Medicaid Regulation of Governmental Providers

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Summary

On May 29, 2007, the Centers for Medicare and Medicaid Services (CMS) issued a rule intended to establish control over the use and misuse of intergovernmental transfers in financing the states' shares of Medicaid costs. The rule clarifies the types of intergovernmental transfers of funds allowable for financing a portion of Medicaid costs, imposes a limit on Medicaid reimbursements for government-owned hospitals and other institutional providers, and requires certain providers to retain all of their Medicaid reimbursements. In addition, the rule would establish documentation requirements to substantiate that a governmental entity is making a certified public expenditure (CPE) when contributing to the state share of Medicaid. The rule has raised considerable concern among states and health care providers that its impact on Medicaid services, providers, and beneficiaries could be severe. In response, Congress placed a moratorium on the implementation of its provisions. The moratorium was recently extended until April 1, 2009. Further, in May of 2008, a federal judge ruled, in a lawsuit brought by a coalition of provider groups, that the rule was "improperly promulgated" and vacated the rule, and remanded the matter back to the agency. The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) includes a Sense of the Congress that the Secretary of Health and Human Services should not promulgate a final rule on cost limits on public providers.

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Background

Medicaid is a state-administered program that is jointly financed by states and the federal government. The federal and state shares of program costs vary for each state based on a formula that takes into consideration each state's per capita income compared with the national per capita income. The formula is designed so that states with per capita income that is relatively lower than other states will pay a lower state share of Medicaid program costs. Nonetheless, many states have found raising their state share of Medicaid program costs to be challenging, particularly during economic downturns.

Intergovernmental transfers (IGTs) are one of the methods used by some states to finance the non-federal share of Medicaid costs. Certain IGTs are specifically allowed for funding the state share of program costs. For example, units of government, such as counties, are able to contribute to the state's share of Medicaid. At least three states currently require counties to fund some part of the state share. Congress specifically protects the ability of states to use funds derived from state or local taxes and transferred or certified by units of government within a state.[1]

Some states have instituted programs where all or portions of the Medicaid state share is paid by hospitals or nursing homes that

- are public providers, however, not units of government; or
- are units of government, but the state share is returned to the provider sometimes through inflated Medicaid payment rates.[2]
- The purpose of such financing arrangements is generally to draw additional federal funds for which a state share may not otherwise be available. While the funds often help to pay for Medicaid or other health care services, those arrangements effectively raise the federal share of Medicaid program spending. These "intergovernmental transfers" are often repaid through Medicaid disproportionate share hospital payments or through inflated Medicaid payment rates[3] for which federal matching amounts are claimed. Alternately, states can make Medicaid payments to the providers, and the providers transfer a portion or all of those payments back to the state through what is claimed as an IGT. Either way, the net impact is to effectively raise the federal matching rate in the state to levels beyond those specified in law.
- In May of 2007, the Department of Health and Human Services issued a regulation tightening the administrative procedures and clarifying the vague definitions that allow these types of financing mechanisms to operate.[4] The

[1] 42 USC 1396b (w)(6)(A).

[2] U.S. Government Accountability Office, *Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight*, GAO-05-836T; 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 Intergovernmental Transfers*, A-03-00-00216.

[3] For a more detailed description of how states are able to utilize inflated payment rates, see CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*, by (name redacted).

[4] Department of Health and Human Services, "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership," 72 *Federal Register* (FR) (continued...)

regulation tightens the definitions of governmental entities and CPEs for the purpose of Medicaid financing, and establishes a ceiling on payment rates for governmental providers equal to the cost of providing Medicaid services. Existing rules that establish ceilings on Medicaid payments to privately owned and operated facilities would not be affected by this rule.

The Provisions of the Rule

Defining a Unit of Government

Section 1903(w)(7)(G) of the Social Security Act (SSA) identifies five types of units of government that may participate in the non-federal share of Medicaid payments: a state, a city, a county, a special purpose district, or other governmental units within the state. The rule would elaborate on those units of government in the following ways. It would include as a state or local governmental entity (including Indian tribes), a unit of government that can demonstrate having generally applicable taxing authority or is a state-operated, city-operated, county-operated, or tribally operated health care provider. Health care providers that assert to be a "special purpose district" or "other" local governmental entity must demonstrate that they are operated by a unit of government by showing that they *have generally applicable taxing authority or that the health care provider is able to access funding as a integral part of a governmental unit with taxing authority*, and that a contractual relationship with the state or local government is not the primary or sole basis for the health care provider to receive tax revenues. The explanation of the regulation goes on to state, "If the unit of government merely uses its funds to reimburse the health care provider for the provision of Medicaid or other services, that alone is not sufficient to demonstrate that the entity is a unit of government."[5]

Sources of State Share and Documentation of Certified Public Expenditures

Prior regulations, in defining the types of public funds that may be available to fund the state share of Medicaid costs, establish that funds "transferred from other public agencies"[6] to the state or local agency and under the state's administrative control can be used to fund the state share of Medicaid. The term "public agency" has been interpreted by some states to include health care providers that are not governmental in nature, but have a public-oriented mission, such as not-for-profit hospitals. The rule would remove the term "public agency" from prior regulations and replace it with the phrase "other units of government (including Indian tribes)" reflecting the statutory language of Section 1903(w)(7)(G) of the SSA.

