



July 2017

## Budget

---

**Poor state funding for public transit and counties  
drives MCO tax fight**

Wendy Patton

# Introduction

---

When the federal government told Ohio to bring the Medicaid managed care organization provider tax (MCO tax) into compliance by broadening its base, the state did. However, Ohio's solution reduced tax collections and left counties and public transit out of the fix.<sup>1</sup> The cut amounts to more than \$200 million a year.

The MCO tax was in the base of the state sales tax. To broaden that base, the Kasich Administration moved it to the health insuring corporation tax, part of the state's domestic insurance tax. That satisfied the federal mandate, but created another problem. Counties and transit agencies piggyback their local sales tax piggybacked to the state tax base. In 2016, those entities received \$209 million from MCO tax revenues (8.2 percent of all county and transit authority sales-tax collections in Ohio).<sup>2</sup> Moving the MCO tax from the sales tax to the insurance tax eliminated these local collections as of July 1, 2017. House Bill 49, the budget bill for 2018-19, provides \$207 million to help counties and transit agencies adjust in the short term, but for the majority the aid will be gone by 2019, and there is no replacement.

In House Bill 49, the General Assembly directed the Kasich Administration to seek permission from the federal government to reverse the cuts for and restore MCO revenues to locals – counties and public transit agencies – for six years (2019–2024). The governor vetoed the provision, warning that even an inquiry could cause the federal government to revoke approval for the entire tax. The House overrode the Governor's veto with an overwhelming majority. At the date this paper was released, the Senate had not voted on any of the House's override provisions.

Ohio already woefully underfunds public transit. A recent study of Ohio's statewide transit needs recommended the state provide at least 10 percent of public transit costs, around \$120 million a year.<sup>3</sup> But the state provides only about \$40 million a year through both the operating and transportation budgets. Loss of the of MCO revenue stream will completely offset the entire amount of state funding for public transit.

Loss of MCO tax revenues is also a harsh fiscal blow to counties, following years of deep cuts in state revenue sharing funds.<sup>4</sup>

This paper examines proposed changes to the MCO tax, offers a background on this provider tax, and reviews the debate about restoring the cuts. We conclude that Ohio should go back to the federal government and ask permission to restore the tax to its former size, so as to continue the MCO tax revenue stream for counties and public transit.

---

<sup>1</sup> Wendy Patton, Medicaid Provider tax fix must not hurt counties, transit agencies, Policy Matters Ohio, July 2016 at <http://bit.ly/2uqWW7E>

<sup>2</sup> David Dewitt, "County auditor warns about loss of sales-tax revenue, Athens News Messenger, May 14, 2017 at <http://bit.ly/2v5KqqD>

<sup>3</sup> The Ohio Department of Transportation's (ODOT) Statewide Study of Transit Needs (<http://bit.ly/2uqNAC7>) recommended the state provide 10 percent of total system costs: \$120 million a year starting in 2015, rising to \$185 million a year by 2025.<sup>3</sup> The state will provide less than \$40 million a year into public transit in 2018 and 2019. Loss of the MCO tax revenues will offset that entirely in 2019.

<sup>4</sup> The County Commissioners Association estimates counties have lost \$100 million in state support over the past 6 years. Suzanne Dulaney, Executive Director of the County Commissioners Association of Ohio, in an e-mail to Policy Matters Ohio, July 12, 2017.

# Changes in the MCO tax

Health care provider taxes have been used by the states since the 1980s. Most states use these funds for financing Medicaid, but states have the policy option to designate or earmark the revenue for any state purpose.<sup>5</sup>

The Congressional Research Service uses this example to demonstrate how a provider tax raises funding for state share of Medicaid as well as other purposes

*"[Consider] a state that collects \$10 million in tax revenue through this provider tax. The state then increases Medicaid reimbursement rates to nursing homes, which means nursing homes with Medicaid enrollees receive an additional \$8 million. With these Medicaid expenditures, the state draws down \$4.8 million (60% of \$8 million) in federal Medicaid matching funds. In this example, the state was able to increase Medicaid payment rates to nursing homes without the use of any state general funds, and the state is left with \$6.8 million to use for other Medicaid or non-Medicaid purposes."*

- Congressional Research Service, "Medicaid Provider Taxes," August 5, 2016 at <http://bit.ly/2uvGLpW>

