

THE PRESIDENT HAS SEEN

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THE WHITE HOUSE

WASHINGTON

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December 1, 2000

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MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed
Barbara Chow

SUBJECT: DPC Weekly Report

1. Education -- 25th Anniversary of the IDEA: Wednesday marked the 25th anniversary of the Individuals with Disabilities Education Act (IDEA). In addition to your photo op with community leaders, the Department of Education had a press conference to release a new report on the status of education for students with disabilities. The report shows that the percent of students with disabilities who are educated in regular classrooms increased from 26 in 1986 to 46 percent in 1997. Furthermore, most states are now showing 50 to 65 percent IDEA student participation in statewide assessments today, compared with less than a ten percent participation rate a decade ago. Data also shows that the rate of disabled students graduating from high school with a regular diploma has increased four percentage points over the past four years, while there has been more than a four percent decrease in the drop-out rate.

2. Education -- California Schools Sue State Over School Construction Bonds: A group of California school districts and organizations sued a state board Monday, saying the new state bond distribution method for school construction hurts growing school districts. The lawsuit, filed in Sacramento Superior Court, contends the new rules are illegal because they hurt school districts that have had their construction plans and matching funds set aside before September. The suit states that the new system will delay funds until there are "no more state funds" left for school construction.

3. Welfare -- Florida Welfare Reform Results: The Manpower Demonstration Research Corporation recently released the final report on Florida's Family Transition Program (FTP), highlighting long-term results from one of the first states to implement time limits. The study found that over a four-year period, FTP significantly increased employment and income and reduced long-term welfare receipt without causing hardship or impacts on child well being. Seventeen percent of families actually reached their time limit and had their benefits cancelled; about three-quarters left welfare before hitting the

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time limit and the remainder received an exemption for medical or other reasons. Those who hit the time limit were a diverse group and were not necessarily the most disadvantaged. Less than half of those who reached the time limit worked steadily in the next 18 months, relying on supports like family, friends, food stamps, and housing assistance. However, families who hit the time limit did not appear worse off than families who left welfare for other reasons, many of whom struggled to make ends meet. FTP began under a welfare reform waiver and operated from 1994 to 1999 in the Pensacola area. It combined a time limit of 24 months in any 60-month period (or 36 out of 72 months for the least job ready) with a variety of requirements, incentives and services to help recipients find work.

4. Physical Activity -- Olympic-Paralympic Event: Last Wednesday's White House program on physical activity was well-received by the advocacy community and the other interested groups who attended both the roundtable led by Secretaries Riley and Shalala and the subsequent Olympic-Paralympic event. Participants expressed appreciation for the steps you have taken, including the July 23rd directive and the report you released last Wednesday, to highlight the need for physical activity among young Americans. The Secretaries' roundtable at the White House before your Olympic-Paralympic remarks was also successful in promoting working relationships among the diverse group of interested stakeholders in this area, and in spurring ongoing momentum for action on this issue.

5. Health Care -- Update on Arkansas UAMS Plan Amendment: Following up on concerns raised by UAMS, HHS decided to permit the medical school to access increased Medicaid funding. As a consequence, Arkansas will see their Medicaid payment increases for UAMS increase by over \$30 million this year and next year. Senator Bumpers, UAMS, and Ray Hanley expressed great gratitude.

6. Health Care -- Update on Medicare Solvency and New Technology Cost Projections: On Thursday, the New York Times accurately reported that the Technical Review Panel on the Medicare Trustees' Reports made their preliminary report to Secretary Shalala, stating that Medicare projected costs should be increased to reflect a more accurate measure of new health care technologies. They determined that such a modification to cost projections would reduce the projected Medicare solvency date from 2025 to 2021. While this would represent a notable decline in the solvency status, it is important to note that in the last 25 years, the Medicare Trust Fund has never been in a stronger financial position than it is today, even if the insolvency date was determined by the Trustees to be 2021. Moreover, the most recent data we have available indicates that spending in 2000 has declined below previous projections. As a result, it appears unlikely that the next Medicare Trustees report would reduce its annual solvency projection by four years even if they used this new methodology.

7. Guns -- Brady Event Follow Up: In response to your request, the Justice and Treasury Departments expect to have an implementation plan ready within 30 days for a system to notify state and local law enforcement when criminals and other restricted persons illegally attempt to purchase firearms in their communities. We will continue to work closely with them on their plan. Next week, the Attorney General will take further

Thank you!
[Signature]

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action to strengthen Brady background checks by sending letters to the governors announcing her plans to improve the collection of certain mental health records. Under federal law, persons who have been committed to a mental institution or were adjudicated as mentally "defective" are not permitted to possess a firearm. Currently, however, many restricted mentally ill persons could pass NICS checks because a number of states have strict privacy laws which prevent them from sharing relevant mental health records with NICS. To address this problem, the Justice Department plans to create a confidential NICS file that will allow more states to share appropriate mental health records without violating state privacy laws.

8. Children and Families -- Child Care: Two complementary reports on child care will be released next week that make the case for a greater investment in child care. These reports can be used to call on Congress to finish their business and make the needed investments in child care, namely the \$817 million increase in CCDBG and the \$1 billion increase in Head Start. The first study is a U.S. Department of Health and Human Services interim report, part of a five-year research effort to explore how states and communities implement policies and programs to meet the child care needs of families moving from welfare to work. This interim report shows that in the three-years since the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act, the states have provided child care subsidies to 30% more children in 12 of the 15 states studied. The report demonstrates, however, that even with this increased investment in child care there remains a significant unmet need for child care subsidies – most states were only serving 15-20 % of eligible children from all federal and state sources. The second study, a report by the Children's Defense Fund, shows that the cost of child care makes child care prohibitive for many low-income families or forces low-income families to choose child care that is low cost and low quality. In fact, the report showed that the average annual cost of child care for a 4-year old in an urban area is more than the average annual cost of public college tuition.



POWELL, GOLDSTEIN, FRAZER & MURPHY LLP

Arkansas UAMS MEDICAID

Date: November 27, 2000

MEMORANDUM

To: Harriet Rabb, General Counsel, U.S. Department of Health and Humans Services

From: Barbara Eyman, Attorney for the University of Arkansas for Medical Sciences

Re: Arkansas' Interpretation of 42 C.F.R. §447.321

cc: Tim Westmoreland, Director of Medicaid and State Operations
Sheree Kanner, General Counsel, HCFA

As you know, Arkansas' Medicaid state plan amendment to establish an outpatient State Operated Teaching Hospital payment is pending before HCFA, with the approval period due to expire tomorrow, November 28. HCFA has informed Arkansas that it disagrees with Arkansas' legal interpretation of the regulation governing the payment (42 C.F.R. §447.321). We understand you will be reviewing the issue today.

Attached is a set of talking points providing some background on this issue, as well as a more detailed legal analysis of the provision in question. We would appreciate your consideration of these materials in making your decision regarding Arkansas' legal interpretation.

If you have any questions, please feel free to contact me at

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UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
PENDING SUPPLEMENTAL MEDICAID PAYMENTS
TALKING POINTS
November 27, 2000

- Last May, Arkansas submitted a proposal to the Health Care Financing Administration (HCFA) to establish a new \$36 million federal Medicaid outpatient payment to the University of Arkansas for Medical Sciences (UAMS), the state's only teaching hospital.
- UAMS is the major safety net hospital in the state, providing approximately \$60 million in uncompensated care annually. Most states are able to cover the uncompensated care costs of their safety net hospitals through Medicaid Disproportionate Share Hospital (DSH) payments. Arkansas, however, is permanently barred from establishing a significant DSH program because it did not move quickly enough to create one before Congress essentially froze the DSH program in place in 1992 -- prohibiting states from increasing their DSH programs from that time forward to any significant extent. As a result, UAMS receives a mere \$53,000 in DSH payments to cover its \$60 million in uncompensated costs. Statewide Arkansas receives only about \$2 million in federal DSH payments as compared to about \$8 billion paid out nationwide.
- The Medicaid payment proposed for UAMS would pay it up to the maximum level permitted under federal regulations -- up to the so-called "upper payment limit" or "UPL."
- HCFA recently issued a proposed regulation to reduce states' flexibility in calculating the UPL. It was attempting to close a "loophole" in the regulation that allowed some states to draw down excessive Medicaid payments purportedly to reimburse providers, but the providers turned around and sent most or all of the payments back to the state, which blatantly used the money for tax cuts, education initiatives and the like.
- The proposed regulation includes protections for "safety net providers," but once again shortchanges Arkansas by limiting those protections to non-state owned safety net providers. Arkansas is being discriminated against simply because its primary safety net institution happens to be state-owned. The proposed regulation therefore adds insult to injury in stacking the laws against Arkansas' safety net and the patients that rely on it.
- Arkansas' proposed payment will no longer be permitted under the new regulation. However, that regulation allows for a 2-year transition period for programs approved before its effective date. Arkansas proposal should be subject to this transition period, meaning that UAMS could be paid through September 30, 2002.
- HCFA has 180 days to approve or deny Medicaid state plan amendments such as Arkansas'. Alternatively, it can allow a proposal to lapse into effect at the expiration of the 180 days without any action on its part.
- Arkansas' proposal is scheduled to lapse into approval on Tuesday, November 28. Throughout the 180-day period that is about to expire, HCFA has told Arkansas that its proposal was going to be allowed to lapse into approval, and that there were no significant

technical problems with it. In August, it issued a set of written questions to the state, which did not indicate any technical problems. On Wednesday November 22, 6 days before the clock was to run out, HCFA for the first time raised a new objection which it claims will force it to deny the proposal if not modified before Tuesday.

