Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Art Hilgart to Christopher Jennings re: phone number and address (partial) (1 page)	07/08/2000	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20145

FOLDER TITLE:
UPL [Upper Payment Limit] [Folder 3]

2012-0463-S
rc829

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

DATE: 10/31/00

TO: Deborah Adler

FAX: 456-5557 **PHONE:** _____

FROM: **Campbell Gardett**
Director, News Division, OASPA
Phone: (202) 690-6343
Fax: (202) 690-6247

TOTAL NUMBER OF PAGES TRANSMITTED: 3

COMMENTS:

RUSH

October 3, 2000

URGENT CLEARANCE

TO: Jane Horvath
Harriet Rabb
Gary Claxton
Andy Hyman
Melissa Skolfield

Attached is the final draft of the UPL press release. Please provide final clearance or comment by 5 p.m. today.

Campbell Gardett
HHS Press Office
(202) 690-6343

DRAFT HHS NEWS

DRAFT AS OF 1 p.m. 10/3/00

FOR IMMEDIATE RELEASE
October XX, 2000

CONTACT: HCFA Press Office
(202) 690-6145

HHS PROPOSES REGULATION TO CLOSE MEDICAID LOOPHOLE

HHS Secretary Donna E. Shalala today announced a proposed rule to close a loophole in Medicaid regulations that costs federal taxpayers billions of dollars without increasing or improving the care provided to Medicaid beneficiaries.

The proposal would stop states from using certain accounting techniques to inappropriately obtain extra federal Medicaid matching funds that are not necessarily spent on health-care services for Medicaid beneficiaries. The changes would be phased in to allow states time to adjust their Medicaid programs to meet the new requirements. States will have an opportunity to comment on all aspects of the proposal before it is finalized.

"We cannot stand by while billions of taxpayer dollars are used without the accountability that federal taxpayers deserve," Secretary Shalala said. "However well-intentioned some states may have been, the practice today clearly constitutes an abuse of the Medicaid system. States and the federal government must operate the Medicaid program in a fiscally sound manner that serves both Medicaid patients and the taxpayers who support the program."

Medicaid is a state and federal partnership that pays for health-care services to certain low-income families and individuals, including children and elderly nursing-home residents. Each state administers its Medicaid program within the general requirements of federal law and regulations, and the state and federal governments share the cost of the program.

Under current Medicaid regulations, states have broad flexibility in setting the Medicaid rates that they pay to nursing homes, hospitals, and other providers. Specifically, the "upper payment limit" requirements allow states to pay facilities in aggregate as much as Medicare would pay for the same services. States also can set varied payment rates for public and private providers.

Some states are using this flexibility to pay excessive rates to a few county or municipal facilities. After the state claims federal matching funds based on those payments, it can require those facilities to return some or all of the extra money for other uses in the state, often unrelated to Medicaid and in some cases unrelated to health care at all. The proposal would still allow states to make higher Medicaid payments to public hospitals, which often serve sicker patients who are less likely to have any health coverage at all.

– more –

The HHS Inspector General is conducting a review of the ways several states have used the extra money generated through this loophole. "We believe that manipulation by states of the upper payment limit requirements undermines the financial integrity of the Medicaid program," said Inspector General June Gibbs Brown.

The use of this loophole has grown rapidly in the past year. Twenty states now have approved plans. These practices have accounted for nearly $2 billion in increased Medicaid costs in Fiscal Year 2000 alone. Further expansion of these practices could cost federal taxpayers tens of billions of dollars over the next five years if left unchecked.

The proposed rule, to be published in the **Oct. XX** Federal Register, would change Medicaid's "upper payment limit" rules to prevent states from averaging payments across public and private facilities. This would prevent states from paying excessive rates to certain government facilities. States still could pay as much as 150 percent of the "upper payment limit" amounts to public hospitals to recognize their special situation as safety-net providers and their delivery of large volumes of uncompensated care.

To allow adequate time for states that have come to rely on the loophole, the proposed rule would phase out the extra payments over five years for states with approved plans before Oct. 1, 1999. Other states with plans that lapsed into effect since then without the Health Care Financing Administration's approval would have a shorter transition period, with payments ending at the start of each state's 2002 budget year. The proposal would not reduce federal Medicaid funding for any state during its 2001 budget year.

In addition, HHS is preparing new legislation to help hospitals that serve a disproportionate share of Medicaid and uninsured patients. Under current law, Medicaid disproportionate share payments to these hospitals are capped at 100 percent of their costs for treating uninsured patients plus any costs for treating Medicaid patients that are not covered by the Medicaid reimbursements that they receive. The new proposal would raise the cap to 175 percent of those costs, helping to ensure the viability of large urban safety-net hospitals.

"The proposed regulations, and the legislation we will forward to Congress, recognize a legitimate use for Medicaid funds to support the hospitals that serve the neediest Americans," HCFA Acting Administrator Michael Hash said. "We recognize that states will need time to adjust to these changes, and we have included a transition period to ensure that facilities which serve low-income persons can be protected. By making these changes, we will help to preserve the public trust in the Medicaid program, which provides vital health-care services to millions of Americans."

The proposed rule has a 30-day comment period, during which states, health-care providers, and others can raise concerns about and suggest alternatives to the proposed changes and transition policies. A final regulation would be published after analyzing those comments.

###

THE WHITE HOUSE

WASHINGTON

October 3, 2000

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE R. LINDSEY

RE: HCFA AND UAMS

This responds to Chris Jennings' memorandum regarding the Arkansas state plan amendment to provide supplemental payments for outpatient services at University of Arkansas for Medical Sciences (UAMS). Chris' memorandum indicated that Arkansas would continue to receive supplemental payments for two years under the proposed regulations and that the Arkansas Medicaid Director had indicated that UAMS would likely be satisfied with a two year payment adjustment. He also noted that the state would benefit from legislation marked up by the House Commerce Committee last week. While both of these developments are helpful, neither provides a long term solution for UAMS.

UAMS is a unique institution in Arkansas, providing the state's only teaching hospital and the cornerstone of Arkansas' health care system. The hospital provides complex specialty care not available anywhere else in the region, including, for example, specialized cancer treatment, neurosurgery, ophthalmology, and high-risk obstetrics. UAMS provides approximately $60 million in uncompensated care to uninsured persons who otherwise would have no place else to turn. These issues are chronic and recurring and not likely to be remedied with only a two-year payment adjustment. UAMS needs stability and security in its Medicaid payments to enable it to provide high quality care and services to Medicaid patients.

Although the disproportionate share hospital (DSH) payment provisions contained in last week's House Commerce Committee markup would help Arkansas, at best, by increasing Arkansas's DSH allotment by $11.5 million (some estimates are significantly lower), the legislation is not a substitute for the supplemental payments for two primary reasons. First, the future of the "extremely low" DSH payment provisions is uncertain. There is no guarantee that these provisions (which had not previously appeared in any other proposed legislation) will remain in a provider payment package considered by the House and Senate. Even if these provisions do remain, the magnitude of the legislative change is much smaller than Arkansas' proposed supplemental payments. The extremely low DSH provisions are, at best, worth $11.5 million in increased federal funding. The proposed supplemental payments are worth $36 million. Neither of these payments come close to covering UAMS' approximately $ 60 million in uncompensated care.