Medicaid is a partnership between states and federal government. The federal government's standard share of the cost of Medicaid services provided in Ohio is 63 percent, although it is much higher for some programs (for example, the federal share for the Medicaid expansion is 95 percent).<sup>6</sup> The federal share is referred to as the Federal Medical Assistance Percentage or "FMAP." The state share, referred to as matching funds or "state match," is raised in part through health care provider taxes in most states.<sup>7</sup>

Federal rules governing provider taxes, or the interpretation of those rules, have changed over time. The federal Deficit Reduction Act of 2005 closed a loophole that had allowed the MCO provider tax to apply only to Medicaid providers. The Act required these taxes to have a broader base. In response, in 2009 Ohio placed the narrowly-based MCO tax into the base of an entirely different tax that was much broader - the sales tax.<sup>8</sup>

In 2014, the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees health care provider taxes, found the base of Ohio's MCO tax was still too narrow: it was located in a broad tax, but it did not apply to all similar health providers. In a letter June

<sup>5</sup> National Council of State Legislatures, "Health Provider and Industry Taxes," January 3, 2017 at <http://www.ncsl.org/research/health/health-provider-and-industry-state-taxes-and-fees.aspx>

<sup>6</sup> Ohio Legislative Service Commission, Medicaid Primer, May 2017 at <http://www.lsc.ohio.gov/publications/2017medicaid-primer.pdf>.

<sup>7</sup> Kaiser family health foundation, States and Medicaid provider taxes and fees, June 23, 2017 at <http://kaiserf.am/2s5eAbL>

<sup>8</sup> Other states, including Michigan, Pennsylvania and California, had placed the MCO tax in a broader but not-related tax and were found to be out of compliance with federal law. See U.S. Department of Health and Human Services, Office of the Inspector General, "Pennsylvania's Gross Receipts Tax on Medicaid Managed Care Organizations Appears To Be an Impermissible Health-Care-Related Tax, May 28, 2014 at <https://oig.hhs.gov/oas/reports/region3/31300201.asp>; also "Ohio's and Michigan's sales and use taxes on Medicaid Managed Care Organizations did not meet the broad-based requirement but are not in compliance," April 2017 at <https://oig.hhs.gov/oas/reports/region3/31600200.pdf>

25, 2014, CMS Director Cindy Mann mandated the base be broadened to include all similar providers.<sup>9</sup>

The Kasich Administration moved the MCO tax into the base of the health insuring corporation tax, a component of the state's insurance tax, effective July 1, 2017. It was made smaller and renamed the Medicaid Health Insuring Corporation (MHIC) tax. The overall rate was lowered and counties and public transit agencies with a local piggybacked sales tax lost MCO tax revenues.<sup>10</sup>

MCO tax revenues raised through the local sales tax were distributed based on the residence of Medicaid enrollees, so counties and transit agencies in low-income areas are hit hard by the change. For example, 25 percent of the sales tax revenue of rural Vinton County came from the MCO tax. Large urban counties also feel the blow. Cuyahoga County will lose about \$21 million a year, and takes a double hit: the annual loss to the region's transit agency, the Regional Transit Authority (RTA), is about the same size.<sup>11</sup>

The Kasich Administration created a transition fund for counties and transit agencies in the new budget for 2018-19. The transition fund would provide time-limited support while local entities decide how to cut services or replace lost revenues. The transition fund holds local entities harmless for the first half of fiscal year 2018 (July 1, 2017 to December 31, 2017) and then provides funding in calendar year 2018 that cushions the blow for some but provides less than a full year's funding for others. For example, Vinton County had received, on average, \$345,435 in MCO taxes annually and will get a total of just over \$2.8 million for both 2017 and 2018 under the transition fund. Highland County received \$814,470 on average, but gets more than \$1.8 in total transitional aid. Medina County on the other hand received \$963,329 in annual MCO tax revenues, but will receive total transitional aid of just \$240,830. Hamilton County got \$14 million, on average, in annual MCO revenues, but will receive just \$9.6 million in total through the transition fund.<sup>12</sup>

The legislature wants to restore the MCO revenue stream to counties and transit agencies on a temporary basis, and with a return to the distribution of revenues under the prior tax. The governor is opposed. The focus of the debate is on Medicaid and provider taxes, but the underlying problem is Ohio's crisis in local government funding. Sluggish economies and deep cuts in state aid have left many counties struggling to deliver services. The state chronically underfunds public transit and the loss of MCO revenues further weakens a transit system that is already struggles to meet market demand.

