Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ALTHOUGH HOSPITAL TAX PROGRAMS IN SEVEN STATES COMPLIED WITH HOLD-HARMLESS REQUIREMENTS, THE TAX BURDEN ON HOSPITALS WAS SIGNIFICANTLY MITIGATED

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November 2018
A-03-16-00202

Office of Inspector General

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Report in Brief
Date: November 2018
Report No. A-03-16-00202

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Although Hospital Tax Programs in Seven States Complied With Hold-Harmless Requirements, the Tax Burden on Hospitals Was Significantly Mitigated

Why OIG Did This Review

Since 2003, the United States Government Accountability Office has identified Medicaid as a high-risk program. Between Federal fiscal years (FYs) 2011 and 2017, Medicaid expenditures rose 42 percent from $430 billion to $610 billion. By FY 2025, Medicaid is projected to have annual expenditures of $958 billion. The Social Security Act requires States to provide at least 40 percent of the non-Federal share of Medicaid expenditures, while up to 60 percent may be derived by local sources, including health-care-related taxes, as long as the taxpayer is not held harmless for the tax payment. However, this cost sharing requirement only applies to the aggregate of annual Medicaid program expenditures, not on a service-specific basis.

Our objectives were (1) to determine if hospital tax programs in seven States were in compliance with hold-harmless requirements and (2) to assess the financial impact of these programs on the States, the Federal Government, and the hospitals in the tax programs we reviewed.

How OIG Did This Review

We reviewed the hospital tax programs of seven States with the largest health-care-related tax programs: California, Illinois, Indiana, Michigan, Missouri, Ohio, and Pennsylvania. For each State, we reviewed hospital tax program documentation to determine compliance with hold-harmless requirements, the level of taxes collected, and the financial impact on the State, Federal Government, and hospitals.

What OIG Found

The health-care-related hospital tax programs in the seven States we reviewed complied with hold-harmless requirements.

The seven States in our review collected $38.4 billion in tax revenue from their hospitals during State FYs 2011 through 2015. The $38.4 billion was used as the State share of Medicaid payments and resulted in a draw-down of $54.6 billion in Federal matching funds for a total of $93 billion. From the $93 billion, $60.2 billion was used for supplemental payments for non-disproportionate share hospitals (non-DSHs) to mitigate most of the hospital tax payments and $32.7 billion was used mostly for additional hospital services.

In the States reviewed, we found that non-DSH supplemental payments exceeded 75 percent of hospital tax payments in each year for all States, except for 2 years in Pennsylvania and 1 year for Ohio. However, since the tax rate was less than the 6 percent safe-harbor threshold, the tax programs could return more than 75 percent of the tax payments to more than 75 percent of the taxpayers without violating the hold-harmless requirement (75/75 requirement). Had the tax rates exceeded 6 percent, CMS could have deemed those hospital tax programs as impermissible, which would disqualify the use of the tax revenue for drawing down Federal matching funds.

What OIG Recommends and CMS Comments

We recommend that CMS re-evaluate the effects of the health-care-related tax safe-harbor threshold and the associated 75/75 requirement to determine if modifications are needed, such as the reduction or elimination of the safe harbor threshold or adjusting the 75/75 requirement, and take appropriate action.

CMS concurred with our recommendation and stated that it will evaluate the effects of the health-care-related-tax threshold and the associated 75/75 requirement to determine if modifications are needed.

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INTRODUCTION

WHY WE DID THIS REVIEW

Since 2003, the U.S. Government Accountability Office has identified Medicaid as a high-risk program due to its size, growth, and diversity of programs as well as concerns about the adequacy of the fiscal oversight over the program. From Federal fiscal year (FY) 2011 through FY 2017, Medicaid expenditures rose 42 percent from $430 billion to $610 billion. By FY 2025, Medicaid is projected to have annual expenditures of $958 billion.

States may use funds from health-care-related taxes to finance a portion of the non-Federal share of Medicaid program expenditures if certain conditions are met, including that the tax payer is not held harmless for the tax payment.[1] The Office of Inspector General (OIG) assesses State health-care-related tax programs to promote economy and efficiency in the Medicaid program. Two recent OIG reports identified possible impermissible health-care-related tax programs in Pennsylvania and West Virginia.[2] Another of our recent reports assessed States' taxes on Medicaid managed care organizations.[3]

OBJECTIVES

Our objectives were:

(1) to determine if hospital tax programs in seven States were in compliance with hold-harmless requirements and

(2) to assess the financial impact of these programs on the States, the Federal Government, and the hospitals in the tax programs we reviewed.

BACKGROUND

The Medicaid Program

Title XIX of the Social Security Act (the Act) authorizes Federal grants to the States for Medicaid programs to provide medical assistance to persons with limited income and resources. While Medicaid programs are administered by the States, they are jointly financed by the Federal and State Governments. The Federal Government pays its share of medical assistance expenditures to States on a quarterly basis according to a formula described in sections 1903 and 1905(b) of

[1] This report uses the term "tax" to include a tax, fee, or assessment.

[2] *Pennsylvania's Gross Receipts Tax on Medicaid Managed Care Organizations Appears To Be an Impermissible Health-Care-Related Tax* (A-03-13-00201, issued May 28, 2014) and *We Could Not Determine Whether West Virginia's Severance and Business Privilege Tax on Behavioral Health Services Is a Permissible Health-Care-Related Tax* (A-03-14-00200, issued January 12, 2016).

[3] *Ohio's and Michigan's Sales and Use Taxes on Medicaid Managed Care Organization Services Did Not Meet the Broad-Based Requirement but Are Now in Compliance* (A-03-16-00200, issued April 18, 2017).

the Act. The amount of the Federal share of medical assistance expenditures is called Federal financial participation (FFP). The FFP is calculated using the State's Federal Medical Assistance Percentage (FMAP).[4] States pay their share of medical expenditures in accordance with section 1902(a)(2) of the Act.

The non-Federal share of Medicaid program expenditures comes from general revenue collected through State income taxes, sales taxes, and other sources such as funds from the Tobacco Master Settlement Agreement.[5] In addition, sections 1902(a)(2) and 1903 of the Social Security Act permit States to generate the non-Federal share of Medicaid expenditures through additional sources. These sources include:

- health-care-related taxes, fees, and assessments and provider donations;
- intergovernmental transfers for supplemental payments made under Medicaid Upper-Payment Limit (UPL) requirements; and
- certified public expenditures.

