

THE WHITE HOUSE
WASHINGTON

Date 9.22.00

To: JENNINGS, MATHEWS

From: The Staff Secretary

ANY COMMENT BEFORE
THIS GOES TO POTUS?

BRIDGET

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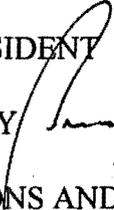
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THE WHITE HOUSE

WASHINGTON

September 21, 2000

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE R. LINDSEY 

RE: HCFA REGULATIONS AND UAMS

The University of Arkansas for Medical Sciences (UAMS) is in financial crisis. UAMS has run a deficit for 8 straight quarters, FY 2000 ended with a \$20 million shortfall, its line of credit has been exhausted, substantial layoffs have already taken place reducing services, and there are concerns about its ability to meet payroll next quarter. Chancellor Harry Ward is retiring October 16, 2000 and a new chancellor, Dodd Wilson, M.D., will begin on that date. Additional new leadership and new procedures are rapidly coming on board with multiple steps being taken to rectify the situation.

The causes for the crisis are many including the general nation-wide tightening of healthcare expenditures, slow UAMS reaction to the new fiscal realities, an enormous load of uninsured patients, and the perennial under-funding of UAMS by the General Assembly.

Early last fall a UAMS team composed of Rick Smith, M.D., Ray Scott, Tom Butler, and Barbara Eyman (Washington-based attorney) begin work on multiple mechanisms to develop new sources of support for UAMS through the Medicaid system. With the assistance and support of the Arkansas Medicaid Program, two state plan amendments were proposed to use UAMS' general revenue as match in order to access federal funds in the form of a State Operated Teaching Hospital payment. One of these plans for an inpatient payment of \$2.4 million/year has been approved by HCFA. The other outpatient plan for \$34 million/year is in the final stages of review by HCFA, which is expected to allow the plan to take effect in December. These plans are very small in relation to how other states are using Medicaid funds for their teaching hospitals, especially those that care for many indigent patients.

While Arkansas was pursuing these state plan amendments, HCFA became concerned about how some states were using the same mechanism, the "Upper Payment Limit" methodology, to draw down federal funds. The Medicaid Administrator, Timothy Westmoreland, has announced his agency's intention to issue regulations to severely curtail a state's ability to receive these funds. HCFA does not appear, in principle, to object to how Arkansas is proposing to use its funds, it is simply trying to close what it considers a loophole in the federal regulations. While these new regulations will not prevent Arkansas' plan from initially taking effect, they will end Arkansas' ability to

fund UAMS through this mechanism unless the rules are crafted with some attention to the state's plight.

HCFA has said that it is "modeling" new rules and is eager to release them. Some states such as California, which accesses \$1.1 billion/year through this mechanism, are likely to remain relatively untouched while other states will likely be severely restricted by the new rules. From UAMS' point of view, it is imperative that the new rules make some allowance so that the state may continue to use this mechanism.

UAMS has proposed several options that would allow HCFA to issue its new rules limiting inappropriate use of the Upper Payment Limit methodology while at the same time allowing Arkansas and states in similar situations to continue to use this mechanism. UAMS, however, believes that without some direction from us, HCFA will move forward with new regulations limiting Arkansas' ability to use this mechanism.

Harry Ward, Rick Smith and others have requested a meeting with you to discuss this problem. Governor Huckabee, former Senator Pryor, former Senator Bumpers and others have written you urging some relief. If you don't have time to meet with UAMS officials, maybe a meeting with Chris would suffice.

cc: Chris Jennings



CENTER ON BUDGET AND POLICY PRIORITIES

September 27, 2000

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 scheme to

¹ Testimony of Kathyrn 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.

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

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

example, if subsequent analyses support the belief that the final rule would significantly harm 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

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.

limitations, the federal government spent an estimated \$9 billion for DSH payments in fiscal year 2000.

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

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 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 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.

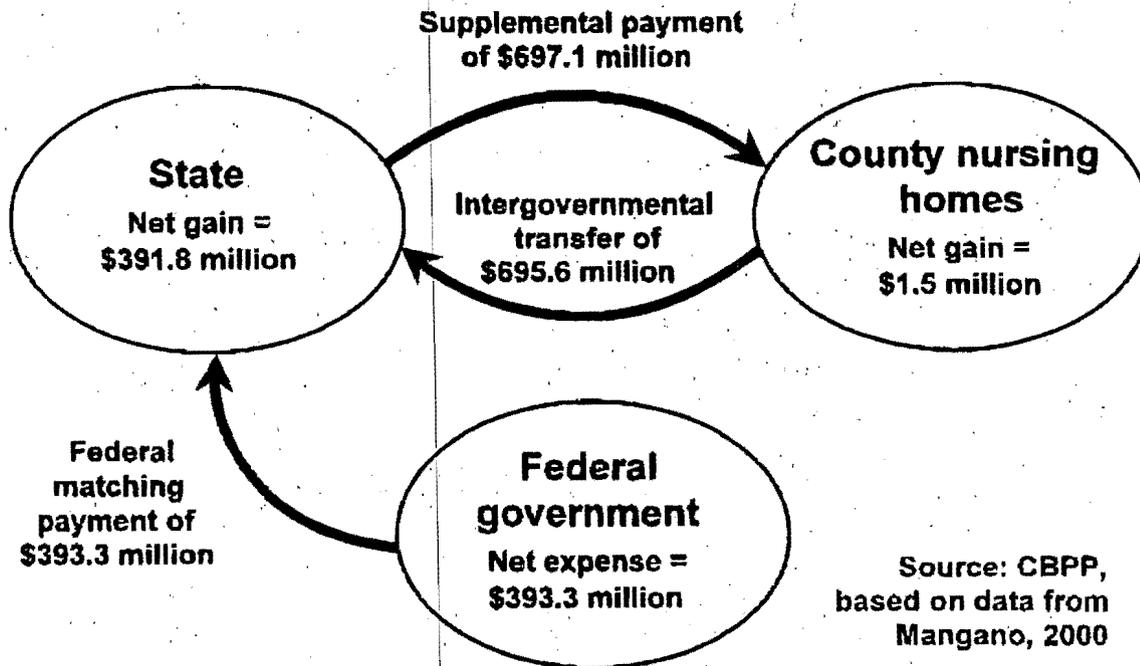
Figure 1 presents data concerning a recent example of the use of this mechanism by Pennsylvania, as reported by HHS' Office of the Inspector General.¹¹ On June 14, 2000, the state paid \$697.1 million in supplemental payments to 23 county nursing homes. Since Pennsylvania has a 54 percent federal matching 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 fro

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



in 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.

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

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

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.”

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.

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.

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 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

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.

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

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.

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.

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

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.

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

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.

mushroom in size. CBO estimates that if Congress were to block this regulation, 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.*

AGENDA: MEDICAID UPPER PAYMENT LIMIT

August 31, 2000

POSSIBLE LIMITS

1. **Transition to new UPL:** 3- to 5-yr transition. Starts in 2002 for approvals prior to 10/1/99; 1-yr transition from effective date of reg for approvals after 10/1/99
 - Maintains commitment to ending the practice while recognizing that States with longstanding approved arrangements need additional time to transition to new UPL
 - Applied uniformly across all provider types (doesn't exclude nursing homes)
 - Most controversial, likely to cause rider; most savings
- 1a. **Public Hospital Exception:** Phase down excess payments for non-State public hospitals to an amount above the new UPL; apply new UPL to all other providers
 - Recognizes the unique situation of safety net hospitals; if public hospitals are the vehicle for this funding, may be more likely to keep enhanced payments
 - Leaves open part of reg; allows new states to apply for this exception
 - Excludes public nursing homes; while justifiable, could cause problems
- 1b. **Waivers:** Allow case-by-case waivers, with a budget neutral or cost effective baseline
 - Essentially grandfathers approved plans due to cost effectiveness test, budget-neutrality
 - Allows HCFA to selectively approve, monitor, adjust enhanced payment arrangements
 - Encouraging waivers, which are determined administratively, would put enormous pressure on approvals; could compromise waiver process, make states unhappy
2. **Limited Grandfather:** Only under narrow circumstances for public hospitals
 - While most are asking for this, states with nursing home plans will object strongly
3. **Legislation:** Acknowledge that we cannot meet goals through regulation
 - Unlikely that Congress will take on this legislation, preferring the status quo
 - Harder to solve in future as more states come in with amendments
 - As likely as Option 1 to cause rider since uncertainty is great

USES OF FUNDS

- **Do we include in reg limits on use of funding for health purposes:** While it may narrow the current uses, it acknowledges that we are allowing for non-Medicaid purposes

TIMING AND PROCESS

AGENDA: MEDICAID UPPER PAYMENT LIMIT: August 31, 2000

REVIEW OF PROBLEMS THAT WE ARE TRYING TO SOLVE

- Avoid rider prohibiting any action on UPL
- End approval of new UPL state plan amendments
- Limit Federal liability on existing state plan amendments
- Avoid disrupting health programs; create incentives for dollars to go to institutions in need
- Avoid setting bad precedent for Medicaid policy

POSSIBLE LIMITS

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USES OF FUNDS

- **Do we include in reg limits on use of funding for health purposes:** While it may narrow the current uses, it acknowledges that we are allowing for non-Medicaid purposes

TIMING

UPL AGENDA

REGULATION UPDATE

- **Transition to new UPL:**
 - Begin in 2002
 - 3-yr transition period starting in 2002 for approvals prior to 10/1/99
 - 1-yr transition from effective date of reg for approvals after 10/1/99
- **Public Hospital Exception:** Phase-down to 150 percent of the new UPL (100 percent of the new UPL for nursing homes, ICFs MR). Rationale: uncompensated care; safety net facilities

LEGISLATION

- **Raise hospital-specific limits on Medicaid disproportionate share hospital (DSH)**

Medicaid DSH has two limits:

- State allotment (set it law and declining as a result of BBA; MSR eliminates cut in '01)
- Hospital-specific DSH cap: This equals:

Medicaid costs + uncompensated care costs – Medicaid payments.

Example: \$2 million in Medicaid costs + \$1 million in uncompensated care = \$3 million
Medicaid pays \$1.8 million. Hospital can get up to **\$1.2 million in DSH**

A number of states are not at their state caps since their hospital-specific DSH limits are more binding. NY has about \$490 million in room below DSH cap.

Proposal: Raising the hospital-specific DSH cap to 175 of net uncompensated care.