---

<sup>9</sup> Centers for Medicare and Medicaid Services, Letter from Director Cindy Mann to state Medicaid Directors, June 25, 2014 at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-14-001.pdf>, cited in Wendy Patton, Op.Cit.

<sup>10</sup> All counties have a sales tax and eight of Ohio's 61 transit agencies have a sales tax. The transit agencies with a sales tax tend to be the largest public transit authorities in the state.

<sup>11</sup> Counties and transit agencies that have the weakest local tax base get more than the average amount they received from one year of MCO tax revenues. Those with a strong tax base received less than they had gotten in a year's time. Ohio Office of Budget and Management, "Proposed transitional aid to counties and transit authorities in response to the termination of sales tax on Medicaid Health Insuring Corporations (MHICs) at [http://budget.ohio.gov/doc/budget/MHIC\\_Transition\\_Aid\\_Table.pdf](http://budget.ohio.gov/doc/budget/MHIC_Transition_Aid_Table.pdf)

<sup>12</sup> *Id.*

## Background on provider taxes

A provider tax can be levied on 19 different health care services, ranging from inpatient hospital services or nursing facility beds to specific services like podiatric or dental services.<sup>13</sup> Ohio has four provider taxes.

States may use provider tax revenues for the state match only if the tax is found by CMS to be levied on a permissible class of services and be broad based and uniform. It must not allow arrangements that return the collected taxes directly or indirectly to the taxpayer (hold-harmless arrangements).<sup>14</sup> It is to be generally redistributive.<sup>15</sup> The federal government can waive the provisions requiring a provider tax to be broad-based or uniform, but cannot waive the 'hold harmless' provision.<sup>16</sup>

There are two tests of a tax structure to determine if it is holding taxpayers harmless in a manner that would disqualify it from being used to draw down federal matching funds.

**First test:** Federal regulations create a 'safe harbor' from the hold-harmless test for provider taxes in which collections are 6.0 percent or less of net patient revenues.<sup>17</sup>

**Second test:** The second test applies if the aggregate tax rate exceeds 6 percent of net patient revenues. The tax may still be permissible, but only if in the aggregate, no more than 75 percent of taxpayers subject to the tax receive an amount equal to more than 75 percent of such taxes paid in the form of enhanced Medicaid payments or other state payments.<sup>18</sup>

According to the Congressional Research Service: " .... a state can impose a provider tax above the threshold amount (currently 6%) and draw down federal matching funds on the tax revenue, as long as the state can prove that the "75/75 rule" has not been violated (i.e., more than 75% of the taxpaying providers do not receive more than 75% of the cost of the tax back through enhanced Medicaid rates).<sup>19</sup>

For taxes that exceed the first test (the 6 percent threshold) but do not violate the second test (the "75/75 rule"), federal regulators will not reject it automatically, but will consider

---

<sup>13</sup> Congressional Research Service, "Medicaid Provider Taxes," August 5, 2016 at <http://bit.ly/2uvGLpW>

<sup>14</sup> U.S. Department of Health and Human Services, Office of the Inspector General, "Ohio's and Michigan's sales and use taxes on Medicaid Managed Care Organizations did not meet the broad-based requirement but are not in compliance," Op.Cit.

<sup>15</sup> California's Legislative Analyst's Office produced an in-depth study of provider taxes ("Managed Care Organization (MCO) tax background," July 2, 2015 at <http://bit.ly/2u2KY2A>. The study states: "Within its waiver request, the state must demonstrate that its proposed tax structure—like a strictly broad-based and uniform tax—would tend to redistribute revenue from non-Medicaid to Medicaid providers. Therefore, if the state attempted to exempt all non-Medicaid providers from the tax, the tax would likely fail to be redistributive and be denied federal approval.

<sup>16</sup> 42 CFR 433.68 - Permissible health care-related taxes.  
<https://www.law.cornell.edu/cfr/text/42/433.68>

<sup>17</sup> Kaiser family health foundation, States and Medicaid provider taxes and fees, June 23, 2017 at <http://kaiserf.am/2s5eAbL>

<sup>18</sup> *Id.*

<sup>19</sup> Congressional Research Service, Op.Cit.

whether a hold harmless arrangement exists by exploring the specific facts and circumstances related to the tax.<sup>20</sup>

### Ohio's restructured Managed Care provider tax

Ohio's new MHIC tax covers 13 firms in total. The firms are divided into two classes: Medicaid and non-Medicaid. Within each class, different fees apply to firms based on size of enrollment. Table 1 shows which corporations are covered by MHIC, and the fees they pay.