The rule also would require a governmental entity using a CPE to submit a certification statement to the state Medicaid agency and have additional documentation available. It would require that a CPE used to fund Medicaid be supported by auditable documentation in a form approved by the

(...continued)

2236, January 18, 2007.

[5] Quotations from preamble of the proposed rule that predated the May final rule, 72 *Federal Register* 2240.

[6] See Title 42 of the Code of Federal Regulations (CFR), Sec. 433.51.

Secretary of Health and Human Services (HHS) and subject to periodic state audit and review. The documentation must at least identify the category of spending under the state Medicaid plan, explain whether the contributing unit of government is exempted from the current law limits on the use of provider taxes or donations,[7] identify actual costs incurred by the unit of government in providing Medicaid services, and demonstrate that the funds are not from federal funds nor are authorized by federal law to be used to match other federal funds.

Cost Limit for Providers Operated by Units of Government and Elimination of Payment Flexibility to Pay Public Providers in Excess of Cost

A number of reports issued by the HHS Office of the Inspector General (OIG) and Government Accountability Office (GAO) have identified questionable Medicaid financing practices in states in which supplemental payments to providers in excess of Medicaid costs have been made.[8] Prior regulations have placed limits on such practices, which are referred to as upper payment limit (UPL) financing arrangements. Under such UPL arrangements, states make Medicaid payments to public hospitals and other public long-term care institutional providers at inflated payment rates set at the statutory ceiling known as the Medicare upper payment limit. The payments generate federal matching. The hospitals or other providers return some or all of the amounts in excess of the usual Medicaid rate to the state through intergovernmental transfers.

The preamble to the proposed rule explains that the excess payments violate another statutory rule requiring Medicaid payments to be consistent with economy and efficiency (42 U.S.C. 1396a(a)(30)(A)). Consequently, the rule would limit reimbursements to governmentally operated providers to amounts that do not exceed cost. This limit would not apply to Indian Health Service facilities and tribal facilities, nor to disproportionate share hospital payments. The Secretary would be required to determine a reasonable method for identifying allowable Medicaid costs. It would also require that Medicaid costs be supported by auditable documentation in a form approved by the Secretary that meets the same standards as for the CPE documentation (see above). If it is found that a governmentally operated provider received an overpayment, those amounts would be credited to the federal government under normal procedures.[9]

The regulation would also require governmental providers to submit an annual cost report to the Medicaid agency that reflects their cost of services to Medicaid recipients during the year. Finally, the rule would make conforming changes, including eliminating 42 CFR 447.271(b) to conform with the limit on payments to governmental providers that do not exceed cost.

[7] Provider taxes and donations, like IGTs, are two other approaches that states have used to raise the non-federal share of Medicaid in the past. Congress acted in 1991 to limit those financing mechanisms, which had been used for similar purposes as IGTs are used today. The 1991 legislation, however, did not address IGTs as one of the three questionable financing approaches.

[8] HHS Office of the Inspector General, *Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers*; U.S. General Accounting Office, *Medicaid: State Financing Schemes Again Drive Up Federal Payments*, GAO/T-HEHS-00-193, September 6, 2000; and, for background information, CRS Report RL31021 (cited above).

[9] Regulations defining those procedures are at 42 CFR Part 433, Subpart F.

Retention of Payments

A provision intended to prevent public providers from receiving Medicaid payments and then transferring, through an IGT or other mechanism, some or all of those payments back to state Medicaid agencies is included as well. The rule would require that providers receive and retain the full amount of the Medicaid payments provided to them for Medicaid services. The rule states that the Secretary will determine compliance with this provision by examining any related transactions.

HHS estimated that the imposition of the rule would reduce federal Medicaid outlays by $3.87 billion over a five-year period starting in (and assuming the rule went into effect) 2007. In early 2008, the Congressional Budget Office estimated the impact to be a reduction in federal outlays of $9 billion over a five-year period starting with FY2008.[10] States, however, in responding to a 2008 survey conducted by the staff of the House Committee on Oversight and Government Reform, estimated their loss of federal Medicaid funds to be over $21 billion for same five-year period beginning in 2008, an amount that is more than five times the HHS estimates.[11]

Opposition to the Rule

States, public and governmental providers, and advocacy organizations have expressed opposition to the rule. All agree that the rule would significantly reduce Medicaid payments in certain states, and concerns are raised about whether those states would be able to fill the funding gap and, if not, what the implications would be for Medicaid beneficiaries and providers. Aside from the concerns about the impact of the considerable loss of federal funds on Medicaid providers and beneficiaries, the rule has been viewed by some as CMS overstepping its authority to limit intergovernmental transfers, when Congress explicitly allows such transfers.