Although 40 percent of non-Federal financing must come from the State, up to 60 percent may be derived from local sources. However, this cost sharing requirement only applies to the total annual Medicaid program expenditures, not to each individual expenditure.

According to the National Conference of State Legislatures, "For FY 2016-2018, the number of states with some type of Medicaid-related provider or insurer taxes or fees has remained stable at 49 states and D.C.[6] The single state not using provider taxes is Alaska."[7]

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[4] The FMAP is the percentage rate used to determine the Federal matching funds for Medicaid program expenditures. The statutory minimum FMAP is 50 percent; the maximum is 83 percent. The percentage is calculated annually based on this formula:

$$1 - ((\text{the State per capita income})^2 \div (\text{the United States per capita income})^2) \times 0.45.$$

[5] The Tobacco Master Settlement Agreement was entered into in November 1998 between the four largest United States tobacco companies and the attorneys general of 46 States. The States settled their Medicaid lawsuits against the tobacco industry for recovery of their tobacco-related health-care costs. In exchange, the companies agreed to curtail or cease certain tobacco marketing practices, as well as to pay, in perpetuity, various annual payments to the States to compensate them for some of the medical costs for persons with smoking-related illnesses.

[6] There were 42 States with hospital tax programs.

[7] National Conference of State Legislatures, *Health Provider and Industry Taxes and Fees*, updated October 10, 2017. Available online at http://www.ncsl.org/research/health/health-provider-and-industry-state-taxes-and-fees.aspx. Accessed on February 2, 2018.

Supplemental Payments

States make supplemental payments to health care providers above what they pay for individual services through Medicaid rates. These additional payments fall into two categories: disproportionate share hospital (DSH) payments and UPL supplemental payments.[8]

DSH payments help offset hospitals' uncompensated care costs for serving Medicaid and uninsured low-income patients. Uncompensated care is the cost of treating Medicaid and uninsured beneficiaries after subtracting any payments from Medicaid, third-party insurers (including Medicare), and the beneficiary. DSH payments are limited at the facility-specific and State levels.[9]

Unlike DSH payments, non-DSH supplemental payments are not required under Federal law, do not have a specified statutory or regulatory purpose, and are not subject to firm dollar limits at the facility or State level. Unlike regular Medicaid payments, which are paid on the basis of covered Medicaid services provided to Medicaid beneficiaries through an automated claims process, non-DSH supplemental payments are not necessarily made on the basis of claims for specific services to particular patients.

In general, States can make non-DSH payments up to the UPL. The UPL is generally a reasonable estimate of the amount that would be paid for Medicaid services under Medicare payment principles. Typically, State Medicaid payment rates are lower than what the Medicare program would pay. Non-DSH supplemental payments can be used to make up the difference between what Medicaid paid and what Medicare would have paid. Although Federal regulations do not specify how States should calculate UPLs, each State's UPL methodology must comply with its State plan approved by the Centers for Medicare & Medicaid Services (CMS).[10] Federal matching funds are not available for Medicaid payments that exceed UPLs.

In a managed care system, pass-through payments are amounts paid to Medicaid managed care plans as non-DSH supplemental payments or "add-ons" to the base capitation rate. The plans are required to pass through the add-on payment to designated contracted providers. Regulations[11] define pass-through payments as any amount required by the State to be added to contracted payment rates between the managed care plans and providers that is not for any of the following purposes:

[8] We refer to UPL supplemental payments as non-DSH supplemental payments.

[9] § 1923(g) of the Act.

[10] Beginning in 2013, States have submitted UPL payment methodologies to CMS on an annual basis (CMS, State Medicaid Director Letter #13-003 (March 18, 2013)).

[11] 42 CFR § 438.6(a).

- a specific service or benefit provided to a specific enrollee covered under the contract,
- permissible provider payment methodologies outlined in 42 CFR §438.6(c)(1) for services and enrollees covered under the contract,
- a sub-capitated payment arrangement for a specific set of services and enrollees covered under the contract,
- graduate medical education payments, and
- federally qualified health center or rural health center (RHC) wraparound payments.

Federal Oversight of State Health-Care-Related Tax Programs

Before 1985, CMS, then known as the Health Care Financing Administration (HCFA), permitted States to finance their share of Medicaid training expenditures through donations from hospitals and other providers as long as the States did not use these donations when claiming Federal matching funds for the training expenditures.[12] In November 1985, HCFA adopted a rule[13] allowing States to count donations as part of the State share when claiming Federal matching funds for all Medicaid program expenditures.

Beginning in 1987, HCFA took steps to disallow Federal matching funds in States suspected of misusing funds generated by health care provider donations and State taxes on health-care-related services. In 1991, Congress enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Tax Amendments).[14] The Tax Amendments were designed to further limit, but not eliminate, States' use of provider donations and tax revenues to finance the State's share of Medicaid expenditures. Specifically, the Tax Amendments limit the use of certain funds donated by providers and revenues generated by certain health-care-related taxes in order to obtain FFP.

Permissible Health-Care-Related Taxes

For a health-care-related tax to be deemed permissible, section 1903(w) of the Act requires the tax to be imposed on a permissible class of health care services; be broad-based or apply to all providers within a class; be uniform, with all providers within a class taxed at the same rate;

[12] Buck JA, Klemm J; "Recent Trends in Medicaid Expenditures," *Health Care Financing Review*, *1992 Annual Supplement;* 1992; p. 281.

[13] 50 Fed. Reg. 46652 (Nov. 12, 1985).

[14] Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, P.L. No. 102-234, § 2 (Dec. 12, 1991), codified at § 1903(w) of the Act.

and avoid hold-harmless arrangements in which collected taxes are returned directly or indirectly to taxpayers.

Section 1903(w)(3)(E) of the Act specifies that the Secretary of Health and Human Services shall approve broad-based and uniformity waiver applications if the net impact of the health-care-related tax is generally redistributive and if the amount of the tax does not directly correlate to Medicaid payments to taxpayers (hold-harmless). The permissible class of health care services and hold-harmless requirements cannot be waived. Federal regulations identify 19 permissible classes of health care items or services that States can tax (42 CFR § 433.56).

