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Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action

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Summary

In accordance with Medicaid statute, the Secretary of Health and Human Services (HHS) has established, through a series of regulatory actions, upper payment limits (UPLs) for inpatient and outpatient services provided by certain types of facilities. In late 2000, the Secretary determined that regulations in effect at that time created a financial incentive for states to make higher than usual payments for care provided at non-state government facilities, namely, county and city facilities, allowing these states to claim higher federal matching dollars. States require these facilities to transfer some or all of the excess funds back to the state (called an intergovernmental transfer or IGT). Then states use these funds to cover part of the state share of Medicaid costs and/or for other purposes. After HHS issued a proposed rule in October of 2000 designed to halt these practices, Congress mandated additional changes to upper payment limits in the *Benefits Improvement and Protection Act of 2000* (BIPA; incorporated by reference into P.L. 106-554). Final regulations that included the BIPA provisions were released by the Clinton Administration on January 12, 2001.

Among other changes, this rule established separate UPLs for inpatient services provided by local government facilities, and for the subset of local public hospitals only, a separate higher payment rate was allowed. It also provided a separate UPL for private facilities. Parallel rules were established for outpatient hospital and clinic services. Three phase-out or transition periods for states with enhanced payment arrangements that were noncompliant were also specified. Application of a specific transition period to a given state was primarily dependent on the effective date of its plan describing the enhanced payment arrangement. Phase-out periods varied in duration, and except for the shortest period, required specific percentage reductions in excess payments for each transition year.

The Bush Administration made two changes to the Clinton final rule: (1) creation of a separate, minimum 1-year transition period for certain states that have only recently received approval for enhanced payment arrangements, and (2) elimination of the higher payment rate for non-state public hospitals.

While there was no legislative action in the 108th Congress dealing with Medicaid UPL rules, there has been considerable on-going interest in how states finance the non-federal share of Medicaid costs, especially the use of IGTs. CBO has estimated that "other payments to providers," largely comprised of UPL dollars, will total $4.8 billion in FY2005, representing approximately 2.7% of federal Medicaid spending this year. The Bush Administration has implemented several strategies to rein in both UPL and IGT practices, including greater scrutiny of state financing methods in Medicaid waiver applications and state plan amendments, and new administration policy distinguishing IGTs that are permissible (e.g., using state and local tax revenues) from those that are impermissible (e.g., recycling mechanisms under which payments to providers are returned to the states). Additional reforms are expected during the 109th Congress.

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Background

Medicaid is a federal-state health program for low income persons. Services are financed jointly by the federal government and the states. For each dollar of state spending, the federal government makes a matching payment.[1]

In the spring of 2000, newspaper reports around the country described seemingly questionable Medicaid accounting practices used by some states to obtain additional federal matching dollars for purposes other than providing services to Medicaid beneficiaries. These reports galvanized concern among some Members of Congress and the Clinton Administration about potential state financing abuses, leading to a series of subsequent legislative and administrative actions. At issue were two interrelated factors — a loophole in the regulations governing upper payment limits (UPLs) and the practice of intergovernmental transfers.

In accordance with statutory requirements that payments for services be consistent with efficiency and economy,[2] the Secretary established through regulation upper payment limits for different types of Medicaid covered services. The regulations in effect during 2000 had been issued in 1987.[3] For the purpose of applying the UPLs for inpatient or institutional care, providers were divided into three primary groups — inpatient hospitals (IPH), nursing facilities (NF), and intermediate care facilities for the mentally retarded (ICF/MR). Within these three provider groups, a secondary distinction was made for facilities that were state-owned or operated. For each of the three primary provider groups (IPH, NF and ICF/MR), two separate UPLs were applied — one for overall aggregate payments to all public and private institutions in the primary group, and the other for aggregate payments to state government facilities in the primary group. Aggregate payments to each primary group of providers (IPH, NF and ICF/MR) could not exceed a reasonable estimate of what would have been paid for those services under Medicare payment principles.

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[1] The federal share of a state's payments for services is known as the federal medical assistance percentage (FMAP). FMAPs are calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita incomes. No state may have an FMAP lower than 50% or higher than 83%.

[2] Section 1902(a)(30) of the Social Security Act.

[3] 52 *Federal Register* pp. 28141-28148 (July 28, 1987).

For outpatient hospital services and clinic services, the 1987 regulations established a single UPL that applied to aggregate payments for all providers combined, and these could not exceed estimates based on Medicare payment principles. Thus, with respect to applying UPLs for outpatient care, no distinctions were made between primary groups of providers or groups of facilities based on ownership (operation) status.

Two additional factors are important to this discussion. First, in the 1987 regulations, there were no separate inpatient or outpatient UPLs for other government facilities, namely, county or city providers. Second, both then and now, states may fund up to 60% of the non-federal share of Medicaid expenditures with local government funds[4] — the source of intergovernmental transfers that also played a role in the state accounting practices that drew the concern of Congress and both the Clinton and Bush Administrations.

In part due to the newspaper reports in early 2000, the Secretary determined that the 1987 regulations created a financial incentive for states to provide excess payments, beyond the usual payment rate, to non-state-operated government facilities (e.g., county or city providers), allowing these states to claim additional federal matching dollars. Subsequently, as part of that process states required the local government facilities to transfer all or a portion of the excess funds back to the state. States then used these funds to cover part of the state share of Medicaid expenditures and/or for other purposes.

Although legal at that time, the Secretary deemed this practice to be inconsistent with the intent of the statute that Medicaid payments be economical and efficient. On July 26, 2000, the Health Care Financing Administration (HCFA)[5] released a letter to state Medicaid directors announcing a forthcoming notice of proposed rulemaking that would close the UPL loophole in the 1987 regulations and would outline transition provisions. In that letter, HCFA noted that excess or enhanced payments may be used for a variety of purposes, both health-related and non-health-related. In addition to financing the state share of Medicaid costs, some states used or planned to use the enhanced funds to cover uncompensated care or to provide community-based services for seniors or the disabled. In other cases, the money was used to fill state budget gaps, for state tax cuts, or to reduce state debt. HCFA argued that while all these purposes may have merit, Medicaid funds are intended to pay only for Medicaid services delivered to Medicaid beneficiaries by Medicaid participating providers.

