# Chapter III: Medicaid Financing

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# HIGHLIGHTS

## Medicaid Financing

**Medicaid is jointly financed by federal and state governments.** State participation in Medicaid is optional, but every state has opted to participate. Some states require their localities to contribute toward the state share of financing.

**The federal government matches states' spending for covered services on an open-ended basis.** The federal matching rate, known as the federal medical assistance percentage (FMAP), varies from state to state and is inversely related to state per capita income. The matching rate for a state can range from 50 percent to 83 percent. The highest matching rate received by a state was 77 percent in 2001. On average, the federal government nominally pays 57 percent of the cost of the program.

**Medicaid is the federal government's second largest health care program, accounting for an estimated seven percent of all federal outlays in FY 2002.** CBO estimates that the federal government will spend $129.8 billion on Medicaid in FY2001 and $295.4 billion in FY 2011, an average annual rate of growth of 8.6 percent.

**Medicaid is the largest grant-in-aid program to states, accounting for over 40 percent of all federal grant funds flowing to states.** Federal payments for Medicaid exceed those for highways and mass transit, education, housing, Temporary Assistance to Needy Families, and food stamps and child nutrition programs.

**Medicaid is also the largest state-run health care program in every state.** In 1999, states spent about 15 percent of their own general fund dollars on Medicaid. If the federal share of Medicaid spending is also included, the portion of state budgets allocated to Medicaid rises to 20 percent on average.

**Medicaid spending and growth in spending varies considerably from state to state.** This is because states have substantial flexibility in defining a benefits package, establishing eligibility criteria, and choosing how they reimburse providers. For example, states have the option of paying for covered services on a fee-for-service basis, through managed care arrangements, or using some combination of the two.

**The principal factors driving Medicaid spending include:**

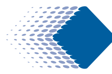
- The number of eligible individuals who enroll,
- The price of medical and long-term care services that Medicaid buys,
- Utilization of covered services by beneficiaries,
- State decisions regarding coverage of optional eligibility groups or optional services, and
- Other factors such as the effectiveness of managed care in achieving savings.

**The bulk of Medicaid expenditures are made on behalf of the elderly and disabled.** Although nearly 75 percent of Medicaid beneficiaries are children and adults, these groups account for less than 30 percent of spending on benefits. The remaining 70 percent of expenditures are made for services provided to the elderly and disabled, who make up only 25 percent of Medicaid beneficiaries.

**Spending for the elderly and disabled is primarily driven by costs associated with long-term care.** Spending associated with long-term care makes up 55 percent of all spending on benefits for the elderly and disabled. Overall, Medicaid is the nation's single largest purchaser of long-term care services, accounting for about 46 percent of all nursing home spending and 38 percent of all home health care spending.

**About 65 percent of Medicaid spending is for optional services.** As a condition of participating in Medicaid, states are required by federal law to cover certain populations and certain services. However, states also have the option of covering populations and services that are not mandatory and receiving matching funds to help pay for the cost of this coverage. Over half of Medicaid spending is for these optional services, such as prescription drugs.

**The federal government may waive the general rules regarding populations and services covered by Medicaid.** There are certain categories of individuals, and certain types of services, for which federal matching funds are not ordinarily available. The Secretary of Health and Human Services may grant exceptions to these limitations on a state-by-state basis through waivers. Waivers are required to be "budget neutral"—i.e., over the life of the waiver, federal Medicaid spending may not exceed what the federal government would have spent in the absence of the waiver.



# Medicaid Financing

## INTRODUCTION

Medicaid, a joint federal-state program, pays for a broad range of health and long-term care services for certain low-income populations, including children, individuals with disabilities, and the elderly. It does so with a combination of federal and state (and in some instances local) funds. Participation in Medicaid is voluntary on the part of states, but since 1982 every state has opted to participate. The federal government matches state spending on an open-ended basis. Federal Medicaid matching payments to states in fiscal year 2001 are projected by the Congressional Budget Office (CBO) to be roughly $130 billion, which represents about seven percent of all federal spending.

Medicaid is a means-tested entitlement program. As such, its benefits are limited to individuals whose income and resources fall below certain thresholds. For these individuals, Medicaid is an entitlement—i.e., a legally enforceable right to have payment made for basic medically necessary care. It is also an entitlement to the states, which have a legally enforceable right to federal matching payments for the costs of covered services furnished to eligible individuals. Medicaid's scale makes it far and away the largest federal grant-in-aid program to the states, accounting for over 40 percent of all federal grant funds flowing to the states.

States choosing to participate in Medicaid enjoy substantial flexibility with respect to defining a benefits package, establishing eligibility criteria, and setting provider reimbursement rates. About 65 percent of Medicaid spending is for optional services—i.e., services that states are not required to cover as a condition of participating in the program. Because of the broad discretion states exercise, Medicaid spending varies considerably from state to state on both a per capita and per beneficiary basis. Similarly, the growth in Medicaid spending varies from state to state as well as from year to year.

Although nearly 75 percent of Medicaid enrollees are children and adults, these groups account for less than 30 percent of spending on benefits. The remaining 70 percent of Medicaid expenditures are made for services provided on behalf of the one quarter of Medicaid enrollees who are elderly or disabled. Medicaid spending for the elderly and disabled is driven primarily by costs associated with long-term care, which make up 55 percent of all spending on benefits for these two groups. Overall, Medicaid is the nation's single largest purchaser of long-term care services, accounting for about 46 percent of all nursing home spending and 38 percent of all home health care spending.

