counties
Governor John H. Sununu, White House
Debra Anderson, White House

NACO
NEVADA ASSOCIATION OF COUNTIES
308 NORTH CURRY STREET, SUITE 205 • CARSON CITY, NEVADA 89703 (702) 883-7863

November 7, 1991

Barbara Vucanovich
U.S. Congress
206 Cannon Office Building
Washington, DC 20515

Dear Congresswoman Vucanovich:

The Nevada Association of Counties urges you to cosponsor H.R. 3595, the Medicaid Moratorium Amendments of 1991. Immediate legislative action is needed to stop the Health Care Financing Administration's efforts to terminate state funding sources for the program.

The October 31 Federal Register clarification does not show any willingness to compromise on voluntary contributions or provider taxes. With the exception of direct county appropriations to state Medicaid programs, long-standing intergovernmental transfers are also under scrutiny. If the regulations stand, the impact on services will be devastating.

H.R. 3595 represents a reasonable and appropriate response to this critical issue. It continues intergovernmental transfers and places a September 30, 1992 moratorium on regulations affecting contributions or taxes. By February 3, 1992, the Secretary of Health and Human Services would be required to submit to Congress the proposed regulations limiting these funding mechanisms. These provisions allow states and counties to continue to serve Medicaid-eligible women, children and the elderly while recognizing that some changes will be necessary before October 1992.

I urge you to cosponsor the legislation. Without action by Congress, counties, states and beneficiaries will be hurt. I look forward to discussing this issue in person with you next week during my visit to Washington, D.C.

Sincerely,

Robert S. Hadfield
Executive Director

RSH/mb

cc: National Association of Counties
Governor John H. Sununu, White House
Debra Anderson, White House

NACO
NEVADA ASSOCIATION OF COUNTIES
308 NORTH CURRY STREET, SUITE 205 • CARSON CITY, NEVADA 89703 (702) 883-7863

November 7, 1991

James Bilbray
U.S. Congress
319 Cannon House Building
Washington, DC 20515

Dear Congressman Bilbray:

The Nevada Association of Counties urges you to cosponsor H.R. 3595, the Medicaid Moratorium Amendments of 1991. Immediate legislative action is needed to stop the Health Care Financing Administration's efforts to terminate state funding sources for the program.

The October 31 Federal Register clarification does not show any willingness to compromise on voluntary contributions or provider taxes. With the exception of direct county appropriations to state Medicaid programs, long-standing intergovernmental transfers are also under scrutiny. If the regulations stand, the impact on services will be devastating.

H.R. 3595 represents a reasonable and appropriate response to this critical issue. It continues intergovernmental transfers and places a September 30, 1992 moratorium on regulations affecting contributions or taxes. By February 3, 1992, the Secretary of Health and Human Services would be required to submit to Congress the proposed regulations limiting these funding mechanisms. These provisions allow states and counties to continue to serve Medicaid-eligible women, children and the elderly while recognizing that some changes will be necessary before October 1992.

I urge you to cosponsor the legislation. Without action by Congress, counties, states and beneficiaries will be hurt. I look forward to discussing this issue in person with you next week during my visit to Washington, D.C.

Sincerely,

Robert S. Hadfield
Executive Director

RSH/mb

cc: National Association of Counties
Governor John H. Sununu, White House
Debra Anderson, White House

AC/TM /Porter Scully

AMERICAN HOSPITAL ASSOCIATION
AMERICAN ASSOCIATION OF EYE AND EAR HOSPITALS
AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION
AMERICAN PROTESTANT HEALTH ASSOCIATION
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
CATHOLIC HEALTH ASSOCIATION
NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS
NATIONAL ASSOCIATION OF PUBLIC HOSPITALS
NATIONAL ASSOCIATION OF REHABILITATION FACILITIES
NATIONAL COUNCIL OF COMMUNITY HOSPITALS
VOLUNTARY HOSPITALS OF AMERICA

November 6, 1991

THE CHIEF of STAFF has seen

The Honorable John Sununu
Chief of Staff
Executive Office of The President
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Governor Sununu

As organizations representing the nation's hospitals we are writing to express our grave concerns over the exclusion of hospitals from the negotiations between Administration officials and the National Governors' Association on the issue of Medicaid voluntary contribution and provider assessment programs and intergovernmental transfers.

These negotiations are being conducted without substantive participation by the hospital community, even though many of the issues under discussion directly affect hospitals. We are concerned about proposals to limit provider voluntary contribution and assessment programs and of particular concern is the proposal to limit Medicaid disproportionate-share payments and the number of hospitals that would qualify for those payments.

In 1989 alone, hospital underpayments from Medicaid amounted to $4.2 billion, covering only 78 percent of costs. For children's hospitals that average drops to 73 percent of costs. If it were not for the Medicaid program's disproportionate-share adjustment many of these institutions would struggle to meet the growing demand for services. As it is, many public and teaching hospitals cannot cover the cost of providing care to Medicaid patients and the medically indigent even when combining the disproportionate-share adjustment with the hospitals' Medicaid reimbursement. If the Administration has concerns about the Medicaid disproportionate-share program, they should be aired through the normal legislative hearing process with all parties involved.

While we believe that the negotiations have been conducted with the best of intentions, we also believe those good intentions cannot be fulfilled behind closed doors without the participation of hospitals. We share a common goal to find an equitable solution to the issue of Medicaid voluntary contributions, provider assessments and intergovernmental transfers; and urge that the hospital community be extended an opportunity to participate in the process.

cc: Dr. Gail Wilensky, Administrator
Health Care Financing Administration

Richard Darman, Director
Office of Management and Budget

From Scully
for call to
Governor Hunt
11-26-91

SUPPORT THE GOVERNORS'/ADMINISTRATION MEDICAID COMPROMISE

1) **The NGA/Administration Agreement IS a "two sided" moratorium**

- the agreement is good short term policy

o it allows all states to keep the Medicaid program and policy that was in effect on Sept. 30, 1991 until at least Sept. 30, 1992;
o it allows other states transitions until as late as June 30, 1993.

2) **The NGA/Administration Agreement allows states the flexibility to continue existing Medicaid programs under legitimate financing plans**

- the agreement is good long term policy

o the abuses in hospital and health provider taxes that resulted in an effective federal match of 100% in some states are addressed;
o states are still allowed to use "provider taxes" to finance their Medicaid programs-- as long as there are no "hold harmless" or "kick back" provisions to the health provider;
o states still have total flexibility to designate hospitals as eligible for special payments (Disproportionate Share payments) to at least their current funding level.

- the structural integrity of the federal/state program will be preserved

3) **Congress has until October, 1992 to change any details of the NGA/Administration compromise without any policy taking effect.**

o The Amended HR 3595 "short term" moratorium provides less policy certainty than the NGA approach. State legislatures meeting in the spring need immediate policy guidance in order to change relevant state statutes.
o If Congress waits until the spring to act the compromise may evaporate under pressure from hospitals and nursing home that unrealistically want to continue the cuurent financing practices that allow virtually unlimited access to "free" federal dollars.

- without action the $5.5 B in unexpected costs for 1992 will at least double to +$10 Billion in 1993 .

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

November 25, 1991
(Senate)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 3595 - Medicaid Moratorium Amendments of 1991
(Bentsen (D) TX)

The Administration strongly supports the agreement that was reached with the National Governors Association. This agreement allows the Medicaid program in every State to continue their pre-September 30, 1991 policies until at least October 1, 1992, and in some cases through June 30, 1993. Further, the agreement equitably addresses the individual fiscal concerns of the States while assuring the long-term structural integrity of the Medicaid program.

The compromise agreement should be passed this year before Congress adjourns. This is a major health and fiscal policy problem for Federal and State governments. The States and many legislatures need clear legislative or regulatory policy guidance before State legislatures meet next spring.

The Administration opposes any temporary moratorium that would leave these issues unresolved until March 1992 or later. Should legislation be presented to the President that includes a "two-sided" moratorium that precludes Federal regulatory activity, and State program expansions, the President's senior advisers would recommend that he veto it if it is not consistent with the Budget Enforcement Act.

* * * * * * *

(Not to be Distributed Outside Executive Office of the President)

This draft position was developed by HRVL/PAD (Tom Scully). The Department of Health and Human Services (per Steven Kelmar, Assistant Secretary for Legislation) agrees with the proposed position. The Department of Justice was not available to review the draft position.

LEGISLATIVE REFERENCE DIVISION DRAFT
11/23/91 - 2:10 p.m.

Medicaid

BROAD BASED PROVIDER TAXES AND DSH LIMITS

Donations

States would not receive federal matching funds for revenues obtained from donations by or on behalf of providers.

- Donations for direct costs related to initial eligibility processing and outreach, including training, by out-stationed workers in hospitals, clinics, and similar settings would be permitted. For any state, the total amount of donations permitted under this provision may not exceed 10 percent of the total administrative expenditures for Medicaid in a state.

- Donations to the state by entities that directly benefit from Medicaid payment are prohibited under this proposal.

- Donations to the state not prohibited under this proposal are allowable. This includes donations from charitable organizations to providers where the source can be clearly traced.

Taxes

Replace the OBRA '90 provider-specific tax provisions with language stipulating that federal matching will be available to match revenues from provider-specific taxes as the state share of Medicaid only if the tax is broad-based; that is, it uniformly applies to all providers in a class and all class-related business of providers.

- Examples of a broad-based tax include a gross receipts tax on all revenues, a tax based on all inpatient days, a head tax on all patients, or a tax on all beds of providers (although the tax could exclude Medicaid business of the providers). If a hospital or other provider is part of a larger entity that includes non-Medicaid provider business, business of a different class of providers, or Medicaid business in another state, the state would not be required to tax that other business of the entity. Services could not be unbundled from what is normally considered to be part of a provider's business.

- Only taxes that apply to all providers in a class at the same rate and on the same tax base would be considered to "uniformly" apply to all providers.

- A "class" of providers refers to, for example, all hospitals, all physicians, or all nursing homes practicing in the state.

- States could exempt from any tax state hospitals and/or other public hospitals or other public entities. States could also apply to the Secretary of HHS for a waiver to exclude other providers in a class from a broad-based provider tax, or to provide for exemptions,

deductions, or credits, if the exemptions, deductions, or credits do not violate the spirit of a broad-based redistributive tax on a class of providers. Examples of permissable waivers would include exemptions for rural or sole community providers, or for facilities with high Medicaid or low-income utilization.

- A state may not guarantee or otherwise agree with providers that all or a portion of the tax will be returned to them. These provisions would not prevent use of the tax to reimburse members of the class for Medicaid services, nor preclude states from relying on such reimbursement to justify or explain the tax. But they would prevent states from holding providers harmless, in whole or in part, for the costs of the tax in any way, including, but not limited to: tax rebates, credits, or Medicaid payments (or a portion thereof) related only to the amount of the total tax paid.

- The provisions of OBRA '90 prohibiting the denial of or limits on payments to a state for expenditures for medical assistance for items or services attributable to taxes of general applicability would be retained.

For purposes of calculating federal matching, total revenues from these broad-based provider tax revenues could not exceed 25 percent of the state share of Medicaid during federal fiscal years 1993-1995.

- The amount of allowable provider-specific tax revenues would be calculated by multiplying the 25 percent figure by the state share of Medicaid expenditures less any revenue derived from donations or provider-specific tax programs that do not meet the requirements of this proposal. The resulting figure represents the permissible revenues from allowable provider-specific taxes that would qualify as expenditures for federal matching purposes.

- Any state in which the revenues from provider donations and provider-specific taxes were in excess of 25 percent in state fiscal 1992 based on the state's Medicaid program and state plan amendments submitted to HCFA by September 30, 1991, would be permitted to use broad-based provider-specific taxes up to that fiscal 1992 percentage, instead of up to 25 percent. This applies whether or not the donations and provider-specific taxes used in fiscal 1992 met the standards of this proposal.

forever?

Related Provisions

- Providers will not be precluded from including the cost of broad-based provider-specific taxes on cost reports submitted to the state. The provision of OBRA '90 precluding inclusion of these taxes would be repealed.

- Nothing in this proposal shall be construed to address states' use of funds transferred to the state from, or expanded by, counties, cities, specific purpose districts, or other governmental entities within the state as the non-federal share of Medicaid expenditures,

California?

unless the source of the funds was donations or taxes that would not otherwise be recognized as the non-federal share under this proposal. HCFA will reinstate its pre-existing regulation on the use of public funds, and provide therein that transferred or certified funds do not lose their character merely because the transferring or certifying entity is also a Medicaid provider.

- HCFA could not refuse federal matching on the "net expenditure" theory for expenditures prior to the effective date of these provisions for any expenditure otherwise permitted by this proposal or under current law while it is applicable.

- Arizona is exempt from this agreement as long as it is covered by its Section 1115(b) waiver.

DSH Upper Payment Limits

Existing law that limits aggregate Medicaid payments to all hospitals (exclusive of disproportionate share payments) to the aggregate amount that would have been paid under Medicare payment principles would remain unchanged. The prohibition in existing law on limiting federal matching for Medicaid DSH payments would be repealed. A separate upper payment limit would be calculated for Medicaid disproportionate share payments. The total of all DSH payments in federal fiscal 1993 and in any future year will not exceed 12 percent of total Medicaid program expenditures in that year.

