Optimizing Federal Medicaid Revenues in Hard Times: A Primer

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States are struggling to balance budgets in hard times. Medicaid is often seen by states as a budget buster, creating enormous pressure to cut the program. This paper provides technical information on **how a state can transform its Medicaid program from a budget problem into a budget solution**. The key is to ensure that the state is drawing down the full amount of Medicaid matching funds from the federal government available under federal law. As with most aspects of Medicaid, there is wide variation among states in the extent to which they are making use of available federal matching funds. *No state* currently makes full use of all of the funding opportunities available to it, and which are described below. Given Medicaid's large impact on every state's budget, making use of those opportunities has important implications for the state budget as a whole.

A state's failure to optimize its federal Medicaid revenues means, in effect, that the state is subsidizing the federal government by rejecting federal funds allocated for the states' use. Regardless of party affiliation or political philosophy, there are few state officials who, if they understand that reality, would argue for subsidizing the federal government when their state is in a budget crisis.

The details of Medicaid financing are complex, and implementation of a Medicaid optimization strategy can, in some states, involve the development of arcane, technically complicated fiscal policies. *Not to worry!* There are numerous consultants that state officials or health care providers can hire who have the requisite expertise and who can help tailor detailed policies that will fit the state's political and economic environment. Federal officials are also willing to help. Secretary of Health and Human Services Kathleen Sebelius, in a 2/15/11 letter to Arizona Governor Janice Brewer, assured the governor that "the full resources of our Department are available to you as you and the [Arizona Hospital] Association work to structure [a hospital] fee in a fiscally responsible and permissible manner to help sustain program coverage in difficult economic times."[1]

The purpose of this short paper is not to train new experts but to give stake-holders and policy makers only as much information as they need to be able to intelligently address issues of broad policy and strategy. Once those issues are settled, and policy makers decide upon a general policy direction, the details of implementation can be delegated to the technical experts. This paper also contains regulatory references and explanations of relevant technical terms, as well as some thoughts on how to develop an advocacy strategy and frame a message

Helping states optimize their federal Medicaid revenues during the upcoming state budget cycle has important long term implications. In 2014, the Affordable Care Act will extend coverage to many uninsured Americans by expanding Medicaid. States are now forced to decide whether to cut benefits to levels that cannot meet the needs of Medicaid's sickest beneficiaries, or whether to make rate cuts that will drive many providers out of the

[1] See:http://www.azgovernor.gov/dms/upload/PR_021511_SebeliusLetter.pdf.

program. Budget decisions made now will affect the capacity of a state's health care infrastructure to weather the changes that are coming in 2014.

I. Premises

A. States' budget picture:

1. States are in a financial bind. Enhanced federal Medicaid matching payments intended to serve as financial stimulus under the American Recovery and Reinvestment Act (ARRA) are ending, and state tax revenues will not return to pre-recession levels for years to come.
2. States' costs and demand for services have risen with the recession.
3. Most states cannot enact sufficient new taxes to make up their deficits.

B. Medicaid's role in state budgets:

1. Most state officials regard Medicaid as a cost center, and an especially problematic cost center at that. Because of health care inflation, Medicaid costs keeps rising more rapidly than state revenues, even in the best of times. Most elected officials perceive the increases as the fault of Medicaid itself, and of government programs generally, rather than understanding that Medicaid costs are driven by the same inflationary pressures that affect all health care.
2. With the expiration of ARRA enhanced Medicaid match, states' Medicaid programs face enormous deficits. The Affordable Care Act's maintenance of eligibility requirement bars states from cutting eligibility, leaving them only two other means of lowering program costs: slashing benefits or reducing provider payments. Political and legal constraints on cutting benefits and provider rates make it difficult for states to solve their Medicaid budget problems by making those cuts.
3. Despite perceptions of Medicaid as a ravenous cost center and budget problem**, Medicaid is also a major revenue center**, because it draws down matching federal funds.
4. Medicaid is the largest source of federal revenues in state budgets.
5. Medicaid is also the principal open-ended federal entitlement in the state budget. As such, it is the only significant source of new federal revenues or, for that matter, new revenues of any type.
6. The only limitation on federal funding is the ability of the state to put up matching dollars.
7. States struggle to maintain their federal Medicaid revenues, because of their difficulties coming up with the state share of the program's costs.
8. Dollars are fungible.

