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ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
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COMMITTEE ON ENERGY AND COMMERCE
2125 Rayburn House Office Building
Washington, DC 20515–6115
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February 18, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Mr. Slavitt,

We write today to better understand the Centers for Medicare and Medicaid Services' (CMS) oversight of state Medicaid programs' use of provider taxes to finance the nonfederal share of program expenditures.

Provider taxes are defined as a health care-related fee, assessment, or other mandatory payment for which at least 85% of the burden of the tax revenue falls on health care providers. Currently, many states use provider taxes to finance a portion of their share of Medicaid expenditures. In order for states to draw down federal Medicaid matching funds, the provider tax must be both broad-based (imposed on all providers in a specific class) and uniform (the same tax for all providers within a specific class). Additionally, states are not allowed to hold providers harmless for the cost of the provider tax, meaning that they cannot guarantee providers will receive their money back. States can receive waivers for broad-based and uniform requirements if they can prove that the tax would remain redistributive and the amount of the tax is not directly correlated to Medicaid payments.

On July 25, 2014, CMS sent a letter to state Medicaid directors and health officials providing guidance on the use of provider taxes, including taxes on managed care organizations (MCO).[1] In that letter, CMS stated that it believed that some states may be impermissibly taxing only Medicaid MCO services by incorporating only Medicaid MCOs into larger (often existing) state and local taxes. These taxes could include gross receipt taxes, tangible personal property taxes, general use taxes, and insurance premium taxes which are otherwise non-health care-related. CMS advised states to review their current practices in light of this guidance and make any changes necessary to achieve compliance.

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[1] https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-14-001.pdf

The Government Accountability Office noted, in a July 2014 report, that while states are increasingly relying on funds from providers to finance the nonfederal share of Medicaid, CMS has not ensured the data on state Medicaid financing are accurate and complete.[2] GAO found that without accurate and complete data, it is difficult for CMS to ensure that states are complying with current limits and requirements. Additionally, GAO has long raised concerns that states may be using financing schemes, including provider taxes, to increase state Medicaid expenditures in order to draw down additional federal matching funds while simultaneously lowering the state's share of the costs.

Given the concerns raised by CMS and GAO, we respectfully request your response to the following:

1. Aside from issuing the July 2014 guidance encouraging states to review their current practices, what actions did CMS take in response to the concern that some states were impermissibly taxing only Medicaid MCO services?

2. More generally, what actions does CMS take to help ensure state provider tax arrangements come into compliance with federal statute and regulations? For example, does CMS provide states with technical assistance, or gather and disseminate best practices amongst states?

3. Does CMS conduct regular reviews and/or audits of each state's provider tax arrangements? If so, please describe the frequency and results of the reviews conducted.

4. If CMS does not conduct regular review of states' provider tax arrangements, how does CMS ensure state compliance? For example, does CMS do ad hoc or special reviews of state's provider tax arrangements? If so, what circumstances would precipitate such a review of a state's provider tax arrangement and which, if any, states have been reviewed in the past year? Past two years?

5. What, if any, states have waivers of the broad-based and/or uniform provider tax requirement and how does CMS ensure that such taxes are redistributive and not directly correlated to Medicaid payments?

6. Please describe the actions CMS takes if it determines that a state's provider tax is inconsistent with federal statute or regulation, including any action to recover federal Medicaid funding that resulted from an impermissible use of provider taxes.

We respectfully request your response to this letter no later than 30 days after receipt of this letter. If you have any questions, please contact Josh Trent or Michelle Rosenberg of our staff at (202) 225-2927.

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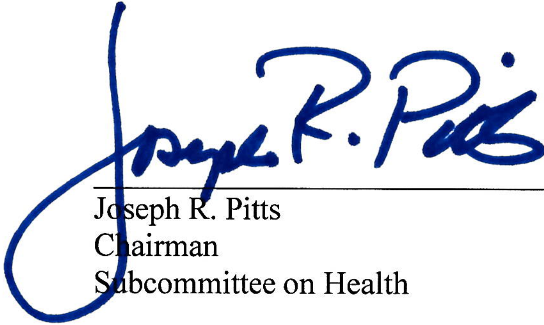
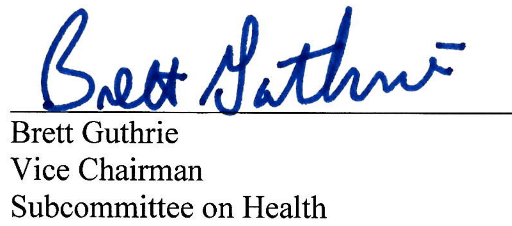
[2] http://www.gao.gov/assets/670/665077.pdf

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health



Brett Guthrie
Vice Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member
Subcommittee on Health