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# ISSUE BRIEF

## The Federal-State Medicaid Match: An Ongoing Tug-of-War over Practice and Policy

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A discussion featuring

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## The Federal-State Medicaid Match

When two levels of government share administration of a program, there are likely to be points of contention. When one of those levels consists of 50 states (and six jurisdictions), each with different administrations, capacities, and politics, the points increase exponentially, bringing in issues of fairness and equity as well. In the federal-state Medicaid program, commonly described as a “partnership” that provides health services for low-income families, some elderly, and persons with disabilities, states must spend their own or their localities’ own dollars in order to receive matching funds for the costs of covered services. The federal-state match has been a continuing area of conflict between the federal government and the states and among the states themselves.

Since the latter 1980s, some states have used “creative financing” to get more federal dollars than they otherwise would qualify for. In turn, the federal government has moved to close the loopholes that have made what it regards as “abusive financing” possible. The loopholes have included provisions making it possible for states to make excessive payments to public health facilities, get donations from or level taxes on providers, and maximize payments to disproportionate-share hospitals (DSHs), in order to increase their federal Medicaid matches.

The latest skirmish came this year. The chairman of the Senate Finance Committee, Sen. William V. Roth (R-Del.), and the director of the Medicaid program in the Department of Health and Human Services’ (DHHS) Health Care Financing Administration (HCFA), Timothy Westmoreland, balked at states’ use of so-called intergovernmental transfers (IGTs) to increase their federal matches. Under this acknowledged gimmick, states get transfers of funds from local governments within their borders and put up the transferred money to obtain additional federal matching dollars. They do this in order to avoid upper payment limits (UPLs), which restrict states from making Medicaid payments that are higher than the Medicare program would pay for the same services. Under current regulations, states are able to pay non-state-owned or -operated facilities far more than the actual costs of care and claim federal matching on the expenditures. This practice is estimated to have cost the Medicaid program an additional \$3.7 billion in fiscal year (FY) 2000 alone.

At Roth’s insistence, HCFA published a proposed rule in the October 10 *Federal Register* banning the practice over time but leaving a loophole involving certain public hospitals that serve the poor. As the chairman pushed for closure on the ban, certain states—those with political clout and lobbying strength—sought to include their own private loopholes in omnibus legislation that was pending at the end of the 106<sup>th</sup> Congress.

Over the years, both the General Accounting Office (GAO) of the U.S. Congress and the Office of the Inspector General (IG), DHHS—the respective congressional and executive watchdogs of the federal purse—have identified successive loopholes. A series of legislators and executive officials have moved to close one loophole after another, but each time a new one has opened up (sometimes because Congress or HCFA sanctioned it), inevitably resulting in a new tug-of-war. The conflict reflects philosophical and political differences in federal Medicaid policy and state Medicaid practice and a clash of values over whether or not the end, achieving a “noble goal,” justifies the means, using “ill-gotten gains.” Usually, the noble goal is to maintain a health safety net for vulnerable people, even though they are not necessarily Medicaid beneficiaries. However, at times, states have chosen to address other health or even non-health-related needs.

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Complicating the situation are the issue's links to a Medicaid policy that goes back to 1981 but which was not fully implemented until 1988. That is a provision for state Medicaid programs to make payments (the Medicaid DSH adjustment) to "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs."<sup>1</sup> For example, earlier loopholes—provider donation and provider tax programs that states undertook to increase their federal Medicaid funds—helped finance their DSH payments, because states could exceed the statutory UPL in providing funds to hospitals providing high volumes of care to low-income patients.

In this Forum session, NHPF will focus on the current federal-state Medicaid match issues that are the subject of HCFA's proposed rule on UPLs. Taking into account the history of the issue, the meeting will lay out what is at stake, how HCFA is addressing it, what kinds of approaches states are taking, how Congress is getting involved, and what the outlook is for the future.