The proposed upper payment limit regulations contain provisions designed to protect states that have relied heavily on this mechanism to fund public hospitals. The regulation

should similarly be drafted to protect Arkansas and similarly situated states. Below are a number of possible ways to create such protection.

1. Exempt extremely low DSH states from the requirement that a separate outpatient UPL be calculated for state operated hospitals. This exemption would *only* apply to outpatient payments and *only* for acute care hospitals. At most 13 states would be affected by this proposal if the House Commerce Committee definition of extremely low DSH is adopted, although narrower definitions are possible.

2. Permanently grandfather-in existing outpatient programs for state-operated hospitals in extremely low DSH states to avoid the requirement that a separate outpatient UPL be calculated for state operated hospitals.

3. For extremely low DSH states, require only that states certify that all of the payments specified in the state plan remain with the specified provider and are not transferred back to the state. This certification requirement would apply only to the outpatient adjustment and only to hospitals. States would be prohibited from supplanting existing state funding.

4. For extremely low DSH states, provide an exemption to the outpatient UPL requirement to allow for additional payments to state operated hospitals up to the amount of unreimbursed Medicaid and uncompensated care costs.

5. Create an administrative exemption specifically for the University of Arkansas for Medical Sciences (UAMS) from the state-operated hospital outpatient UPL. Such an exemption may be legally created on an administrative basis.

Given that the upper payment limit regulation is being designed to protect certain states that have relied on supplemental payments, despite having relatively large DSH programs, it seems particularly appropriate additionally to protect states that need to rely on supplemental payments as a result of extremely low DSH allotments. This consideration will allow states such as Arkansas to have necessary consistency and continuity needed in paying providers that provide essential Medicaid services for their communities.

cc: Chris Jennings

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

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

July 26, 2000

Dear State Medicaid Director:

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

Background

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

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

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

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

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

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

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

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

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

Administration Actions

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

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

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

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

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

Sincerely,

Timothy M. Westmoreland
Director

cc:
All HCFA Regional Administrators

All HCFA Associate Regional Administrators
for Medicaid and State Operations

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

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director, Health Legislation
National Governors' Association

Internal Draft

FYI

Recent Press Descriptions of UPL Payments

Louisiana:

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

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

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

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

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

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

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

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

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

Alaska:

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

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

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

Kansas:

"**An accounting trick** used by other states could allow Kansas to **send the money to nursing homes on the condition that they send it back so the state can spend it elsewhere**.... [Governor Graves of Kansas] is optimistic the state would get the federal funding but said lawmakers should be cautious in spending it because the funding source will probably not be available much long. Since more states are becoming aware of the program, Congress may be inclined to close it, he said."

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

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

"I have identified a number of priorities for the money we could receive from this program," [Gov.] Graves [of Kansas] said. Receiving these funds would help us provide nursing-home care and help our state budget in other areas as well." The governor's plan would send **60 percent of the money to a senior services trust fund to finance an as-yet-undeveloped plan to help qualifying seniors buy prescription medicines.**[1] **Twenty-five percent of the money would go to the state general fund to increase the state's share of school special education program costs.... Fifteen percent would go to create a loan fund for upgrading nursing home facilities."**

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

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

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

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

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

New Jersey:

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

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

---

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

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
1301 PENNSYLVANIA AVENUE, NW, SUITE 950, WASHINGTON DC 20004 | 202.585.0100 | FAX 202.585.0101

Memorandum

DATE: August 25, 2000

TO: Chris Jennings

Jeanne Lambrew

FROM: Christine Capito Burch, Executive Director

SUBJECT: UPL and grandfathering

Attached is a memo from Powell, Goldstein, Frazer and Murphy outlining in further detail the legal basis for our belief that HCFA has the authority to set criteria for grandfathering as part of any NPRM on the upper payment limit issue. We have also sent a copy of this memo to Tim Westmoreland and I discussed it with him earlier this week.

I will be in and out of the office for the next week. If you cannot reach me (202-585-0110) you could call Charlie Luband at Powell, Goldstein (202-624-7215).

f:\uscrs\naph\reg2000\upl\whitehouse82500.doc

POWELL, GOLDSTEIN, FRAZER & MURPHY LLP

Date: August 24, 2000

MEMORANDUM

To: National Association of Public Hospitals & Health Systems

From: Powell Goldstein Frazer & Murphy LLP

Re: Administrative Agency Authority to Promulgate Grandfathering Regulations

HCFA is currently considering changes to Medicaid regulations to address potential abuses of state Medicaid payments using aggregate upper payment limits (UPLs). The regulatory change is intended to curb current abuses by requiring the calculation of separate aggregate UPL requirements for local government providers and for state-operated providers. However, the regulatory change would also disturb non-abusive and long-standing payment methodologies designed to help Medicaid recipients and that states have relied upon to assist safety net providers that serve those patients. One way to mitigate this harm would be to grandfather existing methodologies that benefit safety net providers and vulnerable patients.

You have asked us to examine whether HCFA has the authority to grandfather specific state payment methodologies as it changes the UPL regulation.

QUESTION PRESENTED

Does HCFA have the regulatory authority to grandfather existing UPL payment methodologies? If so, what standards apply and what explanations are necessary?

SHORT ANSWER

HCFA has successfully used grandfathering in the past to preserve the status quo for existing entities while tightening requirements on new applicants. Agencies may use grandfathering as a regulatory tool when justified by rational policy concerns. Policy concerns that have previously justified grandfathering include protection of the status quo, promotion of administrative convenience, respect for policy complexity, assuring agency consistency, and furthering statutory goals. Many of these justifications potentially apply to HCFA using grandfathering in the UPL context.

Courts examine agency actions using grandfathering under the usual standards used to assess agency action. Administrative agencies are given broad rulemaking discretion unless Congress has specifically addressed an issue. In order to establish that regulations are not arbitrary and capricious, an agency must engage in reasoned decisionmaking and be able to explain a rational connection between the facts and the agency's decision.

In the clearest instance of the courts scrutinizing HCFA's regulatory ability to use grandfathering, the courts upheld HCFA's actions. In Clinton Memorial Hospital v. Shalala, the D.C. Circuit upheld a grandfathering provision in HHS regulations that altered the designation

criteria for sole community hospitals (SCHs). 10 F.3d 854 (D.C. Cir. 1993). The Court found that grandfathering SCHs designated prior to the effective date of the new regulations was properly justified by the agency and was not arbitrary and capricious. The approach used by the D.C. Circuit in Clinton Memorial Hospital is consistent with the decisions of other courts that have similarly evaluated agency grandfathering authority.

DISCUSSION

1. **Administrative agencies in general have broad rulemaking authority.**

Agencies in general have broad rulemaking authority to implement statutory aims. Under Section 706 of the Administrative Procedure Act, courts must "hold unlawful or set aside agency action, findings, and conclusions in a number of situations, including instances where agency action is in violation of the constitution, in excess of statutory powers, unsupported by facts or evidence, or fails to follow established legal procedures." 5 U.S.C. § 706 (1996). Agency actions, including rules, found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law" must also be set aside. 5 U.S.C. § 706(A)(2) (1996).

Under the landmark Chevron, Inc. v. Natural Resources Defense Council, Inc. case, the Supreme Court laid out an extremely deferential standard for reviewing courts to evaluate agency action. 467 U.S. 837 (1984). When Congress has addressed the precise question at issue, the court must give effect to the express intent of Congress. However, if the statute is silent or ambiguous, the court defers to the agency's interpretation, if reasonable. Id. at 843-44.

