Congress of the United States

Washington, DC 20515

June 27, 2000

√cc: Chris Jennings

Mr. John Podesta
Chief of Staff to the President
The White House Office
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Mr. Jacob L. Lew
Director, Office of Management and Budget
Executive Office of the President
Executive Office Building
Washington, DC 20503

Dear Mr. Podesta and Mr. Lew:

We, the undersigned Democratic Members of the Pennsylvania Congressional Delegation, are writing to ask for your intervention to stop the issuance of a pending Health Care Financing Administration (HCFA) regulation. We are concerned that it will jeopardize safety net services to low-income Pennsylvanians who use nursing home care, home-based care and supportive living arrangements.

HCFA's regulation would establish an upper payment limit for government-owned nursing facilities that would be separate and distinct from that of private nursing facilities. This technical change will limit the ability of state and county governments to rely on intergovernmental transfers (IGTs) for funding of needed services for low-income, elderly and disabled individuals, even though the IGTs have been protected by federal law since 1991. The Pennsylvania Department of Public Welfare advised our organizations that it anticipates the loss of 80 percent of the funding now part of the IGT if this regulation is approved.

It is our understanding that HCFA has proposed this change to curb abuses with the funding mechanism in some other states. While we believe it is appropriate for the federal Medicaid program to have an upper payment limit, we fear that HCFA's proposal will be so restrictive that it will destroy the program balance which has helped Pennsylvania make tremendous strides in long-term care.

Pennsylvania has used its IGT funds exclusively for healthcare-related purposes since its inception in 1991. We believe this source of funding is essential and should be protected for the following reasons:

- It provides improved services and quality of life for Pennsylvania's elderly and disabled.
- It helps support safety net services provided by Pennsylvania's county governments.
- It provides savings to the state and federal government in the long term, through the development of a community-based infrastructure of services.
- It helps states and long-term care facilities provide appropriate and quality services in the face of greater costs from federal statutory requirements.

States' authority to use IGT funds in the Medicaid program was protected by Congress in 1991. Perhaps the use of intergovernmental transfers deserves reexamination by Congress and we welcome that debate. We are not advocating that fiscal irresponsibility with Medicaid dollars be tolerated. However, Pennsylvania has been relying on the use of IGTs with HCFA's approval to serve its significant number of elderly and indigent residents. We fear that a hastily drafted regulation will have a huge, sudden, negative impact on the nursing homes, home health and mental health services in several large states. Such action would harm the very same vulnerable population we are trying to protect.

Please intervene with Secretary Shalala and express your opposition to the proposed regulation. Thank you.

Sincerely,

JOHN P. MURTHA

RON KLINK

ROBERT BORSKI

PAUL KANJORSKI

TIM HOLDEN

CHAKA FATTAH

FRANK MASCARA

JOSEPH HOEFFEL

ROBERT BRADY

MIKE DOYLE

WILLIAM COYNE

CC: Podesta
Tramontano
Lew
Mathews
Ibarra
Beyer
Jennings

Correspondence

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

ROBERT MENENDEZ
13TH DISTRICT, NEW JERSEY
VICE CHAIR OF THE DEMOCRATIC CAUCUS

COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE
SUBCOMMITTEES:
AVIATION
WATER RESOURCES AND ENVIRONMENT

COMMITTEE ON INTERNATIONAL RELATIONS
SUBCOMMITTEES:
INTERNATIONAL ECONOMIC POLICY AND TRADE
WESTERN HEMISPHERE

Congress of the United States

House of Representatives

Washington, DC 20515–3013

June 27, 2000

REPLY TO:
☐ 405 CANNON H.O.B.
WASHINGTON, DC 20515–3013
(202) 225–7919

DISTRICT OFFICES:
☐ 911 BERGEN AVENUE
JERSEY CITY, NJ 07306
(201) 222–2828
☐ 654 AVENUE C
BAYONNE, NJ 07002
(201) 823–2900
☐ 263 HOBART STREET
PERTH AMBOY, NJ 08861
(732) 324–6212
☐ 3109 BERGENLINE AVENUE
2ND FLOOR
UNION CITY, NJ 07087
(201) 558–0800

cc: Chris Jennings
Jeanne Lambrew

Mr. John Podesta
Chief of Staff
The White House
1600 Pennsylvania Avenue NW
Washington, D.C. 20500

Dear Mr. Podesta:

I understand that the Health Care Financing Administration (HCFA) is planning to issue a proposed rule that will modify the existing federal Medicare upper payment limit, which is intended to curb states' use of intergovernmental transfers (IGTs) to draw down federal Medicaid dollars. I am writing to ask that you re-evaluate the timing of this decision.

I am not writing to debate the underlying intent of HCFA's action; however, I do have an immediate concern about the timing of HCFA's process and how that interfaces with state budget processes. The publication and ultimate implementation of this proposal will essentially change the rules in the middle of the game. Many states, including New Jersey, are finalizing, or have already finalized, their budgets for this year. Some of them have done so assuming that this legal and allowable funding mechanism would be available to them, as it has been to numerous other states.

I understand that HCFA's fast-track approach to this issue is clearly intended to shut out those states that have not traditionally taken advantage of IGTs. However, I believe that it also raises an equity issue between the states that are currently utilizing IGTs and those that are not. My understanding is that those states with approved Medicaid State Plan Amendments will continue, for a set amount of time, to benefit from the use of IGTs through anticipated transition rules. So, not only would HCFA change the rules mid-game for states awaiting approval, but they would create and perpetuate an inequity among states.

