

THE WHITE HOUSE
WASHINGTON
COUNSEL'S OFFICE

FACSIMILE TRANSMISSION COVER SHEET

DATE: 10/5/00

TOTAL PAGES (INCLUDING COVER PAGE): 3

TO: Chris Jennings

ATTN: _____

FACSIMILE NUMBER: 65557

TELEPHONE NUMBER: _____

FROM: Bruce R. Lindsey at 202-456-2100

COMMENTS: _____

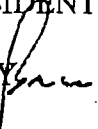
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THE WHITE HOUSE
WASHINGTON

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

10/4/2000

UPL REGULATION ROLLOUT PLAN

(Assumes NPRM goes on display, 1pm, 10/5/00)

PAPER

NPRM	Public
Press Release	Public
Fact Sheet	Public
Internal Qs and As	Internal
Talking Points	Internal

Evening **PRIOR TO REG GOING ON DISPLAY** (After COB -- 6pm -- 10/4/00)
(informed that NPRM will go on display 1pm the next day)

Advocates (Validators)

Center on Budget & Policy Priorities -- Jeanne Lambrew
Judy Feder -- Jeanne Lambrew
Families USA/Judy Waxman -- Tim Westmoreland
Diane Rowland & Andy Schneider-- Tim Westmoreland

Senate Finance Committee

Jennifer Baxendell (Roth) - Jane Horvath (offer all Senate LA briefing for Friday)

Commerce Committee

Bridget Taylor (Dingell) -- Jane Horvath (offer all House LA briefing for Friday)
Karen Nelson (Waxman) -- Jane Horvath

DAY OF DISPLAY ROLLOUT

Members of Congress Calls (10:00 am calls, heads up, day of display)

Rep. Dingell (HHS-KT)
Rep. Waxman (HHS-KT)
Sen. Roth (HHS-KT)

Members of Congress Calls (10:30 am calls, heads up, day of display)

Sen. Harkin (DES)
Sen. Barbara Boxer (HHS-DES)
Rep. Jesse Jackson Jr (HHS-DES)
Sen. Durbin (WH-JP)
Rep. Porter (HHS-JC)
Rep. Obey (HHS-JC)
Rep. Hastert (WH-?)
Rep. Rangel (WH-?)
Sen. Shumer (WH-?)
Sen. Toricelli (WH-?)

Sen Grassley (HHS-MH)
Rep. Jan Schakowsky (HHS-TW)
Rep. Danny Davis (HHS-TW)
Rep. Rush (HHS-TW)
Rep. Blagojevich (HHS-TW)

Members of Congress Calls (1:00 pm calls, day of display)

Sen. Specter (HHS-JC)
Rep. Greenwood (HHS-MH)
Rep. Engel (HHS-MH)
Rep. Shimkus (HHS-TW)
Rep. Becerra (HHS-TW)
Rep. LaHood (HHS-TW)
Rep. Murtha (WH-CB)
Rep. Coyne (WH Leg, follow-up HHS-JH)

Congressional Staff Calls (11:00 am calls, heads up, day of display, unassigned calls to be tasked to HCFA and ASL staff)

Jane Lowensen (Daschle) -- JH (offer all Senate LA briefing for Friday)
Andie King (Gephardt) -- JH (offer all House LA briefing for Friday)
Peter Rhienke (Harkin)
Tony McCann (Porter) -- JH
Mark Mioduski (Obey) -- JH
Amy Jensen (Hastert) -- JH
David Podoff (Moynihan) -- C. Jennings
Ellie Dehoney (Brown) -- JH
Ann Marie Murphy (Durbin)
Jon Sheiner (Rangel) -- JH
Tom Coffey (Schumer)
Kyle Mulroy (Torecelli)
Glenda Booth (Feinstein) -- JH
Steve Giuli (Pallone)
Kim Parker (Rush) -- JH
Sarah Walters (Breaux)
Ted Totman (Grassley) -- JH
J Jackson Jr. staff -- JH
Blagojevich staff Mike -- JH

Congressional Staff Calls (1:00 pm calls, day of display)

Tom Giles (Bliley) -- JH
Shimkus staff
Joel White (Greenwood) -- JH
Allie (Specter)

Murtha staff
Elliot Engel staff
LaHood Staff

State and Local Governments Calls (10:30 am day of display)

Iowa: John Norris (Gov's COS) -- HHS-AH
Phil Buchan (Gov's DC Dir.) --HHS- AH
Illinois: Winnie Pazano/Bernie Robsinson (Gov. Ryan's DC Dir.) --HHS- AH
John Stroger or Orlando Jones (COS) (Cook County Board President) HHS--- AH
Ruth Rothstein (Cook County Hospital) -- HHS-AH
California: Olivia Morgan (Gov's DC Dir) -- HHS-AH
Grantland Johnson (HHS Secretary) -- HHS-AH
Mark Finucane (LA County Health Director) -- HHS-AH
Susan White (LA County) -- HHS-AH
New York: Brad Beckstrom (Gov's DC Dir) -- HHS-AH
NGA: Ray Scheppach -- *Chris Jennings*
Matt Salo -- HHS-AH

State and Local Governments Calls (1 pm NPRM on display)

NASMD: Lee Partridge -- HHS-LB
NASMD: Linda Wertz & Roger Auerbach -- HHS-TW or LB
NACO: Sally McElroy -- HHS-LB
USCM: Crystal Swann -- HHS-LB
NCSL: Joy Wilson -- HHS-AH
Alabama: Sabra Barnett (Gov's Policy Director) -- HHS-AH
Oregon: Tracy Straub (Gov's DC Office)
Pennsylvania: Becky Halkias (Gov's DC Dir) -- HHS-AH
Georgia: Greg Andrews (Gov's DC Dir) -- HHS-AH
Alaska: John Katz (Gov's DC Dir) -- HHS-AH
Tennessee: Wendell Moore (Gov's COS) -- HHS-AH
New Jersey: Susan Spencer (Gov's DC Dir) -- HHS-AH
Kansas: Joyce Glasscock (Gov's COS) -- HHS-AH
North Dakota: Bill Goetz (Gov's COS) -- HHS-AH
Michigan: LeAnne Redick Wilson (Gov's DC Dir) -- HHS-AH
Wisconsin: Mary Kaye Mantho --HHS-AH

Hospital Associations (Beginning when NPRM actually goes on display *1pm*)

National Association of Public Hospitals - Tim Westmoreland
American Hospital Association/Thomas Nickels - Tim Westmoreland
Federation of American Health Systems - Jane Horvath

Other Groups (Beginning when NPRM actually goes on display *1pm*)

SEIU/Carol Regan - Chris Jennings
AFSCME/Carol Burke - Jeanne Lambrew

DAY OF DISPLAY ROLL-OUT BY KEY STATE DELEGATIONS

CA

Waxman (10:00, HHS)
Boxer (10:30am, HHS)
Becerra (1pm, HHS)
Gov's Office (10:30am, HHS)

NY

Shumer (10:30am, WH)
Rangel (10:30am, WH)
Podoff (10:30am, WH)
Engel (1pm, HHS)
Gov's Office (10:30am, HHS)
NY Hospitals (1pm, WH)

IL

Durbin (10:30am, WH)
Hastert (10:30am, WH)
Porter (10:30am, HHS)
Schakowsky (10:30am, HHS)
Blagodevich (10:30am, HHS)
Jackson (10:30 am, HHS)
Rush (10:30am, HHS)
Davis (10:30 am, HHS)
Shimkus (1pm, HHS)
LaHood (1pm, HHS)
Gov's Office (10:30am, HHS)