- Arkansas' proposal is backed by significant political support. Last summer, the current governor and five former governors of Arkansas sent a letter directly to President Clinton urging his approval of the plan. Former Sen. Dale Bumpers has repeatedly urged the Administration to approve the proposal, and has been significantly involved over the last several days in trying to convince HCFA to change its mind. Rep. Vic Snyder has also urged approval.
- HCFA, however, is insisting that it does not have the legal authority to allow Arkansas' plan to take effect in its proposed form.
- We strongly disagree with the HCFA legal interpretation. The language of the governing regulation supports more than one interpretation. We believe that unless patently wrong, HCFA (without having issued any further guidance to states about how to interpret the regulation) must accept Arkansas' reasonable legal interpretation, even if it disagrees with it. For years, HCFA has remained completely silent on how states should calculate upper payment limits and how the regulation should be interpreted. It should not now be permitted to retroactively issue clarifying guidance that will bar a state's alternative but reasonable interpretation.
- Arkansas' interpretation will not have implications for other states. The interpretation is based on the language of the current regulation, which is about to be superceded by the new regulation. The new regulation, we believe, does not support Arkansas' methodology. Therefore, no states will be able to submit proposals moving forward using Arkansas' methodology.
- Moreover, the context in which HCFA is choosing to strictly interpret these regulations is almost surreal. For months, HCFA has approved proposals from states for hundreds of millions of dollars that it knew were not going to be used for the purposes stated in the proposals but rather funneled back to the states to balance budgets, cut taxes or fulfill other items on their policy wish lists (health related or not). Moreover, many of the largest such programs are in states that already have substantial Medicaid. Disproportionate Share Hospital programs amounting to hundreds of millions to over a billion dollars. Arkansas is merely proposing a \$36 million federal payment to supplement its paltry \$2 million DSH allotment, to pay a struggling safety net provider with over \$60 million in uncompensated care. The strict, hyper-legalistic interpretation does not reflect stated Administration priorities to assist struggling safety net providers.
- A fuller discussion of the legal basis for Arkansas' interpretation of the UPL regulation is attached.

Legal Basis for Arkansas' Proposed Outpatient UPL Methodology

Under Medicaid law and regulations, states are granted flexibility in setting payment rates for providers of services to Medicaid beneficiaries. The regulations merely require that total Medicaid payments not exceed the amount that would be paid for the services under Medicare reimbursement principles. However, the current regulation permits states to calculate this upper payment limit (UPL) on an aggregate basis for each type of provider. That is, a state may not pay hospitals more in the aggregate under Medicaid than they would receive in the aggregate under Medicare. As a result, some hospitals can be paid more than Medicare would allow as long as other hospitals are paid less. These limits apply separately to hospital inpatient services, nursing facility services, services to intermediate care facilities for the mentally retarded (ICF/MR), and hospital outpatient and clinic services.

HCFA has not, however, provided specific guidance to states on *how* to calculate the UPL. With respect to hospital outpatient payments, which is what is at issue in Arkansas, the only guidance is contained in the regulation, which provides as follows:

"Payments by an agency for *outpatient hospital services* may not exceed the total payments received by *all providers* from beneficiaries and carriers or intermediaries for providing *comparable services* under comparable circumstances under Medicare."¹

Relying on the language of this regulation, Arkansas has proposed to calculate the outpatient hospital UPL by comparing Medicaid payments statewide for a specified list of services to Medicare payments for those services. The list of services was carefully and conservatively developed to include only those services that hospital outpatient departments provide. There are no items on the list that are not provided by hospital outpatient departments.

Arkansas then calculated the difference between statewide Medicaid and Medicare payments for these services. In calculating this difference, it included Medicaid payments for those services to *all providers* in the state, not just to hospital outpatient departments. For example, hospital outpatient departments provide dental services; therefore, dental services were included on the list. Yet in calculating the gap between Medicaid and Medicare rates for dental services, Arkansas looked at payments for dental services statewide, including both those dental services provided by hospital outpatient departments and those provided by other types of providers.

Arkansas believed that this approach to calculating the outpatient UPL was well grounded in the language of the regulation itself. The regulation states that payments "*for outpatient hospital services* may not exceed the total payments received by *all providers* . . . for providing *comparable services*" using Medicare reimbursement principles. Though the limit is one that applies specifically to outpatient hospital payments, the regulation suggests that the limit may be calculated

¹ 42 C.F.R. §447.521(b) (emphasis added).

by looking at total payments to *all providers*, whether or not they are hospital outpatient departments.

HCFA, by contrast, is interpreting the language of the regulation to preclude Arkansas' approach. It is reading the regulation as if it stated that payments "for outpatient hospital services may not exceed the total payments received *by all outpatient hospital departments* from beneficiaries and carriers or intermediaries for providing *outpatient hospital services [or such services]* under Medicare." The regulation is not so narrowly worded, however, and we believe that HCFA must allow Arkansas to adopt its alternative but reasonable interpretation.

In allowing Arkansas to move forward pursuant to its interpretation, HCFA would not be opening a "pandora's box" that would lead to a flood of state plan amendments adopting this approach. Arkansas' interpretation is based on the current regulation. The proposed regulation is more specific. It provides:

"... aggregate payments by an agency to each group of health care facilities (that is, outpatient hospitals or clinics) may not exceed a reasonable estimate of what would have been paid for each of *those services* under Medicare payment principles."²

The new regulation, in requiring a comparison of Medicaid payments to outpatient hospitals with what would have been paid for "those services" under Medicare, has considerably narrowed the universe of payments that can be compared. Moreover, if HCFA is concerned that allowing Arkansas' interpretation may have implications even under the new regulation, it can clarify the new regulation to prohibit such an approach.

Moreover, we are not asking HCFA to adopt a new and broad interpretation of the term "outpatient hospital services." The regulation establishes a limit on payment for such services, but the limit is based on amounts paid to "all providers" for "comparable services" under Medicare. Arkansas' expansive list of services is based on the interpretation of the phrases "all providers" and "comparable services," not on the phrase "outpatient hospital services." Therefore, there should be no spillover effects on either the new UPL regulation or on any other HCFA regulations that include the term "outpatient hospital services."

In sum, we believe that the regulation, in limiting payments for outpatient hospital services to the amount that Medicare would pay to *all providers* of *comparable services*, permits Arkansas' approach to calculating the UPL. Absent more specific guidance over the years from HCFA on how to calculate the UPL, we believe that Arkansas' interpretation of the regulation is within the realm of reason and therefore should be permitted to take effect.

² 65 Fed. Reg. 60158 (October 10, 2000) (emphasis added). Parallel language is used in the subsections pertaining to payments to government-owned or operated facilities and state-owned or operated facilities.

HANYS

HEALTHCARE ASSOCIATION OF NEW YORK STATE
One Empire Drive, Rensselaer, NY 12144
518.431.7600 / Fax: 518.431.7915

October 5, 2000

Fax #44

TO: All Members

FROM: Daniel Sisto, President

SUBJECT: **Medicaid Intergovernmental Transfer (IGT) Regulation and Statutory Proposal Released; Solution Protects New York State's Program Funding**

Today, the Department of Health and Human Services (HHS) and the Health Care Financing Administration (HCFA) released a proposed rule and statutory recommendations that would restrict the use of Intergovernmental Transfer (IGT) payments in state Medicaid programs and increase the cap on Medicaid disproportionate share hospital (DSH) payments. HCFA's release of this rule comes after months of discussions with Congress, several governors, the American Hospital Association (AHA), HANYS, and other state hospital/health care associations. Importantly, this rule lays out the framework for preserving New York State's IGT funding.

After weeks of discussions between HANYS, the Clinton and Pataki administrations, Senators Daniel Patrick Moynihan (D-NY) and Charles Schumer (D-NY), many of our House Delegation members, and the Greater New York Hospital Association, I am pleased that the process has yielded an acceptable approach to protect New York's funding. To assure the full implementation of this solution, action by Congress and the State Legislature must also occur.

For several months, HCFA has been under increasing pressure to issue regulations that would shut down the IGT mechanism. Public allegations of certain states' use of federal Medicaid dollars for non-health care prompted the Clinton Administration to consider prohibiting all states from using the IGT mechanism. HCFA's initial proposal would have threatened nearly \$500 million in federal funds that New York receives annually and uses to subsidize Medicaid, health care programs for vulnerable populations, and county nursing homes.