- Any state whose DSH payments in federal fiscal 1992 exceeded 12 percent of total Medicaid program expenditures in that year would be entitled in subsequent years to receive federal matching for DSH payments up to the amount of such payments in federal fiscal 1992 that were pursuant to plans in place on or submitted to HCFA by September 30, 1991, or enacted by state legislatures by that date. This limit would remain in effect until DSH payments in that state fell to the specified percentage cap, at which time the state would be entitled to increase DSH payments in proportion to total Medicaid program growth.

- Any state whose percentage of DSH payments in federal fiscal 1992 is less than 12 percent of total Medicaid program expenditures will be entitled in subsequent years to federal matching for additional DSH payments as follows.

  (a) The level of federal fiscal 1992 payments will be increased by the same percentage as the increase in total Medicaid program expenditures in that state for the year in question compared to federal fiscal 1992;

  (b) The state will receive an allocated share of the "DSH growth factor" derived from those states whose DSH payment remain limited by the level of federal fiscal 1992 DSH payments, provided that the overall percentage of DSH payments in the state does not exceed 12 percent of total Medicaid program expenditures.

- The "DSH growth factor" for each state governed by the federal fiscal 1992 payment limit is equal to DSH payments recognized for federal fiscal 1992 times the percentage increase in total Medicaid expenditures for the year in question over the comparable figure for federal fiscal 1992. The aggregate of the DSH growth factor" for all such states will be pooled, reduced and distributed to all other states, as described in the following paragraphs.

- The total "DSH growth factor" pool will first be reduced as necessary to assure that total DSH payments by all states will not exceed in the year 12 percent of total Medicaid program expenditures in the year by all states. HCFA will estimate the amount of the pool each year based on estimates of total program expenditures and DSH payments. The figures will be reconciled at the end of each year, and reconciling adjustments will be made in the estimates for the subsequent year.

- The "DSH growth factor" pool, as reduced in accordance with the preceding paragraph, will be allocated first as necessary to bring up to $1 million the federal fiscal 1992 DSH payment figure for all states whose DSH payments in that year were below that number. The balance of the pool will be allocated in accordance with total Medicaid program expenditures for the year in question of the states participating in the pool.

- In summary, the concept is that states whose federal fiscal 1992 DSH payments are above the national cap will be frozen at that level until program growth brings their percentage down to the national cap. All other states would be entitled to use the growth that otherwise would have been available to those states, subject to an individual state limit and a national spending limit of 12 percent of total Medicaid program expenditures.

- The provisions of Section 1923(c) requiring that DSH payments be proportional to Medicaid or low-income utilization rates of participating hospitals would remain in effect and would be amended to provide that states may not vary payments by type of hospital so as to assure payors of provider-specific taxes that their taxes will be reimbursed without regard to their level of Medicaid participation.

- HCFA would be precluded from restricting the hospitals that states could include in the disproportionate share hospital category.

- The special rule of Section 1923(e) would be retained.

Effective Dates

- The effective date for the donation and provider-specific tax prohibitions would be October 1, 1992, for programs in effect or reflected in state plan amendments as of September 30, 1991. For those states with a fiscal year ending between July 1, and October 1, 1992, the effective date would be January 1, 1992. For those states whose legislatures do not have a regularly scheduled session in 1992, the effective date would be July 1, 1993.

- For the period January 1, 1992, to the effective date, donations and provider-specific taxes not meeting the requirements of a broad-based tax covered by the preceding paragraph are acceptable up to the amount included or specified in state budget documents, submissions to HCFA, or legislation in existence on September 30, 1991.

- Except for the preceding paragraphs, the provisions prohibiting the use of donations or of provider-specific taxes that do not meet the broad-based standard would take effect on January 1, 1992.

- This proposal would not affect provider-specific taxes assessed or donations made on or before December 31, 1992.

Reporting Requirements

- States must provide annually to the Secretary, information related to all provider-specific taxes and donations raised by the state in the aggregate (and for individual facilities) in the preceeding year.

Teleconference
4:00pm - November 14, 1991
Governor Sununu's Office

Governors	State	Telephone #	Contact Person
1. John McKernan	Maine	207/289-3531	Rose Smith
2. John Ashcroft	Missouri	314/751-3816	Joann
3. John Engler	Michigan	313/568-8303	David Bertram
4. Carroll Campbell (Mr)	South Carolina	He will call in to White House Operator #2, but if there is any problem call 803/734-9818 Sally Spade	
5. Pete Wilson	California	He will call in to White House Operator #2, but if there is a problem call Katy Wheeler or Doris at 916/445-2841	
6. William Weld	Massachusetts	He will call in to White House Operator #2, but if there is any problem call Javonne at 617/727-9730.	

Chiefs of Staff

~~1. Stewart Bliss~~ for Governor Roy Romer — Colorado — 303/866-4568 — Maria — cancelled

Ray Scheppach — NGA, Director — 202-624-5316

MEDICAID MEETING

- We wanted to get together to talk to all of you and get your views about the Medicaid compromise.
- We are not happy, but we understand the state fiscal problems.
- As a result, we have been willing to write off $5-6 billion this year -- and a larger amount in future years in exchange for returning some structural integrity to the program.
- Our regulation would save $2-3 billion this year, but we prefer to find a long-term solution that allows for reasonable compromise.

5. Even if we all agree -- and there are still some problems -- we have a lot of legislative work to do if we have any hope of getting this compromise passed.

Very limited Donations
Taxes must be broad based.
Limit of 22% of State can be used this way —
No kickback clauses.

Disproportionate Share.
Can = all Hospitals as Disprop. Share
limit
Cap on it .... 11% of Total Medicaid Exp. could be used for Disprop Share

Transition Time
July 1 @ earliest
Some by Oct. if Oct fiscal year.

Must convert by July August

Texas
If don't get there this year
3 years to 5 down.

Calif 16%

If disprop. share — get governors in
Hold @ absolute $

MEDICAID:

Summary of NGA/Administration Compromise

Program Operation in This Fiscal Year

o All state Medicaid plans would **continue to operate through this fiscal year** under their current program structure, with the following caveats:

1) If a state's fiscal year ends in July, the current program will stay in place until July, 1992;

2) If a state's fiscal year ends in October, the current program will stay in place through October, 1992;

3) If a state legislature is not scheduled to meet before July, 1992, regardless of its fiscal year, its current program will stay in place through October, 1992.

4) "Operation under its current program" allows states to continue to function under state plan amendments filed before September 30, 1991; or under provisions of state law legislated prior to September 30, 1991.

5) The total dollar level of "operations" financed by provider taxes and donations that will be matched by HCFA will be limited to HCFA's best estimate of total state spending expected under a state plan as of September 30, 1991. Should a state have clear evidence--such as legislated budget documentation-- that the reimbursement level should be higher than HCFA's estimate in order to make the state "whole" through this fiscal year under its budget-- HCFA will provide matching funds up to projected state budget levels.

New State Program Parameters (after transition period)

o **Provider Donations:**

1) would generally not be allowed if they were made by, or on behalf of, providers. But,

2) provider donations would be allowed only for the direct cost of clearly specified Medicaid outreach costs-- capped at 10% of a state's matchable administrative costs.

o **Provider Taxes:**

1) Federal matching funds would be available only for "provider

specific taxes" that apply uniformly to all providers in a class-- and to all the business of those providers.

2) A "class" of provider refers to, for example, all hospitals, all physicians or all nursing homes practicing in a state.

3) Provider taxes must be levied on all business (i.e. a gross revenues tax or per patient head tax) to be eligible for a federal match.

4) A state may not effectively guarantee, or in any way indicate to, or reach agreement with, providers that all or any portion of the tax will be returned to them. This prevents full and partial "hold harmless" tax provisions that had led to abuses of state provider taxes.

5) States can apply to the Secretary of HHS for waivers to exclude specific providers from these "broad based" taxes, and still qualify for fedeal matching funds.

6) For purposes of calculating the fedal match, ***total revenues generated by broad-based provider revenues could not exceed 22%*** of the total state Medicaid expenditures presented for federal matching.

7) A three year transistion will be provided for any states currently above the 22% threshold foir provider taxes. These states would have to reduce their percentage of provider taxes by 1/3 each year to reach the cap.

o **Disproportionate Share Payments**

Unlimited Disproportionate Share (DSH) payments have been the primary factor contributing to inapproporiate program spending growth. This compromise allows the states to continue paying at currents rates, but caps total payments to avoid future abuses.

1) States could continue to designate any hospital in a state as a DSH hospital. However, the DSH payments would have to be directly proportional to the hospital's Medicaid or low-income utilization rate. (Note the HCFA reg would have limited DSH payments to hospitals having above the mean number of Medicaid patients in the state).

2) State Medicaid payments to DSH hospitals in any year could not exceed, in the aggregate at set percent (8-11%-- still undetermined) of the total Medicaid expenditures by the state in that year. (Note the aggregate will be 11%, but to grandfather in outlier states, the

11/14
12:00 Noon

BROAD BASED PROVIDER TAXES AND DSH LIMITS

Donations

States would not receive Federal matching funds for revenues obtained from donations by or on behalf of providers.

- Donations for direct costs related to initial eligibility processing and outreach, including training, by out-stationed workers in hospitals, clinics, and similar settings would be permitted. For any State, the total amount of donations permitted under this provision may not exceed 10 percent of the total administrative expenditures for Medicaid in a State.

- Donations to the State by entities that directly benefit from Medicaid payment are prohibited under this proposal.

- Donations to the State not prohibited under this proposal are allowable.

Taxes

Replace the OBRA 90 provider-specific tax provisions with language stipulating that Federal matching will be available to match revenues from provider-specific taxes as the State share of Medicaid only if the tax uniformly applies to all providers in a class and all business of providers.

- A tax must be levied on all class-related business of providers, for example, a gross revenues tax, a tax based on all inpatient days, a head tax on all patients, or a tax on all beds of providers (although the tax could exclude Medicaid business of the provider). The tax may not be based on a factor that is weighted toward the Medicaid business of a provider. However, if a hospital or other provider is part of a larger entity that includes non-Medicaid provider business, business of a different class of providers, or Medicaid business in another State, the State would not be required to tax that other business of the entity. Services could not be unbundled from what is normally considered to be part of a provider's business.

- Only taxes that apply to all providers in a class at the same rate and on the same tax base would be considered to "uniformly" apply to all providers.

- A "class" of providers refers to, for example, all hospitals, all physicians, or all nursing homes practicing in the State.

- States could exempt from any tax State hospitals and/or other public hospitals or other public entities. States could also apply to the Secretary of HHS for a

waiver to exclude other providers in a class from a broad-based provider tax, or to provide for exclusions, deductions, or credits, if the exclusions, deductions, or credits do not violate the spirit of a broad-based redistributive tax covering a class of providers.

- A State may not effectively guarantee or in any way indicate to, or reach agreement with providers that all or a portion of the tax will be returned to them in any way. These provisions would not prevent the use of the tax to reimburse members of the class for Medicaid services, but would prevent States from holding providers harmless, in whole or in part, for the costs of the tax through whatever means, including but not limited to: tax rebates, credits, or Medicaid payments (or a portion thereof) related only to the amount of the tax paid.

For purposes of calculating Federal matching, total revenues from these broad-based provider tax revenues could not exceed 22 percent of the State share of Medicaid.

- The amount of allowable provider-specific tax revenues would be calculated by multiplying the 22 percent figure by the State share of Medicaid expenditures less any revenue derived from donations or provider-specific tax programs that do not meet the requirements of this proposal. The resulting figure represents the permissible revenues from allowable provider taxes that would qualify as expenditures for Federal matching purposes.

- A three year transition period would be allowed for any State in which the revenues from provider donations and provider taxes were in excess of 22 percent in State FY 1992 based on their Medicaid program and State plan amendments submitted to HCFA by September 30, 1991.

- There would be no transition period for the use of provider donations and provider taxes that are not eligible for Federal matching under this proposal.

- For States that qualify for a transition period, the amount of allowable provider-specific tax revenues above the threshold would be subject to Federal matching disallowances if, beginning in State FY 1993 and in each subsequent State FY for the three transition years, the State did not reduce their share of broad-based provider-tax revenues by at least one-third of the percentage difference above the 22 percent limit. For example, in a State that is at a 28 percent level in State FY 1992 would be required to be at 26 percent in State FY 1993, 24 percent in State FY 1994, and 22 percent in State FY 1995.

Related Provisions

- Providers will not be precluded from including the cost of taxes on cost reports submitted to the State.

- Nothing in this proposal shall be construed as authorizing the denial of or limitation on payments to a State for expenditures for medical assistance for items or services attributable to taxes of general applicability.

- Nothing in this proposal shall be construed to address States' use of funds transferred to the State from, or expended by, counties, cities, special purpose districts or other governmental entities within the State as the non-Federal share of Medicaid expenditures unless the source of the funds was donations or taxes that would not otherwise be recognized as the non-Federal share under this proposal. HCFA will reinstate its pre-existing regulation on the use of public funds, and provide therein that transferred or certified funds do not lose their character merely because the transferring or certifying entity is also a Medicaid provider.

