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FAX TRANSMISSION

DATE: 6/21
TO: CHRIS JENNINGS
COMPANY: WHITE HOUSE
TELEPHONE: 456-5560
FAX: 456-5557
FROM: JERRY KLEPNER
TELEPHONE: 530-4842
FAX: 530-4800
NO. OF PAGES: 3 including cover page

COMMENTS:

I THOUGHT THIS MIGHT BE HELPFUL AS YOU REVIEW THE INTERGOVERNMENTAL TRANSFER ISSUE.

JERRY

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CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

PROPOSED MODIFICATIONS TO HCFA DRAFT UPPER PAYMENT LIMIT REGULATIONS

HCFA's draft upper payment limit ("UPL") regulations would add a new Medicaid upper payment limit that would apply to specified types of providers that are government owned or operated. The draft rule would limit Medicaid payments to the amount that these providers would have received, in the aggregate, under Medicare. HCFA would retain the current statewide UPL, which applies in the aggregate to specific provider categories. The changes are intended to halt apparent abuses by certain states that funnel extraordinarily high levels of Medicaid payments to government providers that in turn, redirect the majority of the funds back to the state for other purposes, including non-health related expenditures.

While HCFA's concerns regarding the financial abuses are legitimate, the draft regulations go well beyond this purpose, and would adversely affect those states with appropriate Medicaid financing by local governments as authorized under the Medicaid statute (42 U.S.C. § 1396b(w)(6)). California in particular has for many years relied on intergovernmental transfers of funds from local governments to fund the non-federal share of certain payments for both public and private providers. These local government funds, upon transfer to the State, are separately accounted for and used exclusively for Medicaid program purposes pursuant to State law (e.g., Cal. Welf. & Inst. Code §§ 14085.6 - 14085.8, 14163). Under California's Selective Provider Contracting Program, which operates under Section 1915(b) waivers (42 U.S.C. § 1396n(b)), the supplemental payments that are funded by intergovernmental transfers are individually negotiated between the participating hospital and the California Medical Assistance Commission, an independent State commission.

Set forth below are two alternative options for modifying HCFA's proposed UPL regulations. Both options take into consideration California's particular circumstances.

OPTION A: Insert new paragraph:

> **"(_) *Special state circumstance exception.* The upper payment limitation established under paragraph (_) of this section [regarding Government owned or operated facilities] does not apply in the case of a state that is identified in Section 4721(e) of the Balanced Budget Act of 1997 (Pub. Law No. 105-33)."**

1. This exception is specific to California, and references the federal legislation (BBA 1997) that permitted California public hospitals to receive disproportionate share hospital payments up to 175% of their uncompensated care costs.

2. The BBA 1997 provision for California was enacted in recognition of the historical role of public entities in supporting the nonfederal share of disproportionate share hospital payments and other supplemental payments to hospitals.

2000 Center Street, Suite 308 ■ Berkeley, CA 94704 ■ 510.849.7650 ■ fax: 510.849.1533 ■ www.caph.org

3. This exception for California would continue to protect public hospitals consistent with the intent of the BBA 1997 provision. The statewide aggregate UPL would continue to apply.

OPTION B: Insert new paragraph:

> **"(__) *Waiver Programs.* (1) The upper payment limitation established under paragraph (__) of this section [regarding Government owned or operated facilities] does not apply to payments made under programs initially authorized by waivers [granted prior to the effective date of the regulation] pursuant to Sections 1115 or 1915(b) of the Act. (2) In determining whether a program authorized by Section 1115 or 1915(b) that is referenced in subparagraph (1) is budget neutral or cost-effective, the terms and conditions of the particular program shall apply in lieu of the upper payment limitation established under paragraph (__) of this section."**

1. This exception, which is not specific to California, would exempt waiver programs from the new UPL. The statewide aggregate UPL would continue to apply, however.

2. This exception is in recognition of the separate limitations that are imposed under the specific terms and conditions of the particular waiver program, e.g., cost-effectiveness. California's Selective Provider Contracting Program, for example, has demonstrated cost-effectiveness to the extent of approximately $5.6 billion since its inception in 1983.

3. Since HCFA has wide discretion in the granting of waivers and in setting their terms and conditions, the new UPL is not necessary to curb potential abuses, and would restrict the flexibility and innovation inherent in such programs. For example, key to the success of California's Selective Provider Contracting Program is the system of negotiated rates, which encourages competition in the market and hospital efficiencies in operations and practice patterns. While these factors historically have been given appropriate weight in the evaluation of the program's overall cost-effectiveness, the new UPL would not allow for such flexibility in evaluating this program.

If you have questions or would like to discuss further, please contact Denise K. Martin, President& CEO, California Association of Public Hospitals and Health Systems (CAPH) at 510-649-7650.

CAPH represents more than two dozen hospitals, health care systems and academic medical centers throughout California.

NJHA
NEW JERSEY HOSPITAL ASSOCIATION

cc: Chris Jennings

June 9, 2000

Mr. John Podesta
Chief of Staff
The White House
Washington, DC 20500

Dear Mr. Podesta,

On behalf of the New Jersey Hospital Association and its 108 members, I urge the Clinton Administration to reconsider restricting states' flexibility and their use of intergovernmental transfers (IGTs). I understand that the Health Care Financing Administration is poised to issue a Notice of Proposed Rulemaking that will change the federal Medicare upper payment limit. This could prove devastating to the Garden State's most needy families and harm the state's ability to ensure health access to low income individuals.

