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Patching the Patchwork Quilt: "Reforming" the Medicaid Program—The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

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Last November, Congress passed arguably the most significant modifications to the Medicaid program since that program's inception in 1965. The legislation grew out of a dispute between the states and the federal government over the manner in which states fund their portion of the Medicaid program. The new law, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 ("the Act"),[1] places restrictions on states' sources of funding for the non-federal share of Medicaid expenditures, caps payments to hospitals serving large numbers of Medicaid and low-income patients (so-called disproportionate share hospitals), and radically alters the relationship between the states and the federal government. This article will review the circumstances leading up to this important legislation, examine the provisions of the Act, discuss the many unanswered questions the legislation poses, and reach the conclusion that the legislation fails to address the structural problems that led to the dispute between the states and the federal government.

States Find New Sources of Medicaid Funding

Congress enacted Medicaid[2] Title XIX of the Social Security Act in 1965 to insure access to health care by the poor. Under the terms of participation in Medicaid, states make expenditures to furnish medical assistance to needy individuals, and the federal government reimburses the states for a portion of this cost. The

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1. Pub. L. No. 102-234, 105 Stat. 1793 (codified in scattered sections of 42 U.S.C.A. §§ 1396a & 1396b) [hereinafter "the Act"].

2. Pub. L. No. 89-97, 79 Stat. 286, 343 (codified as amended in scattered sections of 42 U.S.C.A.).

federal government pays between 50 and 83 percent of states' actual costs in providing care to the indigent. (The exact percentage depends upon a state's per capita income.) State and local governments pay the rest.[3] The federal contribution is known as "federal financial participation" or "FFP."

In what was later to become an ironic twist, the Health Care Financing Administration ("HCFA"), the agency responsible for administering the Medicaid program, created the circumstances that led to the eventual passage of last year's legislation. On November 12, 1985, HCFA adopted final regulations that specify which fund sources would be considered state fund sources for purposes of determining federal matching payments.[4] Prior to the final rule, HCFA had allowed states to finance their share of training expenditures through donations to the Medicaid program from hospitals and other providers of health care. Provider donations, however, could not fund other Medicaid expenditures. The November 12, 1985, rule revised this restriction "to permit public and private donations to be used as a State's share of financial participation in the entire Medicaid program."[5] States were now unconstrained in their utilization of provider donations; they lost little time in taking advantage of the more lenient HCFA policy to relieve the increasingly heavy burden of financing their Medicaid programs. This led immediately to controversy and litigation.

In the fall of 1986, the State of West Virginia found itself in a precarious budgetary situation. Facing approximately $44 million in unpaid claims by West Virginia hospitals for services rendered to Medicaid beneficiaries, state officials met with hospital representatives to seek a way out of the budget crisis. At some point in these discussions, it was suggested that the hospitals donate funds to the state's Indigent Care Fund. State officials explained that these donations would be matched with federal dollars, and the funds then would be distributed to the hospitals. In November, 1986, hospitals began making donations, which, according to HCFA, were "based on each hospital's level of outstanding net Medicaid receivables."[6] By the end of January, 1987, 62 hospitals in West Virginia had contributed approximately $22 million to the Indigent Care Fund, which was used to generate over $60 million

3. These payments are referred to as the non-federal share or, not quite accurately, the state share.

4. 50 Fed. Reg. 46,652 (1985) (codified at 42 C.F.R. § 432 (1990)).

5. *Id.*

6. Docket Nos. 87-64 and 87-126, Decision No. 956 (H.H.S. Departmental Grant Appeals Board, W. Va. Department, May 19, 1988).

in federal matching payments. The following year, HCFA issued two separate disallowances totaling almost $60 million. HCFA concluded that the hospital donations failed to "meet the regulatory definition of donated funds which may constitute the state share eligible for federal matching."[7]

The State of West Virginia appealed the disallowances first to the Grant Appeals Board ("GAB") of the Department of Health and Human Services ("HHS") and, ultimately, to the federal court. The GAB agreed with HCFA that the transferred funds did not qualify as donations since the funds had not been "donated under the commonly accepted meaning of the term,"[8] concluding that the donations operated as a "discount in claims." The GAB reduced the claims by the $22 million in donations and recalculated the federal matching payments, upholding $16 million of the disallowance.