PA

Specter (1pm, HHS)
Murtha (1pm, WH)
Greenwood (1pm, HHS)
Coyne (1pm WH/HHS)
Gov's office (1pm, HHS)

IA

Harkin (10:30 am, HHS)
Grassley (10:30 am, HHS)
Gov's Office (10:30am, HHS)

TALKING POINTS

- Today we sent to the Federal Register a Notice of Proposed Rule Making to change the rules by which states use the Medicaid Upper Payment Limit (UPL) to gather excess federal matching funds for use outside the Medicaid Program.
- We take this action today after extensive consultation with various stakeholders: states, individual Members of Congress, hospitals, program advocates, and other providers. There has been a Congressional hearing into this practice and our program management, as well as considerable investigation by the HHS Inspector General and the Congressional General Accounting Office. The abuse of the current system has become well known and well documented.
- The proposal we are putting forward today takes into consideration all that we have heard and learned over the last six months. The proposal comports with our statutory obligations to properly manage the program and maintain its fiscal integrity. At the same time, the proposal recognizes the needs of states and providers who have come to rely on this inappropriate funding mechanism.
- Specifically, we propose to change the upper payment rules to prohibit the averaging and aggregating of payments across publically and privately owned facilities. States will now have to set a separate payment limit for private facilities and another for public facilities – for example, a payment limit for public nursing homes and another for private nursing homes.
- States will continue to be able to use Medicare payment principles in setting these upper limits which should provide considerable leeway underneath the limit because Medicaid payments are generally well below those of Medicare.
- States will continue to be able to use Intergovernmental Transfers. We do not propose to change existing law or regulation in this area.
- For non-state public hospitals, we propose to set the upper payment limit at 150% of the Medicare Upper Payment Limit because we understand the special situation of these vital facilities and the challenges they face.
- We propose to allow states a significant period of transition - particularly those who have been operating these systems for a long time. States who had these systems in effect prior to October 1, 1999 will effectively have 5 years to phase out their programs. States with more recent systems will have two years to phase-out their use. This is consistent with the warning we have given all officials in newer system states that they will not have this system on which to rely because we will be shutting it down.
- No state will have to reduce its funding for the current state fiscal year.

- While we believe our regulation is generous in its provisions to assist hospitals, it does not address the larger issue, which is the financial challenge facing hospitals serving low-income and uninsured patients. As such, we propose to raise both the state disproportionate share hospital (DSH) allotments as well as the public hospital-specific DSH limits. The House Commerce Committee passed on a bipartisan basis a provision to raise state allotments and we will work with Congress to assure that such a proposal passes. In addition we would support raising the hospital-specific DSH limit to 175% of net uncompensated care costs, like California's current limit. These proposals provide a legitimate and stable source of funding for hospitals and states.
- Lastly, I need to remind you that this proposal is just the first phase of our rule making process. We are soliciting comment in the next 30 days and will then publish a final rule, which Congress will have the opportunity to review. Again, our final rule will include the significant transition period I mentioned earlier.
- I hope you can support our action today and will consider what we believe to be our even-handed approach to ending abusive practices that would only undermine the Medicaid program in the long run.

Medicaid and the Upper Payment Limit Pooling
HCFA Q&As
Updated October 04, 2000

INTERNAL USE ONLY

Background:

HCFA has just published a very important Notice of Proposed Rulemaking (NPRM) in the *Federal Register*. The NPRM proposes changes to the definition of the upper payment limit (UPL) as it applies to Medicaid reimbursement to providers such as hospitals and nursing facilities. The regulatory changes proposed in the NPRM are critical to continued fiscal integrity of the Medicaid program. The proposal attempts to balance the needs of beneficiaries, providers and Federal investment in Medicaid.

Over the past several months, the Administration has noted an alarming trend in State's use of the flexibility in current Medicaid payment rules. The practice appears to be creating rapid increases in Federal Medicaid spending, with no commensurate increase in the number of Medicaid beneficiaries who receive coverage, or in the quality or amount of services provided.

Recognizing the current reliance on this practice by states and public hospitals, the proposed regulation includes a generous transition and allows public hospitals to have a higher upper payment limit. We also intend to put forth a legislative proposal to help hospitals that serve a disproportionate share of Medicaid and uninsured patients. Our proposal would dedicate \$10 billion over 10 years to increase Medicaid disproportionate share hospital (DSH) payments. This would be done through a combination of increasing state DSH allotments, similar to what passed the Commerce Committee on a bipartisan basis, and increasing the hospital-specific DSH limits. We would work with Congress on an acceptable formula for the state allotment increases, and would recommend that the hospital-specific limits be raised to 175 percent of net uncompensated care costs beginning in 2002, like California's current limit. We believe this will help ensure the financial viability of large urban safety net hospitals that play a critical role in providing care to our most vulnerable populations.

This is a proposed rule and we will solicit comments on our proposed changes to the UPL policy, as well as the transition provisions and will work with Congress to enact legislation to assist states and safety net providers.

PROPOSED REGULATION

Q1: What is HCFA doing?

A1: HCFA has just published a very important Notice of Proposed Rulemaking (NPRM) in the *Federal Register*. The NPRM proposes changes to the definition of the upper payment limit (UPL) as it applies to Medicaid reimbursement to providers such as hospitals and nursing facilities.

Q2: Why is HCFA issuing this NPRM?

A2: Over the past several months, the Administration has noted an alarming trend in State's use of the flexibility in current Medicaid payment rules. The practice appears to be creating rapid increases in Federal Medicaid spending, with no commensurate increase in the number of Medicaid beneficiaries who receive coverage, or in the quality or amount of services provided. Continuation of this trend could have the long-term effect of undermining the broad-based support for Medicaid, which guarantees critical health services to our most vulnerable populations: low-income children and families, people with disabilities, and the elderly.

Q3: How would the NPRM change current regulations?

A3: We have proposed that States would no longer be able to group private and public (non-State owned) facilities together within each class of provider when applying limits based on Medicare payment principles. The NPRM would create three separate limits for private, State owned, and other governmental facilities. In general, for each of these groups, States could continue to pay up to the maximum total amount available under Medicare payment principles. To recognize the special mission assumed by certain public hospitals, we are proposing higher limits for these facilities.

For nursing homes, intermediate care facilities for people with mental retardation, and free-standing clinics, the regulation will limit the pooling arrangement to 100 percent of what Medicare would pay for services *in that pool*. For non-State public hospitals, the regulation will allow reimbursement within the pool up to 150 percent of what Medicare would pay. The additional 50 percent will help these critical safety net facilities continue to meet the high cost supplementary financial obligations they must meet in providing essential community and social support services to patient populations with generally greater need, lower health care status, and limited private insurance coverage.

Q4: Will stakeholders (States, Congress, providers, etc.) be able to comment on the NPRM?

A4: This is a proposed rule and we will solicit comments on our proposed changes to the UPL policy, as well as the transition provisions. The comment period is 30 days.

Q5: Why is HCFA trying to take away millions of federal Medicaid dollars that states use to provide nursing-home care and other essential services?

A5: The NPRM makes it clear that we simply want to close a loophole that has allowed some states to draw down extra federal matching Medicaid funds inappropriately. These funds may be used for purposes unrelated to Medicaid and, in some cases, unrelated to health care entirely.

Medicaid is a federal-state partnership, and both the state and federal government contribute to its success. We want to pay our fair share of Medicaid's costs of nursing-home care and other medical services that the states provide to low-income Medicaid-eligible children and families, and elderly and disabled residents.