At the national level, CBO projects that federal Medicaid spending will grow at an average annual rate of 9 percent over the coming decade. CBO attributes this growth to a combination of factors, including general growth in medical costs and wages, increases in the prices of prescription drugs, increases in reimbursement rates to managed care organizations (MCOs), expansion in the use of community-based long-term care services, and continued efforts by states to convert programs that they now fund using state dollars into services for which federal Medicaid matching funds would be available.

Medicaid's federal-state matching payments for covered services rely on a formula that is tied to state per capita income. States with per capita incomes above the national average have a lower federal matching rate; those with per capita incomes below the national average have a higher rate. The federal matching rates, or FMAPs (federal medical assistance percentages), vary from a minimum of 50 percent in high per capita income states like Connecticut to 77 percent in low per capita income states like Mississippi. On average, the nominal federal matching rate is 57 percent of the costs of Medicaid benefits. The federal matching rate for administrative costs is generally 50 percent, although for some functions, such as inspections of nursing facilities, the matching rate is 75 percent.

ELIGIBILITY BENEFITS FINANCING ADMINISTRATION GLOSSARY APPENDICES

The general rules regarding populations and services covered by Medicaid are subject to a variety of federally granted waivers. Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services (HHS) to allow states, in the context of demonstrating a policy innovation, to use federal Medicaid matching funds to cover low-income individuals who would not otherwise be eligible—such as single, non-disabled, non-elderly adults. A number of states, including Hawaii, New York, and Tennessee, have used this waiver authority to expand Medicaid eligibility to uninsured, low-income residents. This same waiver authority has also allowed states to target particular Medicaid services, such as family planning, at particular populations, such as post-partum women, who would otherwise not qualify for benefits. Under section 1915(c) of the Social Security Act, the Secretary has authority to allow states to use federal Medicaid matching funds to cover home- and community-based services (HCBS) for individuals at risk of institutionalization, including the frail elderly, individuals with mental retardation, and individuals with mental illness. Every state has received an HCBS waiver for at least one of these populations.

The flexibility that states have to administer their Medicaid programs is nowhere more apparent than in the case of provider reimbursement. States have the option of paying for covered services on a fee-for-service basis, through managed care arrangements, or using some combination of the two. Although at one time states were required to ensure that fee-for-service payment rates for inpatient hospital and nursing home services were "reasonable and adequate," this constraint was repealed by the Balanced Budget Act (BBA) of 1997. Now, states need only ensure that payment rates for these and most other services are "consistent with efficiency, economy, and quality of care," and that they are "sufficient to enlist enough providers so that care and services are available" to Medicaid beneficiaries to the same extent that they are to the general population.[1] With respect to managed care, states are required by federal statute to pay MCOs and other risk contractors on an "actuarially sound" basis. However, as of 2001, there is no federal guidance on these broad statutory standards.

Of course, states are not required to exercise all of the flexibility available to them under federal Medicaid law, and many have chosen not to. Even though the federal government matches at least half of the cost, the decision by a state to expand eligibility to an optional group, to cover an optional benefit, or to increase reimbursement rates to a class of providers is generally not free of cost to the state. The tax revenues a state spends on Medicaid represents state dollars that are not available for other purposes, such as education or corrections or transportation. On the other hand, state tax revenues invested in Medicaid can leverage between $1 and $4 in federal funds for each state dollar, depending upon the state's FMAP. The multiple demands on state budgets, combined with the limitations on resources available to the states, require choices on the part of state policymakers. Because states vary in their policy preferences and resources, they also vary in their exercise of Medicaid flexibility.

One of the central issues in Medicaid financing is the manner in which states make expenditures that qualify for federal matching payments. States have a fiscal and political incentive to minimize the amount of their own funds that they spend on Medicaid and to maximize the amount of federal Medicaid matching funds that they draw down. This incentive has led some states to engage in what the General Accounting Office (GAO) characterizes as "illusory" financing practices that have the effect of increasing federal Medicaid spending without a commensurate increase in state matching payments. In an effort to curb these practices, the federal government has established a complex series of rules governing the use of provider tax revenues and disproportionate share hospital (DSH) payments. It has also established regulatory limitations on administrative payments relating to school-based services and excessive payments to local public hospitals and nursing facilities.

## I. OVERVIEW

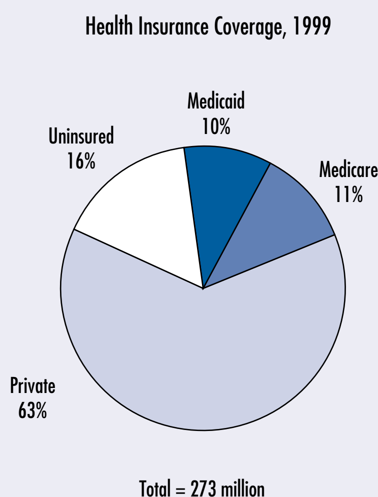
Medicaid is the federal government's second largest health care program, accounting for an estimated seven percent of all federal outlays this fiscal year.[2] It is also the largest state-run health care program in every state in the country.[3] Medicaid purchases a broad range of health and long-term care services on behalf of low-income children, their parents, individuals with disabilities, and elderly individuals.[4] As shown in Figure 3-1, Medicaid covers about ten percent of all Americans and accounts for about 16 percent of all personal health care spending.