States may not use revenues raised through an impermissible health-care-related tax to obtain FFP. When a health-care-related tax is determined to be impermissible, CMS should remove the total amount of the impermissible tax revenues received by the State from the State's medical assistance expenditures when determining the Federal share of State expenditures (42 CFR § 433.57).

States Use of Health-Care Related Tax Revenue

The Figure on the following page demonstrates how States can use health-care-related taxes to finance Medicaid program services. This example is for illustrative purposes only and is not an actual example drawn from any of the States reviewed in this report. The Figure assumes the FMAP is 60 percent. These transactions do not necessarily need to be in this sequential order:

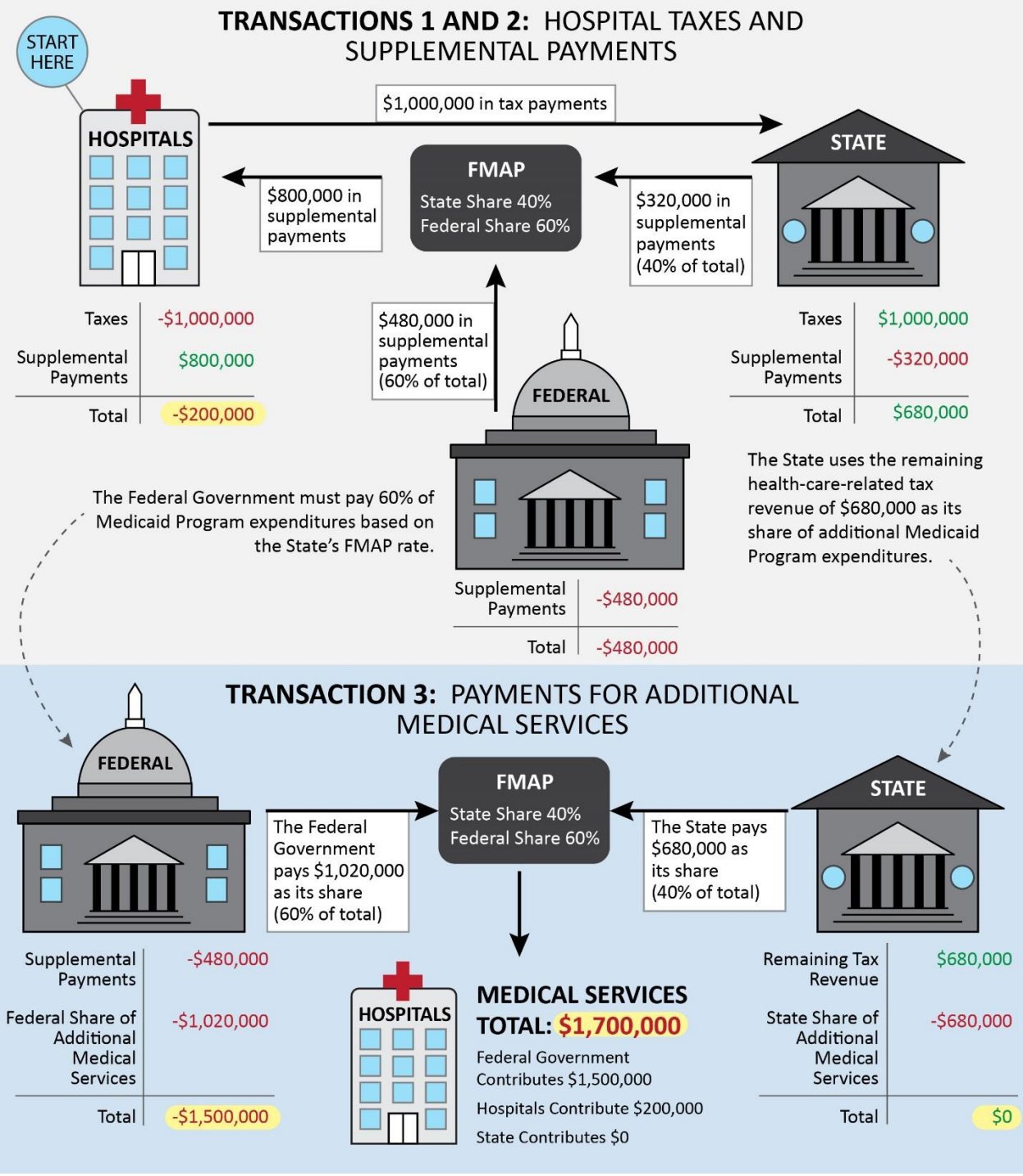
- Providers pay the State $1,000,000 in health-care-related taxes.

- The State pays providers $800,000 in non-DSH supplemental payments: $480,000 Federal share (60% FMAP) and $320,000 State share.

- The State pays hospitals $1,700,000 for medical services: $1,020,000 Federal share (60% FMAP) and $680,000 State share.

The net result of these transactions show that $1,000,000 in tax payments was leveraged into $1,700,000 in Medicaid payments with $1,500,000 funded by the Federal Government ($480,000 + $1,020,000) and $200,000 from provider tax payments ($1,000,000 - $800,000). The State has no gain or loss of net revenue ($1,000,000 - $320,000 - $680,000).

Figure: How States Use Permissible Health-Care-Related Tax Revenues To Finance the State Share of Medicaid Program Services



Hold-Harmless Tests

Federal regulations describe three tests that are applied to health-care-related taxes in order to determine whether taxpayers are held harmless.[15] Taxes that fail any of these tests are determined to have a hold-harmless provision in violation of the law. The three tests are the positive correlation test, the Medicaid payment test, and the guarantee test:

- A tax fails the positive correlation test if the State or other unit of government imposing the tax directly or indirectly provides a non-Medicaid payment to taxpayers in an amount that is positively correlated to either the tax amount or the difference between the Medicaid payment to taxpayers and the tax amount.

- A tax fails the Medicaid payment test if all or any portion of the Medicaid payment to the taxpayer varies based only on the amount of the total tax payments.

- A tax fails the guarantee test if the State or other unit of government imposing the tax provides directly or indirectly for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax. If there is no direct guarantee, a separate test is used to determine if a tax contains an indirect guarantee.