In 2001, the Office of the Inspector General (OIG) completed 7 audits in 6 states examining the enhanced payments under Medicaid to public providers and the use of intergovernmental transfers. In its report[6] summarizing the findings from these

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[4] Section 1902(a)(2) of the Social Security Act.

[5] Under the Bush Administration, HCFA's name was changed to the Centers for Medicare and Medicaid Services or CMS.

[6] U.S. Department of Health and Human Services, Office of the Inspector General: *Review of Medicaid Enhanced Payments to Local Public Providers and the Use of* (continued...)

audits, the OIG concluded: (1) such payments were not based on the actual costs of providing services to Medicaid beneficiaries, nor were they directly related to improving the quality of care provided by these facilities, (2) the majority of enhanced payments to public nursing facilities was returned to the states via intergovernmental transfers, (3) while public hospitals kept a larger portion of the enhanced payments, such hospitals either did not receive Medicaid disproportionate share hospital (DSH)[7] payments, or returned DSH payments to the states via intergovernmental transfers, (4) some of the funds returned to states were used to cover health services, but not necessarily for approved Medicaid benefits, and (5) the states developed mechanisms to attain federal Medicaid funds without contributing their full share of required matching funds. In an earlier analysis,[8] the General Accounting Office (GAO) had drawn similar conclusions from its investigation, noting that these payment arrangements violate the integrity of the federal/state partnership under Medicaid and that states were guilty of replacing state dollars with federal dollars in the process.

Table 1 shows an example of hypothetical payment arrangements for inpatient hospital services provided in private and county-operated facilities in a hypothetical state under the 1987 rules.[9] The hypothetical state uses the total number of hospital days (county and private combined) in a given month and Medicare payment principles ($1,000 per day) to determine an aggregate upper payment limit or total dollar amount for inpatient hospital services. The state claims federal matching funds based on this aggregate amount. Private hospitals are paid the usual daily Medicaid rate ($800), while the balance of the total calculated amount is allotted to county facilities, which yields a much higher average daily payment rate ($2,800). Thus, the state has established two different payment rates for two different ownership categories of hospitals, so that when all payments are combined, the upper payment limit for inpatient hospital services is not exceeded.

The next step in the example involves the return of funds to the state through an intergovernmental transfer from the county facilities. In this example, the county providers return all excess dollars beyond the usual payment rate back to the state. How do private facilities contribute to enhanced payment arrangements? States cannot require private facilities to transfer excess payments back to the state; thus, there is little incentive to provide enhanced payments to these providers. However, as shown in **Table 1**, because private facilities add significantly to the total number of hospital days in determining the upper payment boundary (using Medicare

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[6] (...continued)
Intergovernmental Transfers, A-03-00-00216, September, 2001.

[7] Disproportionate share hospital (DSH) payments are supplemental payments made to hospitals that treat a disproportionate share of uninsured and Medicaid beneficiaries. The intent of Medicaid DSH payments is to provide financial relief to such hospitals.

[8] U.S. General Accounting Office: *Medicaid: State Financing Schemes Again Drive Up Federal Payments*, GAO/T-HEHS-00-193, September 6, 2000.

[9] For simplicity, the example does not include state government facilities because such facilities are few in number, are subject to a separate UPL, and were not the focus of the payment controversy that surfaced in 2000.

payment principles), especially when the state's recognized Medicaid payment for care is lower than Medicare's, they are crucial to the overall aggregation process. In this example, the state gains $200,000 in enhanced payments through an intergovernmental transfer from the county facilities, and in this process, has reduced its own share of total Medicaid costs for acute inpatient care delivered in 1 month.

Changes to Upper Payment Limits: 2000 - Forward

Tables 2 and 3 summarize key components of the series of regulatory and legislative changes made to the 1987 rules governing upper payment limits since 2000. **Table 2** describes UPL modifications for inpatient or institutional care. **Table 3** describes UPL modifications for outpatient hospital and clinic services. In general, to establish consistency, changes made over time with respect to inpatient services were replicated for outpatient care.

The Clinton Administration issued a proposed rule on Medicaid UPLs in October of 2000. In December of 2000, the *Benefits Improvement and Protection Act of 2000* (BIPA), incorporated by reference into P.L. 106-554, required that the final rule include separate UPLs for local government facilities. Thus, the January 12, 2001 final rule[10] established new UPLs for city and county facilities,[11] and separate UPLs specific to privately owned and operated facilities, thereby eliminating the overall aggregate UPLs that had previously applied to all public and private facilities within each primary group. In this final rule, HCFA clarified that these regulations apply only to fee-for-service Medicaid payments. Managed care payments are subject to different regulations.

In terms of allowed payment amounts to facilities, the final rule issued by the Clinton Administration established an exception for payments covering inpatient and outpatient services provided by *non-state-owned or operated public hospitals*. This exception allowed states to pay city and county public hospitals up to 150% of the Medicare payment rate for such services. HCFA justified this exception because these facilities provide access to a wide range of needed care not often otherwise available in underserved areas, deliver a significant proportion of uncompensated care, and are critically dependent on public funding sources such as Medicaid. The January 12, 2001 final rule also required that payments to city and county public hospitals be separately identified and reported to HCFA. Such reporting was intended to ensure both that the higher payments were appropriate and that they were being fully retained by these facilities.

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[10] 66 *Federal Register* pp. 3148-3177 (Jan. 12, 2001), . On January 20, 2001, the Bush Administration released an agency notice delaying by 60 days implementation of final rules issued near the end of the Clinton Administration. The purpose of the delay was to allow for regulatory review by the Bush Administration. Because BIPA required that the final Medicaid UPL rule be issued by the end of CY2000, this rule was allowed to go into effect on its original effective date of March 13, 2001.

[11] Technically, the rule imposed the new UPL on all other government-owned or operated facilities; that is, all non-state government owned or operated facilities. However, Indian Health Services facilities and tribal facilities are not subject to this new UPL. In addition, DSH payments are not counted toward the UPLs.