New Jersey has submitted a state plan amendment that details the state's intentions and the programs that would be supported by the use of intergovernmental transfers. Curtailing that flexibility or declining the state plan amendment would be devastating. In fact, healthcare programs across the Garden State would be jeopardized if forced to replace the $250 million in funds obtained through IGTs.

HCFA's proposed rule, if approved, might jeopardize a number of important health insurance expansions in New Jersey from KidCare (the state's CHIP program) to charity care (the state's health access safety net) to FamilyCare (a proposed low cost insurance initiative). This alone is cause for concern within the hospital industry. Congress has specifically legislated the use of IGTs, and any restriction of the use of IGTs is a significant departure from the policy legislated by Congress.

Your direct intervention is critical. I ask that you speak with HCFA Administrator Nancy Ann Min DeParle and request that the restrictive rule not be issued and allow for New Jersey's state plan to be accepted.

For further information on this matter, please contact Bettina Dill, senior director of federal relations, at 202-544-6259. Thank you in advance for your assistance.

Sincerely,

Gary S. Carter, FACHE
President and CEO

760 Alexander Road ■ PO Box 1 ■ Princeton, New Jersey 08543-0001

LIZ ROBBINS ASSOCIATES

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FAX NUMBER: 202-456-5557

To: Chris Jennings

Date: June 20 , 2000

From: Liz Robbins

Pages: 2

Chris-

This is the letter that twelve Governors including Pataki are about to send to the President, VP, and the Hill. Gov. Ryan is holding it for a few minutes in case there might be any new news, but since the other Governors have it there might be a leak. I understand that despite the fact there are five Democrats on the letter, the release might not be pretty.

5 Dems
7 Reps

June 19, 2000

The Honorable William J. Clinton
President of the United States
Executive Office of the President
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear President Clinton:

We are writing to express our strong opposition to a pending rule that will reduce Federal Medicaid for states. The U.S. Department of Health and Human Services has publicly announced its intention to publish regulations that would dramatically restrict the ability of states to use federal funds through the Medicaid program to provide health services for many of our nation's poorest, most vulnerable and underserved citizens. We ask that you reconsider this regulatory change and choose not to move forward with the alteration.

In 1991, Congress reaffirmed the states' ability to use local government funds for the purpose of obtaining increased federal Medicaid matching funds. The agreement to maintain this option occurred at the same time that Congress eliminated other sources of Medicaid matching funds that were previously available to the states.

Now almost ten years later, the Department of Health and Human Services is proposing to radically restrict this program without an adequate assessment of the impact that such a change would have on state health care budgets. More specifically, we believe there has not been sufficient consideration of any alternative approaches that might lessen the negative impact on the poor, elderly and medically needy.

Let us be clear: The states' ability to continue to provide vital health services to our poorest and most vulnerable citizens will be greatly impaired should this proposal be adopted by your Administration. Examples of programs that are likely to be curtailed include services in public hospitals and county nursing homes serving indigent populations, home and community based care for the elderly, programs that assist the disabled to live independently in the community, expansion of the Children's Health Insurance Program, efforts to reduce the number of uninsured and optional services for Medicaid recipients.

Given the negative consequences of this proposal and the Department's expressed intent to move forward as quickly as possible -- without adequate analysis of the regulation and its unintended consequences – we respectfully request that you not allow HHS to publish this regulation.

Sincerely,

Governor Don Siegelman
Alabama

Governor Tony Knowles
Alaska

Governor Roy Barnes
Georgia

Governor George H. Ryan
Illinois

Governor Tom Vilsack
Iowa

Governor John Engler
Michigan

Governor Mike Johanns
Nebraska

Governor Christine Todd Whitman
New Jersey

Governor George E. Pataki
New York

Governor John Kitzhaber
Oregon

Governor Don Sundquist
Tennessee

Governor Tommy G. Thompson
Wisconsin

cc: The Honorable Albert Gore, Vice President
The Honorable Arlen Specter, Chairman Senate L/HHS/ Ed Appropriations Committee
The Honorable Tom Harkin, Ranking Member Senate L/HHS/ Ed Appropriations Committee
The Honorable John Porter, Chairman House L/HHS/ Ed Appropriations Committee
The Honorable David Obey, Ranking Member House L/HHS/ Ed Appropriations Committee
The Honorable Donna Shalala, Secretary of U.S. Dept. of Health and Human Services

Tim
Jeanne

Office of Inspector General

Memorandum

Date AUG 7 2000

From for June Gibbs Brown
Inspector General

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

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

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

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

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

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

BACKGROUND

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

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

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

SCOPE

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

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

PRELIMINARY RESULTS

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

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

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

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

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

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

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

STATE NUMBER ONE

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

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

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

STATE NUMBER TWO

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

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

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

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

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

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

STATE NUMBER THREE

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

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

SUMMARY

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

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

8-2-00

Clinton / Arkansas

Memo

C Jennings
What's the deal here?

To: President Clinton

From: Lynda Dixon

CC:

Date: 7/26/00

Re: UAMS

Mr. Bowen called today and asked that I send you the enclosed letter signed by all the living governors of the State of Arkansas. All they ask is that you look at this before sending it to one of your aides.

Thanks.

Copied
Jennings
Podesta.

State of Arkansas

July 10, 2000

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President:

We are writing you as Arkansans who have all had the opportunity to serve their state as Governor and continue to serve in many ways. This matter is of urgent interest to the citizens of Arkansas.