9. States cannot afford to subsidize the federal government by paying with pure state or local tax dollars for services that should be the financial responsibility of the Medicaid program. Such services should be covered by Medicaid, so that federal matching payments will share the cost.
10. In spite of their financial straits, ***not a single state is drawing down all of the federal Medicaid match to which it could be entitled.*** All states are subsidizing the federal government by paying by themselves for services that Medicaid should cover.
11. A state's failure to obtain all federal Medicaid matching funds for which it could qualify has a substantial adverse impact not only on Medicaid but on the state's entire budget.

C. The long term implications of current Medicaid budget issues

1. States' ability to fund their Medicaid programs will remain a major budget challenge over the next several yeas, with the Affordable Care Act's expansion of Medicaid eligibility taking effect in 2014.
2. It is essential to help states maintain their Medicaid programs to ensure that Medicaid benefits and provider payments are sufficient in 2014 to meet the needs of the expanded Medicaid population, and to enable the states to obtain the full benefit of the federal match that will become available then.

II. The basics of Medicaid matching

Medicaid is a state-administered health program that is jointly financed by states and the federal government. The federal and state shares of program costs vary for each state based on a formula that takes into consideration each state's per capita income compared with the national per capita income. The formula is designed so that states with per capita income that is relatively lower than other states will pay a lower state share of Medicaid program costs. The Federal Medical Assistance Percentage (FMAP) for wealthier states is 50%; the FMAP for poorer states ranges up to nearly 75% (in the case of Mississippi). For example, if a state has an FMAP of 63.75, that means that the federal government will reimburse the state Medicaid agency $63.75 of every $100 incurred to provide covered medical goods and services to eligible Medicaid enrollees.[2]

Under ARRA, these percentages were temporarily increased for the period between October 1, 2008 and December 31, 2010. These "enhanced FMAP" rates were temporarily extended, but at lower levels, through June 30, 2011. On July 1, 2011, each state's FMAP will return to its normal, pre-ARRA levels. See: http://aspe.hhs.gov/health/fmap.htm.

[2] Administrative costs are generally reimbursed in all states at a 50% rate, although higher rates apply to certain types of expenditures. Administrative costs account for only about 5% of overall Medicaid spending.

Each state Medicaid agency reports its expenditures to the federal Centers for Medicare and Medicaid Services (CMS), and claims reimbursement for the federal share of those expenditures in standardized reports, which are filed quarterly, known as the CMS 37 and CMS 64 reports.[3] The CMS 37 report contains both historical data and projected future expenditures. CMS advances funds to the state on the basis of the CMS 37 projection. The CMS 64 is compiled retrospectively from an audit trail documenting actual expenditures, and reconciles the monetary advance made on the basis of Form CMS 37 filed previously for the same quarter. State officials certify the accuracy of both reports. The federal government reimburses allowable expenditures at the applicable FMAP for that state.

Although federal funding is open-ended, it is constrained by a state's ability to raise its matching share. The state can draw down federal matching funds only to the extent that the state comes up with its own share of the program's costs. To get more federal money, the state has to increase its own Medicaid spending, either by raising more funds *or* by doing a better job of getting credit for the expenditures it is already making.

III. Three approaches to increasing federal Medicaid funding

There are three ways that states – without increasing appropriations of state general tax dollars – can ensure that they draw down all federal Medicaid matching funds that are available under law.

A. Require Medicaid to pay for services now funded by state or local government

Many state and local governments pay the full cost of services that could legally be billed to Medicaid as covered services. An example is school health programs that provide medical, mental health and/or dental services to low income children. Some states have aggressively pursued Medicaid payment for services rendered by local school agencies to children enrolled in Medicaid. These states have been able to reduce by a corresponding amount their direct subsidies to these local school agencies, freeing up the state dollars for expenditure on Medicaid or other budget needs. The effect: school services that were once reimbursed 100% by state and local taxpayers are now reimbursed by the federal government at a rate (50% to 75%, depending on the state) corresponding to its FMAP.

Another overlooked variant is the broad category of "tax expenditures" that are capable of conversion into actual Medicaid spending that would qualify for federal match. A tax expenditure is revenue a government foregoes through the provisions of tax law that exempt certain entities (e.g., non-profit hospitals) or goods (e.g., prescription drugs). Other tax expenditures are deductions, exclusions, deferrals or preferential tax treatment.