Table 4 provides an example of how the Clinton final rule substantially altered the methodology states may use to claim federal matching dollars and the resulting reduction in excess payments states may obtain through intergovernmental transfers from city and county facilities. **Table 4** carries over the basic underlying assumptions defined in **Table 1**. That is, the total number of hospital days, the split in hospital days between private and county facilities, and the basic Medicare and Medicaid payment rates are identical in the two tables.

There are two significant differences between **Table 1** (1987 final rule) and **Table 4** (Clinton final rule). First, under the 1987 final rule, states could combine hospitalizations in public and private facilities in calculating amounts to claim for federal matching. Once private facilities were paid the usual Medicaid rate, and all remaining funds were distributed to county facilities, an intergovernmental transfer of the excess dollars exceeding the usual Medicaid payment rate resulted in a net gain of $200,000 to the state. In contrast, under the Clinton final rule, states must treat private and county facilities separately in claiming federal matching dollars, which substantially reduces the amount of federal funds available to pay county hospitals and to subsequently transfer back to the state.

The second significant difference between **Tables 1** and **4** is the Medicare payment rate used to set the UPL. Under the 1987 rule, states were allowed to pay all providers, regardless of ownership, up to 100% of the Medicare payment rate. Under the Clinton final rule, states were permitted to pay city and county public hospitals up to 150% of the Medicare payment rate (all other providers were subject to the 100% rule). Despite the higher payment rate for local government facilities, considerable savings were still achieved under the Clinton final rule in this example. Private facilities were paid the usual Medicaid rate and federal matching funds were claimed accordingly. Among county public hospitals, a claim for federal matching dollars was based on the higher UPL rate, and these facilities were paid based on these calculations. An intergovernmental transfer from the county hospitals of the excess dollars exceeding the usual Medicaid payment rate resulted in a net gain of $70,000 to the state.

In a new final rule published on January 18, 2002,[12] the Bush Administration eliminated the higher payment rate for city and county public hospitals. Beginning on May 15, 2002,[13] states may pay city and county public hospitals only up to 100%

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[12] 67 *Federal Register*,pp. 2602-2611 (Jan. 18, 2002).

[13] Originally, the effective date of this Bush Administration final rule was March 19, 2002. On March 19, 2002, CMS announced a delay of the effective date of this final rule to April 15, 2002 (67 *Federal Register* p. 12479). The text of this notice does not provide a reason for the delay. However, CMS officials indicated that the delay was undertaken in light of both pending litigation to halt the rule change, and concerns regarding compliance with the Congressional Review Act (CRA). The CRA stipulates that the effective date for a major rule, such as this Bush Administration final rule, cannot be sooner than 60 days after the rule is published in the *Federal Register*, or a report is submitted to Congress, whichever is later. On April 10, 2002, during opening arguments in this lawsuit, the federal district court in Arkansas ruled that since the Senate did not receive the rule until March 15, 2002, the earliest permissible effective date was May 14, 2002. In a press release, CMS announced

(continued...)

of the Medicare payment rate. This rule also eliminated the reporting requirement applicable to all states making enhanced payments to city and county public hospitals. The new rule retained the requirement that states qualifying for a transition period (see below) report annually to CMS actual facility-specific payments made to all facilities and estimates of what Medicare payments would have been to those facilities.

CMS's rationale for the UPL change was based on four considerations. First, CMS argued that the 100% UPL is more than sufficient to ensure access for Medicaid beneficiaries to such facilities. Moreover, states retain the flexibility to pay such hospitals enhanced payments (up to the Medicare payment rate) as long as the UPL is maintained in the aggregate. Second, the higher payments allowed under the January 12, 2001 rule were not necessarily benefitting these hospitals to the fullest possible extent, as evidenced by the OIG findings summarized above. In that analysis, public hospitals were transferring excess UPL payments back to states, or when these hospitals were allowed to retain a portion of such payments, they either were not receiving any DSH payments or were being required to transfer their DSH dollars back to the states. Thus, the net gain for these hospitals was minimized. Third, many city and county public hospitals do qualify for DSH payments, and BIPA increased the hospital-specific DSH limits up to 175% of a hospital's reasonable costs for two state fiscal years beginning in federal fiscal year 2003.[14] So additional funding could be provided through this mechanism. Finally, CMS wanted to restore payment equity across all providers.

Table 5 provides an example of how the Bush final rule reduced funding available to city and county public hospitals, and further reduced the amounts available for intergovernmental transfers from these facilities back to states. Again, the basic underlying assumptions are identical across all three tables in this report. With respect to **Tables 4** and **5** (illustrating the Clinton and Bush final rules, respectively), calculations for private facilities are identical. That is, private facilities were paid the usual Medicaid rate and federal matching funds were claimed accordingly. Because the Bush final rule allows local government hospitals to be paid up to 100% of the Medicare payment rate, rather than 150% under the Clinton final rule, additional savings are achieved. An intergovernmental transfer from the county hospitals of the excess dollars exceeding the usual Medicaid payment rate resulted in a net gain of $20,000 to the state.

In late 2001, some Members of Congress expressed opposition to this new rule. Two bills were introduced (H.R. 3360 and S. 1745) seeking to delay until at least

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[13] (...continued)
that the rule would go into effect on May 15, 2002.

[14] In late December, 2001, the OIG issued an audit report recommending that the upcoming increase in DSH reimbursements may not be warranted or should at least be studied further before implementation. The OIG noted that DSH payments are not always retained by public hospitals and the DSH funds received are not always calculated correctly. For more information, see U.S. OIG, *Reviews Indicate That an Increase in Medicaid Disproportionate Share Hospital Payments to 175 Percent of Uncompensated Care Cost May Not Be Warranted*, A-06-01-00069, December 2001.