As Arkansas' only teaching hospital, UAMS is the foundation for training of physicians, pharmacists, nurses and allied health professionals statewide. Although located in Little Rock, approximately 50% of University Hospital's patients come from outside Pulaski County. This institution is in a financial crisis. It is critical to the future healthcare and economic development of the state, that every effort be made to support the financial stability of this institution ---- now and long-term.

Our state has submitted a proposal to the Health Care Financing Administration (HCFA) to establish desperately needed supplemental Medicaid payments for the state's only academic health center, the University of Arkansas for Medical Sciences (UAMS). Our proposal is for rate enhancements that are perfectly legal under current law. However, HCFA is preparing to issue a regulatory change that will severely limit our ability to provide these critical payments, due to concerns about abuses by some states that are completely unrelated to our proposal. We are taking the extraordinary step of asking for your help in ensuring that the regulatory change does not in any way impact what we propose to do in Arkansas.

We cannot over-emphasize the importance of this proposal to the provision of medical care in our state. UAMS serves as the cornerstone of our health care system, providing complex

specialty care not available elsewhere, training the next generation of doctors (a significant percentage of whom remain in the state to serve its population) and providing enormous amounts of uncompensated care to the state's uninsured and underinsured residents.

All of this care is costly and under-reimbursed, to the extent it is reimbursed at all. Most other states have been able to assist their teaching hospitals in providing this care through the Medicaid Disproportionate Share Hospital (DSH) program. However, in 1991 Congress strictly limited the amount that states may pay hospitals through DSH, which was further limited by the Balanced Budget Act 1997.

Arkansas is consequently prohibited from paying anywhere near UAMS' uncompensated costs through DSH. As a result, UAMS receives annual DSH payments of under $54,000, and statewide the federal DSH allotment is only $2 million (out of a total of $9 *billion* nationwide). Meanwhile, teaching hospitals in neighboring states receive DSH payments of $77 million (University of Mississippi), $80 million (University of Texas Medical Branch at Galveston) and even $106 million (Louisiana State University).

UAMS is facing a severe budgetary crisis, due to a combination of factors, which threatens its ability to continue to serve as an essential health care safety net provider in the future. In FY 1999 UAMS lost $18 million and for FY 2000, UAMS is projecting a $30 million loss. If this trend is not reversed, the very existence of University Hospital is in jeopardy. The University and the state are doing everything we can to alleviate this crisis. But our Medicaid proposal is an essential element of our plan to ensure UAMS' future viability.

Our proposal does not implicate any of the apparent state abuses of Medicaid that we understand have led HCFA to develop the regulatory change. The entire amount of the proposed payments will go to UAMS and will stay with UAMS. Although the non-federal share of the payments will be funded through funds in the UAMS budget rather than general state revenues, these are transfers fully authorized by federal law. After the payments are made, none of the federal funds will be returned to the state Medicaid program or the state general fund – they will all remain with the hospital to cover the costs of Medicaid-eligible care provided. ***In short, our proposal simply does not involve any inappropriate recycling of federal funds or other game-playing that has so disturbed HCFA to date.*** Our unfortunate timing, however, has found us caught in a much larger controversy over which we have no control.

We ask for your help in ensuring that Arkansas' proposal is approved and allowed to take effect permanently. We do not have the history of Medicaid abuses that plague the records of other states. In fact, we have been disadvantaged by not moving quickly enough to claim federal Medicaid funds to which we would otherwise have been entitled. We do not in any way condone the apparent abuses that have gone on in other states. In our case, this funding is very critical to UAMS' future. These monies will not be used for any other propose than assisting UAMS. We ask for your assistance in ensuring that HCFA's impending action does not restrict our ability to implement these supplemental payments for UAMS.

Attached is additional background on this issue for your staff. We would be happy to provide any further information you may find helpful. Your strong consideration of this proposal will be appreciated. As a former Governor, you have dealt with these issues and know them to be factual. Please help us with a final resolution of this critical problem.

Sincerely,

Mike Huckabee
Governor 1996 – Present

David Pryor
Governor 1975 - 1979

Jim Guy Tucker
Governor 1992 - 1996

Dale Bumpers
Governor 1971 - 1975

Frank White
Governor 1981 – 1983

Sid McMath
Governor 1949 - 1953

Attachment
tbs

THE IMPACT OF HCFA'S PROPOSED REGULATORY CHANGE ON ARKANSAS

The University of Arkansas for Medical Sciences is a Critical Element of Arkansas' Health Care Delivery System, Yet It Faces a Crisis

- Arkansas has only one academic health center in the state, the University of Arkansas for Medical Sciences (UAMS). This essential institution provides unique specialty health care services, trains the next generation of doctors to serve state residents, and provides access to care for the uninsured. All of this care is costly and is under-reimbursed or not reimbursed at all.

- UAMS is currently experiencing a severe financial crisis due to a combination of factors including cutbacks in Medicare and third-party reimbursement, increasing numbers of uninsured patients and heightened competition in the health care industry.

- This crisis threatens UAMS future viability, and its continued ability to serve as a critical safety net provider in the state.

Arkansas Has Proposed to Establish a State Operated Teaching Hospital Adjustment for UAMS to Help Resolve Its Crisis

- In May 2000, Arkansas submitted two state plan amendments to HCFA to establish state operated teaching hospital rate adjustments for UAMS. The adjustments – one for inpatient services and the other for outpatient services -- would bring UAMS' rates up to the maximum allowable level permitted under the Medicaid Upper Payment Limit (UPL) regulations.

