

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**PENNSYLVANIA'S GROSS RECEIPTS  
TAX ON MEDICAID MANAGED  
CARE ORGANIZATIONS  
APPEARS TO BE AN IMPERMISSIBLE  
HEALTH-CARE-RELATED TAX**

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May 2014  
A-03-13-00201

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## EXECUTIVE SUMMARY

*Pennsylvania's Gross Receipts Tax on Medicaid managed care organizations appears to be a health-care-related tax that is impermissible for Medicaid funding. Through this tax, Pennsylvania collected \$1.76 billion of taxes from its Medicaid managed care organizations over 3 years and used that money to pay some of its share of capitation payments.*

### WHY WE DID THIS REVIEW

To comply with the requirements of the Deficit Reduction Act of 2005, Pennsylvania discontinued its health-care-related tax on Medicaid managed care organizations (MCOs) in September 2009. Pennsylvania then established a Gross Receipts Tax on the Medicaid revenues of its MCOs to be effective in October 2009.

The objective of this review was to determine whether Pennsylvania's Gross Receipts Tax on the Medicaid revenues of its Medicaid MCOs is a permissible health-care-related tax under Federal requirements.

### BACKGROUND

States may implement managed care delivery programs to increase access to and quality of care for Medicaid beneficiaries and to stabilize the States' Medicaid spending. States contract with managed care entities to provide specific services to enrolled Medicaid beneficiaries, usually in return for a predetermined periodic payment, known as a capitation payment.

Within certain limits, States are permitted to use revenues from health-care-related taxes on certain classes of health care services to help finance the State's share of Medicaid expenditures. Before 2005, the law defined Medicaid MCO services as one of the specified classes of health care services on which States could impose such a health-care-related tax. In 2005, the Social Security Act was amended to redefine this class as services of MCOs (but not limited to Medicaid MCOs). This amendment changed the definition of a broad-based tax for this class of provider. The change was effective October 1, 2009. After October 1, 2009, these taxes had to apply to all MCOs.

Pennsylvania provides Medicaid services through its *HealthChoices* managed care waiver program. In July 2004, Pennsylvania implemented a tax on the income of its Medicaid MCOs. In September 2009, Pennsylvania discontinued that tax and in its place levied a Gross Receipts Tax on income from Medicaid MCO services. In some years, Pennsylvania added a surcharge tax on income covered by the Gross Receipts Tax. For State fiscal years (FYs) 2009–2010 through 2011–2012 (the audit period), Pennsylvania collected approximately \$1.76 billion in Gross Receipts Tax revenue from its Medicaid MCOs. MCOs in Pennsylvania that did not provide Medicaid services were not subject to the Gross Receipts Tax.

## WHAT WE FOUND

Pennsylvania's Gross Receipts Tax on Medicaid MCOs appears to be a health-care-related tax that is impermissible for Medicaid funding. Through the Gross Receipts Tax, Pennsylvania collected tax revenues of \$1,758,155,583 from its Medicaid MCOs during the audit period and applied those revenues to reduce its share of *HealthChoices* Medicaid managed care costs. Pennsylvania included in its capitation rates a supplemental payment to cover the Medicaid MCOs' cost of the Gross Receipts Tax. We calculate that Pennsylvania reimbursed Medicaid MCOs \$1,603,980,052 for the Gross Receipts Tax. (We based our calculation on capitation payments claimed for Federal reimbursement during the audit period.)

Pennsylvania's Gross Receipts Tax on MCOs appears to be a health-care-related tax under the definition established in the Federal regulations. The tax appears to be an assessment on health care items or services, specifically the health care services provided by MCOs. If the tax is determined to be health-care-related, it is impermissible because it is not broad based (the Gross Receipts Tax does not apply to all MCOs) and because it holds the Medicaid MCOs harmless as taxpayers (the State agency includes the cost of the Gross Receipts Tax as a supplemental payment in its capitation payments to Medicaid MCOs).

Under Medicaid rules, revenues from an impermissible health-care-related tax may not be used to finance the State's share of Medicaid expenditures. However, by using revenues from this tax, Pennsylvania lowered its share of MCO capitation payments and increased the Federal share. During our audit period, the Federal Government paid \$981,337,949 for supplemental capitation payments designated to hold the Medicaid MCOs harmless. The MCOs received \$1,603,980,052 in supplemental capitation payments to reimburse them for the Gross Receipts Tax, and Pennsylvania retained \$1,135,513,480 of Gross Receipts Tax revenues in its Medicaid MCO fund. No additional services were provided and no additional beneficiaries were served with the proceeds from the Gross Receipts Tax.

## WHAT WE RECOMMEND

We recommend that CMS:

- determine whether the tax on Medicaid MCOs is an impermissible health-care-related tax and, if so,
  - offset \$1,758,155,583 in Gross Receipts Tax revenue from State Medicaid expenditures: \$533,936,161 from State FY 2009–2010, \$581,452,384 from State FY 2010–2011, and \$642,767,038 from State FY 2011–2012 and
  - offset Gross Receipts Tax revenue from Medicaid expenditures when determining the Federal share of Pennsylvania's Medicaid program expenditures for periods after State FY 2011–2012; and
- clarify its policy concerning permissible health-care-related taxes with all States.

## **STATE AGENCY AND CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OUR RESPONSE**

### **STATE AGENCY COMMENTS**

In its comments on our draft report, the State agency said that it did not agree with our finding or our recommendations to offset Gross Receipts Tax revenue from State Medicaid expenditures. The State agency said that the Gross Receipts Tax on Medicaid MCOs is not a health-care-related tax because the taxes it collected from Medicaid MCOs did not constitute more than 85 percent of all Gross Receipts Tax revenue and because the Medicaid MCOs are not treated differently from other taxpayers. The State agency said that, although the Gross Receipts Tax on Medicaid revenue of MCOs was not a health-care-related tax, it would have been permissible because the hold harmless provision does not prevent the use of the tax to reimburse health care providers for their expenditures. The State agency said that CMS had full knowledge that Pennsylvania extended its Gross Receipts Tax to Medicaid MCOs as a revenue source for the State share in claiming Federal matching funds for its Medicaid program. However, the State agency supported the recommendation that CMS clarify the Federal requirements for health-care-related taxes.

### **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

CMS agreed with our recommendation that it clarify its policy concerning impermissible health-care-related taxes. CMS also said that it “agrees that, based upon the information presented in OIG’s report, it appears that the portion of the gross receipts tax imposed on Medicaid MCOs may be considered a health-care related tax.” CMS said that, if it determines that the Gross Receipts Tax is an impermissible health-care-related tax, it will work with Pennsylvania to develop an approvable tax structure. However, because it has not issued subregulatory guidance to explain this position, CMS did not agree that a disallowance is warranted until the States have clear notice of its interpretation of the health-care-related tax requirements.

### **OUR RESPONSE**

The State agency’s comments incorrectly interpreted the provision to mean that a tax is health care related only if 85 percent of the tax burden falls on health care providers. If less than 85 percent of the burden falls on health care providers, a tax may still be considered a health-care-related tax if it treats health care providers differently from other entities.

We agree with CMS that notice of its interpretation of the statute and regulations is necessary and encourage CMS to provide clarification as soon as possible. Failure to do so will allow additional States to implement tax programs similar to Pennsylvania’s Gross Receipts Tax to obtain additional Federal funds. A proliferation of such tax programs could have a harmful impact on the Medicaid program.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

To comply with the requirements of the Deficit Reduction Act of 2005, Pennsylvania discontinued its health-care-related tax on Medicaid managed care organizations (MCOs) in September 2009. Pennsylvania then established a Gross Receipts Tax on the Medicaid revenues of its MCOs to be effective in October 2009. For State fiscal years (FYs)<sup>1</sup> 2009–2010 through 2011–2012, Pennsylvania collected \$1,758,155,583 in Gross Receipts Tax revenue from its Medicaid MCOs.<sup>2</sup>

### OBJECTIVE

The objective of this review was to determine whether Pennsylvania's Gross Receipts Tax on the Medicaid revenues of its Medicaid MCOs is a permissible health-care-related tax under Federal requirements.