However, some states are using a loophole in the Medicaid "upper payment limit" requirements to pay excessive payment rates to certain government-owned facilities. In

some cases, the states then require those facilities to return large portions of that money. This practice is not consistent with the intent of the Medicaid statute, which specifies that provider payments must be economic and efficient and that states pay their share of the costs. If a state requires facilities to refund its own Medicaid contribution, the practice undermines the requirement that the state share in the funding for its Medicaid program.

Q6: Aren't you just blaming states for the problems that you created?

A6: The way some states have been using the Medicaid upper payment limit is clearly not consistent with the intent of the Medicaid statute. In fact, newspapers reporting on some of these practices quote state officials describing the extra money generated through this loophole as a "windfall" that is "too good to be true." One state official was even quoted as saying, "Every time I hear about it, I feel like I'm a drug dealer or something."

However it is described, the effect of this practice is to raise the federal cost of the Medicaid program without increasing the number of Medicaid beneficiaries, the amount or quality of Medicaid services, or the reimbursements genuinely paid to Medicaid providers. That's the issue we want to address, and we're asking the states for their ideas on how best to achieve this while protecting Medicaid beneficiaries.

Q7: How many states have approved or pending enhanced payment arrangements?

A7: There are 20 states with approved enhanced payment arrangements: Alabama, California, Illinois, Indiana, Iowa, Kansas, Massachusetts, Michigan, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oregon, Pennsylvania, South Carolina, Tennessee, Washington.

There are 11 states with pending enhanced payment arrangements: Alaska, Arkansas, Georgia, Illinois, Louisiana, Michigan, Missouri, Montana, Pennsylvania, South Dakota, Washington.

****Some states have both approved and pending enhanced payment arrangements, and some States have more than one plan approved or pending.**

Q8: How are states using the upper payment limits to get more federal money?

A8: Our concerns involve the way some states are using the Medicaid upper payment limit to draw down extra federal matching Medicaid funds. Specifically, some states are calculating the maximum amount that, in theory, could be paid to each Medicaid facility. This is known as the "upper payment limit." States may pay less than that amount to most healthcare facilities and then add the rest together to create an excessive payment rate to a few county- or city-owned facilities.

These government-owned facilities may be required to return some or all of those excessive payments to the states, where they can be used to offset the state's share of Medicaid costs or other budget needs unrelated to Medicaid. As a result, federal taxpayers in all states pay more than their share of Medicaid program costs in a few states that use these techniques.

Q9: If this is so abusive, why did you let states do this to begin with?

A9: States have significant flexibility to set their Medicaid payment rates as part of their approved plan, and a few states have used this flexibility to an extent not intended or envisioned by HCFA. HCFA's intent was to allow States the flexibility to pay different rates to certain facilities that may have higher costs due to the fact that they may treat sicker patients, have higher staff to patient ratios or have to pay higher labor costs due to their geographic locations.

Until recently, relatively few states used these techniques in their approved Medicaid plans. Now, more and more states are considering these arrangements to increase their federal Medicaid matching funds and balance their budgets. As a result, federal Medicaid costs are projected to increase by billions of dollars without any corresponding increase in the number of Medicaid beneficiaries, in the types and quality of Medicaid services, or in the actual payment rates for Medicaid services.

We published this proposed regulation to close this loophole. We want to gather more input from states, public hospitals, nursing homes, consumers and labor groups about ways to achieve this goal while ensuring a smooth transition period. All these groups will have an opportunity to comment before we would make the regulation final.

Q10: What are you doing to help states transition to the new policy?

A10: The NPRM includes generous transition periods for states with approved enhanced payment arrangements. Longstanding plans (approved before 10/01/99) will have until State Fiscal Year 2006 to come into full compliance with the new regulation. Recently approved plans (10/01/99 and after) will have until September 30, 2002 to come into compliance with the new regulation. Additionally, we are seeking comments on alternative ways to help states make this transition to the new policy during the comment period on the NPRM.

Q11: How much money is wasted nationally this way? How much does (MY STATE) get, and what is (MY STATE) spending the extra money on?

A11: Nationally, tens billions of dollars are at risk because of this loophole. Currently these enhanced payment arrangements are operating in 20 States, there are an additional 11 proposals that are pending. Assuming additional States come forward with the enhanced payment arrangement proposals, the cost of this will continue to escalate. This could have the long-term effect of undermining public support for Medicaid, which guarantees critical health services to our most vulnerable populations: low-income children and families, people with disabilities, and the elderly.

At this point, we're still assessing each state's use of the Medicaid "upper payment limit." State officials would be better able to explain exactly what they are doing, and how they spend any additional money that they received as a result. The HHS Inspector General also is investigating to help us evaluate the practices used in a few states.

Q12: What are the findings of the Inspector General?

A12: The IG's Office is conducting reviews of Medicaid enhanced payments to public providers and the use of intergovernmental transfers (IGT) in six States. The objectives of the reviews are to analyze the use of enhanced payments and to evaluate the financial impact of Upper Payment Limit arrangements coupled with IGTs on the Medicaid program. Although not all of the reviews are complete, the IG has found that the Medicaid enhanced payments to government owned health care facilities in the States were not based on their actual cost of providing services to Medicaid beneficiaries, or directly related to increasing the quality of care provided by public facilities. They also found that a large portion of the enhanced payments were not retained by the facilities to provide services to Medicaid beneficiaries. Instead, the majority of the funds generated in the States reviewed thus far have been transferred back to the State treasury for other uses.

The IG found that if regulations were changed to include a separate aggregate upper limit applicable to payments made only to local government owned facilities, the funds available, to the States reviewed, for enhanced payments to public providers would be significantly reduced. Thus, Federal Medicaid funds that public providers are able to transfer to the State for other uses would be limited.

In an alert memorandum to HCFA dated August 7, 2000, the IG recommended that HCFA move as quickly as possible to issue regulatory changes involving the upper payment limit calculations. They continue to recommend that HCFA take quick action to place a control on the financing mechanisms being used by States to circumvent the Medicaid program requirement that expenditures be a shared Federal/State responsibility.

Q13: Are you going to force states to pay back money that they misspent in the past?

A13: We are not proposing any retroactive changes. Our main goal is to close this loophole and ensure that the money that federal taxpayers contribute to the Medicaid program is used for Medicaid purposes.

Q14: My state says that they use this money to help the public hospitals that care for indigent patients without getting paid. Won't this change hurt public hospitals?

A14: We obviously want to protect those hospitals that serve the neediest Americans, including the network of public hospitals that historically have served as a safety net for those unable to pay for their own care. In fact, the federal government already contributes to this public good through \$14 billion in disproportionate share payments to hospitals.

In the NPRM we recognize the potential impact on non-State public hospitals and set the upper payment limit for public hospitals at 150 percent of the amount Medicare would have paid for the same services. The additional 50 percent will help these critical safety net facilities continue to meet the high cost supplementary financial obligations they must meet in providing essential community and social support services to patient populations with generally greater need, lower health care status, and limited private insurance coverage.

Additionally, we will be proposing legislation to allow states to lift the current DSH cap so that hospitals could receive up to 175% of those costs. We believe this will help ensure the financial viability of large urban safety net hospitals that play a critical role in providing care to our most vulnerable populations.

Q15: How much does this regulation save?

A15: Nationally, tens of billions of dollars are at risk because of this loophole. The changes proposed in the regulation are intended to protect the fiscal integrity of the Medicaid program and prevent costs from spiraling out of control. In the regulation, we are seeking comments from the public on the specific fiscal and programmatic impact of the proposed rule changes.

Q16: How will Congress react to this NPRM?

