



## **An Analysis Of Proposed Rules Restricting Federal Medicaid Payments For Publicly Supported Healthcare Services**

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### **Introduction**

During its 47-year existence, Medicaid has been the subject of countless analyses, articles, books, and studies, in view of its sheer size (federal expenditures standing at \$190 billion in FY 2006),<sup>[1]</sup> its complexity (more than five dozen separate federal eligibility categories), and its importance in the American healthcare system. Medicaid funds nearly 40% of all births,<sup>[2]</sup> covers about one-third of all children,<sup>[3]</sup> and is the primary source of healthcare financing for persons with severe and chronic physical and mental disabilities.<sup>[4]</sup> Medicaid virtually enables the operation of public healthcare providers, such as school-based clinics, community health centers, and public hospitals, whose primary mission under both law and policy is healthcare for the poor, the uninsured, and the medically underserved.

Over the years, several legislative proposals to dramatically structure the federal/state Medicaid financing relationship have been considered and rejected by Congress.<sup>[5]</sup> Now the Bush Administration has come forward with a proposed rule<sup>[6]</sup> titled “Cost Limits for Providers Operated by Units of Government and Provisions to Ensure the Integrity of the Federal-State Financial Partnership.” The rule appears to attempt to achieve the type of fundamental alteration in the federal/state Medicaid financial relationship that has been rejected by Congress numerous times over the years. Moreover, the proposal, if adopted in its current form, could have far-reaching consequences for government healthcare initiatives, ranging from hospital care to publicly supported managed care systems, public primary care clinic networks in medically underserved urban and rural communities, school health services in low income schools, and other governmental initiatives aimed at promoting healthcare access and protecting public health.

According to the Centers for Medicare and Medicaid Services (CMS), this proposal has been undertaken to improve program “economy and efficiency.”<sup>[7]</sup> Ironically, however, it has appeared just as previous efforts to constrain federal Medicaid spending growth have succeeded, and at a time when at least one long term national health expenditure study shows that over the coming four decades, Medicaid financing will remain a stable aspect of total national health care spending.<sup>[8]</sup>

The impact of the proposed rule appears to be significantly understated. CMS places the savings estimate at \$3.87 billion in federal savings over five years. Even cursory discussions with senior healthcare officials around the country suggest a far greater loss of funding. Thus, while the quoted figure is not substantial in the context of Medicaid’s size, its reliability may become an increasingly open question, as scores of individual states and localities begin to seriously focus on the proposal in order to calculate its impact.

Whether the Administration’s proposal represents sound public policy is a matter that in all likelihood will be actively debated in the coming months. As significant, however, are questions regarding the Administration’s legal authority to depart in a sweeping fashion from existing Medicaid statutory policy

regarding state expenditures, particularly since lawmakers rejected similar changes legislatively during the 109th Congress. Indeed, the Notice of Proposed Rulemaking (NPRM) potentially raises Tenth Amendment issues by arguably intruding on the states' power to raise revenues and regulate the delivery of healthcare.

To appreciate the magnitude of the proposal, it is important to understand existing Medicaid statutory policy with respect to state expenditures. This article begins with a brief overview of federal Medicaid regarding state financing of the "non-federal share" of the program, as well as state options for provider payment. The article then turns to the NPRM, examining its key elements and identifying the issues raised.

## Overview

Enacted in 1965, Medicaid is the nation's largest state grant-in-aid program. Medicaid's purpose is to enable "each State, as far as practicable under the conditions of such State"<sup>[9]</sup> to furnish medical assistance to individuals who are eligible for medical assistance and enrolled in the program, and who receive services from participating, qualified providers. The law sets forth extensive requirements related to eligibility, enrollment, benefits and services, coverage and patient protections, provider participation and payment, and state administration.<sup>[10]</sup>

The federal government contributes toward the cost of each state's program on an open-ended basis, and in accordance with a formula that varies by state per capita income. This federal payment for qualifying medical assistance items and services ranges from 50% to 83% of total expenditures.<sup>[11]</sup> Different federal formulas apply to expenditures made in connection with program administration.