Upon learning of this potential regulation, HANYS and AHA registered strong opposition to any proposal that would wipe out legitimate health care programs in many states. Working with Senator Schumer, I communicated directly to the White House that this outcome was completely unacceptable and we secured a commitment that the Clinton Administration would work with us to seek alternatives that would protect New York's legitimate health care spending. Similarly, the

Senator and I worked to facilitate communication between the Clinton and Pataki administrations.

HCFA's proposed regulation and comments of the Secretary of HHS included the following recommendations:

- the imposition of an upper payment limit (UPL) cap on non-state, public hospitals at a level 150% of what Medicare rules would allow;
- a UPL for non-state public nursing homes at 100%;
- an extended transition period: initial effective date of April 1, 2002, followed by a four year phase-in of the new limits;
- a recommendation to enact legislation to increase allowable hospital-specific DSH caps to 175% of net uncompensated care costs (also effective in 2002) and increases to the statewide DSH cap; and
- an adjustment to a state's budget neutrality cap (for waived states like New York).

While we are pleased with this development, this regulation is only the first step in a process that will be needed to operationalize this funding transition. Both Congress and the New York State Legislature will have to enact legislation to codify conforming changes and assure appropriate distribution of these funds. It is essential that federal statutory changes be passed in conjunction with this proposed rule. Moreover, key to this transition is the need for state legislation to ensure that public nursing homes will continue to receive appropriate support and to utilize newly available DSH flexibility for hospitals.

In addition, we are also concerned about the response of Senate Finance Committee Chairman Senator William Roth (R-DE) who has attacked this regulation as inadequate and announced that he would introduce legislation that would override the regulation and rapidly phase out all states' ability to access IGT funds.

HANYS continues working with the Pataki and Clinton administrations, both Senators Moynihan and Schumer, and the New York House Delegation to ensure a successful outcome on the additional legislative steps necessary to complete this transition.

If you have any questions on this issue, please contact Joanne Cunningham, Vice President for Constituency Development and Graduate Medical Education at (518) 431-7726 or Ray Sweeney, Executive Vice President at (518) 431-7729.

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THE WHITE HOUSE

WASHINGTON

September 29, 2000

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MEMORANDUM TO THE PRESIDENT

FROM: Jacob J. Lew
Christopher C. Jennings

USDA/PLURTY

During the last several months, we, along with HHS, have been engaged in intense discussions with state officials and health care providers around the nation about proposed changes to the Medicaid upper payment limit (UPL) – specifically on how to limit this practice that threatens the future viability of Medicaid while minimizing the change's effect on health care delivery systems. We have developed an option that meets these objectives and are seeking your approval on our proposal and plan for releasing it early next week.

All parties involved acknowledge that the continued use of the current UPL will result in rampant Medicaid spending growth. The General Accounting Office (GAO), the HHS Inspector General (IG), the Congressional Budget Office, the Senate Finance Committee, and the Center on Budget and Policy Priorities in a report released this week have affirmed its serious threat to Medicaid and called on the Administration to act. However, as you well know, some states and providers are extremely concerned that changes to UPL will disrupt critical health programs that have been funded through this practice. Some are seeking to block HCFA from publishing any regulatory changes at all. We feel that we have to proposed the rule now because if we leave it to the next Administration, it will be much harder to solve since more states will take advantage of this loophole. In addition, we recommend that the rule be accompanied by a legislative proposal to increase public hospital funding, which has to be enacted in the next few weeks.

We are proposing a regulation that leaves room for additional payments to public hospitals while phasing out the highly suspect practice of nursing home payments to generate enhanced Federal matching payments. These additional payments to public hospitals would be more than offset by phasing out the nursing home practice. This regulation would be coupled with a legislative proposal to allow states to pay public hospitals higher Medicaid disproportionate share hospital (DSH) payments (similar to the current statutory exception that benefits only California). This effectively shifts supplemental payments out of inpatient hospital rates and back into DSH where we have more ability to monitor and change the overall Federal contribution. The legislative proposal would cost approximately \$2.2 billion over 10 years – an amount we will seek above the \$40 billion in provider payment restorations.

This approach has the advantage of providing more resources to those states that have become most dependent on this financing mechanism without singling out states for special treatment. We believe that the governors and their representatives in Congress will hesitate to be excessively critical of this proposal because (1) it is much more generous than they expected and (2) the continuation of this practice has been independently defined as unsustainable. Should

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they move to act, it would likely be to delay the implementation of our regulation and/or link its publication to even more generous financial benefits through legislation. Regardless, we will have positioned the Administration in support of both prudent management of Medicaid and the health care delivery systems supported by this practice. Although HHS believes we are being too generous, they agree that we recommend this option to your for your sign off so we can move forward early next week with a very careful notification process.

BACKGROUND. About 17 states have been using a loophole in Medicaid regulations to overpay public hospitals and nursing homes to generate additional Federal dollars. Another dozen or more states have applied to do the same. It is highly likely that the remaining states will have such amendments by this time next year.

It is instructive to highlight an example of how UPL subjects Medicaid to billions of dollars of excess Federal liability. In Pennsylvania, the state first calculates the maximum allowable supplemental payment to nursing homes under the current UPL. It then has 20 counties with public nursing homes transfer, for one day only, an amount equal to the supplemental payment. The state immediately returns this amount to the counties as supplemental payments for county nursing homes and claims Federal matching payments for them. The state then gains the Federal matching payments that can be used for any purpose.

The GAO, the HHS IG, and some members of the Senate Finance Committee have called on HHS to use its regulatory authority to stop these financing mechanisms immediately. The IG testified that:

The combination of the enhanced payment provision and intergovernmental transfer capabilities between State and local governments has produced an abusive scenario in which some States (1) violate the intended purpose of the Medicaid program to be a Federal/State jointly funded program, (2) divert the enhanced payments away from their intended purpose of improving the quality of care in nursing homes and hospitals, (3) redirect the Federal Medicaid funds generated from this scheme to other Medicaid services or non-Medicaid programs, and (4) fail to base the enhanced payments on prior or anticipated costs at the nursing home facilities.

In fact, the GAO recently stated that "...this financing practice violates the integrity of Medicaid's Federal/state partnership." Editorials recommending that we crack down on this practice have appeared in *The New York Times*, *Washington Post*, and *Pittsburgh Gazette*.

However, as you have heard, the states that use this practice have come to rely on it, in some cases, to fund programs that we fully support. Some of the Federal funds are being used to provide much-needed assistance to public hospitals that are overburdened by increasing uncompensated care liabilities and less generous private sector and Medicare payment policies. Other states are using these funds to increase health care provider reimbursement rates and limited coverage expansions. However, still others are using these funds for road construction, tax reductions, and other state priorities. We do not have the authority to limit this practice for "good uses", but can phase in our changes and leave some room on the hospital side to help mitigate the effects of the proposed regulation (described below).

PROPOSAL. We (OMB, DPC, HHS) have worked with affected states to identify possible modifications to the regulation that would make it more acceptable to them. The constraint of these discussions has been that we could not develop a solution that is a "rifle shot" – it must have broad applicability and be consistent with our goals.

After extensive consultation, we have a proposal that satisfies most – but not all – of what these states say they need. It involves a combined regulatory and statutory proposal that includes a generous transition for nursing homes and leaves room both in the regulation and in statute on the public hospital side. How these states are affected is described below.

Proposed regulation. HCFA's proposed rule would modify Medicaid upper payment limits in regulation by establishing separate aggregate upper payment limits (UPL) for non-state public providers, state providers, and private providers. This disaggregation limits the amount of the supplemental payments that public facilities may receive. Because of their unique roles in their communities, public hospitals could receive payments up to 150 percent of the new UPL.

There would be a five-year phase-out of these excess payments for states with approved plans – with absolutely no change in 2001. Subsequently, the supplemental payments would be reduced in increments of 25 percent until they are at the new limits in 2005.

Legislative proposal: Increasing the hospital-specific DSH cap to 175 percent of uncompensated care costs. OBRA 1993 restricted states from paying a hospital more than 100 percent of its net uncompensated care costs under the Medicaid DSH program. The BBA and last year's restoration bill granted California an exception to this rule, allowing hospitals in that state to be reimbursed up to 175 percent of their uncompensated care costs. This proposal would extend this higher limit to all States. For states currently spending their full statewide DSH allotments, this policy would not provide additional Federal DSH funds but rather additional flexibility in how they finance the state share of their DSH expenditures. States who are not currently spending up to their statewide DSH allotments because of the hospital-specific cap will be able to access additional Federal DSH dollars under their allotments. Preliminary estimate of policy: \$1.2 over five years; \$2.2 billion over ten years. Because the Congress has already begun to mark up these proposals, we recommend that we state that this cost would be in addition to the \$40 billion in provider payment restorations. To the extent that Congress raises its state DSH caps, this proposal's costs would rise.