## THE CURRENT CLAMPDOWN

### The Proposed Regulation on IGTs

HCFA's proposed rule addresses a loophole in Medicaid regulations that allows states to set Medicaid rates for public facilities, such as county- and city-owned hospitals, in excess of both the average payment to other, nonpublic facilities, and the actual cost of providing covered services to persons who are Medicaid beneficiaries. (In 1987, HCFA required states to adhere to the UPL for state-owned or -operated as well as privately operated facilities.) Under this loophole, 19 states permit the public facilities to claim higher Medicaid reimbursement rates (which are federally matched) and then divert or transfer some or all of the federal funds for other state programs. According to HCFA, the agency has applications pending from nine other states to do the same.

The regulation would phase out such arrangements over five years for states with approved plans in effect before October 1, 1999, and over two years for states that have lapsed since that deadline, with the first changes starting in FY 2002. "This change is necessary to ensure that the Medicaid regulations conform to Medicaid statutory requirements that promote efficiency and economy," the proposed regulation says.<sup>2</sup>

The proposed rule would modify Medicaid UPLs for the following services: inpatient hospital, outpatient hospital, nursing facility, intermediate care facility for the mentally ill, and clinic. In terms of each type of Medicaid

inpatient service, "current regulations place an upper limit on overall aggregate payments to all facilities and a separate aggregate upper limit on payments made to state-operated facilities." The proposed regulation "would establish a third aggregate upper limit that would apply to payments made to all other types of government facilities that are not state-owned or state-operated."

In terms of outpatient hospital and clinic services, "current regulations place a single upper limit on aggregate payments made to all facilities." The proposal would establish "a separate aggregate upper limit on payments made to state-owned or -operated facilities and an aggregate upper limit on payments made to all other government-owned or -operated facilities."<sup>3</sup>

There is a significant exception, however, one that the chairman of the Finance Committee strongly opposes. States still will be able to pay as high as 150 percent of the UPL to public hospitals that are not state-owned or -operated. The exception is based on HCFA's belief that "allowing higher Medicaid payments will fully reflect the value of public hospitals' services to Medicaid and the populations it serves." Because the agency is concerned that the "public hospitals may be required by state or local governments to transfer back a portion of payments that they receive under Medicaid," it indicates that it will require in its final rule a separate identification and reporting mechanism on how the funds are used.<sup>4</sup>

The proposed rule, which Acting HCFA Administrator Michael M. Hash signed on October 3 and DHHS Secretary Donna E. Shalala announced on October 5,<sup>5</sup> had a 30-day comment period that ended on November 9. In a statement reacting to the secretary's announcement, Roth concluded that the Clinton administration would not be able to finalize the regulation before it leaves office at the end of January. Commenting on the exception, he said:

The proposed regulation permits facilities to be reimbursed for providing services at a rate one and a half times what Medicare would have paid for a given service. Then states are free to pocket the difference between that payment level and the often much lower Medicaid payment rates through intergovernmental transfers. Not only does the regulation allow those who are exploiting the program to continue to do so, it also invites all others to come in and help themselves. The regulation permits the scam to continue while only modestly attempting to contain its magnitude.<sup>6</sup>

The chairman included a provision to implement the regulation in omnibus legislation, the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Benefits Improvement and Protection Act of

2000, that the 106<sup>th</sup> Congress was seeking to pass as this issue brief went to press. Under the Roth language, the regulation would become effective on December 31, 2000. At the same time, California, Illinois, New York, Pennsylvania, New Mexico, and Wisconsin have gotten provisions in the bill protecting them from the regulation's ban, raising the ire of other states and their legislators that the payments could undermine the Medicaid program itself. The Congressional Budget Office has given the pending UPL reforms a "score" of \$21.5 billion in savings to the federal government over five years and \$76.7 billion over ten years, even with the loopholes that would be permitted in the regulation.