Figure 3-1 also shows that roughly 40 million Americans, representing about 16 percent of the U.S. population, were uninsured in 1999.[5] The single most important factor affecting the number of uninsured—whether low-income or not—is the availability and affordability of employer-based coverage. For example, an Urban Institute study found that in 1997, states with the highest percentages of uninsured adults had the lowest levels of private coverage, and that states with the lowest percentages of uninsured adults had more than 80 percent of their populations privately insured.[6]

Although nearly two-thirds of the uninsured are low-income, Medicaid does not cover all low-income Americans.[7] In 1999, Medicaid covered only 26 percent of the non-elderly individuals with incomes below 200 percent of the federal poverty level ($26,580 for a family of three in that year).[8] In part this is because the federal Medicaid program does not normally make payments on behalf of certain categories of individuals regardless of their poverty, including childless couples and single, nondisabled, nonelderly individuals. (As discussed in Part V, the section 1115 waiver authority has been used to enable states to receive federal matching funds to extend coverage to such groups).

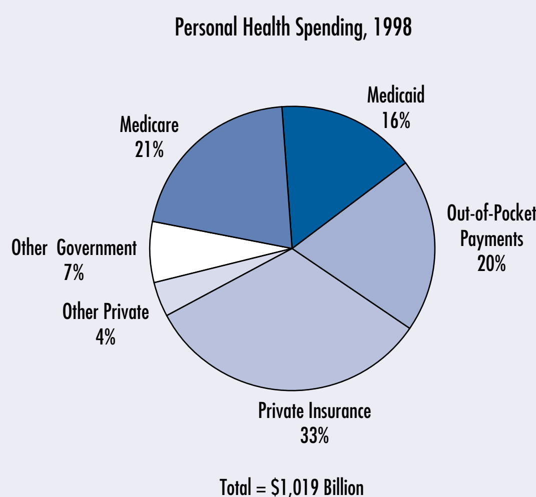
Within these constraints, Medicaid's role is to fill the "insurance gap" created by the unavailability of employer-based coverage for low-income American families and individuals. States vary in the extent to which they design their Medicaid eligibility rules to bridge this gap. For example, in 2000, Minnesota, Missouri, Rhode Island, Tennessee, and Vermont set their Medicaid income eligibility levels for children six to 19 at 250 percent of the federal poverty level or above; in contrast, 21 states set their Medicaid/Child Health Insurance Program eligibility levels for children ages six to 19 at 100 percent of the federal poverty level or below.[9] Nationwide, however, Medicaid remains the single most important source of coverage for those without access to private insurance.[10] And if more individuals who are eligible for Medicaid under their state's Medicaid rules were actually enrolled in Medicaid, the numbers of uninsured would decline significantly.[11] In addition, Medicaid indirectly provides assistance to uninsured individuals not eligible for Medicaid in the form of subsidies to some "safety net" hospitals and clinics that deliver care to the uninsured. The most prominent direct subsidy, discussed in Part VII below, is

**Figure 3-1: Medicaid's Role in the U.S. Health System**




Note: Excludes active military members

SOURCE: March 2000 Current Population Survey




SOURCE: Health Care Financing Administration, Office of the Actuary, National Health Statistics Group.

the Medicaid disproportionate share hospital (DSH) program, through which some states provide payments to certain hospitals to defray a portion of the costs incurred by serving large numbers of uninsured patients.

The purpose of this chapter is to explain the financing of the Medicaid program. It begins with an overview of Medicaid from three perspectives: as a federal-state matching program, as a means-tested entitlement program, and as a federal grant-in-aid program. After reviewing state-by-state differences in federal Medicaid spending, the chapter examines historical Medicaid spending trends at the national level and projections for future spending. It then discusses the policies and procedures governing federal-state matching in the program, as well as the opportunities for states to secure waivers from certain limitations on the types of costs to which federal matching funds may be applied. The chapter also reviews federal rules regarding Medicaid payments to providers and managed care plans. It concludes with a discussion of some current financing issues, including the treatment of tobacco litigation settlement funds, disproportionate share hospital (DSH) payments, and intergovernmental transfers (IGTs) in connection with upper payment limits (UPLs). The chapter does not discuss the financing arrangements specific to particular states.[12] The footnotes are designed to provide a roadmap for readers seeking further information on particular financing issues.

## II. MEDICAID FINANCING CHARACTERISTICS

As a program for financing health and long-term care services, Medicaid has three important characteristics. First, it is a federal-state matching program. Secondly, it is an entitlement program, both for individuals and for states. Finally, it is a federal grant-in-aid program, bringing large flows of federal revenues into state economies.

### Medicaid as a Federal-State Matching Program

Since the enactment of Medicaid in 1965, the federal government has given states the option of receiving federal matching funds to help them pay the costs of basic health care and long-term care for their low-income residents. By 1970, all states but Alaska and Arizona had entered the program and begun receiving federal matching funds; by 1982, with the entry of Arizona, every state had elected to participate. Federal Medicaid matching funds are available to states for the costs of covering certain populations[13] and certain benefits.[14] These matching funds are available on an open-ended basis; that is, the more a state spends on covered benefits for eligible individuals, the more matching funds it receives from the federal government.