The impact of Chevron is somewhat moderated by Motor Vehicle Manufacturers Ass'n of U.S., Inc. v. State Farm Mutual Automobile Insurance Company, 463 U.S. 29 (1983) (hereinafter State Farm). Under State Farm, an agency must engage in reasoned decisionmaking to avoid reversal of its policy choice as arbitrary and capricious. The agency must "examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" 463 U.S. at 43 (citing Burlington Truck Lines v. United States, 371 U.S. 156, 168 (1962)). In language that is widely quoted, the Supreme Court specified that:

> Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

463 U.S. at 43. Taken together, Chevron and State Farm describe the deferential yet searching analysis that reviewing courts apply to agency actions. An agency's interpretation of a statute must be affirmed if it is within the range of reasonable meanings that the statute permits. Agencies are not obligated to choose the best option among many. However, agency action must be consistent with the statute and the agency must be able to rationally explain its choice. See

San Bernardino Mountains Community Hosp. Dist. v. Secretary of Health & Human Servs., 63 F.3d 882 (9th Cir. 1995); Strickland v. Commissioner, Maine Dept. of Human Servs., 48 F.3d 12 (1st Cir. 1995); Batterton v. Francis, 432 U.S. 416, 425-26 (1977). See also, 1 Kenneth C. Davis and Richard J. Pierce, Jr., Administrative Law Treatise, § 7.4 (3d ed. 1994 & Supp. 1999).

2. **HCFA's authority to promulgate grandfathering regulations was upheld by the D.C. Circuit in *Clinton Memorial Hospital v. Shalala.***

In Clinton Memorial Hospital v. Shalala, the D.C. Circuit authoritatively established that HCFA may use grandfathering regulations. 10 F.3d 854 (D.C. Cir. 1993). In 1983 HCFA revised the standards for obtaining designation as a sole community hospital (SCH) for Medicare reimbursement purposes under the prospective payment system. See generally 42 C.F.R. § 412.92. A variety of hospitals challenged the validity of these new regulations on the grounds that they were more stringent than the prior regulations. See San Bernardino Mountains Community Hosp. Dist. v. Sec. of Health & Human Servs., 63 F.3d 882 (9th Cir. 1995); Clinton Mem'l Hosp. v. Shalala, 10 F.3d 854 (D.C. Cir. 1993); Macon County Community Samaritan Mem'l Hosp. v. Shalala, 7 F.3d 762, (8th Cir. 1992) (all upholding the regulations and finding that the agency appropriately exercised its discretion in developing new SCH criteria). The SCH regulations included a grandfathering provision that allowed preexisting SCHs to retain their beneficial Medicare reimbursement status even if they did not qualify as SCHs under the new regulations. See 42 C.F.R. § 412.92(b)(5); 49 Fed. Reg. 234, 271 (Jan. 3, 1984).

Clinton Memorial sued the agency, claiming that the regulations were arbitrary and capricious and did not serve a rational purpose because at the same time that they instituted more rigid requirements, the regulations allowed previously approved entities to circumvent the regulations. Clinton Memorial also argued that the grandfather provision violated equal protection by applying a more lenient standard to preexisting hospitals.

The Court of Appeals rejected the hospital's contentions and found that the grandfathering provision of HCFA's regulations was not arbitrary and capricious and did not violate the Equal Protection Clause. Reviewing the regulation under a deferential standard, the court found that HCFA's stated explanations of administrative convenience and maintaining the status quo adequately justified any disparate treatment. 10 F.3d 854, 860-61. In particular, HCFA argued that grandfathering was appropriate to avoid having to reprocess and reconsider SCH applications and to preserve the status quo for hospitals that had relied on being granted SCH status. See Appellee's Opening Brief at 46.

3. **As long as the agency supplies an appropriate reason for grandfathering, courts have upheld grandfathering regulations.**

When agencies supply a rational reason for grandfathering, courts have upheld grandfathering regulations as a rational exercise of agency discretion. A variety of agencies have faced challenges to regulations that include grandfather clauses. In some cases, challenges have attacked agency implementation of a statutorily-specified grandfathering clause. See National

Resources Defense Council v. Thomas, 838 F.2d 1224 (D.C. Cir. 1988); Sierra Club v. EPA, 719 F.2d 436 (D.C. Cir. 1983); Peabody Coal Co. v. Watt, 553 F. Supp. 1201 (D.D.C. 1982). In others, like Clinton Memorial Hospital, challenges have involved regulatory grandfather clauses. See FCC v. Nat'l Citizens Comm. for Broad., 436 U.S. 775 (1978). Below we discuss the general requirement that a rational reason be provided, and some of the specific justifications that courts have upheld, including protecting the status quo and the interests of entities that have relied on agency policy, ensuring administrative convenience, maintaining agency consistency, and furthering statutory goals.

a. An agency must assert a rational reason for grandfathering.

The D.C. Circuit examined a number of grandfathering provisions included in 1985 Clean Air Act regulations concerning the latest of multiple revisions of EPA regulations attempting to strike a balance between different approaches to pollution control. Because the court accepted some grandfathering approaches and rejected others, the case is particularly illustrative. Nat'l Resources Defense Council (NRDC), Inc. v. Thomas, 838 F.2d 1224 (D.C. Cir. 1988).[1] As in Clinton Memorial Hospital, some of the regulations at issue in NRDC v. Thomas treated pre-regulation entities (here sources of pollution) more leniently than post-regulation entities. In general, one primary factor required by the court was that the agency provide a reason for the disparate treatment.[2] Id. at 1247-48 ("in drawing a distinction between pre-1979 and later stacks, the agency must supply some reason").

---

[1] National Resources Defense Council v. Thomas addresses grandfathering regulations at length, although the regulations under consideration are tied to a statutory provision §123 of the Clean Air Act, 42 U.S.C. § 7423, which includes a grandfathering clause exempting from the Act's requirements stack heights in existence before 12/31/70 or dispersion techniques implemented before that date.

The court considered four grandfather provisions included in the 1985 regulations, which made a variety of changes to Clean Air Act implementing regulations. Two of the grandfather clauses were upheld and two were invalidated. The first grandfather provision failed because the court found that it was not faithful to the statute and that the regulation grandfathered entities that had not necessarily relied on the prior regulation. The second provision appropriately sheltered emissions sources that had relied on pre-1979 regulations. The third grandfather provision was invalidated because it did not adequately explain why particular emissions sources should receive automatic pollution control credits without showing reliance. The fourth grandfather provision, exempting pre-1985 stack mergers from emissions credit limitations in certain circumstances, was upheld because it was deemed to protect the statutory purpose.

[2] The requirement that the agency supply a rational basis is similar to the requirement that there be a rational basis to survive an equal protection clause challenge. The challenge in Clinton Memorial Hospital alleged an equal protection clause violations. In language that the Appellate Court affirmed, the District Court held that deferential rational basis review of economic regulations dictated that a challenged statute or regulation would be struck down only if it "manifests a patently arbitrary classification, utterly lacking in rational justification." Clinton Mem'l Hosp. v. Sullivan, 783 F. Supp. 1429, 1440 (D.D.C. 1992) (citing Weinberger v. Salfi, 422 U.S. 749, 768 (1975)). By determining if the agency has engaged in "reasoned decisionmaking," a reviewing court is essentially performing rational basis review. Just as a failure to show a rational connection between the facts found and a choice made usually results in an agency action being declared as arbitrary and capricious, activities being judged under the rational basis framework "may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational." See Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432, 439 (1989).