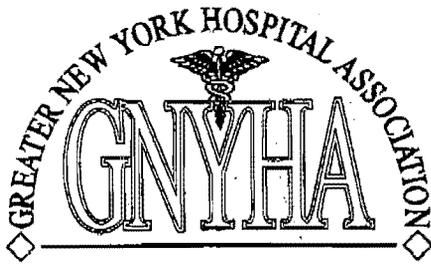
175% (Medicaid costs + uncompensated care costs – Medicaid payments)

Example: \$2 million in Medicaid costs + \$1 million in uncompensated care = \$3 million
Medicaid pays \$1.8 million. Hospital can get up to **\$2.1 million in DSH**

Public hospitals can use local funding for their state match, so that if this state had a 50 percent matching rate, the net Federal gain would be **\$1.05 million**

- **Cost:** \$6 billion over 10 years

FY 1999 DISPROPORTIONATE SHARE HOSPITAL AMOUNTS FROM 4TH QUARTER FY1999 - AS OF JUNE 2000				
(Federal Share)				
STATE	FY-1999 ALLOTMENT	FY - 1999 Expenditures	TOTAL REMAINING	OMB staff believe
				data incomplete
NEW YORK	1,482,000,000	994,760,721	489,299,080	inc.data
LOUISIANA	795,000,000	554,781,808	245,413,300	
PENNSYLVANIA	518,000,000	329,202,535	211,865,679	
INDIANA	197,000,000	68,556,894	167,381,511	
NEW HAMPSHIRE	136,000,000	74,835,134	118,005,576	
ILLINOIS	199,000,000	113,404,932	103,469,997	
MAINE	99,000,000	33,674,627	61,496,802	
TEXAS	950,000,000	949,943,832	54,101,453	
VIRGINIA	68,000,000	26,051,702	44,918,298	inc.data
MISSOURI	423,000,000	382,962,525	40,037,475	
RHODE ISLAND	60,000,000	32,065,557	27,934,443	
CONNECTICUT	194,000,000	169,973,246	24,026,754	
KANSAS	49,000,000	26,190,429	22,809,571	
NORTH CAROLINA	272,000,000	250,996,755	21,003,245	inc.data
MICHIGAN	244,000,000	229,834,545	14,165,455	inc.data
CALIFORNIA	1,068,000,000	1,054,916,477	13,083,523	
WEST VIRGINIA	63,000,000	60,454,141	12,214,749	inc.data
GEORGIA	248,000,000	244,379,186	11,145,855	inc.data
MASSACHUSETTS	282,000,000	280,155,041	11,092,393	inc.data
IOWA	8,000,000	3,168,875	7,108,999	
NEBRASKA	5,000,000	4,948,187	4,862,303	
MINNESOTA	33,000,000	31,799,724	4,358,543	
COLORADO	85,000,000	79,260,114	3,857,594	
NEW MEXICO	9,000,000	9,182,377	2,790,000	
WISCONSIN	7,000,000	5,807,956	2,291,706	
OREGON	20,000,000	20,000,000	1,852,025	
FLORIDA	203,000,000	201,576,168	1,640,285	
ALASKA	10,000,000	8,394,359	1,605,641	inc.data
MISSISSIPPI	141,000,000	139,954,137	1,324,591	
VERMONT	18,000,000	17,466,688	533,312	
ARKANSAS	2,000,000	1,585,360	414,640	
UTAH	3,000,000	2,652,399	347,601	
SOUTH DAKOTA	1,000,000	722,536	277,464	
NEVADA	37,000,000	36,779,999	220,001	
NORTH DAKOTA	1,000,000	815,183	184,817	
WYOMING	95,000	0	95,000	
MONTANA	200,000	147,656	52,344	
OHIO	374,000,000	373,998,468	1,698	
OKLAHOMA	16,000,000	15,998,733	1,265	
ARIZONA	81,000,000	80,999,945	55	
WASHINGTON	171,000,000	170,877,905	-	
TENNESSEE	-	0	-	
SOUTH CAROLINA	303,000,000	303,000,001	-	
NEW JERSEY	582,000,000	582,049,816	-	
MARYLAND	70,000,000	70,000,000	-	
KENTUCKY	134,000,000	134,000,000	-	
IDAHO	1,000,000	1,000,000	-	
HAWAII	-	0	-	
DELAWARE	3,534,500	3,534,500	-	
D.C.	23,000,000	23,000,000	-	
ALABAMA	269,000,000	269,000,000	-	
NATION	9,957,829,500	8,468,861,173	1,727,285,043	
12-Sep-00				



FACSIMILE TRANSMISSION

555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

Date: 8/10/00
Time:

TO: Chris Jennings
FAX# 202-456-5557

FROM: Kenneth E. Raske
President
Phone: 212-246-7100
E-mail: raske@gnyha.org

We are transmitting 5 pages including this cover sheet. If you have not received all of the pages, PLEASE CALL OUR OFFICE AS SOON AS POSSIBLE.

MESSAGE: Per our telephone conversation -- see the attached.

K

Main Number (212) 246-7100
Fax Number (212) 262-6350

Hard Copy will will not be sent by mail.

New Medicaid Upper Payment Limit Regulations and the Feasibility of a Grandfather Provision

The U.S. Health Care Financing Administration (HCFA) has argued that it needs to amend the current Medicaid upper payment limit regulations (42 CFR 447.272) in order to curtail perceived abuses by states and, perhaps more importantly from HCFA's standpoint, to prevent more states from engaging in what HCFA deems to be abusive behavior. Federal officials claim that, due to new state plan amendments submitted since July 1, 2000, Federal Medicaid spending could increase in one quarter alone by \$1.9 billion.

The New York State government, health care advocates, and New York's health care providers have been concerned that HCFA's approach will be so broad that it will prevent New York State from continuing to legitimately draw down several hundred million dollars in Federal funds, as it has done for years under its HCFA-approved State plan, to use these funds as a vehicle to pay for critical health care programs for low-income New Yorkers. While HCFA officials claim the purpose of the proposed regulation is to curtail alleged abuses in other states, it would, in fact, penalize states like New York whose use of such funds has been publicly acknowledged by HCFA as appropriate -- as evidenced by the fact that the agency has approved New York's related State plans for five consecutive years. However, HCFA also claims that it lacks the legal authority to grandfather states like New York, who have used this HCFA-approved funding mechanism for many years, while preventing other states from operating under the current upper payment rules.

After numerous discussions with State officials, it has become clear that HCFA does indeed have the legal authority to grandfather states like New York. Attached is a document prepared by State officials that lays out the statutory authority granted to the Secretary to grandfather New York as well as a number of regulatory provisions that serve as grandfathering precedents. Also attached is regulatory language that would protect states like New York who have appropriately used, for several years, this HCFA-approved funding mechanism from Medicaid cuts while instituting HCFA's new upper payment limit policy for the future, thus protecting the Federal budget from the large increases in spending about which Federal officials are so concerned.

Essentially, the statutory grounds include the general, and extremely broad grant of authority granted the Secretary under Section 1102(a) of the Social Security Act (the Secretary is empowered to "make and publish such rules and regulations...as may be necessary to the efficient administration of the functions with which [she] is charged"); and language in Section 1901 of the Social Security Act that recognizes that circumstances differ from state to state, thus protecting HCFA from arguments that HCFA must treat all states equally ("For the purpose of enabling each State, *as far as*

practicable under the conditions in such State, to furnish ... medical assistance ... to meet the costs of necessary medical services...").

Grandfathering precedents abound both in statute and regulations, including the very regulations implementing the statute that governs provider taxes and intergovernmental transfers. Regulatory examples, that have no matching statutory provision, include:

- Allowing a state to include as a separate class of services for the purposes of provider taxes, services provided "under a waiver under section 1915(c) of the Act" but *only* in a State in which, "as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/MRs prior to the grant of the waiver" (42 CFR 433.56(4));
- Providing a special standard for waivers of the broad based tax requirement *only* for States where "a tax is enacted and in effect prior to August 13, 1993..." (42 CFR 433.68(e)(1)(iii));
- Providing a special standard for waivers of the requirement that provider taxes be uniform across a State but *only* for States with "taxes that vary based exclusively on regional variations, and enacted and in effect prior to November 24, 1992" (42 CFR 433.68(e)(2)(iv)); and
- Providing a special standard for a retroactive effective date for a waiver of provider tax rules, but *only* for States with taxes in effect prior to August 13, 1993 (42 CFR 433.72(c)(1)).

Clearly, there is precedent for grandfathering New York while preventing new abuses.

The attached proposed regulatory language would allow New York to continue its "proportionate share payment" program under current upper payment limit rules while applying HCFA's new rules to plan amendments submitted on or after July 1, 2000.

Attachments

HCFA REGULATORY AUTHORITY

I. General Grant of Authority

Social Security Act 1102(a):

Secretary of the Department of Health and Human Services (DHHS) is empowered to "make and publish such rules and regulations, . . . as may be necessary to the efficient administration of the functions with which [she] is charged" under the Act.

II. Equal treatment of states

Secretary is not required by statute to treat all states exactly the same. The Congressional statement of policy recognizes that circumstances vary from state to state and that practicable conditions in one state may not exist in another.

Social Security Act 1901:

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish . . . medical assistance . . . to meet the costs of necessary medical services, . . . there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title.

III. Regulatory "grandfather" provisions.

All of the following are related to provider taxes and implementation of Social Security Act 1903(w).

- 42 C.F.R. § 433.56(4): Inclusion of SSA § 1915(c) home and community based waiver services in the definition of intermediate care facilities for the mentally retarded, if such waiver was in effect on December 24, 1992;
- 42 C.F.R. § 433.68(e)(1)(iii) and (iv): Provision of different standards for the proportional analysis used in examining a tax for a waiver of the broad based provision of SSA 1903(w), based on the date on which the tax was effective;
- 42 C.F.R. § 433.68(e)(2)(iv): Provision for a separate standard for taxes based on regional variations in examining a tax for a waiver of the uniformity provision of SSA 1903(w), based on the date on which the tax was effective;
- 42 C.F.R. § 433.72(e)(1): Providing for retroactive effective date of a waiver to the date of enactment of a tax in effect prior to August 13, 1993.

42 CFR 447.272 Application of upper payment limits.

- (a) **General rule.** Except as provided in paragraph (c) of this section, aggregate payments by an agency to each group of health care facilities (that is, hospitals, nursing facilities and ICF's for the mentally retarded (ICF's/MR)), may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.
- (b) **State operated facilities.** In addition to meeting the requirement of paragraph (a) of this section, aggregate payments to each group of State operated facilities (that is, hospitals, nursing facilities and ICF's/MR) may not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles.
- (c) **Proportionate share payments.** For any state plan change which provides for "proportionate share payments" to government owned or operated facilities either in aggregate amounts or in amounts related to the amount calculated pursuant to paragraph (a) of this section, and is submitted to HCEA on or after July first, two thousand, in addition to meeting the requirements of paragraph (a), aggregate payments to each group of government owned or operated facilities (that is, hospitals, nursing facilities and ICF's/MR) may not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles.
- (c) **Disproportionate share.** The upper payment limitations established under paragraphs (a) and (b) of this section does not apply to payment adjustments made under a State plan to hospitals found to serve a disproportionate number of low-income patients with special needs as provided in Section 447.253(b)(1)(ii)(A). The payment limitations for aggregate State disproportionate share hospital payments are specified in Sections 447.296 through 447.299. States must submit a separate upper payment limit assurances that their aggregate disproportionate share hospital payments do not exceed the disproportionate share hospital payment limits.

**Memorandum**

AUG 7 2000

Date

Michael Mangano

From

for June Gibbs Brown
Inspector General

Subject

Early Alert - Review of Medicaid Enhanced Payments to Public Providers and Related State Funding Mechanisms (A-14-00-04000)

To

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

The purpose of this memorandum is to provide preliminary results regarding our review of Medicaid enhanced payments to public providers as part of the States' compliance with the upper payment limit regulations in the Medicaid program. The objective of our review is to analyze the use of enhanced payments and to evaluate the impact of the associated State financing mechanisms on the Medicaid program. To date, we have started audit work in six States. This early alert provides preliminary results of work involving three of those States. We will provide information regarding the other three States once our audit work has progressed further.

This memorandum presents only the enhanced payment transactions involved in the upper payment limit calculations. The enhanced payments resulting from these funding mechanisms are separate and apart from regular monthly Medicaid payments made to nursing facilities. Each of the three States used a form of a funding pool in order to make enhanced payments to public providers. One State used funds transferred from county governments as the initial source to fund their pool. The other two used state resources to fund their pools. The use of these funding pools results in Federal funds being expended for the stated purpose of reimbursing nursing facilities for Medicaid costs when in fact the vast majority of the funds are being retained at the State level for their use.