Table 1

Member months	Medicaid member month tiers			Non-Medicaid member month tiers		TOTAL
	Less than 250,000	250,000 to 500,000	More than 500,000	Less than 150,000	More than 150,000	
<b>Rate</b>	<b>\$56</b>	<b>\$45</b>	<b>\$26</b>	<b>\$2</b>	<b>\$1</b>	
Aetna	\$13,665,064	\$0	\$0	\$0	\$0	\$13,665,064
Buckeye	\$14,000,000	\$11,250,000	\$83,457,842	\$293,320	\$0	\$109,001,162
Caresource	\$14,000,000	\$11,250,000	\$384,158,658	\$300,000	\$678,000	\$410,386,658
Molina	\$14,000,000	\$11,250,000	\$91,353,704	\$234,840	\$0	\$116,838,544
ParamountAdvantage	\$14,000,000	\$11,250,000	\$57,032,456	\$107,928	\$0	\$82,390,384
United Healthcare	\$14,000,000	\$11,250,000	\$82,906,590	\$144,028	\$0	\$108,300,618
Community Insurance	\$0	\$0	\$0	\$300,000	\$374,836	\$674,836
Consumers Life	\$0	\$0	\$0	\$16,152	\$0	\$16,152
HealthSpan Integrated Care	\$0	\$0	\$0	\$130,260	\$0	\$130,260
HealthSpan, Inc.	\$0	\$0	\$0	\$152,892	\$0	\$152,892
Humana Health Plan of Ohio	\$0	\$0	\$0	\$278,946	\$0	\$278,946
Medical Health Insuring Corp of Ohio	\$0	\$0	\$0	\$300,000	\$485,722	\$785,722
Premier Health Plan	\$0	\$0	\$0	\$105,624	\$0	\$105,624
<b>Total</b>	<b>\$83,665,064</b>	<b>\$56,250,000</b>	<b>\$698,909,250</b>	<b>\$2,363,990</b>	<b>\$1,538,558</b>	<b>\$842,726,862</b>

Source: Ohio Legislative Service Commission, Memo to Representative William Seitz, April 7, 2017.

Note A member month is the number of members enrolled for services, times 12.

Instead of a percentage rate imposed on the services, Ohio's new managed care tax, the MHIC, is based on a per-member per-month fee. The MHIC was modeled after California's tax, which was approved in 2016 by the federal government. It is broad based, but not uniform: both California and Ohio received waivers that allowed the tax to be non-uniform.

Of the 13 firms subject to the MHIC, six provide Medicaid services which receive reimbursement for the tax and the other seven do not serve the Medicaid program. As currently structured, Ohio's MHIC provider tax satisfies the "75/75 rule," as just 46 percent of the taxpayers receive reimbursement that holds them harmless from the impact of the tax.

A health care provider tax must be generally redistributive, because the Medicaid system benefits the entire health care system. Analysis of the MHIC structure *with the rate restored to reverse the cut to counties and transit agencies* was conducted by consultants to the

<sup>20</sup> e-mailed communication between the County Commissioners Association of Ohio and Anne Karl of Manatt, Phelps & Phillips LLC, dated July 10, 2017 and shared with Policy Matters Ohio by CCAO in e-mailed communications of July 11, 2017.

County Commissioners Association of Ohio. The analysis found the state would continue to meet the requirements of this statistical test.<sup>21</sup>

There is a strong case to be made for reversing the cut and restoring the MHIC tax to its prior size. Analysis reveals it would meet the 75/75 rule, it would be generally redistributive, and no hold harmless arrangement exists.