  An indirect guarantee is determined through a two-prong test. The first prong relates to the rate at which taxpayers are taxed. If the tax is levied at a rate that produces revenues of less than or equal to 6 percent of the taxpayer's net patient service revenues, the tax is permissible even if the unit of government imposing the tax provides directly or indirectly for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.[16, 17] For this reason, the 6-percent threshold is referred to as a "safe harbor."[18]

  The second prong of the indirect guarantee test is the 75/75 requirement. It is only applied to health care-related taxes imposed at a rate greater than the 6-percent threshold specified in the first prong. It is met if more than 75 percent of the taxpayers in the class receive 75 percent or more of the cost of the tax back through enhanced Medicaid or other non-DSH supplemental payments.[19]

[15] 42 CFR § 433.68(f).

[16] 42 CFR § 433.68(f)(3)(i)(A).

[17] From January 1, 2008, through September 30, 2011, section 403 the Tax Relief and Health Care Act of 2006 (P.L. No. 109-432) changed the threshold to 5.5 percent of net patient service revenues. On October 1, 2011, the threshold reverted to 6 percent of net patient service revenues.

[18] 152 Cong. Rec. 23195 (2006).

[19] 42 CFR § 433.68(f)(3)(i)(B).

If a State imposes a health care-related tax above the threshold amount and violates the 75/75 requirement, the tax revenue could still be used to fund Medicaid, but the State would not be able to receive Federal matching funds on that tax revenue. Instead, the revenue from health care-related taxes that do not meet Federal requirements would be removed from the State's Medicaid expenditures before the calculation of FFP.[20]

As of August 2016, no State had imposed a health care-related tax at a rate above the threshold specified in the first prong of the indirect guarantee test.[21]

Appendix B contains Federal hold-harmless requirements.

HOW WE CONDUCTED THIS REVIEW

We reviewed the hospital tax programs in seven States with the largest health-care-related tax programs: California, Illinois, Indiana, Michigan, Missouri, Ohio, and Pennsylvania.[22] For each State, we reviewed hospital tax program documentation reviewed by CMS and compiled the hospital tax payments, non-DSH supplemental payments, and Managed Care Organization (MCO) pass-through payments[23] for each hospital to test the Federal hold-harmless requirements and assess the financial impact of the taxes on the States, the Federal Government, and the individual hospitals. Our review covered State FYs (SFYs) 2011 through 2015.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The health-care-related hospital tax programs in the seven States we reviewed complied with hold-harmless requirements.

[20] 42 CFR § 433.70.

[21] Congressional Research Service, "Medicaid Provider Taxes" (August 5, 2016).

[22] We initially selected the eight States that reported the largest health-care-related tax collections to CMS on the States' quarterly expense report, Form CMS-64. The hospital tax program for the eighth State, New York, did not allow for a comparative analysis because it is not operated in the same way as the other seven States' programs.

[23] Pass-through payments occur when a State makes a capitation payment to the Medicaid MCO and the MCO passes the payment through to the medical facility. The Medicaid MCOs in three States (California, Indiana, and Pennsylvania) made pass-through payments for the State to hospitals. In this review, the term "supplemental payments" includes pass-through payments.

The seven States in our review collected $38.4 billion in tax revenue from their hospitals during SFYs 2011 through 2015. The $38.4 billion was used as the State share of Medicaid payments and resulted in a draw-down of $54.6 billion in Federal matching funds for a total of $93 billion. From the $93 billion, $60.2 billion was used for non-DSH supplemental payments to mitigate most of the hospital tax payments and $32.7 billion was used mostly for additional hospital services.

In the States reviewed, we found that non-DSH supplemental payments exceeded 75 percent of hospital tax payments for 84 percent of the hospitals. However, since the tax rate was less than the 6 percent safe harbor threshold, the tax programs could return over 75 percent of the tax payments to over 75 percent of the taxpayers without violating the hold-harmless requirement (75/75 requirment). Had the tax rates exceeded 6 percent, CMS could deem these hospital tax programs as impermissible for most years, which would disqualify the use of the tax revenue for drawing down Federal matching funds.

THE HOSPITAL TAX PROGRAMS IN THE SEVEN STATES IN OUR REVIEW MET HOLD-HARMLESS REQUIREMENTS

The health-care-related taxes on hospitals in the States we reviewed did not include hold-harmless provisions that would make the taxes impermissible under Federal requirements. The States did not directly guarantee to hold hospitals harmless for the taxes, and hospital taxes did not exceed the threshold of 6 percent in the first prong of the indirect guarantee test.

The positive correlation and Medicaid payment hold-harmless tests also did not apply because the non-DSH supplemental payments were neither non-Medicaid payments nor a Medicaid payment that varied according to the tax amount.

The States used the revenues from these tax programs to fund mostly Medicaid hospital services. Table 1 shows some of the uses of revenue from hospital tax programs.

Table 1: Use of Hospital Tax Program Funds

State	Uses of Hospital Tax Revenue
California	Funded hospitals that serve Medicaid and uninsured patients, children's health care coverage, and direct grants to public hospitals
Illinois	Increased Medicaid reimbursement to hospitals and funded other nonhospital medical services
Indiana	Increased Medicaid reimbursement to hospitals and funded psychiatric services
Michigan	Increased Medicaid reimbursement to hospitals and replaced General Fund/General Purpose dollars as the non-Federal share of Medicaid funding
Missouri	Funded hospital care; primary, urgent, and specialty care for certain uninsured adults; MCO services; Children's Health Insurance Program services; and women's health services
Ohio	Increased hospital reimbursement rates, indigent care services, and MCO incentives
Pennsylvania	Increased Medicaid reimbursement to hospitals, established new or revised existing non-DSH supplemental or DSH payments, and increased MCO reimbursement for inpatient hospital services

THE STATES IN OUR REVIEW COLLECTED $38.4 BILLION IN HOSPITAL TAX REVENUE THAT WAS USED AS THE STATE SHARE TO DRAW DOWN $54.6 BILLION IN FEDERAL MATCHING FUNDS FOR $93 BILLION IN MEDICAID EXPENDITURES

The seven States in our review collected $38.4 billion in tax revenue from their hospitals during SFYs 2011 through 2015. The $38.4 billion was used as the State share of Medicaid payments and resulted in a draw-down of $54.6 billion in Federal matching funds for a total of $93 billion. From the $93 billion, $60.2 billion was used for non-DSH supplemental payments to mitigate most of the hospital tax payments and $32.7 billion was used mostly for additional hospital services. For each State, we estimated the Federal share using a weighted average of each State's FMAP for SFYs 2011 through 2015. Table 2 summarizes the States' use of their hospital tax collections.