Based on preliminary work, we found that the enhanced payments to city and county government owned nursing facilities were not based on the actual cost of providing services to Medicaid beneficiaries, nor have we found a direct relationship in the use of these funds to increase the quality of care provided by these public facilities. We also found that enhanced payments were not being retained by the facilities to provide services to resident Medicaid beneficiaries. Some of the funds transferred back to the State governments may be used for health care related services but not necessarily for Medicaid covered services approved in a State Plan.

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In addition, we believe that the regulatory changes the Health Care Financing Administration (HCFA) has discussed as part of a Notice of Proposed Rulemaking (NPRM) involving the upper payment limit calculations would limit the amount of funds available to the States for enhanced payments to public providers which are part of these financing mechanisms. We believe changes are needed to the upper payment limit regulation to help protect the fiscal integrity of the Medicaid program. Therefore, HCFA should move as quickly as possible to issue the proposed NPRM. We plan to provide reports to HCFA on these individual State reviews once we complete our audit work.

BACKGROUND

Title XIX of the Social Security Act (Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy persons. Each State Medicaid program is administered by the State in accordance with an approved State plan. While the State has considerable flexibility in designing its State plan and operating its Medicaid program, it must comply with broad Federal requirements. The Medicaid programs are administered by the States, but are jointly financed by the Federal and State governments. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid eligible individuals. The Federal Government pays its share of medical assistance expenditures to a State according to a defined formula.

The Act requires a State plan to meet certain requirements in setting payment amounts. In part, this provision requires that payment for care and services under an approved State Medicaid plan be consistent with efficiency, economy and quality of care. This provision provides authority for specific upper limits set forth in Federal regulations relating to different types of Medicaid covered services. These regulations stipulate that aggregate State payments for each class of service (for example, inpatient hospital services, nursing facility services, etc) may not exceed a reasonable estimate of the amount the State would have paid under Medicare payment principles. Federal financial participation (FFP) is not available for State expenditures that exceed the applicable upper payment limits.

Under the present upper payment limit rules, States are permitted to establish payment methodologies that allow for enhanced payments to non-State owned government providers, such as city or county operated facilities. The HCFA intends to revise the upper payment limit regulations to limit the amount of the enhanced payments available to the State Medicaid programs through enhanced payments to public providers. The limits will continue to be based on Medicare payment principles. The HCFA believes the change is necessary to ensure that States adopt payment methods and standards that result in rates that are consistent with efficiency and economy.

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SCOPE

The objective of our review is to analyze the use of Medicaid enhanced payments to public providers and to evaluate the financial impact of the associated State financing mechanisms on the Medicaid program. To date, we have started audit work in six States. Our audit will cover enhanced payments made to public providers during the past 3 years, when applicable. For each State selected, we are attempting to determine the accuracy of the funding pool calculated by the State Medicaid agency for distribution to public providers and attempting to track the dollars that are transferred between State and local governments. In each State, we also selected several county owned facilities that received enhanced payments to determine how the enhanced payments were used, however these reviews are not, as yet, complete.

We presented our results to officials in the three States at the conclusion of our fieldwork to provide the States an opportunity to correct any inaccurate information or to provide additional information that may be applicable. Two of the three States agreed that our facts on the funding mechanism used were accurate and the third State declined to comment at this time.

PRELIMINARY RESULTS

Based on preliminary work, we found that the enhanced payments to city and county government owned nursing facilities were not based on the actual cost of providing services to Medicaid beneficiaries, nor have we found a direct relationship in the use of these funds to increase the quality of care provided by these public facilities. We also found that enhanced payments were not being retained by the facilities to provide services to resident Medicaid beneficiaries. Instead, the vast majority of the enhanced payments were transferred back to the State governments for other uses, some of which may be health care related but not necessarily approved in State Plan Amendments (SPA) for Medicaid coverage.

In the three States reviewed to date, each had created a funding pool to increase reimbursement to city and/or county government owned nursing facilities. The funding pools were calculated by determining the difference between the upper payment limit (based on Medicare payment principles) and the allowable Medicaid payments for each facility in the State. The combined total of the differences for all facilities in the State represents the funding pool. The total pool was distributed to the city and/or county providers (as an enhanced payment) based on the proportionate number of Medicaid beneficiary days at each facility. Once each nursing facility received the enhanced payment (Federal and State share), the majority of the funds were transferred back to the State. The State share was returned to its original source, usually the States's general fund, and the Federal funds were allocated for other uses.

Preliminary information shows that in one State, the facilities did not keep any of the funds. In another State, the facilities kept \$10,000 each and in a third, the facilities kept 3.5 percent of the funds with the remainder going back to the State. In one State, the funds transferred from the facilities back to the State were budgeted for various health and welfare programs, most of which

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related to long term care. In another, the funds went into specific accounts designated for various health and welfare projects. In a third State, the funds went into an account that is primarily used to pay for Medicaid expenditures.

The fiscal responsibility of the Medicaid program is to be shared by the Federal and State governments. However, even though these enhanced payments might be used for health care purposes, the funds consist of only Federal dollars. Thus, the use of the funds for an otherwise—worthwhile health care purpose results in being a totally federally funded activity rather than the shared activity required of the Medicaid program. And, as stated, the health care activity may not be approved as a Medicaid covered service.

In addition, we believe the regulatory changes HCFA has discussed involving the upper payment limit calculation would limit the amount of funds available to the States as part of these financing mechanisms. We also believe HCFA's plan to control these financing activities is a fiscally responsible approach. Implementing the planned NPRM would help better ensure the use of Federal funds for authorized and approved Medicaid purposes.

Below are details we have noted in the three States reviewed to date and provide some insights into the financial transactions which have occurred between the State and local governments. This memorandum presents only the enhanced payment transactions involved in the upper payment limit calculations. The enhanced payments resulting from these funding mechanisms are separate and apart from regular monthly Medicaid payments made to nursing facilities. In the next several weeks, we plan to provide individual State reports to HCFA.

STATE NUMBER ONE

This State began making enhanced payments in the early 1990's. The SPA provided for enhanced payments to county owned nursing facilities (the SPA has been updated/adjusted several times since 1991, but still provides for enhanced payments to county nursing facilities). Since the SPA effective date, the State reported \$5.5 billion in enhanced payments to nursing facilities, resulting in \$3.1 billion in FFP.

For each year, the State determined the available funding pool by calculating the amount of Medicaid funds available under the upper limit regulations. The State then entered into an agreement with the counties, whereby the counties obtained funds through tax and revenue anticipation notes which may be up to the total amount of the funding pool. The funds were then transferred to the State as the initial source to fund the pool. Within 24 hours of receipt, the State transferred the amount received from the counties, plus \$1.5 million in program implementation fees back to the county bank accounts as Medicaid payments for nursing facility services. The counties used the funds to pay the bank notes. The State then reported the enhanced payment to HCFA as a county nursing facility supplementation payment and claimed FFP. The net effect is that the Federal funds included in the supplementation payment remain at the State for their use and were not provided directly to the nursing facilities.

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For the past 3 years, the State reported enhanced payments to nursing facilities totaling \$3.4 billion, with the Federal share totaling approximately \$1.9 billion. Of the \$1.9 billion, \$1.2 billion was budgeted for various health and welfare programs, most of which related to long term care but were not necessarily approved for coverage as part of a SPA. The remaining \$662 million was allocated for unidentified programs that we have not been able to trace.

STATE NUMBER TWO

This State established a funding pool in January 1, 1998. The SPA created a proportionate share funding pool to increase reimbursement to city and county owned nursing facilities (the SPA has been adjusted since January 1998, but still provides for increased reimbursement for city and county owned nursing facilities). Since the plan's effective date, the State claimed \$226 million in enhanced payments to public providers, with the Federal share totaling \$138 million.

Once the funding pools were calculated, the State government provided the State's share of the matching funds (from the State's General Fund). With the State share of funds available, the State then obtained the Federal matching funds. The total amount (State and Federal share) was paid to the city and county owned nursing facilities based on the proportional number of Medicaid beneficiary days at each facility. The payments occurred once per year. The city and county owned facilities kept \$10,000 as a transaction fee and transferred all remaining funds back to the State. The State share of the funds was returned to the general fund and the remaining amount (which would consist solely of Federal funds) went into the Health Care Trust Fund.

The first \$40 million in the Health Care Trust Fund was transferred to a Nursing Facility Conversion Cash Fund. This fund provides grants and loan guarantees for nursing facility conversion to assisted living facilities. Under current State statute, this was a one time only transfer and does not occur with the distribution of every funding pool.

The next \$25 million was transferred to the Children's Health Insurance Cash Fund. This fund is used to provide the State's matching share of funds under Title XXI, and for expenses incurred to administer the program. This was also a one time only transfer and does not occur with the distribution of every funding pool. Any interest earned from the Health Care Trust Fund was transferred to the Excellence in Health Care Trust Fund.

The Excellence in Health Care Trust Fund provided grants for (a) nursing facility conversion, (b) Indian and minority group health education, (c) emergency medical services for children, (d) hospital conversion to limited service rural hospital, (e) health professional recruitment in underserved areas, (f) development of telemedicine capability, (g) expansion of community based aging services, and (h) matching Title XXI. Although these may be health care related activities, they are not necessarily Medicaid program covered activities and have not been approved as a SPA.

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As of April 30, 2000, the Health Care Trust Fund contained \$72 million, the Nursing Facility Conversion Cash Fund had \$36 million, the Children's Health Insurance Cash Fund had a balance of \$25 million, and the Excellence in Health Care Trust Fund contained \$3 million. In total, the trust funds contain \$136 million--again, all Federal funds.

STATE NUMBER THREE

This State had three separate enhanced payments to public providers. The SPA was approved on June 16, 1999 with an effective date of September 1, 1999 and provided for enhanced Medicaid payments to rural hospital based nursing facilities owned by local governments. Further SPAs provided for enhanced Medicaid payments to public hospitals. In this memorandum, we provide preliminary information regarding enhanced payments to the hospital based nursing facilities only. We will provide details involving enhanced payments to public hospitals once our audit work has progressed further.

For the current period, the State calculated a funding pool of \$44 million. Through State financial transactions the FFP was calculated and billed for total of around \$30 million. The total funding pool (Federal and State share) was distributed in equal monthly installments throughout the year to the rural hospital based nursing facilities based on the proportionate number of Medicaid beneficiary days. The facilities receiving the enhancement payments retained 3.5 percent of the total amount and returned 96.5 percent to the State within a few days of receipt. The 96.5 percent received by the State was deposited into a special revenue account. The majority of the funds in this account were used to pay Medicaid program expenditures. Potentially, the net effect of these transactions is that Federal funds will be used to seek additional Federal funds.

SUMMARY

Generally, we found that once the city and/or county owned nursing facilities received enhanced payments (Federal and State share), the majority of the funds were not retained by the facilities to provide services to Medicaid beneficiaries. Rather, the funds were transferred back to the States. The States then have the option of how these funds will be used, whether it be for health care related services or other general State uses. Because the original enhanced payments to the nursing facilities appear to be unrelated to the provision of Medicaid services for which they were claimed to obtain Federal matching funds, HCFA should move forward with regulatory changes that curtail this practice.

