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MEDICAID MORATORIUM AMENDMENTS OF 1991

NOVEMBER 27 (legislative day, NOVEMBER 26), 1991.—Ordered to be printed

Mr. DINGELL, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 3595]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3595), to delay until September 30, 1992, the issuance of any regulations by the Secretary of Health and Human Services changing the treatment of voluntary contributions and provider-specific taxes by States as a source of a State's expenditures for which Federal financial participation is available under the medicaid program and to maintain the treatment of intergovernmental transfers as such a source, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991".

SEC. 2. PROHIBITION ON USE OF VOLUNTARY CONTRIBUTIONS, AND LIMITATION ON THE USE OF PROVIDER-SPECIFIC TAXES TO OBTAIN FEDERAL FINANCIAL PARTICIPATION UNDER MEDICAID.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end of the following new subsection:

"(w)(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any

fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

"(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

"(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

"(II) donations described in paragraph (2)(C);

"(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

"(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

"(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

"(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for administrative expenditures under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this title during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a).

"(C)(i) Except as otherwise provided in clause (ii) subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

"(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

"(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

"(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

"(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

"(iii) In this subparagraph and subparagraph (E), the term 'impermissible tax' means a health care related tax for which a reduction may be made under clause (ii) or (iii) subparagraph (A).

"(E)(i) In no case may the total amount of donations and taxed permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

"(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

"(F) In this paragraph in the case of a State—

"(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

"(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

"(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in 1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

"(2)(A) In this subsection (except as provided in paragraph (6)), the term 'provider-related donation' means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

"(i) a health care provider (as defined in paragraph (7)(B)),

"(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

"(iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraphs (2), (3), (4), (6), or (7) of subsection (a).

"(B) For purposes of paragraph (1)(A)(i)(I), the term 'bona fide provider-related donation' means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

"(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (included costs of training and of preparing and distributing outreach materials) of State or local agency

personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this title and to provide outreach services to eligible or potentially eligible individuals.

"(3)(A) In this subsection (except as provided in paragraph (6)), the term 'health care related tax' means a tax (as defined in paragraph (7)(F) that—

"(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

"(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

"(B) In this subsection, the term 'broad-based health care related tax' means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A) or with respect to providers of such items or services and which, except as provided in subparagraphs (D) and (E)—

"(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

"(ii) is imposed uniformly (in accordance with subparagraph (C)).

"(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

"(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

"(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed or each provider of such items or services in the class;

"(III) in the case of a tax based on revenues or receipts with respect to a class or items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

"(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

"(ii) Subject to subparagraphs (D) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or providers for a holdharmless provision described in paragraph (4).

"(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

"(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this title or title XVIII, or

"(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this title or title XVIII.

"(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers or such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraphs (B) and (C). Permissible waivers many include exemptions for rural or sole-community providers.

"(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

"(I) the net impact of the tax and associated expenditures under this title as proposed by the State is generally redistributive in nature, and

"(II) the amount of the tax is not directly cor-related to payments under this title for items or services with respect to which the tax is imposed.

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph.

"(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

"(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.

"(B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.

"(C) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or

waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

"(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

"(B)(i) In subparagraph (A), the term 'State base percentage' means, with respect to a State, an amount (expressed as a percentage) equal to—

"(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

"(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

"(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

"(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in effect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

"(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

"(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of the date of the enactment of this subsection.

"(6)(A) 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 title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), 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.

"(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

"(7) For purposes of this subsection:

"(A) Each of the following shall be considered a separate class of health care items and services:

"(i) Inpatient hospital services.

"(ii) Outpatient hospital services.

"(iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).

"(iv) Services of intermediate care facilities for the mentally retarded.

"(v) Physicians' services.

"(vi) Home health care services.

"(vii) Outpatient prescription drugs.

"(viii) Services of health maintenance organizations (and other organizations with contracts under section 1903(m)).

"(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

"(B) The term 'health care provider' means an individual or person that receives payments for the provision of health care items or services.

"(C) An entity is considered to be 'related' to a health care provider if the entity—

"(i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;

"(ii) is a person with an ownership or control interest (as defined in section 1124(a)(3)) in the provider;

"(iii) is the employee, spouse, parent, child or sibling of the provider (or of a person described in clause (ii)); or

"(iv) has a similar, close relationship (as defined in regulations) to the provider.