As a result, I respectfully request that HCFA give further consideration to these concerns. The timing of this proposed change seems ill-advised on many different levels, and perpetuating a system of state "haves" and "have-nots" seems to be equally ill-advised. I believe that, through further consideration, these concerns can be addressed and a reasoned, equitable approach to this issue can be accomplished. To that end, I urge HCFA to delay and revise the proposed rule.

Thank you for your consideration of these concerns, and I look forward to your prompt response.

Sincerely,

Robert Menendez
Member of Congress

RM:kw

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updated 5/12/00

State Payment Methodologies

Disclaimer: This chart lists the payment methodologies that include an additional payment for services in non-State-operated governmental facilities. The information on this chart has been reported by States and was derived from State plan amendments submitted to HCFA. The financial statements in this chart have not been validated by HCFA nor have cost-settlements necessarily occurred based on actual payments. Further, it may not represent all payments that will be affected by the proposed upper payment limit regulation or may include payments that will not be affected by the regulation. The purpose of the chart is to illustrate the range and scope of payments that may be impacted by a change in the way HCFA implements the Medicare upper payment limit regulations.

RAI: request for additional information sent to State by HCFA
PSP: proportional share payment

State	SPA #	Annual Federal Fiscal Impact*	1st 90th Day	RAI Issued	State Response Received	2nd 90th Day	Date Approved	Type	Comments**
Alabama	99-02	30,600,000					06/16/99	NF	Payments to rural hospital based NF's
	95-14	30,000,000					9/25/95	IH	Payment adjustment for urban and rural public hospitals based on Medicaid costs.
	95-03	23,000,000					02/01/95	OH	Public hospitals receive supplemental payments determined by the Director of Medical Assistance by analysis of costs incurred and payments already received.
Alaska	00-02	12,000,000	7/11/00					IH	Payment adjustment for government owned hospitals.
Arkansas	concept								The State has received copies of plan amendments from other States (PA? & TN?) and has expressed interest in enhanced payment/ IGT arrangements.
Colorado	91-20	?					1991	IH	Medicaid Major Teaching Hospital Payment (MTHP) Colorado has had special funding for their teaching hospitals since 1991.
Georgia	99-19	402,000,000	3/29/00	3/23/00				IH	Payment adjustment to certain hospitals including any state-owned and operated. State is very vague as to payment.
Illinois	99-09	147,000,000	3/5/00	2/24/00			2/24/00	IH	Direct Hospital Adjustment Payment for county owned hospital. Rates very from $20-100 or $115-195 for obstetrical hospitals with additional payments from $30-$410 per Medicaid Inpatient utilization rate.

State	SPA #	Annual Federal Fiscal Impact*	1st 90th Day	RAI Issued	State Response Received	2nd 90th Day	Date Approved	Type	Comments
Illinois con't	95-19	100,000,000					2/16/96	OH	County owned hospitals in IL with population of over 3 million receive funds from a $200 million pool (Cook County).
	96-13	6,200,000					4/29/97	IH	County hospitals with a population over 3 million receive an adjustment of $15,500 per Medicaid inpatient admission for all future years (Cook County).
	94-13	20,000,000					2/10/95	NF	County NF's receive funds when allowable costs incurred are greater than reimbursable costs.
Indiana	99-05	0+					7/13/99	IH	Add on payment to compensate hospitals that deliver hospital care for the indigent program service; no rate amount listed.
	98-12	0+					2/5/99	IH	Payment adjustment for municipal hospitals; no rate amount listed.
Iowa	99-?	99,600,000 (9 mth)	3/27/00	3/27/00	3/31/00	6/29/00		NF	PSP: Incentive payments to NF's
	97-30	3,331,000					12/28/97	IH	Add on cost per discharge payment for direct and indirect medical education for state owned hospitals.
Kansas	00-01	72,000,000 (9 mth)	6/22/00					NF	PSP: Incentive payments to county NF's
Kentucky	97-03	0+	6/26/97	6/23/97				IH	Teaching hospitals assoc. with University of KY & Univ. of Louisville are paid an upper limit set at 106% of the weighted median per diem cost of all other comparable hospitals.
Louisiana	concept							NF	The Legislature is seriously considering using enhanced payments for NF's. The Legislature has gained approval from one of its committees. The Medicaid agency has informed us that a delegation from the Legislature is is trying to schedule a meeting w/ Sec. Shalala on this issue (last report was early May).
Michigan++	99-16	152,045,735	4/4/00	3/31/00				OH	Hospital pools of $ 350 million; no rate methodology for distribution.
	96-07	165,600,000	Jan. 97					NF	PSP: Incentive payments to county NF's
Missouri	?	60,000,000	7/24/00					NF	PSP: Incentive payments to county NF's