The United States District Court for the Southern District of West Virginia reversed the Board's finding, concluding that in applying the "commonly accepted meaning of donation," the Board had impermissibly revised HCFA's regulation.[9] The Court of Appeals for the Fourth Circuit later affirmed the District Court's judgment.[10]

At about the same time that HCFA challenged West Virginia's funding mechanism, it also sought to disallow matching funds for provider donations in Tennessee. Based upon the GAB's theory in the West Virginia case, HCFA found that the donated funds constituted a discount in claims and issued a disallowance totalling $16.5 million. The GAB, however, declined to follow its West Virginia precedent. "[T]he circumstances here are clearly distinguishable from those considered in *West Virginia*. The transactions here meet HCFA's regulation on its face."[11] The Board went on to note that "HCFA may have had second thoughts about the wisdom of the regulation; we, of course, are bound by it."[12]

Indeed, HCFA was having serious second thoughts about the

7. *Id.*

8. *Id.* at 1.

9. Lipscomb v. Bowen, 750 F. Supp. 197 (S.D. W.Va. 1989), *aff'd sub nom.* Miller v. Hartman, 911 F.2d 723 (4th Cir. 1990).

10. Miller v. Hartman, 911 F.2d 723 (4th Cir. 1990) (unpublished opinion, No. CA 87-333-2 (S.D. W.Va. June 28, 1989)).

11. Docket Nos. 88-137, 88-194, and 89-32, Decision No. 1047 (H.H.S. Departmental Appeals Board, Tenn. Department, May 4, 1989) at 2. Apparently, the fact that the Tennessee hospital did not face massive unpaid Medicaid claims distinguished the two cases.

12. *Id.*

wisdom of its rule. As more and more states sought federal matching funds for provider donations and for taxes applied only to providers, HCFA sought to revise its rule. On February 9, 1990, HCFA issued proposed regulations designed to discontinue federal matching of provider funds. In the summary explaining the change in policy, HCFA stated:

> Due to recent program experience indicating the potential for use of these revenues to affect unfairly the Federal share of Medicaid expenditures, we are proposing to clarify the existing policy on the use of donated funds by requiring the offset of revenues received from donations from expenditures used to calculate the Federal share of Medicaid payments. We are also proposing a new policy providing for similar treatment of revenues derived from taxes applied uniquely to providers.[13]

In justifying the proposed rule, HCFA cited the West Virginia GAB and district court opinions.

Congress, however, was not prepared for such a change in policy. In the Omnibus Budget Reconciliation Act of 1989 ("OBRA 1989"),[14] Congress imposed a one-year moratorium on rule making by HCFA with respect to voluntary contributions and provider taxes. The following year, in the Omnibus Budget Reconciliation Act of 1990 ("OBRA 1990"),[15] Congress extended the moratorium on rule making through December 31, 1991. At the same time, Congress took even stronger action to protect states' ability to fund their state Medicaid program through taxes applied uniquely to providers: nothing in this title "shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes of general applicability imposed with respect to the provision of such items or services."[16] The provision on its face seemed to prohibit HCFA from restricting in any way federal matching payments for taxes levied on providers.

On October 31, 1991, HCFA published an interim final regulation creatively construing the language of OBRA'90; the rule opposed broad restrictions on federal matching payments for provider taxes.[17] Not surprisingly, the rule also provided for the

13. 55 Fed. Reg. 4626 (1990) (to be codified at 42 C.F.R. § 433).

14. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (codified as amended in scattered sections of U.S.C.A.).

15. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (codified as amended in scattered sections of U.S.C.A.).

16. 42 U.S.C.A. § 1396a(t) (West Supp. 1992).

17. The departure in policy was actually announced on September 12, 1991, with the publication of an interim final regulation in the Federal Register. The September 12th

elimination of federal matching payments for provider donations at the expiration of the Congressionally imposed moratorium on January 1, 1992.

Contrary to the clear language of OBRA 1990, the interim final rule gave HCFA sweeping authority to deny FFP to states utilizing provider taxes to fund their Medicaid programs. Under the terms of the rule, FFP would be denied where a provider was "reimbursed" for the cost of a provider-specific tax. The rule explained that HCFA would deem a provider "reimbursed" when a "cost-reimbursed provider includes the cost of the tax on its cost report as an allowable cost" or when a "provider paid on a prospective basis includes the cost of the tax in its base year costs for payment rate calculation" or when "[t]here is *linkage* between payment to the provider and the tax program."[18]

The rule then proceeded to define the term "linkage" in such a way as to give HCFA discretion to disallow FFP for provider-specific taxes in virtually all cases.