Any questions or comments on any aspect of this memorandum are welcome. Please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

FY 1999 DISPROPORTIONATE SHARE HOSPITAL AMOUNTS FROM 4TH QUARTER FY1999 - AS OF JUNE 2000				
(Federal Share)				
STATE	FY-1999 ALLOTMENT	FY - 1999 Expenditures	TOTAL REMAINING	OMB staff believe data incomplete
NEW YORK	1,482,000,000	994,760,721	489,299,080	inc.data
LOUISIANA	795,000,000	554,781,808	245,413,300	
PENNSYLVANIA	518,000,000	329,202,535	211,865,679	
INDIANA	197,000,000	68,556,894	167,381,511	
NEW HAMPSHIRE	136,000,000	74,835,134	118,005,576	
ILLINOIS	199,000,000	113,404,932	103,469,997	
MAINE	99,000,000	33,674,627	61,496,802	
TEXAS	950,000,000	949,943,832	54,101,453	
VIRGINIA	68,000,000	26,051,702	44,918,298	inc.data
MISSOURI	423,000,000	382,962,525	40,037,475	
RHODE ISLAND	60,000,000	32,065,557	27,934,443	
CONNECTICUT	194,000,000	169,973,246	24,026,754	
KANSAS	49,000,000	26,190,429	22,809,571	
NORTH CAROLINA	272,000,000	250,996,755	21,003,245	inc.data
MICHIGAN	244,000,000	229,834,545	14,165,455	inc.data
CALIFORNIA	1,068,000,000	1,054,916,477	13,083,523	
WEST VIRGINIA	63,000,000	60,454,141	12,214,749	inc.data
GEORGIA	248,000,000	244,379,186	11,145,855	inc.data
MASSACHUSETTS	282,000,000	280,155,041	11,092,393	inc.data
IOWA	8,000,000	3,168,875	7,108,999	
NEBRASKA	5,000,000	4,948,187	4,862,303	
MINNESOTA	33,000,000	31,799,724	4,358,543	
COLORADO	85,000,000	79,260,114	3,857,594	
NEW MEXICO	9,000,000	9,182,377	2,790,000	
WISCONSIN	7,000,000	5,807,956	2,291,706	
OREGON	20,000,000	20,000,000	1,852,025	
FLORIDA	203,000,000	201,576,168	1,640,285	
ALASKA	10,000,000	8,394,359	1,605,641	inc.data
MISSISSIPPI	141,000,000	139,954,137	1,324,591	
VERMONT	18,000,000	17,466,688	533,312	
ARKANSAS	2,000,000	1,585,360	414,640	
UTAH	3,000,000	2,652,399	347,601	
SOUTH DAKOTA	1,000,000	722,536	277,464	
NEVADA	37,000,000	36,779,999	220,001	
NORTH DAKOTA	1,000,000	815,183	184,817	
WYOMING	95,000	0	95,000	
MONTANA	200,000	147,656	52,344	
OHIO	374,000,000	373,998,468	1,698	
OKLAHOMA	16,000,000	15,998,733	1,265	
ARIZONA	81,000,000	80,999,945	55	
WASHINGTON	171,000,000	170,877,905	-	
TENNESSEE	-	0	-	
SOUTH CAROLINA	303,000,000	303,000,001	-	
NEW JERSEY	582,000,000	582,049,816	-	
MARYLAND	70,000,000	70,000,000	-	
KENTUCKY	134,000,000	134,000,000	-	
IDAHO	1,000,000	1,000,000	-	
HAWAII	-	0	-	
DELAWARE	3,534,500	3,534,500	-	
D.C.	23,000,000	23,000,000	-	
ALABAMA	269,000,000	269,000,000	-	
NATION	9,957,829,500	8,468,861,173	1,727,285,043	
12-Sep-00				

Background. New York operates a nursing home UPL. It has around 10 (checking) public county nursing homes, mostly in upstate NY. Their Medicaid costs are \$740 million and, on top of that, they receive \$975 million in supplemental payments through UPL. The nursing homes / counties get to keep 20 percent of this (\$195 m) so that the State gets \$390 million. It is using this money to fund its Family Health Plus expansion to low-income parents and childless adults.

While transitions in the reg would help NY and all states, there are no options other than grandfathering that would maintain the nursing home practice. Medicaid is supposed to pay facilities for their costs and while we have precedent in including uncompensated care in the definition of costs, nursing homes don't have any. On grandfathering, Chris and I share HHS's strong concerns that it would be hard to justify substantively and politically.

CA and IL have, generally, proposed to leave room under the new UPL for public hospitals (e.g., have UPL for public hospital be 150 percent of the Medicare UPL), using their uncompensated care costs as the justification. Greater New York Hospital Association (Raske) and separately with Hospital Association of New York State (Cisto) have been exploring whether they could convert from a nursing home to hospital scheme. It looks like it may be a problem because (a) the state pays Medicaid rates close to Medicare rates, so that even creating a new UPL of 150% of Medicare does not leave much room; and (b) public hospitals get significant Medicaid DSH payments. The DSH law created both hospital-specific and state DSH caps. A hospital cannot receive a DSH payment that exceeds 100 percent of its (Medicaid costs + uncompensated care costs) minus Medicaid payments. To the extent that NY increases its Medicaid payments under the new UPL, it has to decrease its DSH payments since all its hospitals are at their hospital-specific DSH limits. Illinois got around this by not providing Cook County with ANY DSH payments. Thus, their only constraint is the current UPL. NY would probably have a problem replicating Cook County since the proposed UPL would have to be high enough to allow for both replacing the DSH payment and providing a supplemental payment equal to the nursing home one. We could not justify such a high UPL.

Given this state of play, we are considering coupling an NPRM that leaves some room on the hospital side with a legislative option to raise the hospital-specific DSH limit (note: California has a hospital-specific limit of 175 percent of net uncompensated care). Medicaid DSH would still be capped at the state level, limiting overall liability, but states like NY, IL, and PA that do not now spend up to their state DSH caps (because of their hospital-specific caps) could do so. It is also consistent with the Congressional interest in improving Medicaid DSH (Congressional proposals have focused on raising the state caps; we have not yet ascertained interest in the hospital-specific caps). This is a more straightforward way of providing assistance and we laid the predicate for it in the July letter on UPL where we said that we would support increasing payments to public hospitals as part of our unallocated giveback pool. We are working on cost estimates / options now.

**State Payments Based on Aggregate Upper Payment Limits
Possible Regulatory Options
August 3, 2000**

The recent Institute of Medicine (IOM) report on America's Health Care Safety Net recommends that **"Federal and state policy makers should explicitly take into account and address the full impact (both intended and unintended) of changes in Medicaid policies on the viability of safety net providers and the populations they serve."**¹ HCFA is currently considering changes to Medicaid regulations to address potential abuses of state Medicaid payments made using aggregate upper payment limits. We understand that HCFA will propose to require calculation of separate aggregate UPL requirements for local government providers and for state-operated providers.

Particularly when viewed in the context of the IOM recommendation, HCFA's proposed policy change is unacceptable. Although intended to limit current abuses, implementing such a rule would disturb non-abusive and long-standing payment methodologies designed to help Medicaid recipients and safety net providers that serve those patients. In addition, HCFA's methodology would not directly address many of the problems identified by HCFA.

A number of options have been suggested for taking into account the needs of safety net hospitals and health systems in the context of addressing the problem of UPL payment-related abuses. This paper is an effort to summarize those options for discussion purposes. **Please note however that this paper does not constitute an endorsement or recommendation of any specific option.**

(A) First and foremost, regardless of the changes proposed to current UPL payment regulations, HCFA has been strongly urged to consider grandfathering those existing methodologies that benefit safety net providers and vulnerable patients.

(B) Modify HCFA's current proposal to include an exception from the UPL for high volume disproportionate share hospital (DSH) providers.

(C) Change the aggregate cap level from a Medicare-based UPL to one based on unreimbursed costs.

(D) Certification and audit of Medicaid expenditures related to intergovernmental transfers.

(E) Apply the customary charge regulation (42 C.F.R. § 447.271) to all services and facilities.

In considering policy options for curbing Medicaid abuses, HCFA should explicitly take into account and address the full impact of HCFA's proposals on the viability of safety net providers and the populations they serve.

¹Institute of Medicine, America's Health Care Safety Net: Intact but Endangered, Executive Summary, Recommendation 1, page 7 (2000).

HCFA Has the Authority to Grandfather States Currently Using Aggregate UPL Methodologies

August 3, 2000

Agencies are given broad rule-making discretion unless Congress has specifically addressed an issue.

- The 1984 Chevron case established the extremely deferential standard by which a court will uphold an agency's interpretation of a statute if the interpretation is reasonable. Chevron, Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984).
- Agency decisions are reviewed for reasonableness to ensure that they are not arbitrary and capricious. Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983).

HCFA has previously used its broad rulemaking authority to enact grandfathering provisions to preserve the status of sole community hospitals while simultaneously tightening eligibility criteria for new applicants.

- In 1983 HCFA promulgated regulations that revised the designation criteria for sole community hospitals (SCHs). These regulations included a grandfathering provision that allowed preexisting SCHs to retain their beneficial Medicare reimbursement status even if they would not qualify as SCHs under the new regulations. 42 C.F.R. § 412.92(b)(5).

A federal court upheld HCFA's sole community hospital grandfathering provision, finding that it did not make the new SCH regulations arbitrary and capricious, and was not a violation of the Equal Protection Clause.

- In rejecting Clinton Memorial Hospital's contention that HCFA's grandfathering provision rendered the new SCH regulations arbitrary and capricious, the D.C. Circuit Court stated that **"the Secretary certainly is allowed to take administrative convenience into account."** Clinton Mem. Hosp. v. Shalala, 10 F.3d 854, 860 (D.C. Cir. 1993).
- The Secretary's administrative interest in grandfathering to avoid reprocessing SCH applicants and his **"interest in preserving the status quo"** for hospitals that had been granted SCH status were upheld as sufficiently rational reasons to justify any disparate treatment of hospitals under the Equal Protection Clause. Clinton Mem. Hosp. v. Shalala, 10 F.3d 854, 860 (D.C. Cir. 1993) (affirming Clinton Mem. Hosp. v. Sullivan, 783 F. Supp. 1429, 1440 (D.D.C. 1992)).

HCFA may similarly grandfather all (or certain distinct categories of) states currently using aggregate UPLs because of its interest in preserving the stability of the health safety net delivery systems in states that have relied for years on current regulations.

Internal Discussion Draft – Do Not Distribute

State Payments Based on Aggregate Upper Payment Limits Possible Regulatory Options August 1, 2000

The recent Institute of Medicine (IOM) report on America's Health Care Safety Net recommends that **"Federal and state policy makers should explicitly take into account and address the full impact (both intended and unintended) of changes in Medicaid policies on the viability of safety net providers and the populations they serve."**¹ HCFA is currently considering changes to Medicaid regulations to address potential abuses of state Medicaid payments made using aggregate upper payment limits. We understand that HCFA will propose to require calculation of separate aggregate UPL requirements for local government providers and for state-operated providers.

Particularly when viewed in the context of the IOM recommendation, HCFA's proposed policy change is unacceptable. Although intended to limit current abuses, implementing such a rule would disturb non-abusive and long-standing payment methodologies designed to help Medicaid recipients and safety net providers that serve those patients. In addition, HCFA's methodology would not directly address many of the problems identified by HCFA.