### Background on HCFA's Latest Action

The most recent round in the federal-state tug-of-war started last spring when HCFA circulated a draft regulatory proposal (to some state organizations and other concerned parties) to extend the UPLs to county and city facilities. Meant to address the UPL loophole, it reflected Westmoreland's concern that HCFA's policy of allowing states to draw down more Medicaid dollars through the IGT mechanism was unfair, not only to states that were not taking part in the practice but also to beneficiaries for whom the Medicaid program was intended.<sup>7</sup>

The Finance Committee subsequently asked the GAO to investigate the matter and pressed Shalala to take action. On June 30, Roth released letters to both in a news release charging "that tens of billions of Medicaid dollars are being bilked from federal taxpayers to fill holes in many states' budgets" and that Medicaid "is not intended to serve as an accounting gimmick to funnel increased federal payments to the states." Referring to the earlier provider donation and provider tax controversies, he warned that, "unless the Administration acts immediately, we are on the brink of a spending scandal unlike any we have seen since Medicaid was used to pay for roads, bridges, and highways."<sup>8</sup>

Westmoreland followed up on July 26 by sending a letter of intent to state Medicaid directors, with copies to the American Public Human Services Association, the National Conference of State Legislatures, and the National Governors' Association. In the letter, he contended that some states are

calculating the maximum amount [the UPL] that, in theory, could be paid to each Medicaid facility; adding these amounts together to create excessive payment rates to a few county or municipal facilities; claiming federal matching dollars based on these excessive payment rates; and then directing these county or

municipal facilities to transfer large portions of the excessive payments back to the state government.<sup>9</sup>

Estimating that federal Medicaid spending for FY 2000 grew by \$3.4 billion over earlier projections, he attributed \$1.9 billion of the increase to funds raised by the UPL loophole.<sup>10</sup> (In the October 10 proposed regulation, DHHS says the overall impact is "approximately \$3.7 billion in federal spending annually... based on state reported federal fiscal information submitted with state plan amendments and state expenditure information where available.")<sup>11</sup>

In the letter, Westmoreland pointed out that some states are using the additional funds to finance various health programs. These include helping pay for uncompensated care, circumventing DSH by going beyond its statutory definition to provide services, boosting the state share of Medicaid, contributing to SCHIP, and funding other health programs (such as community-based care for persons who are elderly or have disabilities). He also cited sources indicating that some states are using, or intend to use, the additional funds to fill budget gaps, reduce state debt, give tax decreases, or pay for education programs. He stated HCFA's intent to issue a proposed regulation in the near future.<sup>12</sup>

When HCFA had not acted by the time Congress returned from its August recess, the Finance Committee held a September 6 hearing on the issue. Westmoreland testified, along with Michael F. Mangano, principal deputy inspector general, DHHS, and Kathryn G. Allen, associate director of health financing and public health issues in the Health, Education, and Human Services Division of GAO.

The philosophical and political differences that characterize the debate over this issue were readily apparent in the opening statements of the senators who participated in the hearing. Whereas Roth said flatly that the current IGT gimmick "cannot and will not be permitted to continue," Sens. Daniel Patrick Moynihan (D-N.Y.) and John B. Breaux (D-La.) were more sanguine. Moynihan indicated that millions of people are now covered because of the payment policy. Breaux pointed out that HCFA had approved the applications of the states that are involved in the practice, which "is legal until it is declared illegal." (Westmoreland has refused to approve any of the pending state Medicaid plan amendments. Because he does not have the right of disapproval, the pending amendments lapse into approval 90 days after submission.) Breaux warned against blaming states for taking advantage of loopholes in order "to provide much needed services." Sen. Chuck Grassley (R-Iowa), who is next in line for the Finance

Committee chairmanship in the 107<sup>th</sup> Congress due to Roth's defeat in the November 2000 election, defended the UPL arrangements of Iowa on the grounds that the money is being used for Medicaid home- and community-based services.

Referring to “manipulative financing schemes,” Mangano used Pennsylvania as an example in his oral testimony and included Alabama and Nebraska in his written statement. He stated that Pennsylvania, which has been involved in the practice since 1991, is expected “to generate about \$900 million in excessive federal financial participation per year if HCFA does not take action to stop this abusive and costly practice.”<sup>13</sup> The following is his description of Pennsylvania's draw-down of \$393.3 million on June 14 of this year:

The Pennsylvania state government calculated a maximum allowable enhanced payment amount that could generate a corresponding federal match. It obtained county government agreements to have 20 counties borrow and transfer, for only one day, tens of millions of dollars into a state bank account. The state immediately repaid the amount to the same county governments, labeling the transaction as a transfer of enhanced payments to the counties for their county-owned Medicaid nursing facilities. The state then billed the federal government for the federal share of the enhanced payments. The remitted federal share was commingled in state accounts that could be used for any purpose the state wished.<sup>14</sup>

Allen testified that “this financing practice violates the integrity of Medicaid's federal/state partnership.” Citing the actual or intended uses of the additional funds in the states of Alaska, Iowa, Michigan, New Jersey, South Dakota, Tennessee, and Washington, she concluded:

Because of the potential for excessive payments to persist in other forms, the Congress should consider implementing a recommendation that remains outstanding from our 1994 work to enact legislation to prohibit Medicaid payments that exceed costs to any government-owned facility. Finally, continuing attempts to exploit program loopholes also point to the need to be ever vigilant to identify the next innovative arrangement before it reaches such financial magnitude that it becomes both a staple of state financing and a potential threat to the integrity of the funding partnership.<sup>15</sup>

## A REVIEW OF PAST PRACTICES

The UPL issue is the latest in a series of attempts by states to drive up the federal dollars that come their way through the federal Medicaid match. Some involve

excessive payments to state facilities, some the matching of funds gained through provider donations or taxes, and some inordinate use of Medicaid DSH payments.

### State Facilities

The first loophole to be addressed involved states' making excessive payments to state-owned or -operated health facilities in order to increase their federal Medicaid matching funds. This practice was restricted in 1987 regulations that established UPLs for state inpatient and institutional facilities.

### Provider Donations and Provider Taxes

The second and third loopholes—states' use of provider donations and provider taxes, respectively—in order to increase their federal Medicaid matching funds drew more attention during the second half of the 1980s than the concern about state facilities, which was more cut-and-dried. In terms of provider donations, HCFA had published a regulation in 1985 that allowed donations, both public and private, to be sources of states' share of Medicaid. In terms of provider taxes, HCFA had put out a Medicaid manual instruction in 1987 that distinguished between taxes of general applicability (imposed on all kinds of goods and services and not just Medicaid providers) and provider-specific taxes (imposed only on health care providers). In general, the first could be used to draw down federal Medicaid matching funds and the second could not.

Estimates by HCFA and the DHHS Office of the IG determined that the state programs cost the federal government nearly \$500 million in FY 1990. By 1991, the amount of revenue generated from state provider donation or tax programs was approximately \$2.3 billion in federal funds. A survey of state Medicaid agencies by the American Public Welfare Association [now the American Public Human Services Association] indicated that this figure could rise to \$6 billion in 1992.<sup>16</sup>

HCFA, the DHHS IG, GAO, and the Senate Finance Committee—the same players involved in the current IGT debate—investigated what they viewed as state schemes to increase federal Medicaid expenses without adding to the states' contributions. A comprehensive report, *Medicaid Provider Tax and Donation Issues*, prepared for the Robert Wood Johnson Foundation by Health Policy Alternatives, Inc., and issued in July 1992 documented the issues, the federal and state perspectives on them, and the practices, with case studies on Connecticut, Delaware, Pennsylvania, Tennessee, and Texas.

For example, Tennessee had used revenues from provider donations to draw down more federal dollars since 1987, when the state legislature authorized the practice, according to Gordon Bonnyman, author of that state's case study. The state faced a rapidly increasing Medicaid budget, which grew from slightly more than \$1 billion in FY 1988 to nearly \$2.3 billion in 1992. The growth was due in part to the state's own commitments to expansion of indigent care and state aid for certain high-volume Medicaid hospitals. It was due in part to federal statutory changes (such as expanded coverage for low-income mothers and children). It also was due in part to other factors, such as health care inflation. In 1987, 30 of the state's 150 hospitals donated \$19 million. The largest donor was Regional Medical Center in Memphis, the largest public hospital in the state.<sup>17</sup>