Medicaid's federal-state matching arrangements reflect several policy objectives. First, they represent a clear fiscal commitment on the part of the federal government toward paying at least half—but not all—of the cost of basic health and long-term care services for certain categories of low-income Americans, regardless of the number of eligible individuals or the extent of their medical needs. This means that states have less of an incentive to "race to the bottom" by adopting eligibility and coverage policies designed to discourage individuals with significant medical needs from moving to, or continuing to reside within, their borders.[15] It also means that federal financing is automatically available to states facing unanticipated public health emergencies among individuals eligible for Medicaid; for example, Medicaid covers an estimated 55 percent of persons living with AIDS and 90 percent of all children with AIDS.[16]

Second, Medicaid's federal-state matching arrangements represent a fiscal incentive for states to extend coverage for health and long-term care services to their low-income residents. As historians have noted, Medicaid was at the time of its enactment an explicit effort on the part of the federal government to encourage states—not localities—to provide basic health care coverage to low-income families with dependent children, the elderly, and individuals with disabilities.[17] In fact, the original Medicaid statute authorized the Secretary of Health, Education, and Welfare to withhold federal matching funds from any state not "making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance."[18] Although this provision was repealed in 1972, Medicaid's matching arrangements were not, and the federal government continues to absorb more than half of the additional costs associated with any increase in benefits or any expansion in the numbers of individuals covered in the majority of states.[19]

As discussed below, the Medicaid matching formula requires high-income states to spend more of their own funds to cover an individual than it requires of low-income states. This does not, however, mean that Medicaid spending per low-income person is higher in low-income states. As Holahan and his colleagues point out, average per capita federal expenditures per low-income person are higher in high-income states like New York and Massachusetts than they are in low-income states like Mississippi and Alabama.[20] Moreover, even

among high-income states, federal Medicaid spending per enrollee varies greatly; in 1998, Medicaid spending per enrollee in New York ($7,180) was more than two and one half times that in California ($2,573).[21] The reasons for this variation go far beyond the federal matching formula to include differences in state policy choices, the demographics of state beneficiary populations, health care costs, and other factors.[22]

Finally, Medicaid's matching arrangements are counter-cyclical. If a state or a region experiences an economic downturn and the number of uninsured low-income individuals increases, federal Medicaid matching funds do not decline; instead, they continue to be available to the affected states at the same rate and on the same open-ended basis to accommodate the resulting growth in the number of program enrollees. The Urban Institute has estimated that an increase in the unemployment rate from 4.5 to 5.5 percent would result in an increase in Medicaid enrollment of 1.6 million.[23] If the number of Medicaid enrollees increases, and if per beneficiary spending remains constant, federal Medicaid matching funds can be a source of revenues for hospitals and clinics serving new program beneficiaries who would otherwise be uninsured.

Of course, states facing declines in tax revenues due to an economic downturn may respond by cutting back on their own Medicaid spending. But this policy choice would not be compelled by Medicaid's matching arrangements. A state in these circumstances could also choose to maintain (or even increase) its level of Medicaid spending, thereby maintaining (or increasing) the amount of federal revenues flowing into its economy. Because most states have enacted balanced-budget requirements, a state facing a budgetary shortfall that sought to maintain or increase funding for its Medicaid program would need to spend any budgetary reserve or "rainy day" fund the state maintained, raise taxes, or reduce funding for state programs or activities that are not a source of federal matching payments.[24]

## Medicaid as a Means-Tested Entitlement

Medicaid contains two entitlements, i.e., legally enforceable rights to have payment made. First, Medicaid is an entitlement to individuals: each person who meets the needs-based eligibility criteria in the state in which she resides has a legally enforceable right to have payment made on her behalf for medically necessary services included in the Medicaid benefits package offered by her state. This distinguishes Medicaid from block grants like the State Maternal and Child Health (MCH) Block Grant and the State Children's Health Insurance Program (SCHIP), under which eligible individuals are not entitled to have payment made on their behalf for medically necessary covered services.[25]

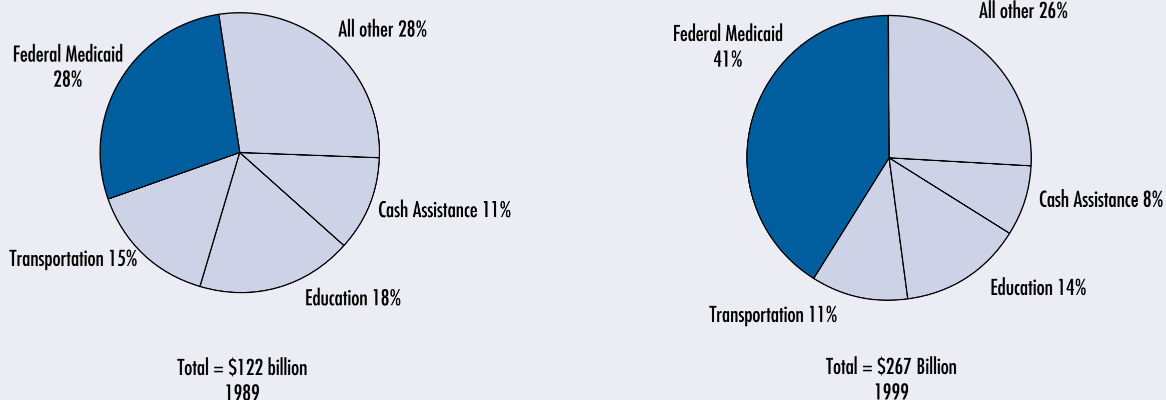
Medicaid is also an entitlement to the states: each participating state has a legally enforceable right to federal matching funds (at the state's statutory matching rate) for all expenditures incurred for covered services on behalf of eligible individuals. As discussed above, this entitlement to the states is open-ended: the more costs a state incurs for covered services on behalf of eligible individuals, the more matching funds the federal government is obligated to pay to the state. Again, this "open-endedness" distinguishes Medicaid from such programs as the SCHIP, which entitle states to federal matching funds but cap the amount of such funds available to a given state in each year. Medicaid's open-ended entitlement for eligible children is also considerably larger than SCHIP's capped allotment. Over the five-year period FY 2001-2005, the federal government is projected to spend a total of $20.6 billion covering children through state-only SCHIP programs; this is roughly equivalent to the $18.4 billion the federal government is estimated to spend insuring children through Medicaid in FY 2001 alone.[26]