A number of options have been suggested for taking into account the needs of safety net hospitals and health systems in the context of addressing the problem of UPL payment-related abuses. This paper is an effort to summarize those options for discussion purposes. **Please note however that this paper does not constitute an endorsement or recommendation of any specific option.**

(A) First and foremost, regardless of the changes proposed to current UPL payment regulations, HCFA has been strongly urged to consider grandfathering those existing methodologies that benefit safety net providers and vulnerable patients. It has been suggested that this option may require legislation. However, most of the abuses identified to date appear to involve nursing homes rather than hospitals, and HCFA could conceivably adopt different rules for different categories of services. The prospect of disrupting certain payment methodologies that benefit safety net hospitals requires that consideration be given to this option.

(B) Modify HCFA's current proposal to include an exception from the UPL for high volume disproportionate share hospital (DSH) providers. HCFA should consider removing application of the UPLs to high-volume DSH hospitals. Because DSH hospitals are subject to a hospital-specific DSH cap based on Medicaid losses and uncompensated care costs incurred, 42 U.S.C. § 1396r-4(g), increasing Medicaid payments can only reduce DSH payments that a state can provide. For example, HCFA could exempt those high-volume providers with low-income utilization rates or Medicaid inpatient utilization rates that require states to include them in their DSH programs under 42 U.S.C. § 1396r-4(b). In order to assure that states do not use new Medicaid payments

¹Institute of Medicine, America's Health Care Safety Net: Intact but Endangered, Executive Summary, Recommendation 1, page 7 (2000).

Internal Discussion Draft – Do Not Distribute

financed by local funds to reduce the state's commitment to Medicaid, HCFA could impose maintenance of effort requirements on state funding of Medicaid as a condition of approval for any new payment methodologies.

(C) Change the aggregate cap level from a Medicare-based UPL to one based on unreimbursed costs. HCFA should reconsider the existing linkage of Medicaid payments and Medicare payments, which is a relic of the days when states were required to use Medicare reasonable cost principles. Instead, the federal share of Medicaid reimbursement could be limited to the amount of the provider's costs that are unreimbursed through Medicare or commercial insurance. In order to assure that states do not use new Medicaid payments financed by local funds to reduce the state's commitment to Medicaid, HCFA could impose maintenance of effort requirements on state funding of Medicaid as a condition of approval for any new payment methodologies.

(D) Certification and audit of Medicaid expenditures related to intergovernmental transfers. HCFA has expressed concern that Medicaid payments funded through intergovernmental transfers (IGTs) are being used for non-Medicaid purposes. In order to address this concern, HCFA should consider requiring states to maintain a separate fund for all federal payments financed through IGTs and to certify that all Medicaid payments from this fund are used only to provide health care to low-income persons. HCFA could conduct audits to confirm these certifications. In order to assure that states do not use new Medicaid payments financed by local funds to reduce state commitment to Medicaid, HCFA could impose maintenance of effort requirements on state funding of Medicaid as a condition of approval for any new payment methodologies.

(E) Apply the customary charge regulation to all services and facilities. Under 42 C.F.R. § 447.271, a Medicaid agency generally "may not pay a provider more for inpatient hospital services than the provider's customary charges to the general public for the services." This rule also contains an exception for "nominal charge providers." By replacing the proposed changes to the Medicare UPL with an expansion of the customary charge UPL to include nursing homes and services other than inpatient hospital care, HCFA may effectively be able to place a more realistic facility-specific limit on provider payments for all institutions that do not qualify for the exception. The nominal charge exception, properly interpreted to apply to true safety net providers, would permit a safety valve for safety net institutions.

In considering policy options for curbing Medicaid abuses, HCFA should explicitly take into account and address the full impact of HCFA's proposals on the viability of safety net providers and the populations they serve.

Internal Draft

Recent Press Descriptions of UPL Payments

Louisiana:

"Borrow \$20 from a friend. Show it to your dad. He gives you \$50. Give the \$20 back to your friend. Walk away with a wallet \$50 fatter. Now imagine you're the state, your friends are [public] nursing homes and your dad is the federal government. Talk in millions instead of twenties and fifties and that, in the most general terms, is how a private consultant is saying Louisiana could save its troubled Medicaid budget."

"[One consultant] said that the more states that jump on board and the faster they do it, the more politically difficult it will be for the federal government to turn off the tap. I don't think there's much appreciation in Congress for giving states less money," [the consultant] said."

--"Transfer System Could Save Medicaid; But It Might be Too Late for Louisiana to Get on Board," Times-Picayune, April 2, 2000.

"State officials confronted with a dismal financial forecast for the next fiscal year have agreed to take a closer look at a proposal that would allow Louisiana to generate up to \$408 million in federal matching money, even though its particulars still make many officials nervous. 'Every time I hear about it I feel like I'm a drug dealer or something,' said [Commissioner of Administration Mark Drennen]."

"The program, pitched last month by a private Philadelphia lobbying firm that represents many health-care interests, would filter millions into the state's Medicaid program by allowing half a dozen nursing homes operated by parishes, municipalities, or the state to take out a loan from a bank or other lending institution and then hand that money to the state, which would then use it to generate a federal match."

"Just in case Washington pulled the plug, [the legislator] said., the state should place all of the money it would receive into a special trust fund that could not be touched for at least three years. Louisiana could, however, spend the interest generated by the money...."

--"Curious Proposal May Save Budget," Times-Picayune, March 11, 2000.

"'This is just trying to get something for nothing,' [one legislator] said. But in supporting the bill, [another legislator] characterized it as 'creative financing.'"

--"Medicaid Financing Bill OK'd by Senate, 36-1: Rest Homes Could Get Dollar Match on Loans," Times-Picayune, March 30, 2000

Alaska:

"In a form of legalized money laundering, the state plans to use hospitals around Alaska to transform millions in federal Medicaid grants into state money that can be used to bring in more federal money. In their yearly struggle to reduce spending from the state's general fund, budget-writers in the Republican-controlled Legislature prowl constantly for ways to replace state money with federal funds. The convoluted money shuffle that entranced members of the [Alaska] Senate Finance Committee last week may be that quest's holy grail--\$20 million in federal money that will replace a similar amount of state money in the Medicaid program in this budget year and the next one.

"[The UPL program] means that the original \$8 million in state money would bring in a total of \$27 million from the federal government. Typically under the 40-60 split, the state would have to spend \$18 million to receive \$27 million from the federal government. So the benefit of this plan is that \$10 million would be freed up from the general fund to be spent on something else. Why isn't this illegal? Because the Health Care Financing Administration authorizes it as a way to bolster small, publicly-owned hospitals that serve remote areas."

—State Plans to Multiply Federal Aid," Anchorage Daily News, April 3, 2000

Kansas:

"An accounting trick used by other states could allow Kansas to send the money to nursing homes on the condition that they send it back so the state can spend it elsewhere....

[Governor Graves of Kansas] is optimistic the state would get the federal funding but said lawmakers should be cautious in spending it because the funding source will probably not be available much long. Since more states are becoming aware of the program, Congress may be inclined to close it, he said."

"[The chair of the legislative appropriations committee] cautioned that the governor might have difficulty confining the spending to the areas he suggested. "This is like throwing Wonder Bread to carp," he said. "The feeding frenzy will begin."

—"State Sees Windfall in Loophole: Department of Aging Staff Find a Way to Raise \$100 million for the Budget by Manipulating a Federal Nursing Home Grant," Wichita Eagle, Feb. 19, 2000.

"I have identified a number of priorities for the money we could receive from this program," [Gov.] Graves [of Kansas] said. Receiving these funds would help us provide nursing-home care and help our state budget in other areas as well." The governor's plan would send 60 percent of the money to a senior services trust fund to finance an as-yet-undeveloped plan to help qualifying seniors buy prescription medicines.⁴ Twenty-five percent of the money would go to the state general fund to increase the state's share of school special education program costs.... Fifteen percent would go to create a loan fund for upgrading nursing home facilities."

--"Kansas Discovers Possible Source of Additional Money: The Little-known Program Could Yield Millions More in Federal Funding," Kansas City Star, Feb. 19, 2000.

"Republican Rep. David Adkins came face to face Thursday with the vision of a \$100 million bonanza of Federal money for Kansas. 'It seems remarkable,' he said. But it seems realistic, too.... 'This isn't illegal,' said State Budget Director Duane Goossen.... "We'd be shirking our fiscal responsibility if this was available and we did not seek it.' Goossen acknowledged that the maneuver was 'a bit of a loophole.'"

--"Kansas Poised to Reap Windfall," Kansas City Star, March 3, 2000.

"The additional money [Governor] Graves [of Kansas] proposes to allocate to social service programs would come from a pool of approximately \$100 million the state is hoping to collect from the federal government through an administrative loophole in the Medicaid program. 'I could be mistaken but election years never seem to be years that money gets taken away in Washington.' Graves said.

--"Graves Would Raise Education, Social Spending," Topeka Capital-Journal, April 19, 2000

New Jersey:

"The state budget could get a windfall of up to \$900 million from the federal government due to a quirk in Medicaid rules that New Jersey treasure officials are quietly tryin to exploit, Whitman administration officials confirmed yesterday.... Senate President DiFrancesco is expected to announce today that he would like to use any windfall created by the influx of federal funds to reduce state debt or for tax cuts."

--"State Seeking Medicaid-loophole Aid," Newark Star-Ledger, April 2000.

⁴Note that Medicaid pays for prescriptions. It is reasonable to assume that all of these expenses are for non-Medicaid beneficiaries.



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

July 26, 2000

Dear State Medicaid Director:

It has come to our attention that some States are using the flexibility in setting the maximum rates that can be paid under the Medicaid program (the so-called "upper payment limits") to pay government-owned facilities at a rate far exceeding their cost of serving Medicaid beneficiaries so that the States can gain Federal Medicaid matching payments without new State contributions. I am writing to say that we intend to address this problem, and to outline our concerns and the process for addressing them.

Background

As you know, under current Federal regulations, States have great flexibility in setting the Medicaid rates that they pay to nursing homes and hospitals. These regulations do establish an overall maximum payment; States may pay facilities a total amount up to the level that Medicare would pay for the same services. However, it appears that some States are:

- calculating the maximum amount that, in theory, could be paid to each Medicaid facility (referred to as the "upper payment limit" or "UPL");
- adding these amounts together to create excessive payment rates to a few county or municipal facilities;
- claiming Federal matching dollars based on these excessive payment rates; and then
- directing these county or municipal facilities to transfer large portions of the excessive payments back to the State government.

It appears that many States allow their county-owned providers to keep only a small fraction of the Federal funds (less than five percent) that are used to provide these excessive "reimbursements." The practical outcome is that the States using this financing mechanism actually gain Federal matching payments without any new State financial contribution. This practice is not consistent with the intent of the Medicaid statute that specifies that provider payments must be economic and efficient. If a State requires facilities to refund its own Medicaid contribution, the practice also effectively undermines the requirement that a State share in the funding for its Medicaid program.

Page 2 – State Medicaid Director

Moreover, this practice appears to be creating rapid increases in Federal Medicaid spending, with no commensurate increase in Medicaid coverage, quality, or amount of services provided. There is preliminary evidence that this current practice has contributed to a spike in Federal Medicaid spending. The States' estimates of Federal Medicaid spending for FY 2000 have already increased by \$3.4 billion over earlier projections. We believe \$1.9 billion of this increase is likely due to the circulation of funds through the UPL loophole. The five-year cost of this growing State practice would be at least \$12 billion, and there is an influx of new State proposals. Currently, 17 States have approved plan amendments and another 11 have submitted amendments. This could have the long-term effect of undermining the core mission and the broad-based support for Medicaid, which guarantees critical health services to our most vulnerable populations: low-income children and families, people with disabilities, and the elderly.