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[3] Further information concerning these forms is posted at the CMS website at: http://www.cms.hhs.gov/MedicaidBudgetExpendSystem/03_CMS37.asp#TopOfPage and http://www.cms.hhs.gov/MedicaidBudgetExpendSystem/02_CMS64.asp#TopOfPage.

Example:

A state could revoke non-profit hospitals' exemption from some or all taxes of general application, such as property, corporate income and sales taxes and increase the hospitals' Medicaid payments to compensate the hospitals for their new tax burdens.[4] There would be no net impact on state revenues and expenditures, or on hospitals' budgets. But the state would realize a substantial increase in federal Medicaid matching, since it would be swapping increased Medicaid expenditures, which are matchable, for tax expenditures, which are not matchable.

Alternative scenario:

A non-profit hospital retains its tax exemption but is required to start paying for a host of government services that it enjoys (e.g., ambulance service, fire and police protection, highway maintenance and other infrastructure services) but has not previously paid for. Local government transfers the hospital's payments to the state as assessments in lieu of taxes, and the state uses the funds for Medicaid. The hospitals' new expenses for these formerly free governmental services are incorporated into its costs, which are passed on to Medicaid. Federal Medicaid match thus shares the cost of local government services which were previously given to Medicaid providers, thereby eliminating what had been, in effect, an indirect local subsidy for the federal government.

B. Treat local public or quasi-public funds as state Medicaid matching funds.

There are two ways to transform local governmental or quasi-governmental dollars into state funds so that they can qualify for federal Medicaid match:

1. *Transferring the dollars to the state government*. This is known as an intergovernmental transfer, or IGT. Once the funds are transferred, the state can use them to fund Medicaid.
2. *Certifying to CMS that local governmental or quasi-governmental expenditures have been incurred for medical expenditures that qualify for federal match.* These funds are known as certified public expenditures, or CPEs. They differ from IGTs in that the funds are spent by the local entity but counted as qualifying Medicaid expenditures by the state, whereas IGTs involve funds that are not spent for Medicaid purposes until they are transferred to the state.

[4] Note that this strategy simply subjects formerly exempt hospitals to the same taxes that other businesses or property owners pay. Because the taxes are not unique to particular categories of health care providers, they do not qualify as health care-related taxes, and are not subject to the special federal regulatory restrictions, discussed below, that apply to health care-related taxes.

Under 42 U.S.C. §§ 1396b(w)(6)(A), federal regulations cannot limit a state's use of IGTs or the amount of such funds that can be used to draw down federal Medicaid matching revenues. The same statute prevents CMS from limiting the amount of CPEs that a state can claim or that will qualify for federal Medicaid reimbursement.

Federal regulations, 42 C.F.R. § 431.51, allow states to define "public agencies" as not just local government entities, like public hospitals or hospital districts, but ostensibly private health care providers that are not governmental in nature, but have a public-oriented mission. This includes, for example, not-for-profit hospitals run by quasi-governmental boards.[5]

It is far more valuable to treat local public funds as an IGT than as a CPE. If transferred to the state as an IGT the resulting federal match is a ***multiple*** of the local fund amount. By contrast, if treated as a CPE, the resulting federal match is only a ***fractio*n** of the local fund amount.

Example:

Indiana's FMAP is 66.52%, or almost exactly two thirds, which makes it easy to use as a hypothetical. Assume that Marion County (Indianapolis) appropriates $1 million to the local public hospital authority that serves, among others, indigent patients and Medicaid beneficiaries:

- If Indiana counts Marion County's $1 million as a CPE, that amount is deemed to be a state Medicaid expenditure. The federal government reimburses the state at Indiana's FMAP rate, which means that <u>the $1 million, if treated as CPE, generates $665,200 in federal funds</u>.

  OR

- If the county transfers the $1 million to the State of Indiana as an IGT, Indiana can use the money to pay the state share – one third, in Indiana's case – of Medicaid costs. If the state spends the $1 million in IGT on Medicaid, the federal government will pay the other two thirds. That means <u>the $1 million, if treated as IGT, generates $2 million in federal funds</u>.

