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Podesta

cc: Jack
Chris

THE WHITE HOUSE

WASHINGTON

'00 JUL 21 PM2:54

July 21, 2000

JP

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 [illegible]
construction, tax reductions, [illegible]

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.

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cc. Jack
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THE WHITE HOUSE

WASHINGTON

'00 JUL 21 PM2:54

July 21, 2000

JP
This looks about right
but has to be handled carefully
Good to allocate extra $ we've
already set aside to it to make
sure spent on Hcare -
I still don't understand exactly
what they're doing

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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.

July 19, 2000

TO: John Podesta
Karen Tramontano
Bruce Reed
Gene Sperling
Chuck Brain
Mickey Ibarra
Melanne Verveer
David Beier
Mary Beth Cahill

FROM: Chris Jennings

RE: Medicaid Upper Payment Limits

At the NGA conference, we committed to the President that we would give him an update on the "upper payment / intergovernmental transfer" Medicaid financing issue. Attached is a draft memo to the President informing him of our recommended plan to transition states away from potentially abusive dependence on unmatched Federal Medicaid payments. The memo also attaches the current draft of the HCFA letter to state Medicaid directors. This memo has yet to be finally reviewed by Jack Lew, but we are circulating it concurrently in order to expedite its clearance.

Please call me or Devorah (65560) with any suggested edits by 10 am tomorrow morning.

DRAFT: July 19, 2000

MEMORANDUM FOR THE PRESIDENT

FROM:

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 in 13 states 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. Already, we have an additional 14 states proposing to implement this financing mechanism. This could lay the predicate for another serious debate about block-granting the Medicaid program.

All of your advisors at HHS, OMB, DPC, NEC, OVP, OFL, IGA, and OPL, as well as John Podesta, agree that it would be untenable to allow these financing schemes to continue unabated. 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.

There is little doubt that 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 notice of proposed rulemaking to be released sometime in August, which would lay out options and solicit further comments before HHS issued final regulations on how to phase out states' dependence on these revenues after the November elections. We feel – and HHS now concurs – that this two-step approach would be more likely to prevent a 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.

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 sometime this week or early next week. 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.

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
(7/18 5:30pm)

Dear State Medicaid Director:

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.

It has come to our attention that some States are pooling these payments in order to pay government-owned facilities at a rate far exceeding the 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.

Background

Under these inappropriate payment practices, 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 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.
For example, one State recently increased its payment to government-owned nursing homes by more than 1,700%. Another State allows the government-owned nursing homes to keep only about $0.5 out of $138 million in increased Federal funds. Another State announced that it intended to use funds generated through the UPL system to pay for debt reduction and education programs. One 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 account for more than $14 billion 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 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. 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 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) on the establishment of UPL rates 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 proposal will include significant transition provisions so that no State or health program will be left with sudden budgetary holes to fill.

Our forthcoming proposal is just that --a proposal. 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 understand what reliance on these financing mechanisms means for some public health care providers; and 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)

THE WHITE HOUSE

WASHINGTON

September 29, 2000

MEMORANDUM TO THE PRESIDENT

FROM: Jacob J. Lew
Christopher C. Jennings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT: AFFECTED STATES

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

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

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

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

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

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

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

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

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

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

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

The States Milk Medicaid

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

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

No one knows the full extent of the phony billing, but more than half the states are either using the current ploy or preparing to do so. The extra cost to the feds is currently estimated to be between $3 billion and $4 billion a year, and rising. The cost of Medicaid has continued to rise in recent years even as the caseload has declined; the increase in phony billing is thought to be the principal reason why.

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

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

The Washington Post

Friday, September 8, 2000

Siphoning Money From Medicaid

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

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

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

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

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

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

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

by Leighton Ku

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

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

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

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

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[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.

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

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

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

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

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

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

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

Background

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

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

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

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

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

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

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

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

Research from the Urban Institute indicates that in recent years, the federal cost of UPL financing arrangements has burgeoned, rising from $313 million in 1995 to $1.4 billion in 1998.[6] Preliminary data from HCFA suggest the federal cost may be at least twice as high by 2001, with a potential federal cost of more than $3 billion.[7]

How Does the UPL Loophole Work?