### BACKGROUND

#### Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Pennsylvania, the Department of Public Welfare (State agency) administers the Medicaid program.

States may seek a waiver to implement managed care delivery programs (Social Security Act (the Act), § 1915(b)). The managed care programs are intended to increase access to and quality of care for Medicaid beneficiaries and to stabilize the States' Medicaid spending. States contract with managed care entities to provide specific services to enrolled Medicaid beneficiaries, usually in return for a predetermined periodic payment, known as a capitation payment. States report capitation payments claimed by Medicaid MCOs on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64).

#### Pennsylvania's Medicaid Managed Care Program

In February 1997, Pennsylvania initiated *HealthChoices*, its section 1915(b) waiver program, which required Medicaid beneficiaries to enroll in managed care plans. The program has two components: physical health and behavioral health. The State agency contracts directly with 11

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<sup>1</sup> Pennsylvania's State FY begins on July 1<sup>st</sup> and ends on June 30<sup>th</sup>.

<sup>2</sup> Pennsylvania officials said that they expected to collect \$657,671,550 in Gross Receipts Tax revenue in State FY 2012–2013.

MCOs for physical health services, such as hospital and physician services, and pays each of these Medicaid MCOs a monthly capitation payment for each enrolled beneficiary. For behavioral health services, the State agency contracts with 34 risk-bearing entities: 32 county governments and 2 private entities.

### **Health-Care-Related Taxes**

Within certain limits, States are permitted to use revenues from health-care-related taxes to finance the State's share of Medicaid expenditures.<sup>3</sup> Health-care-related taxes:

- may be imposed on 19 permissible classes of health care services, including services of MCOs;
- must be broad based, or apply to all services within a class;
- must be imposed at a uniform rate for all services within a class; and
- must not allow arrangements that return the collected taxes directly or indirectly to the taxpayer (hold harmless arrangements).

Federal regulations permit a "safe harbor" from the indirect guarantee hold harmless requirement for health-care-related taxes that do not exceed a 6.0 percent tax rate. Between January 1, 2008, and September 30, 2011, Congress lowered the tax rate to 5.5 percent. After September 30, 2011, the safe harbor tax rate increased to 6.0 percent.<sup>4</sup>

Before 2005, some States, including Pennsylvania, created health care taxes limited to Medicaid MCOs, excluding other MCOs and service providers from the tax. Section 6051 of the Deficit Reduction Act of 2005 revised section 1903(w)(7)(viii) of the Act to redefine this permissible class as services of MCOs (but not limited to Medicaid MCOs).<sup>5</sup> This provision modified the definition of a broad-based tax for this class of provider and was implemented on October 1, 2009.<sup>6</sup> After October 1, 2009, such taxes had to apply to all MCOs.

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<sup>3</sup> Section 1903(w) of the Act permits use of revenues from certain health-care-related taxes. The implementing regulations for section 1903(w) can be found at 42 CFR part 433, subpart B.

<sup>4</sup> 42 CFR § 433.68(f)(3)(i)(A).

<sup>5</sup> The amended section 1903(w)(7)(A)(viii) says that MCOs as a class include "health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation."

<sup>6</sup> 74 Fed. Reg. 31196, 31197 (June 30, 2009).

## **Pennsylvania’s Taxes on Medicaid Managed Care Organizations**

In July 2004, Pennsylvania implemented a 6-percent health-care-related tax limited to the revenue of Medicaid MCOs.<sup>7</sup> In September 2009, anticipating the implementation of the provisions of the Deficit Reduction Act described above, Pennsylvania discontinued that tax. To replace the unallowable health-care-related tax, Pennsylvania looked to its Gross Receipts Tax. Originating in 1864, Pennsylvania’s Gross Receipts Tax was levied on services provided by electric companies, telecommunications companies, transportation entities, and private bankers. Effective October 1, 2009, Pennsylvania established a Gross Receipts Tax on MCOs but limited the tax to gross receipts only “from payments pursuant to a Medicaid managed care contract with the Department of Public Welfare.”<sup>8</sup>

Pennsylvania Act 48-2009 established a Gross Receipts Tax of 5.9 percent on MCO revenue from Medicaid services. The Pennsylvania law states that the revenues collected will be placed in a restricted receipts account to augment its capitation appropriation.

Pennsylvania’s analysis in support of Pennsylvania Act 48-2009 described the MCOs covered by the new law: “...these are the same managed care organizations that paid the recently terminated assessment.”<sup>9</sup> The analysis discussed the effect of the tax, stating that the State will be “making supplemental payments to the Medicaid MCOs that equals the gross receipts tax paid by the MCOs and then seeking [F]ederal reimbursement for the supplemental payments.” Further, the analysis specified that the supplemental payment would be incorporated into the monthly rate that the State agency paid the MCOs.

The Gross Receipts Tax provision of Pennsylvania’s Medicaid MCO Agreement requires that Medicaid MCOs pay the Gross Receipts Tax and states that the State agency “will abide by the Rate Setting Methodology outlined ....” The agreement provides an overview of the rate setting methodology and states that “[t]he administrative/profit load is applied as a percentage of the total capitation rate (e.g. percentage of premium) and does not vary by population.”<sup>10</sup> When computing the capitation rates, the State agency’s actuarial firm did not include the supplemental payment for the Gross Receipts Tax in the cost of services against which it applied actuarial

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<sup>7</sup> Public Welfare Code—Medicaid Managed Care Organization Assessments and Intermediate Care Facilities for Mentally Retarded Persons Assessment (Pennsylvania P.L. 528, No. 69, July 4, 2004).

<sup>8</sup> “Managed Care Organizations,” section 1101(b)(1) of the Tax Reform Code of 1971—Omnibus Amendments (Pennsylvania P.L. 451, No. 48, Oct. 9, 2009) (Pennsylvania Act 48-2009).

<sup>9</sup> Pennsylvania House Committee on Appropriations, Fiscal Notes, House Bill 1531 [enacted as Pennsylvania Act 48-2009], October 7, 2009.

<sup>10</sup> Appendix 6, “Gross Receipts Tax,” Lehigh/Capital, Southeast and Southwest Zones, October 1, 2009, and as amended January 27, 2010, HealthChoices Behavioral Health Agreement Between Commonwealth of Pennsylvania and Allegheny County. This agreement was representative of agreements with other Medicaid MCOs.

adjustments but added the full amount of the tax, including the surcharge when applicable, as a separate load in the rates.<sup>11</sup>

As payers of the Gross Receipts Tax, Medicaid MCOs also became subject to Pennsylvania's Public Utility Realty Tax Act surcharge, which was based on revenues subject to the Gross Receipts Tax. Each year, Pennsylvania calculated the surcharge, if any, for the upcoming calendar year.<sup>12</sup> For calendar year 2011, Pennsylvania posted a surcharge of 0.16 percent of revenues taxed under the Gross Receipts Tax, which affected taxes paid in State FYs 2010–2011 and 2011–2012.<sup>13</sup> Surcharge revenues were also placed in the restricted receipts account.

Including the surcharge, Pennsylvania collected \$1,758,155,583 in Gross Receipts Tax revenue from its Medicaid MCOs from State FYs 2009–2010 through 2011–2012 (the audit period). MCOs in Pennsylvania that did not provide Medicaid services did not pay any Gross Receipts Tax.