"(D) The term 'State' means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

"(E) The 'State fiscal year' means, with respect to a specified year, a State fiscal year ending in that specified year.

"(F) The term 'tax' includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

"(G) The term 'unit of local government' means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State.".

(b) CONFORMING AMENDMENTS.—(1) Section 1902(t) of such Act (42 U.S.C. 1396a(t)) is amended—

(A) by striking "Except as provided in section 1903(i), nothing" and inserting "Nothing", and

(B) by striking "taxes (whether or not of general applicability)" and inserting "taxes of general applicability".

(2) Section 1903(i) of such Act (42 U.S.C. 1396(i)) is amended by striking paragraph (10) inserted by section 4701(b)(2)(B) of the Omnibus Budget Reconciliation Act of 1990.

(c) EFFECTIVE DATE.—(1) The amendments made by this section shall take effect January 1, 1992, without regard to whether or not regulations have been promulgated to carry out such amendments by such date.

(2) Except as specifically provided in section 1903(w) of the Social Security Act and notwithstanding any other provision of such Act, the Secretary of Health and Human Services shall not, with respect to expenditures prior to the effective date specified in section 1903(w)(1)(F) of such Act, disallow any claim submitted by a State for, or otherwise withhold Federal financial participation with respect to, amounts expended for medical assistance under title XIX of the Social Security Act by reason of the fact that the source of the funds used to constitute the non-Federal share of such expenditures is a tax imposed on, or a donation received from, a health care provider, or on the ground that the amount of any donation or tax proceeds must be credited against the amount of the expenditure.

(3) The interim final rule promulgated by the Secretary of Health and Human Services on October 31, 1991 (56 Federal Register 56132), relating to the State share of financial participation under the medicaid program, is hereby nullified and is of no effect. No part of such rule shall be effective except pursuant to a rule promulgated after the date of the enactment of this Act and consistent with this section (and the amendments made by this section).

SEC. 3. RESTRICTIONS ON AGGREGATE PAYMENTS FOR DISPROPORTIONATE SHARE HOSPITALS.

(a) REPEAL OF PROHIBITION OF UPPER PAYMENT LIMIT FOR DISPROPORTIONATE SHARE HOSPITALS.—Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)) is amended by striking "to limit" the first place it appears and all that follows through "special needs or".

(b) LIMITATION ON AGGREGATE PAYMENT ADJUSTMENTS.—

(1) IN GENERAL.—Section 1923 of such Act (42 U.S.C. 1396r-4) is amended by adding at the end the following new subsection:

"(f) DENIAL OF FEDERAL FINANCIAL PARTICIPATION FOR PAYMENTS IN EXCESS OF CERTAIN LIMITS.—

"(1) IN GENERAL.—

"(A) APPLICATION OF STATE-SPECIFIC LIMITS.—Except as provided in subparagraph (D), payment under section 1903(a) shall not be made with respect to any payment adjustment made under this section for hospitals in a State (as defined in paragraph (4)(B)) for quarters—

"(i) in fiscal year 1992 (beginning on or after January 1, 1992), unless—

"(I) the payment adjustments are made—

"(a) in accordance with the State plan in effect or amendments submitted to the Secretary by September 30, 1991,

"(b) in accordance with the State plan in effect or amendments submitted to the Secretary by November 26, 1991, or modification

thereof, if the amendment designates only disproportionate share hospitals with a medicaid or low-income utilization percentage at or above the Statewide arithmetic mean, or

"(c) in accordance with a payment methodology which was established and in effect as of September 30, 1991, or in accordance with legislation or regulations enacted or adopted as of such date; or

"(II) the payment adjustments are the minimum adjustments required in order to meet the requirements of subsection (c)(1); or

"(ii) in a subsequent fiscal year, to the extent that the total of such payment adjustments exceeds the State disproportionate share hospital (in this subsection referred to as 'DSH') allotment for the year (as specified in paragraph (2)).

"(B) NATIONAL DSH PAYMENT LIMIT.—The national DSH payment limit for a fiscal year is equal to 12 percent of the total amount of expenditures under State plans under this title for medical assistance during the fiscal year.