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

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

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

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

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

Three steps are involved in a UPL financing arrangement.[9]

- First, the state makes a special payment to a select group of nursing homes or hospitals. Typically, this is done by making "supplemental payments" (above and beyond the regular Medicaid reimbursements) to county-owned or other local government-owned institutions. The size of these payments is based on the "upper payment limit," which is described in the next section of this analysis. The payments to these selected providers usually exceed the actual cost of delivering care and are much larger than the payments the state really intends to make for the provision of health services.

- Next, the county-owned or other local government-owned facilities return to thestate Medicaid agency a large portion of the supplemental payments. County-owned or other local government-owned facilities are used because they can use intergovernmental transfers to return the money.[10]

- The state claims a federal matching payment for the supplemental payments. The matching funds the state receives can be mingled with other state funds and used for any purpose the state chooses, including paying for other Medicaid or health care expenses, building roads, or financing tax cuts.

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

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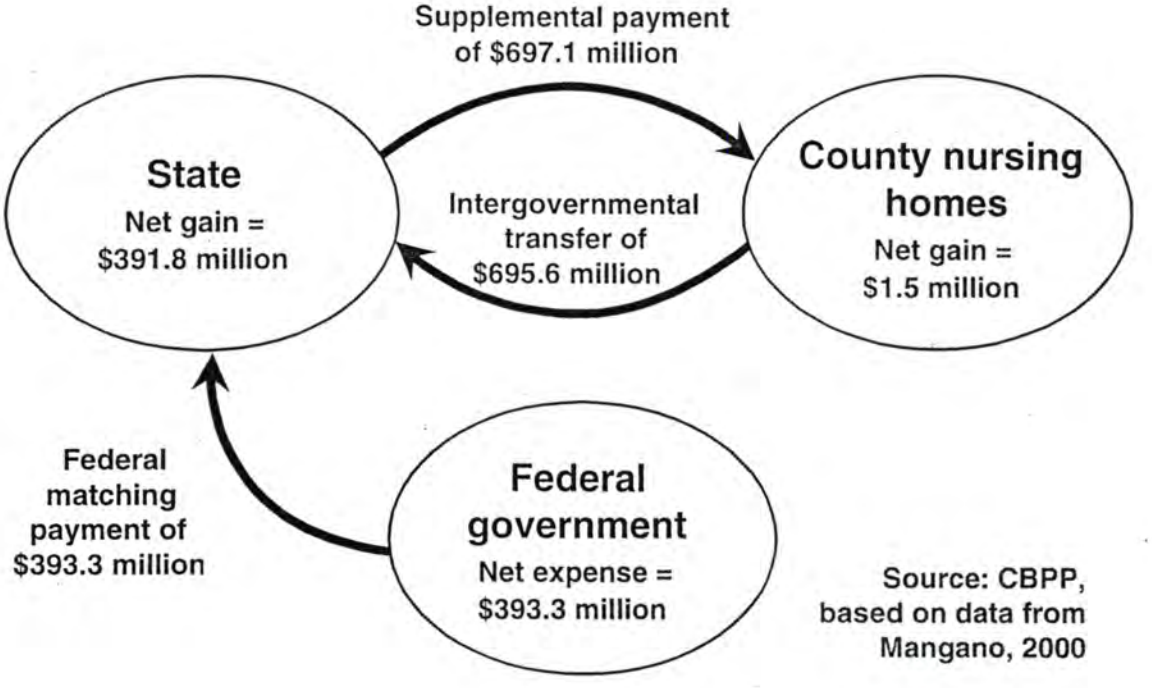
[9] UPL arrangements go by different names in different states. Some states call them "supplemental payment programs" because of the mechanism for making supplement payments to providers, while other states call these arrangements "intergovernmental transfer" programs because of the mechanism by which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



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

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

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

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

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

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

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

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

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

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

UPL Arrangements Distort Medicaid Financing

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

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

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

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[14] Westmoreland, *op cit.*

[15] Mangano and Allen, *op cit.*

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

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

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

What is Known about Current and Proposed UPL Arrangements?