State	SPA #	Annual Federal Fiscal Impact*	1st 90th Day	RAI Issued	State Response Received	2nd 90th Day	Date Approved	Type	Comments
Missouri con't	99-13	5,433,000	9/28/99	9/24/99				IH	Enhanced payment for Direct GME cost to safety net hospitals or children's hospitals.
Minnesota	?	?					approved	NF	Add $16 per bed/per day to county NF's
Montana	concept							NF	Contemplating-The State has submitted questions regarding pooling and IGT's. (Public NF's)
Nebraska	97-10	55,400,00					3/1/98	NF	PSP: Incentive payments to county NF's
New Jersey	?	450,000,000	6/2/00					NF	PSP: Incentive payments to county NF's
North Carolina	99-17	177,555,655					12/22/99	IH	Public hospitals entitled to a lump sum payment equal to costs of Medicaid services plus Medicaid's portion of GME programs, minus Medicaid payments to a public hospital. Hospital must file a certificate of public expenditures with state (IGT).
	95-18A	11,387,650					Jan-97	OH	Public hospitals receive supplemental payments determined by the Director of Medical Assistance by analysis of costs incurred and payments already received.
North Dakota	99-03	7,200,000					Sept. 99	NF	PSP: Incentive payments to county NF's
Oregon	99-06	17,500,000					7/21/99	IH	GME payment for public teaching hospitals. Medicaid costs based on impatient days.
	99-01	25,000,000					4/15/99	NF	Ensure access to care at public operated NF's.
	concept							IH	State has expressed interest in SPAs that have additional payments to public inpatient acute care hospitals with a major teaching program for general practitioners.
Penn.	00-03	6,600,000					6/29/00	NF	Payment adjustments to NF's.
	91-07	475,000,000					11/20/91	NF	PSP: Incentive payments to county NF's

State	SPA #	Annual Federal Fiscal Impact*	1st 90th Day	RAI Issued	State Response Received	2nd 90th Day	Date Approved	Type	Comments
South Carolina	99-07	25,696,000	3/22/00	3/20/00				IH	Small hospital access payment to qualified hospitals; High volume Medicaid adjuster payment. No rate/dollar amount specified.
South Dakota	00-01	10,308,000	6/3/00					NF	PSP: Incentive payments to public owned NF's
Tennessee	99-08	75,200,000	3/14/00	3/14/00	4/4/00	7/3/00		NF	PSP: Incentive payments to county NF's
Texas	concept								The Regional Office has received general questions from the State as to what some of the other States have done in this area and how it works
Utah	00-03	0+	7/8/00					IH	Utah Medicaid will transfer GME funds to a Medical Education Council to be distributed to teaching hospitals.
Virginia	98-15	0+					12/23/98	IH	State owned teaching hospitals receive approx. 60% more funds for indirect medical education.
Wash.	99-08	14,000,000					09/13/99	NF	Payments to hospital operating NF's to improve access in rural areas.
	concept							IH	Rumored to be submitting one or two Spas with additional payments. One SPA is similar to OR's program for GME.

Annual Fed. Total: **$2,452,657,040**

* Data taken from the HCFA-179. However, this is an initial Federal payment. This money may be recycled by the State to draw down another Federal payment for Medicaid.

**Additional payments to public providers may bring providers up to the costs incurred.

+ State claims no Federal fiscal impact (budget neutral).

++Michigan has a long history of using IGT's and paying public providers enhancement payments. This chart only shows the most recent State plan amendments for all States.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

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

DETERMINED TO BE AN ADMINISTRATIVE MARKING
INITIALS: RLCR DATE: 06/11/12
2012-0463-S

~~**CONFIDENTIAL**~~
DRAFT

Dear State Medicaid Director:

I regret that it is necessary to write this letter.

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

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

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

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

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

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

delete

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

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

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

During the time that this rule is being developed, published, and made final, we will use the discretion granted us under the law to avoid affirming any State Plan Amendment creating arrangements of this sort. If, prior to the effective date of the new rule, such a State Plan Amendment reaches the final date for the Health Care Financing Administration (HCFA) action established in the law, it will be deemed effective by virtue of the law, but it will not be affirmatively approved. 2We will exercise our legal option to ask for additional information in all cases; thus, the minimum time for action on such a State Plan Amendment can be expected to be 180 days.

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

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

Sincerely,

Timothy M. Westmoreland
Director

Chris
456-5557

Tim —
one page
[illegible]
conversation
[illegible]

From: "Libbie Buchele" <lbuchele@os.dhhs.gov>
To: BALT2.CO2(RWeaver)
Date: 5/22/00 10:52am
Subject: from today's Medicine & Health

HHS EYES STATE TACTICS TO BOOST MEDICAID MATCHING FUNDS

HCFA and the HHS Inspector General are actively reviewing the growing use of schemes by states to transfer funds into their accounts to boost the value of state dollars eligible for federal Medicaid matching money -- and to transfer them back out again without actually committing to Medicaid the added state dollars used to generate the higher federal matching funds.

A recent New Orleans Times-Picayune story explains the tactic this way: "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 parish-owned nursing homes and your dad is the federal government. Talk in millions instead of twenties and fifties and that, in the most general of terms, is how a private consultant is saying Louisiana could save its troubled Medicaid budget."

The problem from HCFA's point of view is that the state isn't actually committing any more of its own funds to Medicaid that would justify the higher federal matching dollars. And while the added federal dollars often go to serve the Medicaid population, there's increasing concern that they do not.

The Louisiana paper said the arrangement, pitched by a Philadelphia consulting firm, could entail, for example, having nursing homes operated by parishes or municipalities borrow $175 million from banks, transferring it to the state to generate $408 million from Washington, then funneling the $408 million into the Medicaid program and returning the $175 million to the nursing homes. Earlier this year, Kansas was talking about using the tactic not only to fund nursing home care but to provide Rx payment assistance to low-income seniors and to hike per-pupil spending in public schools.

HCFA's concern is that such tactics drive up the cost of Medicaid and make taxpayers subsidize the Medicaid programs of a few states. Almost a dozen states are said to be using the transfer tactics to draw down more federal Medicaid dollars.

