

Opportunities for Maximizing Medicaid Match

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A Policy Decision

- Few states can afford to subsidize the federal Medicaid program.
- To the extent that a state uses state revenues or tax expenditures to cover services that could instead be covered by Medicaid, that state is subsidizing the federal Medicaid program.
- Ending state subsidies for the federal Medicaid program involves a ***policy decision*** by state stakeholders.
- Experts can handle the details.

The Budget Context

- Medical inflation will be with us for the foreseeable future, at rates that will exceed the rate of growth of the general economy – and state revenues.
- Preserving Medicaid *now* has important implications for the future. Implementation of the Affordable Care Act in 2014 depends crucially on Medicaid to cover the most vulnerable of the uninsured.

Basic Concepts

- Most state policymakers understand that Medicaid is a major cost center in the state's budget.
- Many fewer recognize Medicaid's role as a **revenue center**, and Medicaid's potential to generate more federal revenue for the state.
- Federal Medicaid funding is available on an open-ended basis, limited only by the state's ability to pay its matching share.

Money is fungible.

“A dollar is a dollar, is a dollar, is a dollar.”

It makes no difference, financially, whether it is a tax expenditure, revenue shared with local government, or a payment to a provider.

The key to increasing the state’s capacity to match federal Medicaid revenues is reallocating dollars currently being spent or foregone.

3 Approaches to Increasing Federal Medicaid Revenues

1. Require Medicaid to pay for services now funded by state or local government.
2. Treat local public or quasi-public funds as state Medicaid matching funds.
3. Impose health care-related taxes, fees or assessments.

1. Get Medicaid to cover services now paid for by state or local govt.

- A. Do preliminary reconnaissance to look for services (e.g., school health clinics) that could qualify for Medicaid payment but do not. This is low hanging fruit.
- B. The much bigger potential in this area is ***tax expenditures***. States spend enormous amounts on health care through their tax codes, in the form of exemptions for health care providers.

1. Get Medicaid to cover services now paid for by state or local govt.

C. One scenario: Hospital gives up its tax exemption and starts paying property, sales and/or excise taxes of general application. Revenues leverage federal Medicaid match. State increases payments to hospital to offset impact of new taxes.

Such general taxes are not subject to federal restrictions on a “health care-related tax.”

1. Get Medicaid to cover services now paid for by state or local govt.

D. Another scenario: Hospital retains its tax exemption, but starts paying for public services it now receives free (e.g., ambulance service, fire and police protection and other infrastructure services.)

Revenues leverage federal Medicaid match. State increases payments to hospital to offset impact of new fees.

2. Treat local public or quasi-public funds as state Medicaid matching funds.
 - A. Transfer local dollars (e.g., local subsidy for public hospital, clinic or nursing home) to the state government as an “intergovernmental transfer,” or IGT. Use transferred funds to leverage federal match.
 - B. Certify to the federal Centers for Medicare and Medicaid Services (CMS) that local expenditures have been made for purposes that qualify for federal match, and are therefore “certified public expenditures,” or CPE.

IGT vs. CPE?

- CPE is a purely passive accounting exercise. No dollars are transferred or reallocated. Just make sure accountants are claiming credit for qualifying local expenditures.
- IGT involves a transfer, with the technical and political complexities that can involve.

IGT vs. CPE?

- In Illinois, with a 50% Medicaid match rate, IGT enables the same dollar to leverage ***twice as much*** as CPE. (\$1 of CPE nets 50¢ of federal match; the same dollar transferred to the state Medicaid budget nets \$1 of federal match.)
- Optimally, the only CPE in the state budget should be *in kind* expenditures (e.g., public hospital uncompensated care) that cannot be transferred to the state as an IGT.

3. Impose health care-related taxes, fees and assessments.

- Federal regulations permit such taxes, subject to detailed regulations and dollar limits. 42 C.F.R. 433.68.
- Basic requirements:
 - Tax must be “broad-based.”
 - Tax must be uniform throughout jurisdiction.
 - Provider must not be “held harmless”. Specific hold harmless rule provides safe harbor for taxes that do not exceed 5.5% (6.0% as of 10-1-11) of provider’s net operating revenues.

3. Impose health care-related taxes, fees and assessments.

Federal regulations recognize different classes of providers that can be the subject of separate health care-related taxes. 42 C.F.R. 433.56. This creates flexibility to tailor tax to specific provider group.

3. Health care-related taxes - Benefits

- **Stability.** In general, provider revenues will inflate at the same rate as health care costs. Few other state revenue sources can keep pace with medical inflation that drives up Medicaid budgets.
- **Feasibility.** Health care providers that understand the purpose of the tax can be expected to support or, at least, acquiesce in paying the tax.

3. Health care-related taxes - Challenges

- **Mitigation** of the impact on providers that pay the tax:
 - State's can offset the impact of the tax through Medicaid payments (e.g., rate increase, disproportionate share hospital (DSH) grants, graduate medical education (GME) payments) and/or
 - With pure state \$\$ transferred outside of Medicaid program.

3. Health care-related taxes - Challenges

- The details of mitigation can raise an alphabet soup of complexities, e.g., compliance with upper payment limits (UPL).
- But remember that these are, after all, “only” technical challenges, for which – if there is the political will – there are technical solutions.

3. Health care-related taxes - Challenges

Developing political agreement among stakeholders –

- The “I’m from the state capitol, and I’m here to help you” syndrome.
- The use of trust funds and sunset provisions to build confidence.

3. Health care-related taxes - Challenges

Developing political agreement among stakeholders –

- Keep focus on the alternatives, which are almost certain to be much worse.
- “Nothing so wonderfully concentrates the mind as the knowledge that one is to be hanged in a fortnight.” –

Samuel Johnson

3. Resources on Health care-related taxes

The National Council of State Legislatures (NCSL) and the Kaiser Foundation provide updated lists of what states are taxing. These serve as useful checklists. See:

- <http://www.healthmanagement.com/files/Hoping%20for%20Economic%20Recovery,%20Preparing%20for%20Health%20Reform.pdf>, at page 77, Appendix A-3.
- <http://www.ncsl.org/default.aspx?tabid=14359>.

The Elephant in the Room

We must acknowledge legitimacy of concerns re. the federal deficit, **BUT** :

- Washington must address the problem of the federal deficit. It is not something that Illinois can solve for the federal government. Other states will gladly use any funds available by federal law.
- Frame the issue as the state's inability to subsidize the federal Medicaid program.

The Elephant in the Room

- This is a *temporary* solution to get through a rough patch. Both the Obama Administration and GOP propose to phase out matching for health care-related taxes in several years.
- In the meantime, CMS supports states' good faith efforts to maximize federal revenues within current law. See Sebelius letter to AZ Governor: http://www.azgovernor.gov/dms/upload/PR_021511_SebeliusLetter.pdf.



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