> [L]inkage is deemed to exist where any of the following conditions is met:
> - The payment to the provider paying the tax is *related* integrally to the tax program. Examples of this integral relation would be the dedicated use of the tax revenue in a special fund or account to be used to enhance Medicaid payments from the State to the provider paying the tax, or statements of legislative purpose in State enabling legislation or other legislative history or evidence establishing a linkage between the tax and Medicaid payments to the provider paying the tax.
> - A provider is "held harmless" for its tax payment by an effective guarantee that its enhanced Medicaid payment from the State will at least cover the cost of the tax.
> - The provider's tax payment is *correlated significantly* to the State's Medicaid reimbursement or payment (including, for example, disproportionate share hospital adjustments) to the provider.[19]

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rule was then withdrawn and replaced with the October 31st version. "Because of misunderstandings created by certain portions of [the September 12 rule], we [HCFA] are publishing this interim final rule to withdraw and cancel it and to set forth a clearer interim final rule on donations and taxes." 56 Fed. Reg. 56,132 (1991). It is arguable whether the replacement rule is clearer than the original.

18. *Id.* at 56,137 (emphasis added).

19. *Id.* (emphasis added). Federal law requires states to make additional payments to hospitals providing care to a disproportionate number of Medicaid and low income patients. 42 U.S.C.A. § 1396r-4 (West 1992 & Supp. 1992). States had been slow to comply with this requirement, originally enacted in 1981. Many states used provider donations and taxes as a way of financing these payments.

As is obvious from the language of the rule, HCFA reserved for itself virtually unlimited discretion to review state Medicaid funding sources and deny FFP for provider-specific taxes it found objectionable. HCFA did this all under the guise of interpreting federal legislation designed to limit its intrusions into states' funding of their Medicaid program.[20]

The rule confirmed the worst fears of the states and intensified a several-month-old game of "legislative chicken" between the states and the Bush Administration.[21] The Administration intensified its public relations efforts, branding states' programs as "scams and schemes."[22] At the same time, the Administration also skillfully utilized (manipulated) all of the budget tools at its disposal. OMB redefined the budget baseline to include the proposed intermin final rule. Thus, according to OMB, any Congressional legislative action would be "scored" as a potential cost item. This dampened Congress' desire to act since they would have to find offsetting budget reductions in the Medicaid and Medicare programs.

Congressman Henry Waxman (D-CA) quickly moved to introduce and mark-up legislation delaying the October 31st rule. The legislation extended the moratorium on HCFA rule making through September 30, 1992, and required the Secretary of Health

20. On the same day, HCFA also published a proposed rule limiting states' flexibility in designating facilities as disproportionate share hospitals. The rule proposed to allow states to designate as disproportionate share facilities *only* those hospitals with either a (1) "Medicaid utilization percentage at or above the Statewide Medicaid utilization rate arithmetic mean;" or (2) "low income utilization rate at or above the Statewide arithmetic mean low income utilization rate." 56 Fed. Reg. at 56,142 (1991). As justification for this rule, HCFA stated:

> At present, 38 States are either using, or planning to use, donation and tax programs to obtain additional Federal funds. The most common form these programs take is that States use hospital tax and donation revenues as the State share of Medicaid expenditures to secure additional Federal funds. The provider tax amount is usually returned in the form of disproportionate share payments. States use the disproportionate share payments as the vehicle because they are not subject to Medicare upper limits, and current policy permits flexibility in how these payments are made. Therefore, States find it easy to structure payment formulas that can repay providers for their tax costs. Moreover, by having expanded criteria for qualifying as a disproportionate share hospital, States can use the rubric of disproportionate share hospital payments to repay all hospitals in the State for participating in the tax and donation programs.

Id.

21. A draft of the interim final rules had been leaked in late July and, not unexpectedly, it created panic among the states. Pressure on the White House, the Office of Management and Budget ("OMB"), and HCFA was already intense by the time the first version of the rule was published on September 12, 1991.

22. According to Administration officials, approximately 38 states had in place donations or tax programs at the time of these negotiations. Estimates of the federal payments required to match donations and taxes varied wildly, from $5.5 to $12 billion.

and Human Services to report to Congress, no later than February 3, 1992, regarding any intended regulation or legislation dealing with provider-specific taxes. On November 19, 1991, the House passed the legislation by an overwhelming margin.