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

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

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

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

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

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

Do States Need Additional Federal Funds?

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

Table 1 presents data about several measures of the fiscal status of states that currently have or are proposing UPL arrangements. Collectively, these states had state budget balances of $21 billion in state fiscal year 2000.[19] Most of these states had good, positive balances although a few states, such as Alabama, Arkansas, New Hampshire, and Tennessee, faced tight fiscal circumstances. Together, the group of states using or proposing to use UPL mechanisms cut taxes a total of $4.6 billion for the year 2000, although a few states with fiscal problems had to raise taxes. Overall, the strong trend was to cut state taxes. All except four of these states reduced taxes at least once in the past four years.

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

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

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[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% (natl. avg.)	(4,605)		5,574	2,093

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

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

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

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

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

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

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

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

How Might Safety Net Providers Be Affected?

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

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

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

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

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

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

Taking Reasonable and Prudent Regulatory Action

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

- It ought to signal that the federal government is serious about limiting abuses that impair the integrity of Medicaid. Based on what HCFA has said to date, it appears the forthcoming regulation would substantially reduce the size of potential UPL financing arrangements.

- The issuance of the proposed rule can create a mechanism to increase understanding of these issues through the information that states and health care providers submit under the public comment process for the proposed regulation.

- At the very least, the regulation could bring a temporary halt to the proliferation of these financing schemes, enabling the federal government to assess the costs and benefits of these arrangements more carefully before the arrangements mushroom in size. CBO estimates that if Congress were to block this regulation,

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

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

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

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

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

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

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[23] Mangano and Allen, *op cit.*

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.

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.

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

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

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.**[1] **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.

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

File: Medicaid / UPL

AGENDA: UPPER PAYMENT LIMITS IN MEDICAID

July 13, 2000

everyone is sensitive + I don't know exactly the next steps

UPDATE

- Roth letter expressing concern about issue, GAO, IG reports in progress
- Additional letters of concern from PA, NJ delegation
- Cost estimates: Since MSR, state projected 2000 Federal Medicaid spending is up by $3.4 billion, about $1.9 billion of which may result from UPL

CONSENSUS

- Consultation: Plan to meet with key members and groups
- Improvements to NPRM
  - Create preamble that stresses concern about public hospitals and uncompensated care;
  - Commit to multi-year transition for states currently using this practice;
  - Put options rather than a single option in the reg text for transitions so that affected parties do not assume that we favor a single approach
- With publication of NPRM, state support for legislation to limit prospective liability
- Timing for NPRM: Earliest: July 21 Latest: August 24

OPTIONS ON TIMING / ROLLOUT

1. **NPRM at earliest date (July 21)**
   - Postponing NPRM only increases pressure on Administration not to publish it
   - Minimally needed consultation could occur within a week

2. **Delay NPRM to early August, more consultation**
   - Provides time needed for meaningful consultation
   - Releasing while Congress is in session risks riders

3. **Notice of Intent / State Medicaid Directors' Letter now and NPRM in mid August**
   - Ensures that we have cleared language on record about our concerns / priorities
   - Does not formally solicit comment which are likely to be numerous and complicated

4. **Advance NPRM now and NPRM in late August**
   - Addresses the lack of information on the practice
   - Perceived by hospitals as least aggressive – but by critics as an indication of lack of seriousness

United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510–6200

June 30, 2000

The Honorable Donna Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Madam Secretary:

As you know, one of my most important responsibilities as Chairman of the Finance Committee is to provide regular oversight of Medicaid and the other programs under my committee's jurisdiction. Of late, I've become very concerned that unless the Administration acts immediately, we are on the brink of a Medicaid spending scandal unlike any we have seen since the disproportionate share hospital program was used to pay for roads, bridges, and highways.