### *Financing the non-federal share of Medicaid expenditures*

Federal payments are available only in relation to state expenditures; in other words, states do not qualify for federal financial participation unless they make qualifying expenditures. It is how states generate the revenues needed to meet the "non-federal share" requirement that is the focus of the NPRM; this issue has been the subject of considerable scrutiny and legislative activity over the past 15 years or so.

From the time of Medicaid's enactment, states have enjoyed broad latitude in how they derive the state share of total Medicaid expenditures. This broad latitude is in recognition of both the federalism principles that are inherent in state grant-in-aid programs, as well as the historical approach on the part of states to indigent healthcare financing, which rested on a combination of state, city, and county revenues.<sup>[12]</sup>

The original federal statute thus was quite simple where non-federal expenditures are concerned, providing simply that states must "provide for financial participation by the state equal to not less than 40 per centum of the non federal share of the expenditures under the plan . . ."<sup>[13]</sup> Under this provision, states were permitted to amass the non-federal share of total program expenditures through a combination of approaches, relying on both state-generated revenues (general or dedicated), as well as revenues derived through local financing arrangements (again, either general, dedicated, or special purpose).

The broad authority granted to states to generate the non-federal share from various units of government thus has enabled states to create the financial base on which Medicaid rests. This latitude recognizes the variability in state economic conditions, as well as key differences in how states fund and utilize public

healthcare services. In those states that historically utilized publicly funded healthcare providers to furnish care, funds allocated to the support of these providers also could count toward the non-federal share. This was done by attributing to the state Medicaid budget that portion of operating revenues related to Medicaid patients and services. Originally this practice occurred by relatively informal custom. In 1991 Congress regulated the practice, allowing it to take place either by “intergovernmental transfer” or by “certified public expenditure.” This provision, which some may argue acted as a codification and validation of the custom, was part of legislation whose purpose was to curb states’ use of provider donations and contributions as a means of generating the non-federal share. Thus, in shutting down one revenue source for securing non-federal revenues, Congress simultaneously and expressly sanctioned the use of funds from various governmental units to create the non-federal share.<sup>[14]</sup> In enacting the governmental expenditure provisions of the provider tax and donation law, Congress also specified that

Notwithstanding the provisions of [the tax and donation law] the Secretary may not restrict States’ use of funds where such funds are derived for State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a state as the non-Federal share of expenditures under this Title, *regardless of whether the unit of government is also a health care provider.*<sup>[15]</sup> [Emphasis added.]

The provider tax and donation legislation thus addressed two issues where Medicaid funding contributed from units of state and local government were concerned. First, the law formalized the role of units of government in Medicaid financing, which would be accomplished through certified expenditures or intergovernmental transfers. Second, the legislation acknowledged that a unit of government could be either a healthcare provider or a government instrumentality that purchased healthcare services. In either case, public financing would qualify as the non-federal share when certification or transfer procedures were used.

The underlying reason for this alternative drafting approach would appear obvious: at the time of enactment, as is the case now, many governmental healthcare undertakings were carried out either as direct governmental operations or as contractual arrangements with affiliated healthcare enterprises. In many instances, healthcare entities might once have functioned as directly governmentally operated facilities; over time however, their legal structure had been altered in order to allow greater operational efficiencies or broader access to private capital markets. Even in their new structure, however, these healthcare entities existed solely or in major part to carry out the public governmental purposes.

A leading example of this transformation is the Denver Health and Hospital Authority, one of the nation’s leading public healthcare systems and widely acknowledged for the strength of its services and the quality of its care. Today Denver Health serves one in four Denver residents, and its specialized services touch all Colorado residents. A decade ago the Authority, which is a subdivision of the state, was restructured to operate as a publicly financed governmental corporation with a public purpose and function. At the same time, Denver Health lacks certain powers exhibited by other types of units of government, such as the independent power to levy taxes; instead it receives its operating revenues from units of government that hold taxing authority under the state constitution.

### *Provider compensation*

Beyond the question of how states derive the non-federal share of Medicaid expenditures, the statute gives states broad latitude to set payment rates for participating healthcare providers, whether public or private. In setting Medicaid rates, states must comply with certain payment principles including an aggregate upper payment limit on public providers by class. States also must comply with certain “upper

payment limit” rules in the case of publicly operated facilities; these rules have been developed over the past number of years in order to ensure that compensation levels to public providers are appropriate and reasonable.