- The inpatient adjustment would increase rates by approximately $4 million per year and the outpatient adjustment by approximately $52 million per year. The non-federal share (approximately $18 million) of these payments would be financed through funds provided by UAMS.

- These payments are a crucial element of the state's plan to resolve the fiscal crisis at UAMS, which otherwise could threaten the quality and access to care provided to residents of Arkansas.

The Inpatient Adjustment Should Be Expedited Because It Would Not Be Impacted By Any Regulatory Change

- Under current regulations, state-operated hospitals such as UAMS are subject to a separate UPL calculation for inpatient rates. The proposed inpatient rate adjustment for UAMS is in compliance with this requirement.

- No change to this separate UPL for state operated facilities is currently contemplated, to our knowledge, and the inpatient proposal would therefore not be affected by the regulatory change.

- The proposed inpatient adjustment should not be held hostage with other plan amendments that are subject to the regulatory change.

Arkansas Should Not Be Subjected to the More Restrictive Upper Payments to be Proposed by HCFA

- HCFA is poised to modify the UPL regulations in a way that would give states much less flexibility in setting rates. This modification would greatly restrict Arkansas' ability to adjust UAMS' outpatient rates in the manner proposed.

- The purported reason for the regulatory change is the apparent use by some states of Medicaid dollars for non-Medicaid purposes. These states reportedly use payments to public nursing homes and hospitals, combined with intergovernmental transfers, to divert federal Medicaid funds for inappropriate purposes.

- Arkansas does not condone these abuses, and supports HCFA's efforts to halt them.

- Arkansas' plan contains none of these troubling elements. All of the new payments will remain with UAMS. None will be diverted to other uses. The non-federal share will be paid by UAMS entirely from "funds appropriated to State university teaching hospitals" as specifically authorized by statute (42 U.S.C.§1396b(w)(6)(A)).

- Despite Arkansas' unfortunate timing in proposing these adjustments in the midst of controversy, these payments are a legitimate use of Medicaid funds, and are desperately needed to ensure UAMS' viability.

Arkansas Has Historically Received Well Below Its Fair Share of Federal Medicaid Funding, and UAMS Has Consequently Been Deprived of a Desperately Needed Source of Support

- Congress established the Medicaid Disproportionate Share Hospital (DSH) program in the early 1980s to assist safety net hospitals such as UAMS with the enormous unreimbursed costs associated with their missions.

- Over the last decade, Congress has placed increasingly tight limits on the growth in state DSH programs. Because Arkansas was relatively late in establishing a DSH program, it is forever restricted in the amount of DSH payments it can make to safety net hospitals such as UAMS.

- Currently, Arkansas' federal DSH allotment is $2 million. DSH allotments for all states total $9 billion. In other words, Arkansas receives slightly more than two one-hundredths of one percent (.022 percent) of federal DSH dollars nationwide.

- UAMS' annual DSH payment in FY 1998 was $53,964. This amount is dwarfed by the DSH payments received by other teaching hospitals across the country, according to state reports filed with HCFA. For example, in FY 1998 the University of Mississippi and the Medical University of South Carolina each received $77 million, the University of Louisville (KY) received $46 million, the University of Texas Medical Branch at Galveston received $80 million and the Louisiana State University received $106 million.

- The inability of Arkansas to provide DSH payments to UAMS means that the proposed teaching hospital adjustments are even more direly needed. UAMS is trying to cope with the pressures experienced by all teaching hospitals but is doing so in the absence of this critical source of support available to most similarly situated institutions.

- As the attachments indicate, numerous teaching hospitals across the United States have received the DSH payments for over a decade. Also, many states are drawing both DSH and non-DSH supplemental payments. In order to allow UAMS to stabilize its financial status, we are **requesting the proposal made be granted on a permanent basis.**

DSH PAYMENTS TO TEACHING HOSPITALS
(AS REPORTED TO HCFA)

FISCAL YEAR 1998

ATTACHMENT "A"

STATE	TEACHING HOSPITAL	FY '98 DSH PAYMENTS
Arkansas	**Univ.of AR for Med. Sciences**	**$ 53, 964**
Colorado	University of CO Hospital	$ 55,000,000
Connecticut	Yale New Haven Hospital (CT)	$ 44,000,000
Florida	University Medical Center Jacksonville, FL	$ 42,000,000
Kentucky	University of Kentucky Hospital	$ 18,000,000
Kentucky	University of Louisville Hospital	$ 46,000,000
Louisiana	Louisiana St. Univ. Med. Center	$106,000,000
Missouri	University of MO Hospital	$ 23,000,000
Nevada	University of NV Medical Center	$ 59,000,000
New Mexico	University of NM Hospital	$ 4,000,000
Oklahoma	University of Oklahoma Hospital	$ 19,000,000
South Carolina	Med. Univ.of South Carolina	$ 77,000,000
Texas	UTMB – Galveston	$ 80,000,000
Texas	UT Tyler	$ 12,000,000
Texas	MD Anderson – Houston	$ 66,000,000
Virginia	University of Virginia Hospital	$ 41,000,000
Virginia	Medical College of Virginia	$ 89,000,000