## A review of the debate

**What the legislature seeks:** The amendment placed into the budget bill during Conference Committee directed the governor to explore reversing the cut to Ohio's managed care provider tax and restoring its prior size and rate:

*“Not later than October 1, 2017, the Medicaid director shall ask the United States Centers for Medicare and Medicaid Services whether the franchise fee may be increased in a manner that provides for the franchise fee to raise up to an additional two hundred seven million dollars per fiscal year without causing the franchise fee to be an impermissible...”*

The Ohio Legislative Service Commission's synopsis of the amendment describes what happens next if the federal government responds positively to the inquiry:

*“...requires the Medicaid Director to seek federal approval to increase the franchise fee on health insuring corporation plans in a manner that provides for the franchise fee to raise up to an additional \$207 million per fiscal year beginning not sooner than fiscal year 2019 and ending on July 1, 2024.*

*Provides for the additional funds so raised to be distributed to the county treasurer and fiscal officer of each county and transit authority that has experienced reduced sales tax revenues because of the cessation of the sales tax on Medicaid health insuring corporations.”<sup>22</sup>*

**Governor Kasich's veto:** The governor vetoed the provision described above. The veto message read:

*“This provision would require the Department of Medicaid to ask the United States Centers for Medicare and Medicaid services whether the franchise fee may be increased through the health insuring corporation (HIC) franchise fee and, if the fee may be so increased, to request approval for the increase.... Requesting a change puts the approved waiver in jeopardy and risks the loss of the \$615 million net benefit currently permitted by the waiver. Further, the Executive budget already provided transition payments for counties as they adjust their budgets in preparation for the end of the existing tax. Therefore, this veto is in the public interest.”<sup>23</sup>*

---

<sup>21</sup> E-mailed communication from the office of Representative Bill Seitz to Policy Matters Ohio and others (May 17, 2017) containing mathematical analysis from County Commissioners Association of Ohio consultants Cindy Mann and Anne Karl of Manett, Phelps and Phillips LLC

<sup>22</sup> House Bill 49 Conference committee amendment CC6037 synopsis at <http://www.ohiohouse.gov/committee/conference-committee-on-hb49>

<sup>23</sup> Governor Kasich's veto message for Substitute House Bill 49 at <https://www.gongwer-oh.com/public/130/HB49veto.pdf>

**Local Government and public transit position:** Cindy Mann is the former CMS director who signed the guidance requiring that states with taxes structured like Ohio's MCO tax to broaden their base. She provided consulting to the County Commissioners Association of Ohio on this issue. In an e-mail to Director Greg Moody of the Governor's Office of Health Transformation, she stated:

*"We appreciate the importance of Ohio not wanting to lose any ground in terms of the waiver approval granted by CMS regarding the franchise tax but do not believe there is a risk of losing that approval if the state sought CMS's informal opinion of an adjustment in the tax sufficient to restore funds to the counties and transit authorities. If the informal review is positive, the State could then seek a formal approval and, if approved, proceed with that adjustment effective July 2018.....In my experience, it is not at all unusual for a state to make inquiries of CMS about possible changes in their provider taxes and do to so without jeopardizing existing approvals. Indeed I see no basis under the law for CMS to reverse a waiver that met all requirements of federal law simply because the state inquired about an adjustment to its tax."<sup>24</sup>*

**Others have weighed in:** In a letter to legislators. The National Federation of Independent Businesses opposes restoration of the tax.<sup>25</sup>

## A strong case for restoring the tax

**A restored MHIC meets federal requirements.** While restoring the tax to its former level would push the rate to higher than the 6% threshold described earlier, the law could allow a restored MHIC to qualify under the second test of provider taxes, since less than 75 percent of taxpayers receive payment from the tax collections. Further, statistical analysis indicates the MHIC in its current form, but with the higher rate, would remain broadly redistributive. As long as no other "hold harmless" provisions are found within the tax, there is a strong case to be made that the federal government would permit the state to move forward with a request to restore the tax to its prior size.

**A restored MHIC would require a restored distribution of collections.** Restoring the tax to its previous level would require sufficient state match to draw down reimbursement for Medicaid taxpayers in a sum similar to what was provided under the prior tax. Under the MHIC, \$243 million will be used as state match, but under the old MCO tax, an estimated \$303 million would have been used for state match (Table 2). If the tax cut is reversed, a revenue distribution like that under the prior tax would have to be restored.

---

<sup>24</sup> e-mail from former CMS Director Cindy Mann, of Manett Phelps & Phillip LLC, to Ohio Office of Health Transformation Director Greg Moody, in an e-mail of June 4, 2017.