## **HOW WE CONDUCTED THIS REVIEW**

Our review covered \$1,758,155,583 in Gross Receipts Taxes that Pennsylvania collected from its Medicaid MCOs during the audit period. This amount included a \$15,660,507 Public Utility Realty Tax Act surcharge. In this report, we refer to the Gross Receipts Tax and its associated surcharge as the Gross Receipts Tax. We analyzed the Federal and State requirements governing health-care-related taxes and how those requirements related to the Pennsylvania Gross Receipts Tax on Medicaid MCOs.

We conducted this performance audit in accordance with generally accepted government auditing requirements. Those requirements require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

## **FINDING**

Pennsylvania's Gross Receipts Tax on Medicaid MCOs appears to be a health-care-related tax that is impermissible for Medicaid funding. Through the Gross Receipts Tax, Pennsylvania

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<sup>11</sup> The load for a State tax is calculated as a percentage of the *total* capitation payment after it has been "loaded" for administrative costs and agreed-upon profit margins (*Medicaid Rate Setting 101: Capitation Rate Development Process and Considerations*, American Academy of Actuaries, June 16, 2011). (A load is generally a percentage of the service costs added to capitation payments to account for the MCO's administrative costs and profit margins.)

<sup>12</sup> "Surcharge," section 1111-A of the Tax Reform Code of 1971—Omnibus Amendments (Pennsylvania P.L. 559, No. 89, June 29, 2002). Pennsylvania levied the surcharge on revenues subject to the Gross Receipts Tax when refunds for Public Utility Realty Tax appeals exceeded the limit specified in the Tax Reform Code.

<sup>13</sup> Volume 40, Pa. Bulletin, p. 7304 (Dec. 18, 2010). The State agency's actuarial firm adjusted the capitation rates to include payment for the increased tax.

collected tax revenues of \$1,758,155,583 from its Medicaid MCOs during the audit period and applied those revenues to reduce its share of *HealthChoices* Medicaid managed care costs. Pennsylvania included in its capitation rates a supplemental payment to cover the Medicaid MCOs' cost of the Gross Receipts Tax. We calculate that Pennsylvania reimbursed Medicaid MCOs \$1,603,980,052 for the Gross Receipts Tax.<sup>14</sup>

Pennsylvania's Gross Receipts Tax on MCOs appears to be a health-care-related tax under the definition established in the Federal regulations. That is, the tax appears to be an assessment on health care items or services, specifically the health care services provided by MCOs. If the tax is determined to be health-care-related, it is impermissible because it is not broad based (the Gross Receipts Tax does not apply to all MCOs) and because it holds the Medicaid MCOs harmless as taxpayers (the State agency includes the cost of the Gross Receipts Tax as a supplemental payment in the capitation payments to Medicaid MCOs).

Under Medicaid rules, revenues from an impermissible health-care-related tax may not be used to finance the State's share of Medicaid expenditures. However, using revenues from this tax, Pennsylvania lowered its share of MCO capitation payments and increased the Federal share. During our audit period, the Federal Government paid \$981,337,949 for supplemental capitation payments designated to hold the Medicaid MCOs harmless. The MCOs received \$1,603,980,052 in supplemental capitation payments to reimburse them for the Gross Receipts Tax, and Pennsylvania retained \$1,135,513,480 of Gross Receipts Tax revenues in its Medicaid MCO fund. No additional services were provided and no additional beneficiaries were served with the proceeds from the Gross Receipts Tax.

## **FEDERAL AND STATE REQUIREMENTS**

Section 1903(w) of the Act allows States to impose health-care-related taxes on various classes of health care services. Federal regulations clarify that a health-care-related tax is a licensing fee, assessment, or other mandatory payment that is related to (1) health care items or services; (2) the provision of, or the authority to provide, the health care services; or (3) the payment for the health care services or if the tax is not limited to health care items or services it is considered health-care-related if the tax treatment of health care providers is different from the tax treatment of other individuals or entities (42 CFR § 433.55). States must reduce their claims for Federal reimbursement by the revenues collected from health-care-related taxes unless those taxes meet the requirements for an exception as a permissible tax (section 1903(w)(1)(A)).

Federal regulations specify the conditions under which a health-care-related tax will be permissible. The tax may be permissible if it is broad based, or is applied to all services within a class; is uniform, so that all payers of the tax pay at the same rate; and avoids hold harmless arrangements by which collected taxes are returned directly or indirectly to the taxpayers (42 CFR § 433.68).

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<sup>14</sup> We based our calculation of the reimbursement amount for the Gross Receipts Tax on the total capitation payments claimed for Federal reimbursement during our audit period. Because the tax payment schedule differed from the capitation payment schedule and the State agency's claims for the costs of the capitation payments also differed from the tax and capitation schedules, the amounts of tax collected do not exactly match the amounts of the supplemental capitation payments.

The Act and implementing regulations include MCO services as one of the specified classes of health care services on which States may impose a health-care-related tax. Section 6051 of the Deficit Reduction Act of 2005 revised section 1903(w)(7)(A)(viii) of the Act to redefine this permissible class as services of MCOs (but not limited to Medicaid MCOs). This provision modified the definition of a broad-based tax for this class of provider.

Pennsylvania Act 48-2009 established a Gross Receipts Tax of 5.9 percent on MCO revenue from Medicaid services; as defined, not all MCOs are subject to the tax.

Appendix B contains Federal and State requirements related to health-care-related taxes.

### **PENNSYLVANIA’S TAX ON MEDICAID MANAGED CARE ORGANIZATIONS APPEARS TO BE AN IMPERMISSIBLE HEALTH-CARE-RELATED TAX**

During the audit period, Pennsylvania appears to have used an impermissible health-care-related tax to collect revenues of \$1,758,155,583 from its Medicaid MCOs. Pennsylvania applied those revenues to reduce its share of Medicaid expenditures.

#### **Pennsylvania’s Tax on Medicaid Managed Care Organizations Appears To Be a Health-Care-Related Tax**

Pennsylvania’s tax on MCOs appears to be a health-care-related tax under the definition established in the Federal regulations. The tax appears to be an assessment on health care items or services, specifically the health care services provided by MCOs.

Pennsylvania Act 48-2009 defined the Gross Receipts Tax on Medicaid MCOs as 5.9 percent of “the gross receipts received from payments pursuant to a Medicaid managed care contract with the Department of Public Welfare through its Medical Assistance Program under Subchapter XIX of the Social Security Act.”<sup>15</sup>

In addition, the tax appears to be a health-care-related tax because Pennsylvania treats the MCO Gross Receipts Tax differently. Other industries pay gross receipts taxes at different tax rates. For example, telecommunication companies and transportation companies pay a Gross Receipts Tax of 5 percent, and private bankers pay 1 percent, whereas electric companies and Medicaid MCOs pay 5.9 percent.<sup>16</sup> Further, Pennsylvania deposits gross receipts taxes collected from these other industries into the General Fund without restrictions. Gross receipts taxes on Medicaid MCOs are placed in a restricted Medicaid fund.

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<sup>15</sup> Section 1101(b)(1) of Pennsylvania Act 48-2009.

<sup>16</sup> Pennsylvania Department of Revenue, “Gross Receipts Tax.” Accessed on December 20, 2012, at [http://www.portal.state.pa.us/portal/server.pt/community/gross\\_receipts\\_tax/14426](http://www.portal.state.pa.us/portal/server.pt/community/gross_receipts_tax/14426). In some years, the Gross Receipts Tax is augmented by an associated surcharge that increases the total amount of taxes paid.

## **If It Is Health Care Related, Pennsylvania’s Gross Receipts Tax on Medicaid Managed Care Organizations Is Impermissible**

A health-care-related tax may be used to pay the State’s share of Medicaid expenditures only if it meets the requirements for an exception as a permissible tax. However, Pennsylvania’s Gross Receipts Tax on Medicaid MCOs does not meet those requirements. The Gross Receipts Tax on Medicaid MCOs is not broad based, and the Medicaid MCOs are held harmless for the tax payments.