In explaining its decision with respect to EPA grandfathering provisions, the Court of Appeals underscored the importance of a clear justification for the agency's regulations in a case where the statute suggested a slight interest in applying a rule retroactively: "an agency must articulate some equitable rationale for grandfathering. Although we cannot say there is none, we cannot uphold the decision in the absence of any explanation." NRDC v. Thomas, 838 F.2d at 1248. Therefore, providing a rationale for grandfathering is important even where the statutory interests do not seem particularly strong and where the regulatory policy generally accords with the purpose of the statute.

The Supreme Court has similarly indicated that some form of explanation is necessary to support grandfathering regulations. In FCC v. National Citizens Committee for Broadcasting, the National Citizens Committee sought review of FCC regulations governing the prohibition of common ownership of a radio or TV station and a daily newspaper located in the same community. 436 U.S. 775 (1978). Here, the court considered first whether the regulations could be applied only prospectively and then whether the provision to grandfather all but sole-source effective monopolies was legitimate. In affirming the grandfathering of most co-located newspaper-broadcast combinations, the Supreme Court noted that the "limited divestiture requirement reflects a rational weighing of competing policies." Id. at 803.

In recent years, there have been a number of FCC cases dealing with regulations implementing the commission's sweeping Telecommunications Act of 1996. Pub. L. No. 104-104, 110 Stat. 56 (1996). Several of these cases have involved challenges to grandfathering clauses included in regulations. While no single case is cited as justification for grandfathering, the type of rational weighing that was applied in FCC v. National Citizens Committee for Broadcasting continues to be used to justify grandfathering decisions. See, e.g., Report and Order, In the Matter of Review of the Commission's Regulations Governing Television Broadcasting, Television Satellite Stations Review of Policy and Rules, MM Docket Nos. 99-221 & 87-8, FCC 99-209 at 2 (hereinafter FCC Report and Order).

b. Protecting the status quo may justify grandfathering.

In a case challenging an HHS decision under the Medicare Catastrophic Coverage Repeal Act, which included a provision to protect prior beneficiaries from changes, the D.C. Circuit explained that "[g]randfathering typically seeks to provide special relief for persons on whom the new regime might bear with unusual severity, because it specially disrupts their lives, usually because of decisions they are likely to have taken in reliance on the prior regime." Tataranowicz v. Sullivan, 959 F.2d 268, 277 (D.C. Cir. 1992). The Tataranowicz court upheld a limited exemption that was designed to protect the expectations of prior beneficiaries. While this case concerned the agency's interpretation of a specific 'transition' provision in the Act itself, similar reasoning was accepted in upholding the grandfathering regulation devised by the Secretary of HHS to protect sole community hospitals. The district court in Clinton Memorial Hospital similarly recognized the agency's "interest in preserving the status quo for those hospitals that had been granted SCH status." Clinton Mem'l Hosp. v. Sullivan, 783 F. Supp. 1429, 1440

(D.D.C. 1992). The D.C. Circuit affirmed the district court decision. Clinton Mem'l Hosp. v. Shalala, 10 F.3d 854, 860-61 (D.C. Cir. 1993).

In FCC v. National Citizens Comm. for Broad., the Supreme Court similarly validated an agency's effort to minimize the detrimental effect of new regulations on previously approved entities and on the public generally. 436 U.S. 775 (1978). This case involved a challenge to regulations that, in part, grandfathered most commonly owned newspaper-broadcast combinations after a new law prohibited such common ownership. The FCC was unwilling to impose a complete divestiture requirement because, it explained, the hoped-for gain in diversity was not a sufficient justification for the disruption, hardship, losses, and possible diminution of services to public. The Court agreed that full-scale divestiture to meet the new regulatory guidelines was not necessarily in the public's interest because the consequences would disrupt the status quo. 436 U.S. at 807.

The use of grandfathering regulations to avoid disrupting the status quo was also upheld in National Ass'n of Broadcasters v. FCC, 740 F.2d 1190 (D.C. Cir. 1984). The FCC had issued interim rules regarding direct broadcast satellite (DBS) service regulations in anticipation of telecommunications system changes. The court upheld grandfathering provisions that protected the prior investments of existing licensees and avoided disrupting the status quo even while making the business environment more hospitable for new technology.

c. Administrative convenience may justify grandfathering.

In Clinton Memorial Hospital, despite arguments by the hospital that "administrative convenience is an extra-statutory justification which is not an acceptable basis for the regulation," See Appellant's Opening Brief at 48, the court of appeals accepted administrative convenience as grounds for finding that the Secretary had made a rational and valid decision to grandfather existing SCHs. Clinton Mem'l Hosp., 10 F.3d at 860-61. Other courts have similarly allowed administrative convenience as a rational basis for agency grandfathering action.

In Environmental Defense Fund (EDF) v. EPA, the court upheld an agency's decision to implement temporary grandfather regulations to avoid disrupting the implementation process of federal projects previously approved and already underway. 82 F.3d 451, 456-57 (D.C. Cir. 1996) (denying a petition for review of Clean Air Act regulations that included a temporary exemption from Clean Air Act inspections for projects that had undergone recent analyses). In some sense this decision combines both administrative convenience and maintenance of the status quo.

However, other courts have rejected administrative convenience as a justification where there are alternatives that would not cause an administrative burden. In NRDC v. Thomas, the court accepted the argument that having to run emissions demonstrations of all pollution sources that had increased stack height since 1970 would be an administrative burden. 838 F.2d at 1246. However, since EPA had the alternative of adopting a formula that would be reliable enough to

diminish the need for individual demonstrations, the Court refused to uphold portions of the grandfathering regulations on administrative convenience grounds. Id. at 1246.

d. Ensuring agency consistency and protecting those that have relied on established agency policy may justify grandfathering.

Agencies have placed great emphasis on the value of consistent agency policies. For example, the FCC has an interest in protecting both the public interest and the interests of telecommunications and broadcast providers. In FCC v. National Citizens Committee for Broadcasting, by allowing the grandfathering provision, the Supreme Court affirmed the idea that the FCC had an interest in preserving prior policies. Licensees who had given good service had a "legitimate renewal expectancy" because in the past the FCC had viewed "past performance of the incumbent as the most important factor in deciding whether to grant license renewal and thereby to allow the existing owner to continue in operation." 436 U.S at 806. Therefore, in the absence of any finding that co-located entities were detrimental to the public interest, the agency asserted its reasonable interest in ensuring consistency by grandfathering most previously approved entities.

Recently, the FCC again used reliance on preexisting agency policy to establish an argument for grandfathering. In an FCC report and order explaining the Commission's decision to grandfather, the FCC recognized the "need to avoid undue disruption of television local marketing arrangements [(LMAs)] that were entered into in good faith reliance on our previous rules at the time." FCC Report and Order, ¶138 at 59. By considering LMA reliance upon agency policies, the FCC hoped to establish a rational reason why grandfathering should be allowed.

