

The Federal-State Struggle over Medicaid Matching Funds: An Update

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OVERVIEW – *This background paper updates NHPF Issue Brief No. 760, “The Federal-State Medicaid Match: An Ongoing Tug-of-War over Practice and Policy,” December 15, 2000. The paper presents actions taken since then by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, to address what the Bush administration calls “abusive funding practices” used by states to draw federal Medicaid matching funds. Tracing the Clinton and Bush administrations’ policies, the document reviews final regulations, published in January 2001 and January 2002, on these practices. The paper also reports on a lawsuit filed in federal court to block the January 2002 regulations. In addition, it explores the implications of CMS’ actions for the federal government, as well as for the Medicaid disproportionate-share hospital adjustment and the hospitals serving low-income people that the adjustment was meant to protect.*

The Federal-State Struggle over Medicaid Matching Funds: An Update

Whether the most recent regulations affecting state Medicaid matching funds signify the last or just the latest chapter in a two-decades-long policy conflict is not yet clear. These regulations became effective May 14, 2002. Certainly, the Centers for Medicare and Medicaid Services (CMS) would like an end to the struggle over what its administrator, Thomas Scully, has called “Medicaid scams.” The federal government’s clashes with certain states and interest groups that support them have centered on complicated accounting mechanisms designed to increase states’ federal Medicaid matching funds even though the states raise no new dollars. The states have labeled the mechanisms necessary to supplement their Medicaid budgets and protect safety-net hospitals that serve large numbers of low-income and indigent patients. As the federal government has closed off one mechanism after another—excessive payments to public health facilities, donations from or taxes on providers, and maximization of disproportionate-share hospital (DSH) payments—creative states have always been able to pull another out of their hats. State use of intergovernmental transfers (IGTs)—transferring funds from local governments and putting up the transferred money to obtain additional federal matching dollars—has been the central practice over the last ten years.

In the last two years, the Department of Health and Human Services (DHHS) in the administrations of both former President Bill Clinton and President George W. Bush has taken action to curb state practices in drawing federal Medicaid matching funds. The DHHS actions have hinged on a Medicare-based statutory ceiling for state Medicaid payments, called the “upper payment limit” (UPL). Because the UPL was set higher than the amount states actually expend on care for Medicaid beneficiaries, it provided a loophole for states to raise their federal Medicaid payments. Having issued its proposal on October 10, 2000, the Clinton administration promulgated final regulations modifying the Medicaid UPL for hospitals, nursing facilities, intermediate care facilities for the mentally retarded, and clinics on January 12, 2001. In doing so, it created a new limit—150 percent of comparable Medicare payments—that applied to payments to hospitals owned or operated by government entities other than the states themselves.

On January 18, 2002, the Bush administration published final regulations eliminating the year-old 150 percent limit for hospitals that are

***NOTE**—Appended to this background paper is a special section called “Looking Back.” Covering the period from the mid-1980s to the late 1990s, it traces states’ efforts to increase their federal Medicaid matching funds and federal responses to those efforts.*

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government-owned or -operated (other than by states). This new, Bush administration regulation subjected those hospitals to the 100 percent limit. Both the Clinton and the Bush rules authorized transition periods for state compliance. On March 7, 2002, shortly before the March 19 effective date for eliminating the 150 percent limit, the National Association of Public Hospitals and Health Systems (NAPH), American Hospital Association (AHA), National Association of Children's Hospitals (NACH), and Association of American Medical Colleges (AAMC), along with hospitals and hospital associations in five states, filed suit against DHHS. The suit, filed in U.S. District Court in Little Rock, sought an injunction to halt the implementation of the rule on the basis that DHHS had violated the Congressional Review Act (CRA). On May 13, 2002, after the implementation date had been delayed twice, once by DHHS and once by the court, the judge ruled that it would become effective the next day.

THE CLINTON ADMINISTRATION'S CLAMPDOWN: JANUARY 12, 2001

In the last year of the Clinton administration, the chairman of the Senate Finance Committee and the director of the Medicaid program in the Health Care Financing Administration (HCFA), now CMS, actively opposed states' use of IGTs to circumvent UPLs and thereby increase their federal Medicaid matches. The General Accounting Office, also, had conducted studies indicating that states were engaging in abusive practices. Sen. William V. Roth (R-Del.), chairman of the Senate Finance Committee, and Medicaid Director Timothy Westmoreland contended that the Medicaid UPL loophole cost the federal Medicaid program an additional \$3.7 billion in fiscal year (FY) 2000 alone. At Roth's insistence, HCFA published the October 10, 2000, proposed rule in the *Federal Register*, limiting the practice over time but establishing the 150 percent loophole for the government-owned and -operated (though nonstate) hospitals that serve the poor.