Table 2: States' Use of Hospital Tax Collections: SFYs 2011 Through 2015

All Seven States	Estimated State Share	Estimated Federal Share	Total Hospital Payments
Totals	$38,371,321,354	$54,590,083,490	$92,961,404,844

For each non-DSH supplemental and other Medicaid hospital payment, the States are eligible to request FFP at the FMAP currently in effect. Tables 3 and 4 show the amount of estimated State and Federal shares for the non-DSH supplemental payments to hospitals and estimated additional hospital services provided as a result of these tax programs.

Table 3: Non-Disproportionate Share Hospital Supplemental Payments: SFYs 2011 Through 2015

State	Estimated State Share	Estimated Federal Share	Total Payments
California	$11,477,307,328	$12,556,462,041	**$24,033,769,369**
Illinois	4,291,317,476	4,611,512,304	**8,902,829,780**
Indiana	1,620,734,284	3,316,338,185	**4,937,072,469**
Michigan	2,470,759,479	5,063,009,396	**7,533,768,875**
Missouri	1,836,109,452	3,321,971,562	**5,158,081,014**
Ohio	1,939,907,306	3,624,311,497	**5,564,218,803**
Pennsylvania	1,828,362,538	2,264,739,105	**4,093,101,643**
Total	**$25,464,497,863**	**$34,758,344,090**	**$60,222,841,953**

Table 4: Estimated Hospital Services: SFYs 2011 Through 2015

State	Estimated State Share	Estimated Federal Share	Total Payments
California	$3,682,208,115	$4,028,428,020	**$7,710,636,135**
Illinois	1,080,510,127	1,161,131,931	**2,241,642,058**
Indiana	1,161,413,660	2,376,478,678	**3,537,892,338**
Michigan	1,057,354,638	2,166,700,771	**3,224,055,409**
Missouri	3,323,329,603	6,012,716,956	**9,336,046,559**
Ohio	1,371,068,698	2,561,555,404	**3,932,624,102**
Pennsylvania	1,230,938,651	1,524,727,641	**2,755,666,292**
Total	**$12,906,823,492**	**$19,831,739,401**	**$32,738,562,893**

Appendices C through I provide a more complete summary of each State's hospital tax program.

BECAUSE THE STATES IN OUR REVIEW KEPT TAXES BELOW 6 PERCENT, THEY COULD SIGNIFICANLY MITIGATE THE TAX IMPACT ON HOSPITALS

The majority of hospital taxpayers in all seven States received non-DSH supplemental payments that offset most, and in some cases all, of their tax payments, allowing these States to significantly mitigate the tax impact on their hospitals. Had the taxes in any of the seven States

exceeded the 6 percent safe harbor of net patient service revenues in any given year, with a few exceptions, the States would have violated the second prong of the indirect hold-harmless test (75/75 requirement) and the taxes would have been deemed impermissible.

Supplemental Payments for Non-Disproportionate Share Hospitals Totaled at Least 75 Percent of Tax Payments for 84 Percent of Hospital Taxpayers

Non-DSH supplemental payments totaled at least 75 percent of tax payments for 84 percent of hospital taxpayers in our review. As shown in Table 5, percentages varied by both State and SFY and ranged from 66 percent to 95 percent. If there were no safe harbor, all of the hospital tax programs in our review, with the exceptions of Ohio's tax program for 1 FY and Pennsylvania's tax program for 2 FYs, would have violated the indirect guarantee hold-harmless test and been deemed impermissible.

Table 5: Percentage of Hospitals Receiving Non-Disproportionate Share Hospital Supplemental Payments in Excess of 75 Percent

State	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
California	78%	82%	79%	84%	85%
Illinois	92%	92%	93%	94%	93%
Indiana	No Tax[24]	93%	91%	93%	94%
Michigan	79%	78%	82%	83%	84%
Missouri	95%	87%	91%	89%	87%
Ohio	73%	79%	81%	90%	86%
Pennsylvania	82%	79%	76%	66%	67%

Supplemental Payments for Non-Disproportionate Share Hospitals Exceeded Tax Payments for 71 Percent of Hospitals

On average, supplemental payments exceeded hospital tax payments for 71 percent of hospital taxpayers. As shown in Table 6 on the next page, percentages varied by State and by SFY and ranged from 45 to 88 percent.

[24] Indiana's Hospital Assessment Fee Program began on July 1, 2011, during SFY 2012.

Table 6: Percentage of Hospitals Receiving Supplemental Payments in Excess of Tax Payments

State	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SF 2015
California	65%	68%	63%	74%	77%
Illinois	88%	88%	87%	88%	85%
Indiana	No Tax	84%	81%	83%	87%
Michigan	75%	76%	78%	79%	78%
Missouri	48%	48%	54%	45%	50%
Ohio	60%	70%	72%	80%	79%
Pennsylvania	69%	59%	55%	50%	50%

The hospital taxpayers in Table 6 received more in supplemental payments than they paid in State health-care-related taxes. Had the taxes produced revenue above the 6-percent threshold, the taxes on these hospitals would have violated the 75/75 requirement because more than 75 percent of the hospitals received supplemental payments in excess of 75 percent of their tax payments.

CONCLUSION

The results in this report show that the hospital tax programs raised significant amounts of revenue to draw down additional Federal funds while the hospitals' tax payments in the States we reviewed, for the most part, were offset by non-DSH supplemental payments.

The Tax Amendments were intended to limit, not eliminate, States' use of health-care-related taxes. Current and prior administrations have raised concerns about the propriety of health-care-related tax programs and highlighted the need to address them. The Congressional Budget Office estimated that lowering the hold-harmless threshold from 6 percent to 5 percent could save $15.9 billion in Federal funds in the 10-year period from FY 2017 through FY 2026.[25]

Given the magnitude of the funds generated by the hospital tax programs identified in this report, we intend to further study, on a service-specific basis, the composition of the non-Federal share (State or other sources or both) to determine the contribution of all parties in funding Medicaid expenditures and the implications for the Medicaid program.

RECOMMENDATION

We recommend that CMS re-evaluate the effects of the health-care-related tax safe-harbor threshold and the associated 75/75 requirement to determine if modifications are needed,

[25] Congressional Budget Office, *Options for Reducing the Deficit: Limit States' Taxes on Health Care Providers* (December 8, 2016).

such as the reduction or elimination of the safe harbor threshold or adjusting the 75/75 requirement, and take appropriate action.