Tension mounted as the Congressional session neared its close. The Administration issued a threat or promise to veto the Waxman legislation and sharpened its rhetoric against states' programs. The Administration publicly characterized as unacceptable a "one-sided" moratorium that prevented HCFA from issuing rules, but that allowed states to implement or expand donation and tax programs. The Administration also reiterated its intention to implement the October 31st regulation.

Negotiations between the Administration and the National Governors' Association ("NGA") intensified,[23] as did discussions between the Administration and Senator Lloyd Bentsen (D-TX), Chairman of the Senate Finance Committee. The pressure to compromise and avoid implementation of the October 31st rule was intense. The day following the House vote, the Senate Finance Committee reported legislation to the floor; it gutted the Waxman legislation and replaced it with a "dual" moratorium, seeking to lock the status quo in place. The legislation extended the moratorium on HCFA regulations to April 1, 1992. The Finance Committee version also created a moratorium on HCFA regulations regarding payments to, or designation of, disproportionate share hospitals. At the same time, it froze states' use of provider donations and taxes, and froze in place states' designation of, and payment levels for, disproportionate share hospitals. For obvious reasons, those states without provider donation and tax programs opposed the "dual" moratorium.

Meanwhile, fearing that the Administration would simply implement its October 31st rule, thereby eliminating providers as a source of Medicaid funds, NGA staff agreed to compromise with the Administration. Under Administration pressure, the Finance Committee agreed to report, in addition to its substitute legislation, the Administration/NGA "compromise" without recommendation. This action was taken notwithstanding the fact that the negotiators had not reached final agreement and legislative language embodying those principles upon which there was agreement had not been fully drafted. Over the weekend of November 23rd, staff

23. For a discussion of the states' perspective on the negotiations, see Alicia Pelrine, *The Art of the Deal: Health Policy Making on the Fly*, 2 J. AM. HEALTH POL'Y, May-June 1992, at 23.

worked feverishly to complete the compromise legislation. At the same time, NGA staff and its Executive Committee worked to convince the governors that this was the only viable alternative to the October 31st regulations. The Administration met around the clock with key senators, crafting language to protect, at least in the short term, existing donation and tax programs and garner needed political support. On November 26, the Senate, by voice vote, passed the Administration/NGA compromise legislation. The following day, House and Senate conferees, with only minor modifications, agreed to the Senate version of the legislation. On the last day of the session, both the house and senate quickly approved the conference report. Two weeks later, with the President's signature, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991[24] became law.

A Complex Solution to an Ambiguous Problem

The final legislation is sweeping in scope and complex in its resolution of the disagreement between the states and the federal government. The legislation nullifies HCFA's October 31st interim final rule, and in its place imposes limits on the amount and type of provider taxes that will qualify for federal matching payments. Equally significant, the legislation establishes a national limit on payment adjustments to disproportionate share hospitals. Finally, it eliminates federal matching payments for all but selected provider donations.

Provider Taxes

By far the most complicated provisions of the Act deal with federal matching payments for provider-specific taxes, or, in the language of the Act, "health care related taxes." Federal matching payments are available for provider-specific taxes only if the tax is uniform, broad-based, and does not hold providers harmless for the costs of the tax. The phrase "health care related tax" is defined very broadly. It includes "any licensing fee, assessment or other mandatory payment"[25] that "is related to health care items or services, or to the provision of, the authority to provide, or payment for [the health care] items or services."[26] For taxes not limited to health care providers, a tax is considered to be a health care related

24. Pub. L. No. 102-234, 105 Stat. 1793 (codified in scattered sections of 42 U.S.C.A. §§ 1396a & 1396b).
25. 42 U.S.C.A. § 1396b(w)(7)(F) (West Supp. 1992).
26. *Id.* at § 1396b(w)(3)(A)(i) (West Supp. 1992).

tax if at least 85 percent of the burden falls on health care providers. As a general rule, taxes do not include civil or criminal fines or penalties.