### *Gross Receipts Tax Is Not Broad Based*

The Gross Receipts Tax on Medicaid MCOs does not meet the requirement for a broad-based health-care-related tax. When a State chooses a class of health-care-related services to tax, it must tax all services that fall into that class. In this case, the class is defined by the regulation as services of MCOs (42 CFR 433.56). However, Pennsylvania taxes only Medicaid MCOs. In 2013, for example, 30 MCOs provided physical health services in Pennsylvania, of which 11 were contracted to provide Medicaid services. Only the 11 were required to pay the health-care-related tax, and the tax was only on gross revenues for Medicaid services. The remaining 19 MCOs were exempt from the Gross Receipts Tax because they did not provide Medicaid services.

### *Gross Receipts Tax Holds Medicaid Managed Care Organizations Harmless*

Pennsylvania did not comply with the requirement that the Medicaid MCOs not be held harmless. Pennsylvania’s analysis of the effect of its Gross Receipts Tax on Medicaid MCOs states that the State will be “making supplemental payments to the Medicaid MCOs that equals the gross receipts tax paid by the MCOs and then seeking [F]ederal reimbursement for the supplemental payments [sic].” This analysis demonstrates the State’s intent to hold the Medicaid MCOs harmless in the Gross Receipts Tax.

The regulation (42 CFR 433.68(f)(3)(i)) provides a two-prong test to determine whether taxpayers have been held harmless through an indirect guarantee that funds will be returned. Under the first prong, no indirect guarantee would exist (the regulation provides a safe harbor) if the tax (or taxes) represented 5.5 percent or less of the taxpayer’s revenues from the taxed class of services.<sup>17</sup> If the tax rate exceeds the safe harbor percentages, then under the second prong a hold harmless provision would exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments.

Pennsylvania did not achieve the safe harbor during our audit period because its health-care-related taxes exceeded 5.5 percent (or 6.0 percent for State FY 2011–2012). The Gross Receipts Tax for Medicaid MCOs is 5.9 percent. Pennsylvania increased the tax on Medicaid MCOs by a Public Utility Realty Tax Act surcharge of 0.16 percent of taxable revenues for calendar year

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<sup>17</sup> Between January 1, 2008, and September 30, 2011, the indirect guarantee safe harbor applied to a tax rate of 5.5 percent or less. Effective October 1, 2011, the tax rate to which the safe harbor applied became 6.0 percent or less (42 CFR § 433.68(f)(3)(i)(A)).

2011, bringing the health-care-related taxes on Medicaid MCOs above 6.0 percent for State FYs 2010–2011 and 2011–2012.<sup>18</sup>

Pennsylvania also did not meet the requirements of the second prong of the hold harmless test. That is, 75 percent or more of the taxpayers in the class were held harmless under the Gross Receipts Tax imposed by Pennsylvania Act 48-2009 for 75 percent or more of the Gross Receipts Tax they paid. Actuarial reports show that the supplemental capitation payments were calculated as a separate load of 5.9 percent of total capitation payments. This load was not subject to actuarial adjustment and reimbursed Medicaid MCOs for the Gross Receipts Tax in its entirety. In 2011, the load for the Gross Receipts Tax was revised to include payment for the surcharge (6.06 percent).<sup>19</sup> All of the Medicaid MCOs received the capitation payments. As shown in the table below, in all years, the offset payments well exceeded the 75-percent threshold and thus violated the hold harmless limitation.<sup>20</sup>

**Table 1: Offset Payments Exceeded the 75-Percent Threshold**

<b>State FY</b>	<b>Medicaid MCO Gross Receipts Tax Costs</b>	<b>Capitation Payments To Offset Medicaid MCO Gross Receipts Tax Costs</b>	<b>Percent of Tax Received as Offset Capitation Payments</b>
2009–2010	\$533,936,161	\$491,305,502	92.0 percent
2010–2011	\$581,452,384	\$554,855,716	95.4 percent
2011–2012	\$642,767,038	\$557,818,834	86.8 percent
<b>Total</b>	<b>\$1,758,155,583</b>	<b>\$1,603,980,052</b>	

For example, our audit shows that, for State FY 2011–2012, Pennsylvania collected \$642,767,038 in Gross Receipts Taxes from Medicaid MCOs. The DPW [State Agency] Budget Request for FY 2011–2012 estimated a need of \$639,161,594 for supplemental capitation payments to cover the Medicaid MCOs’ costs of the tax for that period.<sup>21</sup>

The collections and payments shown in this report are not equal because of lags between collecting the Gross Receipts Tax and paying the MCOs for their cost of the tax. Because of the timing issues related to collecting the tax and making the payments, the taxes collected do not

<sup>18</sup> Pennsylvania discontinued this surcharge after our audit period.

<sup>19</sup> Note, *HealthChoices Physical Health State Fiscal Year 2011–2012 Rate Development and Certification*, October 2011.

<sup>20</sup> Because we were unable to determine the exact amount for which the factor for the surcharge was applicable, we calculated all offset capitation payments at 5.9 percent. Therefore, the table may understate the offset payments for State FY 2011–2012.

<sup>21</sup> *Fiscal Year 2011–2012 Governor’s Executive Budget: Capitation Estimated Payments for 2011–2012*, p. 138.

equal the supplemental capitation payments made to cover the tax during our audit period.<sup>22</sup> We therefore calculated the amount of the capitation payments for the Gross Receipts Tax using the amount of the unadjusted load included in the rates. During the audit period, we calculated that Pennsylvania paid \$1,603,980,052 in supplemental capitation payments to reimburse MCOs for their Gross Receipts Tax costs.

**PENNSYLVANIA COLLECTED TAXES OF \$1.76 BILLION FROM MEDICAID MANAGED CARE ORGANIZATIONS AND USED THAT MONEY TO PAY SOME OF ITS SHARE OF CAPITATION PAYMENTS**

During our audit period, Pennsylvania collected Gross Receipts Taxes of \$1,758,155,583 from its Medicaid MCOs and paid \$1,603,980,052 in supplemental capitation payments designated to cover the tax. Pennsylvania used \$622,642,103 of the collected taxes to cover its share of the supplemental capitation payments and retained \$1,135,513,480 in its Medicaid fund to pay its share of the *HealthChoices* Medicaid managed care program. The Federal Government paid \$981,337,949 for the supplemental capitation payments designated to hold the Medicaid MCOs harmless in the Gross Receipts Tax. No additional services were provided and no additional beneficiaries were served with the proceeds from the Gross Receipts Tax.

The following table demonstrates the financial effect of Pennsylvania’s tax.

**Table 2: Financial Effect of Pennsylvania’s Tax State Fiscal Years 2009–2010 Through 2011–2012**

	<b>MCOs</b>	<b>Pennsylvania</b>	<b>CMS</b>
<b>Gross Receipts Tax</b>	(\$1,758,155,583)	\$1,758,155,583	
<b>Supplemental Capitation Payments</b>	\$1,603,980,052	(\$622,642,103)	(\$981,337,949)
<b>Net Financial Effect</b>	<b>(\$154,175,531)</b>	<b>\$1,135,513,480</b>	<b>(\$981,337,949)</b>

**CMS SHOULD OFFSET STATE REVENUE FROM IMPERMISSIBLE HEALTH-CARE-RELATED TAXES**

States may not use revenues raised through an impermissible health-care-related tax to help finance their share of Medicaid expenditures. Further, when a health-care-related tax is determined to be impermissible, CMS should offset the total amount of the taxpayer revenues

<sup>22</sup> The Medicaid Agreement, Appendix 6, indicates the date that Gross Receipts Taxes are due and provides the schedule for adjusting future capitation payments to the Medicaid MCOs to repay the full amount of the MCO tax collected. Because the schedules of collections and payment differ from each other and from the filing date of the claim for Federal reimbursement, the amounts of tax collected that we show in this report do not exactly match our calculation of the supplemental capitation payments.

received by a State from medical assistance expenditures when determining the Federal share of State expenditures (42 CFR § 433.57).