The excess Federal Medicaid payments that are shared with State and local governments are put to any number of uses--both health- and non-health-related. It appears some States allow public hospitals to keep a portion of these funds to help pay for uncompensated care. While the Medicaid disproportionate share hospital (DSH) program was created to cover these costs and now accounts for more than \$14 billion annually in Medicaid spending, the DSH program has not always met the growing challenge of caring for the uninsured. Some States have, through the UPL arrangement, circumvented the statutory DSH limits--using indirect means to accomplish what the DSH statute does not allow.

Some States are using these payments to pay the statutory State share of Medicaid or of the State Children's Health Insurance Program (SCHIP). While Medicaid and SCHIP are Federal/State partnerships in which each partner pays a share established in statute, the UPL arrangements shift some portion of a State's share to the Federal government. The result is that Federal taxpayers in all States are forced to shoulder more than their fair share for Medicaid and SCHIP in a few States.

Some States are using the UPL arrangement to finance other health programs. This results in Medicaid funding being used for otherwise laudable health care purposes (such as providing community-based services for senior citizens or persons with disabilities) but for people and/or services not eligible for Medicaid coverage.

Other reports suggest that some States have gone so far as to use--or intend to use--the UPL arrangement for non-health purposes. Several States appear to have used it to fill budget gaps. Another State's local newspaper reported that Federal Medicaid funds would be used for State tax cuts or for reducing State debt. One State announced that it intended to use funds generated through the UPL system to pay for education programs. This practice, which is effectively general revenue sharing, is inconsistent with the Medicaid statute, Congressional intent, and Administration policy.

Page 3 – State Medicaid Director

The HHS Office of Inspector General is conducting a review of UPL practices in a number of States and will be reporting on them soon. We are informed that the General Accounting Office may be investigating as well.

Administration Actions

The Administration is committed to supporting health care providers who serve the uninsured and chronically ill and to assuring that they can continue to do so. The President's budget includes more than \$100 billion over 10 years to expand health insurance to the uninsured. These funds would reduce the uncompensated care in public hospitals. It also includes a long-term care initiative and Medicare and Medicaid provider payment restoration initiative that explicitly target funding to nursing homes and hospitals, which will also help institutions directly. We have urged the Congress to pass this initiative this year and are developing a new, non-Medicaid program that would target money to public hospitals as part of our efforts to ensure access and quality of health care nationwide.

We are also committed to managing the Medicaid program efficiently under the current law so that it continues to serve Medicaid beneficiaries well and retain the confidence of the nation's taxpayers. The Administration is developing a proposal to ensure that Medicaid payments meet the statutory standard of efficiency and economy. We will publish a Notice of Proposed Rulemaking (NPRM) that modifies the current UPL within the next several weeks. As we work to develop this proposal we will continue to meet with you and representatives of consumers, public hospitals, nursing homes, labor, and others to hear concerns and suggestions. We will also explore the idea of legislation that puts an immediate end to paying States that file a UPL State plan amendment in the intervening period before any regulation takes effect.

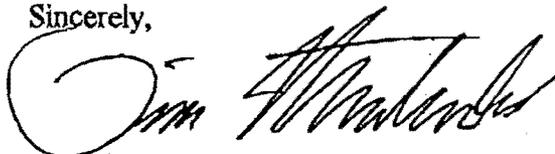
Because a number of State health programs rely substantially on funds generated through this UPL loophole, our NPRM will include adequate transition provisions. We will be soliciting comments on our proposed changes to the UPL as well as the transition provisions. We understand that change will be difficult--just as it was in the early 1990's when the Federal/State financing relationship had to be re-adjusted because of now-illegal State funding mechanisms of donations and taxes. We will specifically solicit comments on proposed transitional periods to address this reliance.

The Medicaid program has been successful over the years in providing vital health care services to millions of low-income Americans. It will continue to be successful only to the extent that it adheres to that mission and ensures that the funds provided are used appropriately and that the

Page 4 – State Medicaid Director

program retains its integrity. The program will enjoy public support only if it maintains public trust. I look forward to working with you to preserve that.

Sincerely,



Timothy M. Westmoreland
Director

cc:

All HCFA Regional Administrators

All HCFA Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director, Health Legislation
National Governors' Association



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

DRAFT – DO NOT QUOTE OR CITE
(tmw 7/25 8 pm)

Dear State Medicaid Director:

It has come to our attention that some States are using the flexibility in setting the maximum rates that can be paid under the Medicaid program (the so-called “upper payment limits”) to pay government-owned facilities at a rate far exceeding their cost of serving Medicaid beneficiaries so that the States can gain Federal Medicaid matching payments without new State contributions. I am writing to say that we intend to address this problem, and to outline our concerns and the process for addressing them.

Background

As you know, under current Federal regulations, States have great flexibility in setting the Medicaid rates that they pay to nursing homes and hospitals. These regulations do establish an overall maximum payment; States may pay facilities a total amount up to the level that Medicare would pay for the same services. However, it appears that some States are:

- calculating the maximum amount that, in theory, could be paid to each Medicaid facility (referred to as the “upper payment limit” or “UPL”);
- adding these amounts together to create excessive payment rates to a few county or municipal facilities;
- claiming Federal matching dollars based on these excessive payment rates; and then
- directing these county or municipal facilities to transfer large portions of the excessive payments back to the State government.

The practical outcome is that the States using this financing mechanism actually gain Federal matching payments without any new State financial contribution.

For example, one State appears to set excessive payment rates to county providers. The amount of the rate in excess of the actual costs is transferred to the State by its counties, which take out bank loans for 24 hours. The State returns the loan – but, because it is claiming the excessive payment rate as a Medicaid expenditure, receives a Federal matching payment for that loan amount. Thus, the State can not only return a higher amount than the loan to the county facilities, but can keep some of the Federal matching payments for other purposes. Another State reportedly allows its county-owned nursing homes to keep only \$0.5 million of the \$138 million in Federal matching payments drawn down for their use. Another State reportedly allows its facilities to keep less than 5% of the excess Federal matching payment. In another State, a State official, acknowledging the loophole, stated, “Every time I hear about it, I feel like I’m a drug dealer or something.”

This practice is not consistent with the intent of the Medicaid statute that specifies that provider payments must be economic and efficient. If a State requires facilities to refund its own Medicaid contribution, the practice also effectively undermines the requirement that a State share in the funding for its Medicaid program.

Moreover, this practice appears to be creating rapid increases in Federal Medicaid spending, with no commensurate increase in Medicaid coverage, quality, or amount of services provided. There is preliminary evidence that this current practice has contributed to a spike in Federal Medicaid spending. The States’ estimates of Federal Medicaid spending for FY 2000 have already increased by \$3.4 billion over earlier projections. We believe \$1.9 billion of this increase is likely due to the circulation of funds through the UPL loophole. The 5-year cost of this growing State practice would be at least \$12 billion, and there is an influx of new State proposals. Currently, 17 States have approved plan amendments and another 11 have submitted amendments. This could have the long-term effect of undermining the core mission and the broad-based support for Medicaid, which guarantees critical health services to our most vulnerable populations: low-income children and families, people with disabilities, and the elderly.

The excess Federal Medicaid payments that are shared with State and local governments are put to any number of uses -- both health- and non-health-related. It appears some States allow public hospitals to keep a portion of these funds to help pay for uncompensated care. While the Medicaid disproportionate share hospital (DSH) program was created to cover these costs and now accounts for more than \$14 billion annually in Medicaid spending, the DSH program has not always met the growing challenge of caring for the uninsured. Some States have, through the UPL arrangement, circumvented the statutory DSH limits--using indirect means to accomplish what the DSH statute does not allow.

Some States are using these payments to pay the statutory State share of Medicaid or of the State Children’s Health Insurance Program (SCHIP). While Medicaid and SCHIP are Federal-State partnerships in which each partner pays a share established in statute, the UPL arrangements shift some portion of a State’s share to the Federal government. The result is that Federal taxpayers in

all States are forced to shoulder more than their fair share for Medicaid and SCHIP in a few States.

Some States are using the UPL arrangement to finance other health programs. This results in Medicaid funding being used for otherwise laudable purposes (such as providing community-based services for senior citizens or persons with disabilities) but for people not eligible for Medicaid.

Other reports suggest that some States have used or are intending to use the UPL arrangement for non-health purposes. Several States appear to have used it to fill budget gaps. Another State's local newspaper reported that Federal Medicaid funds would be used for State tax cuts or for reducing State debt. Another State announced that it intended to use funds generated through the UPL system to pay for education programs. This practice, which is effectively general revenue sharing, is inconsistent with the Medicaid statute, Congressional intent, and Administration policy.

The HHS Office of Inspector General is conducting a review of UPL practices in a number of States and will be reporting on them soon. We are informed that the General Accounting Office may be investigating as well.

Administration Actions

The Administration is committed to supporting health care providers who serve the uninsured and chronically ill and to assuring that they can continue to do so. The President's budget includes more than \$100 billion over 10 years to expand health insurance to the uninsured. These funds would directly reduce the uncompensated care in public hospitals. It also includes a long-term care initiative and Medicare and Medicaid provider payment restoration initiative that explicitly target funding to nursing homes and hospitals, which will also help institutions directly. In addition, the Administration will work with Congress, as it considers provider payment restoration bills, to develop a new, non-Medicaid program that would target money to public hospitals as part of its efforts to ensure access and quality of health care nationwide. We hope the Congress will pass these proposals this year.

We are also committed to managing the Medicaid program efficiently under the current law so that it serves Medicaid beneficiaries well and retains the confidence of the nation's taxpayers. The Administration is developing a proposal to ensure that Medicaid payments meet the statutory standard of efficiency and economy. We will publish a Notice of Proposed Rulemaking (NPRM) that modifies the current UPL within the next several weeks. As we work to develop this proposal we will continue to meet with you and representatives of consumers, public hospitals, nursing homes, labor, and others to hear concerns and suggestions. We will also explore the idea of legislation that puts an immediate end to paying States that file a UPL State plan amendment in the intervening period before any regulation takes effect.

Because many State budgets and a number of State health programs rely substantially on funds generated through this UPL loophole, our NPRM will include adequate transition provisions. We will be soliciting comments on our proposed changes to the UPL as well as the transition provisions. We understand that change will be difficult -- just as it was in the early 1990's when the State/federal financing relationship had to be re-adjusted because of now-illegal State funding mechanisms of donations and taxes. We will specifically solicit comments on proposed transitional periods to address this reliance.

The Medicaid program has been successful over the years in providing vital health care services to millions of low-income Americans. It will continue to be successful only to the extent that it adheres to that mission and ensures that the funds provided are used appropriately and that the program retains its integrity. The program will enjoy public support only if it maintains public trust. I look forward to working with you to preserve that.

Sincerely,

Timothy M. Westmoreland
Director

cc:

(Insert Standard CCs)



Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

Medicaid upper Limit File

DRAFT

Dear State Medicaid Director:

I regret that it is necessary to write this letter.

It has come to our attention that some States are using the flexibility granted to them in establishing provider payment rates to set artificially high payment rates to providers of public services (such as county-owned nursing homes). These States are:

- calculating the maximum amount that, in theory, could have been paid to each Medicaid facility,
- adding these amounts together to create excessive payments to a few county or municipal facilities,
- claiming Federal matching dollars based on these excessive payments, and
- then directing these public facilities to give large portions of the excessive payments back to the State.

While some States use these Federal matching funds for purposes that are otherwise laudable, it appears that much of the money is used for non-Medicaid activities; in some cases it appears that the money is even used for non-health purposes. In any case, the practice violates the spirit of the Medicaid funding mechanism.