CMS COMMENTS

CMS concurred with our recommendation and stated that it will evaluate the effects of the health-care-related-tax threshold and the associated 75/75 requirement to determine if modifications are needed. CMS's comments are included in their entirety as Appendix J.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For SFYs 2011 through 2015, seven States (California, Illinois, Indiana, Michigan, Missouri, Ohio, and Pennsylvania) collected $38.4 billion in tax payments from hospitals.[26] These States also made supplemental payments to hospitals during the same period. We reviewed these seven States' health-care-related tax programs for compliance with Federal hold-harmless requirements.

We did not review the overall internal control structure of each State's Medicaid program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining whether there was a hold-harmless arrangement for each State's hospital tax program. We did not extend our review to any other health-care-related tax program in these seven States.

We conducted our audit from January 2016 to March 2017.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal statutes and regulations on health-care-related taxes specifically pertaining to hold-harmless requirements;
- held a discussion with CMS officials to gain an understanding of hold-harmless requirements and how CMS reviews State health-care-related tax proposals;
- collected health-care-related hospital tax data from California, Illinois, Indiana, Michigan, Missouri, Ohio, and Pennsylvania;
- estimated how much Federal reimbursement each State received based on States' FMAP rates;
- added the States' tax collections to the States' draw-down of Federal funds to determine the total funds available to each State;
- collected data on supplemental Medicaid payments made to hospitals in California, Illinois, Indiana, Michigan, Missouri, Ohio, and Pennsylvania;
- compared the States' tax collections to the supplemental payments received by hospitals to assess the financial impact for each hospital;

[26] We initially selected the eight States that reported the largest health-care-related tax collections to CMS on the States' quarterly expense report, Form CMS-64. The hospital tax program for the eighth State, New York, did not allow for a comparative analysis because it is not operated in the same way as the other seven States' programs.

- provided to each State the summary of the State's results (Appendices C through I) for the State's review and comment; and

- met with CMS officials to discuss our findings and recommendations.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: FEDERAL HOLD-HARMLESS REQUIREMENTS

SOCIAL SECURITY ACT

The Social Security Act section 1903(w)(4), codified under 42 U.S.C. section 1396b(w), states:

> (4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:
>
> > (A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.
> >
> > (B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.
> >
> > (C)(i) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.
> >
> > (ii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on November 1, 2006, except that for portions of fiscal years beginning on or after January 1, 2008, and before October 1, 2011, "5.5 percent" shall be substituted for "6 percent" each place it appears.
>
> The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

MEDICAID REGULATIONS

On February 22, 2008, CMS published a final rule to clarify the standards for the hold-harmless test.[27]

[27] 73 Fed. Reg. 9685 (Feb. 22, 2008).

Medicaid regulations (42 CFR section 433.68(f)) state that:

> *(f) Hold harmless*. A taxpayer will be considered to be held harmless under a tax program if any of the following conditions applies:
>
> (1) The State (or other unit of government) imposing the tax provides for a direct or indirect non-Medicaid payment to those providers or others paying the tax and the payment amount is positively correlated to either the tax amount or to the difference between the Medicaid payment and the tax amount. A positive correlation includes any positive relationship between these variables, even if not consistent over time.
>
> (2) All or any portion of the Medicaid payment to the taxpayer varies based only on the tax amount, including where Medicaid payment is conditional on receipt of the tax amount.
>
> (3) The State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount.
>
> (i)(A) An indirect guarantee will be determined to exist under a two prong "guarantee" test. If the health care-related tax or taxes on each health care class are applied at a rate that produces revenues less than or equal to 6 percent of the revenues received by the taxpayer, the tax or taxes are permissible under this test. The phrase "revenues received by the taxpayer" refers to the net patient revenue attributable to the assessed permissible class of health care items or services. However, for the period of January 1, 2008 through September 30, 2011, the applicable percentage of net patient service revenue is 5.5 percent. Compliance in State fiscal year 2008 will be evaluated from January 1, 2008 through the last day of State fiscal year 2008. Beginning with State fiscal year 2009 the 5.5 percent tax collection will be measured on an annual State fiscal year basis.
>
> (B) When the tax or taxes produce revenues in excess of the applicable percentage of the revenue received by the taxpayer, CMS will consider an indirect hold harmless provision to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments. The second prong of the indirect hold harmless test is applied in the aggregate to all health care taxes applied to each class. If this standard is violated, the amount of tax revenue to be offset from medical assistance

> expenditures is the total amount of the taxpayers' revenues received by the State.

The provision contained in 42 CFR section 433.68(f)(3)(i)(A) stating that "if the health care-related tax or taxes on each health care class are applied at a rate that produces revenues less than or equal to 6 percent of the revenues received by the taxpayer, the tax or taxes are permissible under this test" is often referred to as a safe harbor.

Enforcement of Regulations Permanently Delayed

The Tax Amendments required CMS to obtain input from States on the implementing regulations located at 42 CFR section 433.68(f) regarding FFP limitations when States receive funds from provider-related donations or revenues from health-care-related taxes. This resulted in an interim final rule in 1992[28] and a final rule in 1993.[29]

In January 2001, CMS issued disallowances to five States, imposing reductions in FFP for violations of the hold-harmless standard for periods going back to either October 1, 1992, or July 1, 1993. The five States appealed the disallowances to the Department of Health and Human Services' Departmental Appeals Board (the Board), which issued its ruling in June 2005. In that ruling,[30] the Board concluded that CMS's basis for its disallowances was inconsistent with its regulations. CMS issued disallowances to the five States based on its determination that those States' tax programs violated the statutory hold-harmless prohibition. However, the Board found that CMS's application of the positive correlation test and the guarantee test was inconsistent with the wording of those tests as described in statute and regulation as well as in preamble text of the regulation.

In regard to the positive correlation test, the Board found that the regulation and its preamble clearly described positive correlation in statistical terms (i.e., a relationship in which one variable increases as the other variable increases). However, the Board found that CMS concluded that a positive correlation existed without applying any statistical analysis and instead based its determination on subjective factors that were specifically rejected in the development of the regulation.