"(C) PUBLICATION OF STATE DSH ALLOTMENTS AND NATIONAL DSH PAYMENT LIMIT.—Before the beginning of each fiscal year (beginning with fiscal year 1993), the Secretary shall, consistent with section 1903(d), estimate and publish—

"(i) the national DSH payment limit for the fiscal year, and

"(ii) the State DSH allotment for each State for the year.

"(D) CONDITIONAL EXCEPTION FOR CERTAIN STATES.—Subject to subparagraph (E), beginning with payments for quarters beginning on or after January 1, 1996, and at the option of a State, subparagraph (A) shall not apply in the case of a State which defines a hospital as a disproportionate share hospital under subsection (a)(1) only if the hospital meets any of the following requirements:

"(i) The hospital's medicaid inpatient utilization rate (as defined in subsection (b)(2)) is at or above the mean medicaid inpatient utilization rate for all hospitals in the State.

"(ii) the hospital's low-income utilization rate (as defined in subsection (b)(3)) is at or above the mean low-income utilization rate for all hospitals in the State.

"(iii) The number of inpatient days of the hospital attributable to patients who (for such days) were eligible for medical assistance under the State plan is equal to at least 1 percent of the total number of such days for all hospitals in the State.

"(iv) The hospital meets such alternative requirement as the Secretary may establish by regulation, taking into account the special circumstances of children's hospitals, hospitals located in rural areas, and sole community hospitals.

"(E) CONDITION FOR OPTION.—The option specified in subparagraph (D) shall not apply for payments for a quarter beginning before the date of enactment of legislation establishing a limit on payment adjustments under this section which would apply in the case of a State exercising such option.

"(2) DETERMINATION OF STATE DSH ALLOTMENTS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the State DSH allotment for a fiscal year is equal to the State DSH allotment for the previous fiscal year (or, for fiscal year 1993, the State base allotment as defined in paragraph (4)(C)), increased by—

"(i) the State growth factor (as defined in paragraph (4)(E)) for the fiscal year, and

"(ii) the State supplemental amount for the fiscal year (as determined under paragraph (3)).

"(B) EXCEPTIONS.—

"(i) LIMIT TO 12 PERCENT OR BASE ALLOTMENT.—A State DSH allotment under subparagraph (A) for a fiscal year shall not exceed 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year, except that, in the case of a high DSH State (as defined in paragraph (4)(A)), the State DSH allotment shall equal the State base allotment.

"(ii) EXCEPTION FOR MINIMUM REQUIRED ADJUSTMENT.—No State DSH allotment shall be less than the minimum amount of payment adjustments the State is required to make in the fiscal year to meet the requirements of subsection (c)(1).

"(3) STATE SUPPLEMENTAL AMOUNTS.—The Secretary shall determine a supplemental amount for each State that is not a high DSH State for a fiscal year as follows:

"(A) DETERMINATION OF REDISTRIBUTION POOL.—The Secretary shall subtract from the national DSH payment limit (specified in paragraph (1)(B)) for the fiscal year the following:

"(i) the total of the State base allotments for high DSH States;

"(ii) the total of State DSH allotments for the previous fiscal year (or, in the case of fiscal year 1993, the total of State base allotments) for all States other than high DSH States;

"(iii) the total of the State growth amounts for all States other than high DSH States for the fiscal year; and

"(iv) the total additions to State DSH allotments the Secretary estimates will be attributable to paragraph (2)(B)(ii).

"(B) DISTRIBUTION OF POOL BASED ON TOTAL MEDICAID EXPENDITURES FOR MEDICAL ASSISTANCE.—The supplemental amount for a State for a fiscal year is equal to the lesser of—

"(i) the product of the amount determined under subparagraph (A) and the ratio of—

"(I) the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year, to

"(II) the total amount of expenditures made under the State plans under this title for medical assistance during the fiscal year for all States which are not high DSH States in the fiscal year, or

"(ii) the amount that would raise the State DSH allotment to the maximum permitted under paragraph (2)(B).