Richard Durbin
UNITED STATES SENATOR ■ ILLINOIS

FAX

+ Time Sensitive

TO: Chris Jennings Melissa

OFFICE: _____

FAX NO: (_____) _____

FROM: Anna Maria Kulik

PHONE: (2 0 2) _____

DATE: _____

PAGES *(including this cover sheet)*: _____

NOTE: Illinois Delegation will be sending this letter. Senator Durbin has already spoken to Secretary Shalala on this topic + is timely to bring it up with the President

364 Russell Senate Office Building • Washington, D.C. 20510 • (202) 224-2152 (202) 228-0400-fax

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,

_____ _____

_____ _____

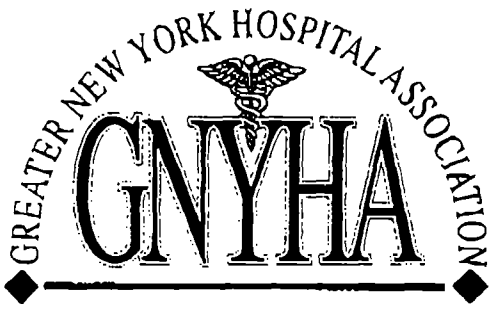
_____ _____

_____ _____

_____ _____

_____ _____

_____ _____



FACSIMILE TRANSMISSION

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

Date: _____

Time: _____

TO: CHRIS JENNINGS
Name
202/456-5557
Location

FROM: KEN RASKE
Name

Location

We are transmitting 4 pages including this cover sheet. If you have not recieved all of the pages, PLEASE CALL OUR OFFICE AS SOON AS POSSIBLE.

Message: CHRIS, I JUST WANTED YOU TO HAVE THIS FYI.

KEN

Main Number 212/246-7100
Fax Number 212/262-6350

Hard Copy [ ] will [ ] will not be sent by mail.

GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA
Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

May
Twenty Three
2000

VIA FACSIMILE AND MAIL

Nancy-Ann Min DeParle
Administrator
U.S. Health Care Financing Administration
309-G Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20101

Re: Medicaid Upper Payment Limit Regulations

Dear Ms. DeParle,

I very much appreciate the opportunity to share GNYHA's thoughts on changes that the Health Care Financing Administration (HCFA) is contemplating making to the Medicaid upper payment limit (UPL) regulation, 42 C.F.R. section 447.272, which the caps the Medicaid payments a State may make to providers.

We are very concerned that the changes being considered would have a significant adverse effect on funding for New York's extensive array of health care programs, including Medicaid, the budget for which was just finalized and which included an extension of current law payments without any new provider cuts. We fear this effect because, as contemplated by section 1903(w)(6)(A) of the Social Security Act, New York has traditionally used and continues to rely upon funds transferred or certified by local governments as the non-Federal share of its Medicaid expenditures for both acute and long term care services. Such provisions have been part of New York's approved Medicaid state plan for many years, and the funds generated by them has helped to fund public providers as well as freed up purely State dollars to achieve other critical priorities on New York's health care agenda.

Some examples of these priorities that New York has undertaken as state initiatives include newly created health insurance expansions, subsidies, and demonstration programs for families, low income workers, and small businesses; continuation and significant expansion of prescription drug subsidies for the elderly and for persons with HIV; health education and anti-

smoking campaigns; mental health initiatives; public health programs for pregnant HIV-positive women and their children; until passage of Federal legislation, a state-only Child Health Plus health insurance program; and a myriad of other public health, health service, and outreach initiatives that have sought to meet the needs of medically underserved and low income populations over the years. The amounts spent on such State-funded programs has no doubt easily met or exceeded the amounts that might be identified under the new UPL parameters HCFA is considering.

New York's health care infrastructure for vulnerable patients is progressive and extensive. It is also financed through complicated and inter-related funding streams which include taxes on payers (and, now, on cigarettes) as well as the Medicaid program. As I know you appreciate, maintenance of historical funding levels for Medicaid - including State budget assumptions regarding the amount of available Federal Financial Participation (FFP) -- is critical to maintaining this infrastructure. We were extremely fortunate at the end of last year when agreement was reached among the Governor and both houses of the State legislature to maintain New York's excellent health care system for all patients, including those covered by Medicaid or not insured at all. This resulted in an extension of the New York Health Care Reform Act (HCRA), which established pools for indigent care, graduate medical education, public health programs, and other health care priorities; the creation of the significant insurance expansions described above, and a commitment not to make further cuts in the Medicaid program for the next three years. All of these programs were enacted assuming certain levels of support for the Medicaid program

This State legislation is absolutely critical to maintaining the viability of hospitals, health centers, and other providers who are otherwise feeling intense financial pressures from changes in the reimbursement climate, managed care discounts and denials, and increasing numbers of uninsured patients. It is especially critical to providers who serve low income populations.

Our analysis of institutional cost reporting data submitted by hospitals for 1997 and 1998 showed that there was significant deterioration in both operating and bottom line margins. Operating margins declined from 1.63% in 1997 to 0.15% in 1998, and bottom line margins dropped from 1.83% to 0.86%. Our preliminary data from 1999 shows that this downward trend continued. This is further confirmed by a comparison of operating margins for 166 hospitals around the State performed by the Healthcare Association of New York State from audited financial statements and survey data, which found that there was significant operating margin deterioration from 1998 to 1999 Statewide (from -0.6% to -1.8%) and in New York City as well (from -0.6% to -2.1%). Our hospitals could not withstand cuts in the Medicaid or other health care programs.

We understand that you are considering different changes to the regulation and we do not purport to address the situation is in other states. However, we would greatly appreciate it if HCFA would consider the following points, which are relevant to New York's health care infrastructure.