Legal Justification

In the October 10, 2000, proposal, DHHS summarized existing UPL law in the following manner:

In 1986, the Congress affirmed the use of upper limits on payments for inpatient hospital services, nursing facility services, and [intermediate care facility, now intermediate care facility for the mentally retarded] services....The current upper limits were last changed in a final rule in the *Federal Register* (52 FR 28141) on July 28, 1987 that addressed the application of the UPL to states that had multiple payment rates for the same class of services. This rule addressed the differential rate issue in the context of state-operated facilities because several audits had revealed that the circumstances of state-operated facilities resulted in a lack of incentives to curb excessive payments....States established payment methodologies

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which paid state-owned or -operated facilities at a higher rate than privately operated facilities. Higher Medicaid payments to state-owned or -operated facilities allowed states to obtain additional federal Medicaid dollars to cover costs formerly met entirely by state dollars. To ensure payments to state-operated facilities would be consistent with efficiency and economy, the final rule applied the Medicare UPL test to state-operated facilities separate from other facilities. However, the final rule did not create a separate UPL for other government facilities, allowing their payments to count toward the same aggregate UPL as private facilities.¹

Roth and Westmoreland indicated that this policy encouraged states to overpay nonstate government facilities because the “states, counties, cities, and/or public providers [could], through this practice, lower current state or local spending and/or gain extra federal matching payments.” States could set rates for county or city facilities at substantially higher levels than for proprietary and nonprofit facilities and obtain federal government matching for payments they received under those higher rates.²

An Example of Money Laundering

A transaction by Pennsylvania provides an example of how this worked. Cited in a paper by Andy Schneider and David Rousseau, the June 14, 2000, transaction involved 23 nursing facilities operated by 20 counties:

The state Medicaid agency first calculated the amount of payments for nursing facility services that could be made under the aggregate UPL applicable to all nursing facilities in the state, private as well as county. For purposes of this transaction, the amount that all nursing facilities would be paid under Medicare principles was at least \$700 million more than the amount the state actually paid all nursing facilities, county and private, in the aggregate for caring for Medicaid residents. Because there was at the time no UPL for aggregate payments to county nursing facilities in Pennsylvania, the state was able to pay the entire \$700 million to the county nursing facilities.

The 20 counties borrowed \$695.6 million from a bank and transferred it to the state Medicaid agency’s transaction account in the same bank. The state Medicaid agency added a \$1.5 million “transaction fee” from state funds and transferred \$697.1 million to the county bank accounts as supplemental payments to the county nursing homes for treating Medicaid patients. The counties repaid the bank its \$697.1 million and deposited the \$1.5 million transaction fee into the account of the County Commissioners Association of Pennsylvania. Having made this “expenditure,” the state Medicaid agency then claimed, and [HCFA] paid, \$393.3 million in federal Medicaid matching funds (\$697.1 multiplied by the state’s federal medical assistance percentage [FMAP] of 56.4 percent). According to the Office of Inspector General (OIG), “none of the [\$697.1 million] supplementation payments reached the participating nursing facilities, and the Medicaid residents received no additional services. Pennsylvania retained the entire \$393,342,145 in federal financial participation to use as it pleased.”³

States could set higher rates for county or city facilities than for proprietary and nonprofit facilities and obtain federal government matching for payments received under those higher rates.

Transitions to Compliance

When Congress passed the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), it directed HCFA to provide—in the agency’s rule finalizing its October 10, 2000, proposed regulations—a transition period of up to eight years for states that had an approved plan or methodology in effect as of October 1, 1992. (The October 10 proposal included two transition periods: until September 30, 2002, for noncompliant states with approved Medicaid state plan amendments with an effective date on or after October 1, 1999; and until January 1, 2005, for those with amendments approved before October 1, 1999.) The purpose was to help wean the states from the extra matching funds. The final rule—published in the January 12, 2001, *Federal Register*—included the BIPA-mandated third transition period, so that states with pre-FY 1993 plans had an eight-year schedule of payments. Depending upon their state Medicaid plans, states with provisions approved on or after October 1, 1992, but before October 1, 1999, had a phased payment-transition period through FY 2005 (five years); states with provisions approved on or after October 1, 1999, were granted a phased payment-transition period through FY 2002 (two years). (See Table 1 for a review of the annual federal fiscal impact on states, depending upon their individual transition periods.)