"(4) DEFINITIONS.—In this subsection:

"(A) HIGH DSH STATE.—The term 'high DSH State' means, for a fiscal year, a State for which the State base allotment exceeds 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year.

"(B) STATE.—The term 'State' means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

"(C) STATE BASE ALLOTMENT.—The term 'State base allotment' means, with respect to a State, the greater of—

"(i) the total amount of payment adjustments made under subsection (c) under the State plan during fiscal year 1992 (excluding any such payment adjustments for which a reduction may be made under paragraph (1)(A)(i)), or

"(ii) $1,000,000.

The amount under clause (i) shall be determined by the Secretary and shall include only payment adjustments described in paragraph (1)(A)(i)(I).

"(D) STATE GROWTH AMOUNT.—The term 'State growth amount' means, with respect to a State for a fiscal year, the lesser of—

"(i) the product of the State growth factor and the State DSH payment limit for the previous fiscal year, or

"(ii) the amount by which 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year exceeds the State DSH allotment for the previous fiscal year.

"(E) STATE GROWTH FACTOR.—The term 'State growth factor' means, for a State for a fiscal year, the percentage by which the expenditures described in section 1903(a) in the State in the fiscal year exceed such expenditures in the previous fiscal year.".

(2) CONFORMING AMENDMENTS.—(A) Such section 1923 is further amended—

(i) in subsection (a)(2)(B), by striking "subsection (c)," and inserting "subsections (c) and (f),"; and

(ii) in subsection (c), by striking "In order" and inserting "Subject to subsection (f), in order".

(B) Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended by inserting "and section 1923(f)" after "of this section".

(c) LIMITS ON AUTHORITY TO RESTRICT DSH DESIGNATIONS.—Subsection (b) of such section is amended by adding at the end the following new paragraph:

"(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1903(w)(1)(A)(iii) if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1903(w)(4).".

(d) STUDY OF DSH PAYMENT ADJUSTMENTS.—

(1) IN GENERAL.—The Prospective Payment Assessment Commission shall conduct a study concerning—

(A) the feasibility and desirability of establishing maximum and minimum payment adjustments under section 1923(c) of the Social Security Act for hospitals deemed disproportionate share hospitals under State medicaid plans, and

(B) criteria (other than criteria described in clause (i) or (ii) of section 1923(f)(1)(D) of such Act) that are appropriate for the designation of disproportionate share hospitals under section 1923 of such Act.

(2) ITEMS INCLUDED IN STUDY.—The Commission shall include in the study—

(A) a comparison of the payment adjustments for hospitals made under such section and the additional payments made under title XVIII of such Act for hospitals serving a significantly disproportionate number of low-income patients under the medicare program; and

(B) an analysis of the effect the establishment of limits on such payment adjustments will have on the ability of the hospitals to be reimbursed for the resource costs incurred by the hospitals in treating individuals entitled to medical assistance under State medicaid plans and other low-income patients.

(3) REPORT.—Not later than January 1, 1994, the Commission shall submit a report on the study conducted under paragraph (1) to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives. Such report shall include such recommendations respecting the designation of disproportionate share hospitals and the establishment of maximum and minimum payment adjustments for such hospitals under section 1923 of the Social Security Act as may be appropriate.

(e) EFFECTIVE DATE.—(1) The amendments made by this section shall take effect January 1, 1992.

(2) The proposed rule promulgated by the Secretary of Health and Human Services on October 31, 1991 (56 Federal Register 56141), relating to the standards for defining disproportionate share hospitals under the medicaid program, shall be withdrawn and canceled. No part of such proposed rule shall be effective except pursuant to a rule promulgated after the date of the enactment of this Act and consistent with this section (and the amendments made by this section).

SEC. 4. REPORTING REQUIREMENT.

(a) IN GENERAL.—Section 1903(d) of the Social Security Act (42 U.S.C. 1396b(d)) is amended by adding at the end the following:

"(6)(A) Each State (as defined in subsection (w)(7)(D)) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to—

"(i) provider-related donations made to the State or units of local government during such fiscal year, and

"(ii) health care related taxes collected by the State or such units during such fiscal year.

"(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under section 1923(c) during such fiscal year.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to fiscal years ending after the date of the enactment of this Act.