By and large however, state programs enjoy considerable payment latitude under the statute. They can structure payment arrangements to recognize the full array of costs associated with the provision of healthcare (including capital for building and facility upgrades such as health information technology). They also can set rates that exceed those paid by Medicare. Finally, states can build into their compensation arrangements financing components that recognize the core costs associated with developing and furnishing healthcare, such repayment of capital loans, additional payments to support teaching, and compensation approaches such as “pay for performance” in order to incentivize quality improvement, technology innovation (including information technology), or other types of desirable performance.

### **The Proposed Rule: Elements and Issues**

The NPRM Preamble begins by seeming to acknowledge that the routine state plan submission and amendment process functions as the means by which state compliance with these requirements can be readily measured and achieved: “[s]ince the summer of 2003, we have received and processed over 1000 state plan amendments related to state payments to providers. Of these, approximately 10 percent have been disapproved. . . or withdrawn.”<sup>[16]</sup>

Despite the ability of the state plan amendment procedure to identify and correct state administration approaches that fail to adhere to federal requirements, the agency argues that more is needed. In doing so, CMS points to the Preamble to the 1992 federal regulations implementing the 1991 provider tax and donation legislation, which specifically reserved the power to revisit the question of what constitutes a valid transfer from a unit of government to the state.<sup>[17]</sup>

The rule proposes three changes in law as a follow-on to this 1992 reservation of power: (a) a redefinition of the types of expenditures that will be considered intergovernmental in nature; (b) a related, proposed revision in the meaning of a “unit of government” in order to achieve this alteration in the range of permissible spending, and (c) changes in how public providers can be paid, despite Congress’ failure to act on a nearly identical proposal during the 109th Congress. In all three instances, the proposed rule’s connection to the statute appears tenuous at best.

*What types of expenditures would count toward the non-federal share?*

After noting that the statute does not define an intergovernmental transfer (IGT), the Preamble goes on to assert (without citing any basis) that the “plain meaning” of an IGT “in a Medicaid context” involves *an actual transfer of tax revenues* from local governmental units to the state agency, rather than a transaction in which a state agency is refunded by a governmental healthcare provider for that portion of the non-federal share owed by the provider/unit of government. No explanation is given for this assertion that in order to qualify under the statute, an intergovernmental transfer must involve the actual transfer of tax revenues to a state agency as opposed to refunds.<sup>[18]</sup>

A refund system both ensures that a local unit of government actually makes up its portion of the non-federal share but also is consistent with healthcare institutional cash flow needs. Under a refund arrangement, a public provider pays its share only when it receives an actual payment for services. Were the entity to be required to make a prospective revenue transfer in advance of actual payment for care, such a requirement could disrupt the revenues vital to maintaining essential healthcare services.

### *What constitutes a unit of government?*

Beyond delineating the procedures that must be used to achieve an intergovernmental transfer, the proposed rule would redefine the meaning of a governmental transfer to prohibit healthcare providers from being considered “units of government” unless the provider:

is operated by a unit of government as demonstrated by a showing of the following: (A) the health care provider has generally applicable taxing authority; or (B) the health care provider is able to access funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care providers expenses, liabilities, and deficits, so that a contractual arrangement with the state or local government is not the primary or sole basis for the health care provider to receive tax revenues.[19]

In essence, this proposed rule seeks to set aside contractual arrangements between healthcare systems and units of government, ostensibly because such arrangements demonstrate insufficient nexus to government to count as a governmental expenditure. Furthermore, it seems the proposal would present significant enforcement issues, since doing so would require federal lawyers and auditors to examine state and local governmental arrangements to verify their legal and structural underpinnings.

Beyond questions related to intrusiveness and enforceability, CMS’ proposal seems to sweep away, without explanation, longstanding principles of law that recognize that public functions can be carried out by government in myriad ways, through direct operation as well as by contractual arrangement. Very few governmental functions are considered non-delegable under law;[20] indeed, in the modern world contracts underlie the provision of governmental health services, from hospital care to immunization clinics, Medicaid managed care operations, school based health clinics, clinics that identify and treat communicable diseases, and healthcare entities that have “first responder” duties in the face of public health threats.