DISCUSSION. This proposed regulation is a significant compromise from our original policy – ~~probably losing half of the potential savings that the regulation would otherwise generate.~~ ~~The five-year transition will be viewed as new and, by most, as a good start.~~ Most public hospitals ~~will be appreciative.~~ The states using nursing homes may complain about the hospital exception, but many will be able to shift some of their supplemental payments to hospitals to accomplish similar goals. The GAO and IG will likely criticize it for not going far enough or fast enough.

The legislative proposal would result in extra Federal revenue to help states affected by this regulation – and, in fact, provide them with more Federal funding in 2002 before the major reductions have kicked in. As such, it will likely draw criticism from fiscal conservative since it is hard to rationalize why a hospital needs more than its net uncompensated care costs. HHS is concerned that it creates an incentive for states to keep people uninsured, since they could draw down more Federal match on DSH than on coverage. Some Congressional staff believe it will be hard, at this late date, to get this into the mix of a give-back bill.

Attachments: Affected States; Editorials; Center on Budget and Policy Priorities' paper

ATTACHMENT: AFFECTED STATES

California. California's public hospitals have a carefully-negotiated arrangement with counties and the state that balances two funding streams: Medicaid DSH payment and supplemental payments under the UPL. California has been providing its hospitals with supplemental payments since the early 1980s and is, as far as we can tell, the only state that allows the hospitals to keep the entire amount of the payment. They can do this, however, because California is the only state that has a higher cap on the amount an individual hospital can receive under Medicaid DSH – and counties share the higher Federal matching payments with the state. Thus, reducing the UPL will directly reduce payments to public hospitals.

The State of California and California Association of Public Hospitals believe that, to continue its current practice, the new UPL for public hospitals would have to be 160 to 175 percent of the UPL. This is higher than the 150 that we are proposing, but Rep. Waxman's staff suggest this is an acceptable place to begin. Because California already has the 175 percent hospital-specific DSH cap, they do not benefit from the legislative proposal.

Illinois. Apparently, when the Medicaid DSH and provider tax laws were passed in 1991, the state shifted all of its DSH practice into UPL. It works primarily through Cook County Hospital which is one of the few public hospitals in the state. Rather than providing it with DSH, which is capped at the hospital level, it uses excess supplemental payments under UPL to generate additional Federal matching payments. County staff say they have \$250 million in Medicaid costs and \$350 million in uncompensated care for a gross cost of \$600 million. While DSH payments would be limited so that the sum of the Medicaid and DSH payment would equal \$600 million, UPL has no such constraint. As such, the combined Medicaid base payment and supplemental payment to Cook County equal \$1.2 billion, of which Federal Medicaid pays half. About \$320 million of the Federal funding remains in the hospital while the state uses the other \$280 million as the state share of supplemental payments to private and non-profit hospitals.

Cook County has informally indicated that both its hospital and the state could live with the proposed regulation and the legislative proposal if we make room within the state DSH allotment, raising it from \$182 million to about \$420 million. While there are various legislative proposals in the giveback packages to increase state allotments, this is a much higher increase than anyone appears to be contemplating. That said, it is easier to get "rifle-shot" state DSH caps (as happened in the BBA) than it is to modify the rule or 175 percent DSH cap proposal.

Iowa. This issue of UPL came to the White House and OMB's attention because Iowa filed a state plan amendment to raise its public nursing home per diem from \$85 to more than \$1,000. HHS discovered that, without a change in regulation, it could not turn down this amendment which went into effect last spring. Governor Vilsack is using Federal funding generated through this practice to offset the costs of his efforts to deinstitutionalize people with disabilities, pursuant to the Olmstead Supreme Court Ruling.

Senator Harkin and the Governor have been told that we need to close down this practice, and they are asking mostly for adequate time to transition. We are working with the state now to see exactly what length transition they would accept.

New York: Like Iowa, New York operates its system through county nursing homes. These nursing homes get, in aggregate, supplemental payments of \$975 million, half of which is matched by the Federal government (\$488 million). The counties and nursing homes get to keep 20 percent of the amount (\$98 million) while the remaining amount, \$390 million, is supposedly used by the state to help fund its proposed expansion of CHIP to parents, Family Health Plus. The state chose to use nursing homes rather than hospitals for these supplemental payments because the state spends up to the hospital-specific limits in Medicaid DSH in its public hospitals. Thus, every dollar of UPL money would decrease DSH by a dollar. While Illinois handled this problem by not giving Cook County DSH money in the first place, it would be extremely difficult to do this in New York given DSH spending of about \$870 million.

Our proposal would help New York as follows. First, nothing would happen in 2001, except for the BBA givebacks that will definitely improve the financial status of New York hospitals and nursing homes. Second, in 2002, we would implement the higher hospital-specific DSH cap (175 percent of net uncompensated care) while only reducing the supplemental payments to nursing homes by one-quarter. The DSH cap proposal would provide New York with probably about \$300 million, while the phase-out of the nursing home supplemental payment would probably keep close to \$300 million in the system. As a result, in 2002, the state would actually be able to access more dollars than they can today – not counting the provider giveback dollars. In subsequent years, the phase-out of the UPL will not be completely offset by the higher DSH cap but the net impact over 5 years will probably be close to budget neutral.

We have worked with the Hospital Association of New York and Greater New York Hospital Association on this option, since they have the technical understanding of the State's financing structure. They indicate that they would prefer for us to increase the DSH cap to 200 percent of net uncompensated care per hospital, which we do not think that we could justify from a policy and political point of view (we have had a hard time defending California's 175 percent cap; going higher for all states would be an extra hurdle). That said, they recognize that our proposal goes a long way towards keeping them whole.

Pennsylvania: Pennsylvania has a nursing home situation that has been in effect for a number of years. The Inspector General found that \$3.1 billion in excess Federal matching payments were made from 1992 to 1999 for 23 county nursing homes. While the state claims that it uses these funds for nursing homes and other services for the elderly, the IG could not track the money.

As in Iowa and New York, the proposed regulation would end the nursing home supplemental payments. However, it is not clear that the state could use the DSH proposal to offset proposed changes. The delegation has been single-mindedly seeking a legislative "grandfather" to allow the state to keep what it has. Such a rider was proposed at the House Commerce Committee BBA giveback mark up by Rep. Greenwood and may also appear on the Labor/HHS appropriations bill since Senators Specter, Harkin and Porter all have state interests in this issue.

The States Milk Medicaid

THE STATES are forever complaining about excessive federal regulation. Federal aid comes wrapped in too many rules, the governors say; why not just give us the money and get out of our energetic way? But the answer is, in part, that without the rules the states will rip off the federal programs. The record is clear; the latest example involves, once again, Medicaid, by far the largest of the grant programs.

The federal government reimburses the states for a little over half the cost of Medicaid, the health care program for the poor. What the states have once again done is find a legal way to pad their bills. They overstate their costs, the feds pay half the overstated amounts, and the states walk away with a dividend that they can use for other purposes. Sometimes those involve health care, even health care for the poor, but sometimes not. In effect, the accountants have converted Medicaid into a form of general revenue sharing.

No one knows the full extent of the phony billing, but more than half the states are either using the current ploy or preparing to do so. The extra cost to the feds is currently estimated to be between \$3 billion and \$4 billion a year, and rising. The cost of Medicaid has continued

to rise in recent years even as the caseload has declined; the increase in phony billing is thought to be the principal reason why.

The administration will shortly publish a proposed regulation to stop what amounts to theft on the part of the states. But if past is prologue—this sort of thing has happened before—it will take awhile to cut off the funds. The states use the poor as pawns; they warn that an end to their scheme will have dire consequences for the health care of the poor. No politician, nor administration, is eager to have those laid at its doorstep, least of all in an election season.

At a Senate Finance Committee hearing the other day, Chairman William Roth said the health care program for the poor has been turned into "a bank account for state projects having nothing to do with health care." The practice "cannot . . . continue," he intoned. But it's unlikely that Congress will take action; too many members, including many who deplore the cost of the program, come from states that benefit. The administration should use its regulatory powers, said the chairman. No matter that he and others who feel the same way are normally foes of regulation. What are regulators for, if not to be heavies while politicians flee?

The Washington Post

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Siphoning Money From Medicaid

New York and 16 other states are manipulating Medicaid reimbursement laws to pull billions more dollars out of Washington than Congress intends. Some states use the largesse to treat the poor. Others use the windfall to pay ordinary bills. Either way the practice should be curtailed before it undermines political support for the always-embattled Medicaid program.