The Bush administration later added another provision, one affecting states with provisions pending approval or approved after March 13, 2001. HCFA [CMS] issued a proposed rule on April 3, 2001, and a final rule on September 5, 2001, giving states an end-of-FY 2002 transition if they had provisions effective after September 30, 1999, and approved before January 22, 2001. It provided a transition until the later of November 5, 2001, or one year from a provision’s approval date for states with provisions that were effective after September 30, 1999; submitted to HCFA before March 13, 2001; and approved by HCFA [CMS] after January 21, 2001. In a report issued October 30, 2001, GAO questioned the CMS action: “Less than a month after the revised UPL regulation became effective, [CMS] decided to amend the regulation to shorten the time some states were allowed for compliance. This reversal resulted in the approval of new financing schemes for several states that had pending proposals mimicking the schemes identified last year.”⁴

Provisions in Effect as of March 13, 2001

The January 12, 2001, regulations, which became effective March 13, 2001, did the following:

- For hospitals, nursing facilities, intermediate care facilities for the mentally retarded, and clinics, they established separate UPLs for those that were state-owned or -operated, for public facilities that were not state-owned or -operated, and for facilities that were privately owned or operated.

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TABLE 1
Transition Periods and Fiscal Impact of
Upper Payment Limit Programs

State	Maximum Transition Period			Annual Federal Fiscal Impact*
	8 year	5 year	2 year	
Alabama		✓		\$141,600,000
Alaska			✓	\$12,000,000
Arkansas			✓	\$40,700,000
California	✓			\$754,300,000
Georgia			✓	\$402,500,000
Illinois	✓			\$569,500,000
Indiana		✓		\$136,400,000
Iowa			✓	\$127,500,000
Kansas			✓	\$77,800,000
Louisiana			✓	\$483,000,000
Michigan		✓		\$306,200,000
Minnesota		✓		\$4,800,000
Missouri			✓	\$76,300,000
Montana			✓	\$700,000
Nebraska	✓			\$55,400,000
New Hampshire		✓		\$14,200,000
New Jersey			✓	\$448,000,000
New Mexico		✓		\$31,300,000
New York		✓		\$495,800,000
North Carolina			✓	\$149,600,000
North Dakota		✓		\$25,900,000
Oregon		✓		\$48,700,000
Pennsylvania	✓			\$858,100,000
South Carolina		✓		\$48,600,000
South Dakota			✓	\$20,500,000
Tennessee			✓	\$248,300,000
Virginia ¹			✓	NA
Washington		✓		\$91,500,000
Wisconsin²	✓			\$105,000,000
Total (29 States)	5	11	13	\$5,774,200,000

NOTE: States in **bold** operate UPL programs under more than one state plan amendment, each of which may be subject to different transition periods. The annual federal fiscal impact includes the sum of payments made under all these amendments.

¹ Virginia's UPL program was not included in the September 2001 OIG report; however, an October 2001 GAO report estimated that Virginia's recently approved UPL amendment would net the state \$218 million in FY 2002.

² Wisconsin also received approval for an additional UPL program after the publication of the OIG report. The GAO estimates that this program will result in \$504 million in additional federal payments to Wisconsin in FY 2002.

* These represent only the annual initial federal payment under each state's plan amendment(s) as of October 2000.

Source: Andy Schneider and David Rousseau, "Upper Payment Limits: Reality and Illusion in Medicaid Financing," Kaiser Commission on Medicaid and the Uninsured Issue Paper #4043, February 2002, 17; available at <http://www.kkf.org>. Table based on data contained in Office of the Inspector General, Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers, A-03-00-00216, September 2001, Appendix B.

■ They closed the UPL loophole that allowed states to use IGTs to obtain additional federal Medicaid matching dollars but raised the UPL for hospitals owned or operated by government entities (other than the states) to 150 percent of Medicare costs because of the higher expenditures they were said to incur as safety-net institutions.

In the January 12, 2001, regulations, HCFA indicated:

We have identified 29 states with approved and/or pending rate proposals that target enhanced Medicaid payments to hospitals and NF [nursing facility] facilities that are owned or operated by county or local governments. There are 18 states with approved state plan amendments or waivers and 5 states with pending plan amendments. In addition, there are 6 states that have both approved and pending plan amendments. We estimate that these proposals currently account for approximately \$4.5 billion in federal spending in FY 2001.⁵

THE BUSH ADMINISTRATION'S ULTIMATE STAND: JANUARY 18, 2002

The Bush administration's FY 2002 budget included a proposal to further limit state use of the UPL loophole, for an estimated saving of \$606 million in FY 2002 and \$17.3 billion in FY 2002 through FY 2011.⁶ While opposing the loophole, DHHS nonetheless approved UPL amendments to certain states' Medicaid plans. Examples include Florida, Virginia, and Wisconsin.