Newspapers in the States considering or using this practice have termed it "an accounting trick," a "windfall," and a "loophole." A consultant is cited as predicting that "the more states that jump on board and the faster they do it, the more politically difficult it will be for the federal government to turn off the tap." State officials are quoted as saying it is "too good to be true," and "help for our state budget" and general fund; one particularly candid official said, "Every time I hear about it, I feel like I'm a drug dealer or something."

Perhaps most succinctly, one newspaper describes the process as follows:

"Borrow \$20 from a friend. Show it to your dad. He gives you \$50. Give the \$20 back to your friend. Walk away with a wallet \$50 fatter. Now imagine you're the state, your friends are [public] nursing homes and your dad is the federal government. Talk in millions instead of twenties and fifties...."

The effect of this practice is generally to raise the Federal cost of the Medicaid program without increasing the number of Medicaid beneficiaries, the amount or quality of Medicaid services, or the reimbursements genuinely paid to Medicaid providers.

As has often been stated, Medicaid is a Federal-State partnership to provide medical assistance to low-income people. Both partners should pay their share of the cost of the program. Their respective shares are established in statute. These financing arrangements work to shift some portion of a State's share to the Federal Government. The result is that Federal taxpayers in all States are forced to shoulder more than their fair share for Medicaid in a few States.

I am writing to say that it is our intention to stop this practice. We have already begun to develop and intend to publish immediately a Notice of Proposed Rulemaking (NPRM) containing a new upper payment limit to curb this practice. If the final rule incorporates such a limit, we will shortly thereafter request that all States bring their plans into conformance voluntarily. We will take disallowances and bring compliance actions against any State that does not do so voluntarily.

During the time that this rule is being developed, published, and made final, we will use the discretion granted us under the law to avoid affirming any State Plan Amendment creating arrangements of this sort. If, prior to the effective date of the new rule, such a State Plan Amendment reaches the final date for the Health Care Financing Administration (HCFA) action established in the law, it will be deemed effective by virtue of the law, but it will not be affirmatively approved. We will exercise our legal option to ask for additional information in all cases; thus, the minimum time for action on such a State Plan Amendment can be expected to be 180 days.

You should also know that the Office of the Inspector General of the Department of Health and Human Services is examining the current rates paid to public facilities, the intergovernmental transfers that are taking place from these facilities, and the use of funds that are transferred. That investigation has already commenced.

The Medicaid program has been successful over the years in providing vital health care services to millions of low-income Americans. It will continue to be successful only to the extent that it adheres to that mission and ensures that the funds provided are used appropriately, and that the program retains its integrity. The program will enjoy public support only if it maintains public trust. I look forward to working with you to preserve that trust.

Sincerely,

Timothy M. Westmoreland
Director

cc:

All HCFA Regional Administrators

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Lee Partridge
Director, Health Policy Unit
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Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director, Health Legislation
National Governors' Association

THE WHITE HOUSE

WASHINGTON

July 21, 2000

MEMORANDUM FOR THE PRESIDENT

FROM: Jack Lew
Chris Jennings

RE: Upper Payment Limits in Medicaid

At the National Governors Association Conference earlier this month, you were approached by a number of governors soliciting your assistance in stopping or moderating a regulation that was recently leaked but not officially released by HCFA. The Medicaid rule would prohibit states from using a loophole in Medicaid "upper payment limits" and intergovernmental transfers to recycle local funds to increase Federal Medicaid funding without an increase in state matching dollars. This memo responds to your request for background information on this issue and an update on our recommended strategy for dealing with it.

BACKGROUND

The leveraging of additional Federal Medicaid funds, without accompanying state matching dollars, has contributed to a rapid, recent rise in Federal Medicaid spending without any measurable commensurate increase in coverage expansion, quality of care, or services provided. Without question, if this practice is allowed to continue, Federal Medicaid spending will increase dramatically to the type of double-digit growth that we saw in the late 1980s and early 1990s. Currently, 17 states have approved financing mechanisms in place and another 11 states have pending proposals and another 11 states have pending proposals.

All of your advisors at HHS, OMB, DPC, NEC, IGA, and OPL, as well as John Podesta, agree that it would be damaging to the Medicaid program to allow these financing schemes to continue unabated. When per capita Medicaid costs soared ten years ago, there was a serious effort to end the Medicaid entitlement and submit to a block grant to the states. Your veto of reconciliation in 1995 was necessary to prevent it.

Senator Roth, the Inspector General, and the General Accounting Office are in various stages of investigations to highlight this problem and criticize our lack of response. Having said this, your advisors also have serious concerns about how any regulatory action to stop this practice would affect states and health care providers serving vulnerable Medicaid and uninsured patients. Some of the Federal funds extracted from the upper payment limit financing loophole are being used to provide much-needed assistance to public hospitals that are being 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, education investments, and to help balance budgets.

Although HHS wanted to move expeditiously to release a notice of proposed rulemaking that highlighted our intention to disallow this practice, your White House advisors concluded that it would be better to create a two-step process that would initially describe our concerns about these financing practices but express sympathy for their uses in a letter to state Medicaid directors and commit to a consultation process that will lead to a better understanding of the use of these dollars and possible preferable alternatives to stop this practice. We would then follow this letter with a substantially revised notice of proposed rulemaking that outlines options for transition to be released sometime in August. It would solicit further comments, and HHS would not issue the final regulations until after the November election. We feel – and HHS now concurs – that this two-step approach would be more likely to prevent legislative riders in September prohibiting any HHS action in this regard.

We are also considering whether we should simultaneously release an independent legislative proposal to provide additional Federal funding targeted directly to public hospitals and / or other providers disproportionately serving the uninsured and underinsured populations. This funding would likely come from the half of your \$40 billion provider restoration fund that has yet to be specified. The idea is that such funding could help mitigate the effect of the regulation. We are developing options for your review.

LIKELY RESPONSE FROM STATES / PROVIDERS

While we agree that we should proceed with our recommended rollout, you should know that the proposed letter and the subsequent NPRM will likely generate significant protest from the States currently authorized or those who eventually want to use this loophole, as well as the providers benefiting from it. Fourteen governors have written to you urging that you quash the HCFA rule. Among the most vocal Democrats have been Governors Vilsack (IA), Siegelman (AL), Ryan (IL) and Davis (CA). Other elected officials, particularly Cook County Commission President John Stroger (D), as well as health care providers such as the public hospitals, have also registered strong protest to the proposed change. Although they acknowledge that there is a problem, they say that this particular financing mechanism is used for desirable purposes.

However, preliminary conversations with experts, advocates for the Medicaid program and budget experts suggests that they are willing to join with the Inspector General and GAO in stating that this practice is inappropriate and threatens not only Medicaid but the perception of public health insurance programs and the Federal budget outlook more generally.

CURRENT STATUS OF RECOMMENDED ADMINISTRATION ACTION

If you do not have any objection with our recommended two-step approach to phasing out states' dependence on the upper payment limit financing mechanism, we would recommend that we authorize HHS to release the previously mentioned letter raising our concerns about this issue next Wednesday. (Attached is the current draft of this letter.) We will work to ensure that the release of this letter includes an effective communications, state-based, Congressional, and health care provider rollout plan. It would include a strategy to ensure that the public and policy-makers understand the risk of allowing these financing mechanisms to continue unaddressed. If we succeed, the public response from the states and providers may be more muted.



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

DRAFT – DO NOT QUOTE OR CITE
(7/20 9pm)

Dear State Medicaid Director:

It has come to our attention that some States are using the flexibility in setting the maximum rates that can be paid under the Medicaid program (the so-called “upper payment limits”) to pay government-owned facilities at a rate far exceeding their cost of serving Medicaid beneficiaries so that the States can gain extra Federal Medicaid matching payments. I am writing to say that we intend to address this problem, and to outline our concerns and the process for addressing them.

Background

As you know, under current Federal regulations, States have great flexibility in setting the Medicaid rates that they pay to nursing homes and hospitals. These regulations do establish an overall maximum payment; States may pay facilities a total amount up to the level that Medicare would pay for the same services. However, it appears that some States are:

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- directing these county or municipal facilities to give large portions of the excessive payments back to the State government.

The practical outcome is that the States using this financing mechanism actually gain Federal matching payments without any new State financial contribution.

[Examples to be supplied] For example, one State Another State appears] In another State, a State official, acknowledging the loophole, stated, “Every time I hear about it, I feel like I’m a drug dealer or something.”

This practice is not consistent with the intent of the Medicaid statute that specifies that provider payments must be economic and efficient. If a State requires facilities to refund its own Medicaid contribution, the practice also effectively undermines the requirement that a State share in the funding for its Medicaid program.

Moreover, this practice appears to be creating rapid increases in Federal Medicaid spending, with no commensurate increase in Medicaid coverage, quality, or amount of services provided. There is preliminary evidence that this current practice has contributed to a spike in Federal Medicaid spending. The States’ estimates of Federal Medicaid spending for FY 2000 have already increased by \$3.4 billion over earlier projections. We believe \$1.9 billion of this increase is likely due to the circulation of funds through the UPL loophole. The 5-year cost of this growing State practice would be at least \$12 billion, and there is an influx of new State proposals. Currently, 17 States have approved plan amendments and another 11 have submitted amendments. This could have the long-term effect of undermining the broad-based support for Medicaid, which guarantees critical health services to our most vulnerable populations: low-income children and families, people with disabilities, and the elderly.

The excess Federal Medicaid payments that are shared with State and local governments are put to any number of uses -- both health- and non-health-related. It appears some States allow public hospitals to keep a portion of these funds to help pay for uncompensated care. While the Medicaid disproportionate share hospital (DSH) program was created to cover these costs and now accounts for more than \$14 billion annually in Medicaid spending, the DSH program has not always met the growing challenge of caring for the uninsured. Some States have, through the UPL arrangement, circumvented the statutory DSH limits--using indirect means to accomplish what the DSH statute does not allow.

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Other reports suggest that some States have used or are intending to use the UPL arrangement for non-health purposes. Several States appear to have used it to fill budget gaps. Another State's local newspaper reported that Federal Medicaid funds would be used for State tax cuts or for reducing State debt. Another State announced that it intended to use funds generated through the UPL system to pay for education programs. This practice, which is effectively general revenue sharing, is clearly not consistent with the Medicaid statute, with Congressional intent, or with Administration policy.

The HHS Office of Inspector General is conducting a review of UPL practices in a number of States and will be reporting on them soon. We are informed that the General Accounting Office may be investigating as well.

Administration Actions

The Administration is committed to supporting health care providers who serve the uninsured and chronically ill and to assuring that they can continue to do so. The President's budget includes more than \$100 billion over 10 years to expand health insurance to the uninsured. These funds would directly reduce the uncompensated care in public hospitals. It also includes a long-term care initiative and Medicare and Medicaid provider payment restoration initiative that explicitly target funding to nursing homes and hospitals, which will also help institutions directly. We hope the Congress will pass these proposals in the coming months.

We are also committed to managing the Medicaid program efficiently under the current law so that it serves Medicaid beneficiaries well and retains the confidence of the nation's taxpayers. The Administration is developing a proposal to ensure that Medicaid payments meet the statutory standard of efficiency and economy. We intend to publish a Notice of Proposed Rulemaking (NPRM) that modifies the current UPL within the next several weeks. As we work to develop this proposal we will continue to meet with you and representatives of consumers, public hospitals, nursing homes, labor, and others to hear concerns and suggestions. We will also explore the idea of legislation that puts an immediate end to paying States that file a UPL State plan amendment in the intervening period before any regulation takes effect.