In order to be considered "broad-based," a tax must be levied "uniformly" on "all items or services" in a "class" of health care items or services. In order to be uniform, a tax must meet one of the following statutory criteria:

- For licensing fees and similar taxes, the tax amount must be the same for every provider within the class.
- For taxes or fees based upon a facility's number of beds, the amount must be the same for each bed tax.
- For taxes based upon revenues or receipts, the tax must be imposed "at a uniform rate for all items or services (or providers of such items or services) in the class [and be based] on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services [or providers]. . . ."[27]

If one of these criteria is not met, a state may seek special HCFA approval of its tax. The eight "classes" of items or services upon which a tax must be levied are 1) inpatient hospital services, 2) outpatient hospital services, 3) nursing facility services (other than services of intermediate care facilities for the mentally retarded), 4) services of intermediate care facilities for the mentally retarded, 5) physicians' services, 6) home health care services, 7) outpatient prescription drugs, and 8) services of health maintenance organizations.[28] The statute provides that the Secretary may also designate other classes by regulation.

States may exempt public hospitals (including state-owned hospitals) and federal hospitals from a broad-based provider tax and may apply to the Secretary for a waiver to exempt other classes of hospitals such as rural hospitals or sole community hospitals.[29]

Federal matching payments are not available for a provider tax where the state holds providers harmless for the costs of the tax. A state is deemed to hold providers harmless for the costs of a tax if:

> (A) [t]he State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this subchapter) 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) [a]ll or any portion of the payment made under this sub-

27. *Id.* at § 1396b(w)(3)(C)(i)(I)-(III).
28. *Id.* at § 1396b(w)(7)(A) (West Supp. 1992).
29. *Id.* at § 1396b(w)(3)(E) (West Supp. 1992).

chapter to the taxpayer varies based only upon the amount of the total tax paid.

(C) [t]he 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.[30]

Finally, the statute places limits on the amount of state Medicaid expenditures that can be financed by provider taxes. Revenues from provider-specific taxes cannot exceed 25 percent of the state's share of Medicaid expenditures or the state's "base percentage," whichever is greater. A state's base percentage equals the total amount of provider donation and taxes projected to be collected in state fiscal year 1992, divided by estimated non-federal Medicaid expenditures in that year.[31]

These provisions became effective on January 1, 1992, except for certain states that were granted transition periods by the Act. For those states with tax programs in effect at the time of passage of the Act, the provisions become effective on either October 1, 1992, January 1, 1993, or July 1, 1993, depending upon the beginning of a state's fiscal year and/or next legislative session.

Provider Donations

As a general rule, the Act eliminates federal matching payments for provider donations. FFP will continue for "bona fide" provider donations,[32] that is, donations that have "no direct or indirect rela-

30. *Id.* at § 1396b(w)(4) (West Supp. 1992).

31. *Id.* at § 1396b(w)(5) (West Supp. 1992).

32. During the course of tussling over provider donations, the Administration raised an additional issue — intergovernmental transfers of funds. Many commentators read the September 12 version of the rule as restricting matching payments for local funds transferred to state Medicaid programs. Local participation in the funding of the non-federal share is contemplated by § 1902(a)(2) of the Social Security Act. The legislation explicitly resolves this issue and requires HCFA to match intergovernmentally transferred funds:

> Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this subchapter, regardless of whether the unit of government is also a health care provider, except as provided in section 1396a(a)(2) of this title, unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

42 U.S.C.A. § 1396b(w)(6)(A) (West Supp. 1992). The Act then goes on to require the Secretary to utilize notice and comment rule making in order to change its policy with respect to the matching of governmentally transferred funds.

tionship . . . to payments made under this subchapter to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity. . . ."[33] The statute also allows, in limited circumstances, for continued federal matching payments for donations to fund eligibility workers. The transition periods described above also apply to states with respect to the use of non-bona fide provider donations.[34]

Disproportionate Share Payments

As significant as the legislation's restrictions on provider donations and taxes are the limitations on states' payments to facilities serving disproportionate numbers of Medicaid and other low income patients.[35] Beginning in 1981, Congress required states, in developing hospital reimbursement rates, to consider hospitals that serve a disproportionate number of Medicaid and low-income patients. Such so-called "disproportionate share hospital" ("DSH") payments have been crucial to the survival of high volume Medicaid providers. The new legislation limits DSH payments.