Washington is supposed to pay between 50 percent and 73 percent of Medicaid costs, depending on the state. But a loophole lets a state inflate its costs above what they actually are, thereby extracting more money from Washington than the state deserves. Take a state whose federal share is 50 percent. It might pay nursing homes \$80 a day to care for Medicaid patients, but federal law might permit that state to pay as much as, say, \$100. Under the loophole, the state in effect pays the nursing home \$80 but charges the federal government as if it were paying \$100. The state collects half of \$100 rather than half of \$80, raising Washington's share to 63 percent from 50 percent.

The loophole could cost Washington up to \$80 billion over the next five years. An "early alert" prepared by the inspector general says the three states examined did not use the ill-gotten money to improve the quality of health care.

The administration has warned the states that it intends to eliminate the loophole. Its stance deserves support for reasons that go beyond good governance. In the early 1990's states exploited a similar loophole, driving up Medicaid costs by 25 percent or so a year. Congress struck back, coming close to ending the Medicaid entitlement, by which states lay automatic claim to extra federal money when Medicaid rolls rise.

If the administration lets the latest loophole remain, the costs could become huge, compelling Congress to cut back Medicaid reimbursements. New York — which uses the loophole to collect about \$480 million of the more than \$14 billion it draws from Washington each year to pay for Medicaid — and other states with large Medicaid rolls would become the big losers.

The administration has promised to phase out the loophole and pledged to help states that need more money to care for the poor by lobbying Congress for a direct allocation of new money. Several consumer groups that work on behalf of health care for the poor, like Families USA, support the administration because the loophole diverts money from the federal Medicaid program to pay for other state programs.



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LIMITING ABUSES OF MEDICAID FINANCING: HCFA'S PLAN TO REGULATE THE MEDICAID UPPER PAYMENT LIMIT

by Leighton Ku

The Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS) plans to issue a proposed regulation soon to restrict a rapidly spreading Medicaid financing scheme that is costing the federal government significant sums and about which the General Accounting Office (GAO) and HHS' Office of Inspector General (OIG) have raised strong warnings.¹ Under this financing mechanism, a state pays selected nursing homes, hospitals or other institutions more than the actual costs the facilities incur for medical services they provide. The state then requires these health care providers to transfer most of the extra payments back to the state. The state draws down federal matching funds based on the inflated payments it has made to the providers. As a result, the state collects additional federal money without contributing any state funds. The federal Medicaid funds gathered through these schemes can be used by states for any purpose they choose, including for activities that are neither related to health care nor authorized by Congress.

This practice, although apparently legally permissible (the GAO has referred to it as a loophole in the current rules), runs contrary to the basic principle that the federal government and states share the costs of the Medicaid program. The practice effectively enables states to increase the federal government's share of Medicaid costs (and decrease the state share), without Congressional approval.

In many cases, these financing arrangements do not improve the quality of health care provided or benefit health care providers. The financing mechanisms frequently operate in a manner that siphons extra federal money to state coffers without affecting the provision of health care. To date, this has been particularly true in financing arrangements that involve nursing homes. On the other hand, in some cases these financing arrangements have been used to provide important additional resources to safety net hospitals that provide care for the uninsured and HCFA's regulation ought to be sensitive to this distinction.

States using these arrangements generally have a variety of alternative ways to secure fiscal resources, including making different policy choices about the use of state budget surpluses and tapping tobacco lawsuit settlements. Most states that are employing this financing

¹ Testimony of Kathryn Allen, U.S. General Accounting Office before the Senate Finance Committee, Sept. 6, 2000. Testimony of Michael Mangano, Office of the Inspector General, Dept. of Health and Human Services, before the Senate Finance Committee, Sept. 6, 2000.

scheme to secure added federal dollars are not in fiscal difficulty, as is evidenced by the fact that most of them have cut state taxes in the past few years.

Some states claim the additional federal funds they have secured through the use of these financing arrangements have been used for Medicaid expansions or improvements. It is not clear, however, that this has occurred to any significant degree. The validity of this claim is difficult to determine, but if the claim were true, one might expect to find that the states using these practices have somewhat broader Medicaid eligibility criteria than states not employing them. In fact, the opposite is the case — the states using these financing arrangements have narrower Medicaid eligibility criteria, on average, than states not using them.

These financing mechanisms are now proliferating. If no action is taken, these practices will cause federal Medicaid expenditures to spiral upward by billions of dollars in future years. The resulting cost increases might eventually be used to justify new efforts to cut Medicaid or alter its basic character. In the 1990s, widespread state use of a variant of this loophole, along with other factors, caused federal Medicaid costs to rise at alarming rates; these cost increases became a significant factor in an effort that culminated in Congressional approval of a proposal to replace Medicaid with a block grant. (The proposal was not enacted because of a presidential veto.) At a minimum, the additional federal costs that will result from the increasing spread of these financing practices are likely to make it harder to secure support in coming years for the provision of new resources for further expansions in Medicaid or the State Children's Health Insurance Program (SCHIP) that are aimed at reducing the number of uninsured.

HCFA plans to publish a proposed regulation in the next few weeks to prevent these financing arrangements from spreading further and triggering billions of dollars of unnecessary federal expenditures. Although the precise contents of the regulation will not be known until the regulation is published, HCFA has suggested it will seek to limit the scope of this loophole while providing a multi-year "transition period" to let states and providers restructure their financing arrangements gradually.²

Some in Congress are reportedly considering an effort to attach a "rider" to an appropriation or other bill to block HCFA from proceeding with this rule. This analysis finds such an action would be unwise. HCFA should complete action this year. The Congressional Budget Office estimates that blocking the regulation would increase federal costs by \$1.5 billion in fiscal year 2001 alone. The added costs would be higher in subsequent years and, if the regulation is blocked, state use of these arrangements is likely to escalate. It should be noted that if Congress refrains from blocking the regulation now, it will not lose the ability to act at a later time to modify the regulation. Congress always can act at a later date if it concludes, after reviewing the final regulation and examining these issues, that the rule needs to be changed. For example, if subsequent analyses support the belief that the final rule would significantly harm

² Testimony of Timothy Westmoreland, Director, Center for Medicaid and State Operations, HCFA, to the Senate Finance Committee, Sept. 6, 2000.

selected safety net hospitals, Congress could establish a more straightforward and accountable method of increasing funding for those hospitals, rather than continuing the current abuse-prone financing arrangements.

Background

Since its creation in 1965, the fundamental principle in Medicaid financing has been that the federal government and the states share the program's costs. For each state dollar spent, the federal government contributes one to four dollars in matching payments. In 2001, the Medicaid program will cost \$219 billion, of which \$124 billion — or 57 percent — will be borne by the federal government.³ The Medicaid statute gives states substantial authority to design and administer the program. The requirement that states share in the cost helps to ensure they act prudently in stewarding federal resources.

In the late 1980s and early 1990s, state abuse of a similar Medicaid mechanism, called disproportionate share hospital (DSH) payments, placed this relationship in jeopardy.⁴ Many states began using complex accounting maneuvers to increase the federal matching payments without the states having to expend any additional state funds. By the early 1990s, states were using this accounting loophole to draw down billions of dollars in additional federal funds.

These financing mechanisms involving DSH payments contributed to an explosion in federal Medicaid expenditures in the late 1980s and early 1990s, which in turn provided some of the impetus for efforts in the mid-1990s to block-grant Medicaid or place caps on it. Rancorous disputes ensued between the federal government and the states about DSH funding arrangements, which culminated in a series of laws enacted in 1991, 1993 and 1997 that tightened the DSH rules and limited the maximum DSH payments that states may receive.⁵ Even with these limitations, the federal government spent an estimated \$9 billion for DSH payments in fiscal year 2000.

³ Based on the March 2000 Congressional Budget Office baseline. The extent to which the federal government matches state costs depends on the per capita income in each state. In wealthier states, the federal government pays 50 percent of the total cost. In poorer states, the federal share can rise as high as 83 percent.

⁴ Disproportionate share hospitals are those that serve a high proportion of Medicaid and low-income uninsured patients, as designated by the state Medicaid agencies, and therefore become eligible for special payments (DSH payments). Although the original legislative intent was to help safety net hospitals, many states designed their DSH policies to divert a large share of the funds to state coffers instead. As noted later, these abuses led to a series of legislative changes.

⁵ Jocelyn Guyer, Andy Schneider and Michael Spivey, *Untangling DSH: A Guide for Community Groups to Using the Medicaid DSH program to Promote Access to Care*, Boston MA: Access Project, 2000. Andy Schneider, Stephen Cha and Sam Elkin, "Overview of Medicaid DSH Provisions in the Balanced Budget Act of 1997," Center on Budget and Policy Priorities, Sept. 3, 1997. The 1997 Balanced Budget Act ratchets down the level of federal DSH funds that any state can receive from fiscal year 1998 through 2002. In this session of Congress, there are proposals to freeze DSH allotments at the 2000 levels rather than further reduce them.