The administration started on a regulatory route to limit the practice in August 2001. Shortly after he took over as administrator of the newly named CMS, Scully announced that he "planned to reduce the [Medicaid] UPL to 100 percent of Medicare rates." In October 2001, he sent eight hospital organizations a letter saying that CMS had new UPL regulations under consideration but not specifically targeting the 100 percent limit.⁷

A Proposal to Stand Firm and a Response from Congress

CMS published a proposed rule in the November 23, 2001, *Federal Register* to modify the Medicaid UPL provisions by removing the 150 percent UPL for inpatient and outpatient hospital services furnished by public hospitals that were not owned or operated by state governments. In issuing the proposal, CMS indicated that it was "part of this Administration's efforts to restore fiscal integrity to the Medicaid program and reduce the opportunity for abusive funding practices based on payments unrelated to actual covered Medicaid services."⁸ A couple of days before the proposed regulations appeared, CMS sent a letter to the states, indicating that it would not approve any state plan amendments that allowed payments in excess of this limit.

In response, at the end of 2001, Congress included language in the report to the FY 2002 appropriations measure for the Departments of Labor, Health and Human Services, and Education (Labor/HHS/Education)

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urging CMS to assess the proposal's implementation and consult with the states and other stakeholders about it. Moreover, Rep. Nathan Deal (R-Ga.) and Sen. Blanche Lincoln (D-Ark.) introduced companion legislation in late November 2001 to delay until "at least January 1, 2003, any changes in Medicaid regulations that modify the Medicaid UPL for nonstate government-owned or -operated hospitals."⁹

Finalization of the Administration's Position

The Bush administration's ultimate stand came early the next year, when CMS published the final rule in the January 18, 2002, *Federal Register*. In line with the proposed regulations, the final version lowered the UPL for nonstate government-owned or -operated hospitals from 150 percent to 100 percent. The regulations, which were to have been effective March 19, 2002,¹⁰ provided for the following:

- They closed the loophole for hospitals that are government-owned or -operated (though not by state governments) so that the hospitals could receive 100 percent—rather than 150 percent—of the UPL for services to Medicaid patients. They therefore removed the special recognition such hospitals had been given by the January 12, 2001, regulation.

- They retained the transition periods that had been established by the January 12 and September 5, 2001, rules. However, they made clear that these transition periods would not apply to the reduction (which was to be effective March 19, 2002) of the UPL from 150 percent to 100 percent.

CMS justified the regulations in this way:¹¹

- It indicated that a higher UPL is not necessary "to achieve the objective of assuring access for Medicaid beneficiaries at public hospitals." It contended that the 100 percent UPL would be sufficient to assure access and that states would have "some flexibility to make enhanced payments to selected public hospitals" under this limit.

- It asserted that it did "not believe that the higher payments are necessarily being used to further the mission of these hospitals or their role in serving Medicaid patients." It based this on OIG reports demonstrating that

a portion of the enhanced payments made as part of the UPL process are being transferred directly back to the state via IGTs and used for other purposes (which may include funding the state share of other Medicaid expenditures). In cases for which hospitals did retain UPL-related enhanced payments, the OIG found that these same hospitals either did not receive DSH payments or, if they did, typically returned the DSH payments directly back to the state through IGTs.

- It said that "many of the public safety net hospitals affected by this rule qualify as DSH hospitals" and that BIPA had increased the limits for state Medicaid DSH payments (see section on "Medicaid DSH's Connection to the Medicaid Match Issue").

The final, January 18, 2002, version of the rule lowered the UPL for nonstate government-owned or -operated hospitals from 150% to 100%.

■ It stated that it wished to “restore payment equity among hospital providers and across other provider types.”

■ It summed up: “The main result is that the federal government is effectively paying more than its share of state Medicaid expenditures.”

As a result, states could claim federal matching funds for reimbursing Medicaid providers up to—but no more than—100 percent of what Medicare would pay for such services.