Because Tennessee's federal Medicaid percentage was 70 percent (that is, the federal government pays 70 cents and the state pays 30 cents), the \$19 million generated approximately \$63 million, Bonnyman reported. Of the \$63 million, \$24 million increased DSH subsidies, \$31 million went to expanded Medicaid coverage for pregnant women and children who were below 100 percent of the federal poverty level, and the balance for a rise in the annual inpatient hospital coverage limit from 14 to 20 days. Most of the subsidies went to the providers that had provided the donations.<sup>18</sup>

When HCFA disallowed most of the matching funds raised by the donations, the state, while appealing the disallowance and continuing with its donation policy, turned to a hospital gross receipts tax (similar to one used by Florida) as a means of increasing its federal matching funds. Because some hospitals opposed the tax, the state and the hospital industry agreed instead on sharp increases in hospital licensing fees. The legislature approved the hospital license fee policy in 1989 and extended the mechanism to nursing homes in 1990. Meanwhile, the DHHS Departmental Appeals Board had reversed HCFA's disallowance of the donations mechanism, so the state had both the donations and tax options open to it.<sup>19</sup>

As more states moved to take advantage of the provider donation and tax policies, HCFA became more and more concerned. As it considered revising the 1985 regulation and the 1987 instruction, Congress—spurred by the states—imposed moratoria on its taking action in 1989 and in 1990. After considerable debate during 1991, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 were enacted, banning provider donations and restricting

provider taxes as mechanisms for states to draw down federal Medicaid matching funds.

### Medicaid DSH Payments

The fourth loophole involves Medicaid DSH payments. The Medicaid DSH program offered states a mechanism to increase federal Medicaid dollars after the Omnibus Budget Reconciliation Act (OBRA) of 1987 had established minimum criteria for them to meet beginning July 1, 1988, and had required them to make payment adjustments to hospitals qualifying under the criteria.<sup>20</sup> DSH was an attractive mechanism because, as already indicated, states could exceed the UPL in providing funds to hospitals providing high volumes of care to low-income patients.

According to a September 1998 Urban Institute study of Medicaid spending, “between 1990 and 1992, Medicaid grew at an extraordinary 27.1 percent annual growth rate, with expenditures increasing from \$73.7 billion to \$119.9 billion in just two years.” The study indicates that DSH payments “increased by over 250 percent per year.” From 1990 to 1992, “DSH payments grew at an average annual rate of 263 percent, accounting for about \$1.3 billion in 1988 and growing to more than \$17 billion by 1992.” From 1995 to 1996, in contrast, the growth rate fell to -19.6 percent, reflecting efforts to curb the program.<sup>21</sup>

The 1991 legislation that banned provider donations and restricted the types of provider taxes that states could use also had provisions limiting the growth of DSH payments to the level of overall program expenditures and capping DSH payments at 12 percent of program expenditures. Subsequent legislation, OBRA 1993, provided that only those hospitals that had Medicaid utilization of at least 1 percent could receive DSH payments and prohibited states from paying hospitals more than they were losing through low Medicaid reimbursement rates or uncompensated care. Both the 1991 and the 1993 laws had a chilling effect on states' DSH payments to hospitals and on states' Medicaid programs.<sup>22</sup>

As states changed their DSH programs to comply with the 1993 legislation, which became effective for different categories of hospitals in 1994 and in 1995, they began to turn to IGTs, shifting funds between different levels of government. “For the DSH program, many states began to transfer funds from public institutions such as state psychiatric facilities, university hospitals, and county or metropolitan hospitals to the state Medicaid agency.” The state then provided DSH payments to the facilities and received federal Medicaid matching funds in the process.<sup>23</sup>

The Balanced Budget Act of 1997 (BBA) included additional restrictions on the states. It imposed state-specific “caps” on the total federal matching payments available to hospitals receiving DSH payments. In addition to the provisions in the pending congressional omnibus bill to implement the UPL regulation and allow protections for certain states, the legislation would raise the BBA caps for FY 2001 and future years.

It is important to note—to prevent confusion—that there is also a Medicare DSH adjustment. An add-on to Medicare prospective payment system diagnosis-related groups, it is defined differently than the Medicaid DSH. The Medicare DSH, as stated in the Social Security Amendments of 1983, directs the DHHS secretary “to take into account the special needs . . . of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under Part A [Medicare].” The Medicare DSH adjustment has no bearing on the federal-state Medicaid match situation.