<sup>25</sup> National Federation of Independent Businesses at <http://www.nfib.com/content/nfib-in-my-state/healthcare/nfibohio-requests-one-veto-be-sustained/>

Table 2

Distribution of funds	Old MCO tax	New MHIC tax
State Medicaid match	\$243	\$303
Other state uses	\$615	\$558
Local distribution	\$0	\$195
<b>TOTAL</b>	<b>\$858</b>	<b>\$1,056</b>
<b>Reimbursement to Medicaid</b>		
State share	\$243	\$303
Federal share	\$611	\$756
<b>TOTAL</b>	<b>\$854</b>	<b>\$1,059</b>

*Source: For Old MCO tax - Policy Matters Ohio, based on projections for 2018 MCO tax provided by the Ohio Office of Budget and Management to the County Commissioners Association of Ohio and published in their Statehouse Report, July 15, 2016 at <http://bit.ly/2tfT1KN>. For new MHIC tax, projections are taken from Legislative Service Commission analysis of the executive budget Health Insuring corporation fee in the Comparison Document (as enacted), page 32, at <http://www.lsc.ohio.gov/fiscal/comparedoc132/en/mcd.pdf>*

**Federal laws allow an inquiry. If that inquiry gets a positive response, states can apply to restore the MHIC to its former level.** There are no new Medicaid laws in place that would invalidate an inquiry. Congress is considering major changes to Medicaid that may affect provider taxes but that discussion is far from settled. State legislators can only rely on today’s rules, not tomorrow’s concerns. The override of the Governor’s veto indicates lawmakers in the House want to make the inquiry regardless of the uncertainty around health care financing in Washington.

**Concerns of danger to the existing tax from an inquiry are overstated.** The state has received an approval of the new tax structure from the federal government, placed in effect July 1, 2017 (see Appendix). An inquiry into further change for a temporary period of time is not cause for the federal government to revoke approval.

**The new MHIC tax affects few health insuring corporations and the rate on non-Medicaid insurers is very low.** The base of the restructured tax affects just 13 of the 47 health insuring corporations listed on the website of the Ohio Department of Insurance. Of these 13 firms, six are Medicaid providers. For them, the tax is covered by Medicaid reimbursement. MHIC collections from the non-Medicaid firms in the base is just four hundredths of one percent of total MHIC collections. The adjustment needed to restore funding to counties and public transit has only a small impact on the non-Medicaid health insuring corporations in the base.<sup>26</sup>

<sup>26</sup> Quantitative analysis in E-mailed communication from the office of Representative Bill Seitz to Policy Matters Ohio and others (May 17, 2017), Op.Cit.

## Summary and recommendations

---

The state restructured its managed care organization provider tax at the request of the federal government, but in so doing, eliminated more than \$200 million a year that counties and transit agencies depended on. The General Assembly directed the executive branch to temporarily reverse the cut until 2024. The Governor vetoed the provision; the House overrode the veto. The Senate has not yet voted. Senators should concur with the House.

Dangers to the existing tax from an effort to restore the MHIC tax are overstated, since the current tax has been approved. While the management of federal agencies has changed, Medicaid laws have not. The Kasich Administration has not explained their concern that the existing approval of the MHIC would be revoked in response to an inquiry.

Reversing the cut to the managed care organization provider tax would mean restoring the former distribution, with more funds dedicated to Medicaid reimbursements. This would require a redistribution of the MHIC tax collections, some of which is already programmed in the General Revenue Fund of the 2018-19 state budget. Some appropriations might need to be shifted.

The impact of reversing the MHIC tax cut to non-Medicaid taxpayers is small. Few health insurers pay this tax. The fees on non-Medicaid insurers are quite low.

Lawmakers have proposed a workable, if temporary, solution to public transit and county funding needs in the context of a tight state budget. In the longer run, a permanent solution needs to be developed. This problem, after all, is the result of a crisis in local government funding, not a crisis in the Medicaid system.

The state should be funding public transit at the levels recommended by the Department of Transportation's Statewide Transit Needs study: \$120 million a year, rising to \$185 million a year by 2025.<sup>27</sup>

Counties have been cut and are operating with an estimated \$100 million less than they had in 2010.<sup>28</sup> The state needs to provide sufficient funding for counties, the administrative arm of the state for many judicial, health and human services.

Funding needed in the long term by public transit and counties should be raised by closing unnecessary and unproductive tax breaks in the \$9 billion tax expenditure budget.

---

<sup>27</sup> Ohio Department of Transportation, Op.Cit.