- HCFA could not refuse Federal matching on the "net expenditure" theory for expenditures prior to the effective date of these provisions for any expenditure otherwise permitted by this proposal or under current law while it is applicable.

DSH Upper Payment Limits

The prohibition on limiting Federal matching for Medicaid DSH payments would be repealed. Aggregate Medicaid payments to all non-disproportionate share Medicaid hospitals would continue to be limited by the aggregate amount that would have been paid under Medicare payment principles. A separate upper payment limit would be calculated for Medicaid disproportionate share hospitals.

- The provisions of Section 1923(c) requiring that DSH payments be proportional to Medicaid or low-income utilization rates of participating hospitals, would remain in effect, except that any variation by type of hospital may not result in an overall distribution of DSH payments that substantially deviates from the proportional distribution required by this provision.

- The aggregate dollar amount of State DSH payments nationwide may not exceed, in FFY 1993 and future years, the estimated percentage, (approximately 11 percent nationwide) that such payments will be of total expenditures for medical assistance under Medicaid in FFY 1992 based on plans submitted by States to HCFA or enacted by State legislatures by September 30, 1991.

Each State would be held to the nation-wide cap unless it is covered by the following sentence. Any State whose total DSH payments exceeded that specified percentage in FY 1992 may continue to make DSH payments in an aggregate dollar amount that does not exceed the dollar amount expended by the State on DSH payments based on legislative or budget documents, or State plans submitted by September 30, 1991. The percentage limitation shall be adjusted annually to assure that total permitted DSH payments in the year are equal in percentage of total expenditures for medical assistance under Medicaid to the FFY 1992 DSH payment amount specified above.

Effective Dates

- The effective date for the donation and provider specific tax prohibitions would be July 1, 1992 for programs in effect or reflected in State plan amendments as of September 30, 1991. Except for those States with a fiscal year ending between July 1 and October 1, 1992, and those States whose legislatures do not have a regularly scheduled session in 1992, the effective date would be October 1, 1992.

- For the period January 1, 1992 to the effective date, donations and taxes not meeting the requirements of a broad-based tax are acceptable up to the amount included or specified in State budget documents, submissions to HCFA, or legislation in existence on September 30, 1991.

- This proposal would not effect provider-specific taxes assessed or donations made on or before December 31, 1991.

Reporting Requirement

- States must provide annually to the Secretary information related to all provider-specific taxes and donations raised by the State and the total amount of DSH payments made by the State in the aggregate, [and for individual facilities], in the preceding year.

271555

CARDINAL'S OFFICE
1011 FIRST AVENUE
NEW YORK, NY 10022

THE CHIEF of STAFF
has seen

September 16, 1991

BY FAX

Dear Governor Sununu,

I am deeply concerned about the State of Oregon's intention to request a waiver from the federal government in order to implement a Medicaid rationing program. I strongly support the comprehensive letter addressed by Bishop James Malone to Secretary Louis Sullivan, August 6, 1991. Bishop Malone is Chairman of the Domestic Policy Committee of the National Conference of Catholic Bishops. I will not attempt to report the details or the arguments Bishop Malone presents, but simply express my personal alarm over the Oregon effort, and single out a few examples of its potential impact.

The list of health services to be excluded is extremely worrisome. Even more frightening, however, is that the plan would deprive the poorest of the poor of necessary health care services. In addition to limiting critically necessary medical services for poor women and children, the Oregon plan proposes to increase subsidies for abortion.

I see the proposal as the beginning of a long-term effort to use the "quality of life" as a determinant of who receives care and who does not. It ultimately amounts to "the survival of the fittest". Further, I see it as the beginning of infanticide, and as a way of trying to rid Oregon of AIDS. Persons with AIDS, and especially babies with AIDS, would be frighteningly vulnerable. Finally, I consider it of a piece with Oregon's strong effort to pass euthanasia and assisted-suicide legislation. In my judgment, to permit this kind of program as a model for the states is to reverse radically everything this nation purports to believe.

I understand it is the ultimate goal of the State of Oregon to expand Medicaid coverage to all persons whose income falls below the poverty level. That is a laudable end, except that I understand that the very class that it proposes to cover will be covered in other ways, at least on a "phased-in" basis. Even if this is not the case, however, the proposed rationing program is, in my judgment, an unjust and inappropriate means to achieving that end. I strongly urge that the request for the waiver be denied.

Faithfully,

John Cardinal O'Connor

Archbishop of New York

The Honorable
John H. Sununu
Chief of Staff to the President
The White House
Washington, DC 20500

UNITED STATES CATHOLIC CONFERENCE

Department of Social Development and World Peace
Office of Domestic Social Development
3211 4th Street N.E. Washington, DC 20017-1194 (202)541-3185 FAX (202)541-3322 TELEX 7400424

August 6, 1991

Secretary Louis W. Sullivan
Department of Health and Human Services
200 Independence Avenue
Washington, D.C. 20410

Dear Secretary Sullivan:

The United States Catholic Conference, the public policy arm of the nation's Roman Catholic bishops, urges you to deny Oregon's request for a waiver to implement its Medicaid rationing proposal. The details of the plan are now clear and final action has been taken by the Oregon legislature; we understand that the waiver request is imminent.

As you know, the U.S. bishops called for a national health insurance program in 1981, and we continue to support universal access to health care as a basic human right. We can appreciate and even applaud Oregon's plan to expand Medicaid coverage to all persons with incomes below the poverty level.

Good intentions, however, cannot justify Oregon's proposed intentional rationing of health care for the poor. The proposal is inequitable in concept, arbitrary and capricious in effect, violative of the purposes of the Medicaid program, and cruelly life-threatening for the most vulnerable of the state's children.

The Proposal Is Fundamentally Inequitable in Concept

The Oregon proposal to fund only certain health services from a list developed by the state is a radically new rationing concept. Unlike the rationing familiar to us in moments of national crisis, this plan is to be applied, not to all citizens of Oregon, but only to its poor. While in future years the listings may be used to establish <u>minimum coverage</u> for those with private insurance, Oregon now plans to use them as the <u>maximum coverage</u> for the poor under the Medicaid program. It is only the poor and most vulnerable -- those eligible for Medicaid -- whose health care is to be rationed. *For more than one hundred and sixty thousand poor women and children currently covered by Medicaid, the plan would take away medical coverage for over 120 medical conditions, almost one-fifth of the treatments in Oregon's medical listings.*

This fundamental inequity is exacerbated by the proposed double standard within the Medicaid eligible population. The Oregon plan would initially exempt tens of thousands of Medicaid recipients who are aged, blind, and disabled from the rationing

scheme. Their medical care actually constitutes more than two-thirds of the state's total Medicaid bill and is the fastest growing part, while care for children on Medicaid comprises less than 15 percent of Oregon's Medicaid budget. While the Conference does not think Oregon's plan is appropriate for any of the state's poor, it would not be out of place to observe that these insulated groups are far more politically well-organized than are poor women and children.

The Effect of the Proposal is Arbitrary and Capricious

In its 1991 Report to the Governor and the Legislature, the Oregon Health Services Commission wrote:

> Therefore, the Commission defined basic health care in terms of society as a whole: Basic health care is a minimum below which no person should fall. Given this definition, the Commission went further to describe basic in terms of **essential** and **very important** categories of health services. All of the "essential" services and most of the "very important" must be included in a basic health care package.

Despite its own Commission recommendation, the Oregon Legislature did not agree to provide this "basic health care." The Legislature approved only a partial listing of covered services and excluded eight "essential" health services -- including seven in the "acute fatal" and "chronic fatal" categories -- and more than fifty "very important" health services. Even within the conceptual structure of the Oregon plan, its failure to fund basic health care is arbitrary and capricious. *It is a product of political and fiscal considerations, not good medicine, justice, or sound social policy.*

Oregon's ability to fund even this level of medical care beyond next year remains in serious doubt. The actuarial section of the Commission report acknowledges that by the end of the first year (1992-93) of the plan only sixty percent of the expected participants will be enrolled. Fiscal estimates for the first year included that assumption. Only three years later is the program "expected to reach a steady-state of enrollment..." Thus, maintenance of the initial level of covered services in Oregon will require infusions of funding in the second, third, and subsequent years far above the already increasingly high levels of medical inflation. Yet, Oregon has adopted a new Ballot Measure 5 which will acutely limit state funding for human resources and will make increased Medicaid funding in coming years very difficult. *In coming years, the Oregon Legislature may exclude more and more "essential" and "very important" health services and further erode "basic health care" for Medicaid participants, primarily women and children.*

The Oregon proposal is an experiment, applying an untested series of hypotheses, the opinions of eleven Commission members, and the legislature's fiscal constraints to the health, well-being, and even life-and-death decisions for hundreds of thousands of poor Oregonians. *There is no generally accepted scientific or medical method for achieving Oregon's purposes in the listings, and Oregon's chosen method has never been tested.* To develop its scheme, the Commission compared benefits, treatments, and outcomes across widely differing kinds of medical conditions, and then quantified them in a highly novel -- but completely untested -- methodology. The state now proposes that its initial experiment be substantially funded with federal Medicaid dollars and applied, in lieu of the current standard of "all medically necessary care and services," to non-consenting poor women and children.

The risks of trading the current standard of "all medically necessary care and services" for the proposed rationing scheme was underscored in the Legislature's rejection of proposals to apply the same listings to the health insurance programs of state employees and members of the Legislature themselves.

Use of the listings also threatens traditional medicine's focus on the care and cure of individual patients. It would shift us from patient-centered to procedure-driven medical practice. It would take away individualized medical decisions about what is good or even life-saving for a particular patient and substitute in its place a generalized determination of what seems to be good for some averaged population.

The listings thus also threaten to change the traditional relationship between physicians and patients, at least for poor patients. Many doctors already refuse to participate in Medicaid because of underfunding of services. These radical and pervasive changes in medical practice could seriously aggravate the current shortage of doctors and other providers in Medicaid by substituting the political judgments underlying the listings for the medical judgments of individual physicians. The losers, again, would be poor women and children.

Finally, the arbitrariness of the state proposal is highlighted by the Legislature's decision to increase subsidies for abortion, funded only from state funds under this plan but expanded now to additional thousands of persons, in lieu of funding life-saving health care for the poor in Oregon.

The Proposal Violates the Purposes and Terms of the Medicaid Law

The purpose of the Medicaid law is to enable the states to furnish "medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services..." The clear purpose was to provide

medical coverage to the two groups singled out since the Depression for special government care and protection: poor families with children and the aged, blind, and disabled. In the interim, Congress has adopted a number of mandates and options focused on expansion of coverage for both groups. These culminated in the 1990 law that will insure coverage of all poor children by the year 2001.

Oregon's proposal would now reverse that long-standing federal policy. On the one hand Oregon protects the politically more powerful group of elders and persons with disabilities from drastic benefit cuts while, on the other, it subjects the more vulnerable group of its poorest women and children to the state's untested and procrustean plan. The addition of other poor persons to the reduced benefits scheme cannot be justification for exposing the poorest women and children to the broad dangers inherent in this untried plan.

Secondly, not only does the proposed plan not provide the basic health care recommended by Oregon's own Commission, but it totally discards the provision of medically necessary care and services required under the Medicaid law and protected for years by both Congress and the courts.

Thirdly, Oregon's poor children have little to gain and much to lose under the proposal. The Medicaid amendments of 1989 and 1990 have entitled all poor children to all medically necessary care and services. All states, including Oregon, must extend coverage to all poor children under age 19 on a phased-in basis, covering all children up to age 9 by the first year of Oregon's proposed experiment and to age 12 by the time of its full implementation. It is these younger children who have the most costly health needs, the most to gain by congressional mandates, and the most to lose in Oregon's scheme. *In fact, almost every pregnant woman and child under six with family incomes under 133% of the poverty line and every poor Oregon child under nine loses essential and very important, even life-saving, medical care under the plan.*

Recently Congress expanded the provision of medical care to children in America by revising the Medicaid early and periodic screening, diagnostic, and treatment provisions. Congress required every state to provide coverage to eligible children under age 21 for virtually all Medicaid benefits recognized under federal law and needed to correct or ameliorate defects and physical and mental illnesses and conditions discovered in screening. Oregon proposes to eliminate these protections and services to its poor children.

Furthermore, while Oregon protests that its plan is intended to benefit poor women and children, it proposes to eliminate the medically needy program for pregnant women and children under age 18. This provision was designed by Congress specifically to assist women and children whose incomes exceed eligibility

standards but who have medical problems giving rise to excessive medical costs. Oregon would strip them of this medical coverage.

Finally, the radically experimental and untested nature of the Oregon proposal threatens the health, well-being, and lives of hundreds of thousands of poor Oregonians, its poorest women and children and thousands of others. Both ethics and public policy dictate that experimentation involving human subjects, such as research under the Medicaid program, be subject to strict controls. In each such case, the government must exercise extreme care to analyze whether the risks involved in the experiment are outweighed by the benefits to those involved. The government must also establish safeguards to protect the rights and welfare of the subjects of all such demonstrations.

This Conference repeatedly has insisted that research and experimentation on human subjects be allowed only when the experiment has the informed consent of the subjects; or, in the care of those unable to consent, when the experiment (1) may enhance the well being or meet the health needs of the subjects; or (2) will pose no added risk of suffering, injury or death to the subjects; and (3) can be expected to develop knowledge that cannot be obtained by other means.