The new financing arrangements that now are spreading — and that are the subject of this analysis — are generally known as “upper payment limit” (UPL) arrangements. They bear strong similarities to the DSH financing mechanisms and essentially are a variant of those practices. Both types of arrangements use complex accounting gimmicks to secure additional federal funds for states without actual state matching contributions. Also like the DSH schemes, the UPL arrangements have been used for various purposes; some UPL arrangements have helped support safety net hospitals that care for Medicaid patients and the uninsured, while other UPL arrangements do not aid health care providers and are designed primarily to provide a windfall for state governments.

One key difference between the older DSH and the newer UPL financing arrangements is that the DSH program has been subject to close scrutiny. Congress acted in 1991, 1993, and 1997 to curb the worst abuses in DSH financing schemes. In contrast, the federal government currently has almost no regulatory authority today to limit UPL abuses. Under current regulations, HCFA has little option but to approve state proposals to exploit the UPL financing mechanism.

Research from the Urban Institute indicates that in recent years, the federal cost of UPL financing arrangements has burgeoned, rising from \$313 million in 1995 to \$1.4 billion in 1998.⁶ Preliminary data from HCFA suggest the federal cost may be at least twice as high by 2001, with a potential federal cost of more than \$3 billion.⁷

How Does the UPL Loophole Work?

Before describing the Rube Goldberg-like accounting arrangements inherent in UPL practices, it may be useful to discuss the key concept underlying these financial arrangements. A state makes inflated payments to a select group of nursing homes, hospitals or other health care facilities that a county or other local government owns, with the payments being in excess of the actual cost of the medical services these institutions provide to Medicaid beneficiaries.⁸ The state then requires these providers to give back much or all of this extra money to the state in the form of “intergovernmental transfers.” The state uses the large payments it has made to the providers to claim a large federal matching payment, which will equal at least 50 percent of the payment the

⁶ These are conservative estimates based on data from 40 states. See Teresa Coughlin, Leighton Ku and Johnny Kim, “Reforming the Medicaid Disproportionate Share Hospital Program in the 1990s,” Urban Institute, Jan. 2000, forthcoming in *Health Care Financing Review*.

⁷ Westmoreland, *op cit.* At this point, HCFA has not been able to determine a more rigorous estimate of the federal budget impact.

⁸ In addition to nursing homes and hospitals, these rules can be applied to residential institutions for people who are mentally retarded or who have developmental disabilities, but there are no known examples of such financing arrangements with regard to residential institutions.

state has made to the providers. The state thus receives these federal matching dollars without having put up a commensurate amount of state funds.

Three steps are involved in a UPL financing arrangement.⁹

- First, the state makes a special payment to a select group of nursing homes or hospitals. Typically, this is done by making “supplemental payments” (above and beyond the regular Medicaid reimbursements) to county-owned or other local government-owned institutions. The size of these payments is based on the “upper payment limit,” which is described in the next section of this analysis. The payments to these selected providers usually exceed the actual cost of delivering care and are much larger than the payments the state really intends to make for the provision of health services.
- Next, the county-owned or other local government-owned facilities return to the state Medicaid agency a large portion of the supplemental payments. County-owned or other local government-owned facilities are used because they can use intergovernmental transfers to return the money.¹⁰
- The state claims a federal matching payment for the supplemental payments. The matching funds the state receives can be mingled with other state funds and used for any purpose the state chooses, including paying for other Medicaid or health care expenses, building roads, or financing tax cuts.

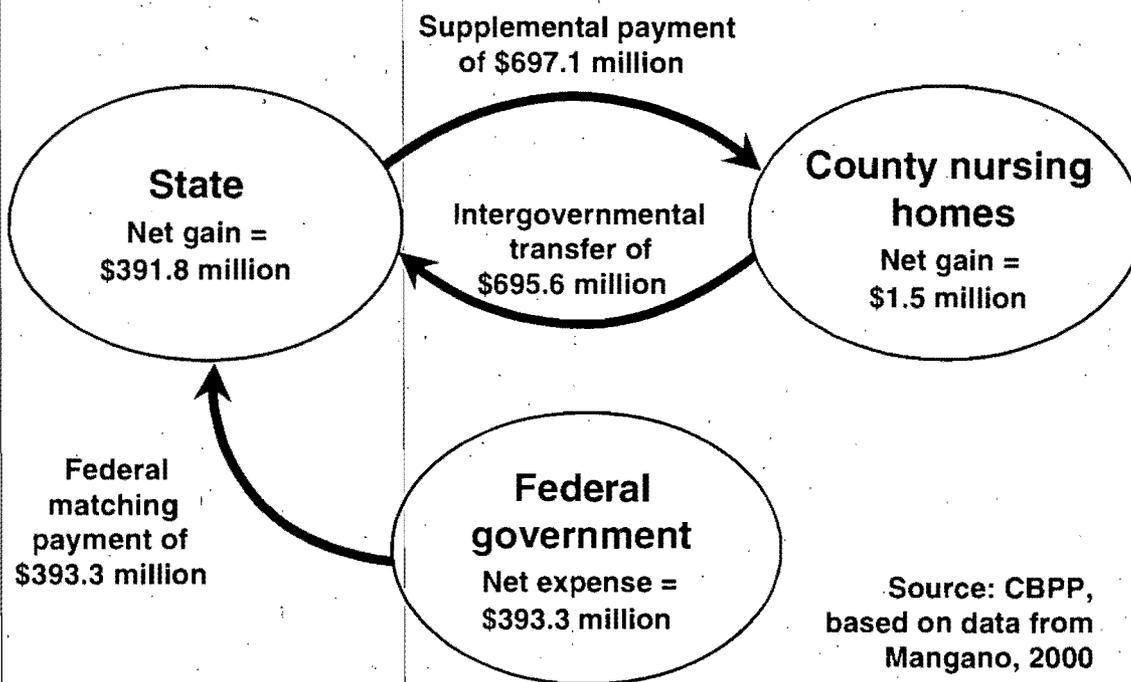
Figure 1 presents data concerning a recent example of the use of this mechanism by Pennsylvania, as reported by HHS’ Office of the Inspector General.¹¹ On June 14, 2000, the state paid \$697.1 million in supplemental payments to 23 county nursing homes. Since Pennsylvania has a 54 percent federal matching rate, it received \$393 million in federal matching funds (which is 54 percent of the \$697.1 million payment the state made to the nursing homes). The nursing homes, in turn, returned \$695.6 million of the \$697 million to the state, doing so *on the same day* they received these payments from the state. The result was a small net gain to the nursing homes of \$1.5 million — the amount of intergovernmental transfers is typically set so that no provider incurs a net loss — and a windfall for the state government of \$392 million. (The state paid a net amount of \$1.5 million to the nursing homes while receiving \$393 million from the federal government.) Although, the federal government paid a large amount to the state, apparently no additional health services were secured for this money.

⁹ UPL arrangements go by different names in different states. Some states call them “supplemental payment programs” because of the mechanism for making supplement payments to providers, while other states call these arrangements “intergovernmental transfer” programs because of the mechanism by which providers return funds to the state.

¹⁰ Privately-owned facilities are barred by federal law from making equivalent donations to the state Medicaid agencies.

¹¹ Mangano, *op cit.*

Figure 1
Flow of UPL Funds in Pennsylvania on June 14, 2000



Source: CBPP,
 based on data from
 Mangano, 2000

Essentially, the only “real” money in such a transaction is the federal matching money. Both the state and the providers secure net financial gains without any contribution of state matching dollars. In this example from Pennsylvania, the state made most of the money, and the nursing homes kept little. UPL arrangements also can be structured to let the providers keep much or most of the money.

OIG and GAO have found that other states, including Alabama, Nebraska and Michigan, have arrangements similar to Pennsylvania’s that are designed primarily to divert federal Medicaid funds to the state.¹² The OIG concluded that: “States did not base the enhanced payments on the actual costs of providing services or increasing the quality of care to Medicaid residents of the targeted nursing facilities. The counties involved in the enhanced payment scheme provided little or none of the sham enhanced payments to the participating nursing facilities to provide services to Medicaid residents.”

¹² Mangano, *op cit.* and Allen, *op cit.*

What is the Upper Payment Limit and How Would the Forthcoming HCFA Regulation Change It?

The size of these financing schemes is governed by what is known as the "upper payment limit." Federal law gives states considerable flexibility regarding payments to health care providers, but it stipulates that, in general, Medicaid payments can be no higher than the amount that *Medicare* would pay for the same service.¹³ Medicare's equivalent payments form the "upper payment limit" for Medicaid. The payment rates that states use in Medicaid are usually lower than the Medicare rates, with the exact gap varying by state and type of medical service.

The test of whether Medicaid payments exceed this "upper payment limit" is not based on the Medicare payment level for a single procedure or even on the payment level for all services that a single provider delivers. Instead, the upper payment limit is the aggregate amount of all payments that could be made to an entire "class" of providers if every provider were paid the Medicare rate for all services. Medicaid regulations currently establish two classes of health care providers: state-owned facilities and non-state providers, with the class of non-state providers including both local-government-owned facilities and private providers. To illustrate how the upper payment limit works, we use a hypothetical example.