- We understand that HCFA's concerns may have been triggered by certain activities by states that may have drawn down Federal Medicaid funds for non-health care related purposes, and that such practices may even have raised concerns about possible improprieties. We urge that, to the extent possible, egregious situations should be addressed on their own merits rather than through revision of regulations of general applicability that will have unintended and undesirable effects on providers of care and low income patients in states like New York.

- If the new upper payment limit requirements are pursued, then they should not be applied to states that have dedicated funds to health care programs for the underserved in amounts that are equivalent to those derived from otherwise permissible local government contributions.

- In the alternative, if the new requirements were to apply, then, in order to avoid disruption to state health and Medicaid programs and in recognition that the new requirements would negate established state budget assumptions and practices, current levels of Medicaid funding resulting from local government funding should be grandfathered and could be capped, but should not be required to decrease or be eliminated.

As you know, we are tremendously appreciative of the work that you and HCFA undertake every day and thank you for your willingness to consider our concerns. Please call me if you have any questions whatsoever on this issue.

My best.

Sincerely,

Kenneth E. Raske
President

Susan J. White & Associates, Inc.

1020 North Fairfax Street
Suite 202
Alexandria, VA 22314

TELEPHONE: 703 683-2573
TELECOPIER: 703 683-0865

Memo To:	Chris Jennings, Deputy Assistant to the President for Health Policy Development
Fax:	202 456-5557
Pages:	Five
From:	Susan J. White, Cook County Washington DC Representative
Date:	May 24, 2000
Subject:	**Meeting Request; President Stroger Letters to the President and Vice President**

I wanted to be certain that you had copies of the letters from John Stroger, President of the Cook County Board of Commissioners, to the President and Vice President on the subject of Intergovernmental Transfers and the impact on Cook County.

President Stroger's Chief of Staff, Orlando Jones, and the Chief of the Bureau of Health Services, Ruth Rothstein, and others for Cook County along with representatives from the State of Illinois will be in a meeting with the Vice President's office tomorrow at 2 PM.

I understand that the State of Illinois via its representatives here in Washington has also requested a meeting with you on this important issue. Cook County would participate in this meeting as well.

If there is some information I can furnish or some way in which I can be helpful, please let me know.

Attachments

OFFICE OF THE PRESIDENT
BOARD OF COMMISSIONERS OF COOK COUNTY
118 NORTH CLARK STREET
CHICAGO, ILLINOIS 60602
(312) 443-6400
TDD (312) 443-5255

JOHN H. STROGER, JR.
PRESIDENT

May 22, 2000

The Honorable William Jefferson Clinton
The President of the United States
The White House
Washington, DC 20500

Dear Mr. President:

I am seeking your help to prevent an action by the Health Care Financing Administration (HCFA) that would have a devastating impact on the finances of the Cook County Bureau of Health Services and Cook County government.

I have recently learned that HCFA is developing a rule that could have the effect of cutting Medicaid payments to the Cook County Bureau of Health Services by up to $200 million annually. That represents nearly two-thirds of the Bureau's total Medicaid revenue, or 30 percent of the Bureau's total budget. The contemplated rule could also cut more than $300 million from the State of Illinois health care program.

The rule under development could alter the way in which the Bureau (which includes three hospitals, 30 clinics and public health services throughout the nation's third largest county) and all government institutional health facilities are subject to a Medicaid reimbursement ceiling called the "upper limits" test. Such a proposed change would undermine the State of Illinois' Intergovernmental Transfer (IGT) Agreement with Cook County, which was established in 1991 and is authorized and compliant with federal regulations 42 CFR 447.272 and 42 CFR 447.321 -- the sections proposed to be amended by the new rule. I understand that the rule is being developed to address concerns that HCFA has with a small number of other states, not with Illinois, involving nursing homes, not public hospitals.

During the years that the IGT has been in place, with full, ongoing approval from HCFA, Cook County has committed significant resources to improving access to health care for the uninsured. We cannot overemphasize the immediate, negative impact the proposed HCFA rule change could have on Cook County's ability to deliver health services to its neediest families.

For many years, we have worked with your Administration to ensure that the health care needs of children and families in Cook County are being met through a variety of programs and initiatives. The County now operates a comprehensive 'safety net' for patients, 80% of whom are uninsured. The Bureau has enrolled more children in the Illinois KidCare program than any other provider in the State of Illinois. Your direct intervention is critical to ensuring that the County's efforts are not undermined and that access to important services continues.

There has never been an administration in Washington as sensitive as yours is to the needs of the uninsured and the role that public hospitals play in the health care safety net. I urge you to use your influence to insure that public hospitals are excluded from the devastating impact the proposed HCFA rule would otherwise have. We ask that the proposed rule not be issued, and please assure that HCFA does not continue down this path.

Thank you for your assistance.

Sincerely,

John H. Stroger, Jr.

OFFICE OF THE PRESIDENT
BOARD OF COMMISSIONERS OF COOK COUNTY
118 NORTH CLARK STREET
CHICAGO, ILLINOIS 60602
(312) 443-6400
TDD (312) 443-5255

JOHN H. STROGER, JR.
PRESIDENT

May 22, 2000

The Honorable Albert Gore
The Vice President of the United States
The White House
Washington, DC 20501

Dear Mr. Vice President:

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Thank you for your assistance.

Sincerely,

John H. Stroger, Jr.