### Use of Matching Funds

During the late 1980s and early 1990s, rumors were rife that some states were using federal Medicaid matching funds raised through provider donations and provider taxes in creative ways, such as to build high-ways. In testimony before the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce [now the Commerce Committee] in 1991, HCFA Administrator Gail R. Wilensky said:

We believe that some states are using these “free” federal funds to increase services, expand access, and make other positive changes. But nothing in the current situation even allows us to ensure that ‘free’ federal funds are used in this manner.

On the other hand, the IG reported “these programs are generally not used to increase services to Medicaid recipients or improve the quality of care. More often, they are ‘carefully crafted’ finance techniques that allow states to reduce their share of Medicaid costs and force the federal government to pay more.”

In any case, these funds are fungible and states can use federal funds generated through donation and tax programs for any purpose they want.<sup>24</sup>

It was not until the passage of the BBA that the use of matching funds “for any purpose they want” was addressed. The act imposed an “explicit ban . . . on the use of federal Medicaid matching funds for non-health related items such as bridges, roads, stadiums, or other items not covered by a state’s Medicaid plan.”

### CONFLICT OF VALUES

The tug-of-war between the federal government and state governments over the UPL issue is indicative of bigger concerns, such as the difficulties inherent in a federalist system of shared power and the challenges of administering a program that has federal rules but gives states considerable latitude. Moreover, as individual states seek legislative exceptions to regulatory provisions, the problems may be exacerbated, as Congress regulates by exception to the executive branch’s rules that implement the laws that Congress put in place. The fact that there may be good intentions on both sides—for example, HCFA’s seeking fiscal prudence and administrative fairness while the states strive to provide services to vulnerable people—reflects a conflict in values.

As indicated, states tend to justify the draw-down practice on the basis that it helps pay for Medicaid and other health services and, hence, satisfies a social good. In testimony submitted to the Senate Finance Committee at the time of its September hearing, Ann Patla, director of the Illinois Department of Public Aid, indicated that her state provides “health care coverage to nearly 10 percent more children, elderly, and disabled individuals than [it] did one year ago.” Moreover, she said that Illinois had increased its commitment to “supporting high-volume Medicaid hospitals that also treat a significant number of the uninsured, continuing cost-based reimbursement for federally qualified health centers, and shoring up the primary-care infrastructure in Illinois.” She contended that, if HCFA reversed direction on the UPL issue, Illinois stood to lose \$500 million a year.<sup>25</sup>

A recent review of HCFA’s intent to regulate Medicaid UPLs by Leighton Ku of the Center on Budget and Policy Priorities charted the fiscal status of states with approved or proposed Medicaid UPL arrangements (see Table 1, page 8). In presenting the table, Ku provided the following explanation:

[The table] 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 FY 2000. [He described the balances as cumulative surpluses, including “rainy day fund” reserves.] 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.<sup>26</sup>

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

	<b>FY 2000 State Balance (mil. \$)</b>	<b>FY 2000 Balance as % of Budget</b>	<b>FY 2000 Tax Changes En- acted in 1999 (mil. \$)</b>	<b>No. of Past 4 Years with State Tax Cut</b>	<b>FY 2001 Tobacco Settlement (mil. \$)</b>	<b>FY 1997 State DSH Profits (mil. \$)</b>
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 (nat'l. avg.)	(4,605)		5,574	2,093

Source: Leighton Ku, "Limiting Abuses of Medicaid Financing: HCFA's Plan to Regulate the Medicaid UPL," Center on Budget and Policy Priorities, September 27, 2000, 9-10; accessed November 8, 2000, at <http://www.ebpp.org/9-27-00health.htm>.

\* State had at least one approved UPL arrangement in September 2000, when Ku published his paper. The other states had pending proposals, and Florida, Texas, and Wisconsin had initiated discussions with HCFA.

\*\* UPL arrangement has lapsed into approval since publication of Ku paper.