In regard to the indirect guarantee test, the Board found that the regulation and preamble text clearly stated that the two-prong indirect guarantee test would be applied if an explicit guarantee did not exist. However, the Board found that CMS did not state or show that any explicit guarantees existed and determined that the States' tax programs contained indirect guarantees without finding that any of the tax programs failed the two-prong indirect guarantee test. As a result, the Board reversed CMS's disallowances. To clarify the

[28] 57 Fed. Reg. 55118 (Nov. 24, 1992).

[29] 58 Fed. Reg. 43156 (Aug. 13, 1993).

[30] DAB No. 1981 (2005).

hold-harmless requirements, CMS published a final rule on February 22, 2008. The final rule was to go into effect on April 22, 2008.[31]

Although the final rule was to be effective in April 2008, section 7001(a)(3)(A) of the Supplemental Appropriations Act of 2008 (P.L. No. 110-252), imposed a partial moratorium until April 1, 2009, prohibiting CMS from taking action to implement any provisions of the final rule affecting the hold-harmless changes. This moratorium was extended by section 5003(a) of the American Recovery and Reinvestment Act of 2009 (P. L. No. 111-5) until July 1, 2009. In June 2009, CMS announced it was further delaying enforcement of its final rule to June 30, 2010.[32]

[31] 73 Fed. Reg. 9685 (Feb. 22, 2008).

[32] 74 Fed. Reg. 31196 (Jun. 30, 2009).

APPENDIX C: SUMMARY OF CALIFORNIA'S HOSPITAL TAX PROGRAM

Program Name: Hospital Quality Assurance Fee Program			
Effective Date		January 1, 2010	
Tax Base	Calendar Year 2010 Bed-Days		
Tax Rate	Per bed-day rate, which varies depending on the year and type of medical insurance: private managed care, private fee-for-service, or Medi-Cal (Medicaid)		
Total Tax Collected			$15,159,515,443
Estimated Receipt of Federal Funds			$16,584,890,061
Total Funds Available			$31,744,405,504
Supplemental Payments to Hospital Taxpayers From Tax			$24,033,769,369
Estimated Additional Medicaid Services Provided From Tax			$7,710,636,135
SFY	Hospitals Taxed	Hospitals With Supplemental Payments Greater Than Tax*	Hospitals With Supplemental Payments at Least 75% of Tax
2011	239	156 (65%)	186 (78%)
2012	240	162 (68%)	197 (82%)
2013	240	152 (63%)	189 (79%)
2014	242	179 (74%)	204 (84%)
2015	233	180 (77%)	198 (85%)

* The numbers and percentages may not match exactly because of rounding.

APPENDIX D: SUMMARY OF ILLINOIS'S HOSPITAL TAX PROGRAM

Program Name: Hospital Provider Assessment Program			
Effective Date		Inpatient Tax: July 1, 2008	Outpatient Tax: June 10, 2012
Tax Base	Inpatient	Occupied Bed-Days Excluding Medicare Bed-Days	
Tax Rate	Inpatient	$218.38 per day	
Tax Base	Outpatient	Outpatient Gross Revenue	
Tax Rate	Outpatient	0.8766%	

Total Tax Collected	$5,371,827,603
Estimated Receipt of Federal Funds	$5,772,644,235
Total Funds Available	$11,144,471,838
Supplemental Payments to Hospital Taxpayers From Tax	$8,902,829,780
Estimated Additional Medicaid Services Provided From Tax	$2,241,642,058

SFY	Hospitals Taxed	Hospitals With Supplemental Payments Greater Than Tax*	Hospitals With Supplemental Payments at Least 75% of Tax*
2011	216	189 (88%)	198 (92%)
2012	217	191 (88%)	199 (92%)
2013	217	188 (87%)	201 (93%)
2014	217	191 (88%)	204 (94%)
2015	218	186 (85%)	202 (93%)

* The numbers and percentages may not match exactly because of rounding.

APPENDIX E: SUMMARY OF INDIANA'S HOSPITAL TAX PROGRAM

Program Name: Hospital Assessment Fee Program[33]					
Effective Date		July 1, 2011			
Tax Base	Inpatient	Inpatient Bed-Days			
Tax Rate	Inpatient	2012 $185.67/day	2013 $199.25/day	2014 $214.24/day	2015 $199.31/day
Tax Base	Outpatient	Outpatient Equivalent Bed-Days			
Tax Rate	Outpatient	2012 $35.75/day	2013 $48.45/day	2014 $41.42/day	2015 No Tax

Total Tax Collected	$2,782,147,944
Estimated Receipt of Federal Funds	$5,692,816,863
Total Funds Available	$8,474,964,807
Supplemental Payments to Hospital Taxpayers From Tax	$4,937,072,469
Estimated Additional Medicaid Services Provided From Tax	$3,537,892,338

SFY	Hospitals Taxed	Hospitals With Supplemental Payments Greater Than Tax*	Hospitals With Supplemental Payments at Least 75% of Tax*
2012	141	118 (84%)	131 (93%)
2013	140	114 (81%)	128 (91%)
2014	139	116 (83%)	129 (93%)
2015	139	121 (87%)	131 (94%)

* The numbers and percentages may not match exactly because of rounding.

[33] CMS granted Indiana a waiver for the broad-based and uniformity requirements per 42 CFR § 433.68.

APPENDIX F: SUMMARY OF MICHIGAN'S HOSPITAL TAX PROGRAM

Hospital Quality Assurance Assessment Program		
Effective Date	October 1, 2002	
Tax Base	Net Patient Revenue Less Medicare Revenue	
Tax Rate	SFY 2011	4.4%
Tax Rate	SFY 2012	4.9%
Tax Rate	SFY 2013	5.2%
Tax Rate	SFY 2014	5.1%
Tax Rate	SFY 2015	5.4%
Total Tax Collected		$3,528,114,117
Estimated Receipt of Federal Funds		$7,229,710,167
Total Funds Available		$10,757,824,284
Supplemental Payments to Hospital Taxpayers From Tax		$7,533,768,875
Estimated Additional Medicaid Services Provided From Tax		$3,224,055,409

SFY	Hospitals Taxed	Hospitals With Supplemental Payments Greater Than Tax*	Hospitals With Supplemental Payments at Least 75% of Tax*
2011	165	124 (75%)	131 (79%)
2012	164	124 (76%)	128 (78%)
2013	162	126 (78%)	133 (82%)
2014	162	128 (79%)	135 (83%)
2015	161	126 (78%)	135 (84%)

* The numbers and percentages may not match exactly because of rounding.