January 1, 2003, any changes in Medicaid regulations that would modify the rule allowing payments of up to 150% of the Medicare payment rate to city and county public hospitals. Both bills would have also required the Secretary of HHS to submit a report to Congress, at least 3 months prior to publication of any such rule, describing a plan to mitigate the loss of funding to these facilities as a result of new regulations, and also providing recommendations for legislative action as deemed appropriate. Finally, in early 2002, a Senate amendment was added to, and later withdrawn from, H.R. 622 (the Temporary Extended Unemployment Compensation Act of 2002) that would have delayed until at least June 30, 2002, any regulatory changes to the UPL rule affecting city and county public hospitals. No further action has been taken to date.

Transition Periods for Achieving Full Compliance with New Rules

While the creation of new UPLs by facility type was expected to result in significant savings in federal Medicaid spending (see discussion below), at the time of these rule changes, federal policymakers considered the impact of these regulatory changes on state budget planning. Instead of requiring full compliance with the latest UPL rules immediately, some states qualified for one of several transition periods that allow phase out of excess payments over a specified length of time beyond the effective date of the applicable rule. **Table 6** summarizes the key components of these transition periods as defined in the final rule issued by the Clinton Administration, which incorporated BIPA requirements, and the changes subsequently made by the Bush Administration.

Most of the transition period provisions were defined in the January 12, 2001 Clinton Administration final rule. The goal of this rule was to provide a phase-out period commensurate with the length of time states had relied on the additional federal funds gained through using enhanced payment arrangements that were curtailed. States with short-term reliance on these arrangements were required to phase out excess payments relatively quickly. States that have relied on enhanced payment arrangements for a number of years were allowed a relatively long period of time in which to phase out excess payments. Other states fell in the middle.

One feature is common to all transition period rules. State fiscal year (SFY) 2000 is the base period for determining the amount of excess payments (i.e., the difference between payments made under enhanced arrangements and amounts that would result from application of the new UPLs) that must be phased out.

The January 12, 2001 final rule created three transition groups with short, medium, and long phase-out periods (see **Table 6** for these details). The shortest transition group consisted of states with approved plans effective on or after October 1, 1999. For such payment plans, the phase-out period formally began on March 13, 2001 (the effective date of the rule) and ended on September 30, 2002.

The second transition group consisted of those states with approved plans effective after October 1, 1992 and before October 1, 1999. For this group, the

phase-out period formally began in SFY2003. Aggregate payments for the specified provider groups must be reduced to the applicable UPL in increments over 3 years (i.e., 25% reduction in the first year, 50% in the second year, and 75% in the third year) leading to full compliance with the UPL by the end of the fourth year, SFY2006.

Finally, the third transition group, defined in BIPA and incorporated into the January 12, 2001 final rule, includes states with approved plans effective on or before October 1, 1992. For these states with the longest reliance on the additional federal dollars associated with such payment arrangements, the phase-out period began with the first state fiscal year that started after September 30, 2002 (either SFY2003 or SFY2004)[15] and ends on September 30, 2008. Regardless of the starting point, all such states must be in compliance with the applicable UPL by October 1, 2008 — the beginning of federal fiscal year (FFY) 2009. BIPA also specified the schedule of percentage reductions in excess payments incorporated into the January 12, 2001 final rule. Such excess payments must be reduced by 15% increments over each of six consecutive periods (full SFYs for the first five periods and a partial SFY for the sixth period). The final 10% reduction occurs at the end of the transition period such that full compliance with the final UPL is achieved by October 1, 2008.

On September 5, 2001, the Bush Administration issued a final rule[16] that amended the transition period provisions in the January 12, 2001 final rule. The main purpose of the September 5, 2001 rule was to specify a new phase-out period for certain states that had enhanced payment plans that were pending HCFA approval as of the effective date of the prior final rule (i.e., March 13, 2001).[17] Specifically, this rule divided states previously subject to the shortest transition period (those with plans effective on or after October 1, 1999) into two subgroups. The subgroup of states that received plan approval before January 22, 2001 (the first business day of the new Bush Administration) qualified for the original transition period ending on September 30, 2002. The remaining states that had submitted payment plans before March 13, 2001 but received plan approval on or after January 22, 2001 were required to eliminate excess payments above the UPL by November 5, 2001 (the effective date of this rule), or by one year from the effective date of the plan, whichever is later. At the time this rule was issued, four states fell into this latter group — Florida, Michigan, Wisconsin, and Virginia. CMS indicated that this rule ensured that these 4 states had at least one full year to implement their enhanced payment plans.[18]

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[15] In 46 states, the state fiscal year runs from July to June. In New York, the state fiscal year begins in April and ends in March. In Texas, the state fiscal year is September to August. Among these 48 states, the first state fiscal year that began after September 30, 2002 was SFY2004. Finally, in Alabama and Michigan, the state fiscal year is the same as the federal fiscal year (October to September). For these two states, the first state fiscal year that began after September 30, 2002 was SFY2003.

[16] 66 *Federal Register* pp. 46397-46399 (Sept. 5, 2001).

[17] HCFA also determined that such plans should be reviewed under the UPL rules in place prior to March 13, 2001 and not under the provisions of the January 12, 2001 final rule.

[18] Shortly after the September 5, 2001, final rule was published, the GAO issued a report (continued...)

While the January 18, 2002 rule issued by the Bush Administration did *not* alter transition period provisions of the two prior final rules, this rule clarified that some states with enhanced payment arrangements for city and county public hospitals that exceed the newest UPL would not qualify for a transition period. Under the January 12, 2001 final rule, states qualified for a transition period if they met two criteria: (1) payments to city and county public hospitals exceeded 150% of the Medicare payment rate (or for all other providers within a primary group, payments exceeded 100% of the Medicare payment rate), *and* (2) the date of approval/effectiveness for such a payment plan fell within the parameters specified in the rule (see **Table 6** for details). In the case of city and county public hospitals, such states had until the end of the applicable transition period to reduce payments to 150% of the UPL. Plans that allowed payments up to 150% of the UPL were in compliance with the January 12, 2001 rule, and so no payment reductions were required and no transition period applied. However, the new January 18, 2002 final rule lowered the UPL for city and county public hospitals from 150% to 100% of Medicare payment rates. Thus, state plans approved under the prior January 12, 2001 rule that paid such hospitals greater than 100% and up to 150% of the UPL had to reduce such payments to 100% of Medicare payment rates by May 15, 2002. Such state plans (if any) did not qualify for any of the previously defined transition periods, because they did not meet both criteria outlined above.