Specifically, I am concerned that a loophole in current regulations permits states to use non-state governmental facilities to maximize the draw down of federal Medicaid dollars in a way that inappropriately circumvents the existing matching relationship between state and federal funds that is at the heart of the Medicaid program. Federal funds drawn down through this Medicare upper payment limit mechanism are being used overtly to fill in holes in state budgets. Medicaid is intended to provide health care to eligible vulnerable populations. It is not intended to serve as an accounting gimmick to funnel increased federal payments to the states.

I understand that the Health Care Financing Administration is planning to release a notice of proposed rulemaking related to revisions in upper payment limit requirements for Medicaid services provided in hospitals, nursing facilities, clinics, and intermediate care facilities. I encourage the Administration to move swiftly so that HCFA can begin to receive the expert feedback that will be needed to develop a final rule that fairly and promptly stems the patterns of abuse we are beginning to see.

In particular, I am concerned to have learned from budget analysts that despite actual declines in the Medicaid caseload, real increases in Medicaid spending have been projected in recent months, directly attributable to the upper payment limit mechanism in question. To see dramatic increases in Medicaid spending, accompanied by decreases in numbers of Medicaid beneficiaries, can only be troubling to anyone who cares about the long-term viability of the program. Absent quick regulatory action by HCFA, I think this would be an excellent topic for an oversight hearing before my committee.

I look forward to working with you and HCFA officials to make sure the Medicaid program stays true to its original mission. To that end, I am asking the General Accounting Office to evaluate this billing mechanism that permits states to be reimbursed at rates that significantly exceed the reasonable costs of services provided to Medicaid beneficiaries. I am also asking GAO to update its work on Medicaid intergovernmental transfers of federal reimbursements, with a focus on determining how widely used this mechanism is within state Medicaid programs, quantifying the level of federal funding that flows through intergovernmental transfers, and, to the extent possible, following this flow of funds to their ultimate destination.

Thank you for your prompt attention to my concerns. If I can be of assistance to you on this matter, please do not hesitate to let me know.

Sincerely,

William V. Roth, Jr.
Chairman

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.

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

State's finances brighten By ROGER MYERS, The Capital-Journal Kansas City, MO 6/30/00

he state has received the first installment of what it hopes will be more than $100 million in extra federal funds, Gov. Bill Graves announced Thursday. During a news conference in his office, the governor said about $20 million in additional Medicaid funds had been received from the Health Care Financing Administration earlier this week. In another positive financial development, Graves said state revenue collections have met projections for the current fiscal year, which will end with the close of business today.

That contrasts sharply with last fiscal year when the state collected $73.4 million less than had been estimated. That significant undercollection of revenue led Graves to reduce already approved state agency budgets by 1.5 percent, and it clamped tight spending restrictions on the 2000 Legislature.

"We have money in the bank from HCFA on the Intergovernmental Transfer," Graves said of the program that was created to receive the extra federal funds. "We have drawn down our first payment. It's for the last quarter of this fiscal year." The state hoped to obtain a total of $120 million during the first year's operation of the Intergovernmental Transfer Program by receiving a payment for the final quarter of this fiscal year, in addition to $20 million in each of the four quarters of the coming fiscal year. Graves said the state will to be cautious about how long the program will continue because a number of other states have adopted similar programs. **"For the time being, we'll just sit on the money and continue to monitor the situation in Washington,"** he said. "HCFA is trying to decide how to respond. The Congress has been involved, and the Clinton administration is involved in trying to figure out what to do."