Although it is much more financially advantageous to use local funds for IGTs than to treat them as CPEs, there are two reasons why states nonetheless count them as CPEs:

- As CPEs, the funds need not be transferred out of local government control. A CPE is a passive accounting device in which the state, after the fact, gets to claim local agency expenses as its own. The local agency does not need to do anything differently from what it would have done anyway, it costs local government

[5] The regulation is consistent with 42 U.S.C. § 1396b(w)(7)(G), which recognizes the right of states to define what constitutes a "unit of local government" capable of generating CPEs or IGTs.

nothing, and the only state officials who have to do any extra work are the accountants.

By contrast, IGTs involve an actual transfer to the state, which in turn requires the state to adjust its other financial dealings with the agency to compensate the local agency for the transfer. The local agency has to trust the state to make it whole. Political and personal factors can make such trust difficult to come by.

Although these political and technical considerations are real, there is no legitimate reason – given the seriousness of the budget crisis – why state and local officials should not be able to overcome these obstacles to converting such CPEs into IGTs.

- A more justifiable reason to use CPEs is to enable the state to claim credit for certain non-cash items. These include the county hospital's depreciation expense, allowable indirect cost or overhead, and allowable Medicaid share of charity care. These are expenses that cannot be captured by local government and re-appropriated to the state. The only way to get credit for these types of expenses is to treat them as CPEs.

C. Impose provider taxes, fees and assessments

During a time when elected officials and the public strongly oppose raising taxes, there is one tax that is still politically feasible, because it can elicit the support – or, at least, the acquiescence – of those who will pay the tax. That is a tax on Medicaid providers, the revenues from which are used to fund the Medicaid program.[6]

During the 1990s, there were continuing disagreements between the states and federal government about whether states should be able to use provider taxes to match federal Medicaid funds. Federal regulations now explicitly authorize the use of health care-related taxes for that purpose, subject to certain conditions and dollar limits. 42 C.F.R. § 433.68.

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[6] President Obama is proposing to phase down the ceiling on matchable health care-related taxes, but not until FY 2015. The HHS Budget in Brief publication [http://www.hhs.gov/about/FY2012budget/fy2012bib.pdf] summarizing the health provisions of the President's FY 2012 budget, released February 14, 2011, contains the following statement at page 63:

Medicaid: Use of Provider Taxes to Pay State Share of Medicaid:

Limit States' ability to use provider taxes to pay the State share of Medicaid by phasing down the Medicaid provider tax threshold from the current law level of 6 percent in FY 2014, to 4.5 percent in FY 2015, 4 percent in FY 2016, and 3.5 percent in FY 2017 and beyond. Restricting the use of provider taxes was recommended by the National Commission on Fiscal Responsibility and Reform. [Effective FY 2015]

In order to be able to match the revenues from a health care-related tax:

- The tax must be "broad-based."
- The tax must be uniformly imposed throughout the jurisdiction;
- The tax program must not violate federal "hold harmless" prohibitions designed to prevent states from guaranteeing providers that they will get back any money they pay in taxes.

The hold harmless regulation provides a "safe harbor" for health care related taxes that do not exceed a specified percentage of a provider's net operating revenues. The safe harbor provision effectively places a ceiling on the amount of the tax that will be matched. That amount is 5.5% (rising to 6% after September 30, 2011) of the providers' net operating revenues. 42 C.F.R. 433.68(f)(3)(i)(A).[7]

Federal regulations categorize health services into different classes. 42 C.F.R. § 433.56. A state can target a tax at one or more of the classes; each such tax will be analyzed separately for its compliance with § 433.68.

- Inpatient hospital services
- Outpatient hospital services
- Nursing facility services
- Intermediate care facility services for the mentally retarded (ICF/MR)[8]
- Physician services
- Home health care services
- Outpatient prescription drugs
- Managed care organizations (including HMOs and preferred provider organizations)
- Ambulatory surgical centers (only the facilities' services, not the surgeries performed in them)
- Dental services

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[7] Net operating revenue means gross charges of facilities less any deducted amounts for bad debts, charity care and payer discounts. 42. C.F.R. § 433.68(d)(a)(iii). In effect, it is all revenues actually collected by the provider. At 5.5 or 6% of net operating revenues, a provider tax on hospitals, nursing homes or outpatient prescription drugs will generate large amounts of revenue.