<sup>28</sup> Suzanne Dulaney, Executive Director of the County Commissioners Association of Ohio, Op.Cit.

# Appendix

## Approval letter of MHIC waiver

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



John B. McCarthy, Director  
Ohio Department of Medicaid  
P.O. Box 182709  
50 West Town Street, Suite 400  
Columbus, Ohio 43218

DEC 07 2016

Dear Mr. McCarthy,

This is in response to your request for waiver of the broad-based and uniformity requirements related to your managed care organization (MCO) tax. Ohio is requesting this waiver as an update to its previous MCO tax to satisfy CMS' updated policy requirements. Upon review and consideration of the information formally provided to the Center for Medicare & Medicaid Services (CMS) on November 09, 2016, I am pleased to inform you that your request for waiver of the broad-based and uniformity provisions of sections 1903(w)(3)(B) and (C) of the Social Security Act (the Act) is approved.

The tax structure for which Ohio requested waiver would be imposed as follows beginning state fiscal year (SFY) 2018:

- Cumulative Ohio Medicaid member months from 0 to 250,000 are taxed \$56.00 per month;
- Cumulative Ohio Medicaid member months from 250,001 to 500,000 are taxed \$45.00 per month;
- Cumulative Ohio Medicaid-member months in excess of 500,000 are taxed \$26.00 per month;
- Cumulative Other member months from 0 to 150,000 are taxed \$2.00 per month;
- Cumulative Other member months in excess of 150,000 are taxed \$1.00 per month.

Section 1903(w)(3)(E) of the Act specifies that the Secretary shall approve uniformity (and broad-based) waiver applications if the net impact of the tax is generally redistributive.

The federal regulation at 42 CFR 433.68(e)(2) describes the statistical test necessary for a state to demonstrate that the proposed structure is generally redistributive. Ohio's statistical demonstration is addressed below. Moreover, the federal regulation at 42 CFR 433.68(f) describes the circumstances in which a hold harmless arrangement would exist. Upon review of the Ohio statute implementing the proposed MCO tax and the review of Ohio's proposed methodology for increasing Medicaid reimbursement to managed care organizations, it appears that no hold harmless arrangement exists between the associated increases in Medicaid reimbursement.

To determine the generally redistributive nature of the proposed member month tax, Ohio calculated the slope (expressed as B1) of a linear regression for a broad-based and uniform tax in which the dependent variable was each MCO's percentage share of the total tax paid, if the tax was uniformly imposed on all member months in the state and the independent variable was each MCO's Medicaid member months. Ohio then calculated the slope (expressed as B2) of a linear regression for the state's actual proposed tax program in which the dependent variable was each MCO's percentage share of the total tax paid and the independent variable was the number of Medicaid member months for each MCO.

Using the patient day and tax rate data you provided, CMS also performed the regression analysis calculations required in the regulations for the proposed tax. CMS finds that the result of the generally redistributive calculation for the tax is **1.0001**.

Page 2 – Mr. McCarthy

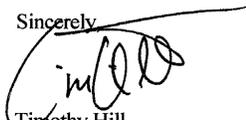
Therefore, we are able to approve your request to modify your waiver of the broad-based and uniformity provisions of sections 1903(w)(3)(B) and (C) of the Act for the proposed MCO tax. Please be advised that any future changes to the taxing structure, including a non-uniform change to the approved tax rates, will require the State of Ohio to submit a new broad-based and/or uniformity waiver request.

The federal regulations at 42 CFR 433.72(c)(2) specify that a waiver will be effective for tax programs commencing on or after August 13, 1993, on the first day of the calendar quarter in which the waiver is received by CMS. CMS received the State of Ohio's initial request for waiver of the broad-based and uniformity requirements on November 09, 2016, with a requested effective date of July 1, 2017. Therefore, the effective date of Ohio's request for waiver of the broad-based and uniformity requirements is July 1, 2017.

CMS reserves the right to perform a financial management review at any time to ensure that the state operation of the tax on nursing facilities continues to meet the requirements of section 1903(w) of the Act.

I hope this information addresses all of your concerns. If you have further questions or need additional information please contact Rich Cuno at (410) 786-1111.

Sincerely,



Timothy Hill  
Deputy Director

# Acknowledgements

---

This work was made possible in part by:

**Center on Budget and Policy Priorities**

**The George Gund Foundation**

**The Ford Foundation**