The EPA has also used reliance upon agency policies and the value of agency consistency as a justification for grandfathering provisions. In upholding some of the questioned regulations at issue in NRDC v. Thomas, the court reasoned that protecting emissions sources that had relied on a particular pollution dispersion methodology prior to the change in regulation "would not 'maintain a situation that Congress sought to end.'" NRDC v. Thomas, 838 F.2d at 1247 (citing Sierra Club, 719 F.2d 436, 468 (D.C. Cir. 1983)).

Administrative consistency and reliance is only a legitimate justification where the entity in question can show reliance upon the prior regulations. Therefore, in cases where the agency regulations have fluctuated broadly, there is a less compelling case for grandfathering. See NRDC v. Thomas, 838 F.2d. 1224, 1245. Similarly, the argument for agency consistency is weakened if there is no specified burden due to the new regulations. Id. at 1250-51.

e. Furthering the statutory goals may justify grandfathering.

Statutory language, legislative history, and the context of the legislation are all legitimate indications of Congress's intent and should be considered when devising agency regulations. The Medicaid statute controlling the UPL methodology issue provides very broad language

regarding Congress' statutory intent. The statute states that a Medicaid state plan must provide information "to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan ...." 42 U.S.C. §1396a(30)(a). Although this language is very broad, other agencies have used broad statutory language to justify grandfathering.

For example, when the FCC considers the values of diversity and competition in securing the public interest it does so in accordance with its statutory mandate of ensuring that broadcast licensees applying for renewals have served the "public interest, convenience, and necessity." 47 U.S.C. §309(k)(1). FCC cases therefore discuss the consideration of what is in the public interest when deciding whether or not to grandfather. See Malrite T.V. of N.Y. v. FCC, 652 F.2d. 1140, 1149 (2d Cir. 1981) (holding that the FCC was not required to grandfather if in its judgment the public interest would be disserved); FCC v. Nat'l Citizens Comm. for Broad., 436 U.S 775 (holding that grandfathering most co-located combinations was in the public interest despite the expressed purpose of the new regulations to promote media diversity); and FCC Report and Order, discussed above.

Similarly, in a case challenging rules governing conformity with Clean Air Act state implementation plans, the D.C. Circuit Court of Appeals upheld the EPA's temporary grandfathering provisions as furthering statutory goals. See Envtl. Defense Fund (EDF) v. EPA, 82 F.3d at 456 (holding that the regulations avoided unnecessary inspections, redundancy, and disruption while meeting statutory requirements about minimum conformity inspections).

At the same time, an agency cannot act in such a way as to frustrate statutory goals. In a 1999 case, the EPA's conformity requirements (40 C.F.R. §93.102 (c)(1)) were challenged and the court found that the EPA's interpretation of the statute "eviscerates the requirements" of Clean Air Act provisions by allowing projects to receive federal funds during periods of plan and program conformity lapses. EDF v. EPA, 167 F.3d 641, 647 (D.C. Cir. 1999). Similarly, when invalidating some of the EPA smoke stack emissions regulations that included grandfathering provisions, the NRDC v. Thomas court clearly stated that, "[a]gainst the seemingly weak claims for grandfathering is the possible frustration of the statutory goal. This looks significant." 838 F.2d at 1246. Therefore, an inability to adequately explain grandfather regulations coupled with the risk of frustrating statutory goals mitigates against deferring to the agency.

f. Deferring to agency expertise when considering complex regulations may justify grandfathering.

Finally, although we have found no case applying this reasoning to grandfathering challenges, courts in general have often found that complex administrative issues justify heightened deference to agency expertise and this may be an adequate justification for grandfathering. See, e.g., La Casa del Convaleciente v. Sullivan, 965 F.2d 1175, 1178 (1st Cir. 1992) (noting that "where a complex scheme of Medicare reimbursement is at issue, the Secretary is entitled to a heightened degree of deference"). See also Gray Panthers v. Schweiker, 453 U.S. 34, 43-44 (1982) (noting that "[p]erhaps appreciating the complexity of what it had

wrought, Congress conferred on the Secretary exceptionally broad authority to prescribe standards" for implementing an act and holding that when Congress explicitly delegates to the Secretary the authority to define terms in the Social Security Act and in Medicare, the Secretary's definitions are entitled to legislative effect); Batterton v. Francis, 432 U.S. 416, 425 (1977); Gray v. Powell, 314 U.S. 402, 411-12 (1941).

The Supreme Court has held that, in cases where precise information was impossible to ascertain, judgments or predictions may be upheld even without complete factual support in the record. FCC v. National Citizens Comm. for Broad., 436 U.S. at 814. In National Citizens Committee, the Supreme Court explained that "a forecast in the direction in which future public interest lies necessarily involves deductions based on the expert knowledge of the agency." 436 U.S. at 814 (quoting FPC v. Transcontinental Gas Pipe Line Corp., 365 U.S. 1, 29 (1961)). The Court deferred to the FCC's analysis and affirmed the grandfathering provision, even though it was impossible for the FCC to determine the precise effect of the regulation. In cases where information about the effects of new regulations is either difficult to obtain or uncertain, an agency's expert opinion is entitled to deference if its reasoning is explained. But see U.S. West, Inc. v. FCC, 182 F.3d 1224 (10th Cir. 1999) (refusing to extend, in a case where the record was much more complete than it was in FCC v. Nat'l Citizens Comm. for Broad., the finding in FCC v. Nat'l Citizens Comm. for Broad. that the agency can rely on its common sense judgment).

4. Courts have approved selective grandfathering in certain cases.

It is important to recognize that grandfathering may even be selective in nature. In FCC v. National Citizens Committee for Broadcasting the FCC crafted the grandfathering regulation so that it did not apply to *all* preexisting co-located newspaper-broadcast entities. 436 U.S. 775 (1978). Although the grandfathering was the result of prospective application of new regulations, sixteen co-located broadcast-newspaper combinations that each constituted an effective local monopoly were excluded and the court upheld this agency decision. Grandfathering regulations have thus been allowed in cases where only a defined subset of the preexisting class was grandfathered.

CONCLUSION

Agencies such as HCFA are given broad rulemaking authority unless Congress has previously and specifically addressed an issue. Accordingly, if the agency can establish a reasonable basis for that regulatory approach, grandfathering is permissible as part of an administrative rulemaking. An agency may justify grandfathering regulations in numerous ways, including by asserting an interest in administrative convenience and in preserving the status quo. Therefore, HCFA may grandfather all, or certain distinct categories of, state methodologies using aggregate UPLs because (1) nothing in the controlling Medicaid statute prevents HCFA from doing so and (2) HCFA has an interest in preserving the stability of the health safety net delivery systems in states that have relied for years on current regulations. This conclusion is supported by existing federal court decisions examining grandfathering regulations promulgated by numerous administrative agencies.

Richard Durbin
UNITED STATES SENATOR ■ ILLINOIS

FAX

Chris Jennings

TO: Tim Westmoreland

OFFICE: _____

FAX NO: (_____) _____

FROM: Anne Marie Murphy

PHONE: (2 0 2) 224-8464

DATE: Aug 11, 2000

PAGES *(including this cover sheet):* _____

NOTE: The State's first crack at drafting an exception with some fiscal integrity controls, as we discussed recently. This draft does not contain separate accounting between "Medicaid" + "uncompensated care" because the state wasn't sure how to do this (or had heartburn over the real reason) Tightening the language up or adding to MOE is fine with Senator Durbin

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

DRAFT

Confidential

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

[Maintenance of benefits–beneficiaries]

PART 435–Eligibility in the States, district of columbia, the northern Mariana Islands, and american samoa

Subpart A–General Provisions and Definitions

Sec. 435.10 State plan requirements.