A16: While members of Congress are clearly interested in the impact of the NPRM on their state and programs, the Administration has received support for moving forward to protect the fiscal integrity of the Medicaid program and the federal treasury. Senator Roth and Representatives Waxman and Dingell have supported the Administration's deliberative and careful consideration of this issue.

Q17: Didn't Congress make it clear that Intergovernmental Transfers (IGTs) are protected by law?

A17: The NPRM does not change or limit the use of Intergovernmental Transfers. The use of IGTs is protected in 1903(w). This NPRM addresses regulatory changes associated with payment principles in 1902(a)(30).

Q18: Why can't we grandfather states currently using this practice?

A18: We believe it would be inequitable and legally tenuous to grandfather certain state practices. We have proposed adequate transition periods, special limits for non-State public hospitals, and are submitting legislation to address some of the serious concerns raised about the potential negative impact on providers.

Q19: Is this NPRM aggressive enough to solve the problems?

A19: While the NPRM does not make changes overnight, we believe this NPRM balances the need to protect the fiscal integrity of the Medicaid program. The proposals in the NPRM represent our best attempt at a solution that balances the needs of beneficiaries, providers and Federal investment in Medicaid.

Q20: Why is there special treatment for public hospitals and not other providers?

A20: The Administration sets out special limits and will submit legislation related to public hospitals because we recognize that public hospitals provide a lot of uncompensated care. This is not the case in nursing homes. Most nursing home patients have Medicaid, Medicare, private insurance or pay out of pocket for care.

Q21: Can this regulation become final in this Administration?

A21: That is our intention. After the 30-day comment period, we will work diligently to address comments and publish a final regulation as soon as possible thereafter. Because it is a major rule, it will go into effect 60 days from the final rule's publication which we hope to be by January 20th, 2001.

Q22: Why did it take so long to put out the NPRM?

A22: This is an important change that impacts Medicaid programs, providers and states. We have approached this issue seriously and deliberatively trying to balance many competing interests.

Q23: Why are we making UPL funding illegal for those States that spend all of the money on worthy, Medicaid-eligible services or other health care related services?

A23: We recognize that some States have ear-marked this UPL money for worthy health related services and sometimes even for Medicaid covered services. Unfortunately, once the money is returned to the State treasuries there is no way for HHS to effectively track the money. Even if a State specifically ear-marks the money for health care purposes, the UPL money could be just be supplanting other health care dollars which could then be freed up to pay for roads and bridges.

This UPL money is Medicaid money and federal statute and regulation restrict Medicaid spending to Medicaid eligible services and populations. While some States are using this money to pay for laudable, health care related services, if the services or the people receiving them are not covered under Medicaid statute, it is inappropriate for this money to be used to pay for the services. Even when States use UPL money to pay for Medicaid services for Medicaid eligibles, the financing arrangements are still a problem. Because the money is recycled through State treasuries, there are little or no real State matching dollars put up. The IG and GAO believe these UPL payment arrangements violate both the letter and the spirit of the Medicaid laws.

Our proposal recognizes that many States are using this money for worthy purposes and the NPRM includes provisions to help States continue to fund hospitals that have a significant burden of charity care. We are also proposing legislation to help Medicaid DSH hospitals.

Q24: What is the legislative proposal and how is it related to the NPRM?

A24: Recognizing the financing challenges facing hospitals that serve low-income and uninsured patients, we support increasing Medicaid disproportionate share hospital (DSH) payments by \$10 billion over 10 years. This would be done through a combination of increasing state DSH allotments, similar to what passed the Commerce Committee on a bipartisan basis, and increasing the hospital-specific DSH limits. We would work with Congress on an acceptable formula for the state allotment increases, and would recommend that the hospital-specific limits be raised to 175 percent of net uncompensated care costs beginning in 2002, like California's current limit.

Q25: How will you pay for this? Is it part of your \$40 billion dedication for provider payment restorations?

A25: At this point, the House and Senate are considering provider restoration bills that cost \$70 to \$80 billion over 10 years. The House has already included \$8 billion for Medicaid DSH. Surely, this initiative can be funded within these totals in the final bill.

Q26: Will you not publish the final rule on UPL if Congress does not pass this legislation?

A26: We intend to publish a final rule irrespective of the Congressional decision about our legislation. That said, we think that there is every likelihood that Congress will pass this proposal since part of it has already passed the Commerce Committee on a bipartisan basis; the majority of members of Congress are cosponsors of legislation to increase DSH, and hospitals and consumer advocates are united in their support of it.

Q27: How much does your regulation save and are you reinvesting those savings in your legislation?

A27: The cost of the current practice is tens of billions of dollars. Some of these excess Federal payments are being used for safety-net providers – in part, because programs to help them are underfunded. This why – regardless of the proposed regulation – we need to provide a stable and appropriate funding stream for hospitals that serve low-income patients. Our proposed \$10 billion investment in Medicaid disproportionate share hospitals (DSH) will go a long way towards providing the steady funding that is needed to enable these institutions to continue to provide access to critical health care in underserved communities.

Q28: What are the Congressional Budget Office (CBO) scores on this proposal?

A28: There are two CBO scores related to this issue that have been reported publicly although neither one was released officially by CBO. One of the scores was about \$127 billion over ten years. We understand this to be the savings associated with legislative action to shut down the UPL loophole. The other figure is around \$61 billion over ten years. This figure represents the costs associated with legislative action to block HHS from moving forward with a regulation to close the UPL loophole. Neither of the CBO scores is related in any way to the specific proposal we published today.



CENTER ON BUDGET AND POLICY PRIORITIES

September 27, 2000

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

by Leighton Ku

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

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

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

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

¹ Testimony of Kathryn Allen, U.S. General Accounting Office before the Senate Finance Committee, Sept. 6, 2000. Testimony of Michael Mangano, Office of the Inspector General, Dept. of Health and Human Services, before the Senate Finance Committee, Sept. 6, 2000.

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

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

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

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

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

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

example, if subsequent analyses support the belief that the final rule would significantly harm selected safety net hospitals, Congress could establish a more straightforward and accountable method of increasing funding for those hospitals, rather than continuing the current abuse-prone financing arrangements.

Background

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

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

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

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

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

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

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

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

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

Research from the Urban Institute indicates that in recent years, the federal cost of UPL financing arrangements has burgeoned, rising from \$313 million in 1995 to \$1.4 billion in 1998.⁶ Preliminary data from HCFA suggest the federal cost may be at least twice as high by 2001, with a potential federal cost of more than \$3 billion.⁷

How Does the UPL Loophole Work?

Before describing the Rube Goldberg-like accounting arrangements inherent in UPL practices, it may be useful to discuss the key concept underlying these financial arrangements. A state makes inflated payments to a select group of nursing homes, hospitals or other health care facilities that a county or other local government owns, with the payments being in excess of the actual cost of the medical services these institutions provide to Medicaid beneficiaries.⁸ The

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

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

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

state then requires these providers to give back much or all of this extra money to the state in the form of "intergovernmental transfers." The state uses the large payments it has made to the providers to claim a large federal matching payment, which will equal at least 50 percent of the payment the state has made to the providers. The state thus receives these federal matching dollars without having put up a commensurate amount of state funds.

Three steps are involved in a UPL financing arrangement.⁹

- First, the state makes a special payment to a select group of nursing homes or hospitals. Typically, this is done by making "supplemental payments" (above and beyond the regular Medicaid reimbursements) to county-owned or other local government-owned institutions. The size of these payments is based on the "upper payment limit," which is described in the next section of this analysis. The payments to these selected providers usually exceed the actual cost of delivering care and are much larger than the payments the state really intends to make for the provision of health services.
- Next, the county-owned or other local government-owned facilities return to the state Medicaid agency a large portion of the supplemental payments. County-owned or other local government-owned facilities are used because they can use intergovernmental transfers to return the money.¹⁰
- The state claims a federal matching payment for the supplemental payments. The matching funds the state receives can be mingled with other state funds and used for any purpose the state chooses, including paying for other Medicaid or health care expenses, building roads, or financing tax cuts.