States also justify the draw-down practice on the basis of preserving safety-net providers. Examples include California's reliance on IGTs to increase funding for its public hospitals and Illinois's dependence upon them to add dollars—approximately \$200 million a year, according to Patla's testimony—to Cook County Hospital and its clinics, which serve “indigent children and families, pregnant women, seniors, and people with disabilities.”<sup>27</sup> HCFA's exemption for public hospitals that are not state-operated in part addresses this issue, although opponents contend that the provision just opens up another loophole.

## KEY QUESTIONS

The Forum session will address the following issues:

- The “federal-state partnership” has been a hallmark of the Medicaid program, particularly during the last eight years, as both the administration and states sought greater flexibility for the states. Will there always be a tug-of-war between calls for strict federal rules, on one hand, and flexibility for the states, on the other? Is a partnership possible when so many dollars are involved? Does flexibility necessarily invite the use of various mechanisms or loopholes by states, or by certain states? Would a block-grant approach be better? Or worse?
- Does the ease with which states can circumvent the federal-state Medicaid matching process mean the process is inherently flawed?
- In terms of the regulations governing the federal-state Medicaid match, how important are fairness and equity among the 50 states?
- Given the fact that certain states have been using the UPL loophole for close to a decade, why did HCFA not close it—or try to close it—earlier?
- What are the justifications for HCFA's exception for public hospitals in its proposed regulation, which states that states could pay as much as 150 percent of the UPL to hospitals that have public ownership or operation, as long as the controlling entity is not the state itself?
- Are HCFA's transition provisions reasonable for weaning states from IGTs?
- What are the advantages for states that are seeking legislative fixes to exempt them from the proposed ban? The disadvantages to other states?
- What are the implications of HCFA's intended policy for Medicaid beneficiaries? For other persons who need health care and are unable to pay for it?

- What is the relationship between the succession of federal match loopholes and various federal policies? For example, to Medicaid “unfunded mandates”? To Medicaid DSH? To lack of coverage for persons who are uninsured and do not qualify for Medicaid, Medicare, SCHIP, or certain other programs?
- What role have legislative or regulatory “fixes” had in the history of this federal match issue? What role are they having now, relative to UPLs? Do they undermine the Medicaid program?
- Given the fragmented health “system” in the United States, does the end justify the means if the goal is to provide needed health services to vulnerable people?

## THE FORUM SESSION

**Timothy Westmoreland**, director of the Center for Medicaid and State Operations, HCFA, will begin the meeting with a short description of HCFA's efforts to restrict use of IGTs by states to draw down federal Medicaid matching dollars, reasons for the agency's action, and the outlook for closure on it. He has been director of the center since October 1999, after having spent four years as a senior policy fellow at the Georgetown University Law Center and a senior advisor to the Henry J. Kaiser Family Foundation. He also has served as the Washington representative to the Elizabeth Glaser Pediatric AIDS Foundation. Earlier, he served as counsel to the House Energy and Commerce Committee (now the Commerce Committee) Subcommittee on Health and the Environment. He is a graduate of Yale Law School.

**Kathryn G. Allen**, director, Health Care—Medicaid and Private Health Insurance Issues, at GAO, will describe the congressional agency's current analysis of the UPL issue as well as reference the agency's work on earlier financing mechanisms used by states to gain federal Medicaid payments. She has been at GAO for 24 years. At the present time, she directs work on Medicaid, SCHIP, long-term care, and private health insurance. Her career includes leadership positions in GAO's Seattle and European field offices and direct staff support to the National Commission to Prevent Infant Mortality. A certified government financial manager, she has received numerous rewards from GAO.

**Ann Patla**, director of the Illinois Department of Public Aid, will offer a state perspective on the UPL debate. As head of the department, she is responsible for the administration of the state's Medicaid, KidCare, and Child Support Enforcement Program. Before taking

her current post in early 1999, she was a senior consultant with the University of Illinois at Chicago, where she worked on managed care issues, juvenile treatment, and research and evaluation. She also helped design a new center on aging and geriatric medicine. Earlier, she served as associate secretary of the Illinois Department of Human Services and director of the Illinois Department of Mental Health and Developmental Disabilities. She has a doctorate in humane letters degree from the Chicago School of Professional Psychology and is working on a Ph.D. degree in public policy analysis at the University of Illinois at Chicago.