THE JUDICIARY AS ARBITER: DELAY BUT NOT BLOCKAGE OF THE JANUARY 18, 2002, FINAL REGULATIONS

Charging that the Bush administration’s January 18 rule would “jeopardize health care services for the poor, uninsured, and disabled,” the NAPH, AHA, NACH, and AAMC, along with hospital associations and hospitals in the states of Arkansas, California, Florida, Georgia, and New York, filed suit on March 7, 2002, in the U.S. District Court for the Eastern District of Arkansas to prevent the rule’s scheduled March 19 implementation. According to a joint press release, the suit “sought an injunction to halt arbitrary and capricious Medicaid UPL rules that result in disabling cuts to the Medicaid program—totaling \$27 billion over ten years.” The plaintiffs contended that DHHS “in promulgating the final UPL rules...made an arbitrary and capricious decision that will cause irreparable harm to the nation’s public hospitals and the patients they serve.”¹² Specifically, the organizations charged that DHHS had violated the Congressional Review Act by not giving the House of Representatives and Senate the review periods mandated under the law.

According to GAO, the CRA “requires that an agency promulgating a major rule must delay the effective date for 60 days from the date of publication in the *Federal Register* or receipt of the rule by Congress, whichever is later.” The House received the rule on February 14, 2002, and the Senate received it on March 15. Because each body of Congress has to receive a rule before the 60-day counting begins, the UPL rule could not become effective until May 14, 2002—60 days after the Senate received it on March 15—rather than on March 19, the date announced by CMS.¹³

Moreover, in filing the suit, the associations referred to language Congress had included in the report to the FY 2002 Labor/HHS/Education appropriations measure requesting that the administration “carefully consider the impact of any change in special public hospital payments.” NAPH President Larry Gage, asserting that the rules would “cause a massive financial devastation of the nation’s public hospitals,” accused DHHS of giving “the hospitals and the Congress short shrift [by pushing] these funding cuts through in violation of the Administrative Procedures Act (APA).”¹⁴

Earlier, DHHS, responding to comments to the proposed regulations, had indicated in the January 18, 2002, final regulations that it had not violated the APA in changing its position from the one it had adopted a year before:

Comment: One commenter suggested that we have not met the requirements of the APA in publishing this rule. The commenter noted that relevant case law regarding the APA permits an agency to change a regulation if it can demonstrate good cause for making the change and can clearly explain the reasons for its departure from its prior stance. The commenter noted that before the January 12, 2001, rule took effect, the President announced a proposal to modify this UPL. The commenter believes we cannot articulate a reasonable basis for our policy reversal and, as a result, we cannot meet the requirements of the APA.

Response: We disagree. In publishing this rule, we have adhered to the law. In publishing this rule, we have based our actions on a review of the OIG reports pertaining to UPL payments as well as our own review of the new state plan amendments submitted after the January 2002 rule took effect and our further analysis of the requirements of the Medicaid statute. This additional information and analysis underlay the President's proposal to modify the UPL, and the proposal has been promulgated using full notice and comment procedures. Therefore, this regulatory action to modify the UPL does not violate the APA.¹⁵

However, after the lawsuit was filed, DHHS postponed implementation of the effective date by one month. On April 10, based on the department's failure to follow the CRA, the federal judge ordered an additional 30-day delay in implementation, bringing the new effective date to May 14, 2002. According to the American Hospital Association, the two delays resulted in an additional \$300 million in payments that hospitals otherwise would not have received.¹⁶ Having lost the lawsuit, the interest groups turned their attention to Congress, both for resolutions of disapproval in both houses and for legislation to overturn the regulations.

MEDICAID DSH'S CONNECTION TO THE MEDICAID MATCH ISSUE

Medicaid DSH funds have been central to the Medicaid match struggle between the federal and state governments because states have used creative accounting mechanisms—mainly provider donations, provider taxes, and IGTs—to obtain funds from hospitals for their portion of DSH payments. “It should be noted that use of such mechanisms is largely restricted to financing the DSH program,” Teresa A. Coughlin, Leighton Ku, and Johnny Kim write in a paper on the Medicaid DSH program published by the Urban Institute in January 2000.¹⁷ They explain, as follows:

Generally, states finance their share of other parts of the Medicaid program (such as inpatient hospital care, physician care, and the like) with monies from state general revenue. While several states [for example, the large states California and New York] require local government participation in

supporting the Medicaid program, local financing has not historically relied on financing mechanisms used to fund DSH.¹⁸

The authors offer the following example:

A typical transaction might begin with a state receiving \$10 million in revenue—in the form of a tax, IGT, or CPE [certified public expenditure]—from a hospital. The state would then make a \$12 million DSH payment back to the provider. Assuming the state has a 50 percent federal matching rate, the state would get \$6 million in federal Medicaid funds. At the end of the transaction, the provider would have netted \$2 million (\$12 million minus \$10 million) in DSH payments, all from federal funds. The state has thus received \$4 million in federal money without spending any of its own funds. The federal government has paid \$6 million in DSH payments, but only \$2 million has actually been gained by the hospital.¹⁹

Whereas the Balanced Budget Act of 1997 (BBA) had cut Medicaid DSH funding, BIPA increased state DSH allotments. It provided that a state's FY 2001 allotment would be equal to what it received for FY 2000, increased by the percentage change in the consumer price index (CPI) for that year, subject to a ceiling equal to 12 percent of the state's total medical assistance expenditures for FY 2000. For FY 2002, the allotment would equal the amount the state received in FY 2000, increased by the CPI for FY 2001, subject to a ceiling equal to 12 percent of its total medical expenditures in that year. BIPA also included a formula increase for low-DSH states.

In addition, BIPA applied to all states a provision that was in the BBA and extended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA). The BBA authorized DSH payments for hospitals in California up to a ceiling of 175 percent of the cost of care provided to Medicaid recipients and individuals with no health insurance or other third-party coverage for services during the year (the net of nondisproportionate share Medicaid payments and other payments by uninsured individuals). The BBRA indefinitely extended the provision, which was set to expire July 1, 1999, and BIPA, as noted, made it applicable to other states. BIPA also included funds (in addition to DSH payments) for certain public hospitals not owned or operated by a state; not receiving DSH payments as of October 1, 2000; and with utilization by low-income persons greater than 65 percent.

While CMS has moved to reduce UPL gimmicks, including those involving use of DSH funds, Congress has acted to increase DSH funding, roughly within the same time period. In justifying its UPL restrictions, CMS has cited the DSH increases as cushions for safety-net hospitals. It is important to note that, now that UPL appears to be settled, at least for the time being, DSH payments are at issue. Some legislators are indicating that they would like to raise the 175 percent DSH ceiling that BIPA made applicable to all states. Policy people on both sides of the UPL debate seem to agree that it is much more straightforward for Congress and CMS to address state Medicaid funding shortfalls directly through DSH (or

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through FMAP) rather than to have a tug-of-war with states over UPL and other loopholes in federal Medicaid regulations.

OBJECTORS' PREDICTIONS OF THE IMPACT ON THE STATES AND THEIR MEDICAID POPULATIONS

Individually and jointly, various hospital associations, policy groups, and other organizations have objected to the UPL restrictions. Most recently, in comments to the Bush administration's proposed regulations, in letters to Health and Human Services Secretary Tommy Thompson and to Scully, in press releases and interviews, and in publicity surrounding their legal attempt to block the January 2002 regulations, they have used various rationales.

The dominant rationale centers on inadequate Medicaid funding. As a result of the decline in the economy, states are facing budget deficits this fiscal year. According to the National Governors Association, the deficits are expected to be between \$35 billion and \$50 billion. Reducing the UPL for public hospitals not owned or operated by state governments, and thereby decreasing states' Medicaid matching funds, exacerbates the states' plight.²⁰ A survey by the National Conference of State Legislatures on states' health priorities for 2002 showed that "42 states will address Medicaid budget shortfalls, 40 states will attempt to maximize federal Medicaid payments, 37 states will review Medicaid reimbursement rates, 37 states will explore using Medicaid waivers, and 28 states will consider cutting Medicaid benefit packages."²¹

Another key rationale focuses on potential damage to the safety net. Removing the 150 percent category reduces "state flexibility to increase payments to public safety net hospitals" and takes funds "from Medicaid providers who use the funds to provide care to Medicaid patients."²² Moreover, the reduction of the UPL will have an adverse effect on "the health care safety net in specific states." It could result in hospitals cutting services or closing. It could reduce "access to critically needed health services for the uninsured, including immigrants and working families."²³

Still another rationale—the basis for the interest groups' lawsuit—is based on procedural grounds. As noted, one ground is alleged violation of the APA. According to this argument, the January 18, 2002, regulations supersede an agreement between Congress and the Clinton administration that was part of BIPA and the January 12, 2001, regulations that took effect in March 2001. That legislation called for states to report how they were spending Medicaid funds; CMS moved ahead without evaluating the states' responses.²⁴ Moreover, the FY 2002 Labor/HHS/Education appropriations also instructed CMS to give the matter careful consideration. The other ground is violation of the CRA—not giving adequate review time to the House and Senate—which seemingly was taken care of by the DHHS- and court-ordered delays in implementation and the federal judge's final ruling on the interest group lawsuit.