As of January, 2004, preliminary data from CMS indicated that 23 states had UPL payment plans that did or may qualify for a transition period. Five of these states had more than one such payment plan (e.g., one applying to inpatient hospital services and another applying to nursing facility care). Of the 29 payment plans identified by CMS, 18 were for nursing facility care, 7 were for inpatient hospital services, and 4 applied to outpatient hospital services. Twelve plans were expected to qualify for the shortest transition periods which have now expired. Eleven plans were expected to qualify for the transition period that terminates at the end of SFY2006, and finally, 6 plans were expected to qualify for the longest transition period (ending on October 1, 2008).

What about Intergovernmental Transfers?

In its October 10, 2000 proposed rule, HCFA gave two reasons for not making a policy change to intergovernmental transfers that can be used to finance up to 60% of the non-federal portion of Medicaid expenditures. First, HCFA acknowledged that states and local governments have developed unique arrangements for sharing Medicaid costs. Second, there are statutory restrictions on the Secretary's authority

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[18] (...continued)
criticizing the approval of UPL plans in these four states. In that report, GAO claimed that the Bush Administration had reversed an earlier decision to deny approval of pending amendments that did not comply with the Clinton final rule. Both CMS and the states involved defended these approvals, arguing that GAO was improperly singling out certain states and officials for criticism. CMS further noted that key Administration officials with prior ties to Virginia and Wisconsin had recused themselves from the approval process. For further details, see U.S. GAO, *Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes,* GAO-02-147, October 2001.

to limit intergovernmental transfers.[19] Thus, no such changes are included in any of the final UPL rules issued to date.

Early Estimates of the Costs and Savings Associated with Changes to UPL Rules

At the time that the Clinton final rule was issued in January 2001, HCFA had identified 29 states with approved or pending enhanced payment plans that would involve city and county facilities. Going beyond the FY2001 budget baseline, HCFA projected that the federal share of enhanced payments to city and county facilities may reach $10 billion per year by FY2006, and over the next 10 years, cumulative spending for such payments could total more than $90 billion. In developing these projections, HCFA assumed that in the absence of the final rule, about one-half of the remaining 21 states would eventually submit plans to institute similar enhanced payment arrangements. HCFA estimated that about two-thirds of the enhanced payments would exceed the UPLs established in the final rule, yielding a potential savings of nearly $55 billion over the next 10 years.

In a preliminary estimate of an earlier version of BIPA,[20] CBO indicated that the UPL provisions would result in considerably greater savings of $76.7 billion over the 10-year period ending with FY2010 ($21.5 billion for FY2001 through FY2005). Savings were accelerated in the second half of the 10-year period as the phase-out or transition periods expire.

Finally, the Bush Administration projected further savings associated with its two final rules that amended Medicaid upper payment limits. First, a savings of $0.5 billion for FY2001 and FY2002 was estimated for the September 5, 2001 final rule that created a separate, minimum 1-year transition period for certain states that received approval for enhanced payment arrangements after January 22, 2001. Second, elimination of the higher payment rate for city and county public hospitals was expected to save $9 billion over FY2002 through FY2006.

Current Issues for the 109th Congress

While there was no further legislative action in the 108th Congress dealing with Medicaid UPL rules, there was still considerable on-going interest in how states finance the non-federal share of Medicaid costs, especially the use of intergovernmental transfers. In early 2004, the Subcommittee on Health of the House Energy and Commerce Committee held two hearings on this issue, as did the House Budget Committee.[21] In January 2005, House Energy and Commerce

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[19] Section 1903(w)(6) of the Social Security Act.

[20] The UPL provisions in H.R. 5661, for which CBO provided its preliminary budget estimate, were substantively identical to those contained in the conference agreement that eventually became incorporated by reference into P.L. 106-554.

[21] Both Subcommittee on Health hearings were entitled *Inter-governmental Transfers: Violations of the Federal-State Medicaid Partnership or Legitimate State Budget Tool?* and

(continued...)

Committee Chairman Barton sent letters to hospitals in 10 states requesting information on additional federal dollars received via IGTs and how those funds were spent by those hospitals.[22] In addition, GAO published another report on UPL practices across states and CMS' efforts to improve oversight, noting that although both Congress and CMS have narrowed the UPL loophole, it has not been eliminated[23] because no changes have been made to the Medicaid UPL standard which remains tied to the Medicare payment rate, nor to federal statute or regulations governing IGTs.

To date, CMS has not released an official count of all currently active UPL payment plans. At the conclusion of their transition periods, the 29 payment plans described above may continue to be in effect, but at a minimum must be in full compliance with the current UPL rules.

Medicaid program administrative data available at the federal level do not include the detail necessary to determine accurately the amount of UPL payments across states. Since 2001, in its Medicaid baseline estimates, CBO has included projected spending for "other payments to providers" which is largely comprised of UPL dollars. The impact of the UPL changes described in this report is evident in CBO's spending projections. Such payments were projected to grow from $3.9 billion in FY2000 to $7.4 billion in FY2002, roughly 5% of federal Medicaid payments in that year. Beginning in FY2003, other payments to providers were expected to fall to $6.0 billion, with further reductions to $5.2 billion and $4.8 billion in FY2004 and FY2005, respectively, representing about 2.7% of federal Medicaid payments in FY2005. Projections through FY2009 show additional drops in other payments to providers.

The Bush Administration has proposed other strategies to rein in UPL and IGT practices. For example, the President's FY2005 Budget Proposal included a plan to cap Medicaid reimbursements to government-operated providers to no more than the cost of Medicaid services and to restrict the use of certain IGTs, with estimated savings of $1.5 billion in FY05 and $9.6 billion over 5 years. In its analysis of the President's budget,[24] CBO elected not to estimate savings from these proposals since the Administration did not provide specific details about how the proposed changes to Medicaid would achieve savings.