The state of Oregon does not argue that the women and children who will receive less care under the proposed rationing plan will receive any benefit, yet one must presume that those same pregnant women and children will suffer from the denial of what Oregon itself says are "essential" and "very important" health care services. The potential danger to patients to be treated under the Oregon proposal becomes clearer when we realize that the Legislature found it necessary to exempt health care providers from malpractice suits based on denial of necessary care that is "below the cutoff line" applied to the listings.

In this case, the vast majority of the subjects of the Oregon plan will be children incapable of voluntary consent to the experiment. A humane medical ethic suggests that children should not be subjected to an experimental plan unless the research might benefit them as individuals. Before allowing states to subject children to such experimentation, the federal government then has a particularly heavy legal and ethical responsibility to protect their health and lives.

Furthermore, before allowing states to impose deductions, cost sharing, or similar charges on their Medicaid patients, federal law requires the Secretary to ensure that the new co-payments do not become a barrier to access to necessary care or result in injury to Medicaid patients. Even more rigorous protections must be applied to a waiver request that would exclude more than 120 health services from the Medicaid program -- or require the poor to purchase them from their own funds, the most direct form of "cost sharing" imaginable!

The Proposal Threatens the Lives of Oregon's Most Vulnerable Children

While expanding abortion services, Oregon's proposal directly terminates access to care to 120 health services for a hundred and sixty thousand poor women and children currently covered by its Medicaid program. This is more than just an experiment in health care financing or an alteration in the funding structure of the state program. *In fact, the plan could result in federally sanctioned medical neglect leading to the deaths of poor women and children.* One such example occurs in the case of extremely premature and low birthweight newborns, whose survival has been given low priority in the state's listings. In the case of these young children, individualized medical and ethical decisions should be made by appropriate family members and professionals. Instead, Oregon proposes an automatic, cost-based, and formula-triggered denial of funding for treatment and thus sentences these children to almost certain death.

In view of the numerous moral, ethical, and policy imperatives against the kind of experimentation proposed for the poor of Oregon, the Roman Catholic Bishops of this nation must oppose the Oregon experiment. We urge you to deny the waiver requested by the state and to retain the protections and benefits of the current Medicaid statute.

Sincerely yours,

+ James W. Malone

Bishop James W. Malone
Chairman
Domestic Policy Committee

cc: Honorable Lloyd Bentsen
Honorable Henry A. Waxman
Dr. Gail Wilensky

UNITED STATES CATHOLIC CONFERENCE
Migration and Refugee Services
3211 4th Street N.E. Washington, DC 20017-1194 (202) 541-3220 FAX (202) 541-3399 TELEX 7400424
National Office

Dear Governor Sununu —

THE CHIEF of STAFF has seen

The attached information relates to the Oregon situation about which we have spoken.

My concern is shared by Cardinal O'Connor, as well as the U.S.C.C. Dep't of Social Development and Peace. This waiver would, in effect, make possible more abortions.

Sincerely in Christ,

Bernard Cardinal Law

9/12/91

OREGON CATHOLIC CONFERENCE

2838 East Burnside Street
Portland, Oregon 97214
(503) 234-5334

Representing the Archdiocese of Portland and the Diocese of Baker on issues of public policy

August 9, 1991

For additional information, please contact:
Bob Castagna -- 233-8387

OREGON CATHOLIC CONFERENCE OPPOSES STATE OF OREGON REQUEST FOR MEDICAID WAIVER

The Oregon Catholic Conference, the public policy office of the Archdiocese of Portland and the Diocese of Baker, today declares its opposition to the State of Oregon's request that the federal government grant Oregon a waiver to implement an experimental Medicaid rationing program.

Our opposition today is consistent with the Oregon Catholic Conference's previously expressed position during the 1989 and 1991 legislative sessions and during the deliberations of the Oregon Health Services Commission. We welcome the support and collaboration of the United States Catholic Conference in opposing Oregon's request for a waiver from the current Medicaid program.

The Oregon Catholic Conference enthusiastically supports the intention to expand access to health care and applauds Oregon's efforts to raise to national attention the plight of those who are denied access to health care. The Conference however, finds itself unable to support Oregon's Medicaid rationing proposal and must oppose the request for a federal waiver.

The Oregon Catholic Conference objects to the rationing aspects of the Oregon Medicaid proposal, particularly when the rationing initially is focused on the poor women and children who are the primary beneficiaries of Medicaid in order to provide benefits to those who are less poor. When society as a whole is not being asked to accept rationing of health care for everyone, the Oregon Catholic Conference objects to the rationing aspects of the proposal being focused on the poor. The uncertain financial climate in the state of Oregon after the passage of Ballot Measure 5 does not inspire confidence that the state will be able to maintain a commitment to basic health care which is comprehensive. The Oregon Medicaid proposal ought not jeopardize the coverage of those poor women and children currently receiving federal Medicaid benefits.

Under Oregon's proposal, there is no guarantee of a continued comprehensive health care benefits package for the poor. The services to be provided will fluctuate according to the state's fiscal climate and political decisions increasingly made more difficult by the passage of Ballot Measure 5 and the absence so far of replacement revenues.

The Oregon Catholic Conference objects to the emphasis on quality of life and quality of well-being in Oregon's proposal. This emphasis can jeopardize the rights of individuals and shift the focus from the dignity of the individual patient and that patient's individual needs to a formula-approach to providing health care services.

The Oregon Catholic Conference objects to the inequities

contained in the structure of the Oregon Medicaid proposal, particularly if insufficient resources are available. Under the proposal, if insufficient resources are available during a contract period, the reimbursement rate for providers is not reduced; but health services are reduced by eliminating services for the eligible population. Equity demands that there be a balance between the reduction of services and a just reduction in the reimbursement rates providers receive.

The Oregon Catholic Conference has objections of the most serious kind for the increased number of state-financed abortions which would occur under the plan. The Conference objects to the State of Oregon requesting the federal government to ratify an increase in the number of state-financed abortions and the state's categorization of abortion as an "essential" health care service.

The U.S. bishops called for a national health insurance program in 1981. The Oregon Catholic Conference continues to support universal access to health care as a basic human right. Unfortunately, the Oregon Medicaid proposal falls short of that goal in its experimental rationing of health care for the poor. The Oregon Catholic Conference, then, respectfully requests the federal government to deny Oregon's application for a waiver from the current Medicaid program.

-30-

UNITED STATES CATHOLIC CONFERENCE NEWS

DATE: August 9, 1991

FROM: Deacon Chris Baumann

O - 202-541-3200
H - 703-503-9664

FOR IMMEDIATE RELEASE

U.S. CATHOLIC BISHOPS CONFERENCE OPPOSES OREGON STATE REQUEST FOR MEDICAID WAIVER

WASHINGTON - In a strongly worded letter to Health and Human Services Secretary, Louis Sullivan, Bishop James Malone, Chairman, Domestic Policy Committee, United States Catholic Conference (USCC), urged the denial of a waiver request by the State of Oregon to implement its Medicaid rationing proposal. The waiver is the final step clearing the way for a proposal that would, among other things, reduce the amount of medical care to poor women and children.

Bishop Malone applauded Oregon's plan to expand Medicaid coverage to all persons with incomes below the poverty level. However, Bishop Malone points out that the proposal is "inequitable in concept, arbitrary and capricious in effect, violative of the purposes of the Medicaid program, and cruelly life-threatening for the most vulnerable of the state's children."

The Oregon proposal to fund only certain health services from a list developed by the state is a radically new rationing concept. Unlike other rationing plans familiar to us in times of national crisis, this plan is applied not to all citizens of Oregon but only to a certain segment of those eligible for Medicaid, namely, the poor, in particular poor women and children.

Bishop Malone said the use of a listing of authorized procedures "threatens traditional medicine's focus on the care and cure of individual patients. It would shift us from patient-centered to procedure-driven medical practice. It would take away individualized medical decisions about what is good or even life-saving for a

particular patient and substitute in its place a generalized determination of what seems to be good for some averaged population".

"The arbitrariness of the state proposal," said Bishop Malone, "is highlighted by the legislature's decision to increase subsidies for abortion, funded only from state funds under this plan but expanded now to additional thousands of persons, in lieu of funding life-saving health care for the poor in Oregon."

In stating the proposal violates the purposes and terms of the Medicaid Law, Bishop Malone said, "The purpose of the Medicaid Law is to enable the states to furnish 'medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services...' The clear purpose was to provide medical coverage to the two groups singled out since the Depression for special government care and protection: poor families with children and the aged, blind, and disabled. In the interim, Congress has adopted a number of mandates and options focused on expansion of coverage for both groups. These culminated in the 1990 law that will insure coverage of all poor children by the year 2001." The proposal by the state of Oregon would reverse that long-standing federal policy.

In the letter, Bishop Malone says the proposal will threaten the lives of Oregon's most vulnerable children. "While expanding abortion services, Oregon's proposal directly terminates access to care to 120 health services for a hundred and sixty thousand poor women and children currently covered by its Medicaid program".

Bishop Malone concludes, "In view of the numerous moral, ethical, and policy imperatives against the kind of experimentation proposed for the poor of Oregon, the Roman Catholic Bishops of this nation must oppose the Oregon experiment. We urge you to deny the waiver requested by the state and to retain the protections and benefits of the current Medicaid statute."

# # #

UNITED STATES CATHOLIC CONFERENCE

Department of Social Development and World Peace
Office of Domestic Social Development
3211 4th Street N.E. Washington, DC 20017-1194 (202)541-3185 FAX (202)541-3322 TELEX 7400424

August 6, 1991

Secretary Louis W. Sullivan
Department of Health and Human Services
200 Independence Avenue
Washington, D.C. 20410

Dear Secretary Sullivan:

The United States Catholic Conference, the public policy arm of the nation's Roman Catholic bishops, urges you to deny Oregon's request for a waiver to implement its Medicaid rationing proposal. The details of the plan are now clear and final action has been taken by the Oregon legislature; we understand that the waiver request is imminent.

As you know, the U.S. bishops called for a national health insurance program in 1981, and we continue to support universal access to health care as a basic human right. We can appreciate and even applaud Oregon's plan to expand Medicaid coverage to all persons with incomes below the poverty level.

Good intentions, however, cannot justify Oregon's proposed intentional rationing of health care for the poor. The proposal is inequitable in concept, arbitrary and capricious in effect, violative of the purposes of the Medicaid program, and cruelly life-threatening for the most vulnerable of the state's children.

The Proposal Is Fundamentally Inequitable in Concept

The Oregon proposal to fund only certain health services from a list developed by the state is a radically new rationing concept. Unlike the rationing familiar to us in moments of national crisis, this plan is to be applied, not to all citizens of Oregon, but only to its poor. While in future years the listings may be used to establish <u>minimum coverage</u> for those with private insurance, Oregon now plans to use them as the <u>maximum coverage</u> for the poor under the Medicaid program. It is only the poor and most vulnerable -- those eligible for Medicaid -- whose health care is to be rationed. *For more than one hundred and sixty thousand poor women and children currently covered by Medicaid, the plan would take away medical coverage for over 120 medical conditions, almost one-fifth of the treatments in Oregon's medical listings.*

This fundamental inequity is exacerbated by the proposed double standard within the Medicaid eligible population. The Oregon plan would initially exempt tens of thousands of Medicaid recipients who are aged, blind, and disabled from the rationing

scheme. Their medical care actually constitutes more than two-thirds of the state's total Medicaid bill and is the fastest growing part, while care for children on Medicaid comprises less than 15 percent of Oregon's Medicaid budget. While the Conference does not think Oregon's plan is appropriate for any of the state's poor, it would not be out of place to observe that these insulated groups are far more politically well-organized than are poor women and children.

The Effect of the Proposal is Arbitrary and Capricious

In its 1991 Report to the Governor and the Legislature, the Oregon Health Services Commission wrote:

> Therefore, the Commission defined basic health care in terms of society as a whole: Basic health care is a minimum below which no person should fall. Given this definition, the Commission went further to describe basic in terms of **essential** and **very important** categories of health services. All of the "essential" services and most of the "very important" must be included in a basic health care package.

Despite its own Commission recommendation, the Oregon Legislature did not agree to provide this "basic health care." The Legislature approved only a partial listing of covered services and excluded eight "essential" health services -- including seven in the "acute fatal" and "chronic fatal" categories -- and more than fifty "very important" health services. Even within the conceptual structure of the Oregon plan, its failure to fund basic health care is arbitrary and capricious. *It is a product of political and fiscal considerations, not good medicine, justice, or sound social policy.*

Oregon's ability to fund even this level of medical care beyond next year remains in serious doubt. The actuarial section of the Commission report acknowledges that by the end of the first year (1992-93) of the plan only sixty percent of the expected participants will be enrolled. Fiscal estimates for the first year included that assumption. Only three years later is the program "expected to reach a steady-state of enrollment..." Thus, maintenance of the initial level of covered services in Oregon will require infusions of funding in the second, third, and subsequent years far above the already increasingly high levels of medical inflation. Yet, Oregon has adopted a new Ballot Measure 5 which will acutely limit state funding for human resources and will make increased Medicaid funding in coming years very difficult. *In coming years, the Oregon Legislature may exclude more and more "essential" and "very important" health services and further erode "basic health care" for Medicaid participants, primarily women and children.*

The Oregon proposal is an experiment, applying an untested series of hypotheses, the opinions of eleven Commission members, and the legislature's fiscal constraints to the health, well-being, and even life-and-death decisions for hundreds of thousands of poor Oregonians. *There is no generally accepted scientific or medical method for achieving Oregon's purposes in the listings, and Oregon's chosen method has never been tested.* To develop its scheme, the Commission compared benefits, treatments, and outcomes across widely differing kinds of medical conditions, and then quantified them in a highly novel -- but completely untested -- methodology. The state now proposes that its initial experiment be substantially funded with federal Medicaid dollars and applied, in lieu of the current standard of "all medically necessary care and services," to non-consenting poor women and children.