Reducing the UPL for public hospitals not owned or operated by state governments, and thereby decreasing states' Medicaid matching funds, exacerbates states' budgetary plight.

A final argument relates to the Clinton and Bush administrations' charges that states are using Medicaid UPL payments for non-Medicaid purposes. This is countered by OIG and Urban Institute reviews contending "that safety net hospitals retain UPL payments to a significant extent. In two of the three states reviewed, the OIG found that at least two-thirds of UPL payments remained with the public hospitals."²⁵ The persuasiveness of "a significant extent" and "at least two-thirds" seemingly is in the eye of the beholder, because, as indicated, CMS also used the OIG review to justify its position in the January 18, 2002, final regulations.

THE PAST AS PROLOGUE

The federal-state struggle over Medicaid matching funds is largely a saga of gimmicks that states have used to address their own budget problems over the last decade. In 2002, "states are in a somewhat tougher situation [than in the past] because DSH has been capped and UPL must shrink, so they have fewer gimmicks available," according to Leighton Ku of the Center on Budget and Policy Priorities. "New proposals to temporarily increase FMAP could serve as a pressure relief valve to help states." (For example, the National Governors Association contends that a temporary increase, even of a couple of percentage points, would benefit states considerably.) In Ku's view, the new FMAP proposal "is a straightforward and non-gimmicky way to get fiscal relief, as compared to mechanisms like DSH and UPL. Part of the underlying problem is that the FMAP formula does not properly act in a countercyclical fashion."²⁶

While Washington, D.C., and state capitals are used to extended debates over policy issues, the IGT UPL controversy has been particularly wearing. More often than not, it has focused on the implications of banning what states readily admit are accounting schemes rather than on the intent and substance of Medicaid law and regulation. The controversy also has highlighted states' ingenuity and ingenuousness in interpreting federal and even state laws and their implementation by regulation. Whether the debate that a federal judge has just "settled" leads to another chapter in the raising of state Medicaid matching funds or becomes part of a larger debate on federal and state Medicaid reforms remains to be seen.

Many thanks to those who contributed to this background paper by providing information and/or reviewing the final document. Kathy Allen and Tim Bushfield of the General Accounting Office made numerous helpful suggestions and recommended additional citations drawn on GAO's work. Leighton Ku of the Center on Budget and Policy Priorities provided thoughtful comments, as well, and permitted the Forum to use a particularly pertinent DSH example. David Rousseau of the Kaiser Commission on Medicaid and the Uninsured reviewed the document and, along with Andy Schneider of Medicaid Policy, LLC, graciously

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allowed NHPF to cite a UPL example and reprint a table from a recent paper on UPL. While these and other experts on UPL, as credited in the paper, contributed to the final product, the Forum bears final responsibility for its contents.

ENDNOTES

1. 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; Proposed Rule," *Federal Register*, 65, no. 196 (October 10, 2000): 60152; accessed October 17, 2000, at <http://frwebgate4.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=61191811685+1+0+0&WAISaction=retrieve>.
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SOME DEFINITIONS

Certified public expenditure (CPE)—An expenditure certified by a public agency to represent its contribution in providing care to Medicaid recipients or uninsured persons.

Federal medical assistance percentage (FMAP)—The federal share of Medicaid, based on the relationship between each state's per capita personal income and the national average per capita personal income over three calendar years; recalculated every year.

Intergovernmental transfer (IGT)—A transfer of funds from one level of government to another. In the context of this background paper, a transfer of funds from local government to state government so that the state Medicaid program may use the local transfer as part of state funds that draw federal Medicaid matching dollars.

Medicaid disproportionate-share hospital (DSH) program—Enacted in 1981, a provision for state Medicaid programs to make payments to “take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs.”

Medicaid match—The match of federal Medicaid funds to state Medicaid dollars, which is designed, roughly, to even out federal Medicaid spending per Medicaid recipient (the current federal matching formula varies by state, with poorer states receiving more generous matching than richer states). Usually expressed in percentages, e.g., 50 percent federal, 50 percent state matching.

Medicare disproportionate-share hospital (DSH) adjustment—Enacted in 1983, an add-on to the diagnosis-related-group rate under the Medicare prospective payment system, “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 [the Medicare hospital program].”