DSH ALLOTMENTS DATA

TOTAL FY 2000 DSH ALLOTMENT FOR ALL STATES: $9 BILLION (+)

ATTACHMENT "B"

STATE	FEDERAL ALLOTMENT	PAYMEMT PER MEDICAID/UNINSURED PERSON (FY '98) (National Avg.: $218.96)*
ARKANSAS	**$ 2 M**	**$3.11 M**
CALIFORNIA	$ 931 M	////
GEORGIA	$ 228 M	////
KANSAS	$ 36 M	////
LOUISIANA	$ 658 M	////
MISSISSIPPI	$ 129 M	////
MISSOURI	$ 379 M	////
NEW YORK	$1,361 M	////
TEXAS	$ 765 M	////

*Coughlin, Ku & Kim, "Reforming the Medicaid Disproportionate Share Hospital Program I the 1990s, Urban Institute, January 2000)

copied Podesta

cc. Jack Chris

THE WHITE HOUSE

WASHINGTON

00 JUL 21 P2:54

July 21, 2000

JP

This looks about right but has to be handled carefully. Good to allocate extra $ while already set aside to it to make sure $ spent as they say they will

MEMORANDUM FOR THE PRESIDENT

FROM: Jack Lew
Chris Jennings

RE: Upper Payment Limits in Medicaid

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

BACKGROUND

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

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

Senator Roth, the Inspector General, and the General Accounting Office are in various stages of investigations to highlight this problem and criticize our lack of response. Having said this, your advisors also have serious concerns about how any regulatory action to stop this practice would affect states and health care providers serving vulnerable Medicaid and uninsured patients. Some of the Federal funds extracted from the upper payment limit financing loophole are being used to provide much-needed assistance to public hospitals that are being overburdened by increasing uncompensated care liabilities and less generous private sector and Medicare payment policies. Other states are using these funds to increase health care provider reimbursement rates and limited coverage expansions. However, still others are using these funds for road construction, tax reductions, education investments, and to help balance budgets.

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

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

LIKELY RESPONSE FROM STATES / PROVIDERS

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

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

CURRENT STATUS OF RECOMMENDED ADMINISTRATION ACTION

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

DATE: _____

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
ROOM 405H, HUMPHREY BUILDING
200 INDEPENDENCE AVE, SW
WASHINGTON, D.C. 20201

PHONE: (202)690-7450 *FAX: (202)690-8425*

TO: Deona Adler

OFFICE: _____

FAX: 456-5557

FROM:

[X] JANE HORVATH
[ ] KRISTINE BRADSHER
[ ] SHARON CLARKIN
[ ] DEBORAH DRAYER
[ ] JOANNE JEE
[ ] LEO LUBERECKI
[ ] ROGER MCCLUNG
[ ] JACK MITCHELL
[ ] ZENO ST CYR
[ ] PAUL SELTMAN
[ ] STEPHANIE WILSON
[ ]
[ ]
[ ]
[ ]

(INCLUDING COVER): _____

REMARKS:

Congress of the United States
Washington, DC 20515

October 17, 2000

The Honorable Dennis Hastert
Speaker
United States House of Representatives
The Capitol
Washington, D.C. 20515

The Honorable Trent Lott
Majority Leader
United States Senate
The Capitol
Washington, D.C. 20510

Dear Mr. Speaker and Mr. Leader,

On October 5, the Health Care Financing Administration (HCFA) published a Notice of Proposed Rulemaking (NPRM) which would make changes to the definition of the upper payment limit (UPL) as it applies to Medicaid reimbursement to providers such as hospitals and nursing facilities. The NPRM was in response to alarming information from the Office of the Inspector General and the General Accounting Office that states are utilizing a payment loophole in a way that undermines the integrity of the Medicaid program. While the HCFA proposal may not fully contain the exploitation of the Medicaid program, it is at least a first step in reining in abuses and will limit the magnitude of the problem. We are writing to express our opposition to any effort to undermine or weaken the proposed regulation, including grandfathering. If anything, Congress should be working to close the loophole fully.

Nationally, tens of billions of dollars are at risk because of the misuse of an enhanced payment arrangement. This payment scheme could have the long-term effect of jeopardizing public support for Medicaid. The practical effect of this reimbursement rule loophole is to raise the federal cost of the Medicaid program, while at the same time minimizing the costs to the states. Currently these enhanced payment arrangements are operating in 20 states and there are an additional 11 proposals that are pending. Assuming additional states come forward with the enhanced payment arrangement proposals, the cost of this will continue to escalate.

In fact, the Congressional Budget Office estimates that truly closing the payment loophole would save taxpayers $47 billion over the next five years and $127 billion over the next decade. For context, if unchecked, inappropriate federal spending due to program exploitation will be more than double what we are projected to spend on the

PRINTED ON RECYCLED PAPER

State Children's Health Insurance Program over the same period of time.

We understand concerns expressed by some members that in certain cases states are using these additional dollars to finance state health programs or other Medicaid spending. However, these funds are fungible and it is virtually impossible to account for their use. Moreover, buying out the state's financial participation responsibility with federal dollars clearly violates statutory intent. The transition period that HCFA has established for phasing out these schemes should mitigate the budgetary effect of the closing of this loophole and give states the opportunity to develop alternative ways to finance these health programs.