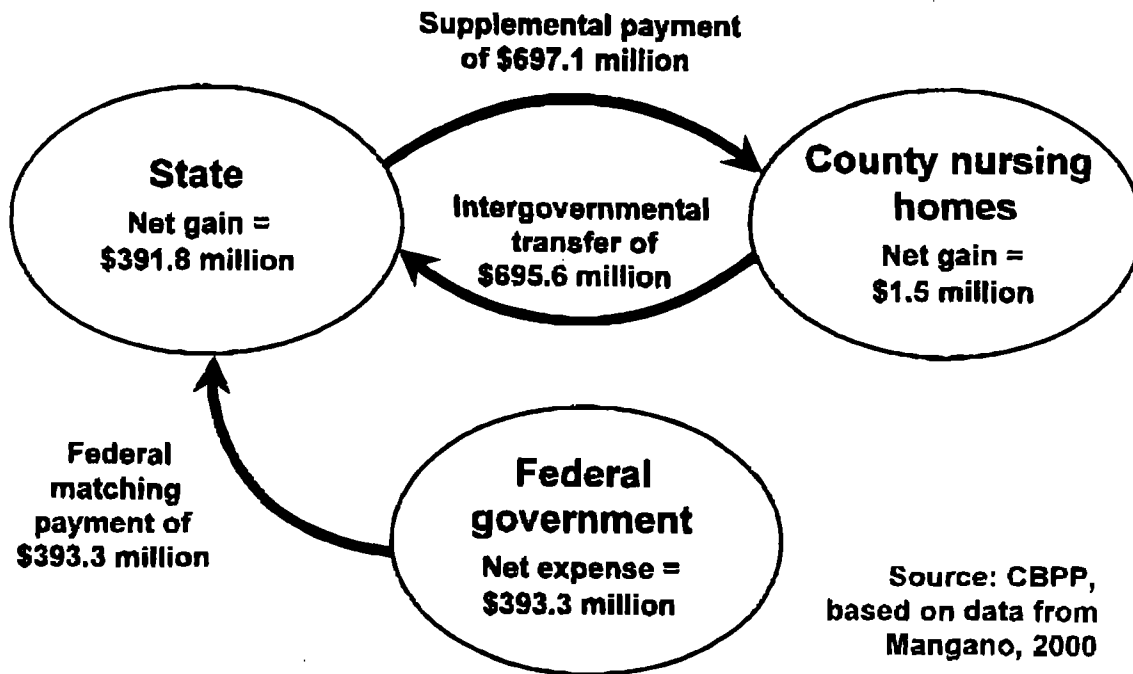
Figure 1 presents data concerning a recent example of the use of this mechanism by Pennsylvania, as reported by HHS' Office of the Inspector General.¹¹ On June 14, 2000, the state paid \$697.1 million in supplemental payments to 23 county nursing homes. Since Pennsylvania has a 54 percent federal matching rate, it received \$393 million in federal matching funds (which is 54 percent of the \$697.1 million payment the state made to the nursing homes). The nursing homes, in turn, returned \$695.6 million of the \$697 million to the state, doing so *on the same day* they received these payments from

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

¹⁰ Privately-owned facilities are barred by federal law from making equivalent donations to the state Medicaid agencies.

¹¹ Mangano, *op cit.*

Figure 1
Flow of UPL Funds in Pennsylvania on June 14, 2000



in the state. The result was a small net gain to the nursing homes of \$1.5 million — the amount of intergovernmental transfers is typically set so that no provider incurs a net loss — and a windfall for the state government of \$392 million. (The state paid a net amount of \$1.5 million to the nursing homes while receiving \$393 million from the federal government.) Although, the federal government paid a large amount to the state, apparently no additional health services were secured for this money.

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

OIG and GAO have found that other states, including Alabama, Nebraska and Michigan, have arrangements similar to Pennsylvania’s that are designed primarily to divert federal Medicaid funds to the state.¹² The OIG concluded that: “States did not base the enhanced payments on the actual costs of providing services or increasing the quality of care to Medicaid

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

residents of the targeted nursing facilities. The counties involved in the enhanced payment scheme provided little or none of the sham enhanced payments to the participating nursing facilities to provide services to Medicaid residents.”

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

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

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

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

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

HCFA has intimated that the proposed regulation it plans to publish would tighten the UPL limits by making county or local government-owned facilities a separate class from private facilities.¹⁴ That would not eliminate the potential for states to make supplemental payments but would greatly reduce the possible size of these payments and narrow the scope of these financing maneuvers. Depending on how the regulation is drafted, this might mean that under the above example, the maximum amount of supplemental payments the state could make to county nursing homes would be one-fifth of the amount the state now can make (i.e., \$200 million rather than \$1 billion).

UPL Arrangements Distort Medicaid Financing

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

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

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

¹⁴ Westmoreland, *op cit.*

¹⁵ Mangano and Allen, *op cit.*

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

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

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

What is Known about Current and Proposed UPL Arrangements?

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

Some earlier information about these financing arrangements is available from an Urban Institute study. In a survey the Institute conducted in 1998, the Urban Institute found that 12 of the 40 responding states were using UPL mechanisms at that time.¹⁸ The study reported these UPL systems primarily involved hospitals and that the financial gains under these arrangements were being reaped principally by the hospitals, rather than the states. Of \$1.4 billion in additional federal funds being secured through these arrangements, \$1.3 billion were going to benefit county facilities (mostly hospitals) while relatively little, about \$100 million, was being retained by the states. Although it thus appears that these UPL funds did reach hospitals in these states — particularly public hospitals in California and Illinois — the UPL mechanisms in question were designed so the states contributed virtually none of the additional money and the federal government provided virtually all of it.

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

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

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

Do States Need Additional Federal Funds?

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

Table 1 presents data about several measures of the fiscal status of states that currently have or are proposing UPL arrangements. Collectively, these states had state budget balances of \$21 billion in state fiscal year 2000.¹⁹ Most of these states had good, positive balances although a few states, such as Alabama, Arkansas, New Hampshire, and Tennessee, faced tight fiscal circumstances. Together, the group of states using or proposing to use UPL mechanisms cut taxes a total of \$4.6 billion for the year 2000, although a few states with fiscal problems had to raise taxes. Overall, the strong trend was to cut state taxes. All except four of these states reduced taxes at least once in the past four years.

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

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

It certainly is true that states must make difficult budget decisions and work hard to balance their budgets. But the data indicate these states generally could have made fiscal choices

¹⁹ The state balance is its cumulative surplus, which may include Rainy Day Fund reserves.