APPENDIX G: SUMMARY OF MISSOURI'S HOSPITAL TAX PROGRAM

Federal Reimbursement Allowance Program		
Effective Date		October 1, 1992
Tax Base	Net Inpatient/Outpatient Revenue	
Tax Rate	SFY 2011	5.45%
Tax Rate	SFY 2012	5.45% (1st quarter) 5.95% (2nd – 4th quarter)
Tax Rate	SFY 2013	5.95%
Tax Rate	SFY 2014	5.95%
Tax Rate	SFY 2015	5.95%

Total Tax Collected	$5,159,439,055
Estimated Receipt of Federal Funds	$9,334,688,518
Total Funds Available	$14,949,127,573
Supplemental Payments to Hospital Taxpayers From Tax	$5,158,081,014
Estimated Additional Medicaid Services Provided From Tax	$9,336,046,559

SFY	Hospitals Taxed	Hospitals With Supplemental Payments Greater Than Tax*	Hospitals With Supplemental Payments at Least 75% of Tax*
2011	150	72 (48%)	140 (95%)
2012	147	70 (48%)	128 (87%)
2013	149	80 (54%)	136 (91%)
2014	149	67 (45%)	133 (89%)
2015	150	75 (50%)	131 (87%)

* The numbers and percentages may not match exactly because of rounding.

APPENDIX H: SUMMARY OF OHIO'S HOSPITAL TAX PROGRAM

During our audit period, Ohio had two hospital tax programs: the Hospital Care Assurance Program and the Hospital Franchise Fee Program.

Program Name: Hospital Care Assurance Program		
Effective Date		July 1, 1994
Tax Base	Adjusted Total Facility Cost	
Tax Rate	SFY 2011	0.98%
Tax Rate	SFY 2012	0.87%
Tax Rate	SFY 2013	0.84%
Tax Rate	SFY 2014	0.84%
Tax Rate	SFY 2015	0.84%
Program Name: Hospital Franchise Fee Program		
Effective Date		October 14, 2010
Tax Base	Adjusted Total Facility Cost less Medicare Costs	
Tax Rate	SFY 2011	1.39%
Tax Rate	SFY 2012	2.57%
Tax Rate	SFY 2013	2.67%
Tax Rate	SFY 2014	2.58%
Tax Rate	SFY 2015	2.65%

Total Tax Collected	$3,310,976,004
Estimated Receipt of Federal Funds	$6,185,866,900
Total Funds Available	$9,496,842,904
Supplemental Payments to Hospital Taxpayers From Tax	$5,564,218,802
Estimated Additional Medicaid Services Provided From Tax	$3,932,624,102

SFY	Hospitals Taxed	Hospitals With Supplemental Payments Greater Than Tax*	Hospitals With Supplemental Payments at Least 75% of Tax*
2011	207	124 (60%)	151 (73%)
2012	216	152 (70%)	171 (79%)
2013	211	152 (72%)	170 (81%)
2014	210	169 (80%)	189 (90%)
2015	214	169 (79%)	184 (86%)

* The numbers and percentages may not match exactly because of rounding.

APPENDIX I: SUMMARY OF PENNSYLVANIA'S HOSPITAL TAX PROGRAM

Program Name: Quality Care Assessment Program		
Effective Date		July 1, 2010
Tax Base	Net Inpatient Revenue	
Tax Rate	SFY 2011	2.95%
Tax Rate	SFYs 2012 Through 2015	3.22%

Total Tax Collected	$3,059,301,188
Estimated Receipt of Federal Funds	$3,789,466,746
Total Funds Available	$6,848,767,934
Supplemental/MCO Pass-Through Payments to Hospital Taxpayers From Tax	$4,093,101,642
Estimated Additional Medicaid Services Provided From Tax	$2,755,666,292

SFY	Hospitals Taxed	Hospitals With Supplemental Payments Greater Than Tax*	Hospitals With Supplemental Payments at Least 75% of Tax*
2011	173	119 (69%)	142 (82%)
2012	178	105 (59%)	139 (79%)
2013	178	98 (55%)	135 (76%)
2014	179	90 (50%)	119 (66%)
2015	178	89 (50%)	120 (67%)

* The numbers and percentages may not match exactly because of rounding.

APPENDIX J: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: OCT 10 2018

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma SV
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Although Hospital Tax Programs in Seven States Complied With Hold-Harmless Requirements, the Tax Burden on Hospitals Was Significantly Mitigated (A-03-16-00202)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS takes seriously its responsibilities to protect taxpayer funds by ensuring the appropriateness of the Federal financial participation of Medicaid expenditures claimed by states.

Because Medicaid is jointly funded by states and the Federal Government, and is administered by states within Federal guidelines, both CMS and states have key roles as stewards of the program, and work together closely to carry out these responsibilities. As such, CMS conducts multiple activities to oversee Medicaid expenditures and verify that Federal financial participation matches states' actual expenditures. To assist states in their financial reporting, CMS provides guidance and training to make sure that states have mechanisms and systems to track and report expenditures accurately.

This federal-state partnership is central to the success of the Medicaid program, however, it depends on clear lines of responsibility and shared expectations. In a 2008 final rule[1], CMS published the standards for the hold-harmless test, which outlines the scenarios under which states may use funds from health-care-related taxes to finance a portion of the non-Federal share of Medicaid program expenditures. States may not use revenues raised through an impermissible health-care-related tax to obtain Federal financial participation for its Medicaid program. When a health-care-related tax is determined to be impermissible, CMS has the authority to remove the total amount of the impermissible tax revenues received by the state from the state's expenditures for medical assistance before calculating the Federal share of state medical expenditures[2]. However, as OIG noted, all seven states reviewed complied with the hold-harmless requirements.

OIG's recommendation and CMS' response is below.

[1] 73 Fed. Reg. 9685 (February 22, 2008)
[2] 42 CFR 433.57

OIG Recommendation

The OIG recommends that CMS re-evaluate the effects of the health-care-related tax safe-harbor threshold and the associated 75/75 requirement to determine if modifications are needed, such as reduction or elimination of the safe harbor threshold or adjusting the 75/75 requirements, and take appropriate action.

CMS Response

CMS concurs with OIG's recommendation. CMS will evaluate the effects of the health-care-related tax threshold and the associated 75/75 requirement to determine if modifications are needed.