The risks of trading the current standard of "all medically necessary care and services" for the proposed rationing scheme was underscored in the Legislature's rejection of proposals to apply the same listings to the health insurance programs of state employees and members of the Legislature themselves.

Use of the listings also threatens traditional medicine's focus on the care and cure of individual patients. It would shift us from patient-centered to procedure-driven medical practice. It would take away individualized medical decisions about what is good or even life-saving for a particular patient and substitute in its place a generalized determination of what seems to be good for some averaged population.

The listings thus also threaten to change the traditional relationship between physicians and patients, at least for poor patients. Many doctors already refuse to participate in Medicaid because of underfunding of services. These radical and pervasive changes in medical practice could seriously aggravate the current shortage of doctors and other providers in Medicaid by substituting the political judgments underlying the listings for the medical judgments of individual physicians. The losers, again, would be poor women and children.

Finally, the arbitrariness of the state proposal is highlighted by the Legislature's decision to increase subsidies for abortion, funded only from state funds under this plan but expanded now to additional thousands of persons, in lieu of funding life-saving health care for the poor in Oregon.

The Proposal Violates the Purposes and Terms of the Medicaid Law

The purpose of the Medicaid law is to enable the states to furnish "medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services..." The clear purpose was to provide

medical coverage to the two groups singled out since the Depression for special government care and protection: poor families with children and the aged, blind, and disabled. In the interim, Congress has adopted a number of mandates and options focused on expansion of coverage for both groups. These culminated in the 1990 law that will insure coverage of all poor children by the year 2001.

Oregon's proposal would now reverse that long-standing federal policy. On the one hand Oregon protects the politically more powerful group of elders and persons with disabilities from drastic benefit cuts while, on the other, it subjects the more vulnerable group of its poorest women and children to the state's untested and procrustean plan. The addition of other poor persons to the reduced benefits scheme cannot be justification for exposing the poorest women and children to the broad dangers inherent in this untried plan.

Secondly, not only does the proposed plan not provide the basic health care recommended by Oregon's own Commission, but it totally discards the provision of medically necessary care and services required under the Medicaid law and protected for years by both Congress and the courts.

Thirdly, Oregon's poor children have little to gain and much to lose under the proposal. The Medicaid amendments of 1989 and 1990 have entitled all poor children to all medically necessary care and services. All states, including Oregon, must extend coverage to all poor children under age 19 on a phased-in basis, covering all children up to age 9 by the first year of Oregon's proposed experiment and to age 12 by the time of its full implementation. It is these younger children who have the most costly health needs, the most to gain by congressional mandates, and the most to lose in Oregon's scheme. *In fact, almost every pregnant woman and child under six with family incomes under 133% of the poverty line and every poor Oregon child under nine loses essential and very important, even life-saving, medical care under the plan.*

Recently Congress expanded the provision of medical care to children in America by revising the Medicaid early and periodic screening, diagnostic, and treatment provisions. Congress required every state to provide coverage to eligible children under age 21 for virtually all Medicaid benefits recognized under federal law and needed to correct or ameliorate defects and physical and mental illnesses and conditions discovered in screening. Oregon proposes to eliminate these protections and services to its poor children.

Furthermore, while Oregon protests that its plan is intended to benefit poor women and children, it proposes to eliminate the medically needy program for pregnant women and children under age 18. This provision was designed by Congress specifically to assist women and children whose incomes exceed eligibility

standards but who have medical problems giving rise to excessive medical costs. Oregon would strip them of this medical coverage.

Finally, the radically experimental and untested nature of the Oregon proposal threatens the health, well-being, and lives of hundreds of thousands of poor Oregonians, its poorest women and children and thousands of others. Both ethics and public policy dictate that experimentation involving human subjects, such as research under the Medicaid program, be subject to strict controls. In each such case, the government must exercise extreme care to analyze whether the risks involved in the experiment are outweighed by the benefits to those involved. The government must also establish safeguards to protect the rights and welfare of the subjects of all such demonstrations.

This Conference repeatedly has insisted that research and experimentation on human subjects be allowed only when the experiment has the informed consent of the subjects; or, in the case of those unable to consent, when the experiment (1) may enhance the well being or meet the health needs of the subjects; or (2) will pose no added risk of suffering, injury or death to the subjects; and (3) can be expected to develop knowledge that cannot be obtained by other means.

The state of Oregon does not argue that the women and children who will receive less care under the proposed rationing plan will receive any benefit, yet one must presume that those same pregnant women and children will suffer from the denial of what Oregon itself says are "essential" and "very important" health care services. The potential danger to patients to be treated under the Oregon proposal becomes clearer when we realize that the Legislature found it necessary to exempt health care providers from malpractice suits based on denial of necessary care that is "below the cutoff line" applied to the listings.

In this case, the vast majority of the subjects of the Oregon plan will be children incapable of voluntary consent to the experiment. A humane medical ethic suggests that children should not be subjected to an experimental plan unless the research might benefit them as individuals. Before allowing states to subject children to such experimentation, the federal government then has a particularly heavy legal and ethical responsibility to protect their health and lives.

Furthermore, before allowing states to impose deductions, cost sharing, or similar charges on their Medicaid patients, federal law requires the Secretary to ensure that the new co-payments do not become a barrier to access to necessary care or result in injury to Medicaid patients. Even more rigorous protections must be applied to a waiver request that would exclude more than 120 health services from the Medicaid program -- or require the poor to purchase them from their own funds, the most direct form of "cost sharing" imaginable!

The Proposal Threatens the Lives of Oregon's Most Vulnerable Children

While expanding abortion services, Oregon's proposal directly terminates access to care to 120 health services for a hundred and sixty thousand poor women and children currently covered by its Medicaid program. This is more than just an experiment in health care financing or an alteration in the funding structure of the state program. *In fact, the plan could result in federally sanctioned medical neglect leading to the deaths of poor women and children.* One such example occurs in the case of extremely premature and low birthweight newborns, whose survival has been given low priority in the state's listings. In the case of these young children, individualized medical and ethical decisions should be made by appropriate family members and professionals. Instead, Oregon proposes an automatic, cost-based, and formula-triggered denial of funding for treatment and thus sentences these children to almost certain death.

In view of the numerous moral, ethical, and policy imperatives against the kind of experimentation proposed for the poor of Oregon, the Roman Catholic Bishops of this nation must oppose the Oregon experiment. We urge you to deny the waiver requested by the state and to retain the protections and benefits of the current Medicaid statute.

Sincerely yours,

+ James W. Malone

Bishop James W. Malone
Chairman
Domestic Policy Committee

cc: Honorable Lloyd Bentsen
Honorable Henry A. Waxman
Dr. Gail Wilensky

26297

STATE OF ALABAMA

GOVERNOR'S OFFICE

MONTGOMERY 36130

GUY HUNT
GOVERNOR

August 6, 1991

THE CHIEF of STAFF has seen

The Honorable John Sununu
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Governor Sununu:

As we discussed, Alabama is facing a crisis in our Medicaid program. I have enclosed additional information regarding the potential effect of the elimination of provider specific taxes on Alabama. If we lose our ability to collect the provider specific taxes, passed overwhelmingly by the legislature, we will lose $795 million out of our $1.6 billion FY 1992 Medicaid budget. This represents a devastating blow to a program that is efficient and effective in providing health care services to the most needy.

At my direction, the health care agencies in this state have worked diligently to maximize every resource to insure a health beginning in life for every Alabama baby and a long, healthy, productive life for our senior citizens. Needless to say, the Federal government has continually placed mandates on states without providing the necessary financial support needed to fully implement them. We have been successful in Alabama in developing the resources needed to implement major changes in the Medicaid program -- many changes commended by national health leaders. We have not supplanted the state's responsibility to finance health care. We have continually and significantly increased the amount of funding for the Medicaid and Public Health budgets. Our provider specific tax package even includes a clause that makes the tax null and void if the Legislature fails to appropriate the current level of funding for Medicaid ($139 million).

We have not forgotten our role as conservative molders of the future. Our programs emphasize prevention and managed care -- both programs guarantee cost savings in the future. They also guarantee a more efficient health care system. Our Medicaid program operates at less than 3 percent administrative costs -- fully over 97 percent of our dollars go to finance health care services for the most vulnerable in our society. The Secretary of HHS has commented that Alabama's Maternity Waiver should be used as a model for other states.

We are making tremendous progress in Alabama. I recently was delighted to announce a dramatic reduction in our infant mortality

rate -- from 12.1 deaths per 1,000 live births to 10.9. This decline would not have been possible without the Medicaid expansions.

I do not need to tell you the difficulty facing states today. Without the ability to collect provider specific taxes our Medicaid program would be devastated. I see no alternative but to scale back the program dramatically. My Medicaid Commissioner has told me at that point we would not be in compliance with Federal mandates and could not comply with the mandate outlined in the Boren Amendment. We would be faced with the very real decision of closing the Medicaid program all together.

More importantly, I know the President's compassion for those in need. I feel confident that he would support our position. As you may know, there is a growing consensus supporting voluntary contributions/provider specific taxes. I believe there is a median ground that can protect the federal budget from unlimited drains on it while allowing states the flexibility in provider specific taxes we believe are legally ours. I have enclosed suggested options for the Administration. I would recommend Option III as the most viable.

I appreciate your attention to this issue. I have enclosed additional information for your review.

Sincerely,

Guy Hunt

Guy Hunt

/skf

OPTIONS FOR VOLUNTARY CONTRIBUTIONS
PROVIDER SPECIFIC TAXES

I. **Eliminate Voluntary Contributions. Maintain significant flexibility for provider specific taxes.**

Pros: Most states were anticipating the complete elimination of voluntary contributions.

If voluntary contributions are allowed past December 31, 1991 the estimates for their costs would have to be added to the budget's baseline.

Maintaining taxes allows states a funding source necessary to maintain program.

Taxes are legislative in nature. They go through intense public debate and have the support of the political leadership in a state.

Cons: Without any restriction on payment rates for disproportionate share hospitals states could develop innovative programs to transfer all financial responsibility for Medicaid to the Federal Government.

II. **Eliminate both voluntary contributions and provider specific taxes.**

Pros: Would reduce the Federal outlay for Medicaid until states changed their state tax laws.

Cons: Federal government would have to win a lawsuit brought on by several states and advocacy organizations supporting the legal contention that OBRA '90 and the conference language clearly allow taxes (whether or not of general applicability).

Given OBRA '90 language the projected cost for provider specific taxes should already appear in baseline through estimating Federal legislative costs of Medicaid optional and mandated services.

State revenue agencies and the budget officers will oppose due to the Federal encroachment on the state's right to tax. Would raise a 10th Amendment issue.

Advocacy groups would speak loudly about the Administration's lack of compassion for the poor and elderly.

III. **Place reasonable limits on disproportionate share payments through legislation.**

Pros: Reasonable limits, in line with Congressional intent that Medicaid be used as a source for payment for uncompensated care for non-Medicaid recipients, would limit the financial liability for the Federal Government.

It is difficult for a state to argue why a hospital should get paid more than its combined costs for Medicaid and its uncompensated care burden.

and opinions are the responsibility solely of The Journal, which is beholden only to the common good and to conscience.

200 Washington Avenue, Montgomery, Ala. 36104 • 262-1611

8.3.91

A fight for life

Much of the health-care progress made in Alabama in recent years, most notably the decline in the infant mortality rate, has come through expansion of the Medicaid program. If a proposed federal rules change becomes reality, the state will take a devastating blow and untold thousands of Alabamians will suffer.

The proposal reeks of unfairness and callous unconcern for the welfare of low-income people. The human toll that would be exacted if Alabama lost $795 million — almost half the Medicaid budget — boggles the mind and chills the soul.

At issue, at least in the minds of the numbers-crunchers in the Office of Management and Budget, is a revenue provision approved last year by Congress to help poorer states raise more money in order to qualify for more federal matching funds. This was an enormous boon to Alabama and 17 other states.

Here, higher taxes were paid voluntarily by hospitals, nursing homes and pharmacies — all of which do a lot of Medicaid business — with the revenue used to obtain more federal matching funds. Alabama has a very favorable federal-state matching ratio of almost 3-to-1.

The intent of Congress is beyond dispute. Alabama and the other states wisely reacted to it and have gotten considerable benefit as a result. Now OMB wants to change the rules.

This is wrong from every angle. To begin with, Congress authorized this process and it is Congress' place to change it, not OMB's. A legal challenge by the Justice Department at OMB's request would be an insult to Congress and to the states that enacted measures to benefit their citizens under this congressionally approved process.