SEC. 5 INTERIM FINAL REGULATIONS.

(a) IN GENERAL.—Subject to subsection (b), the Secretary of Health and Human Services shall issue such regulations (on an interim final or other basis) as may be necessary to implement this Act and the amendments made by this Act.

(b) REGULATIONS CHANGING TREATMENT OF INTERGOVERNMENTAL TRANSFERS.—The Secretary may not issue an interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under title XIX of the Social Security Act, except as may be necessary to permit the Secretary to deny Federal financial participation for public funds described in section 1903(w)(6)(A) of such Act (as added by section 2(a) of this Act) that are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

(c) CONSULTATION WITH STATES.—The Secretary shall consult with the States before issuing any regulations under this Act.

And the Senate agree to the same.

JOHN D. DINGELL,
HENRY A. WAXMAN,
NORMAN F. LENT,
Managers on the Part of the House.

LLOYD BENTSEN,
JAY ROCKEFELLER,
DONALD W. RIEGLE,
BOB PACKWOOD,
DAVE DURENBERGER,
Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3595), to delay until September 30, 1992, the issuance of any regulations by the Secretary of Health and Human Services changing the treatment of voluntary contributions and provider-specific taxes by States as a source of a State's expenditures for which Federal financial participation is available under the medicaid program and to maintain the treatment of intergovernmental transfers as such a source, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

1. USE OF VOLUNTARY CONTRIBUTIONS, PROVIDER-SPECIFIC TAXES, AND INTERGOVERNMENTAL TRANSFERS BY STATES TO RECEIVE FEDERAL MATCHING FUNDS UNDER MEDICAID

Current Law

The Technical and Miscellaneous Revenue Act of 1988, as amended by the Omnibus Budget Reconciliation Act of 1990, prohibits the Secretary from issuing any final regulation prior to December 31, 1991, changing the treatment of voluntary contributions or provider-paid taxes used by States to receive Federal matching funds. The Omnibus Budget Reconciliation Act of 1990 prohibits the Secretary from denying or limiting payments to a State from expenditures attributable to taxes, whether or not of general applicability, imposed with respect to the provision of medical services. The Secretary is permitted to deny matching funds for Medicaid payments made to reimburse a hospital, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF-MR) for taxes imposed by a State solely with respect to such facilities.

House Bill

Extends the moratorium on issuance of new regulations through September 30, 1992. Permanently prohibits the issuance of regula-

tions that change the treatment of public funds used as the State share of Medicaid, including public funds contributed by an agency that provides Medicaid services. Provides that any regulation changing the treatment of voluntary contributions may not apply to contributions made before January 1, 1993, except that FY 1993 Federal financial participation (FFP) related to a State's use of contributions must not exceed the amount of FFP related to such contributions in FY 1991. Prohibits the Secretary from reducing payments to States based on quarterly State expenditure estimates because such estimates include amounts attributable to contributions, intergovernmental transfers, or provider-paid taxes, or from assessing any penalty or taking other regulatory action against a State related to its use of such contributions, transfers, or taxes. The prohibitions apply to payments for quarters beginning on or after January 1, 1992, and ending on or before September 30, 1992 (for intergovernmental transfers and provider-paid taxes) or December 31, 1992 (for voluntary contributions), and to actions taken by the Secretary during the same periods.

Senate Amendment

Provides that, for the purpose of computing Federal matching funds, State Medicaid spending for a quarter (other than in Arizona) is to be reduced by the amount of any revenues received by the State or a local government on or after January 1, 1992, from:

Provider-related donations (donations from a medical provider, related entity, or administrative contractor), except "bona-fide" donations, and donations in the form of payment for outstanding Medicaid eligibility workers. Beginning in Federal FY 1993, donations related to outstationing are limited to 10 percent of State administrative costs.

Health care related taxes (those related to provision of health services and 85% paid by providers or those not equally imposed on non-health items) that are not broad-based. Broad-based taxes are defined as those uniformly imposed on all non-Federal nonpublic providers in the same class in the State or locality or all items or services in the class furnished by such providers. A tax is imposed uniformly if the amount, rate, and or base for the tax is the same for all subject providers, and the tax does not provide for credits, deductions or exclusions that have the effect of refunding all or a portion of the tax. A tax may be uniform even if it applies only to services not covered under Medicaid or Medicare or non-Medicare revenues. The Secretary may treat a tax as broad-based on application by the State if the tax and related spending are generally redistributive and the tax and Medicaid payments are not directly correlated. Waivers may include exemptions for rural or sole community providers.