Let's say that the gap between the Medicaid payments a state makes to all county-owned nursing homes in the state and the equivalent amount that Medicare would pay is \$200 million. Let's also assume that the gap between the Medicaid payments the state makes to private nursing homes and the Medicare payment levels is \$800 million. The upper payment limit for this class of providers, which encompasses both local government-owned providers and private providers, would consequently be \$1 billion more than the amount the state actually pays. To exploit the upper-payment-level loophole, this state could make an extra, or supplemental, payment of \$1 billion to the county-owned nursing homes, secure virtually the entire \$1 billion back from these nursing homes as an intergovernmental transfer, and receive at least \$500 million in federal matching funds for engaging in this maneuver. The state is allowed to use the maneuver — and to direct the entire \$1 billion in supplemental payments to county-owned nursing homes despite the fact that the gap between the actual payments these facilities receive and the Medicare payment rate is \$200 million — because, as noted, the upper payment limit applies to an entire "class" of providers and private facilities are in the same class as the county-owned facilities.

HCFA has intimated that the proposed regulation it plans to publish would tighten the UPL limits by making county or local government-owned facilities a separate class from private

¹³ The noteworthy exception to this rule is that Medicaid DSH payments can be made above the upper payment limit for hospitals. Thus, hospitals may receive supplemental UPL payments as well as DSH payments.

facilities.¹⁴ That would not eliminate the potential for states to make supplemental payments but would greatly reduce the possible size of these payments and narrow the scope of these financing maneuvers. Depending on how the regulation is drafted, this might mean that under the above example, the maximum amount of supplemental payments the state could make to county nursing homes would be one-fifth of the amount the state now can make (i.e., \$200 million rather than \$1 billion).

UPL Arrangements Distort Medicaid Financing

As noted, one effect of these practices is that states can increase the federal government's share of Medicaid expenses without Congressional approval. While this appears legal, it is contrary to the spirit of the Medicaid statute.

OIG has estimated that Pennsylvania has increased the federal matching rate for its total Medicaid program from 54 percent to 65 percent in fiscal year 2000 by using these financing arrangements. The GAO has noted that New Jersey's pending UPL proposal could lift the federal share of Medicaid expenses that state receives from 50 percent to 60 percent. The GAO also estimates that Michigan increased the federal share of Medicaid costs it received from 56 percent to 68 percent by using similar practices in the past.¹⁵

UPL transactions also have another negative side-effect: they can distort apparent Medicaid spending trends and thereby inject confusion into policy debates. Some states have begun to raise alarms that their Medicaid budgets are on the rise again, pointing as evidence to growing total Medicaid spending (i.e., state plus federal spending) in their states. As shown above, however, UPL systems can increase *apparent* total Medicaid spending while decreasing the actual expenditure of state funds. Some of the complaints about rising Medicaid costs and their effects on state budgets rely on figures that are inflated because they reflect the use of these financing mechanisms and thus make total Medicaid expenditures in a state — and the drain on the state budget — appear larger than they actually are (because the total expenditure figures include the extra federal matching payments and fail to net out the intergovernmental transfer revenues from providers that help finance the transactions).¹⁶ The appropriate measure of Medicaid's actual cost to a state is the amount of Medicaid expenditures financed from the state's

¹⁴ Westmoreland, *op cit.*

¹⁵ Mangano and Allen, *op cit.*

¹⁶ Many states also look at state budgets excluding federal matching revenue, but might still have distorted apparent state Medicaid expenditures if they do not subtract the amount of intergovernmental transfer funds that are paid by health care providers.

general fund revenues, a measure that excludes federal matching payments and nets out the revenues contributed through intergovernmental transfers.

It is worth recalling that in the early 1990s, Medicaid spending rose very sharply in substantial part because of the explosion in Medicaid DSH payments, which shot up almost twenty-fold from \$403 million in 1990 to \$8.0 billion in 1992. This was interpreted as a sign that Medicaid was out of control and threatening to wreak havoc on state budgets, even though states were actually using DSH payments to reduce their share of program expenditures. The so-called Medicaid "cost crisis" was a major contributing factor in the push of the early and mid-1990s for proposals to restrict Medicaid funding by eliminating or limiting the program's entitlement status, such as by converting the program to a block grant or capping it.¹⁷ Both houses of Congress approved such changes in 1995; the changes were not enacted only because of a Presidential veto. Concerns about rapid Medicaid spending growth in this period also brought federal Medicaid eligibility expansions to a halt until the creation of SCHIP in the 1997 Balanced Budget Act. Congress expanded Medicaid eligibility in each year from 1984 to 1990, but then cost concerns brought this legislative trend to a standstill.

What is Known about Current and Proposed UPL Arrangements?

Information about the extent to which states are using UPL schemes is fragmentary: HCFA, OIG and GAO are still collecting data on this matter. It appears that 19 states have at least one approved UPL financing arrangement (some of these states have proposals pending for additional UPL financing mechanisms), while nine states have proposals pending for UPL systems, and three states have initiated discussions with HCFA about submitting a UPL proposal. As these figures indicate, UPL financing schemes show signs of spreading rapidly. If left unchecked, they are likely to increase federal expenditures by billions of dollars.

Some earlier information about these financing arrangements is available from an Urban Institute study. In a survey the Institute conducted in 1998, the Urban Institute found that 12 of the 40 responding states were using UPL mechanisms at that time.¹⁸ The study reported these UPL systems primarily involved hospitals and that the financial gains under these arrangements were being reaped principally by the hospitals, rather than the states. Of \$1.4 billion in additional federal funds being secured through these arrangements, \$1.3 billion were going to benefit county facilities (mostly hospitals) while relatively little, about \$100 million, was being retained by the states. Although it thus appears that these UPL funds did reach hospitals in these states — particularly public hospitals in California and Illinois — the UPL mechanisms in question were

¹⁷ Teresa Coughlin, Leighton Ku and John Holahan, *Medicaid Since 1980: Costs, Coverage and the Shifting Alliance Between the Federal Government and the States*, Washington, DC: Urban Institute, 1994, pages 91-97.

¹⁸ Coughlin, et al., 2000, *op cit.* One state responded to the survey, but did not provide data about its UPL system.

designed so the states contributed virtually none of the additional money and the federal government provided virtually all of it.

The nature of UPL systems appears to have changed substantially since 1998, however, with the changes adding urgency to HCFA's current efforts to prevent these financing mechanisms from proliferating. The more recent UPL systems seem to be based primarily on county nursing homes rather than hospitals and apparently are being used to benefit state governments, with few of the added dollars going to the health care providers. Although there is potential for misuse of UPL financial arrangements involving either hospitals or nursing homes, there is more evidence of this type of abuse in the nursing home-based arrangements.

Do States Need Additional Federal Funds?

Some state officials defend the use of UPL financing arrangements, arguing that their states need the additional federal funds and that the funds help to pay for Medicaid and other health care programs, including program expansions. It is difficult to evaluate such statements, since a state's "need" for additional revenue is not absolute but is relative to other competing budget and political priorities. It should be noted, however, that most states are in the midst of a period of economic prosperity and have substantial budget surpluses.

Table 1 presents data about several measures of the fiscal status of states that currently have or are proposing UPL arrangements. Collectively, these states had state budget balances of \$21 billion in state fiscal year 2000.¹⁹ Most of these states had good, positive balances although a few states, such as Alabama, Arkansas, New Hampshire, and Tennessee, faced tight fiscal circumstances. Together, the group of states using or proposing to use UPL mechanisms cut taxes a total of \$4.6 billion for the year 2000, although a few states with fiscal problems had to raise taxes. Overall, the strong trend was to cut state taxes. All except four of these states reduced taxes at least once in the past four years.

In addition, these states have state tobacco settlements worth a total of \$5.6 billion in 2001. Preliminary data indicate that only a portion of those funds, which were based on the value of total (state plus federal) Medicaid expenditures for treatment of smoking-related illnesses, have been used for health-related purposes.

A final potential alternative resource for these states is money they have made from their use of similar financing mechanisms in their Medicaid DSH programs. In state fiscal year 1997, the latest year for which data are available, the states using or proposing to use UPL schemes garnered an additional \$2.1 billion in federal funds from DSH, kept in state coffers. Federal DSH allocations have been reduced since then, and it is reasonable to think that states' DSH profits have declined somewhat, although recent data are not yet available.

¹⁹ The state balance is its cumulative surplus, which may include Rainy Day Fund reserves.