To: Jeanne L.
From: Caroline/Jeff/Lilly

DRAFT
May 22, 2000

SUGGESTED LANGUAGE FOR LABOR-HHS APPROPRIATIONS CONCERNING APPLICATION OF THE UPPER LIMITS TEST

Background:

HCFA is drafting an amendment to Federal regulations which set forth what is known as the "upper limits" test. Under the upper limits test, State Medicaid spending is limited to what would have been paid using "Medicare payment principles" – i.e., the total amount that the Medicare program would have paid for the same services. The test is applied in the aggregate statewide, rather than on a facility-by-facility basis.

In addition, the Medicaid regulations impose a separate sub-limit for "State-operated" facilities in each of the three classes of inpatient facilities -- hospitals, nursing facilities and intermediate care facilities for the mentally retarded. This limit also is imposed within each sub-category on a statewide basis. With respect to the upper limits test, HCFA reportedly is proposing to change the phrase "State-operated" to "government-operated," thereby including county, township and other local government-owned facilities in the separate sub-limit.

The Issue:

The proposed HCFA rule change contradicts years of hard work and cooperation between State, Federal and local officials to finance critical health care programs for our nation's neediest citizens. The HCFA would place an additional and serious constraint on a State's ability to design its Medicaid program in a way that best meets its citizens' health care needs. Specifically, the proposed change would limit a State's ability to direct higher rates into facilities that are in most need of these rates. Some states pay certain hospitals higher rates than others, based on the percentage of services they provide to Medicaid beneficiaries and other low-income individuals. Section 6005 of the HCFA State Medicaid Manual explicitly recognizes that this is permissible under the existing "upper limits" test.

Suggested Bill Language:

"Notwithstanding any other provision in law, the Committee directs HCFA not to issue proposed regulations that would modify the upper limits test applied to State Medicaid spending pursuant to 42 C.F.R. §§ 447.272 and 447.321."

Suggested Report Language:

"The Committee is aware that HCFA is developing regulations that would modify the upper limits test applied to State Medicaid spending pursuant to 42 C.F.R. §§ 447.272 and 447.321. Notwithstanding any other provision in law, the Committee directs HCFA not to issue proposed regulations absent additional explicit Congressional direction."

4242509

Doc 538867

OFFICE OF THE GOVERNOR
STATE OF MISSOURI
JEFFERSON CITY
65101

MEL CARNAHAN
GOVERNOR

STATE CAPITOL
ROOM 216
(314) 751-3222

June 22, 2000

The President
The White House
Washington, DC 20500

Dear Mr. President:

I am writing in regard to an important matter to the State of Missouri. It has come to my attention that the U.S. Department of Health and Human Services (HHS) intends to publish regulations that would significantly restrict a state's ability to secure Medicaid federal matching funds needed to provide critical health-related services to vulnerable populations. Under current law, states are permitted to file claims for federal matching funds to help in efficiently operating their Medicaid programs.

One area of tremendous importance in Missouri is adequate reimbursement for nursing facility services. On April 21, 2000, Missouri submitted a state plan amendment to secure additional Medicaid funds using the Intergovernmental Transfers (IGT). Under Missouri's plan, every penny would go into the state's nursing home program. At a time when this industry is being asked to care for more and more vulnerable citizens, these funds would be a crucial step in the right direction. We are asking your help in stopping HHS from issuing this regulatory change.

I appreciate your attention to this serious matter. Please let me know if you need any additional information.

Very truly yours,

Mel Carnahan

Mel Carnahan

MC:kds

GOVERNOR GRAY DAVIS

cc: Podesta
Ibarra
Jennings
Lee
Mathews
Tramontano
Benez

June 21, 2000

The Honorable Bill Clinton
President of the United States
The White House
1600 Pennsylvania Ave., NW
Washington, D.C. 20500

Dear President Clinton:

I am writing to express my serious concern with the pending rule that may limit federal Medicaid funding for beneficiary services and providers in California. The Health Care Financing Administration (HCFA) intends to publish regulations that will reduce essential federal Medicaid funding for California's public and private hospitals providing care to Medicaid patients.

I fully support HCFA's intent to preserve the Medicaid program's fiscal integrity. However, I would oppose regulations that would have detrimental effects on access to services and the delivery system providing care to Medicaid beneficiaries and the general population. While it is important that the federal government prevent the spending of Medicaid funds for uses other than health care, the proposed change has significant unintended consequences on funding for health services. These proposed rule changes should be drafted so as not to affect Medicaid funding for programs that maintain access to health care.

Currently, California administers the Selective Provider Contracting Program (SPCP) which uses intergovernmental transfers. Under this program the State negotiates Medi-Cal reimbursement rates with each selected provider and provides supplemental payments that ensure Medicaid beneficiaries' access to care. Most notably, these program funds assist hospitals in maintaining the operation of emergency rooms and trauma centers. Limiting these programs would jeopardize health care services for Medicaid beneficiaries and would likely lead to the closure of emergency rooms in California. The State of California does not transfer any of these funds back to the State for any purpose. All funds in this program go exclusively for its intended purposes.

The program operates under a "1915(b)" HCFA waiver that requires the SPCP to be cost effective and has saved the state and federal government billions of dollars over the last seventeen years. HCFA renewed the SPCP waiver in December 1999, after an extensive review of the program.

HCFA intends to release the proposed regulations within the next few weeks. To avoid detrimental effects on essential health services, the proposed rule should be revised to allow for the continuation of existing Medicaid programs that are cost effective and ensure access to services for Medicaid beneficiaries and low-income patients.

Thank you for your attention in this matter.