Beyond questions of Washington political turf, however, lie issues of human suffering. If OMB proceeds with this effort, then Alabama really is involved in a fight for life.

This state cannot sustain a funding loss of this size, or anywhere near it. The reductions in services would be draconian, the pain of the affected people incalculable.

Taking that much money away would cripple Alabama's Medicaid program. The state would be unable to pay its share of nursing home costs for thousands of elderly people. The decline in the infant mortality rate made possible by the expansion of Medicaid that brought more pregnant women into the health care system would surely be reversed. The tens of thousands of Alabamians who depend on Medicaid for basic health care would doubtless see their access to that care curtailed.

On top of everything else, OMB in essence is attempting to tell Alabama what it can do with the tax revenue it collects, which is totally outside OMB's authority. If the bean-counters there don't like the Medicaid arrangement, let them take it up with Congress. Trying to strong-arm a rules change with such staggering impact is unconscionable.

MONT Adv. Journal 8.3.91

STATES USING VOLUNTARY CONTRIBUTIONS AND/OR PROVIDER SPECIFIC TAXES

Contributions	Taxes
Alabama (91)	Alabama (92)
Tennessee	Tennessee
Louisiana	Florida
Florida	New York
Mississippi	South Carolina
Massachusetts	Arkansas
California	Arkansas
Georgia	Ohio
South Carolina	Kentucky
Maryland	Maine
West Virginia	
Montana	

States proposing provider specific taxes/contributions

Illinois	Kansas
Indiana	Michigan
Mississippi	North Carolina
Oregon	Pennsylvania
Utah	Vermont

Howard Dean, M.D.
Governor

212057

State of Vermont
Office of the Governor
Pavilion Office Building
Montpelier, Vermont 05609
(802) 828-3333

THE CHIEF of STAFF
has seen

September 20, 1991

John H. Sununu
Chief of Staff
White House
1600 Pennsylvania Ave., N.W.
Washington, D.C. 20500

Dear ~~Mr. Sununu~~: John,

I am writing to convey my grave concern about the federal regulation issued in September which limits the ability of states to fund Medicaid. This interim final regulation prohibits use of donated funds and drastically restricts use of provider taxes to help pay for Medicaid.

Vermont's revenue stream from these sources totals $24 million, 13 percent of our total Medicaid budget. This revenue is critical to our state.

If allowed to be implemented, the new Department of Health and Human Services regulation will cut deeply into Vermont's ability to sustain a viable Medicaid program. The lack of these funds will have a devastating impact on the program, and will lead inevitably to severe reductions in the benefits provided and the population we are able to help.

The regulation reverses existing law and rule, and reflects a complete alteration of the foundation on which the state-federal Medicaid partnership has been based for the past quarter century. What is worse, it comes at a time when revenues, already under severe economic stress, have been stretched even further to accomodate new recipient groups, new provider certification mandates and new benefit package expansions emanating from Washington.

This regulatory action will only serve to weaken the already strained capacity of the states to preserve and improve services to low income individuals and families. I urge you to do what you can to ensure that the regulation will not be implemented.

Sincerely,

Howard Dean, M.D.
Governor

HD/ar

Withdrawal/Redaction Sheet
(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
01. Note	To John Sununu Re: Attached fax from the National governors' Association (1 pp.)	9/20/91	P/5	

Collection:

Record Group: Bush Presidential Records
Office: Chief of Staff, White House Office of
Series: Sununu, John, Files
Subseries: Issues Files
WHORM Cat.:
File Location: Health Care 1991 [6]

Open on Expiration of PRA
(Document Follows)
By JP (NLGB) on 10/28/05

Date Closed:	1/4/2005	**OA/ID Number:**	29160-006
FOIA/SYS Case #:	1998-0004-F[2]	**Appeal Case #:**	
Re-review Case #:	2005-0426-S	**Appeal Disposition:**	
P-2/P-5 Review Case #:		**Disposition Date:**	
AR Case #:		**MR Case #:**	
AR Disposition:		**MR Disposition:**	
AR Disposition Date:		**MR Disposition Date:**	

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P-1 National Security Classified Information [(a)(1) of the PRA]
P-2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P-3 Release would violate a Federal statute [(a)(3) of the PRA]
P-4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P-5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P-6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Removed as a personal record misfile.

Freedom of Information Act - [5 U.S.C. 552(b)]

(b)(1) National security classified information [(b)(1) of the FOIA]
(b)(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
(b)(3) Release would violate a Federal statute [(b)(3) of the FOIA]
(b)(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
(b)(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
(b)(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
(b)(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
(b)(9) Release would disclose geological or geophysical information

Lanny feels that this doesn't break any new ground on the issue - he's trying to get hold of Tom Scully.

THE CHIEF of STAFF
has seen

To: Governor Sununu

Re: Medicaid, Donations and Taxes

This is the one pager on what we would like.

Thanks,

Ray Scheppach

1. **Delay implementation of the interim final regulations as law until October 1, 1992, or until congressional intent is clarified. Further, states need transition time to adjust their programs to reflect the ultimate compromise.**

   - o Simply postponing the effective date of these regulations without clarifying congressional intent about what is and is not permissible, puts the states in jeopardy of retroactive sanctions.

2. **Provide for the continuation of voluntary donations and contributions by:**

   - o Setting a reasonable cap on provider donations; (For example, states might agree to limit provider donations to ten percent of the state share of their Medicaid expenditures) and

   - o Permitting uncapped charitable contributions to the Medicaid program.
     - o For example, the March of Dimes raised money and contributed the money to Florida, North Carolina, and New Mexico to enable these states to conduct state-wide outreach projects to stimulate Medicaid enrollment.

3. **Clarify congressional intent with respect to provider taxes by including language that would:**

   - o Restate Congress's intent that both provider-specific as well as general taxes are permissible and qualify for federal reimbursment. Therefore, there is no need for HHS to define "provider" in regulation.

   - o Clarify that institutional providers may not include the cost of the tax on their cost reports as a cost of doing business; or

   - o Provide that FFP is only available for that portion of an institional providers tax that is not based on federal Medicaid revenues; and

   - o If either of the preceding items are included in legislation, there will be no need for "linkage" language in the final regulations.

4. **Prohibit HHS from changing current law with respect to inter-governmental transfers.**

   - o Current law, both statutory and regulatory says that no more than 60 percent of a state's share of Medicaid can come from local government and

   - o If a provider is also a governmental entity, their status as a governmental entity prevails.

SEPTEMBER 25, 1991

Medicaid Taxes and Donations

The Problem

- Provider-specific taxes and donations:
  - increase Federal Medicaid costs without additional State spending (Attachment A); and
  - alter the traditional Federal-State partnership and the matching rate in the Medicaid program (Attachment B).

Background

- HCFA published a regulation in February 1990 which would disallow Federal matching payments for donations and taxes paid by Medicaid providers.
- In November 1990, Congress permanently prohibited Federal matching for selected provider taxes and delayed until January 1, 1992, publication of a final regulation limiting Federal matching for provider donations. (Attachment C)
- Despite Congressional action and HCFA's clear intent to implement the law to limit Federal matching during the one-year phase out, more than 38 States have established donation and/or tax plans. (Attachments D and E)
- Federal costs of these plans are estimated to be $4-5 billion in FY92 and grow to more that $12 billion in FY96.
- Some particularly bad public policy results include:
  - giving hospitals a "hold harmless" guarantee that they will receive back from Medicaid at least as much as they have paid to the State in special Medicaid-only taxes; and
  - organizing hospitals to borrow funds to be donated to the State, which returns the funds--with the Federal match--back to the hospitals in the form of higher Medicaid payments.
  - inflating physician bills by up to 5 times the current amount, "taxing" back the full increase, without changing physician reimbursement;

Considerations

- o Some States may not have heeded the warning signals or were not aware of the ramifications of the statutory restrictions on donations and taxes. Consequently, HCFA implementation of the statute may have an abrupt fiscal effect on some States.

- o Some State legislatures may not be scheduled to meet in a timeframe that allows for corrective action.

- o For these reasons, HCFA may entertain waiver proposals that allow individual States to:

    - submit a mutually agreed upon plan that allows the State to continue current practices for a reasonable transition period until July 1992, in exchange for an agreement that the State will meet the requirements of the statute and regulation after that period.

- o This would allow States to comply with the regulation and continue sound policies without calling State legislatures into emergency sessions.

Attachments

A: Description of tax and donations

B: How taxes and donations alter the Federal match

C: Medicaid statute--OBRA 90 provisions

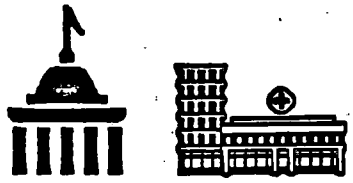
D: Tax and donation plans in Alabama, Illinois, Ohio, and Maine

E: IG summary of all States' donations and taxes plans

V2

How Typical Taxes and Donations Schemes Work

State and Hospitals Strike an Agreement



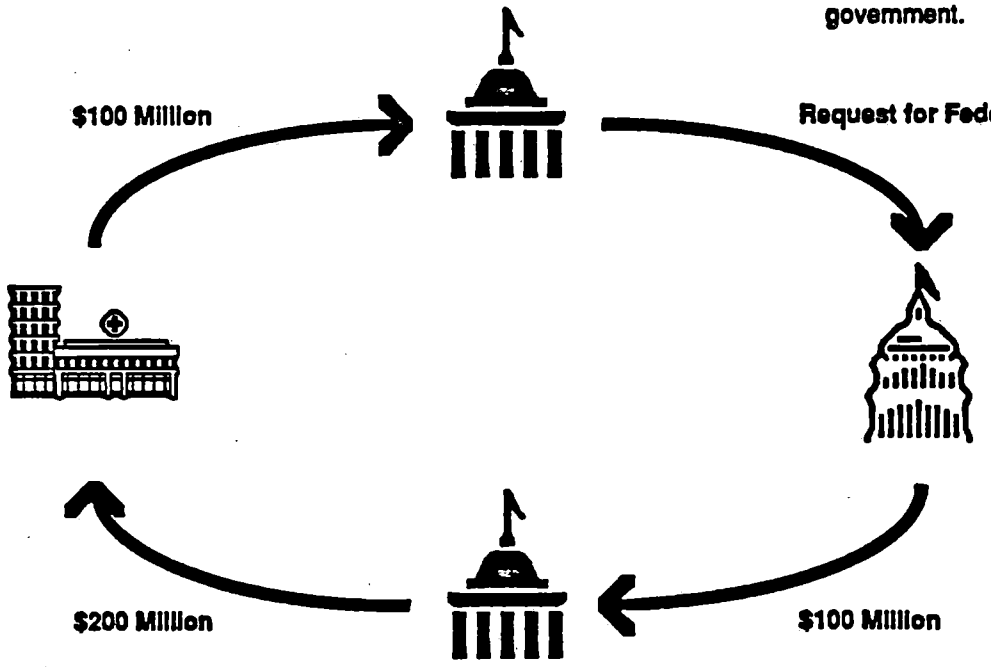
1. A hospital agrees to donate funds to state or to support a specific "tax" *to be matched by Federal government.*

2. State in return increases the hospital's disproportionate share payments.

$1 will get you $2

1. Hospitals "loan" $100 million in taxes or donations to state.

2. State deposits "loan" from provider taxes or donations into a fund. State requests "matching" funds from Federal government.