In effect, the Act places a moratorium, at the outset, on DSH spending. Prior to October 1, 1992, states may not increase DSH payments. After October 1, 1992, the Act imposes a national aggregate DSH payment limit as well as state specific limits. For federal fiscal year beginning on October 1, 1992, the legislation imposes a nationwide aggregate cap on disproportionate share payments equal to 12 percent of the total amount of expenditures (excluding expenditures for administrative costs) under state plans for that year. Prior to the beginning of each federal fiscal year, the Secretary will estimate national Medicaid expenditures and calculate and publish the national limit.[36]

The aggregate cap is then "allotted" to individual states. Each state's allotment is calculated by first determining the state's "base allotment." The base allotment is the greater of the "allowable" DSH payments during federal fiscal year 1992 or $1 million.[37] Allowable DSH payments are defined as those 1) made pursuant to a State Medicaid plan in effect or submitted to HCFA by September 30, 1991, or 2) made pursuant to a state law or regulations adopted as of September 30, 1991.[38]

33. *Id.* at § 1396b(w)(2) (West Supp. 1992).
34. *Id.*
35. *Id.* at § 1396r-4.
36. *Id.* at § 1396r-4(f)(1) (West Supp. 1992).
37. *Id.* at § 1396r-4(f)(4)(C).
38. *Id.* at § 1396r-4(f)(1)(A)(i). These provisions also protect payments made pursu-

In calculating these base allotments, HCFA first determines whether a state is a "high" or a "low" DSH state. A "high" DSH state is simply one whose federal fiscal year 1992 disproportionate share payments exceed 12 percent of its expenditures for medical assistance.[39] For high DSH states, the dollar amount of DSH payments in any fiscal year may not exceed the base allotment until such time as the base allotment, as a percentage of Medicaid payments, is 12 percent or less. Thus, states currently spending above the 12 percent limit on a state-specific basis are not forced to reduce disproportionate share payments. However, they may not adjust payments for inflation or otherwise increase payments until such time as total state Medicaid spending increases to the point where disproportionate share payments equal less than 12 percent of total Medicaid spending. For all "low" DSH states, the base allotment is adjusted annually by a "growth factor" and a "supplemental amount." Before the beginning of each federal fiscal year, the Secretary calculates the national DSH limit by multiplying the next fiscal year's estimated Medicaid expenditures by 12 percent. From that amount, the Secretary subtracts the total of the previous year's DSH allotments for both high and low DSH states; the Secretary also subtracts the aggregate of states' "growth amounts." A state's growth amount equals the product of the state's rate of inflation in its Medicaid program multiplied by the previous year's allotment. After subtracting the base allotments and growth amounts, any remaining amount, the so-called "redistribution pool," is apportioned among the low DSH states based upon the states' Medicaid expenditures as a percentage of the total of Medicaid expenditures by non-high DSH states.[40]

The legislation prohibits HCFA from restricting a "State's authority to designate hospitals as disproportionate share hospitals . . . ."[41] The flexibility enjoyed by states under current statutory provisions is retained and the October 31st proposed rule governing states' designation of disproportionate share hospitals under the Medicaid program is withdrawn and canceled.

The provisions of the new legislation are, in certain circumstances, "sunsetted." Beginning on or after January 1, 1996, the DSH cap will not apply to a state if: 1) the state limits the number

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ant to certain state plan amendments (and subsequent modifications) submitted between October 1, 1991 and November 26, 1991.

39. *Id.* at § 1396r-4(f)(4)(A).

40. *Id.* at § 1396r-4(f)(2).

41. *Id.* at § 1396r-4(b)(4) (West Supp. 1992).

of hospitals that it designates as disproportionate share hospitals;[42] 2) Congress has enacted legislation establishing federal standards for DSH payments; and 3) the state chooses to follow the new federal standards.[43]

MANY QUESTIONS, FEW ANSWERS

Unfortunately, the Act creates as many questions as answers. HCFA is left to try to interpret vague, ambiguous phrases in the quickly-drafted legislation with little legislative history to guide its decisions. Even under the best of circumstances, HCFA is unlikely to issue regulations implementing the Act before early fall. States are thus left to try to comply with the Act with no guidance from HCFA.

With respect to provider taxes, HCFA faces not only difficult questions regarding appropriate interpretations of such key concepts as "uniformity" and "broad-based," but also faces fundamental questions regarding the very scope of the Act. For example, what is a "health care related tax?" Is a property tax levied by local governments with a rate uniquely applied to health care providers a health care related tax? Apparently this is not the type of tax that HCFA was concerned with in negotiating the provisions of the Act. Yet, the Act can be read in such a way as to implicate this type of tax.