Sincerely,

Gray Davis

GRAY DAVIS

OPTIONS FOR MEDICAID UPL ISSUE

	Vehicle	Policy	Timing	Implications*
1	Current NPRM	Apply the upper payment limit requirement to county/local hospitals and nursing homes, excluding private providers Current states: Transition could same as other new regulations	Pending/ future states: Could be disapproved November 1 at earliest when final reg takes effect Current states: Would have to comply either immediately on November 1 or at end of next state legislative session	Has been leaked; has generated concern from hospitals, states, members Legislation to block action likely to get high score with this option since it is the most aggressive
2	NPRM with public hospital transition	Apply the upper payment limit requirement to county/local hospitals and nursing homes, excluding private providers Current states: Build in explicit transition	Pending/ future states: Could be disapproved November 1 at earliest when final reg takes effect Current states: Allow public hospitals 3 to 5-year transition	Transition would increase acceptability of NPRM, although we have not yet vetted the idea Legislation to block action may get a lower score with this option due to the transition
3	Notice of Intent / Advanced NPRM	Publish a statement with our concerns about abuses and public hospital inpact; commit to ending practice, ask for specific ideas on options, impact and transitions within 30 days	Pending/ future states: Could be disapproved January 1 at earliest when final reg takes effect Current states: Final regulation would be published December 1 and would probably include some type of transition	Allows for more buy-in to the NPRM Legislation to block action may get a lower score before NPRM
4	Same as above with legislative proposal to stop paying on pending plan amendments	Announce support for legislation that allows us to stop paying on pending/future state plans Publish Notice now, NPRM in September	Pending/ future states: Could be disapproved upon enactment o legislation (July, September) Current states: Final regulation would be published January 1 and would probably include some type of transition	Legislation to stop payments would produce savings Legislation to block action may get a lower score before NPRM

* All options assume that Administration acts before Congress does.

Likely CBO Scoring of UPL Amendments

CBO approach to scoring legislative actions

- CBO scoring of amendments is dependent on HCFA action indicating Medicaid UPL rule will be issued. If no action, probability of scoring decreases.

- Strength of HCFA action affects the size of CBO's baseline adjustment. Strongest action is publication of final rule, but CBO not likely to distinguish between NPRM and NOI.

Amendment Options

1. Prohibition on HCFA publishing regulation

Assuming publication of an NPRM or NOI, this amendment has highest costs. Costs result from baseline impact and "advertising effect."

Assuming no publication of NPRM or NOI, amendment still has modest costs due to "advertising effect."

2. Amendment that (1) imposes a moratorium on payments for new and pending State Plan Amendments and (2) grandfathers existing State Plan Amendments.

Assuming publication of an NPRM or NOI, amendment has costs due to grandfathering, but costs are lower than prohibition against HCFA rule. CBO unclear on scoring of new and pending State Plan amendments.

Assuming no publication of NPRM or NOI, CBO likely to score no or small costs due to grandfathering existing plans, and potentially savings from pending and new plans.

Impact of NPRM Options on CBO Baseline

NPRM published as is (i.e. no transition period) – Results in largest downward adjustment to CBO baseline. Any subsequent legislative action has largest scoring effect.

NPRM published with 3-5 year transition period – CBO baseline adjusted downward, but not as much due to costs incurred during transition period. Any subsequent legislative action has smaller scoring effect.

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updated 5/12/00

State Payment Methodologies

Disclaimer: This chart lists the payment methodologies that include an additional payment for services in non-State-operated governmental facilities. The information on this chart has been reported by States and was derived from State plan amendments submitted to HCFA. The financial statements in this chart have not been validated by HCFA nor have cost-settlements necessarily occurred based on actual payments. Further, it may not represent all payments that will be affected by the proposed upper payment limit regulation or may include payments that will not be affected by the regulation. The purpose of the chart is to illustrate the range and scope of payments that may be impacted by a change in the way HCFA implements the Medicare upper payment limit regulations.

RAI: request for additional information sent to State by HCFA
PSP: proportional share payment

State	SPA #	Annual Federal Fiscal Impact*	1st 90th Day	RAI Issued	State Response Received	2nd 90th Day	Date Approved	Type	Comments**
Alabama	99-02	30,600,000					06/16/99	NF	Payments to rural hospital based NF's
	95-14	30,000,000					9/25/95	IH	Payment adjustment for urban and rural public hospitals based on Medicaid costs.
	95-03	23,000,000					02/01/95	OH	Public hospitals receive supplemental payments determined by the Director of Medical Assistance by analysis of costs incurred and payments already received.
Alaska	00-02	12,000,000	7/11/00					IH	Payment adjustment for government owned hospitals.
Arkansas	concept								The State has received copies of plan amendments from other States (PA? & TN?) and has expressed interest in enhanced payment/ IGT arrangements.
Colorado	91-20	?					1991	IH	Medicaid Major Teaching Hospital Payment (MTHP) Colorado has had special funding for their teaching hospitals since 1991.
Georgia	99-19	402,000,000	3/29/00	3/23/00				IH	Payment adjustment to certain hospitals including any state-owned and operated. State is very vague as to payment.
Illinois	99-09	147,000,000	3/5/00	2/24/00			2/24/00	IH	Direct Hospital Adjustment Payment for county owned hospital. Rates very from $20-100 or $115-195 for obstetrical hospitals with additional payments from $30-$410 per Medicaid Inpatient utilization rate.