Table 1
Fiscal Status of States with Approved or Proposed Medicaid UPL Arrangements

	FY 2000 state balance ¹	FY 2000 balance as % of budget ¹	FY 2000 tax changes enacted in 99 ²	# of past 4 years with state tax cut ³	FY 2001 tobacco settlement	FY 1997 state DSH profits ⁴
	(mil. \$)		(mil. \$)		(mil. \$)	(mil. \$)
Alabama*	41	0.8%	147	1	112	(25.0)
Alaska	867	37.9%	0	1	24	6.0
Arkansas	0	0.0%	11	0	57	(0.5)
California*	3,012	4.6%	(295)	4	884	376.0
Georgia	545	3.8%	0	3	170	74.0
Illinois*	1,350	5.9%	82	2	322	168.0
Indiana*	1,617	17.8%	(233)	3	141	109.0
Iowa*	574	12.0%	(8)	4	60	8.0
Kansas	318	7.2%	28	3	58	32.0
Louisiana	58	1.0%	(10)	4	156	462.0
Massachusetts*	1,706	8.7%	(68)	4	280	227.0
Michigan*	1,285	13.9%	(376)	3	301	not avail.
Minnesota*	2,370	20.5%	(2,084)	3	462	(17.0)
Missouri	435	6.1%	(478)	3	158	288.0
Montana	165	15.1%	7	1	29	(0.0)
Nebraska*	271	11.6%	100	2	41	not avail.
New Hampshire*	0	0.0%	617	0	46	not avail.
New Jersey*	1,174	6.0%	(70)	3	268	3.0
New Mexico*	143	4.2%	(2)	2	41	not avail.
New York	1,170	3.2%	(1,092)	4	884	18.0
North Carolina*	38	0.3%	6	3	162	158.0
North Dakota*	41	5.3%	(2)	2	25	0.7
Oregon*	526	10.8%	(93)	1	80	19.0
Pennsylvania*	1,511	7.8%	(328)	2	398	not avail.
South Carolina*	464	8.7%	(6)	3	82	32.0
South Dakota	37	4.8%	20	0	24	0.7
Tennessee*	212	3.1%	not avail.	0	169	0.0
Washington	1,175	11.6%	(478)	1	142	154.0
Total	21,105	6.4% (natl. avg.)	(4,605)		5,574	2,093

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

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

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

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

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

other than to use UPL mechanisms. For example, Pennsylvania, which has one of the most visible UPL arrangements, had a substantial state budget surplus in 2000 and recently reduced taxes. These states understandably believe it is to their advantage to use these financing arrangements to divert federal resources to state coffers, using lawful means. Taxpayers in other states, however, who ultimately pay for federal expenditures, might wonder whether it is fair for their federal taxes to be used to enlarge budget surpluses and effectively help to fund tax cuts or other program expenditures in states with UPL systems.

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

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

How Might Safety Net Providers Be Affected?

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

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

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

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

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

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

Taking Reasonable and Prudent Regulatory Action

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

- It ought to signal that the federal government is serious about limiting abuses that impair the integrity of Medicaid. Based on what HCFA has said to date, it appears the forthcoming regulation would substantially reduce the size of potential UPL financing arrangements.
- The issuance of the proposed rule can create a mechanism to increase understanding of these issues through the information that states and health care providers submit under the public comment process for the proposed regulation.
- At the very least, the regulation could bring a temporary halt to the proliferation of these financing schemes, enabling the federal government to assess the costs and benefits of these arrangements more carefully before the arrangements

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

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

mushroom in size. CBO estimates that if Congress were to block this regulation, that action would cost the federal government \$1.5 billion in fiscal year 2001. The cost would be expected to be considerably larger in subsequent years.

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

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

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

²³ Mangano and Allen, *op cit.*

Editorial: Medicaid manipulation

Chris from Tim
Pittsburg Post-Gazette for 9/17/00

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Editorial: Medicaid manipulation

Pennsylvania cashes in on a legal loophole

Sunday, September 17, 2000

Pennsylvania is one of several states drawing a total of \$3.5 billion a year more in Medicaid reimbursements for nursing home care than Congress intended and using it in ways never anticipated. One official calls it legal money laundering.

It's not illegal, and in fact, Pennsylvania officials point out that the federal approved the commonwealth's plans each and every year. But it is still a shell game that threatens the integrity of the system and may ultimately undercut support for the Medicaid program. The Health Care Financing Administration wants to stem the abuse, and states that have benefited are protesting mightily. But the change should be made.

Pennsylvania was one of the first states to work the system for a hefty reimbursement above the 54 percent federal share of Medicaid-approved nursing home care. That was in 1991. Billions of dollars later, Pennsylvania is none too interested in bricking up the loophole. Indeed, the state exhibits righteous indignation at the notion that it did anything untoward.

The federal government will provide significant additional cash to states for nursing home care up to a certain level if state or local governments ante up matching funds. But in this scheme, the local matching funds are raised but never spent for nursing home care. In one transaction in 1999, according to federal auditors, 20 counties, including Allegheny, borrowed a total of \$695.5 million and deposited it in a state bank account for the purpose of triggering the increased reimbursement. Then, before you could say Jack Robinson, a sum of \$697 million was sent back to the counties from the state so that the loans could be immediately repaid, including the cost of the bank's transaction fee. When the state was forwarded \$393 million from Washington, it was essentially found money.

The state Department of Public Welfare insists that this interpretation of the facts is mistaken. Yes, the \$695.5 million came from the counties, but the \$697 million was sent back to a nursing home account (which still may have gone to repay the loans). Further, that \$697 million was made

up of \$393 million from the feds and \$304 million from the counties, so that the money left in Harrisburg is really county money, not federal money.

Got it? So which cup is the ball under?

There's no doubt that Pennsylvania, one of the most effective manipulators of this regulatory language - to the tune of \$3 billion in federal payments between 1992 and 1999 - has crossed every "t" and dotted every "i." But despite this scrupulous attention to detail, the fact remains that the federal money did not lead to vast expansions or improvements of the nursing homes in the state; it merely supplanted state funds for many of the operating costs.

The state's excruciatingly legalistic explanations of the validity of the scheme are not convincing. Nor should it be continued merely because the Health Care Financing Administration approved its use up until this point. While just a few states were maneuvering around the regulatory language to hit the reimbursement jackpot, the federal government was neither as concerned nor as vigilant as it should have been. Now that more states are trying to get a piece of the action, the federal government estimates the loophole unplugged could cost it some \$70 billion over the next five years.

The new regulation has not yet been promulgated, but it will likely significantly reduce the amount of excess Medicaid reimbursements the states can seek to reflect the actual amount of money spent for care and to retain the federal-state cost-sharing formula that has been established.

All that said, Pennsylvania has used the funds, by and large, for nursing homes and other services for the elderly. And losing hundreds of millions of dollars a year will surely be painful, even in these flush times. The Health Care Financing Administration has promised to minimize the blow by easing the transition, and it has suggested that Congress pick up some of the slack to pay for programs that are valuable, even though they don't fit under this particular Medicaid reimbursement umbrella.

We hope it makes good on its word, and that Congress heeds the advice. But in the end, it is in the best interest of the program, the nation and even the state to protect the integrity of the Medicaid program and to uphold the spirit as well as the letter of the law.

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HANYS

HEALTHCARE ASSOCIATION OF NEW YORK STATE
One Empire Drive, Rensselaer, NY 12144
518.431.7600 / Fax: 518.431.7915

October 5, 2000

Fax #44

TO: All Members

FROM: Daniel Sisto, President

SUBJECT: **Medicaid Intergovernmental Transfer (IGT) Regulation and Statutory Proposal Released; Solution Protects New York State's Program Funding**

Today, the Department of Health and Human Services (HHS) and the Health Care Financing Administration (HCFA) released a proposed rule and statutory recommendations that would restrict the use of Intergovernmental Transfer (IGT) payments in state Medicaid programs and increase the cap on Medicaid disproportionate share hospital (DSH) payments. HCFA's release of this rule comes after months of discussions with Congress, several governors, the American Hospital Association (AHA), HANYS, and other state hospital/health care associations. Importantly, this rule lays out the framework for preserving New York State's IGT funding.