Graves said whether Congress adds a prescription drug plan to Medicare will have a big impact on the Kansas Intergovernmental Transfer Program. On Wednesday, the U.S. House adopted a prescription drug plan for Medicare and sent it to the Senate. About 70 percent of the money the state receives from the Intergovernmental Transfer Program will be put into a Senior Services Trust Fund. Money in that fund will be invested by the Kansas Public Employees Retirement System, and the interest and dividends it generates will be used to finance a prescription drug plan for senior Kansans

Graves said if Congress adds a prescription drug plan to Medicare, it would nullify the Kansas plan. Money that would have been used to fund the state's drug plan for seniors could be spent on other programs, he said. "I expect there will be some adjustments made to this," the governor said. **"But we'll draw down and keep some amount of money. The question will be if it's anywhere close to what we originally anticipated."**

Under the Intergovernmental Transfer Program, the state will put about $80 million into a special fund and then distribute it to about 40 nursing homes across the state. Once the nursing homes touched the money, HCFA would send the extra Medicaid money. However, the nursing homes have contracts to return most of the extra money to the state after subtracting a small amount for a handling fee. Federal law allows a state to count money as aid to nursing homes if those homes ever touch the money, even if the homes don't keep the money long enough to spend it.

Graves said the state achieved its current fiscal year revenue estimate of $4.159 billion Wednesday. "So there is going to be a dramatic turnaround in the state's fiscal position from where we were a year ago when we were about to come in $73 million below the estimate," he said. "It'd be fair to say I'm already breathing a little easier. It'll be a lot more enjoyable Fourth of July this year. "The question now is, how far did we exceed the estimate for fiscal year 2000 (the current fiscal year)?" Revenue collections had exceeded estimates by about $30 million through the end of May. Duane Goossen, state budget director, said that amount of unanticipated revenue will grow by tonight.

Attn: Ruby Shamir

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WASHINGTON, D.C. 20003
(202) 544-6093 (202) 544-1465
robassoc@erols.com

DATE:

TO: Melanne FAX NUMBER: 456-6244

FROM: Liz PAGE(S): 4+cover

Can't wait to hear about THE meeting.

Did you see The Schumer Moynahan letter about adverse impact ON NY of potential HHS/OMB action?

Another copy of Harkin Spector letter and my cover note also attached

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Washington Representatives
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2211 Broadway
New York, NY 10024
212/580-2308
Fax:212/580-8048

To: Melanne Verveer

Date: July 11, 2000

From: Liz Robbins

Pages: 2+ cover

Letter from Spector and Harken (attached)

- Clearly indicates they would be ready to critique any Administration action that did not differentiate how IGT's spent-i.e. those states spending on Medicaid populations and those spending on roads etc.
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United States Senate

WASHINGTON, DC 20510

June 16, 2000

Ms. Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
200 Independence Avenue, S.W., Room 309G
Washington, DC 20201

Dear Ms. Min DeParle:

We are writing to express our concern about the impact the Health Care Financing Administration's (HCFA) expected changes to the Medicare Upper Payment Limit may have on New York's nursing homes and network of health care programs serving our most vulnerable residents.

New York has been a national model for expanding health care coverage to uninsured and underserved residents. With HCFA's approval, the state has used and continues to rely on funds transferred or certified by local governments to add to the state's share of Medicaid expenditures. The funds generated have been critical in supporting the delivery of vital health care services, including Medicaid, and the recent expansion of health coverage for children and the uninsured through the New York Health Care Reform Act.

We recognize the need to prevent states from using federal Medicaid dollars to subsidize non-health care related purposes, but we are concerned that, if implemented immediately, this rule change will have harmful and unintended effects on the provision and delivery of services, particularly to the low-income and underserved, in New York. It is our understanding that federal Medicaid dollars to New York could decrease by over $450 million as a result of the expected changes. In a time of growing need, particularly in county nursing homes, these reductions would likely mean an erosion of care for residents who need it most.

We appreciate your consideration and hope you will be mindful of the potential impact of such a rule on New York. Please do not hesitate to contact Kirsten Beronio for Senator Moynihan at 224-4399 or Debra Barrett for Senator Schumer at 224-7392 for further information.

Sincerely,

Daniel Patrick Moynihan
United States Senator

Charles E. Schumer
United States Senator

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.

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

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DATE: 7/14/00
TO: Ruby FAX NUMBER: 4566244
FROM: Liz PAGE(S): 5 + cover

Ruby -

Here is all the stuff I sent to Melanne yesterday, and my take on the letters.

Liz

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