In order to qualify for Medicaid, individuals must demonstrate that their incomes and (in many cases) resources are below certain thresholds. For this reason, Medicaid, like Supplemental Security Income (SSI) and Food Stamps, is considered a "means-tested" individual entitlement. In contrast, programs like Social Security and Medicare are non-means-tested entitlements, because eligibility for benefits does not depend upon whether an individual has "means"—that is, certain levels of income or resources. For purposes of the federal budget, both Medicaid and Medicare are treated as mandatory or "direct" spending, in contrast to discretionary or "appropriated" programs like the MCH Block Grant.[27]

## Medicaid as a Federal Grant-In-Aid Program

In 1999, the federal government paid out about $267 billion to the states for purposes ranging from cash assistance for the poor to education to highway construction and maintenance. Medicaid is far and away the largest of these federal grant-in-aid programs to the states, accounting for over 40 percent of all federal funds received by the states.[28] As shown in Figure 3-2, between 1989 and 1999, federal grants to states more than doubled, rising from $122 billion to $267 billion. During that same time, federal Medicaid spending grew by over 200 percent, from $35 billion to $108 billion.

**Figure 3-2: Medicaid as a Share of Total Federal Grants to States, 1989 and 1999**




SOURCE: Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2001: Historical Tables,* Table 12–3.

Of the federal grants to states in 1999, $113.8 billion, or 43 percent, were attributable to health care programs. Medicaid accounted for $108.0 billion, or 95 percent, of these health care grants-in-aid. Among the remaining federal health grant programs, the largest (in terms of outlays) were grants for substance abuse and mental health services ($2.2 billion), the SCHIP Block Grant ($0.6 billion), and various Public Health Service grant programs ($1.4 billion), including the MCH Block Grant.[29] Federal intergovernmental revenues are one of four sources of state general revenues, and Medicaid is the single largest program in this revenue stream.[30]

Even when viewed in the broader context of all federal spending and revenues, Medicaid has an important distributional impact. An analysis by Harvard's Kennedy School of Government of the "balance of payments" between the states and the federal government—i.e., whether a state sends more to the federal government in taxes than it receives in federal spending—concludes that there is a net redistribution from wealthier to less wealthy states, and that this redistributive impact is increasing over time. In part, the analysts found that this is because lower-income states are receiving greater shares of federal grants to state and local governments. This concentration of grant funds is, in turn, partially due to "the increase in Medicaid as a component of Federal grants."[31]

Federal grant-in-aid dollars are generally considered to be "federal financial assistance" for purposes of federal civil rights laws. Recipients of "federal financial assistance" are prohibited from discriminating against individuals on the basis of race, color, or national origin;[32] gender;[33] age;[34] and disability.[35] Because federal Medicaid matching funds are "federal financial assistance," state Medicaid agencies, as well as the providers and managed care plans to which they make payments for furnishing covered services to Medicaid beneficiaries, are subject to federal civil rights requirements. As most recently evidenced by the Supreme Court's decision in *Olmstead v. L.C.,* the precise meaning of these antidiscrimination prohibitions is subject to interpretation by the federal courts, even when the policies or practices of states are at issue.[36]

***Distribution of Federal Medicaid Funds Among States.*** Federal Medicaid matching funds are not distributed equally among the states. As shown in Table 3-1 on the next page, four states accounted for over one third (37.6 percent) of all federal Medicaid spending in 1998: New York (15.9 percent); California (10.9 percent); Texas (5.8 percent); and Pennsylvania (5.0 percent). Ten states receive well over half (59.3 percent) of all federal Medicaid matching payments: the top four plus Ohio (4.0 percent); Florida (3.9 percent); Illinois (3.9 percent); Michigan (3.3 percent); Massachusetts (3.3 percent); and New Jersey (3.2 percent).

***Federal Medicaid Spending Differences State-by-State.*** The variation in federal Medicaid spending from state to state is striking. One measure of this variation is per capita spending—i.e., the amount of federal Medicaid funds a state receives in a year divided by the state's total population (not just Medicaid beneficiaries). In 1998, for example, federal Medicaid spending averaged $355 per capita for the U.S. as a whole but ranged from $153 per capita in Nevada to $1,003 per capita in the District of Columbia (see Table 3-2 on the previous page). Figures