## **RECOMMENDATIONS**

We recommend that CMS:

- determine whether the tax on Medicaid MCOs is an impermissible health-care-related tax and, if so,
  - offset \$1,758,155,583 in Gross Receipts Tax revenue from State Medicaid expenditures: \$533,936,161 from State FY 2009–2010, \$581,452,384 from State FY 2010–2011, and \$642,767,038 from State FY 2011–2012 and
  - offset Gross Receipts Tax revenue from Medicaid expenditures when determining the Federal share of Pennsylvania’s Medicaid program expenditures for periods after State FY 2011-2012; and
- clarify its policy concerning permissible health-care-related taxes with all States.

### **STATE AGENCY AND CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

#### **STATE AGENCY COMMENTS**

In its comments on our draft report, the State agency said that it did not agree with our finding or our recommendations to offset Gross Receipts Tax revenue from State Medicaid expenditures. The State agency said that the Gross Receipts Tax on Medicaid MCOs is not a health-care-related tax because the taxes it collected from Medicaid MCOs did not constitute more than 85 percent of all Gross Receipts Tax revenue and because the Medicaid MCOs are not treated differently from other taxpayers. The State agency said that, although the Gross Receipts Tax on Medicaid revenue of MCOs was not a health-care-related tax, it would have been permissible because the hold harmless provision does not prevent the use of the tax to reimburse health care providers for their expenditures. The State agency said that CMS had full knowledge that Pennsylvania extended its Gross Receipts Tax to Medicaid MCOs as a revenue source for the State share in claiming Federal matching funds for its Medicaid program. However, the State agency supported the recommendation that CMS clarify the Federal requirements for health-care-related taxes.

The State agency’s comments are included in their entirety as Appendix C.

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

CMS agreed with our recommendation that it clarify its policy concerning impermissible health-care-related taxes. CMS also said that it “agrees that, based upon the information presented in OIG’s report, it appears that the portion of the gross receipts tax imposed on Medicaid MCOs

may be considered a health-care related tax.” CMS said that, if it determines that the Gross Receipts Tax is an impermissible health-care-related tax, it will work with Pennsylvania to develop an approvable tax structure. However, because it has not issued subregulatory guidance to explain this position, CMS did not agree that a disallowance is warranted until the States have clear notice of its interpretation of the health-care-related tax requirements.

CMS included several technical suggestions in its comments, which we have addressed as appropriate. CMS’s comments, excluding technical comments, are included as Appendix D.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

The State agency’s comments incorrectly interpreted the provision to mean that a tax is health care related only if 85 percent of the tax burden falls on health care providers. If less than 85 percent of the burden falls on health care providers, a tax may still be considered a health-care-related tax if it treats health care providers differently from other entities.

We agree with CMS that notice of its interpretation of the statute and regulations is necessary and encourage CMS to provide clarification as soon as possible. Failure to do so will allow additional States to implement tax programs similar to Pennsylvania’s Gross Receipts Tax to obtain additional Federal funds. A proliferation of such tax programs could have a harmful impact on the Medicaid program.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

During the audit period, Pennsylvania collected \$1,758,155,583 in gross receipts taxes from its Medicaid MCOs. This includes a \$15,660,507 Public Utility Realty Tax Act surcharge on revenues subject to the Gross Receipts Tax. Our review was based on an analysis of the Federal and State requirements and applying those requirements to the Pennsylvania Gross Receipts Tax on MCOs.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining whether Pennsylvania's Gross Receipts Tax on MCOs is a permissible health care tax. We did not extend our review to any other health care program in Pennsylvania.

We conducted our audit from May 2012 to April 2013 and performed our fieldwork at the State agency's office in Harrisburg, Pennsylvania, and at the CMS offices in Baltimore, Maryland.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal statutes and regulations on provider health care taxes;
- reviewed Pennsylvania's statutes implementing taxes on Medicaid MCOs;
- reviewed Pennsylvania's analysis, explanatory materials, and sample actuarial reports providing the basis for the capitation payment rates for Medicaid MCOs;
- reviewed an executed MCO agreement with the State agency;
- reviewed data provided by the State agency concerning MCO Gross Receipts Tax payments for the audit period;
- reviewed Pennsylvania's State budget documentation for Gross Receipts Tax revenues and Medicaid MCO capitation payments;
- estimated supplemental capitation payments made to Medicaid MCOs to offset their gross receipts tax payments by multiplying total capitation payments claimed by Pennsylvania on Form CMS-64 by 5.9 percent, the rate identified in the Pennsylvania *HealthChoices* capitation rate proposals;<sup>23</sup>

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<sup>23</sup> States may include in their capitation rates the cost of permissible taxes, including permissible health-care-related taxes. Pennsylvania included the cost of its Gross Receipts Tax in its proposed capitation rates for Medicaid MCOs.

- held discussions with State agency officials to gain an understanding of the operation of Pennsylvania’s Gross Receipts Tax program;
- held discussions with CMS officials concerning health-care-related taxes; and
- met with CMS and Pennsylvania officials to discuss our findings and recommendations.

We conducted this performance audit in accordance with generally accepted government auditing requirements. Those requirements require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX B: FEDERAL AND STATE REQUIREMENTS

### FEDERAL LAWS AND REGULATIONS

#### Permissible Health-Care-Related Taxes and the Services They Cover

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 amended the Act by adding section 1903(w), relating to permissible donations and health-care-related provider taxes. Section 1903(w) allows provider taxes as long as they:

- are imposed on a permissible class of health care services;
- are broad based, or applied to all providers within a class;
- are uniform in that all providers are taxed at the same rate;
- do not exceed 25 percent of the non-Federal share of Medicaid expenditures; and
- avoid hold harmless arrangements by which collected taxes are returned directly or indirectly to taxpayers.

Section 1903(w)(7)(A) defined classes of services on which States might levy health-related taxes, including “Services of health maintenance organizations (and other organizations with contracts under section 1903(m)).” Section 1903(m) of the Act identifies Medicaid MCOs.

Section 6051 of The Deficit Reduction Act of 2005 amended section 1903(w)(7)(A)(viii) of the Act to redefine this permissible class of health care services as “Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).” The revised provision did not limit the class of service to Medicaid MCOs. During our audit period, the implementing regulations listed 19 classes of taxable health care services (42 CFR § 433.56).

A tax is considered a health-care-related tax if certain conditions found in section 1903(w)(3)(A) of the Act and its implementing regulations are met.

As clarified in the Federal regulations, a health-care-related tax is a licensing fee, assessment, or other mandatory payment that is related to (1) health care items or services; (2) the provision of, or the authority to provide, the health care services; or (3) the payment for the health care services (42 CFR § 55(a)). A tax is considered to be health care related if the tax is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different from the tax treatment provided to other individuals or entities (42 CFR § 433.55(c)).

## **Requirements for Health-Care-Related Taxes**

A State may receive health-care-related taxes without receiving a reduction in its Federal share provided that the tax meets the requirements of section 1903(w) of the Act. In particular, the tax must be broad based; must be uniformly imposed; must be applied to the providers, items, or services within a class to be taxed as described above; and must avoid hold harmless clauses.

The tax is broad based if it is imposed on all health care items or services in the class or imposed on providers of such items or services furnished by all non-Federal, nonpublic providers in the State (42 CFR § 433.68(c)). The tax is considered uniformly imposed if it is imposed on the same services and is applied at the same rate for all payers of the tax. The tax is not considered uniformly imposed if it is not redistributive, for example, if the amount of tax directly correlates to payments under Medicaid (42 CFR § 433.68(d)).