Given that no one can say with certainty how many governmental undertakings are built on contractual arrangements rather than direct governmental undertakings, the potential impact of this proposal would be nearly incalculable at this point. Indeed, the answer would become evident only were federal officials to scrutinize every single governmental healthcare arrangement serving Medicaid beneficiaries, in order to determine the propriety of the state’s claim for federal funding.

This level of involvement into the inner workings of state units of government appears to have no basis in the statute and, given the modern approach to the provision of governmental services generally, seems very problematic. Indeed, this attempt to restructure the inner workings of state and local governments may achieve the near-legally-impossible and actually step over the line that separates Congress’ considerable Spending Clause powers from states’ Tenth Amendment authority. Based on this assessment, it is not difficult to understand why the nation’s governors on February 23 sent a letter to congressional leaders objecting to the proposal.[21]

### *Limiting payments to public providers*

The proposed rule also would impose new limitations on state powers to devise payment standards for public healthcare providers. With the exception of the Indian Health Service and tribal facilities operated under the Indian Self-Determination and Education Act, the proposed rule would limit payment to an “individual provider’s cost of providing Medicaid services to eligible Medicaid recipients.”[22] This shift to a mandatory, facility-specific cost structure appears to have no basis in the statute, and it would have several consequences.

First, such a shift would eliminate the ability of state Medicaid programs to employ the same types of payment innovations in the case of public hospitals (and presumably publicly operated managed care systems, nursing facilities, and clinics) that increasingly are in use today.

Second, the regulation appears to prohibit payment of costs other than the marginal costs associated with treating Medicaid patients, leaving public providers uncompensated for the range of costs that underlie healthcare. As a result, public healthcare entities would likely face a serious financial impact, since for most, Medicaid is not only *not* a marginal payor but in fact is the largest payor. The NPRM requires that costs be supported “using information based on the Medicare cost report.”<sup>[23]</sup> At the same time, however, the NPRM also carefully avoids recognizing that all Medicare-allowable costs will be recognized in calculating payments, including capital-related costs and the costs of graduate medical education (GME) and health professions training. Indeed, the Preamble notes specifically that “the Secretary will determine a reasonable method for identifying allowable Medicaid costs that incorporates . . . OMB Circular A-87 [and] Medicare cost principles *as appropriate*.”<sup>[24]</sup> [Emphasis added.] Since the President’s budget proposes to eliminate state authority to recognize GME as a permissible Medicaid cost,<sup>[25]</sup> one can presume just how many Medicare costs would become impermissible in a Medicaid context, a deadly blow to the public healthcare system, especially large teaching hospitals that both furnish care and train physicians and other health professionals.

Third, by requiring facility-specific costs rather than permitting aggregation by class of provider, the proposed rule would override existing, carefully developed, Medicaid upper payment limit regulations (UPLs)<sup>[26]</sup> governing payments to governmental healthcare services. The rule would effectively ratchet down permissible payment levels for public entities to levels well below existing permissible standards.

The proposed rule also requires that the full amount of all computable payments received by public healthcare providers be retained in order to be permissible.<sup>[27]</sup> This sounds sensible in principle, but in practice is likely an inaccurate and inefficient way of thinking about healthcare. Public healthcare providers, like any business, operate with an annual budget. In a year when revenues exceed budgets, a public entity, just like its private counterparts, may be expected to repay funds to its sponsor. It is unclear why public entities should be any different in this regard. Furthermore, the inefficiencies in enforcing such a requirement are substantial. One need only read the enforcement provision of the NPRM to appreciate the problem:

The Secretary will determine compliance with this provision by examining any associated transactions that are related to the provider’s total computable payment to ensure that the State’s claimed expenditure, which serves as the basis for Federal Financial Participation, is equal to the State’s net expenditure and that the full amount of the non-Federal share of the payment has been satisfied. <sup>[28]</sup>

Finally, the proposed rule would prohibit state Medicaid programs from paying providers more for inpatient hospital services than the “provider’s customary charges to the general public for the services.”<sup>[29]</sup> But a hospital’s customary charge to the general public may in fact be discounted to adjust for income, insurance status, and other factors that are not relevant when setting a Medicaid rate.