[8] The regulation also includes in this class home and community-based services (HCBS) for people with intellectual disabilities. Taxes on HCBS for people with intellectual disabilities are subject to special restrictions that foreclose a tax on those services, however, in most states. See 73 *Federal Register* 9685, 9689 (February 22, 2008), http://edocket.access.gpo.gov/2008/pdf/E8-3207.pdf.

- Podiatry services
- Chiropractic services
- Optometric/optician services
- Psychological services
- Therapist services
- Nursing services
- Lab and X-ray services
- Emergency ambulance services

The fact that different provider interest groups are classified separately enables a state to be selective about which services it taxes. That flexibility is politically helpful, as discussed below.

The Kaiser Commission on Medicaid and the Uninsured published a September 2010 50-state survey that found that in 2011, 47 states (all but Alaska, Hawaii, and Wyoming) will rely on revenues from provider taxes to help fund their programs. 34 states have hospital taxes, 34 states have ICF/MR taxes, 38 states have nursing facility taxes, and 11 states tax managed care organizations. 15 states tax other provider categories, such as pharmacies.[9] The National Council of Legislatures (NCSL) has posted similar data more recently at its website.[10] Although almost all states currently use some form of provider tax, few make full use of this revenue mechanism.[11]

IV. Political and Technical Constraints

The challenge for any strategy that involves an actual transfer of funds to the state – IGTs, taxes, assessments in lieu of taxes – is how to make the arrangement work for key stakeholders.[12] In essence, if local governments or health care providers transfer funds or

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[9] V. Smith, et al., "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011" (September 2010), posted at http://www.healthmanagement.com/files/Hoping%20for%20Economic%20Recovery,%20Preparing%20for%20Health%20Reform.pdf, at page 77, Appendix A-3.

[10] NCSL, "Health Care Provider and Industry Taxes and Fees" (February 2011), posted at: http://www.ncsl.org/default.aspx?tabid=14359.

[11] Even those states that have been the most active in developing health care-related taxes continue to lose available Medicaid match by exempting providers from taxes of general application.

[12] CPEs do not require a transfer of control of funds to the state and therefore do not have these challenges.

make payments to state government to support the Medicaid program, how can they be made whole. Federal regulations permit states to fashion some arrangements that achieve that purpose while outlawing others.

A. Designing provider payments to mitigate health care-related tax burdens

A basic principle regarding health care-related taxes is that the state cannot create an arrangement though which taxpayers are held harmless for the amount of taxes paid. 42 C.F.R. § 433.68(f). The regulation defines prohibited "hold harmless" arrangements in a very specific manner. The regulation bars state policies that return funds to health care-related taxpayers based explicitly on the amount of taxes paid.

On the other hand, states have substantial flexibility in how they set rates for providers. For example, in the case of hospitals, states not only pay for services provided to Medicaid beneficiaries. A state Medicaid program also pays additional subsidies, known as "disproportionate share hospital", or DSH, payments, to hospitals that serve a disproportionate number of Medicaid or low-income patients. 42 C.F.R. Part 447, Subpart E. These are hospital-specific payments and, although payments must be set according to a uniformly applied formula, the formula can be adjusted so that its application favors some hospitals more than others.

States have discretion to make yet another set of targeted payments, known as "graduate medical education" or "GME" payments, to hospitals that host medical residency programs. These Medicaid payments, which apply Medicare rules to the calculation of payment amounts, include both direct GME and indirect ("IME") medical education expenses. See 42 C.F.R. Part 413, Subpart F and 42 C.F.R. § 412.105. Such payments can reach a surprisingly large industry subgroup that includes many more institutions than those that are academic centers.

In an illustration of the potential interplay of these different provisions, some states have designed health care-related taxes to impose a heavier tax burden on safety net hospitals that serve large numbers of Medicaid and low-income patients. In those states, providers that serve relatively few Medicaid patients pay a smaller tax. The safety net hospitals can bear the heavier tax burden, because the state's DSH and GME payments to those hospitals offset the amount of the taxes. The state thus adjusts the tax and the targeted Medicaid payments so that most hospitals bear little or no net burden. The "hold harmless" prohibition does not permit the state to guarantee that every hospital will be reimbursed the amount of the taxes it pays. But it can protect the great majority of providers and so reduce the effective burden on the industry as a whole. That is critical to gaining the industry's support for, or at least acceptance of, the tax. Provider taxes in California and Colorado that have recently received federal approval can serve as helpful models for other states.[13]

[13] See description of the California hospital assessment posted at:

In addition to these different types of payments that are governed by the federal regulations, states can fashion other categories of payments, develop a formula for calculating the payments, and incorporate that formula into the hospital payment methodology described in the state Medicaid plan. The Medicaid Act gives states latitude to define in their State Medicaid Plan a payment methodology that produces payments consistent with efficiency, economy and quality of care. 42 U.S.C. § 1396a(a)(30). Illinois, for example, has done just that by providing for supplemental payments to hospitals. In contrast to DSH, which is subject to regulatory definitions of charity care and other limits, the Illinois State Plan Amendment has a state prescribed definition of charity care which is used to calculate supplemental payments. In addition to giving the state more flexibility, such special payments have the advantage that they are not subject to being reduced as the ACA takes effect, which is what will happen to federal matching for DSH payments.[14]

An important regulatory constraint on these arrangements is the "upper payment limit" or "UPL" regulation, 42 C.F.R. Part 447, Subpart F. Under this regulation, a state's aggregate payments to hospitals, other than DSH payments,[15] cannot exceed the amount that Medicare would pay for the services. The UPL can limit the ability of states to make targeted payments (e.g., GME payments) that are large enough to offset the burden of provider taxes. The UPL can have that effect if the targeted payments, when added to all other Medicaid reimbursements to hospitals within the same category, exceed the aggregate upper limit imposed by the regulations. The design of a health care-related tax and associated reimbursement policies must take the UPL and other regulations into account in order to make sure the tax revenues qualify to draw down federal Medicaid matching revenues.

(It is important to remember, though, that the UPL is an aggregate limit that is calculated separately for each of three categories of hospitals. States therefore have the

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http://www.mossadams.com/publications/documents/healthcare/Advisory_California%20Hospital%20Program-101310.pdf

The Colorado tax is described at:
http://www.ncsl.org/portals/1/documents/health/COArticle810.pdf
and the CMS approval letter is posted at:
http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-Disposition&blobheadername2=MDT-Type&blobheadervalue1=inline%3B+filename%3D439%2F471%2FColorado+Tax+Waiver+Approval+Letter.pdf&blobheadervalue2=abinary%3B+charset%3DUTF-8&blobkey=id&blobtable=MungoBlobs&blobwhere=1251624798329&ssbinary=true

[14] J.Holahan and S. Dorn, "What is the Impact of the Patient Protection and Affordable Care Act (PPACA) on the States?", Robert Wood Johnson Foundation (June 2010), p. 3; http://www.rwjf.org/files/research/65049.pdf.

[15] DSH payments are excluded from the application of the UPL but are specifically subject to other limits. See 42 C.F.R. § 447.272(c)(2)) and 42 U.S.C. § 1396r-4.

flexibility to exceed the UPL for some hospitals, so long as payments to other hospitals within the same category are low enough to keep the total of payments below the category-wide limit.)[16]

B. Political factors

The willingness of local governments or health care providers to transfer revenues or pay taxes to sustain Medicaid will depend on perceptions of how they will otherwise fare. Providers that have little Medicaid business and therefore little stake in sustaining the program are likely to oppose the imposition of any health care-related tax or the reduction of their exemption from generally applicable taxes. Local governments that have a history of conflict with state government may distrust state officials too much to be willing to participate in intergovernmental transfers. On the other hand, Medicaid providers and local governments that depend on substantial state funding (whether via Medicaid payments to local public providers or otherwise) will likely be able to see the value of protecting Medicaid.

A silver lining in the states' current budgetary crises is that most Medicaid stakeholders understand that the states' budget problems are real and serious, and they realize those problems put the stakeholders' Medicaid revenues at risk. The threat of catastrophe can foster an openness to federal Medicaid maximization proposals that, in better times, would not receive a moment's consideration.

V. Developing a strategy

A comprehensive approach to maximizing a state's federal Medicaid revenues involves the following actions.

A. Impose health care-related taxes. – *Do this first*, because it requires legislative action that may be subject to imminent deadlines, requires lead time to engage more stakeholders and policy makers, and has the potential to produce the largest revenues. (If your state is one of the few that has almost maxed out its ability to use health care-related taxes, look at opportunities to adjust policies, like tax exemptions for health care providers, that indirectly subsidize the federal government. See p. 14, below.)