4. State disburses total trust fund amount to hospital as disproportionate share hospital payment.

3. Federal government "matches" "loan" in state fund.

MEDICAID
Provider Taxes and Refundable Donations Only Increase Federal Spending: An Illustrative Example
($ millions)

	Before Tax and Donation Schemes	After Tax and Donation Schemes	Net Change
State General Fund	+$500	+$500	No Change
Hospital Taxes and Donations	+$0	+$400	+$400
Federal FFP (Match)	+$500	+$900	+$400 (+80%)
Gross Medicaid Payment to Providers	+$1,000	+$1,800	+$800
Less Hospital Taxes and Donations	+$0	-$400	-$400
Net Payment to Providers (and Federal Share)	+$1,000 (50%)	+$1,400 (64%)	+$400 (+14%)

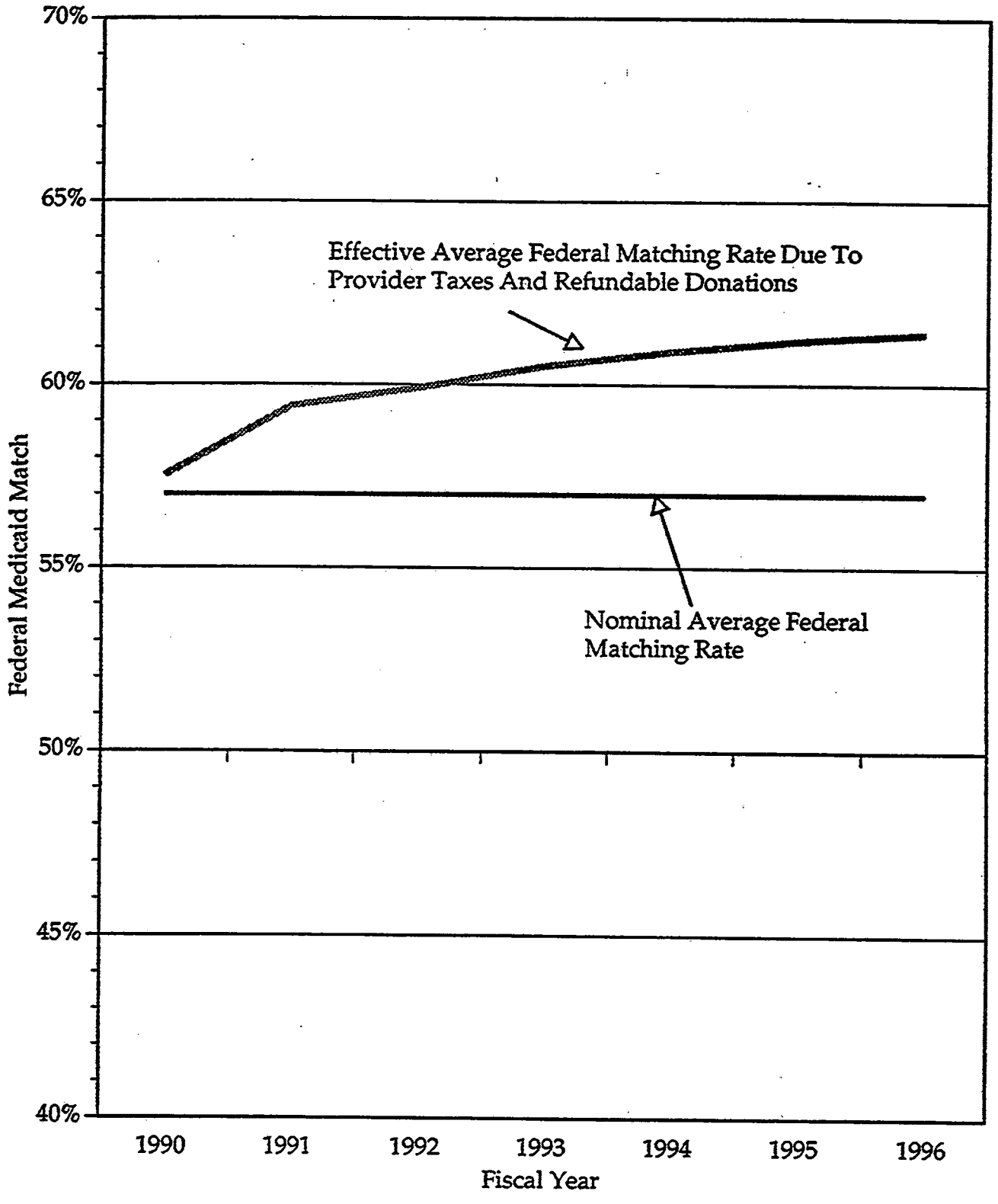
Provider Taxes and Refundable Donations
Federal Expenditures for Nine Selected States
($ Millions)

State	FY92 Expenditures	FY92 Tax/Donation Estimates	Formula Matching Rate	Effective Matching Rate*
Alabama /1	$826	$246	73.1%	79.8%
California /1	$4,738	$800	50.0%	58.1%
Florida /3	$2,218	$329	55.2%	59.1%
Illinois /1	$1,493	$600	50.0%	70.1%
Maine /2	$329	$96	66.7%	78.5%
Massachusetts /1	$1,853	$255	50.0%	52.3%
Michigan /2	$1,594	$271	54.8%	63.0%
New Hampshire /2	$128	$35	50.0%	63.7%
Pennsylvania /1	$2,192	$407	57.4%	63.5%

/1 Portion of Taxes and Donations reflected in FY92 Expenditures
/2 Taxes and Donations NOT reflected in FY92 Expenditures
/3 Taxes and Donations reflected in FY92 Expenditures

*Figures are estimated based on best available information on taxes and donations.

Chart 3
Provider Tax and Refundable Donation Schemes Increase The Effective Federal Medicaid Match



Source: Office of Management and Budget

OBRA 90 Established Statutory Limitations on HCFA Authority to Eliminate Tax Schemes

- Section 1902(t) of the Social Security Act--added by OBRA 90--places a general limit on HCFA authority to deny or limit FFP for taxes:

  "Except as provided in section 1903(i), nothing in this title (including sections 1903(a) and 1905(a)) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes (whether or not of general applicability) imposed with respect to the provision of such items or services."

- Section 1903(i)(10)--added by OBRA 90--gives HCFA specific authority to deny federal matching for some provider-specific taxes:

  "Payment under the preceding provisions of this section shall not be made --

  * * * *

  with respect to any amount expended for medical assistance for care or services furnished by a hospital, nursing facility, or intermediate care facility for the mentally retarded to reimburse the hospital or facility for the costs attributable to taxes imposed by the State solely with respect to hospitals or facilities."

August 16, 1991

Taxes and Donations: Alabama

Program Description. Alabama has converted its donations program to a provider-specific tax on DSH hospitals, nursing facilities, and pharmacies. The State uses funds to support DSH payments, increase reimbursements, and finance benefit expansions.

How the Program Operates.

- Alabama imposes the taxes identified below on the following providers:

  DSH Hospitals -- variable tax based on 65% of gross inpatient revenues, multiplied by the Medicaid utilization rate of the individual hospital ("hold-harmless" provision included).

  Nursing Facilities -- $999.96 per year for each bed in that facility ("hold-harmless" provision included). This represents an approximate 3% tax on the facilities' operating revenues.

  Pharmacies -- 10 cents for each prescription filled or refilled with a retail price of $3.00 or more.

- The State temporarily deposits the tax revenue into the Alabama Health Care Trust Fund that generates Federal matching and makes Medicaid payments.

- The State then provides higher DSH payments and reimbursements to these facilities and claims these increases and costs of benefit expansions as expenditures for Federal matching funds at a 73%/27% rate. The Alabama statutory language contains a "hold-harmless" provision for DSH hospitals and nursing facilities that guarantees facilities reimbursement for the amount of the tax and the Federal matching it generates.

- In effect, the Federal government finances 100 percent of the increase in payments and the cost of benefit expansions.

Program Cost and Effective Match. The program is estimated to generate an additional $246 million from the Federal government. As a result, the estimated effective Federal matching rate for the Alabama Medicaid program will rise from 73 to 80 percent.

Problems with the Program and Possible Alternatives. The Alabama plan is unacceptable because it increases Federal Medicaid payments without an actual increase in the State Medicaid contribution. Funds raised through a broad-based tax that applied to health care providers other than just hospitals, nursing facilities, and ICF/MRs would be eligible for Federal Medicaid matching if providers were taxed at a uniform rate and on the same base. A tax on Medicaid revenues is already illegal under current law.

August 16, 1991

Taxes and Donations: Illinois

Program Description. Illinois has established a tax on providers' gross Medicaid receipts. The recently enacted tax plan will increase payment to providers without expanding benefits or services.

How the Program Operates.

- Illinois will impose a tax (with a "hold-harmless" provision) on the following providers of medical services:

  Hospitals – variable tax based on 50% of the difference between a hospital's anticipated annualized spending and its total Medicaid base year spending. The State will also impose a 5% tax on gross Medicaid receipts for all hospitals, a tax that is unallowable under pre-OBRA 90 law. Illinois will also impose a 50% tax on critical care access payments.

  County Hospitals -- variable tax based on 60% of the difference between the gross Medicaid receipts received from the State and $78 million. Because the language restricts counties to those with over 3 million people, Cook County is the only county in this category.

  Nursing Facilities – 15 percent of gross Medicaid receipts.

  Intermediate Care Facilities for the Mentally Retarded -- 15 percent of gross Medicaid receipts.

  Community Mental Health Centers -- varies by year and gross payment levels.

- The State temporarily deposits the tax revenue into five separate trust funds that generates Federal matching and makes Medicaid payments.

- The State then provides higher DSH payments and reimbursements to these facilities and claims these increases as expenditures for Federal matching funds at a 50%/50% rate.

- In effect, the Federal government finances 100 percent of the increase in payments to providers.

Program Costs and Effective Match. The program will generate an estimated $600 million from the Federal government above the initial HCFA projection of $1.5 billion for FY92. As a result, the estimated effective Federal matching rate for the Illinois Medicaid Program will rise from 50 to 70 percent.

Illinois, continued

Problems with the Program and Possible Alternatives. The Illinois plan is unacceptable because it increases Federal Medicaid payments without an actual increase in the State Medicaid contribution. Funds raised through a broad-based tax that applied to health care providers other than just hospitals, nursing facilities, and ICF/MRs would be eligible for Federal Medicaid matching if providers were taxed at a uniform rate and at the same base. A tax on Medicaid revenues is already illegal under current law.

August 16, 1991

Taxes and Donations: Ohio

Program Description. Ohio will selectively tax hospitals and then return the funds to the hospitals, along with the Federal match, in the form of higher Medicaid payments.

How the Program Will Operate

- Ohio taxes hospitals an amount between .5% and 5% of the hospitals' total operating costs.
- The tax revenue, along with Federal matching funds, will be returned to the hospitals in the form of add-on disproportionate share hospital payments.
- All hospitals are "held harmless"--they are guaranteed to receive back from the State in additional Medicaid payments at least as much as they pay in taxes.
- Ohio is also considering an expansion of the provider tax to include nursing homes and other cost-based providers.

Program Costs.

- The IG estimates that Ohio's tax plan will draw $200 million in Federal funds in FY92

August 16, 1991

Taxes and Donations: Maine

Program Description. Maine has passed legislation to levy a 6 percent tax on gross operating revenues for acute care hospitals. Under the program, the State would expand the definition of a disproportionate share hospital by lowering the Medicaid utilization threshold from 15 to 3 percent, low enough to qualify most hospitals to qualify for DSH payments. Funds would be used to finance higher DSH payments, mandated expansions, and on-going program costs. HCFA is currently reviewing the State plan amendment.

How the Program Will Operate.

- Maine will impose a 6 percent tax on all acute care hospitals that will be billed on a monthly basis (includes "hold-harmless" provision).

- The State will temporarily deposit the tax revenue into a separate trust fund that will generate Federal matching and make Medicaid payments.

- The State will then provide higher DSH payments to these facilities and claim these increases as expenditures for Federal matching funds at a 67%/33% rate. Within 30 days, Maine will repay these facilities an amount equal to the tax plus 15% to cover bad debt and charity care.

- In effect, the Federal government will finance 100 percent of the increase in payments to providers.

Program Cost and Effective Matching Rate. The program will generate an estimated $83 million from the Federal government above the initial HCFA projection of $329 million for FY92. As a result, the estimated effective Federal matching rate for the Maine Medicaid Program will rise from 67 to 77 percent.

Problems with the Program and Possible Alternatives. The Maine proposal is unacceptable because it increases Federal Medicaid payments without an actual increase in the State Medicaid contribution. Funds raised through a broad-based tax that applied to health care providers other than just hospitals, nursing facilities, and ICF/MRs would be eligible for Federal Medicaid matching if providers were taxed at a uniform rate and on the same base. A tax on Medicaid revenues is already illegal under current law.

APPENDIX

ESTIMATE OF FEDERAL FUNDS TO BE GENERATED
BY STATE TAX AND DONATION PROGRAMS
FISCAL YEARS 1991-1993
(in thousands)

STATE	PROGRAM TYPE	FFP FY 1991 REPORTED AS OF 6/91	UPDATE FFP REPORT FY 1991	UPDATE FFP REPORT FY 1992	UPDATE FFP REPORT FY 1993
ALABAMA	DONATION	$288,000	$288,000	$ 0	$ 0
ALABAMA	TAX	0	0	229,439	229,439
ARKANSAS	TAX	0	22,494	84,667	105,254
CALIFORNIA	DONATION	68,000	81,000	75,000	75,000
FLORIDA	DONATION	0	0	119,400	0
FLORIDA	TAX	189,000	189,000	210,142	231,114
GEORGIA	DONATION	56,000	56,000	139,000	0
HAWAII	TAX	1,000	1,907	1,851	1,851
IDAHO	DONATION	150	150	0	0
ILLINOIS	DONATION	0	62,250	250,000	250,000
INDIANA	DONATION	0	63,000	63,000	63,000
KENTUCKY	TAX	221,000	249,000	382,684	435,559
MAINE	TAX	0	0	96,100	0
MARYLAND	TAX	27,500	27,500	55,000	55,000
MASSACHUSETTS	DONATION	307,000	513,000	255,000	0
MICHIGAN	DONATION	0	134,000	134,000	134,000
MINNESOTA	TAX	0	23,250	93,000	93,000
MISSISSIPPI	DONATION	0	2,000	140,000	148,000
MISSISSIPPI	TAX	0	1,000	64,000	60,000
MISSOURI	DONATION	130,000	237,000	168,000	0
MONTANA	TAX	0	785	3,200	0
NEVADA	TAX	0	0	30,000	0
NEW HAMPSHIRE	DONATION	0	35,000	35,000	0
NEW JERSEY	DONATION	0	75,500	258,000	0
NEW MEXICO	DONATION	0	360	360	360
NEW YORK	DONATION	0	0	0	341,350
NEW YORK	TAX	102,000	227,500	301,250	341,450
NORTH CAROLINA	DONATION	110,000	154,000	53,216	126,388
OHIO	TAX	65,000	200,000	200,000	200,000
PENNSYLVANIA	DONATION	292,000	365,000	407,000	349,000
RHODE ISLAND	DONATION	0	40,000	120,000	0
SOUTH CAROLINA	DONATION	0	56,598	169,981	169,981
SOUTH CAROLINA	TAX	161,000	161,000	59,358	59,358
TENNESSEE	DONATION	224,000	224,000	0	0
TEXAS	DONATION	244,000	218,000	264,000	269,000
UTAH	DONATION	0	18,000	12,400	13,200
VERMONT	TAX	0	0	15,200	6,982
WASHINGTON	DONATION	500	34,500	34,500	34,500
WISCONSIN	TAX	0	0	25,000	48,000
TOTAL		$2,486,150	$3,760,794	$4,523,748	$3,792,786

MAINE

The State is in the process of establishing two programs. The first is a 6 percent tax on the gross operating revenues of acute care hospitals. The funds generated by this tax will be returned to the hospitals in the form of disproportionate share payments. The State will claim federal financial participation (FFP) for these payments. This program is designed to generate Federal funds of $79.2 million in Fiscal Year 1992. The Federal dollars will be used at the State's discretion. The second program will group Maine's two State hospitals as one provider which in turn will quality both hospitals for increased disproportionate share payments. The additional FFP generated by this plan is estimated at $16.5 million. Total FFP generated by both plans is estimated at $96.1 million per year.