A State plan must–

(a) Provide that the requirements of this part are met; ~~and~~

(b) Specify the groups to whom Medicaid is provided, as specified in subparts B, C, and D of this part, and the conditions of eligibility for individuals in those groups~~.~~; and

(c) In the case of agencies that have chosen to use the provisions of paragraphs 447.271(b)(2) or 447.321(c)(2) of part 447, the specification of groups may be no less comprehensive, and the conditions of eligibility of individuals in those groups may be no more restrictive, than provided for in the State plan in effect on September 30, 1999.

DRAFT
Confidential

[Dedicated fund]

PART 433–STATE FISCAL ADMINISTRATION

Subpart A–Federal Matching and General Administration Provisions

Sec. 433.32 Fiscal policies and accountability.

A State plan must provide that the Medicaid agency and, where applicable, local agencies administering the plan will–

(a) Maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements;

(b) Retain records for 3 years from date of submission of a final expenditure report;

(c) Retain records beyond the 3-year period if audit findings have not been resolved; ~~and~~

(d) Retain records for nonexpendable property acquired under a Federal grant for 3 years from the date of final disposition of that property.; and

(e) Agencies that have chosen to use the provisions of paragraphs 447.271(b)(2) or 447.321(c)(2) of this part must maintain a separate distinguishable account into which Federal funds, claimed as a result of expenditures for hospital services made, in whole or in part, with local public funds, are deposited and from which funds are disbursed for low-income health care purposes only. Upon deposit, funds in such account shall no longer be considered Federal funds.

[44 *FR* 17935, Mar. 23, 1979]

[Maintenance of effort]

Subpart B–General Administrative Requirements State Participation

Sec. 433.53 State plan requirements.

A State plan must provide that–

(a) State (as distinguished from local) funds will be used both for medical assistance and administration;

(b) State funds will be used to pay at least 40 percent of the non-Federal share of total expenditures under the plan; and

(c) State and Federal funds will be apportioned among the political subdivisions of the State on a basis that assures that–

(1) Individuals in similar circumstances will be treated similarly throughout the State; and

(2) If there is local financial participation, ~~lack~~–

(i) Lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of services or level of administration under the plan in any part of the State.

(ii) Agencies that have chosen to use the provisions of paragraph 447.271(b)(2) or 447.321(c)(2) of this part must ensure that funding from local sources for services subject to the aggregate payment limitations specified in sections 447.272 and 447.321 of this part have not been used to reduce the amount of State funds used to pay for the non-Federal share of total expenditures under the plan below the level State funds so expended in the twelve month period ending September 30, 1999.

DRAFT

~~Confidential~~

[57 *FR* 55138, Nov. 24, 1992; 58 *FR* 6095, Jan. 26, 1993]

DRAFT

Confidential

[Upper payment limits]

PART 447–Payments for services

Subpart C–Payment for Inpatient Hospital and Long-Term Care Facility Services

Sec. 447.257 FFP: Conditions relating to institutional reimbursement.

FFP is not available for a State's expenditures for hospital inpatient or long-term care facility services that are in excess of the amounts allowable under this subpart.

[52 *FR* 28147, July 28, 1987]

Sec. 447.271 Upper limits based on customary charges.

(a) Except as provided in paragraph (b) of this section, the agency may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.

(b) The agency may pay a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider's charges were equal to or greater than its costs.

Sec. 447.272 Application of upper payment limits.

(a) General rule. Except as provided in paragraph (c) of this section, aggregate payments by an agency to each group of health care facilities (that is, hospitals, nursing facilities and ICFs for the mentally retarded (ICFs/MR)), may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.

(b) ~~State~~ Government-owned or -operated facilities.

(1) In addition to meeting the requirement of paragraph (a) of this section, aggregate payments to each group of ~~State~~ government-owned or -operated facilities (that is, hospitals, nursing facilities and ICFs/MR) may not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles.

(2) For purposes of the preceding paragraph (1), the agency may choose to define the amount that can reasonably be estimated would have been paid under Medicare payment principles to hospitals owned or operated by a unit of local government (that is, other that the State) that have a low-income utilization rate, as defined at *42 U. S. C.* 1396r(b)(3), in excess of 30 percent to include services to both Medicaid beneficiaries and the uninsured and may multiply the result by a factor of two.

(c) Disproportionate share. The upper payment limitation established under paragraphs (a) and (b) of this section does not apply to payment adjustments made under a State plan to hospitals found to serve a disproportionate number of low-income patients with special needs as provided in Sec. 447.253(b)(1)(ii)(A). The payment limitations for aggregate State disproportionate share hospital payments are specified in Secs. 447.296 through 447.299. States must submit a separate upper payment limit assurance that its aggregate disproportionate share hospital payments do not exceed the disproportionate share hospital payment limits.

[52 *FR* 28147, July 28, 1987, as amended at 56 *FR* 48867, Sept. 26, 1991; 57 *FR* 43924, Sept. 23, 1992; 57 *FR* 55143, Nov. 24, 1992]

Subpart F–Payment Methods for Other Institutional and Noninstitutional Services

Sec. 447.321 Outpatient hospital services and clinic services: Upper limits of payment.

(a) General rule. FFP is not available for any payment that exceeds the amount that would be payable to providers under comparable circumstances under Medicare.

(b) Application of the rule. Payments by an agency for outpatient hospital services may not exceed the total payments received by all providers from beneficiaries and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare.

DRAFT

~~Confidential~~

(c) Government-owned or -operated providers.

(1) In addition to meeting the requirement of paragraph (b) of this section, aggregate payments by any agency for outpatient hospital services provided by a government-owned or -operated providers may not exceed the amount that would be payable to providers under comparable circumstances under Medicare.

(2) For purposes of the preceding paragraph (1), the agency may choose to define the amount that would be payable under comparable circumstances to providers under Medicare that are owned or operated by a unit of local government (that is, other that the State) and that have a low-income utilization rate, as defined at 42 *U. S. C.* 1396r(b)(3), in excess of 30 percent, to include services to both Medicaid beneficiaries and the uninsured and may multiply the result by a factor of two.

52 *FR* 28148, July 28, 1987]

Recent Press Descriptions of UPL Payments

Louisiana:

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

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

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

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

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

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

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

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

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

"I have identified a number of priorities for the money we could receive from this program," [Gov.] Graves [of Kansas] said. Receiving these funds would help us provide nursing-home care and help our state budget in other areas as well." The governor's plan would send **60 percent of the money to a senior services trust fund to finance an as-yet-undeveloped plan to help qualifying seniors buy prescription medicines.**[1] **Twenty-five percent of the money would go to the state general fund to increase the state's share of school special education program costs.... Fifteen percent would go to create a loan fund for upgrading nursing home facilities."**

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

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

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

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

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

New Jersey:

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

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

---

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

Alaska:

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

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

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

Kansas:

"**An accounting trick** used by other states could allow Kansas to **send the money to nursing homes on the condition that they send it back so the state can spend it elsewhere**.... [Governor Graves of Kansas] is optimistic the state would get the federal funding but said lawmakers should be cautious in spending it because the funding source will probably not be available much long. Since more states are becoming aware of the program, Congress may be inclined to close it, he said."