1. Look at the different categories of health care providers recognized by 42 C.F.R. § 433.56 and listed on page 8, above. Each category can potentially be the subject of a separate health care-related tax. Compare those categories to the lists of health care-related taxes already in effect in your state.[17] Do an informal cost-benefit analysis to

[16] The three categories are: state government-owned or operated facilities; government-owned or operated facilities that are neither owned or operated by the state; and privately-owned and operated facilities. 42 C.F.R. §§ 447.272 and 447.321.

[17] See the Kaiser Commission or National Council of State Legislatures references on p. 9, above.

determine whether the political "costs" (including delays and uncertainty of outcome) of pursuing a tax on a new category are outweighed by the amount of revenues generated. Follow the Willy Sutton Principle ("I rob banks, because that's where they keep the money") by going after those categories whose collective revenues are large enough to generate significant tax receipts for the state. Focus on providers that have a sufficient stake in Medicaid, and that understand that they do, to recognize that they are at risk unless they take steps to keep the program from being cut. Prime examples are hospitals, nursing homes and pharmacies.

Ambulance providers are another likely category because, although they would not generate as large revenues as institutional providers, they have a substantial Medicaid patient load, and many may be governmental or quasi-governmental agencies (facilitating the use of either IGTs or health care-related taxes).

The National Conference of State Legislatures' survey of states' health care-related taxes, cited at page 9, is a useful aid in discussing tax options with Medicaid stakeholders and state officials. In almost any state, it is possible to point to other jurisdictions that are using health care-related taxes that are not being tapped in that state.

> **QUICK TIP:** If your state already has a health care-related tax, make sure state officials are aware that the ceiling on the rate at which the tax can qualify for federal match increases from 5.5% to 6.0% of a provider's net operating revenue on October 1, 2011. The state should make sure it adjusts the tax rate to capture the additional match. 42 C.F.R. 433.68(f)(3)(i)(A).[1]

2. State officials need not – and in some anti-tax states probably should not – propose a health care-related tax. To the extent that budget pressures require them to propose cuts in Medicaid, they should focus any cuts on Medicaid services or payments affecting those provider categories that are the most promising objects of a health care-related tax. Again, the Willy Sutton Principle should guide their decisions, giving priority to those providers that are large enough to generate substantial tax revenues.[18] The proposals should be presented in a manner that does not mask or minimize the harm that will result if they are implemented. Officials can candidly express their regrets and acknowledge how harmful the cuts will be, but honestly state

[18] State officials may find that approach counter-intuitive. In efforts to do as little harm as possible, some officials propose cutting optional services like hearing aids, eyeglasses or hospice services, while sparing "core services" like hospital care. Providers affected by such proposals cannot generate significant amounts of health care-related taxes and typically lack the political sophistication to put together a revenue proposal to forestall the cuts. Such proposals do not generate the same sense of urgency as cuts to hospitals or nursing homes, but they in fact cause significant harm to vulnerable beneficiaries. They are more likely to actually take effect, because they do not generate alternative revenue solutions, in contrast to proposals to cut larger providers capable of averting the reductions.

that they are unable to spend money the state does not have. The point is to frame the crisis in a way that highlights the harmful realities, and that leaves it to the providers themselves to propose the imposition of a tax.

If a provider group expresses interest in paying a health care-related tax, state officials should work with them by providing the technical information needed to assess the impact of various policy alternatives.

3. Educate the public, which is likely opposed to new taxes, on the costs of cutting Medicaid. The point should be made that every state dollar "saved" by cutting Medicaid costs an additional X dollars (depending on the state's FMAP) in federal dollars. Such "savings" are punishing in their impact on the sick, the state's health care infrastructure, its economy and on jobs. This message supports the framing of a Medicaid maximization strategy as a means of drawing all federal funds that are available to the state. To quantify the impact of cuts (or, conversely, Medicaid expenditures), go to the Families USA Medicaid calculator at: http://www.familiesusa.org/issues/medicaid/other/medicaid-calculator/medicaid-calculator-states-map.html.

B. Capture all current spending by state and local government that could qualify as CPEs or be redirected as IGTs. – This may be easier to accomplish because it probably does not require legislative approval or as broad support as health care-related taxes. These mechanisms do not generate as much revenue as provider taxes, however.