# TABLE 3-1: FEDERAL AND STATE SHARES OF MEDICAID EXPENDITURES, 1998

| | Expenditures, Benefits & DSH (millions) | FMAP 1998* | Federal Share (millions) | State Share (millions) |
|---|---|---|---|---|
| **United States** | **$169,316** | **56.5%** | **$95,600** | **$73,715** |
| Alabama | 2,330 | 69.3 | 1,615 | 715 |
| Alaska | 370 | 59.8 | 221 | 149 |
| Arizona | 1,858 | 65.3 | 1,214 | 644 |
| Arkansas | 1,416 | 72.8 | 1,032 | 385 |
| California | 18,383 | 51.2 | 9,418 | 8,965 |
| Colorado | 1,590 | 52.0 | 826 | 764 |
| Connecticut | 2,895 | 50.0 | 1,448 | 1,448 |
| Delaware | 422 | 50.0 | 211 | 211 |
| District of Columbia | 742 | 70.0 | 519 | 222 |
| Florida | 6,617 | 55.7 | 3,682 | 2,935 |
| Georgia | 3,598 | 60.8 | 2,189 | 1,409 |
| Hawaii | 594 | 50.0 | 297 | 297 |
| Idaho | 449 | 69.6 | 312 | 137 |
| Illinois | 6,648 | 50.0 | 3,324 | 3,324 |
| Indiana | 2,600 | 61.4 | 1,597 | 1,003 |
| Iowa | 1,447 | 63.8 | 923 | 525 |
| Kansas | 1,070 | 59.7 | 639 | 431 |
| Kentucky | 2,615 | 70.4 | 1,840 | 775 |
| Louisiana | 3,200 | 70.0 | 2,241 | 959 |
| Maine | 1,112 | 66.0 | 735 | 378 |
| Maryland | 2,667 | 50.0 | 1,334 | 1,334 |
| Massachusetts | 5,601 | 50.0 | 2,800 | 2,800 |
| Michigan | 5,663 | 53.6 | 3,034 | 2,629 |
| Minnesota | 2,938 | 52.1 | 1,532 | 1,406 |
| Mississippi | 1,689 | 77.1 | 1,302 | 387 |
| Missouri | 3,320 | 61.2 | 2,031 | 1,289 |
| Montana | 405 | 70.6 | 286 | 119 |
| Nebraska | 847 | 61.2 | 518 | 329 |
| Nevada | 528 | 50.0 | 264 | 264 |
| New Hampshire | 768 | 50.0 | 384 | 384 |
| New Jersey | 5,451 | 50.0 | 2,726 | 2,726 |
| New Mexico | 1,019 | 72.6 | 740 | 279 |
| New York | 26,993 | 50.0 | 13,497 | 13,497 |
| North Carolina | 4,689 | 63.1 | 2,958 | 1,731 |
| North Dakota | 340 | 70.4 | 239 | 100 |
| Ohio | 6,729 | 58.1 | 3,912 | 2,817 |
| Oklahoma | 1,339 | 70.5 | 944 | 395 |
| Oregon | 1,729 | 61.5 | 1,063 | 666 |
| Pennsylvania | 8,522 | 53.4 | 4,550 | 3,972 |
| Rhode Island | 973 | 53.2 | 517 | 456 |
| South Carolina | 2,319 | 70.2 | 1,629 | 690 |
| South Dakota | 360 | 67.8 | 244 | 116 |
| Tennessee | 3,758 | 63.4 | 2,381 | 1,377 |
| Texas | 9,752 | 62.3 | 6,074 | 3,679 |
| Utah | 688 | 72.6 | 499 | 189 |
| Vermont | 401 | 62.2 | 250 | 152 |
| Virginia | 2,324 | 51.5 | 1,197 | 1,128 |
| Washington | 3,345 | 52.2 | 1,744 | 1,600 |
| West Virginia | 1,279 | 73.7 | 942 | 337 |
| Wisconsin | 2,719 | 58.8 | 1,600 | 1,119 |
| Wyoming | 201 | 63.0 | 127 | 74 |

Note: FMAPs are from the Federal Register (FR Doc 00-4164; Feb. 23, 2000). Does not include administrative costs, accounting adjustments, or the U.S. Territories. Total spending including these additional items was about $176.9 billion in FY 1998. Figures may not sum to totals due to rounding. "DSH" refers to disproportionate share hospital payments.

*The Federal Medical Assistance Percentage (FMAP) is used to determine the amount of Federal matching of State medical expenditures. The percentages in this table apply to expenditures for medical services (except family planning, which is subject to a higher matching rate). Most administrative costs are matched at 50 percent for all states, but higher rates apply to certain adiminstrative functions.

SOURCE: Urban Institute estimates based on data from HCFA-64 reports.

## TABLE 3-2: FEDERAL MEDICAID EXPENDITURES PER ENROLLEE AND PER CAPITA, 1998

| | Federal Expenditures per Enrollee | Federal Expenditures per Capita |
|---|---|---|
| **United States** | **$2,158** | **$355** |
| Alabama | 2,137 | 380 |
| Alaska | 2,413 | 345 |
| Arizona | 1,745 | 261 |
| Arkansas | 2,418 | 393 |
| California | 1,318 | 285 |
| Colorado | 2,174 | 210 |
| Connecticut | 3,137 | 439 |
| Delaware | 1,970 | 281 |
| District of Columbia | 3,577 | 1,003 |
| Florida | 1,704 | 256 |
| Georgia | 1,586 | 286 |
| Hawaii* | 1,616 | 251 |
| Idaho | 2,623 | 249 |
| Illinois | 1,788 | 275 |
| Indiana | 2,421 | 272 |
| Iowa | 2,834 | 326 |
| Kansas | 2,482 | 247 |
| Kentucky | 2,606 | 469 |
| Louisiana | 2,382 | 527 |
| Maine | 3,338 | 600 |
| Maryland | 2,097 | 264 |
| Massachusetts | 2,676 | 466 |
| Michigan | 2,113 | 310 |
| Minnesota | 2,696 | 321 |
| Mississippi | 2,204 | 476 |
| Missouri | 2,102 | 382 |
| Montana | 3,064 | 320 |
| Nebraska | 2,447 | 312 |
| Nevada | 1,738 | 153 |
| New Hampshire | 3,253 | 320 |
| New Jersey | 2,582 | 342 |
| New Mexico | 2,159 | 405 |
| New York | 3,590 | 744 |
| North Carolina | 2,276 | 402 |
| North Dakota | 3,838 | 374 |
| Ohio | 2,517 | 348 |
| Oklahoma* | 2,020 | 283 |
| Oregon | 1,946 | 322 |
| Pennsylvania | 2,476 | 382 |
| Rhode Island | 3,277 | 548 |
| South Carolina | 2,005 | 427 |
| South Dakota | 2,928 | 343 |
| Tennessee | 1,637 | 430 |
| Texas | 1,932 | 308 |
| Utah | 2,497 | 239 |
| Vermont | 1,791 | 430 |
| Virginia | 1,616 | 177 |
| Washington | 1,716 | 303 |
| West Virginia | 2,481 | 539 |
| Wisconsin | 2,961 | 312 |
| Wyoming | 2,469 | 258 |