In attempting to define "uniformity," the Act becomes circular. With respect to taxes on revenues or receipts, a tax is considered to be imposed uniformly "if the tax is imposed at a uniform rate." This apparently simple concept leads to a number of difficult questions. Can a state, for example, utilize a progressive or regressive tax, one in which the tax rate varies according to levels of income? Can a state exempt all income or revenues above or below a set level?

Even more troublesome is the concept of "generally redistributive." Where a tax is not broad-based, the statute provides that a state can obtain a waiver for the tax from HCFA if the state can demonstrate that the tax is "generally redistributive." Redistribu-

42. Only hospitals meeting one of the following criteria could qualify as a DSH: 1) "[t]he hospital's medicaid inpatient utilization rate . . . is at or above the mean medicaid inpatient utilization rate for all hospitals in the State"; 2) "[t]he hospital's low-income utilization rate is at or above the mean low-income utilization rate for all hospitals in the State"; or 3) "[t]he number of inpatient days [for Medicaid-eligible patients] is equal to at least 1 percent of the total number of such days for all hospitals in the State." *Id.* at § 1396r-4(f)(1)(D).

43. *Id.*

tive from whom to whom? And how redistributive is "generally" redistributive?

Similarly, a state must demonstrate that there is no "payment, offset, or waiver that *guarantees* to hold taxpayors harmless for any portion of the costs of [a provider] tax."[44] The Act does not explain what constitutes a "guarantee." Does this provision preclude any improvement in reimbursement rates for providers subject to the tax? The Act seems to allow for such improvement in reimbursement rates, but it is less than clear in its treatment of this subject.

All of these questions will have to be addressed as HCFA attempts to implement the Act; all of them will have to be answered with little guidance from Congress.

CONCLUSION

There is, without doubt, some merit to the Administration's claim that states used provider donations and taxes to "unfairly affect" the federal share of Medicaid expenditures. In some cases, states displaced state general revenue funds with provider funds. In others, states "borrowed" provider funds, leveraged federal matching funds, returned the donations or taxes to providers, and kept the federal matching payments for itself.

The states no doubt relished this ability. For years, states had complained about federal mandates to expand Medicaid coverage or services. The year before the passage of this Act, the NGA had adopted a resolution opposing further mandates. States had seen their Medicaid budgets hemorrhage, with little concern from Washington. Through the use of provider donations and taxes, states had found a way to stop this hemorrhaging; they passed the expense back to Washington.

The Act put a (temporary) end to this skirmishing. The Administration regained some budget predictability with limits on growth of state Medicaid spending, and states protected the ability to use donations and taxes in certain circumstances. Yet, one is left with the question: while this legislation has resolved the current dispute between the federal government and the states, how has it improved access to or quality of care to indigent patients? Has it addressed the fundamental problems in the Medicaid program? The obvious answer to these questions is no. The vast majority of federal funds generated by provider donations and taxes were used

44. *Id.* at § 1396b(w)(4) (emphasis added).

to improve access to care by indigent patients and expand services or increase payments to hospitals serving the indigent. Even still, approximately 37 million Americans have no health care coverage, and Medicaid providers have been and continue to be notoriously underpaid for their care to indigent patients (notwithstanding the Boren Amendment).[45] Perhaps states had found a way to "unfairly affect" federal matching rates, but such measures were prompted by the failure of the Administration and Congress to engage in meaningful health care reform. Obviously, the statute does nothing to address these fundamental problems.

The states have attempted to protect the status quo and to retain some ability to use provider donations and taxes to fund Medicaid expenditures. In time, the pressures that led to their creative use of these funding mechanisms will build again, and states will have few alternatives to respond to these pressures. In the end, they will be left with no choice but to cut reimbursement to providers, reduce program services, or restrict eligibility. None of these alternatives is attractive or acceptable.

The simple fact is that the Medicaid program is irreparably broken. The Act is simply another patch to the patch-work quilt called Medicaid, but it does nothing to improve the long term viability of the program or address the health care crisis facing this country. The Medicaid program must be replaced. Hopefully that will be done sooner rather than later, but it will be done, because it must be done.

45. The Boren Amendment requires states to pay providers. 42 U.S.C.A. § 1396a(a)(13)(A) (1992). (Medicare and Medicaid Amendments of 1980, tit. X, Pub. L. No. 96-499, 94 Stat. 2609).