Governors' concerns were expressed in a letter from the National Governor's Association to House and Senate leadership dated February 25, 2008.[12] The letter calls on Congress to take immediate action to delay implementation of the rules, fearing that their implementation would inappropriately shift costs to states at a time when some states are facing particularly difficult fiscal situations. The governors point out that the new rules reflect a departure from past practices and are based on new and unsupported interpretations of Medicaid law. Finally, the letter reminds members of the Congress that some of the rule changes were considered and rejected when the Deficit Reduction Act of 2005 (DRA) was deliberated.

On March 11, 2008, a lawsuit was filed in the United States District Court for the District of Columbia by a coalition of provider groups led by the National Association of Public Hospitals and Health Systems, the American Hospital Association, and the Association of American

[10] See Congressional Budget Office, *Medicare, Medicaid and SCHIP Administrative Actions Reflected in CBO's Baseline, February 29, 2008*. Since the implementation of this rule has been delayed, these cost estimates would need to be adjusted for the time difference.

[11] *The Administration's Medicaid Regulations: State-by-State Impacts*, Prepared for Chairman Henry Waxman by the Majority Staff, U.S. House of Representatives, Committee on Oversight and Government Reform, March 2008.

[12] http://www.nga.org/portal/site/nga/menuitem.cb6e7818b34088d18a278110501010a0/?vgnextoid=fda42e9a3f158110VgnVCM1000001a01010aRCRD.

Medical Colleges.[13]. The lawsuit asked the court to reject the rule on three grounds: that CMS has overstepped its authority in limiting intergovernmental transfers, that Congress has barred the agency from imposing a cost limit on Medicaid payments to governmental providers, and that CMS improperly issued the rule.

From NAHP's website:

> The litigants make three major claims:
>
> (1) The rule defines "units of government" more narrowly than permitted under law and severely restricts options for states to finance the non-federal share of their Medicaid program expenditures. The CMS definition usurps states' ability to determine the governmental status of entities within states, severely limiting the type of governmental entities that can make intergovernmental transfers to fund the non-federal share of the program;
>
> (2) CMS does not have the authority to limit Medicaid payments to public providers to cost while continuing to allow private providers to be paid under a different methodology. Congress rejected cost-based reimbursement and payment limits in the early 1980s in favor of granting states flexibility to tailor Medicaid reimbursement to their unique needs. A cost limit imposed solely on governmental hospitals is counter to clear Congressional intent and is arbitrary and capricious in violation of the Administrative Procedure Act. It also upends decades of Medicaid payment policies established by CMS and relied on by states.
>
> (3) The moratorium signed by the President on May 25, 2007 effectively prevented CMS from issuing a final rule the same day.[14]

Indeed, a ruling in this case, filed on May 23, 2008, found the latter claim compelling. U.S. District Court Judge James Robertson has prohibited the implementation of the final rule.[15] The rule was vacated and the matter returned to the agency. In response to the ruling, a spokesman for CMS suggested that the judge's finding is technical in nature only and that the substance of the rule will ultimately be upheld.[16]

Congress has taken action as well. In May of 2007, Congress enacted a one-year moratorium on the implementation of the rule.[17] That moratorium was extended until April 1, 2009, as part of H.R. 2642, The Supplemental Appropriations Act of 2008 (the War Supplemental), signed by the President on June 30, 2008. The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) includes a Sense of the Congress that the Secretary of HHS should not promulgate a final rule on cost limits on public providers (nor on two other rules regarding graduate medical education and rehabilitative services). The Congressional Budget Office and the Joint Committee on Taxation estimate that this Sense of the Congress, in combination with new and extended moratoria on other Medicaid rules (affecting case management services, school-based services, provider taxes,

[13] Alameda County Medical Center v. Leavitt, No. 1:08-cv-00422 (D.C. filed March 11, 2008.)

[14] http://www.naph.org/naph/Communications/Litigation_backgrounder_FINAL.pdf.

[15] U.S. District Court for the District of Columbia, Alameda County Medical Center,

et al. v. Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services, et al., Civil Action No. 08-0422.

[16] Reichard, John, *Judge Blocks Rule Cutting Payments to Hospitals for the Poor*, CQ Healthbeat News, May 23, 2008.

[17] The U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (Iraq War supplemental, P.L. 110-28), signed into law on May 25, 2007.

and outpatient hospital services), would increase federal spending by $105 million in FY2009.[18] Separate cost estimates for the provisions affecting each individual regulation were not provided.

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[18] The Congressional Budget Office and the Joint Committee on Taxation, *Estimate of Division B of H.R. 1 (ERN09560.LC, February 12, 2009)*, February 12, 2009.