The patterns of spending we are seeing today in the Medicaid program are reminiscent of the program exploitation that occurred a decade ago through states' creative uses of Medicaid's disproportionate share hospital (DSH) program. The DSH scandal should have taught us a clear lesson – we have to move swiftly to shut down program abuse before it becomes institutionalized. The longer the abuse continues, the more difficult it becomes to shut down. We owe it to the 40 million Americans who rely on Medicaid to defend the financial integrity of the program. Any attempt to block HCFA in its efforts to begin to stem the abuse will weaken Medicaid in the long run. We cannot stand by and let that happen. Accordingly, we will be carefully monitoring all legislation considered between now and adjournment to see that no effort is made to undermine HCFA's proposed regulation. We ask for your assistance in working with us to help HCFA do the right thing and put the Medicaid program back on solid ground.

Thank you for your consideration of our views and we will look forward to working with you as this session of Congress draws to a close.

Sincerely,

Don Nickles

John Dingell

William Roth, Jr.

Richard Bryan

UPL CONSULTATION AND ROLL OUT

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

POTENTIAL SUPPORTERS - **One Week Before**
Senator Roth
Representative Dingell
Representative Bliley
Representative Waxman
Representative Obey

DAMAGE CONTROL - **One Day Before display**
Senator Moynihan
Senator Specter
Senator Harkin
Senator Durbin
Senator Toricelli
Representative Rangel

DAMAGE CONTROL - **Day of Display**
Representative Hastert
Representative Porter

LEADERSHIP CALLS - One Day Before (John Podesta, Secretary Shalala?)
Senator Daschle
Senator Lott
Representative Gephardt

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

FINANCE COMMITTEE

MEETING 1- One Week Before
Senator Baucus
Senator Graham
Senator Conrad
Senator Rockefeller
Senator Kerry

Judy Feder JMM
Judy Waxman TW
Bob Greenstein JMM
Diane Rowland TW

MEETING 2 - One Week Before
Senator Roth
Senator Hatch
Senator Jeffords

NAPH TW
AHA

Senator Mack
Senator Nickles
Senator Gramm

COMMERCE COMMITTEE

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

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

SENATE APPROPRIATIONS COMMITTEE

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

MEETING 6 - One Week Before
Senator Domenici
Senator Cochran

HOUSE APPROPRIATIONS COMMITTEE

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

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

DAY OF RELEASE BRIEFINGS

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

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET

OFFICE OF HEALTH AND PERSONNEL
OLD EXECUTIVE OFFICE BUILDING, ROOM 238
FAX NUMBER: (202) 395-5631

FAX SHEET

DATE: 8/4

PLEASE DELIVER THE FOLLOWING PAGES TO:

NAME: Tim Westmoreland / Chris Jennings

FAX NUMBER: 410-786-0025 65557

NUMBER OF PAGES (Including cover page): ___

FROM:

JEANNE LAMBREW	**395-5178**	X
MOLLY O'MALLEY	**395-9132**	___
JENNIFER FERGUSON	**395-3816**	___

COMMENTS:

Any other edits?

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

The Honorable Arlen Specter
United States Senate
Washington, D.C. 20510

Dear Senator Specter:

I am responding to your letter dated June 28th regarding modifications to Medicaid upper payment limits (UPL). The Department of Health and Human Services (HHS) issued a State Medicaid Director's letter on July 26th that outlines its approach for addressing this issue, including its plan to issue a Notice of Proposed Rule Making (the letter is enclosed). However, I want to respond to the questions that you posed about Medicaid UPL policy.

1. What is the statutory basis for the Department of Heath and Human Services (Department) to issue a proposed rule modifying the upper payment limit regulations codified at 42 CFR sections 447.272 and 447.321?

   Section 1902(a)(30) of the Social Security Act. This provision requires Medicaid payments to be consistent with efficiency, economy, and quality of care. HHS also believes that maintaining fiscal integrity is essential to its commitment to Medicaid, the people it serves, its health care providers and the taxpayers who pay for it.

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 revenues sources precluded by this rule." (56 Fed Reg. 56132)?

   HHS is not preparing to make any changes to the rules relating to intergovernmental transfers (IGTs). Under section 1902(a)(2) of the Act, States can use local resources to help them finance their share of Medicaid program expenditures. However, it has come to our attention that some States have been using a combination of high Medicaid payment rates to public providers and intergovernmental transfers to gain extra Federal Medicaid matching payments. To address the issue, HHS is considering changes to the regulation regarding Medicaid Upper Payment Limit (UPL). UPLs relate directly to Medicaid service payments as they place a ceiling on the maximum amount States can pay for Medicaid services that have been furnished to eligible individuals.

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.

   HHS believes all States may rely on IGTs to some degree to finance their share of Medicaid program costs. Under section 1902(a)(2) of the Act, States can use local resources to fund up to 60 percent of their share of program costs.

4. Has the Health Care Financing Administration (HCFA) approved these methodologies through the State Plan process?

   HCFA has approved payment methodologies that target enhanced payments to public providers of Medicaid services, consistent with the goal of allowing States flexibility in provider payments. The methodologies are approvable because when combined with payments to non-public Medicaid providers, total payments comply with current aggregate UPL requirements. However, it has recently become clear that the aggregate UPL requirements may not achieve their goal of ensuring that payments be consistent with efficiency, economy, and quality of care.

5. Which States have pending State plan amendments to alter these arrangements?

   Alaska, Georgia, Illinois, Kansas, Kentucky, Michigan, Missouri, New Jersey, Pennsylvania, South Carolina, South Dakota, and Utah. Iowa and Tennessee also had amendments, but they were recently deemed approved.