Note: Expenditures shown are estimated federal shares of total expenditures per enrollee in each state, calculated using each state's Federal Medical Assistance Percentage, or FMAP. Actual federal shares may differ slightly from these estimates because the FMAP is different for certain services (e.g., family planning). Does not include administrative costs, accounting adjustments, or the U.S. Territories. Expenditures per enrollee do not include disproportionate share hospital payments (DSH). Per capita expenditures include DSH. Enrollees are people who sign up for Medicaid for any length of time in a given fiscal year.

*Denotes states where significant amounts of expenditures and/or numbers of enrollees were either missing or categorized as "unknown" (no reported enrollee group or cash assistance status) in the original data released from HCFA. The estimates shown rely heavily on supplemental data sources.

SOURCE: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports and population data from the March 1998 Current Population Survey.

for spending per enrollee do not include federal matching funds intended as payments for "disproportionate share" (DSH) hospitals, which have high volumes of Medicaid and/or uninsured patients. As discussed in Part VII below, the variation in state-to-state spending in federal Medicaid DSH payments is even more pronounced due to the DSH program's idiosyncratic development.

Many factors contribute toward such large variations in federal Medicaid per capita spending. These include a state's federal matching rate (discussed below) and the number of low-income residents in relation to the state's total population. A significant factor, however, is each state's policy preferences. Some states place more emphasis than do others on using Medicaid as a policy tool to reduce the number of uninsured residents by expanding eligibility criteria. Similarly, some states place higher priority than do others on replacing state funds with federal Medicaid dollars. As discussed in Part VII, this "Medicaid maximization" can take different forms, including expansion in the types of benefits Medicaid covers to include public health or mental health services that have traditionally been paid for largely by states and localities. Finally, states have different policy preferences regarding the types of delivery systems they wish to encourage; those seeking to attract managed care plans may enhance the capitation rates their Medicaid programs are willing to pay.

One indicator of these policy differences may be seen in the distribution of federal Medicaid funds in relation to other federal dollars spent by states. In 1999, Medicaid expenditures accounted for about 43 percent of all federal funds spent by the states. However, federal Medicaid funds accounted for only 21 percent of all federal funds spent by Alaska, but 52 percent of federal funds spent by Arkansas. Perhaps even more telling is the contrast between California, where only 29 percent of federal dollars spent by the state were attributable to Medicaid, and New York, where 65 percent of total federal dollars spent by the state were from Medicaid.[37]

## III. MEDICAID SPENDING TRENDS

This section describes federal Medicaid spending trends, past and projected. These trends reflect Medicaid's financing structure as an open-ended, federal-state entitlement program in which states have substantial discretion in determining eligibility, defining benefits, and setting provider reimbursement. These trends have shaped, and will continue to influence, the debate at the federal level over Medicaid financing policy for both health and long-term care services.

To understand these trends, it is important to keep in mind that the bulk of Medicaid expenditures are made on behalf of the elderly and disabled. Although nearly 75 percent of Medicaid enrollees are children and adults, these groups account for less than 30 percent of spending on benefits. The remaining 70 percent of Medicaid expenditures are made for services provided on behalf of the one quarter of Medicaid enrollees who are elderly or disabled. Medicaid spending for the elderly and disabled is driven primarily by costs associated with long-term care, which make up 55 percent of all spending on benefits for these two groups. Overall, Medicaid is the nation's single largest purchaser of long-term care services, accounting for about 46 percent of all nursing home spending and 38 percent of all home health care spending.[38]

### Historical Medicaid Spending Trends

There have been five distinct periods in the history of Medicaid spending.[39] Throughout each of these periods, the same basic factors explain much of Medicaid spending: number of enrollees, inflation in the prices of services covered, and utilization of covered services. Over the past decade or so, two other factors have contributed significantly to federal Medicaid spending: payments to disproportionate share (DSH) hospitals and intergovernmental transfers (IGTs) under upper payment limits (UPLs) (these are discussed in Part VII). The relative impact that each of the three basic factors has on national Medicaid spending trends will vary over time. In addition, state fiscal behavior varies from state to state and, for any particular state, may vary over time depending on the state's policy preferences. Thus, the spending trends in any particular state do not necessarily correspond to the federal Medicaid spending trends described below.

The first period of Medicaid spending extends from 1965 through 1972. It reflects the introduction of Medicaid and the implementation of the program by every state except Alaska and Arizona. During this time, federal Medicaid outlays rose from $300 million to $4.6 billion, an average annual increase of 53 percent. During this period, the number of Medicaid beneficiaries increased from 0.5 million in 1965 to 17.6 million in 1972.