After weeks of discussions between HANYS, the Clinton and Pataki administrations, Senators Daniel Patrick Moynihan (D-NY) and Charles Schumer (D-NY), many of our House Delegation members, and the Greater New York Hospital Association, I am pleased that the process has yielded an acceptable approach to protect New York's funding. To assure the full implementation of this solution, action by Congress and the State Legislature must also occur.

For several months, HCFA has been under increasing pressure to issue regulations that would shut down the IGT mechanism. Public allegations of certain states' use of federal Medicaid dollars for non-health care prompted the Clinton Administration to consider prohibiting all states from using the IGT mechanism. HCFA's initial proposal would have threatened nearly \$500 million in federal funds that New York receives annually and uses to subsidize Medicaid, health care programs for vulnerable populations, and county nursing homes.

Upon learning of this potential regulation, HANYS and AHA registered strong opposition to any proposal that would wipe out legitimate health care programs in many states. Working with Senator Schumer, I communicated directly to the White House that this outcome was completely unacceptable and we secured a commitment that the Clinton Administration would work with us to seek alternatives that would protect New York's legitimate health care spending. Similarly, the

Senator and I worked to facilitate communication between the Clinton and Pataki administrations.

HCFA's proposed regulation and comments of the Secretary of HHS included the following recommendations:

- the imposition of an upper payment limit (UPL) cap on non-state, public hospitals at a level 150% of what Medicare rules would allow;
- a UPL for non-state public nursing homes at 100%;
- an extended transition period: initial effective date of April 1, 2002, followed by a four year phase-in of the new limits;
- a recommendation to enact legislation to increase allowable hospital-specific DSH caps to 175% of net uncompensated care costs (also effective in 2002) and increases to the statewide DSH cap; and
- an adjustment to a state's budget neutrality cap (for waived states like New York).

While we are pleased with this development, this regulation is only the first step in a process that will be needed to operationalize this funding transition. Both Congress and the New York State Legislature will have to enact legislation to codify conforming changes and assure appropriate distribution of these funds. It is essential that federal statutory changes be passed in conjunction with this proposed rule. Moreover, key to this transition is the need for state legislation to ensure that public nursing homes will continue to receive appropriate support and to utilize newly available DSH flexibility for hospitals.

In addition, we are also concerned about the response of Senate Finance Committee Chairman Senator William Roth (R-DE) who has attacked this regulation as inadequate and announced that he would introduce legislation that would override the regulation and rapidly phase out all states' ability to access IGT funds.

HANYS continues working with the Pataki and Clinton administrations, both Senators Moynihan and Schumer, and the New York House Delegation to ensure a successful outcome on the additional legislative steps necessary to complete this transition.

If you have any questions on this issue, please contact Joanne Cunningham, Vice President for Constituency Development and Graduate Medical Education at (518) 431-7726 or Ray Sweeney, Executive Vice President at (518) 431-7729.

THE WHITE HOUSE
WASHINGTON
COUNSEL'S OFFICE

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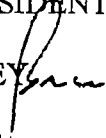
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THE WHITE HOUSE
WASHINGTON

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

10-2-00

THE WHITE HOUSE
WASHINGTON

September 29, 2000

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Lew
Jennings
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MEMORANDUM TO THE PRESIDENT

FROM: Jacob J. Lew
Christopher C. Jennings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT: AFFECTED STATES

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

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

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

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

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

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

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

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

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

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

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

The States Milk Medicaid

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

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

No one knows the full extent of the phony billing, but more than half the states are either using the current ploy or preparing to do so. The extra cost to the feds is currently estimated to be between \$3 billion and \$4 billion a year, and rising. The cost of Medicaid has continued

to rise in recent years even as the caseload has declined; the increase in phony billing is thought to be the principal reason why.

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

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

The Washington Post

FRIDAY, SEPTEMBER 8, 2000

Siphoning Money From Medicaid

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

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

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

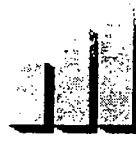
The administration has warned the states that it intends to eliminate the loophole. Its stance deserves support for reasons that go beyond good governance. In the early 1990's states exploited a similar loophole, driving up Medicaid costs by 25 percent or so a year. Congress struck back, coming close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

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

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

The New York Times

MONDAY, SEPTEMBER 11, 2000



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September 27, 2000

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

by Leighton Ku

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

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

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

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

¹ Testimony of Kathryn Allen, U.S. General Accounting Office before the Senate Finance Committee, Sept. 6, 2000. Testimony of Michael Mangano, Office of the Inspector General, Dept. of Health and Human Services, before the Senate Finance Committee, Sept. 6, 2000.

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

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

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

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

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

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

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

Background

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

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

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

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

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

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

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

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

Research from the Urban Institute indicates that in recent years, the federal cost of UPL financing arrangements has burgeoned, rising from \$313 million in 1995 to \$1.4 billion in 1998.⁶ Preliminary data from HCFA suggest the federal cost may be at least twice as high by 2001, with a potential federal cost of more than \$3 billion.⁷

How Does the UPL Loophole Work?

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

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

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

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

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

Three steps are involved in a UPL financing arrangement.⁹

- First, the state makes a special payment to a select group of nursing homes or hospitals. Typically, this is done by making “supplemental payments” (above and beyond the regular Medicaid reimbursements) to county-owned or other local government-owned institutions. The size of these payments is based on the “upper payment limit,” which is described in the next section of this analysis. The payments to these selected providers usually exceed the actual cost of delivering care and are much larger than the payments the state really intends to make for the provision of health services.
- Next, the county-owned or other local government-owned facilities return to the state Medicaid agency a large portion of the supplemental payments. County-owned or other local government-owned facilities are used because they can use intergovernmental transfers to return the money.¹⁰
- The state claims a federal matching payment for the supplemental payments. The matching funds the state receives can be mingled with other state funds and used for any purpose the state chooses, including paying for other Medicaid or health care expenses, building roads, or financing tax cuts.

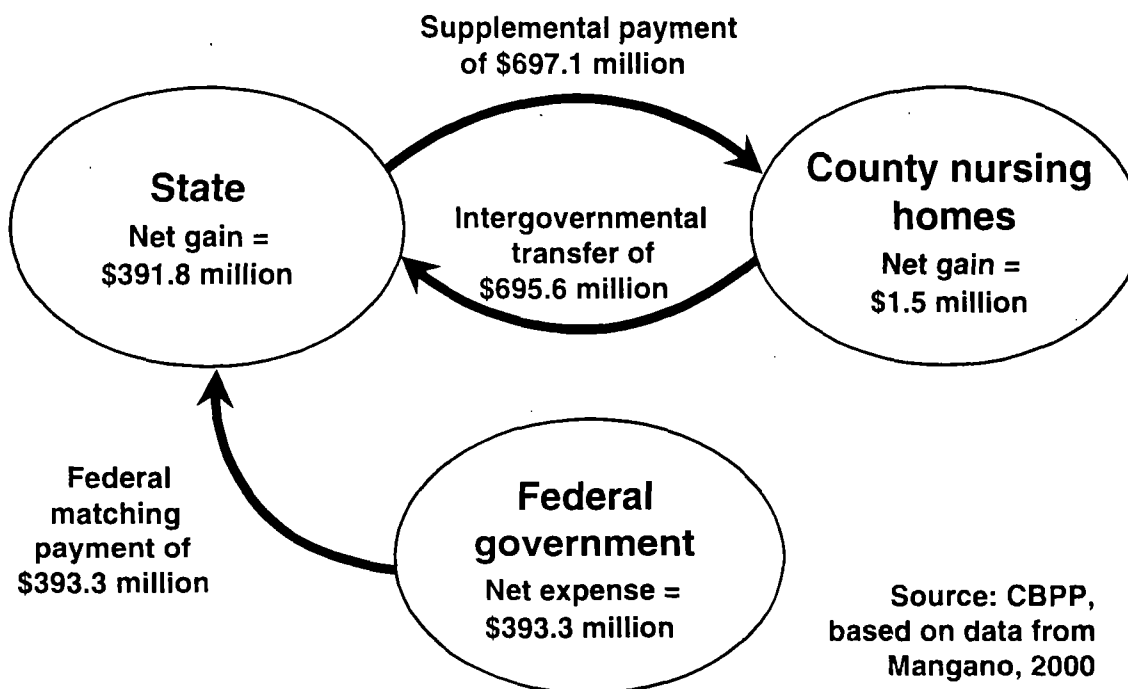
Figure 1 presents data concerning a recent example of the use of this mechanism by Pennsylvania, as reported by HHS’ Office of the Inspector General.¹¹ On June 14, 2000, the state paid \$697.1 million in supplemental payments to 23 county nursing homes. Since Pennsylvania has a 54 percent federal matching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