6. We understand the Inspector General is undertaking reviews of IGTs mechanisms in some States. Why is the Department moving forward to promulgate a rule prior to completion of this review?

   The Department is reviewing all evidence and options to protect both the fiscal integrity of the Medicaid program and the providers who deliver its care. Before developing a final policy, HHS will take into consideration any findings and recommendations that may be forthcoming from the Inspector General as well as other public comments HHS may receive on the policy changes presented in the NPRM.

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.

   As we have previously indicated, IGTs have their own statutory basis that is separate and distinct from UPLs. Changes in UPL policy should not have an impact on a State's ability to use 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?

   Medicaid statute does not authorize Federal payments for non-Medicaid purposes or for use in replacing State spending on Medicaid. Section 1903(a) of the Act authorizes payment of Federal Medicaid dollars to States for medical assistance expenditures they incur. Medical assistance is defined in section 1905(a) of the Act to refer to a specified set of health care services furnished to a defined class of individuals. However, recognizing the current reliance on these types of arrangements, it is likely that any regulation change will build in a transition period to allow States to adapt and find alternative funding sources.

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.

   A policy change on UPL would be done through an NPRM process, which will allow HHS to collect information and receive public input on the potential impact of these policies on the larger health care delivery system before issuing a final policy. In proposing changes, HHS will maintain its strong commitment to protecting and expanding programs that serve low-income families and the providers that serve them.

10. How will the proposed rule impact access to health care services provided by State facilities and not-for-profit community facilities?

    Medicaid payments for State-run inpatient hospital services, nursing facility services and intermediate care facility services for the mentally retarded are already subject to a more stringent upper limit policy. Not-for-profit facilities should not be affected. The ~~problem~~ situation has arisen in some city and county-owned facilities.

11. How will the proposed rule affect implementation of the State Children's Health Insurance Progam (SCHIP)?

    The NPRM should not affect the State Children's Health Insurance Program, since States are prohibited from using Federal funds for the State share of their programs.

12. Please describe all alternative oversight authority the Secretary has under current law to ensure appropriate utilization of Medicaid funds.

    Under current law, the Secretary's authority to ensure appropriate utilization of Medicaid funds flows from Section 1902(a)(30) of the Social Security Act which requires Medicaid payments to be consistent with efficiency, economy and quality of care. This has been interpreted through regulation.

13. Has the Department received any direction from Congress to undertake this rulemaking?

    This issue can be resolved administratively and is consistent with Medicaid law. The Secretary did recently receive a letter from Senator Roth encouraging HCFA to promptly issue the NPRM so that we can receive public input and expertise in developing a final policy.

The Medicaid program has been successful over the years in providing vital health care services to millions of needy Americans. It will continue to be successful only to the extent that it adheres to that mission and ensures that funds provided are used appropriately for health coverage for low-income families, elderly, and people with disabilities. I believe the changes are needed to preserve the integrity of the Medicaid program and hope you will support them once they have been officially proposed for public comment.

A similar letter has been sent to Senator Harkin who co-signed your letter to me. I hope you find the above responses helpful. If I can be of any further assistance to you on this matter, please let me know.

Sincerely,

Jacob J. Lew
Director

Enclosure

Identical Letter Sent to The Honorable Tom Harkin

Congress of the United States

00 JUN 7 PM 2:54

House of Representatives

Washington, DC 20515

May 24, 2000

The Honorable William Jefferson Clinton
The White House
Washington, DC 20500

Dear Mr. President:

As representatives of the state of Illinois, we wish to enlist your assistance in an urgent matter that requires the immediate attention of your Administration. This matter affects both the State of Illinois and Cook County.

We recently learned that the Health Care Financing Administration (HCFA) has drafted a Medicaid rule that would have a devastating impact on Illinois' and Cook County's ability to provide vital health care services to its most medically vulnerable residents.

The rule under development would alter the manner in which the Cook County Bureau of Health Services (covering three hospitals, 30 clinics, and public health services) and all government institutional health facilities are reimbursed under a Medicaid reimbursement ceiling called the "Medicare upper limits" test. This would clearly limit Cook County's ability to provide uncompensated care for the county's uninsured. In fact, this rule could severely restrict many public hospitals in their mission to provide health care to the uninsured.

It is our understanding that the rule is being developed to address concerns that HCFA has with violations in other states of Sec. 4724 of the Balanced Budget Act of 1997 (BBA). Sec. 4724 prohibits states from using Medicaid funding for non-health related spending, including spending on roads, bridges and stadiums. However, the proposed rule change does not address violations of this section of the BBA. Instead it is targeted at restricting payments to government operated facilities. A more appropriate remedy for violations of Sec. 4724 would be to require a dedicated health care fund for money drawn down through Intergovernmental Transfers (IGTs), with full accounting to assure that all Medicaid dollars are in fact spent on health care services.