Federal regulations specify in detail the limitations relating to hold harmless provisions. An indirect guarantee will be determined to exist under a two prong “guarantee” test. If the tax or taxes produce revenues for the State that are below a specified limit, the taxes will be considered permissible for the purpose of the hold harmless provision. Between January 1, 2008, and September 30, 2011, this safe harbor limit was 5.5 percent of the provider revenues. After September 30, 2011, the safe harbor limit reverted to 6 percent or less of these revenues (42 CFR § 433.68(f)(3)(i)(A)).

If the tax does not fall within the indirect guarantee, or safe harbor, a second test for indirect hold harmless provisions applies to all health care taxes applied to each class. CMS will consider an indirect hold harmless provision to exist if 75 percent of the taxpayers in the class receive 75 percent or more of their total tax back in enhanced Medicaid payments or other State payments (42 CFR § 433.68(f)(3)(i)(B)).

CMS may waive the broad-based and uniform tax requirements if the tax is deemed generally redistributive but may not waive the hold harmless requirement (42 CFR § 433.72).

## **PENNSYLVANIA LAWS**

Regarding the taxation of Medicaid MCOs, Pennsylvania Act 48-2009, section 1101(b.1), “Imposition of Tax, Managed Care Organizations,” states:

Every managed care organization now or hereafter incorporated or organized by or under any law of the Commonwealth or a political subdivision thereof, or now or hereafter organized or incorporated by any other state or by the United States or any foreign government and doing business in this Commonwealth that is a party to a Medicaid managed care contract with the Department of Public Welfare shall pay to the State Treasurer, through the Department of Revenue, a tax of 59 mills upon each dollar of the gross receipts received from payments pursuant to a Medicaid managed care contract with the Department of Public Welfare through its Medical Assistance Program under Subchapter XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.). This subsection shall also apply to a Medicaid managed care organization, as defined in section 1903(m)(1)(A) of the

Social Security Act (42 U.S.C. § 1396b(m)(1)(A)); to a county Medicaid managed care organization; and to a permitted assignee of a Medicaid managed care contract. This subsection shall not apply to an assignor of a Medicaid managed care contract. The revenue collected under this subsection shall be placed in a restricted receipts account in the General Fund and is appropriated as an augmentation to the capitation appropriation of the Department of Public Welfare. If the Centers for Medicare and Medicaid Services of the Department of Health and Human Services issues a written determination of a deferral, disallowance or disapproval of Federal financial participation on the grounds that the tax imposed under this subsection constitutes an impermissible health-care-related tax under Subchapter XIX of the Social Security Act, the Secretary of Public Welfare shall notify the Secretary of Revenue of that determination. If notification is made under this paragraph, the tax under this subsection shall cease to be imposed after the last day of the month in which notification is made.

Section 1111-A of the Tax Reform Code of 1971—“Surcharge” (Omnibus Amendments (Pennsylvania P.L. 559, No. 89, June 29, 2002), established a Public Utility Realty Tax Act surcharge to be calculated by the State each year. Section 1111-A(c) states that “for the fiscal year, each entity subject to the tax imposed by section 1101 [see above] shall pay to the Commonwealth a surcharge upon each dollar of the gross receipts required to be reported under section 1101 ....” Gross receipts of providers of certain telecommunications services are excepted from the tax. Section 1111-A(d) specifies that, in years for which a surcharge is imposed, the State will publish the surcharge rate in the *Pennsylvania Bulletin*. For calendar year 2011, Pennsylvania published a surcharge tax rate of 0.16 percent.<sup>24</sup>

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<sup>24</sup> Volume 40, Pa. Bulletin, p. 7304 (Dec. 18, 2010).

## APPENDIX C: STATE AGENCY COMMENTS



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

January 22, 2014

Stephen Virbitsky  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Inspector General  
Office of Audit Services, Region III  
Public Ledger Building, Suite 316  
150 S. Independence Mall West  
Philadelphia, Pennsylvania 19106

Dear Mr. Virbitsky:

The Department of Public Welfare (DPW) has reviewed the draft Report Number A-03-13-00201, titled, "Pennsylvania's Gross Receipts Tax on Medicaid Managed Care Organizations Is an Impermissible Health-Care-Related Tax". According to the draft Report, the objective of this audit was to determine if the Gross Receipts Tax is a permissible health care-related tax under Federal requirements.

DPW notes that you have asked CMS to comment on the "validity of the facts and reasonableness of the recommendations in the report." You have also offered DPW the opportunity to respond to the draft Report.

DPW reviewed and disagrees with the conclusions and recommendations included in the draft Report. As explained below, Pennsylvania's Gross Receipts Tax is **not** a health care-related tax as defined in federal law. Further, given that CMS was fully informed of Pennsylvania's Gross Receipts Tax, before and after it was enacted, and approved Pennsylvania's managed care contracts and capitation payments recognizing and reimbursing the tax cost, it would be entirely unreasonable for CMS to retroactively deny the Commonwealth nearly \$1 billion in federal matching funds for prior fiscal periods or take any other measures to disrupt this legitimate funding source going forward. Finally, DPW also question certain factual findings included in the draft Report, which are identified below.

**Office of Inspector General (OIG) Recommendation:** We recommend that CMS offset \$1,758,155,583 in Gross Receipts Tax revenue from State Medicaid expenditures: \$533,936,161 from State FY 2009-2010, \$581,452,384 from State Fiscal YY 2010-2011, and \$642,767,038 from State FY 2011-2012.

**OIG Recommendation:** We recommend that CMS offset Gross Receipts Tax revenue from Medicaid expenditures when determining the Federal share of Pennsylvania's Medicaid program expenditures for periods after State FY 2011-2012.

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**Department of Public Welfare (DPW) Response:**

OIG's recommendations are based upon its conclusion that Pennsylvania's Gross Receipts Tax is an impermissible health care-related tax. OIG's conclusion is incorrect and its proposed sanction is unreasonable and unjust for the following reasons:

I. Pennsylvania's Gross Receipts Tax is Not a Health Care Related Tax under Federal Law.

A health care-related tax is defined in § 1903(w)(3)(A) of the Social Security Act as a tax 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.

Section 1903(w)(3) further specifies that, for purposes of subsection (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." 42 USC 1396b(w)(3)(A).

As noted in the draft Report, Pennsylvania's Gross Receipts Tax (GRT), which was first enacted in 1864, taxes the gross receipts of pipeline, conduit, steamboat, canal, slack water navigation, and transportation companies; telephone, telegraph, and mobile telecommunications companies; electric light, water power, and hydroelectric companies; express companies; palace car and sleeping car companies; freight and oil transportation companies, private banks and, since 2009, managed care organizations (MCOs). The OIG concluded that the GRT became a health care-related tax when it was extended to MCOs in 2009. Although it applies to MCOs, the GRT meets neither prong of the statutory definition of a health care-related tax.

Just because a state tax applies to health care providers does not mean the tax is "related to health care items or services." Rather, as specified in § 1903(w)(3)(A), 85 percent of the burden of the tax must fall on health care providers. Under federal regulations, the extent of health care providers' tax burden is measured by comparing the tax revenues that the providers pay to the total tax revenues collected. 42 CFR § 433.55(b). When it issued its 1992 Interim Final Rule adopting this provision, the then Health Care Financing Administration (HCFA) offered the following example in explaining how it would apply:

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Assume that a State imposes a tax of 5 percent on gross revenues of hospitals and gas stations. The tax generates \$100 million in revenues during the State fiscal year, of which \$90 million is paid by the hospitals and is deposited into the State General Fund. ... Since 90 percent of the tax revenue in this example is generated from providers of health care services, the tax paid by the provider is considered to be a health care-related tax under section 1903(a)(w)(3)(A)(i) of the Act.