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Page 4 – State Medicaid Director

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Sincerely,

Timothy M. Westmoreland
Director

cc:

(Insert Standard CCs)

Medicaid Upper Payment Limit

United States Senate
WASHINGTON, DC 20510

June 28, 2000

The Honorable Jacob J. Lew
Director
Office of Management and Budget
Old Executive Office Building, Room 252
Washington, D.C. 20503

Dear Mr. Lew:

We understand that the Administration will soon release a proposed regulation modifying the "Upper Limits" test set forth in 42 C.F.R. §§ 447.272 and 447.321 as it applies to Intergovernmental Transfers (IGT) and Medicaid matching funds. Such a policy change could have a significant adverse impact on the acute and long-term health care services available to thousands of vulnerable people in our States. Because of this major potential impact, we are writing to request that you provide us detailed answers to some basic questions we have about the substance and process involved with IGTs and any possible policy changes. We strongly urge that we be provided this information prior to the promulgation of any regulations in this area. Specifically, we would like you to respond to the following questions:

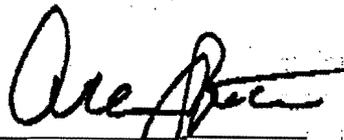
1. What is the statutory basis for the Department of Health and Human Services (Department) to issue a proposed rule modifying the upper limit regulations codified at 42 C.F.R. §§ 447.272 and 447.321?
2. Why does the Department intend to reverse the position taken in the preamble to its October 31, 1991, Interim Final Rule, which stated: "We are making clear that this rule does not invalidate the longstanding practice of using intergovernmental transfers for financing a portion of the State's Medicaid program as long as such transfers are not derived from State or local revenue sources precluded by this rule." (56 Fed. Reg. 56132)?
3. Which States and to what degree are those States using funds transferred or certified by local units of government (IGTs) as the non-Federal share of Medicaid expenditures?
4. Has the Health Care Financing Administration (HCFA) approved these methodologies through the State Plan process?
5. Which States have pending State Plan amendments to alter these arrangements?
6. We understand the Inspector General is undertaking reviews of IGT mechanisms in some States. Why is the Department moving forward to promulgate a rule prior to completion of this review?
7. Please describe in detail the impact of any upper limits regulatory changes on the ability of these States to utilize IGTs as a portion of the non-Federal share of Medicaid expenditures.

The Honorable Jacob J. Lew
Page Two

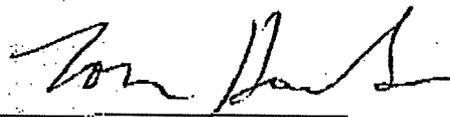
8. How will the proposed rule differentiate between States that are using these Medicaid funds for health and/or Medicaid related purposes and those that may not be spending match dollars in this manner? What would be the justification for not differentiating between such States?
9. What analyses have been done on how any policy change in this area would impact access to health care for low income individuals and families in each affected State? Please provide us these analyses, including separate data for non-State public hospitals and non-State public nursing homes.
10. How will the proposed rule impact access to health care services provided by State facilities and not-for-profit community facilities?
11. How will the proposed rule affect implementation of the State Children's Health Insurance Program (SCHIP)?
12. Please describe all alternative oversight authority the Secretary has under current law to ensure appropriate utilization of Medicaid funds.
13. Has the Department received any direction from Congress to undertake this rulemaking?

Thank you for your attention to this important matter of mutual concern.

Sincerely,



Arlen Specter



Tom Harkin

cc: Secretary Donna Shalala
Administrator Nancy-Ann Min DeParle

DRAFT: OPTIONS FOR MEDICAID UPL ISSUE

?

	Vehicle	Policy	Timing	Implications
A	NPRM	Apply the upper payment limit requirement to county/local hospitals and nursing homes, excluding private providers Transition not specified	<u>Pending/ future states' plans:</u> Could be disapproved November 1 when final reg starts <u>Current states:</u> Would have to comply either immediately or	Has been leaked; what has generated concern from hospitals, states, members Livingston amendment most likely to get highest score with this option since it is the most aggressive
B	NPRM	Apply the upper payment limit requirement to county/local hospitals and nursing homes, excluding private providers Allow public hospitals 3 to 5-year transition	<u>Pending/ future states' plans:</u> could be disapproved November 1 <u>Current states:</u> would have to comply either immediately or	Transition would increase acceptability of NPRM, although we have not yet vetted Livingston amendment likely to get a lower score with this option due to the transition
C	NOI / ANPRM Legislative proposal to stop paying on pending plan amendments	Publish a statement with our concerns about both abuses and public hospital; ask for specific ideas on transitions within 30 days	<u>Pending/ future states' plans:</u> Could be disapproved upon enactment (July, September) <u>Current states:</u> Final regulation would be published December 1 and would probably include some type of transition	Not being specific and soliciting input puts burden on plans, hospitals to come up with plan; buys us time Legislation could produce savings with strong commitment to reg. Livingston amendment has less savings if scored now, highest cost if scored after NPRM in August

Medicaid Upper Payment Limits File

QUESTIONS AND ANSWERS FOR NGA CONFERENCE

UPPER PAYMENT LIMIT

Q: Are you going to issue a regulation to stop the use of Medicaid financing mechanisms to support public hospitals and other health care providers?

A: We are currently reviewing a range of options designed to achieve the appropriate balance between the need to prudently manage the program and to ensure that program costs do not explode with the very real and unmet health care needs of our most vulnerable populations. As the Senate Finance Committee Chairman, the General Accounting Office, and the Inspector General have made clear, it would be untenable for the Federal government to sanction the expanded use of this financing mechanism. At the same time, we recognize how certain providers delivering care to large numbers of the uninsured and chronically ill could be adversely affected by a sudden change in financing policy. We are in the process of collecting the best information possible about the extent to which these financing mechanisms are being utilized, and the best ways to effectively address this situation.

Q: When will you issue guidance on this subject, so the Congress and the States know your formal position?

A: We have not finalized our work on this issue. Therefore, we do not have a specific timetable for releasing our position.

Q: Why is the Administration pushing to prevent states from using Medicaid dollars to support their public hospitals? Don't you understand the impact this change would have on public hospitals and other critical health care institutions?

A: Our commitment to ensuring adequate financing for the provision of high quality services in both the Medicaid and Medicare programs is well known. The President has proposed to significantly increase provider reimbursement within the Medicare program, as well as the Medicaid program, through changes in the disproportionate share payment formula. We have also proposed to invest over \$110 billion over the next 10 years in health insurance coverage, so that we can significantly reduce the uncompensated care costs that burden many public hospitals and other health care institutions. Having said this, we need to make certain that Medicaid dollars are spent consistent with the intent of the law, and that state reimbursement commitments aren't inappropriately shifted to the Federal government. If we don't manage the Medicaid program efficiently, taxpayers will understandably lose confidence in its ability to cost-effectively deliver critically necessary health care services. Our challenge, therefore, is to balance the very real and unmet health care needs of our most vulnerable populations against the need to prudently manage the program.

S-CHIP REDISTRIBUTION

Q: What is the Administration's position on redistribution of unspent S-CHIP funds?

A: We have taken the position that we will enforce current law should the Congress fail to pass any modifications to the S-CHIP distribution formula. We have explicitly indicated our support for a two-year extension of the availability of unspent S-CHIP funds should the Congress pass coverage expansion legislation through S-CHIP or Medicaid consistent with the proposals in the President's FY 2001 budget.

VERMONT 1115 WAIVER REQUEST

Q: What is the Administration's position on Vermont's proposal to increase prescription drug coverage for low-income seniors?

A:

ARKIDS FIRST

Q: When is the Administration going to decide on whether to grant Arkansas' request to allow families to choose which program – Medicaid or S-CHIP – to enroll their children in?

A: We are undertaking a comprehensive and thorough review of Arkansas' proposal and hope to have an answer for the state soon.

Q: There is broad, bipartisan support for ARKids. Recognizing this, why can't you commit to allowing the parents of Arkansas the choice of enrolling their children in the new ARKids program, rather than the old Medicaid program?

A: It is impossible to have a free choice if there are serious barriers to parents choosing one option over another. The Governor and his representatives acknowledge that there are numerous barriers to enrolling in Medicaid that are not present for parents signing up for the ARKids program. Specifically, requirements for Medicaid that are not existent for those in the ARKids program include: a complicated assets test, a separate face-to-face interview, and an overall more complicated and intimidating application process. We can and should have the discussion about the issue of choice, but there must be a fair choice first. In this regard, we will continue to offer our assistance to helping the state simplify the Medicaid eligibility process. We believe we must avoid unhelpful rhetoric and move forward to constructive dialogue on this matter. And we are committed to doing just that.

Q: But Governor Huckabee has already offered to eliminate many of the barriers to enrollment in Medicaid in his state. Isn't his proposal good enough?

A: We've been quite clear during our negotiations with the state that the differences between the programs need to be eliminated – and they have not been. We are still reviewing the state's proposal and we are working hard to get back to them in a timely fashion.

Q: **Are you letting Washington politics jeopardize the delivery of health care to the children of Arkansas?**

A: Absolutely not. There are clearly many parties in and outside of Arkansas interested in this issue. We cannot forget that decisions affecting one state's Medicaid program has potential major implications for all others. However, the decision about this and any other Medicaid issue will be made strictly on the merits with the best interest of children in mind. For this reason, we are not taking any action that would threaten the loss of health coverage for any child in the state.

UPL CONSULTATION AND ROLL OUT

MEMBER MEETINGS WITH JACK LEW, KEVIN THURM, NANCY ANN DE PARLE, MIKE HASH

POTENTIAL SUPPORTERS - One Week Before

Senator Roth
Representative Dingell
Representative Bliley
Representative Waxman
Representative Obey

DAMAGE CONTROL - One Day Before display

Senator Moynihan
Senator Specter
Senator Harkin
Senator Durbin
Senator Toricelli
Representative Rangel

DAMAGE CONTROL - Day of Display

Representative Hastert
Representative Porter

LEADERSHIP CALLS - One Day Before (John Podesta, Secretary Shalala?)

Senator Daschle
Senator Lott
Representative Gephardt

TIM WESTMORELAND MEETINGS WITH KEY STAFF OF MEMBERS WHO COULD SUPPORT HHS

FINANCE COMMITTEE

MEETING 1- One Week Before

Senator Baucus
Senator Graham
Senator Conrad
Senator Rockefeller
Senator Kerry

MEETING 2 - One Week Before

Senator Roth
Senator Hatch
Senator Jeffords

Senator Mack
Senator Nickles
Senator Gramm

COMMERCE COMMITTEE

MEETING 3 - One Week Before
Representative Dingell
Representative Waxman
Representative Stupak
Representative Gene Green
Representative Pallone
Representative Brown

MEETING 4 - One Week Before
Representative Bilirakis
Representative Bliley
Representative Upton
Representative Coburn

SENATE APPROPRIATIONS COMMITTEE

MEETING 5 - One Week Before
Senator Leahy
Senator Reid
Senator Mikulski
Senator Dorgan

MEETING 6 - One Week Before
Senator Domenici
Senator Cochran

HOUSE APPROPRIATIONS COMMITTEE

MEETING 7 - One Week Before
Representative Hoyer
Representative Sabo
Representative DeLauro

MEETING 8 - One Week Before
Representative Bonilla
Representative Miller (FL)

DAY OF RELEASE BRIEFINGS

Senate Finance Committee - all health LAs
House Commerce - all health Las