## Conclusion

For over 40 years, the Medicaid program’s inner financial workings have rested atop a delicate and complex approach to state and local financing consisting of both cash payments and direct funding of health services for low-income and medically underserved populations, some of whom are enrolled in Medicaid. This approach is essential, if for no reason other than Medicaid’s restrictive federal eligibility

categories, which exclude millions of low income adults and prevent states from ensuring access to healthcare through a pure cash financing model. Systems of healthcare focused on vulnerable populations must be able to combine all revenue sources to achieve healthcare access, operational efficiency, and quality care.

Congress codified broad, governmental financing arrangements in 1991, when it addressed the issue of provider taxes and donations. Subsequent reforms, such as the development of upper payment limit standards and procedures for certifying public expenditures, have been developed to refine this approach to governmental financing. The same factors that led federal lawmakers to preserve governmental financing in 1991 are even more present today; uninsured rates have grown dramatically, and the revenues needed to maintain essential healthcare services have soared.

The stakes are enormous in this proposed rule: nearly 47 million Americans are uninsured, and an equal number have only a precarious tie to health insurance coverage. Any diminution of governmental ability to finance Medicaid while maintaining the public health service infrastructure would have enormous, system-wide consequences. Given the effectiveness of past reforms aimed at curbing excessive federal spending on public health services, a wiser course at this point would be to retain current policy.

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[1] Testimony of Donald B. Marron, Acting Director, Congressional Budget Office, before the Senate Special Committee on Aging (July 13, 2006), available at <http://www.cbo.gov/ftpdocs/73xx/doc7387/07-13-Medicaid.pdf> (accessed Feb. 25, 2007).

[2] *Id.*

[3] *Id.*

[4] *Id.*

[5] Legislation to block grant Medicaid was considered and rejected during the 104th Congress. A 2003 proposal from the Bush Administration to partially block grant Medicaid was not considered.

[6] 72 Fed. Reg. 2236-2248 (Jan. 18, 2007).

[7] 72 Fed. Reg. 2241.

[8] Richard Kronick and David Rousseau, "Is Medicaid Sustainable? Spending Projections for the Program's Second Forty Years," *Health Affairs Web Exclusive*, available at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.2.w271> (accessed Feb. 25, 2007).

[9] 42 U.S.C. § 1396 (2006).

[10] The most detailed overview of Medicaid can be found in the CCH Medicare/Medicaid Guide.

[11] 42 U.S.C. § 1301(a)(8)(B), as explained in CCH Medicare/Medicaid Guide ¶ 14,905.

[12] Robert and Rosemary Stevens, *Welfare Medicine in America* (Free Press, NY, NY 1974).

[13] 42 U.S.C. § 1396a(a)(2) (2006).

[14] Pub. L. No. 102-234, The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, amended by § 4722(a)(1)-(2) of the Balanced Budget Act of 1997 Pub. L. No. 105-33 and subsequent laws.

[15] 42 U.S.C. § 1396b(w)(6)(A).

[16] 72 Fed. Reg. 2237.

[17] *Id.*

[18] Proposed 42 C.F.R. §433.51(b).

[19] Proposed 42 C.F.R. §433.50(a)(1).

[20] *American Manufacturers Mut. Ins. Co. v Sullivan*, 526 U.S. 40 (1999).

[21] Letter from NGA to the Hon. Nancy Pelosi, Speaker, U.S. House of Representatives, Harry Reid, Senate Majority Leader, Mitch McConnell, Senate Minority Leader, and John Boehner, House Minority Leader (Feb. 23, 2007).

[22] Proposed 42 C.F.R. § 447.206(c).

[23] *Id.*

[24] 72 Fed. Reg. 2241.

[25] Budget of the United States (Feb. 5, 2007).

[26] 72 Fed. Reg. 2242; proposed 42 C.F.R. § 447.321.

[27] Proposed 42 C.F.R. § 447.207.

[28] Proposed 42 C.F.R. § 447.207.

[29] Proposed 42 C.F.R. § 447.271.

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