Table 1
Fiscal Status of States with Approved or Proposed Medicaid UPL Arrangements

	FY 2000 state balance ¹	FY 2000 balance as % of budget ¹	FY 2000 tax changes enacted in 99 ²	# of past 4 years with state tax cut ³	FY 2001 tobacco settlement	FY 1997 state DSH profits ⁴
	(mil. \$)		(mil. \$)		(mil. \$)	(mil. \$)
Alabama*	41	0.8%	147	1	112	(25.0)
Alaska	867	37.9%	0	1	24	6.0
Arkansas	0	0.0%	11	0	57	(0.5)
California*	3,012	4.6%	(295)	4	884	376.0
Georgia	545	3.8%	0	3	170	74.0
Illinois*	1,350	5.9%	82	2	322	168.0
Indiana*	1,617	17.8%	(233)	3	141	109.0
Iowa*	574	12.0%	(8)	4	60	8.0
Kansas	318	7.2%	28	3	58	32.0
Louisiana	58	1.0%	(10)	4	156	462.0
Massachusetts*	1,706	8.7%	(68)	4	280	227.0
Michigan*	1,285	13.9%	(376)	3	301	not avail.
Minnesota*	2,370	20.5%	(2,084)	3	462	(17.0)
Missouri	435	6.1%	(478)	3	158	288.0
Montana	165	15.1%	7	1	29	(0.0)
Nebraska*	271	11.6%	100	2	41	not avail.
New Hampshire*	0	0.0%	617	0	46	not avail.
New Jersey*	1,174	6.0%	(70)	3	268	3.0
New Mexico*	143	4.2%	(2)	2	41	not avail.
New York	1,170	3.2%	(1,092)	4	884	18.0
North Carolina*	38	0.3%	6	3	162	158.0
North Dakota*	41	5.3%	(2)	2	25	0.7
Oregon*	526	10.8%	(93)	1	80	19.0
Pennsylvania*	1,511	7.8%	(328)	2	398	not avail.
South Carolina*	464	8.7%	(6)	3	82	32.0
South Dakota	37	4.8%	20	0	24	0.7
Tennessee*	212	3.1%	not avail.	0	169	0.0
Washington	1,175	11.6%	(478)	1	142	154.0
Total	21,105	6.4%	(4,605)		5,574	2,093
		(natl. avg.)				

* State has at least one approved UPL arrangement in September 2000. The other states have pending proposals. Three additional states, Florida, Texas and Wisconsin have initiated discussions with HCFA about potential UPL arrangements.

1. Source: National Association of State Budget Officers, *Fiscal Survey of States: August 2000*.

2. Source: Tax Analysts. "State Tax Actions 1999," *State Tax Notes, March 20, 2000*. Positive numbers are tax increases, while negative numbers are tax cuts.

3. Source: National Conference of State Legislatures. *State Policy Reports*, 18(11), 2000.

4. Source: Coughlin, et al. 2000, *op cit*. The sum of gains by state hospitals and state "residual" gains.

It certainly is true that states must make difficult budget decisions and work hard to balance their budgets. But the data indicate these states generally could have made fiscal choices other than to use UPL mechanisms. For example, Pennsylvania, which has one of the most visible UPL arrangements, had a substantial state budget surplus in 2000 and recently reduced taxes. These states understandably believe it is to their advantage to use these financing arrangements to divert federal resources to state coffers, using lawful means. Taxpayers in other states, however, who ultimately pay for federal expenditures, might wonder whether it is fair for their federal taxes to be used to enlarge budget surpluses and effectively help to fund tax cuts or other program expenditures in states with UPL systems.

Some states defend the fact that they have siphoned off so much of the windfall funds they have captured through UPL arrangements (and have left providers with so little) by arguing that the extra money is rebudgeted to support Medicaid or other health care expenditures. It is not possible to determine the validity of this argument. Money is fungible; the additional funds go in general state coffers and can be mixed with other money. There is no way to ascertain the exact source of the money going to Medicaid. If \$100 million retained by a state from UPL transactions is used to support Medicaid, this could mean that \$100 million in other state money that otherwise would be used for Medicaid becomes available for another budget function, such as road construction or sports arenas. It is impossible to know whether states' Medicaid or health care budgets would be lower than they are today in the absence of these additional funds.

Another way to try to assess the claim that the additional funds help support state Medicaid programs is to examine whether states with UPL systems have broader Medicaid eligibility criteria than other states. We compared the Medicaid eligibility criteria for families in the states with approved UPL financing schemes to the criteria for states with no approved or pending UPL arrangements. Medicaid eligibility for families was actually a little higher in the states with no UPL systems than in the states with UPL systems. In states without UPL systems, the average income threshold for a family of three was 85 percent of the poverty line in the year 2000. In the states with UPL systems, the average threshold was 77 percent.²⁰

How Might Safety Net Providers Be Affected?

The current, incomplete evidence suggests that UPL systems involving nursing homes have been used primarily to divert funds to state governments, while UPL systems that involve hospitals have tended to provide hospitals with additional resources. This suggests that efforts to limit UPL systems might harm some hospitals unless alternative sources of funding can be developed. Some discussions concerning the forthcoming HCFA regulations have focused on the reliance on UPL funds of California public hospitals and Cook County Hospital in Chicago.

HCFA will need to be cautious in regulating UPL systems that involve hospitals, as the current evidence suggests the hospital-based mechanisms have been less abused. Even so, the hospital-based UPL systems merit scrutiny for three reasons. First, even if UPL systems

²⁰ In these comparisons we assumed that all the income was earned income.

involving hospitals historically have helped hospitals, such systems could be structured in the future to divert more money to state governments, like the nursing home-based schemes. New UPL systems for hospitals need careful review.

Second, states have other methods to help hospitals, most notably through their Medicaid DSH programs. As shown in Table 1, the Urban Institute study indicated that in 1997 the state of California had a windfall of \$376 million and Illinois of \$168 million, secured through the manipulations of their DSH programs.²¹ States could restructure their DSH programs so that more of the gains are directed to safety net hospitals, rather than being diverted to state coffers.

Third, it is not clear that additional funds provided to public hospitals are used to provide more health care; they might simply supplant other local funds. For example, a recent University of Chicago study analyzed hospital financial data from California for the years 1990 to 1995. It found that every additional dollar in DSH payments that public hospitals in California received was associated with a one dollar reduction in local government subsidies, so that "virtually none of the billions of dollars received by these facilities results in improved medical care quality for the poor."²²

Taking Reasonable and Prudent Regulatory Action

HCFA is expected to issue a proposed regulation in the next few weeks and to complete the rulemaking by the end of this year. The proposed regulation should serve three important public policy purposes.

- It ought to signal that the federal government is serious about limiting abuses that impair the integrity of Medicaid. Based on what HCFA has said to date, it appears the forthcoming regulation would substantially reduce the size of potential UPL financing arrangements.
- The issuance of the proposed rule can create a mechanism to increase understanding of these issues through the information that states and health care providers submit under the public comment process for the proposed regulation.
- At the very least, the regulation could bring a temporary halt to the proliferation of these financing schemes, enabling the federal government to assess the costs and benefits of these arrangements more carefully before the arrangements mushroom in size. CBO estimates that if Congress were to block this regulation,

²¹ In DSH, states can profit by either taking in more revenue from providers and the federal government than they spend in DSH payments or by making excess payments to state-owned hospitals. See Coughlin, et al. *op cit*.

²² Mark Duggan, "Hospital Ownership and Public Medical Spending," National Bureau of Economic Research Paper 7789, July 2000, and forthcoming, *Quarterly Journal of Economics*, Nov. 2000.

that action would cost the federal government \$1.5 billion in fiscal year 2001. The cost would be expected to be considerably larger in subsequent years.

Given the history of the Medicaid DSH program, it seems reasonable to assume there eventually will be federal legislation in this area, even after HCFA issues its regulation. HCFA's regulatory solution is not the only possible mechanism to check the growth of these financing arrangements. In addition, both OIG and GAO have suggested there may be a need for Congressional action to help curtail questionable financing schemes.²³ OIG has recommended, for example, that states be required to demonstrate that additional payments actually are available to the facilities and that these funds are used to help patients. GAO has suggested that states should not be able to pay government-owned facilities more than the actual costs of care.

If Congress wishes to modify these rules in the future, it will have that legislative option. It can do so after it reviews the HCFA regulation. Since the regulation has not yet been issued and data about state UPL arrangements are so fragmentary, there are no sound estimates of the effects the regulation would have on specific hospitals. However, after the rule has been issued and during the transition period that HCFA has said it would provide, Congress could more carefully analyze the effects of the new rules and decide – before the rules are fully in effect – whether to modify the rules or to take some action to cushion the effects on certain providers. For example, if analyses indicated that specific safety net hospitals would be harmed by the rule, Congress could enact legislation that would provide subsidies to such providers in a more straightforward and accountable fashion than through the current UPL arrangements.

If the proposed rule is blocked now, however, it is likely that abuses will continue to spread, and it will become even harder to reel in the abusive financing practices in the future. We might therefore view the forthcoming HCFA regulation as the first step in a longer process of determining appropriate federal policy in this area. Letting HCFA act quickly to put regulations in place should stop the abuses from proliferating and give Congress time to act later if it so chooses.

²³ Mangano and Allen, *op cit.*