1. Search all state spending to identify non-Medicaid programs that now pay with entirely state funds for goods or services that could qualify for Medicaid reimbursement. Discontinue those programs, redirect the state funding into the Medicaid budget and make sure that Medicaid now covers the services that were previously covered by the state program.
2. Search all local government spending for health expenditures that could qualify as certified public expenditures.
    - If the expenditures involve "hard" spending of appropriated local government funds, convert them to IGTs by transferring the funds to the state government for Medicaid purposes. Use Medicaid to pay for the services that were formerly funded with the local funds that have now been transferred to the state. If necessary to provide assurances that the transferred funds will in fact be used for Medicaid, create a trust fund or otherwise enact state legal restrictions guaranteeing their use for that purpose.
    - If the expenditures are "soft" spending, such as unreimbursed bad debt at the county owned hospital or nursing home, audit the amounts so that they can be counted as certified public expenditures eligible for partial federal Medicaid reimbursement.

C. Eliminate indirect state and local subsidies going to the federal Medicaid budget. – This requires legislative action and broad provider support but has the potential for generating substantial revenues. It will be more politically feasible and financially necessary in those states that have already made maximum use of health care-related taxes. (If your state still has opportunities to raise substantial revenues from health care-related taxes, you should focus on those opportunities first.)

Identify state and local tax expenditures that currently benefit health care providers, such as exemptions from generally applicable property, business or sales taxes. Because these are taxes of general application, the revocation of these exemptions, and the use of any resulting tax revenues for Medicaid, are not subject to the federal regulatory restrictions on health-care related taxes. The state therefore has more latitude in adjusting Medicaid payment policies to offset the impact of the taxes.[19] And revenues from these sources will be unaffected by the phase-down of federal Medicaid match for health care-related taxes, proposed to begin in FY 2015.

[19] Charging providers' taxes of general application or fees-in-lieu-of-taxes actually increases the state's flexibility in designing health care related taxes that are subject to the federal regulations. Such generally applicable taxes or fees in lieu thereof become part of the providers' cost structure under Medicare cost accounting principles. Those new costs increase the upper payment limit for that category of providers, thereby giving the state more flexibility to increase their Medicaid payments to offset the impact of health care-related taxes.

Another variant is to leave the exemptions in place but collect fees in lieu of taxes for the public service the providers use, such as fire and police protection, ambulance service, etc. Such fees should not exceed the reasonable value of the services, net of any taxes the provider already pays that support the services.

VI. Framing the Message and Addressing Possible Objections

The perception among some in Washington is that state optimization of federal Medicaid revenues is somehow illegitimate gamesmanship. It is unfair, however, to fault states for making use of funding opportunities established by federal law. To do otherwise leaves the states in the position of subsidizing the federal government during a period when the states have budget crises of their own. Framing the message in terms of elimination of state subsidies for the federal Medicaid budget is a way of appealing across the partisan and ideological spectrum.

A variety of possible objections can be anticipated from different quarters. The proposal may need to be adjusted to address those objections:

- With respect to objections by those concerned about adding to the federal deficit, it is important to acknowledge that concern but note that the state is in no position to solve a problem that is of the federal government's making and that will require the federal government to solve.
- To preclude arguments that a health care-related tax is a "sick tax" that will increase the medical bills of paying patients, include a provision prohibiting providers from passing along the tax to consumers. If the tax is mitigated by offsetting Medicaid payments, this is a sensible safeguard, since a provider would have no basis in fact for blaming increased charges on the tax.
- To assure providers or local governments that taxes paid or funds transferred to the state will be used for Medicaid purposes, create a "trust fund" or impose similar legal restrictions limiting the use of the revenues to Medicaid only.
- Another way to reassure providers and budget hawks is to include a sunset provision in any tax measure, so that the tax law is temporary and expires on a specified date. That will give providers some assurance that the state will use the revenues as promised, since officials know that the providers can block the renewal or extension of the tax if the state fails to honor its commitments. Budget hawks who are skeptical of *any* new revenue measures have an assurance that the measure is only a temporary response to the extraordinary budget crisis caused by the Great Recession.

  Even if the state does not include a sunset provision, it is worth noting to skeptics that the Obama Administration has proposed to phase down the states' ability to use health care-related taxes after 2014 to leverage federal revenues.[20] This may make it easier to sell policy makers and stakeholders on the use of provider taxes as a temporary stopgap.

[20] See n. 6, above.