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

¹⁰ Privately-owned facilities are barred by federal law from making equivalent donations to the state Medicaid agencies.

¹¹ Mangano, *op cit.*

Figure 1
Flow of UPL Funds in Pennsylvania on June 14, 2000



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

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

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

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

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

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

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

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

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

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

UPL Arrangements Distort Medicaid Financing

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

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

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

¹⁴ Westmoreland, *op cit.*

¹⁵ Mangano and Allen, *op cit.*

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

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

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

What is Known about Current and Proposed UPL Arrangements?

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

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

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

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

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

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

Do States Need Additional Federal Funds?

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

Table 1 presents data about several measures of the fiscal status of states that currently have or are proposing UPL arrangements. Collectively, these states had state budget balances of \$21 billion in state fiscal year 2000.¹⁹ Most of these states had good, positive balances although a few states, such as Alabama, Arkansas, New Hampshire, and Tennessee, faced tight fiscal circumstances. Together, the group of states using or proposing to use UPL mechanisms cut taxes a total of \$4.6 billion for the year 2000, although a few states with fiscal problems had to raise taxes. Overall, the strong trend was to cut state taxes. All except four of these states reduced taxes at least once in the past four years.

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

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

¹⁹ The state balance is its cumulative surplus, which may include Rainy Day Fund reserves.

Table 1
Fiscal Status of States with Approved or Proposed Medicaid UPL Arrangements

	FY 2000 state balance¹	FY 2000 balance as % of budget¹	FY 2000 tax changes enacted in 99²	# of past 4 years with state tax cut³	FY 2001 tobacco settlement	FY 1997 state DSH profits⁴
	(mil. \$)		(mil. \$)		(mil. \$)	(mil. \$)
Alabama*	41	0.8%	147	1	112	(25.0)
Alaska	867	37.9%	0	1	24	6.0
Arkansas	0	0.0%	11	0	57	(0.5)
California*	3,012	4.6%	(295)	4	884	376.0
Georgia	545	3.8%	0	3	170	74.0
Illinois*	1,350	5.9%	82	2	322	168.0
Indiana*	1,617	17.8%	(233)	3	141	109.0
Iowa*	574	12.0%	(8)	4	60	8.0
Kansas	318	7.2%	28	3	58	32.0
Louisiana	58	1.0%	(10)	4	156	462.0
Massachusetts*	1,706	8.7%	(68)	4	280	227.0
Michigan*	1,285	13.9%	(376)	3	301	not avail.
Minnesota*	2,370	20.5%	(2,084)	3	462	(17.0)
Missouri	435	6.1%	(478)	3	158	288.0
Montana	165	15.1%	7	1	29	(0.0)
Nebraska*	271	11.6%	100	2	41	not avail.
New Hampshire*	0	0.0%	617	0	46	not avail.
New Jersey*	1,174	6.0%	(70)	3	268	3.0
New Mexico*	143	4.2%	(2)	2	41	not avail.
New York	1,170	3.2%	(1,092)	4	884	18.0
North Carolina*	38	0.3%	6	3	162	158.0
North Dakota*	41	5.3%	(2)	2	25	0.7
Oregon*	526	10.8%	(93)	1	80	19.0
Pennsylvania*	1,511	7.8%	(328)	2	398	not avail.
South Carolina*	464	8.7%	(6)	3	82	32.0
South Dakota	37	4.8%	20	0	24	0.7
Tennessee*	212	3.1%	not avail.	0	169	0.0
Washington	1,175	11.6%	(478)	1	142	154.0
Total	21,105	6.4%	(4,605)		5,574	2,093
		(natl. avg.)				

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

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

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

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

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

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

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

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

How Might Safety Net Providers Be Affected?

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

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

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

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

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

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

Taking Reasonable and Prudent Regulatory Action

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

- It ought to signal that the federal government is serious about limiting abuses that impair the integrity of Medicaid. Based on what HCFA has said to date, it appears the forthcoming regulation would substantially reduce the size of potential UPL financing arrangements.
- The issuance of the proposed rule can create a mechanism to increase understanding of these issues through the information that states and health care providers submit under the public comment process for the proposed regulation.
- At the very least, the regulation could bring a temporary halt to the proliferation of these financing schemes, enabling the federal government to assess the costs and benefits of these arrangements more carefully before the arrangements mushroom in size. CBO estimates that if Congress were to block this regulation,

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

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

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

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

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

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

²³ Mangano and Allen, *op cit.*

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THE WHITE HOUSE
WASHINGTON

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October 1, 2000

MEMORANDUM TO THE PRESIDENT

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*Why summit + what state
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FROM: Chris Jennings
Cc: Bruce Lindsey
RE: Status of Arkansas / UAMS State Medicaid Amendment

This memo is written as a follow-up to Bruce Lindsey's memo regarding the Arkansas state plan amendment to provide supplemental payments for outpatient services at University of Arkansas for Medical Sciences (UAMS). The State and UAMS have raised concerns that the upcoming upper payment limit regulation that we are considering (see memo submitted on September 29) will prohibit their proposed financing mechanism and its associated revenue for UAMS.

After reviewing their situation and the draft regulation, it does appear that the Arkansas financing proposal – like all other approved UPL arrangement – would have to be phased out. However, because of the way that we are structuring the regulation, the State and UAMS would receive the benefit of their financing plan for a full two years. Our draft proposal would give states that have been approved in between last year and the effective date of the regulation two years to prepare to comply with the regulation. Since Arkansas's amendment is scheduled to be approved on December 7, it will qualify for this transition.

In addition, the State may benefit from proposals in the Medicare provider payment restoration package that would raise the State's Medicaid disproportionate share hospital (DSH) allotment. In fact, just this last week, the House Commerce Committee marked up its provider payment restoration package that would raise Arkansas's Medicaid disproportionate share hospital (DSH) allotment.

Yesterday, I reviewed the status of the legislation and regulation with Medicaid Director Ray Hanley. He was surprised and pleased to learn that the draft regulation would benefit Arkansas and UAMS for two years. Although he stated that they would, of course, prefer a permanent funding stream from UPL, he felt that UAMS would be quite satisfied with this approach. He also was encouraged about the House Commerce Committee action.

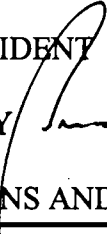
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THE WHITE HOUSE
WASHINGTON

September 21, 2000

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE R. LINDSEY 
RE: HCFA REGULATIONS AND UAMS

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

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

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

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

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

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

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

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

cc: Chris Jennings