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[21] (...continued)
were held on March 18, 2004 and April 1, 2004. The House Budget Committee hearing, *A Closer Look: Inspectors General Address Fraud, Waste and Abuse in Federal Mandatory Programs*, held on July 9, 2003, included testimony on Medicaid vulnerabilities that included a discussion of UPL and IGT issues.

[22] Mary Agnes Carey: *Barton Sends Queries on Medicaid Funding Transfers*, CQ HealthBeat News, January 14, 2005.

[23] U.S. General Accounting Office, *Medicaid: Improved Federal Oversight of State Financing Schemes is Needed*, GAO-04-228, February 13, 2004.

[24] Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2005*, March, 2004.

Administration officials have taken some steps to curb what they have identified as improper state financing mechanisms. In late 2003, CMS began requesting detailed information regarding sources of the state share of Medicaid funding from states applying for Medicaid waivers and submitting Medicaid state plan amendments. Subsequently, in early January of 2004, the Administration announced via a federal register notice a proposed change to a required state budget reporting form (CMS-37) that would have allowed CMS to obtain up-front information on states' proposed financing components for their Medicaid programs before state budgets were adopted. The purpose of the reporting change was to identify and resolve potential funding and expenditure issues early on, thus avoiding subsequent recoupment of federal Medicaid payments deemed inappropriate. After a number of publicized complaints from states about the proposed change (and an inadvertent one-day comment period), in February of 2004, the Secretary of HHS announced that CMS would not move forward with its planned reporting form revision until consultation with states had been completed, and that when new proposed regulations are published, states would have a 60-day comment period.

Also in early 2004, via letters exchanged with Senator Grassley, the CMS Administrator described the agency's current policy regarding permissible and impermissible IGTs in the Medicaid program. CMS identified a true, protected IGT as one in which the state share of Medicaid costs is comprised of state and local tax revenues or certified public expenditures (CPEs).[25] In other words, only units of state or local governments can make protected IGTs or CPEs. Furthermore, IGTs must be derived from state or local tax revenues. In order for a health care provider to make a protected IGT/CPE, it must have access to state or local tax revenues (i.e., must either have direct taxing authority or must be able to access funding as an integral part of the governmental unit with taxing authority). An unprotected IGT was defined as an IGT that uses "recycling mechanisms" under which payments to providers for services are returned to the state. In this case, the recycling process shifts the cost of Medicaid from state/local governments to the federal government, thus increasing the federal matching rate (as in the examples provided in **Tables 1, 4 and 5** of this report).

Others outside of CMS[26] have questioned the agency's narrow interpretation of Medicaid statute and regulations on IGTs and CPEs, and the agency's authority to change its policy without legislative or regulatory action. These groups are concerned that some, perhaps many, providers identified as public agencies by states in the past may not meet the CMS definition of an entity that can make protected IGTs or CPEs (e.g., hospitals on public property that were formerly owned and operated by city or county governments, but that are now quasi- or fully-independent). These groups are also concerned that the limitations on IGTs and

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[25] Certified public expenditures can be used as part of the state share of Medicaid costs when such funds are certified by the contributing public agency as representing expenditures eligible for federal matching dollars. Such public funds cannot be federal funds. (See 42 CFR 433.51.)

[26] Letters to Senator Grassley from the law firm of Covington and Burling, dated May 18, 2004, and letter to Mark McClellan, Administrator of CMS, from the National Association of Public Hospitals and Health Systems, dated June 9, 2004.

CPEs now being imposed by CMS will require some states to cut back on eligibility, benefits and/or provider payments to offset the loss of now impermissible IGTs and CPEs that formerly made up part of states' share of Medicaid expenditures.

In the coming months, Congress and the Administration are likely to discuss Medicaid reform as one mechanism for reducing the federal deficit. The shape of that reform is yet to be determined, but it is anticipated that restructuring Medicaid will be part of the President's FY2006 Budget Proposal, to be released in early February. Modifications to the methods states currently employ to finance the non-federal share of Medicaid costs may be one component of the President's budget and/or other proposed legislation in the 109th Congress.

Table 1. Hypothetical Example of Enhanced Payment Arrangement and Intergovernmental Transfer Under 1987 Federal Regulations — Inpatient Hospital Services Delivered in One Month

Assumptions in hypothetical state:

- 1,000 total days of general acute inpatient care in a given month;
- 900 of these days in private hospitals and 100 in county public hospitals;
- Medicaid pays $800 per day;
- Medicare pays $1,000 per day;
- Medicaid federal matching rate is 50%.

Calculations:

- State has an approved plan to use 100% of the Medicare payment rate in calculating the UPL for inpatient hospital services. Theoretically, *Medicare* would pay $1,000,000 (1,000 hospital days x $1,000/day = $1,000,000) for inpatient care provided in all hospitals during the month. This becomes the upper payment limit for *Medicaid* payments for hospitals, and is the basis for claiming federal matching dollars.
- State share of Medicaid payments is $500,000 (50% of $1,000,000 = $500,000).
- Federal share of Medicaid payments is $500,000 (50% of $1,000,000 = $500,000).
- State pays the usual rate to private hospitals @ $720,000 since it cannot require such facilities to make an intergovernmental transfer of excess payments above the usual rate back to the state.
  ($800/day x 900 private hospital days = $720,000)
- State pays the remaining $280,000 to county public hospitals (yielding an average daily rate of $2,800).
  ($1,000,000 - $720,000 = $280,000 or $2,800/day for 100 county public hospital days).
- Through an intergovernmental transfer, the state requires the county public hospitals to return $200,000 in excess payments above the amount that would have been paid at the usual rate.
  (100 county public hospital days x $800/day = $80,000 based on the usual rate)
  ($280,000 - $80,000 = $200,000 returned to state)
- Thus, **state gains $200,000**; options for using these funds include:
  — no further action: state draws down $500,000 in federal funds with only $300,000 in state dollars (original state share of $500,000 is reduced by $200,000 gain) for general acute inpatient care delivered in 1 month;
  — use funds for purposes other than covering Medicaid costs;
  — use funds to restart process of drawing down additional federal dollars with no additional state contribution.