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## ENDNOTES

1. Added to Title XXIX of the Social Security Act by the Omnibus Budget Reconciliation Act of 1981.
2. Health Care Financing Administration (HCFA), "Medicaid Program; Revision to Medicaid Upper Payment Limit Requirements for Hospital Services, Nursing Facility Services, Intermediate Care Facility Services for the Mentally Retarded, and Clinic Services," *Federal Register*, 65, no. 196 (October 10, 2000, 60151-53).
3. HCFA, 1.
4. HCFA, 60153.
5. HCFA Press Office, "HHS Proposes Regulation to Close Medicaid Loophole"; accessed October 5, 2000, at <http://www.hcfa.gov/news/pr2000/pr001005.htm>.
6. Committee on Finance, U.S. Senate, "Roth Says Administration Now Sanctioning Abuse of Medicaid Program with Proposed Regulation," Press Release #106-482, October 5, 2000.
7. Bureau of National Affairs, "Senate Finance Committee Chairman Asks for Investigation of State Medicaid Spending," *BNAs Health Policy Report*, July 10, 2000, 1164-65.
8. Senate Finance Committee, "Roth Warns of Multi-Billion Dollar Medicaid Payment Scheme," Press Release #106-411, June 30, 2000.
9. Timothy Westmoreland, letter to state Medicaid directors, July 26, 2000; accessed August 16, 2000, at <http://www.hcfa.gov/medicaid/smd72600.htm>.
10. Westmoreland, letter.
11. HCFA, 60155.
12. Westmoreland, letter.
13. Michael F. Mangano, "Medicaid: Manipulation of Upper Payment Limit Requirements to Increase Federal Funds to States," testimony before the Senate Finance Committee, September 6, 2000, 3-5, (appendix) 3.
14. Mangano, testimony, 3.
15. Kathryn G. Allen, "Medicaid: State Financing Schemes Again Drive Up Federal Payments," U.S. General Accounting Office testimony before the Senate Finance Committee, September 6, 2000, 1-11.
16. Debra Lipson, "The Question behind the Medicaid Provider Tax Debate: What Constitutes a State Dollar?" National Health Policy Forum Issue Brief No. 625, July 12, 1993, 4.
17. Gordon Bonnyman, "Tennessee's Use of Provider Donations and Taxes to Finance Its Medicaid Program," *Medicaid Provider Tax and Donation Issues*, Health Policy Alternatives, Inc., Washington, D.C., July 1992.
18. Bonnyman, "Tennessee's Use."
19. Bonnyman, "Tennessee's Use."
20. Karen Matherlee and Judith Miller Jones, "Hospitals of Last Resort? An Examination of the Medicare and Medicaid Disproportionate-Share Adjustments," National Health Policy Forum Issue Brief No. 542, April 30, 1990, 7.
21. John Holahan, Brian Bruen, and David Liska, "The Decline in Medicaid Spending Growth in 1996: Why Did It Happen?" Urban Institute, September 1998, 1-2; accessed August 9, 2000, at [http://www.urban.org/health/decline\\_spending.html](http://www.urban.org/health/decline_spending.html).
22. Holahan, "Decline," 2, 4.
23. Teresa Coughlin and David Liska, "The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues," Urban Institute, undated, 4-5; accessed August 9, 2000, at <http://www.newfederalism.urban.org/html/anf14.html>.
24. Gail R. Wilensky, Statement before the Subcommittee on Energy and Commerce, House of Representatives, October 16, 1991, 3.
25. Ann Patla, "Statement of the State of Illinois Department of Public Aid, Oversight Hearing on Medicaid UPLs," submitted to the Senate Finance Committee, September 6, 2000.
26. Leighton Ku, "Limiting Abuses of Medicaid Financing: HCFA's Plan to Regulate the Medicaid UPL," Center on Budget and Policy Priorities, September 27, 2000; accessed November 8, 2000, at <http://www.cbpp.org/9-27-00health.htm>.
27. Patla, "Statement," 2.