If, in this example, the hospitals paid \$60 million in tax revenue and the gas stations paid \$40 million, **the tax would not be considered health care-related, and would not be subject to the remaining provisions of the law.**

57 Fed. Reg. 55127 (November 24, 1992) (emphasis added). Later, in its 1993 Final Rule on Health Care-Related Taxes, HCFA reaffirmed that “a State can add health care providers to an already existing non-health care-related tax without penalty as long as it meets the 85-percent test.” 58 Fed. Reg. 43159 (August 13, 1993).

At no time since Pennsylvania's GRT was amended in 2009 to apply to MCOs have MCOs been responsible for 85 percent or more of the tax revenue collected. To the contrary, the GRT paid by MCOs has never exceeded 33 percent of the aggregate revenues derived from the GRT in any SFY. In concluding that the GRT is a health care-related tax, the draft Report overlooks this critical fact, and focuses instead solely on the application of the tax to MCOs. Under this logic, the 85 percent test would become superfluous and any number of state or local taxes, including corporate taxes, income taxes, sales and uses taxes, would be transformed into health care-related taxes subject to § 1903(w). HCFA recognized that Congress did not intend that result when it enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law 102-34. As HCFA stated in its hospital/gas station example, “The fact that this tax includes hospitals does not in and of itself subject it to the provisions of Pub. L. 102-234.” Here, because MCOs pay considerably less than 85 percent of the tax revenues collected under the GRT, the GRT is not a health care-related tax under § 1903(w)(3)(A)(i).

As noted above, the GRT is not limited to health care providers. Therefore, it is also necessary to examine whether MCOs are treated the same as other companies subject to the tax in determining whether the GRT is a health care related tax under § 1903(w)(3)(A). The draft Report claims that MCOs are treated differently under the GRT because they are assessed at a higher tax rate than other companies and the proceeds collected from MCOs are deposited into a restricted fund account while other GRT revenues are

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deposited into the General Fund without restriction. DPW disagrees with the conclusion that MCOs are subject to disparate treatment.

The GRT is administered by the Pennsylvania Department of Revenue in the same manner for MCOs as other companies. MCOs must report and pay their tax at the rate specified in the GRT law at the same time and in the same way as other companies. If they fail to correctly report and pay their GRT, they are subject to the same penalties imposed on other taxpayers. While the GRT does provide for different tax rates depending on the type of company, your report fails to note that MCOs are taxed at the same effective tax rate as electric companies, which, on average, accounted for approximately 45 percent of all GRT revenues during SFYs 2010, 2011 and 2012. Further, as noted in the draft Report, MCOs are also assessed the same periodic surcharge levied on other companies subject to the GRT.

Because MCOs are treated the same as other companies subject to the GRT, the GRT is not a health care-related tax under § 1903(w)(3)(A)(ii). That the tax proceeds collected from MCOs are deposited in a restricted account makes no difference in how the MCOs are treated under the tax. As HCFA stated in its 1992 Interim Rule, "Nor is the dedicated use of the tax revenue a consideration in determining the applicability of the statutory requirements. Rather, in determining whether or not the provisions of the law apply to this tax program, it must first be determined, in accordance with section 1903(w)(3)(A) of the Act, if the tax program is considered 'health care-related.'" 57 Fed. Reg. 55127 (November 24, 1992). With the exception of the restrictions in § 1903(w), which only apply to health care-related taxes, Congress has placed no restrictions on the use of state tax revenues to fund Medicaid expenditures.

Under federal regulations, public funds appropriated directly to and under the administrative control of the state Medicaid agency can be used as the state share in claiming federal financial participation so long as the public funds are not federal funds. 42 CFR § 433.51. The GRT revenues meet these requirements: they are public funds derived from a non-health care-related state tax, which are appropriated directly to the State Medicaid agency and under its administrative control.

II. The State Appropriately Recognizes and Reimburses the GRT in its MCO Payments.

Because the GRT is not a health care related-tax as defined in §1903w(3)(A), the restrictions and requirements relating to such taxes do not apply. Consequently, it is unnecessary to address the reasons why OIG believes the GRT is an impermissible tax. Nonetheless, DPW takes issue with OIG's conclusion that MCOs are held harmless simply because our rate setting methodology appropriately recognizes and reimburses the GRT tax as an

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allowable administrative cost. Federal law specifically provides that the hold harmless provisions of § 1903(w)(3) “shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this subchapter nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.” 42 U.S.C. § 1396b(w)(4)(C) Consistent with this statutory provision, CMS has acknowledged that states may reimburse the Medicaid portion of providers’ fee costs and that states can and do use health care-related taxes to support their Medicaid Programs, including making supplemental payments to providers paying the health care-related fees. See, e.g., 73 Fed. Reg. at 9687, 9690-9691, 9692, and 9694.

For Pennsylvania, failure to account for the GRT would have violated the requirement that the State pay MCOs based on actuarially sound capitation payment rates. See 42 CFR § 433.8(c). Indeed, to comply with that requirement, DPW amended its managed care contracts and updated its rate setting methodology and payments after the GRT extended to MCOs in 2009 to specifically recognize and reimburse the GRT as an allowable cost. Before doing so, DPW was required to seek and obtain CMS approval. CMS initially raised questions about the changes DPW was proposing. In response, DPW advised CMS that the GRT was a mandatory cost incurred by the MA MCOs under current state law and that Pennsylvania’s proposed payment structure was intended to recognize and reimburse that mandatory tax cost when it comes due in a manner that does not exceed the final tax obligation of the MCOs. DPW described in detail how the payments would be made and provided CMS with a certification from its actuary that the proposed payment structure would result in actuarially sound rates to the MA MCOs. DPW noted that the payments made under the MCO contracts properly reflected the liability of the MCOs for legitimate costs incurred under current state law, including the GRT and advised that its payments would not be actuarially sound if they did not include an appropriate allowance for the GRT obligation. Only after careful and extended consideration of these proposed changes did CMS approve the MCO contracts and rate methodology. In each of the following years since 2009, CMS has continued to approve Pennsylvania’s contracts and payment structure recognizing and reimbursing the GRT.

### III. Denying Federal Matching Funds for the GRT Would Be Unreasonable and Unjust.

As noted above, the GRT is not a health care-related tax; rather it is a legitimate state revenue source of public funds that qualify as the state share in claiming FFP. Had CMS concluded otherwise, it had ample opportunity to notify Pennsylvania. Instead, with full knowledge that Pennsylvania had extended the GRT to MCOs, CMS not only acquiesced in this funding source – it affirmatively approved Pennsylvania’s managed care contracts and payment structure recognizing and reimbursing the GRT as an allowable cost for federal claiming purposes. Moreover, CMS did this knowing full well that the GRT only applied to Medicaid MCOs.

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Before the GRT was enacted, the Commonwealth's then State Medicaid Director met with and had multiple conversations with CMS officials, including the CMS Administrator, to explain the circumstances in Pennsylvania and Commonwealth's need to find an alternate funding source for the Medicaid managed care assessment which was sun-setting as a result of changes in federal law. Pennsylvania was not alone in attempting to deal with the significant financial consequences of this change. Other states, including California, Ohio and Michigan, faced with the same challenge, either had or were in the process of enacting laws to extend existing state taxes to make up for the anticipated funding shortfalls. CMS advised State officials that, until it made changes to its existing regulations, the states could implement these measures to avoid funding crises for their State Medicaid Programs.

Relying on these assurances from its Federal partner, Pennsylvania proceeded in good faith to extend the GRT and, with Federal approval, has used the proceeds from this tax ever since to support its Medicaid Program. After waiting more than three years, it would be unreasonable and fundamentally unjust for CMS to reverse course, recover nearly \$1 Billion in federal funds, and withdraw this financial support going forward. The consequences of such actions would be devastating, not only to the Commonwealth's Medical Assistance Program and the individuals who rely on this safety net, but to Pennsylvania's economy as a whole. Particularly at a time when the Commonwealth is seeking to provide greater access to health care coverage for uninsured low-income Pennsylvanians, it is essential that this critical funding source remains intact.