Source: Adapted from an unpublished example developed by HCFA (now CMS).
Note: **Tables 1**, **4**, and **5** are for illustrative purposes only, using a simplified example. Under Medicare, hospitals are not paid on a per diem basis, and are instead paid based on a formula that takes into account diagnosis and use of resources during a given inpatient stay. Under Medicaid, states rarely pay for inpatient services on a per diem basis, instead using a wide variety of other methods.

Table 2. Upper Payment Limit Rules for Inpatient or Institutional Care

Key components	1987 regulation	Clinton Administration final rule (1/12/01) — effective on 3/13/01	Bush Administration final rule (1/18/02) — effective on 5/15/02
Facility groups to which separate upper payment limits are applied.[a]	Two separate UPLs applied to: (1) all public and private facilities combined, (2) state facilities only.	Retains separate UPL for state facilities in 1987 regulation. Adds a separate UPL for city and county facilities[b] (with exception described below). Adds separate UPL for private facilities. Drops UPL for all facilities combined in 1987 regulation.	Same as 1/12/01 final rule.
Exceptions to rule[c] that payments cannot exceed 100% of the Medicare payment rate.	None	City and county public hospitals may be paid up to 150% of the Medicare payment rate.	Eliminates exception made for city and county public hospitals in 1/12/01 final rule.

a. Providers are divided into three primary groups for the purposes of applying UPLs: (1) inpatient hospitals (IPH), (2) nursing facilities (NF), and (3) intermediate care facilities for the mentally retarded (ICF/MR). Within each primary group, further distinctions are made based on facility ownership or operation: (1) state government, (2) other government, namely city and county, and (3) private. The UPLs are applied at the facility-type level within each primary group.
b. BIPA required that the final rule include a separate UPL for government facilities that are not state owned or operated.
c. Originally specified in a final rule issued on December 19, 1983 (48 FR 56046).

Table 3. Upper Payment Limit Rules for Outpatient Hospital and Clinic Services

Key components	1987 regulation	Clinton Administration final rule (1/12/01) — effective on 3/13/01	Bush Administration final rule (1/18/02) — effective on 5/15/02
Facility groups to which separate upper payment limits are applied.[a]	Single UPL applied to all facilities across all primary groups combined.	Adds two separate UPLs for (1) state facilities, and (2) city and county facilities.[b] Adds separate UPL for private facilities. Drops UPL for all facilities combined in 1987 rule.	Same as 1/12/01 final rule.
Exceptions to rule[c] that payments cannot exceed 100% of the Medicare payment rate.	None	City and county public hospitals may be paid up to 150% of the Medicare payment rate.	Eliminates exception made for city and county public hospitals in 1/12/01 final rule.

a. Providers are divided into three primary groups for the purposes of applying UPLs: (1) inpatient hospitals (IPH), (2) nursing facilities (NF), and (3) intermediate care facilities for the mentally retarded (ICF/MR). Within each primary group, further distinctions are made based on facility ownership or operation: (1) state government, (2) other government, namely city and county, and (3) private. With the exception of the 1987 regulation, the UPLs are applied at the facility-type level within each primary group.

b. BIPA required that the final rule include a separate UPL for government facilities that are not state owned or operated.

d. Originally specified in a final rule issued on December 19, 1983 (48 FR 56046).

Table 4. Hypothetical Example of Enhanced Payment Arrangement and Intergovernmental Transfer Under Clinton Administration Final Rule (1/12/01) — Inpatient Hospital Services Delivered in 1 Month

Assumptions in hypothetical state (same as **Table 1**):

- 1,000 total days of general acute inpatient care in a given month;
- 900 of these days in private hospitals and 100 in county public hospitals;
- Medicaid pays $800 per day;
- Medicare pays $1,000 per day;
- Medicaid federal matching rate is 50%.

Clinton Final Rule requires states to treat private and county hospitals **separately** in calculating a UPL for each group. This rule also allows states to pay county public hospitals up to 150% of the Medicare payment rate ($1,500 per day).

Calculations for **Private Hospitals** under Clinton Rule:

- State has an approved plan to pay private hospitals up to 100% of the Medicare payment rate. Theoretically, *Medicare* would pay $900,000 (900 private hospital days x $1,000/day = $900,000) for inpatient care provided in private hospitals during the month. This becomes the upper payment limit for *Medicaid* payments for this group. But there is little incentive to pay these facilities the Medicare rate, since the state cannot require an intergovernmental transfer back to the state of any payments above the usual Medicaid rate.
- State pays the usual Medicaid rate for private hospital days, yielding a total cost of $720,000.(900 private hospital days x $800/day = $720,000)
- State share of Medicaid payments is $360,000 (50% of $720,000 = $360,000).
- State claims federal match of $360,000 (50% of $720,000 = $360,000).

Calculations for **County Public Hospitals** under Clinton Rule:

- State has an approved plan to use 150% of the Medicare payment rate in calculating the UPL for county public hospitals. Thus, theoretically, *Medicare* would pay $150,000 (100 county hospital days x $1,500/day = $150,000) for inpatient care provided in county public hospitals during the month. This becomes the upper payment limit for *Medicaid* payments for this group. State pays entire amount to county public hospitals anticipating an intergovernmental transfer later on.
- State share of Medicaid payments is $75,000 (50% of $150,000 = $75,000).
- State claims federal match of $75,000 (50% of $150,000 = $75,000).
- Through an intergovernmental transfer, the state requires the county public hospitals to return $70,000 in excess payments above the amount that would have been paid at the usual Medicaid rate.
  (100 county hospital days x $800/day = $80,000 based on the usual rate)
  ($150,000 - $80,000 = $70,000 returned to state)
- Thus, **state gains $70,000**; options for using these funds include:
  — no further action: state draws down $75,000 in federal funds with only $5,000 in state dollars (original state share of $75,000 is reduced by $70,000 gain) for general acute inpatient care delivered in 1 month;
  — use funds for purposes other than covering Medicaid costs;
  — use funds to restart process of drawing down additional federal dollars with no additional state contribution.

Note: See note to **Table 1**.