Health care related taxes that are broad-based but to which a hold harmless provision applies. A hold harmless provision is one that provides for: a non-Medicaid payment to the provider that is correlated to the tax or to differences between the tax and Medicaid payments; Medicaid payment varying on the

basis of taxes paid; or the State or locality guarantees that some or all of the tax will be offset in some other way.

Broad-based taxes in amounts that exceed 25 percent of the State share of Medicaid or (if greater) the State's "base percentage" in all or part of State fiscal years beginning on or after January 1, 1992, and before October 1, 1995. The base percentage is equal to the total of provider donations and/or health care related taxes (whether or not permissible) projected to be collected during the State 1992 fiscal year, divided by the estimated State share of Medicaid spending for the year. In the case of a tax not in effect (or increased) during the full base year, the Secretary is to compute the base percentage as if it were in effect for the full year. Donations are to be counted only under a program in effect or reported to the Secretary by September 30, 1991; taxes are to be counted if they were in effect or legislation or regulations had been adopted, as of November 22, 1991.

Permits matching for certain otherwise prohibited revenues received before October 1, 1992 (for States with fiscal years beginning on or before July 1), January 1, 1993 (for States with fiscal years beginning after July 1), or July 1, 1993 (for a State that has an enacted provider tax on November 4, 1991, or whose legislature is not scheduled to meet in 1992 or 1993); prohibits a disallowance or withholding of FFP related to donations or taxes before the applicable date. Matching is permitted for donations only under a program in effect or reported to the Secretary by September 30, 1991. Countable donations for a State's 1993 fiscal year may not exceed those for the State's 1992 fiscal year. Matching is permitted for non-broad-based taxes, or broad-based taxes with a hold harmless provision, only if the taxes were in effect or legislation or regulations had been adopted, as of November 22, 1991. Increases after that date are not permitted. The sum of allowed donations and taxes (including broad-based taxes) for the part of a State's fiscal year occurring in calendar year 1992, or for all of State fiscal year 1993 may not exceed 25 percent (or the base percentage) of the State share of Medicaid.

Prohibits the Secretary from restricting States' use of funds derived from State or local taxes (including funds appropriated to State-owned teaching hospitals) transferred from or certified by local government units (including units that are providers) unless the transfers exceed the 40 percent limit on local government sharing in Medicaid or stem from otherwise prohibited donations or taxes.

Conference agreement

The agreement includes the Senate amendment with modifications. The Secretary is required to withdraw the October 31, 1991, interim final rule with respect to donations and taxes. The Secretary may not change current treatment of intergovernmental transfers except through the formal APA regulatory process (except as needed to deny matching for public funds described in section 1903(w)(6)(A) that are derived from donations or taxes that

would not otherwise be recognized). Use appropriations made to State university teaching hospitals is to be treated as a permissible transfer. The conferees note that current transfers from county or other local teaching hospitals continue to be permissible if not derived from sources of revenue prohibited under this act. The conferees intend the provision of section 1903(w)(6)(A) to prohibit the Secretary from denying Federal financial participation for expenditures resulting from State use of funds referenced in that provision.

2. RESTRICTIONS ON AGGREGATE PAYMENTS FOR DISPROPORTIONATE SHARE HOSPITALS

Current Law

Prohibits the Secretary from limiting payment adjustments made by States to hospitals serving a disproportionate number of low-income patients with special needs.

House Bill

No provision.

Senate Amendment

Effective January 1, 1992, establishes a national limit on disproportionate share hospital payment adjustments during each fiscal year equal to 12 percent of total Medicaid spending for that year. Limits a State's disproportionate share adjustments:

In the part of FY 1992 beginning on or after January 1, 1992, to those made under the State plan in effect or as submitted by September 30, 1991, or under a methodology established and in effect by that date, or legislation or regulations adopted by that date. A State plan amendment in effect or submitted by November 26, 1991, may be used if it designates only disproportionate share hospitals with a Medicaid or low-income percentage at or above the Statewide arithmetic mean. Higher payment adjustments are permitted if necessary to meet the minimum prescribed by Medicaid law.