State	SPA #	Annual Federal Fiscal Impact*	1st 90th Day	RAI Issued	State Response Received	2nd 90th Day	Date Approved	Type	Comments
Illinois con't	95-19	100,000,000					2/16/96	OH	County owned hospitals in IL with population of over 3 million receive funds from a $200 million pool (Cook County).
	96-13	6,200,000					4/29/97	IH	County hospitals with a population over 3 million receive an adjustment of $15,500 per Medicaid inpatient admission for all future years (Cook County).
	94-13	20,000,000					2/10/95	NF	County NF's receive funds when allowable costs incurred are greater than reimbursable costs.
Indiana	99-05	0+					7/13/99	IH	Add on payment to compensate hospitals that deliver hospital care for the indigent program service; no rate amount listed.
	98-12	0+					2/5/99	IH	Payment adjustment for municipal hospitals; no rate amount listed.
Iowa	99-?	99,600,000 (9 mth)	3/27/00	3/27/00	3/31/00	6/29/00		NF	PSP: Incentive payments to NF's
	97-30	3,331,000					12/28/97	IH	Add on cost per discharge payment for direct and indirect medical education for state owned hospitals.
Kansas	00-01	72,000,000 (9 mth)	6/22/00					NF	PSP: Incentive payments to county NF's
Kentucky	97-03	0+	6/26/97	6/23/97				IH	Teaching hospitals assoc. with University of KY & Univ. of Louisville are paid an upper limit set at 106% of the weighted median per diem cost of all other comparable hospitals.
Louisiana	concept							NF	The Legislature is seriously considering using enhanced payments for NF's. The Legislature has gained approval from one of its committees. The Medicaid agency has informed us that a delegation from the Legislature is is trying to schedule a meeting w/ Sec. Shalala on this issue (last report was early May).
Michigan++	99-16	152,045,735	4/4/00	3/31/00				OH	Hospital pools of $ 350 million; no rate methodology for distribution.
	96-07	165,600,000	Jan. 97					NF	PSP: Incentive payments to county NF's
Missouri	?	60,000,000	7/24/00					NF	PSP: Incentive payments to county NF's

State	SPA #	Annual Federal Fiscal Impact*	1st 90th Day	RAI Issued	State Response Received	2nd 90th Day	Date Approved	Type	Comments
Missouri con't	99-13	5,433,000	9/28/99	9/24/99				IH	Enhanced payment for Direct GME cost to safety net hospitals or children's hospitals.
Minnesota	?	?					approved	NF	Add $16 per bed/per day to county NF's
Montana	concept							NF	Contemplating-The State has submitted questions regarding pooling and IGT's. (Public NF's)
Nebraska	97-10	55,400,00					3/1/98	NF	PSP: Incentive payments to county NF's
New Jersey	?	450,000,000	6/2/00					NF	PSP: Incentive payments to county NF's
North Carolina	99-17	177,555,655					12/22/99	IH	Public hospitals entitled to a lump sum payment equal to costs of Medicaid services plus Medicaid's portion of GME programs, minus Medicaid payments to a public hospital. Hospital must file a certificate of public expenditures with state (IGT).
	95-18A	11,387,650					Jan-97	OH	Public hospitals receive supplemental payments determined by the Director of Medical Assistance by analysis of costs incurred and payments already received.
North Dakota	99-03	7,200,000					Sept. 99	NF	PSP: Incentive payments to county NF's
Oregon	99-06	17,500,000					7/21/99	IH	GME payment for public teaching hospitals. Medicaid costs based on impatient days.
	99-01	25,000,000					4/15/99	NF	Ensure access to care at public operated NF's.
	concept							IH	State has expressed interest in SPAs that have additional payments to public inpatient acute care hospitals with a major teaching program for general practitioners.
Penn.	00-03	6,600,000					6/29/00	NF	Payment adjustments to NF's.
	91-07	475,000,000					11/20/91	NF	PSP: Incentive payments to county NF's

State	SPA #	Annual Federal Fiscal Impact*	1st 90th Day	RAI Issued	State Response Received	2nd 90th Day	Date Approved	Type	Comments
South Carolina	99-07	25,696,000	3/22/00	3/20/00				IH	Small hospital access payment to qualified hospitals; High volume Medicaid adjuster payment. No rate/dollar amount specified.
South Dakota	00-01	10,308,000	6/3/00					NF	PSP: Incentive payments to public owned NF's
Tennessee	99-08	75,200,000	3/14/00	3/14/00	4/4/00	7/3/00		NF	PSP: Incentive payments to county NF's
Texas	concept								The Regional Office has received general questions from the State as to what some of the other States have done in this area and how it works
Utah	00-03	0+	7/8/00					IH	Utah Medicaid will transfer GME funds to a Medical Education Council to be distributed to teaching hospitals.
Virginia	98-15	0+					12/23/98	IH	State owned teaching hospitals receive approx. 60% more funds for indirect medical education.
Wash.	99-08	14,000,000					09/13/99	NF	Payments to hospital operating NF's to improve access in rural areas.
	concept							IH	Rumored to be submitting one or two Spas with additional payments. One SPA is similar to OR's program for GME.

Annual Fed. Total: **$2,452,657,040**

* Data taken from the HCFA-179. However, this is an initial Federal payment. This money may be recycled by the State to draw down another Federal payment for Medicaid.

**Additional payments to public providers may bring providers up to the costs incurred.

+ State claims no Federal fiscal impact (budget neutral).

++Michigan has a long history of using IGT's and paying public providers enhancement payments. This chart only shows the most recent State plan amendments for all States.

Reg leaked –

- possible that some states are doing this w/o complying & putting in SPA?
- OR ~~GA~~ ~~SPA~~ approved that they're interpreting more broadly →

poss part of waivers as well

IL delegation letter; WI klink

NY Lazio & Rangel

Jennifer B. wants to stop

Cmt staff wants to shut it down