Table 5. Hypothetical Example of Enhanced Payment Arrangement and Intergovernmental Transfer Under Bush Administration Final Rule (1/18/02) — Inpatient Hospital Services Delivered in 1 Month

Assumptions in hypothetical state (same as **Table 1**):

- 1,000 total days of general acute inpatient care in a given month;
- 900 of these days in private hospitals and 100 in county public hospitals;
- Medicaid pays $800 per day;
- Medicare pays $1,000 per day;
- Medicaid federal matching rate is 50%.

Clinton Final Rule requires states to treat private and county hospitals **separately** in calculating a UPL for each group — No change under Bush Final Rule. Bush Final Rule allows states to pay county public hospitals up to 100% (not 150%) of the Medicare rate.

Calculations for **Private Hospitals** under Bush Rule — **No change** from **Table 4**:

- State has approved plan to pay private facilities up to 100% of the Medicare payment rate. Theoretically, *Medicare* would pay $900,000 (900 private hospital days x $1,000/day = $900,000) for inpatient care provided in private hospitals during the month. This becomes the upper payment limit for *Medicaid* payments for this group. But there is little incentive to pay these facilities the Medicare rate, since the state cannot require an intergovernmental transfer back to the state of any payments above the usual Medicaid rate.
- State pays the usual Medicaid rate for private hospital days, yielding a total cost of $720,000.
  (900 private hospital days x $800/day = $720,000)
- State share of Medicaid payments is $360,000 (50% of $720,000 = $360,000).
- State claims federal match of $360,000 (50% of $720,000 = $360,000).

Calculations for **County Public Hospitals** under Bush Rule:

- State has an approved plan to use 100% of the Medicare payment rate in calculating the UPL for county public hospitals. Thus, theoretically, *Medicare* would pay $100,000 (100 county hospital days x $1,000/day = $100,000) for inpatient care provided in county public hospitals during the month. This becomes the upper payment limit for *Medicaid* payments for this group. State pays entire amount to county public hospitals anticipating an intergovernmental transfer later on.
- State share of Medicaid payments is $50,000 (50% of $100,000 = $50,000).
- State claims federal match of $50,000 (50% of $100,000 = $50,000).
- Through an intergovernmental transfer, the state requires the county public hospitals to return $20,000 in excess payments above the amount that would have been paid at the usual Medicaid rate.
  (100 county hospital days x $800/day = $80,000 based on the usual rate)
  ($100,000 - $80,000 = $20,000 returned to state)
- Thus, **state gains $20,000**; options for using these funds include:
  — no further action: state draws down $50,000 in federal funds with only $30,000 in state dollars (original state share of $50,000 is reduced by $20,000 gain) for general acute inpatient care delivered in 1 month;
  — use funds for purposes other than covering Medicaid costs;
  — use funds to restart process of drawing down additional federal dollars with no additional state contribution.

Note: See note to **Table 1**.

Table 6. Transition Periods For Compliance with Upper Payment Limits [a]

Key components	Clinton Administration final rule (1/12/01) — effective on 3/13/01	Bush Administration final rule (9/5/01) — effective on 11/5/01
How state plans are grouped for applying transition period rules.	Creates three mutually exclusive groups: Group 1 — approved plans effective on/after 10/1/99. Group 2 — approved plans effective after 10/1/92 and before 10/1/99. Group 3 — approved plans effective on/before 10/1/92.[b]	Divides Group 1 as defined in 1/12/01 final rule into two separate groups: Group 1A — plans effective on/after 10/1/99 and approved before 1/22/01. Group 1B — plans effective on/after 10/1/99 that were submitted before 3/13/01 and approved on/after 1/22/01. Retains Groups 2 and 3 as identified in 1/12/01 final rule.
Base period for determining amount of excess payments that must be phased out.	State fiscal year 2000.[c]	Same as 1/12/01 final rule.
When phase-out begins.[d]	Group 1 — with effective date of final rule, i.e., 3/13/01. Group 2 — SFY2003. Group 3 — first state fiscal year that begins after 9/30/02, i.e., SFY2003 or SFY2004.	Groups 1A and 1B — 3/13/01. Groups 2 and 3 — same as 1/12/01 final rule.

Key components	Clinton Administration final rule (1/12/01) — effective on 3/13/01	Bush Administration final rule (9/5/01) — effective on 11/5/01
Percentage reduction in excess payments each year of phase-out.	Group 1 — not specified; states must be in compliance by end of phase-out period. Group 2 — excess payments must be reduced in 25% increments over each of 4 consecutive years (SFY2003-SFY2006). Group 3 — excess payments must be reduced in 15% increments over each of 5 consecutive years (SFY2004-SFY2008),[e] plus 15% reduction for the portion of SFY2009 occurring before 10/1/08, with the final 10% reduction achieved as of 10/1/08.	Groups 1A and 1B — not specified; states must be in compliance by end of phase-out period. Group 2 — same as 1/12/01 final rule. Group 3 — same as 1/12/01 final rule.
When phase-out ends — date by which full compliance with UPLs is required.	Group 1 — phase-out ends on 9/30/02. Group 2 — by end of SFY2006. Group 3 — phase-out ends on 9/30/08.	Group 1A — phase-out ends on 9/30/02. Group 1B — phase-out ends on 11/5/01 or 1 year from effective date of plan, whichever is later. Groups 2 and 3 — same as 1/12/01 final rule.

a. Not applicable to the 1987 UPL regulation.
b. BIPA created this third group and outlined the associated transition period requirements that were incorporated into the 1/12/01 final rule.
c. Represents the last complete SFY prior to this rule change.
d. For all plans that qualify for a transition period, that period begins on March 13, 2001 and ends with the date associated with the phase-out schedule for that transition group. The rules governing the phase-out schedules for reducing payments that exceed the UPL have different beginning and ending dates, depending on the transition group. The beginning dates for the phase-out schedule are shown in this row. The ending dates for the phase-out schedule are shown in the last row of this table.
e. This schedule applies to states that begin the phase-out in SFY2004. For those states that begin the phase-out in SFY2003, the schedule is modified accordingly (i.e., the process begins in SFY2003). See row labeled “when phase-out begins.