**OIG Recommendation:** We recommend that CMS clarify its policy concerning permissible health-care-related taxes with all states.

**DPW Response:** DPW supports the OIG's recommendation. Pennsylvania's objective has always been to comply with federal law. For that reason, DPW sought guidance from CMS before the GRT was enacted and has repeatedly sought and obtained CMS approval in recognizing the GRT as an allowable cost in our payment structure. As stated in DPW's earlier response, CMS advised Pennsylvania and other states that they could implement measures to expand non health care-related taxes until CMS made changes to its regulations. If and when those changes are made, Pennsylvania will comply. Until then, however, GRT revenues qualify under applicable federal law and regulations as the state share in claiming federal financial participation.

Finally, DPW reviewed the validity of the draft report and has identified the following questionable or inaccurate facts:

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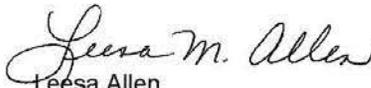
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- After significant effort, recognizing the limitations related to timing differences, and following the methodology provided by the OIG<sup>1</sup>, DPW is unable to verify the following amounts and requests that OIG provide additional information detailing the bases for these findings:
  - \$1,603,980,052 was reimbursed to MCOs for the Gross Receipts Tax.
  - \$981,337,949 of payment in FMAP by the Federal government.
  - \$1,135,513,480 of Gross Receipts Tax revenue was retained by the state.
- DPW contracted with 8 MCOs for physical health services and not 11 as identified on page #2 of the draft report.

Thank you for your consideration of our response. If you have questions or concerns regarding this request, please contact Alexander Matolyak, Director, Division of Audit and Review at (717) 783-7786 or [amatolyak@pa.gov](mailto:amatolyak@pa.gov).

Sincerely,



Leesa Allen  
Executive Medicaid Director

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<sup>1</sup> DPW calculated these amounts using the following input received via email from the OIG in mid-November 2013, "The capitation payments were calculated by multiplying 5.9 percent times total capitation payments reported on the CMS 64".

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## APPENDIX D: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

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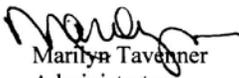
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** DEC 16 2013

**TO:** Daniel R. Levinson  
Inspector General

**FROM:**   
Marilyn Tavenner  
Administrator

**SUBJECT:** Office of Inspector General Draft Report: "Pennsylvania's Gross Receipts Tax on Medicaid Managed Care Organizations (MCOs) Is An Impermissible Health Care-Related Tax (A-03-13-00201)"

Thank you for the opportunity to review and comment on the above subject OIG's draft report. The Centers for Medicare & Medicaid Services (CMS) appreciates the information presented in the report and offers the following comments.

The OIG drafted this report to determine whether Pennsylvania's gross receipts tax was in compliance with federal statutory and regulatory provisions governing health care-related taxes. CMS was aware that OIG was reviewing several Pennsylvania tax programs imposed on health care providers. During those conversations, CMS provided information related to CMS's approval of some of Pennsylvania's health care-related taxes (e.g., nursing facility services, and inpatient hospital services). When questions arose regarding the gross receipts tax, CMS noted that it had not reviewed this tax for approval. The draft report indicates that:

- the gross receipts tax imposed on Medicaid MCOs is health care-related;
- the gross receipts tax imposed on Medicaid MCOs is not broad-based since it only applies to Medicaid MCOs; and
- the gross receipts tax imposed on Medicaid MCOs violates hold harmless provisions as the capitation payments paid to the Medicaid MCOs guaranteed to repay the MCOs for the entire cost of the tax.

**OIG Recommendations:**

The OIG's findings indicate that Pennsylvania's gross receipts tax imposed is impermissible and recommends that CMS:

- offset \$1,758,155,583 in Gross Receipts Tax revenues from State Medicaid expenditures: \$533,936,161 from State FY 2009-2010, \$581,452,384 from State FY 2010-2011, and \$642,767,038 from State FY 2011-2012;

- offset Gross Receipts Tax revenues from Medicaid expenditures when determining the Federal share of Pennsylvania's Medicaid program expenditures for periods after State FY 2011-2012; and
- clarify its policies concerning permissible health care-related taxes with all States.

**CMS Response:**

As discussed below, CMS partially agrees with these recommendations.

The CMS agrees that further guidance is needed on what constitutes a health care-related tax, in situations like the one reviewed by OIG. Section 1903(w)(3)(A)(i) of the Social Security Act (the Act) defines a health care-related tax using multiple tests that must be applied. Health care-related taxes include taxes related to: (1) health care items or services; (2) the provision of, or the authority to provide, the health care items or services; or (3) payment for such items or services. Section 1903(w)(3)(A)(ii) further stipulates that a health care-related tax includes taxes that are not limited to health care items or services, but provide for different or unequal treatment for individuals or entities that are paying for or providing health care items or services. Any tax must be fully evaluated against all components of the statutory definition.

The statute further stipulates that if 85 percent of the tax burden falls on health care providers, it is considered to be related to health care items or services. CMS agrees with OIG that this provision does not mean the converse – that if less than that burden falls on health care providers, it is necessarily not related to health care items and services. But a number of states appear to have relied on this erroneous reading in crafting tax programs. To the extent that states may not understand this provision, and may be under the impression that it creates a safe harbor for any tax on health care providers, there is some likelihood that those states will assert that they had inadequate notice and should not be adversely affected by an unpublished interpretation of the statute and regulation. As a result, CMS does not agree with OIG that a disallowance is warranted until the states have clear notice of the federal interpretation of the statute and regulation.

Similarly, the issue of whether the tax at issue is imposed on a range of industries or just on Medicaid MCOs, is one that has not been expressly addressed in sub-regulatory guidance and could be subject to challenge by the state. The OIG distinguished the gross receipt tax on Medicaid MCOs from the gross receipts tax imposed on other industries subject to the tax (i.e., electric companies, telecommunications companies, transportation entities and private bankers) because the gross receipts tax on Medicaid MCOs is imposed at different tax rates than on such other industries.

Under the Pennsylvania's gross receipts tax, Medicaid MCOs were subsumed into a larger taxing structure, therefore we are concerned that Pennsylvania will likely claim that it is not appropriate to separate the gross receipts tax into several separate taxes by industry. In the aggregate among all industries, Pennsylvania will likely argue that the gross receipts tax is not health care-related because 85 percent of the aggregate burden does not fall on health care providers. And as such, Pennsylvania may believe that the portion of the gross receipts tax imposed on Medicaid MCOs would not be subject to federal Medicaid requirements as a separate health care-related tax. CMS agrees that, based upon the information presented in OIG's report, it appears that the portion of the gross receipts tax imposed on Medicaid MCOs may be considered a health care-related tax. CMS has not issued sub-regulatory guidance to explain this position and, as a result,

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CMS does not agree with OIG that a disallowance is warranted until the states have clear notice of the federal interpretation of the statute and regulation.

In other words, since CMS has not specifically provided guidance on the inclusion of Medicaid health care providers or services into larger (often existing) non-health care-related taxes, CMS believes the appropriate course of action is to clearly articulate the meaning of the statutory requirements defining a health care-related tax. In addition, if after CMS's review we determine it is an impermissible health-related tax under the statute; CMS will work with Pennsylvania to develop an approvable tax structure. However, CMS will not pursue financial recoveries for periods prior to issuance of the national guidance.

The CMS appreciated the opportunity to review and comment on this OIG report, and we look forward to working with OIG on this and other issues.