Vermont

The State is in the process of establishing a tax program for hospitals, nursing homes and Home Health Agencies. All taxes will be placed into the Health Care Improvement Trust Fund and will be will be returned to the providers in the form of disproportionate share payments. The State will generate $15.2 million of FFP by claiming these payment for federal Match.

New Hampshire

The State plans to assess acute care hospitals 7.5% of their gross receipts and return this money to the hospitals in the form of disproportionate share payments. The State will generate additional FFP of $35 million by this plan in FY 1992.

Rhode Island

The State is currently planning some type of funding mechanism related to disproportionate share payments. Full details are not yet available. The additional FFP to be generated by the plan is estimated at $40 million for FY 1991 and $120 million for FY 1992.

Massachusetts

The State plans to use its Uncompensated Care Pool (UCP) as a mechanism for obtaining additional FFP. The system works like this:

a) hospitals draw money from the State's (UCP)
b) The State assesses and collects from these hospitals for the amount drawn down from the UCP.
c) The State returns the money to the assessed hospitals.
d) Upon "paying" the hospitals the State claims the amount paid as a disproportionate share hospital payment and claims the amount for Medicaid reimbursement.

Additional FFP to be generated by the plan is estimated to be $513 million for State Fiscal Year 1991 and $255 million for State Fiscal Year 1992.

New Jersey

Historically, this State met its disproportionate share payments through a statewide pooling arrangement involving all acute care hospitals. The arrangement provided for reimbursement of the total amount of uncompensated care provided by each participating hospital. A statewide average uncompensated care rate was applied evenly to all inpatient Medicaid claims. The add-on rate in 1990 was 17.3%. In FY 1992, the add-ons were eliminated. Now, funds are transferred from the Health Care Trust Fund to the Medicaid agency. These funds are then distributed to hospitals in New Jersey as disproportionate share payments.

This funding mechanism, which went into effect June 10, 1991, will shift $76 million of expenditures from the State to the Federal government in FY 1991 and $250 million in FY 1992. This has freed up State funds which will be used for non-Medicaid purposes. The State does not plan to implement any new Medicaid Services as a result of this tax program.

In addition, the State has established a .53% hospital tax on gross inpatient revenues. This is expected to raise $36 million in State revenues but only $8 million will go towards expanding eligibility for Medicaid, up to 185 percent of the poverty level for pregnant women and infants.

New York

The State has passed a plan similar to the New Jersey plan. They have eliminated the add-ons to Medicaid inpatient rates. The plan transfers money from the State's regional and statewide pool network to a Disproportionate Share Fund controlled by the State Medicaid agency, These funds are then distributed to hospitals as disproportionate share payments. This new method will not result in any additional funds going to the hospitals, but will serve to shift Medicaid costs of $170.6 million in FY 1991 and $227.5 million in FY 1992, from the State to the Federal government. The State does not plan to implement any new Medicaid services as a result of this provider tax program.

In addition, the State passed a .6% tax to be applied against the gross receipts of all health care facilities in New York State. The proceeds from this tax, estimated to be $140 million in 1991, will go to the State Treasury for general purposes. The State reports that data is not available to determine what portion of the proceeds related to Medicaid receipts by the Health Care facilities. Therefore, the potential impact on the States's share of Medicaid expenditures cannot readily to determined.

Maryland

This State has a tax program effective April 9, 1991 Under this program, the State increased fees to providers, other than hospitals, and then deducted the increase as a tax before making the provider payments. Maryland claims the total providers' fee (including the tax) for FFP. The increase in the fees was not paid to the providers. Instead, the State retained the increase as a tax and used it to claim the Federal match. The additional FFP generated by the plan is estimated to be $27,500,000 for FY 1991 and $55,000,000 for FY 1992. According to State officials, there are no plans to use these revenue to fund additional services for Medicaid recipients.

Pennsylvania

This State is planning two donation programs. One for hospitals, the other for nursing homes. Under these program, the Pennsylvania State Association will establish a non-profit corporation to borrow $585 million ($365 for hospitals and $220 for nursing homes). The non-profit corporation will donate the money to the State, which in turn will give it back to the hospitals and nursing homes and claim it for Federal Matching. The providers will then return the funds to the corporation so that it can repay the loan. The State will generate $333 million in additional FFP.

Alabama

The state passed a tax program related to disproportionate share hospitals on May 16, 1991. At the current time specific details are not available. The plan is designed to generate FFP of $ 228 million. All revenues generated by the plan will be used for the Medicaid program. The plan will enhance services being provided to MA recipients as well as implementing new services such as patenting classes, rural physician differential, physical therapy at nursing homes.

North Carolina

The State legislature has adopted a donation program that is related to disproportionate share payments. They will enhance services currently being provided. No new services are being considered. Addition FFP generated is estimated at $154 million for FY 1992.

South Carolina

The State has implemented a provider tax and donation program. The plan is related to hospital disproportionate share payments. The programs will generate $161 million and $217 million in additional FFP in FY 1991 and 1992 respectively.

Florida

The State implemented a provider tax in 1984. The tax is 1.5 percent of gross operating revenue. The funds generated by the tax along with the associated FFP are used for a range of Medicaid services. All hospitals whicch service the Medicaid population are eligible to receive these funds. The program will generate $189 million in FY 1991 and $329 million in FY 1992.

Georgia

In 1990, Georgia established an Indigent Care Trust Fund through which hospitals donate funds to the State Agency. These funds are returned to the hospitals in the form of disproportionate share payments. The donated amount for FY 1991 is estimated at $35 million and $82 for Fy 1992. These donations will generate FFP of $56 million and $139 million in FY 1991 and 1992 respectively.

Kentucky

The States provider tax program is related to disproportionate share hospitals and has been expanded to include other participating Medicaid providers. The tax rate has been increased from 1% to 5%. The funds generated will be used to enhance services already being provided to recipients. No new services are being considered. Additional FFP generated by the plan is estimated to be $249 million for FY 1991 and $347 million for FY 1992.

Mississippi

The States provides tax program is related to disproportionate share payments. Funds will be used to enhance services already being provided. No new services are being considered. Additional FFP to be generated by the plan is estimated at $63.9 for FY 1992.

Specific information on the Mississippi donation program is not available.

Tennessee

The States hospital license fee and nursing home user's fees are related to disproportionate share and have recently been increased. The revenues generated will be going into the general fund and then returned to the Medicaid program. The program is designed to generate $224 million in FY 1991.

Illinois

This State is considering a Provider Participation Fee Trust Fund. As drafted, it's a 15% tax on the providers Medicaid gross receipts. Monies generated from the plan will be placed into one of the five Trust Funds and used for drawing down additional FFP. In return, a reimbursement methodology will be developed which shall enhance payments to providers.

Additional FFP to be generated by the Plan is estimated at $250 million per year. This plan has not yet been implemented.

Indiana

The State is assessing a percentage of their gross patient revenues. The assessment will be returned to the hospitals in the form of disproportionate share payments. The program will generate $63 million per year.

Michigan

They are planning a tax and donation program relating to the States disproportionate share payments. The estimate of FFP to be generated by the program is $134 million per year.

OHIO

The State is assessing an amount between .5 and 5 percent of the hospitals total operating costs. The assessed funds combined with the related FFP will be returned to the hospitals as disproportionate share payments.

The State is also considering an expansion of the program to include nursing homes and other cost based providers. Additional FFP generated by the program is currently estimated at $200 million per year.

Minnesota

The State legislature has passed a tax and donation program. The funds will be credited to the State's general fund, the intended usage is to cover Medicaid matching requirements for

existing programs. No new services are planned. Estimated FFP to be generated by the program is $93 million annually.

Wisconsin

The State legislature has instituted an assessment program targeting nursing homes. The assessments will be used to fund the State's share of annual rate increases for all Medicaid Nursing Homes over the next two years. It is estimated that the plan will raise $25 million in additional FFP for FY 1992 and $48 million for FY 1992.

Texas

The States donation plan transfers funds from State-owned teaching hospitals to be used as the State match. The program is related to disproportionate share payments. The payments are intended to reimburse qualifying hospitals for Medicaid as well as non-medicaid patients. Therefore, a portion of Federal funds generated by the program are effectively used to pay for Non-Medicaid related services. The agreement between the State Medicaid agency and the hospitals appears to permit funds in excess of the amounts transferred to be used for unspecified purposes.

Arkansas

Effective July 1, 1991, the States instituted a tax on all Medicaid providers, except State owned facilities. The tax amounts to 15 percent on the gross Medicaid proceeds derived by providers from that portion of the payment made from State revenue. The State estimates that it will collect $18 million per year which will generate about $54.3 million in FFP.

IOWA

This State is actively investigating the merits of initiating a tax program. No specific information is available at this time.

Kansas

This State is considering a provider specific tax similar to Kentucky and Tennessee.

Nebraska

This State is considering a donation program. No specific information is available at this time.

Missouri

This State's plan is a combination of donations and local taxes. They are considering a provider tax plan. The State has not added any additional Medicaid covered services. Latest estimates for the 4th quarter of FY 1991 indicate that the FFP for donations and local tax revenues may be about $40 million higher than previously expected.

Colorado

Currently, the State is not using either a tax or donation program, However, the State is planning to implement one or both in the future.

Montana

This State has a tax on long term care providers. Funds are deposited in the State's general revenue fund. The State will return these funds along with the associated FFP to the facilities in the form of increased per diem rates. A portion of the provider tax revenue will be available for other appropriations. The excess tax revenues could potentially be appropriated to non-medicaid programs. The program will generate $785,000 in FFP during FY 1991.

North Dakota

This State is considering a tax or donation program, however, they are still in the planning stage and no specifics are available.

South Dakota

This State is considering a provider specific tax. No details are available.

Utah

This State is currently accepting donations from Hospitals. The funds and the associated FFP are being returned to the hospitals. The State estimates that the current program will generate $18 million in FFP for FY 1991. No additional Medicaid services are proposed. The State has also expressed an interest in a provider tax program in the future. No details are available.

Wyoming

Wyoming is considering implementation of one or other options, however, they are still in the planning stage and no specifics are available.

Hawaii

Hawaii has currently implemented an excise tax on all Medicaid claims. This tax will generate close to $2 million in FY 1991.

The State is considering implementation of a donation program similar to that of Massachusetts. Hawaii is projecting a $35 million dollar deficit for their medicaid program and hope this program will alleviate the problem.

California

The State has a donation program which is solely related to the Medicaid disproportionate share program. The funds generated by this plan will be used to reimburse eligible hospitals disproportionate share payments. No new services will result from the implementation of the program. Additional FFP generated by the plan in FY 1991 $80.85 million and $75 million or FY 1992.

Nevada

This States legislature has passed an amendment authorizing a tax on hospitals. It is awaiting the governors signature. This program will be used to reimburse disproportionate share payments for services provided to indigent and low-income patients. Proceeds from the tax will be credited to a hospital tax account in Nevada's general fund. These funds are then transferred to the Medicaid budget account along with the FFP and used to reimburse providers. This plan will not result in any additional services being made available for Medicaid recipients. It is estimated that this program will generate $30 million of additional FFP in FY 1992.

Alaska

This State has not implemented and does not plan to implement any provider tax or donation programs at this time.

Washington

The State has both a tax and donation program. The tax is 20% on the State portion of Medicaid payments made to hospitals. The State then take these funds and the related FFP and increases the reimbursement to hospitals allowing them to recover more than he tax amount. Any remaining funds will be available for general State purposes. The state's indigent

care program historically was 100% State funded. Now they plan to expand the current disproportionate share payments to include these people.

One local county is donating funds for a single hospital. These donations are transferred to the State to a drawdown additional FFP. This one hospital is a major recipient of disproportionate share payments. No new services are being considered as a result of the tax or donation program. Additional FFP generated by the plans is estimated to be $104 million through FY 1993.