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

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

July 26, 2000

Dear State Medicaid Director:

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

Background

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

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

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

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

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

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

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

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

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

Administration Actions

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

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

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

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

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

Sincerely,

Timothy M. Westmoreland
Director

cc:
All HCFA Regional Administrators

All HCFA Associate Regional Administrators
for Medicaid and State Operations

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

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director, Health Legislation
National Governors' Association

From Tim

Recent Descriptions of UPL Payments

Louisiana:

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

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

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

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

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

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

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

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

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

Alaska:

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

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

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

Kansas:

"**An accounting trick** used by other states could allow Kansas to **send the money to nursing homes on the condition that they send it back so the state can spend it elsewhere**.... [Governor Graves of Kansas] is optimistic the state would get the federal funding but said lawmakers should be cautious in spending it because the funding source will probably not be available much long. Since more states are becoming aware of the program, Congress may be inclined to close it, he said."

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

"I have identified a number of priorities for the money we could receive from this program," [Gov.] Graves [of Kansas] said. Receiving these funds would help us provide nursing-home care and help our state budget in other areas as well." The governor's plan would send **60 percent of the money to a senior services trust fund to finance an as-yet-undeveloped plan to help qualifying seniors buy prescription medicines.**[1] **Twenty-five percent of the money would go to the state general fund to increase the state's share of school special education program costs.... Fifteen percent would go to create a loan fund for upgrading nursing home facilities."**

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

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

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

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

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

New Jersey:

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

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

---

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

PATTON BOGGS LLP
ATTORNEYS AT LAW

2550 M Street, NW
Washington, DC 20037-1350
202-457-6000

Facsimile 202-457-6315

To:	**Chris Jennings**
Company:	
Fax Number:	456-5557
Phone Number:	456-5560
Total Pages Including Cover:	3
From:	**Jody Trapasso**
Sender's Direct Line:	202-457-6535
Date:	July 10, 2000
Client Number:	11830.100

Comments:

For your information, attached please find draft language on Medicaid's institutional upper payment limit tests that are supported by the State of Illinois. Please contact me if you have any questions or need additional information. Thank you in advance for your attention to this matter.

If you did not receive all of the pages or find that they are illegible, please call 202-457-5626.

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

DRAFT

~~CONFIDENTIAL~~

Alternative to the "proposed" changes to the institutional upper payment limit tests. Federal regulation places aggregate limits on Medicaid funding for institutional inpatient services (42 *CFR* 477.272) and hospital outpatient services (42 *CFR* 477.321). State Medicaid agencies have made use of the gap between traditional Medicaid reimbursement levels and those upper payment limits to access additional federal funds that, through intergovernmental transfer arrangements, are returned to the State and spent, usually, but not necessarily, on health care related services. This alternative is intended to make the States accountable to the HCFA for the use of those funds by providing for necessary assurances and a separate accounting of the funds.

PART 433–STATE FISCAL ADMINISTRATION

Subpart A–Federal Matching and General Administration Provisions

Sec. 433.32 Fiscal policies and accountability.

A State plan must provide that the Medicaid agency and, where applicable, local agencies administering the plan will–

(a) Maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements;

(b) Retain records for 3 years from date of submission of a final expenditure report;

(c) Retain records beyond the 3-year period if audit findings have not been resolved; ~~and~~

(d) Retain records for nonexpendable property acquired under a Federal grant for 3 years from the date of final disposition of that property~~.~~; and

(e) Maintain a separate distinguishable account–

(1) Into which Federal funds, claimed as a result of expenditures for institutional services made, in whole or in part, with local public funds, are deposited, and

(2) From which funds are disbursed only for expenditures related to the health care needs of low income individuals.

(3) Transition. This paragraph (e) shall be effective no later than the beginning of the beginning of the State fiscal year following the convening of the first regular session of the State legislature subsequent to adoption of this provision.

[44 *FR* 17935, Mar. 23, 1979]

Subpart B–General Administrative Requirements State Participation

Sec. 433.53 State plan requirements.

A State plan must provide that–

(a) State (as distinguished from local) funds will be used both for medical assistance and administration;

(b) State funds will be used to pay at least 40 percent of the non-Federal share of total expenditures under the plan; and

(c) State and Federal funds will be apportioned among the political subdivisions of the State on a basis that assures that–

(1) Individuals in similar circumstances will be treated similarly throughout the State; and

(2) If there is local financial participation~~, lack~~ –

(i) Lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of services or level of administration under the plan in any part of the State.

(ii) Funding from local sources for services subject to the aggregate payment limitations specified in sections 447.272 and 447.321 of this *Code* have not been used to reduce the amount of State funds used to pay for the non-Federal share of total expenditures under the plan below the level State funds so expended in the twelve-month period ending September 30, 2000.

[57 *FR* 55138, Nov. 24, 1992; 58 *FR* 6095, Jan. 26, 1993]

GRANDFATHER PROPOSAL

Any proposal should include a grandfather provision under the "General Rule" that specifies:

"The agency shall maintain payment methodologies under approved State Plans or State Plan Amendments initially submitted by June 1, 2000."

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Art Hilgart to Christopher Jennings re: phone number and address (partial) (1 page)	07/08/2000	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20145

FOLDER TITLE:
UPL [Upper Payment Limit] [Folder 3]

2012-0463-S
rc829

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

ART HILGART
P6/(b)(6)

P6/(b)(6)

[001]

July 8, 2000

To: Christopher Jennings

Dear Chris Jennings,

Why do I despise Al Gore? It's not because he pretends to take on the drug industry while proposing to give them unlimited dips into the Medicare cookie jar. It's not because he gave the Elk Hills oil deposits to contributors. It's not even because he favors a trade policy in which all the U.S. exports is jobs.

No, it's because I will feel guilty when I vote for Ralph Nader and George Bush wins the election.

Art Hilgart

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*

FROM:

TO: Chris Jennings

OFFICE: _____

FAX: _____

- [ ] JANE HORVATH
- [ ] CHRISTINE BRADSHER
- [ ] PATTI BRANDT
- [X] SHARON CLARKIN
- [ ] DEBORAH DRAYER
- [ ] JOANNE JEE
- [ ] KELLY GREEN KAHN
- [ ] LEO LUBERECKI
- [ ] ROGER MCCLUNG
- [ ] JACK MITCHELL
- [ ] TANISHA PARKER
- [ ] PAUL SELTMAN
- [ ] ZENO ST. CYR II
- [ ] STEPHANIE WILSON
- [ ]

(INCLUDING COVER): _____

REMARKS:

POTENTIAL MEMBERS WHO COULD SUPPORT OUR NPRM ON UPPER PAYMENT LIMIT

Senate Finance Committee

Senator Baucus
Senator Graham
Senator Conrad

Senator Roth
Senator Hatch
Senator Jeffords
Senator Mack

Senator Breaux
Senator Kerry

Senator Gramm

House Commerce Committee

Cong. Dingell
Cong. Waxman
Cong. Stupak
Cong. Gene Green
Cong. Barrett
Cong. Pallone

Cong. Bilirakis
Cong. Bliley
Cong. Upton

Cong. Brown

Cong. Ganske
Cong. Coburn

Senate Appropriations Committee

Senator Leahy
Senator Reid
Senator Mikulski

Senator Domenici
Senator Cochran

House Appropriations Committee

Cong. Obey
Cong. Hoyer
Cong. Sabo
Cong. DeLauro

Cong. Bonilla
Cong. Miller (FL)

Senate Budget Committee

Senator Sarbanes

Senator Mack

House Budget Committee

Cong. Spratt
Cong. Minge
Cong. Weygand
Cong. Kleczka

Cong. Shays

Groups

Families USA
Center for Budget and Policy Priorities.