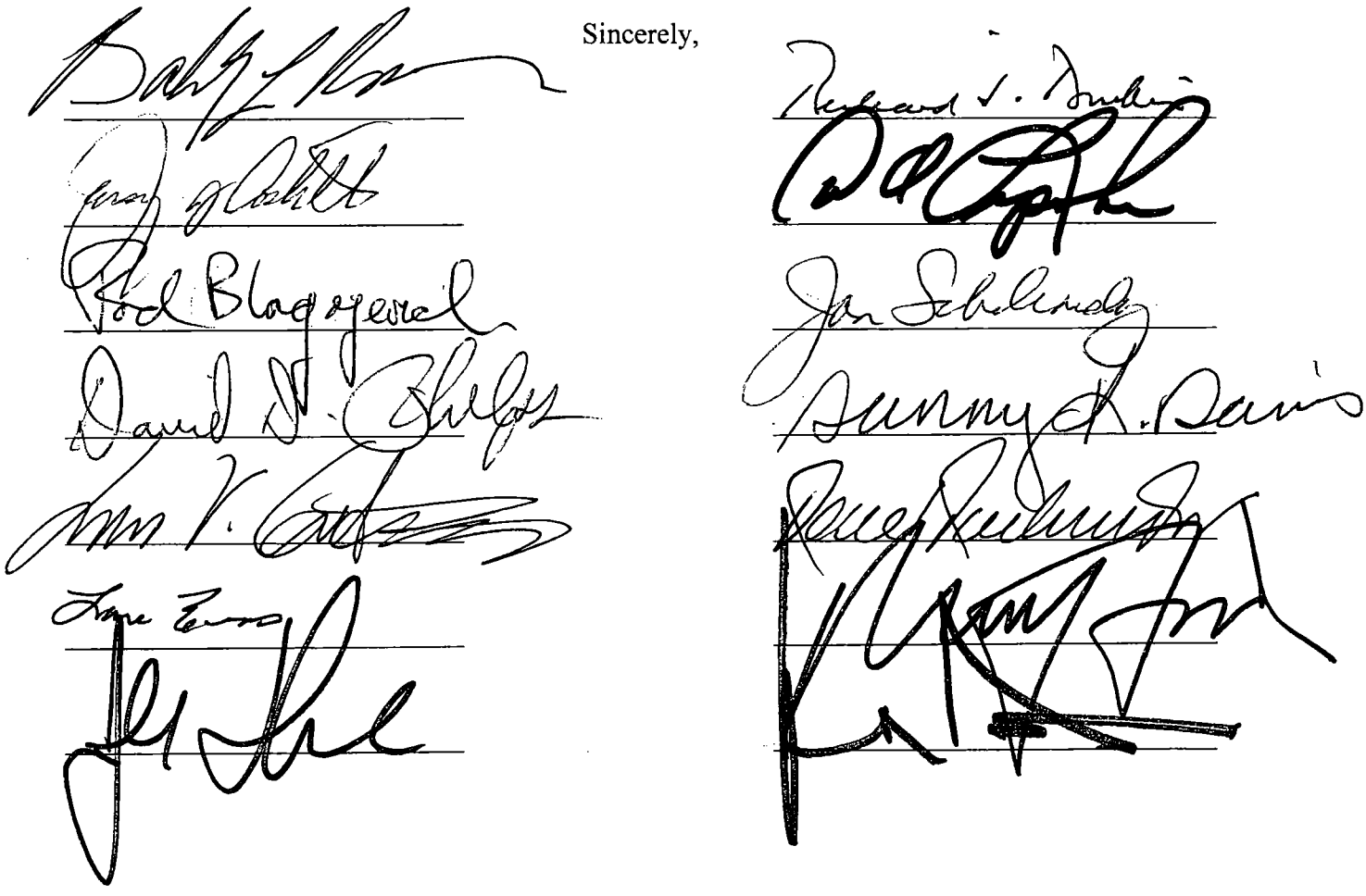
Illinois does not use Medicaid funding for non-health related spending. Yet Illinois would be very adversely affected by this poorly targeted proposed rule. The proposed change, as we understand it, would undermine the State of Illinois' IGT Agreement with Cook County, which originated in 1991 and was amended in 1996, 1998 and 1999. Since its inception, the IGT Agreement has been in full compliance with the Code of Federal Regulations (42 CFR 447.272 and 42 CFR 447.321) and has earned the ongoing approval of the Health Care Financing Administration. HCFA's proposed rule change would have an immediate and drastic effect on Illinois' ability to deliver health services to its neediest families.

The state of Illinois has committed over the last few years to ensuring that the health care needs of children and families in the state are met. The state has embraced a variety of the Administration's programs and initiatives, including the State Children's Health Insurance Program (SCHIP), and the Ticket to Work-Work Incentives Act. Through the IGT Agreement, the state has enhanced the ability of pregnant women and children to receive needed health services. The IGT Agreement has also enabled the County to provide a comprehensive 'safety net' of health services for its patients, 80% of whom are uninsured. All of these new programs would be put in jeopardy by HCFA's proposed rule. The rule could jeopardize the entire Children's Health Insurance Program in Illinois and the new Ticket to Work-Work Incentives Act for Illinoisans with disabilities. Furthermore, it could financially cripple the Cook County health system so that it was no longer able to provide necessary uncompensated care for county residents.

Your Administration has been particularly focused on increasing access for all Americans to health care. We are therefore asking for your direct intervention to ensure that the efforts of both the State of Illinois and Cook County are not undermined and that access to important health care services continue. We are asking that the proposed rule be withdrawn and that the Administration work with us on an approach that addresses violations of Sec. 4724 without doing damage to the health care advances that are in place in our state.

Thank you in advance for your immediate attention to this matter. We are available to discuss this matter with you at your convenience.

Sincerely,



Thomas W Ewing

Philip M. Crane

Judy Biggert

cc: The Vice President
The Honorable Donna E. Shalala