For FY 1993 and subsequent fiscal years, to the amount of the State's disproportionate share hospital (DSH) allotment. The DSH allotment for a State is equal to the previous year's allotment (or, for FY 1993, its "base allotment"), increased by the State growth factor and the State supplemental amount for the fiscal year. The base allotment is equal to the greater of the State's payment adjustment during FY 1992 (subject to the limits for that year) or $1 million. The growth factor is the annual percentage increase in the State's Medicaid spending. The supplemental amount is an amount payable to States that are not high DSH States. (A State is a high DSH State for a fiscal year if its base allotment exceeds 12 percent of its total Medicaid spending for that fiscal year.)

The supplemental amounts are established from a pool whose size is determined by subtracting from the amount of the national DSH limit the amounts of: (a) the base allotment for high DSH States, (b) total allotments to non-high DSH

States for the previous year, (c) total "growth amounts" for non-high DSH States for the current year, and (d) any additional amounts needed to bring State's payment adjustments up to statutory minimums. A State's growth amount is the greater of: the State's allotment for the previous year times the growth factor; or the difference between the allotment for the previous year and 12 percent of total current year Medicaid spending. The supplemental amount for each non-high DSH State is the lesser of (a) a share of the pool proportionate to the State's share of all Medicaid spending by non-high DSH States or (b) the amount that would raise the State's allowable payment adjustments to 12 percent of its Medicaid spending.

Requires the Secretary to publish State allotments and national limits for each fiscal year before the beginning of the year. Limits on payment adjustments do not apply in Arizona.

Prohibits a State from using DSH payment adjustments to hold providers harmless for health care related taxes after the effective date of limits on the use of such taxes. With this exception, prohibits the Secretary from restricting a State's authority to designate disproportionate share hospitals.

Conference Agreement

The agreement includes the Senate amendment, with modifications.

After January 1, 1996, a state will not be subject to the aggregate limit on payment adjustments if it designates as DSH's only facilities whose low-income or Medicaid utilization rate exceeds the State mean, that account for at least 1 percent of all Medicaid days in the State, or that meet other criteria established by the Secretary, taking into account the special circumstances of rural, sole community, and childrens hospitals.

This option will be available only after Congress has established limits in law on payment adjustments to DSH hospitals or States electing the option. The Prospective Payment Assessment Commission is required to submit a report to Congress by January 1, 1994, on appropriate methods for establishing appropriate minimum and maximum adjustment amounts and criteria for DSH designation.

3. REPORT

Current Law

No provision.

House Bill

Requires the Secretary to report to the House Energy and Commerce and Senate Finance Committees by February 3, 1992, on any regulations the Secretary intends to issue to limit the use of contributions and provider-specific taxes, the specific types of contributions and taxes that would remain permissible, and any legislation the Secretary thinks appropriate.

Senate Amendment

No provision.

Conference Agreement

The agreement does not include the House provision.

4. BUDGET COMPLIANCE PROVISIONS

Current Law

No provision.

House Bill

Provides that the applicable cost estimates for the purposes of the Balanced Budget and Emergency Deficit Control Act of 1985 shall 0 in increased outlays and receipts for FY 1991 through FY 1995.

Senate Amendment

No provision.

Conference Agreement

The agreement does not include the House provision.

5. STATE REPORTS

Current Law

No provision.

House Bill

No provision.

Senate Amendment

Requires States to report annually on donations received and taxes collected by the State or local governments during each fiscal year and the amount of payment adjustments made to disproportionate share providers during the year, beginning with fiscal years ending after the date of enactment.

Conference Agreement

The agreement includes the Senate amendment.

6. INTERIM FINAL REGULATIONS

Current Law

No provision.

House Bill

No provision.

Amendment

Requires the Secretary, after consultation with States, to issue mplementing regulations.

JOHN D. DINGELL,
HENRY A. WAXMAN,
NORMAN F. LENT,
Managers on the Part of the House.

LLOYD BENTSEN,
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