DRAFT AGENDA: UPPER PAYMENT LIMITS IN MEDICAID

July 13, 2000

UPDATE

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

CONSENSUS

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

OPTIONS ON TIMING / ROLLOUT

1. **NPRM at earliest date (July 21)**
   - Postponing NPRM only increases pressure on Administration not to publish it
   - Minimally needed consultation could occur within a week
2. **Delay NPRM to early August, more consultation**
   - Provides time needed for meaningful consultation
   - Releasing while Congress is in session risks riders
3. **Notice of Intent / State Medicaid Directors' Letter now and NPRM in mid August**
   - Ensures that we have cleared language on record about our concerns / priorities
   - Does not formally solicit comment which are likely to be numerous and complicated
4. **Advance NPRM now and NPRM in late August**
   - Addresses the lack of information on the practice
   - Perceived by hospitals as least aggressive – but by critics as an indication of lack of seriousness

UPL CONSULTATION AND ROLL OUT

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

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

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

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

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

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

FINANCE COMMITTEE

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

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

Senator Mack
Senator Nickles
Senator Gramm

COMMERCE COMMITTEE

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

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

SENATE APPROPRIATIONS COMMITTEE

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

MEETING 6 - One Week Before
Senator Domenici
Senator Cochran

HOUSE APPROPRIATIONS COMMITTEE

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

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

DAY OF RELEASE BRIEFINGS

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

Friday morning

Dear State Medicaid Director,

In the last several months, many of you have inquired about the status of the Administration's potential changes to the upper payment limits under Medicaid. This letter is an interim response, outlining our process and priorities as we strive to address this issue and maintain our commitment to Medicaid, its providers, the people it serves, and the people who pay for it.

insert BAD stuff

It has come to our attention that some States have been using a combination of the high Medicaid payment rates to public providers and intergovernmental transfers to gain extra Federal Medicaid matching payments. In some cases, it appears that the public hospitals and nursing homes are the primary beneficiaries of this practice, which helps offset their rising costs of uncompensated care. Other States claim that they are using these funds to expand their State Children's Health Insurance Programs (SCHIP), implement the Olmstead decision, or invest in other priorities shared by the Administration. Still others are reported to be using funds for non-Medicaid and non-health purposes, like tax cuts and reducing class size. Irrespective of how these funds are used, this practice is not consistent with Medicaid law that specifies that provider payments must be economic and efficient. Moreover, it has contributed to recent, rapid rises in Federal Medicaid spending, with no commensurate increase in Medicaid coverage, quality, or amount of services provided. This will have the long-run effect of undermining the broad-based support for Medicaid which guarantees critical health services to our most vulnerable populations: low-income children and families, people with disabilities and the elderly. As such, the Administration is contemplating actions to address this practice.

BACKGROUND

As you know, States have an incentive to set reasonable and efficient provider payment rates since they pay a percent of total Medicaid costs. However, this incentive does not extend to public hospitals and nursing homes. If the payment rate to a public provider is high, then the Federal matching payment is high. While this would imply a higher State payment as well, States can use intergovernmental transfers to either count existing public hospital or nursing home payments as its Medicaid contribution or recoup its contribution to the public providers. Through such an arrangement, a State can increase Federal funding with no net increase in State expenditures.

Current regulations include an upper payment limit for Medicaid rates but it has become apparent that this limit is not binding for many public providers. These regulations stipulate that aggregate State payments for each class of service (inpatient and outpatient hospital, nursing facility, and intermediate care facility services) may not exceed a reasonable estimate of the amount the State would have paid under Medicare payment principles. The use of a single upper limit on overall aggregate payments allows States to develop methodologies that differentiate rates for non-State government and private facilities, paying the public facilities significantly higher than private facilities. In a State

with more private than public facilities, a small reduction in private rates can allow for a large increase in rates for public facilities. In one recent state plan amendment, the proposed rate for public nursing homes was over 12 times higher than that of private nursing homes. This allows excess Federal matching payments to be generated and, through the use of intergovernmental transfers, shared with State and local governments.

It appears that, in some States, these higher payments are kept by public hospitals and nursing homes to help pay for uncompensated care. While Medicaid disproportionate share hospital (DSH) payments are intended to cover these costs, this program has not successfully enabled hospitals to meet the growing challenge of caring for the uninsured. States can, through the current upper payment limit, circumvent statutory DSH limits.

States also appear to be using excess Federal matching payments resulting from this practice for health-related purposes. Several States claim that these excess Federal payments have provided the resources needed to expand coverage to uninsured children through SCHIP. Others report that this practice is generating the State share of the costs of providing care to people in the most integrated setting, as required by the Americans with Disabilities Act. ~~One governor announced his intent to Federal~~ payments generated through the upper payment limit ~~/ intergovernmental transfer practice to ex~~pand prescription drug coverage to low-income seniors.

Finally, reports suggest that some States have used this practice for non-health care purposes. Several States appear to have used it to fill budget gaps, replacing State Medicaid contributions with Federal Medicaid funding generated from this practice, with no net increase in Medicaid services. This results in an increase in the effective Federal matching rate for these States beyond the legally-set formula. Another State's local newspaper reported that Federal Medicaid funding would be used for tax cuts or reducing State debt. This type of general revenue sharing is clearly not consistent with Medicaid statute, Congressional intent, or Administration policy.

There is preliminary evidence that this practice has contributed to a spike in Federal Medicaid spending. The State estimates of Federal Medicaid spending for FY 2000 have increased by $3.4 billion since the Mid-Session Review; about $1.9 billion of it may have resulted from existing states' practices or the influx of new applicants. The 5-year cost would be about $12 billion. Currently, about [12] States have approved waivers and another [14] have applied for it.

ADMINISTRATION ACTIONS

While it is clear that the current upper payment limits allow for payments that are not economic and efficient, the solution and its impact are not obvious. It may be the case that higher payments to public hospitals or nursing homes are justifiable given their cost structures and mission to serve Medicaid and uninsured people. It is also probable that a dramatic and sudden change in upper payment limits could undermine States ability to fund their Medicaid and SCHIP programs. On the other hand, allowing this practice to

continue could result in the type of skyrocketing Medicaid costs in the early 1990s that strained the Federal budget and undermined support for the Medicaid program.

The Administration is in the process of developing a proposal to ensure that Medicaid payments meet the statutory obligation of efficiency and that any change has adequate input and transition. We intend to publish a Notice of Proposed Rule Making (NPRM) in the next several weeks. As we work to develop this proposal, we will meet with you and representatives of consumers, public hospitals, nursing homes, unions and others to hear concerns and suggestions. We will also explore the idea of legislation that puts an immediate end to paying States that file a state plan amendment in the intervening period before any regulation takes effect. These proposed actions are intended to maintain the Administration's commitment to protecting Medicaid, recognizing how important it is to low-income seniors, families, and people with disabilities. The Administration also is committed to ensuring the viability of safety net providers who provide critical health services to the growing number of uninsured. [needs work]