Upper payment limit (UPL)—A restriction on states from making Medicaid payments that are higher than reasonable estimates of the amounts the Medicare program would pay for the same services.

Looking Back

The UPL controversy delineated in this background paper is one of a series of disputes between the federal government and state governments over attempts by the states to drive up the federal Medicaid matching funds they receive. In the mid-1980s, DHHS objected to states' making excessive payments to state-owned or -operated health facilities in order to increase their federal Medicaid matching funds. Regulations promulgated in 1987 restricted this practice by establishing UPLs for state inpatient and institutional facilities.

States' use of provider donations and provider taxes to increase their federal Medicaid matching funds became an issue in the late 1980s. HCFA had published a regulation in 1985 that allowed donations, both public and private, to be sources of states' share of Medicaid. Moreover, the agency had put out a Medicaid manual instruction on provider taxes 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 federal Medicaid matching funds and the second could not.

Estimates by HCFA and the Office of Inspector General (OIG) indicated that the state provider donation and provider tax programs "cost the federal government nearly \$500 million in FY 1990," according to a 1993 NHPF issue brief. By 1991, "the amount of revenue generated from state provider donation or tax programs was approximately \$2.3 billion in federal funds" and was rapidly rising.¹

HCFA, the OIG, and Congress investigated what they viewed as schemes by the states to increase their federal Medicaid matching funds without increasing their own contributions. A comprehensive report, *Medicaid Provider Tax and Donation Issues*, prepared for the Robert Wood Johnson Foundation in 1992 by Health Policy Alternatives, Inc., documented the issues, the federal and state perspectives on them, and the practices. The report also provided case studies on Connecticut, Delaware, Pennsylvania, Tennessee, and Texas.²

Tennessee offered a good example of the use of revenues from both provider donations and provider taxes. Beginning in 1987, when the Tennessee legislature authorized the practice, Tennessee used revenues from provider donations to draw federal dollars, 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 to several factors. One factor was the state's commitment to expansion of

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indigent care and state aid for certain high-volume Medicaid hospitals. Another involved federal statutory changes (such as expanded coverage for low-income mothers and children). Yet another was health care inflation.³

That first year, 30 of Tennessee's 150 hospitals donated \$19 million. The largest donor was Regional Medical Center in Memphis, which was the largest public hospital in the state. Because the state's federal Medicaid percentage was 70 percent (that is, the federal government paid 70 cents and the state paid 30 cents), the \$19 million generated approximately \$63 million, Bonnyman reported. Of the \$63 million, \$24 million increased Medicaid 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 provided a rise from 14 to 20 days in the annual inpatient hospital coverage limit. Most of the subsidies went to the providers that had provided the donations.⁴

When HCFA disallowed most of the matching funds raised by the donations, Tennessee, while appealing the disallowance and continuing with its donation policy, turned to a provider tax—a hospital gross receipts tax—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 1990.⁵

Meanwhile, the DHHS Departmental Appeals Board had reversed HCFA's disallowance of the donations mechanism. Therefore, Tennessee had both the donations and the provider tax options open to it.

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—in 1989 and 1990 imposed moratoria on actions by HCFA. 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 federal Medicaid matching dollars.

The 1991 legislation also included provisions limiting the growth of Medicaid DSH payments to the level of overall program expenditures and capping Medicaid DSH payments at 12 percent. Since enactment of the Omnibus Budget Reconciliation Act (OBRA) of 1987, DSH (enacted in 1981) had become an attractive mechanism for states because they could exceed the UPL in providing funds to hospitals that provided high volumes of care to low-income patients. The 1987 legislation both required states to make the payment adjustments to qualified hospitals and established minimum criteria for them to follow in doing so. Subsequent legislation, OBRA 1993, provided that only those hospitals that had Medicaid utilization of at least 1 percent could receive DSH payments. The act

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also 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. Medicaid had grown "at an extraordinary 27.1 percent annual growth rate, with expenditures increasing from \$73.7 billion to \$119.9 billion in just two years" between 1990 and 1992, according to a September 1998 Urban Institute study. "[Medicaid] 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.⁶

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.⁷ HCFA, the OIG, and Congress—especially the Senate Finance Committee and the General Accounting Office—then turned their attention to states' use of IGTs in order to avoid UPL restrictions and claim federal matching on the transferred funds. This is the background for the IGT-UPL debate that has involved CMS (the former HCFA), Congress, and interest groups since 2000.

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