During the second period, which extends from 1973 through 1980, federal Medicaid outlays grew from $4.6 billion to $14.0 billion, an average annual growth rate of 15 percent. These spending trends reflect the enactment in 1971 and 1972 of three new institutional coverage options for states: intermediate care facilities (ICFs); intermediate care facilities for the mentally retarded

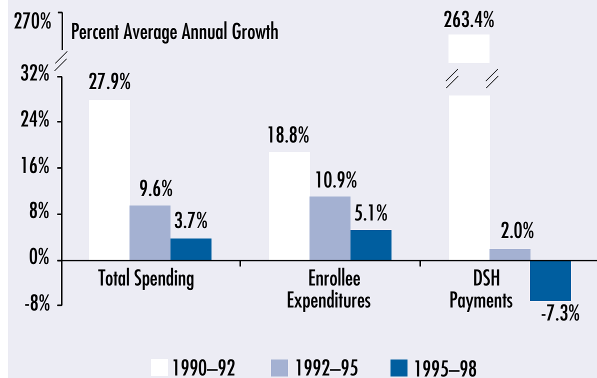
(ICFs/MR), and inpatient psychiatric hospital services for individuals under age 21. These trends also reflect the implementation of the Supplemental Security Income (SSI) program for aged and disabled individuals. The number of Medicaid beneficiaries rose from 19.6 million in 1973 to 21.6 million in 1980.

The third period in federal Medicaid spending began in 1981, with the unsuccessful efforts of the Reagan Administration to cap federal Medicaid matching payments, and ended in 1989. During this time, Congress, in eight separate budget bills, enacted a series of changes in Medicaid that had conflicting spending impacts. Some provisions were designed to reduce federal Medicaid spending growth in order to lower the federal budget deficit. Other provisions were designed to expand eligibility for certain categories of individuals, such as low-income children and pregnant women, or make other program improvements that would have the effect of increasing federal (and state) Medicaid spending. Federal Medicaid outlays during this period rose at an average annual rate of 11 percent, from $16.8 billion to $34.6 billion. The number of Medicaid beneficiaries rose from 22.0 million in 1981 to 23.5 million in 1989.

The fourth period began in 1990 and ended in 1992. During this time, federal Medicaid spending escalated dramatically, from $41.1 to $67.8 billion, an average annual growth rate of 28 percent. This period in federal Medicaid spending was defined largely by increases in federal payments intended for DSH hospitals.[40] As shown in Figure 3-3, federal DSH funds increased from $1.3 billion in 1990 to $17.7 billion in 1992, an average annual growth rate of 263 percent. As discussed in more detail in Part VII, these federal dollars, which were intended to assist hospitals serving large numbers of Medicaid beneficiaries and uninsured patients, were often applied to other purposes through what the General Accounting Office characterized as "illusory" financing arrangements.[41] Nationally, Medicaid enrollment increased during this period from 28.9 million to 35.8 million beneficiaries.

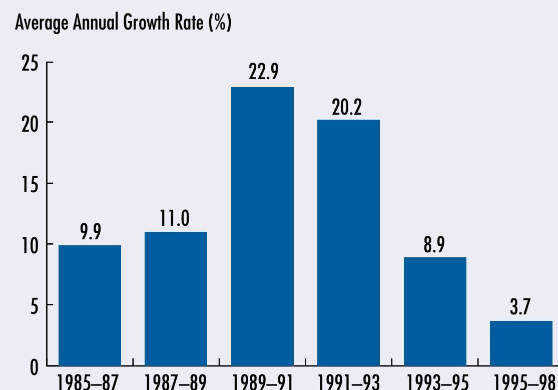
The fifth period in federal Medicaid spending begins in 1993 and extends to the present. It encompasses the time when the 1991 and 1993 Congressional reforms regarding DSH payments began to take effect, extends through the 1996 repeal of the Aid to Families with Dependent Children (AFDC) program, and continues through the 1997 enactment of Medicaid spending reductions in the Balanced Budget Act to the present. During this period, federal Medicaid spending has risen from $75.8 billion in 1993 to an estimated $115 billion in 2000. Over this period, the average annual rate of growth in spending was 6 percent, although this masks a substantial slow-down in the growth rate between 1995 and 1998 to an average of 3.7 percent (Figure 3-4). This deceleration in part reflects declines in DSH payments, declines in enrollment of adults and children resulting from implementation of the 1996 welfare legislation, and a strong economy.[42] The number of Medicaid enrollees fell from 41.7 million in 1995 to 40.4 million in 1998. By 2002, however, the number of enrollees is projected by CBO to rise to 44.7 million.

**Figure 3-3: Rate of Growth in Medicaid Spending by Category, 1990–1998**




SOURCE: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports, 2001.

**Figure 3-4: Rate of Growth in Medicaid Spending by Category, 1990–1998**



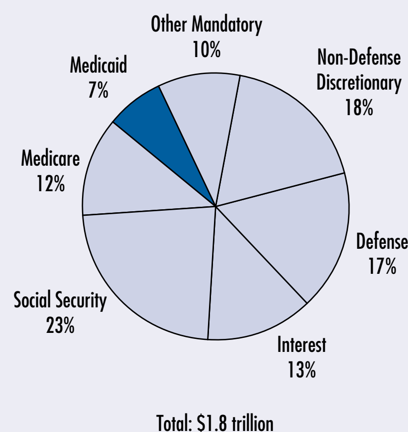

SOURCE: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports, 2001.

## Projected Medicaid Spending Trends

According to the CBO, the low annual growth rates in federal Medicaid spending during the mid-1990's will not continue. CBO estimates that federal Medicaid outlays will grow at an average annual rate of 9 percent over the next 10 years, from $130 billion in 2001 to $267 billion in 2010.[43] This compares to a 7.3 percent annual growth in overall health care spending through 2010.[44] CBO bases this estimate on a number of factors. In the short run, these are: (1) use of "upper payment limit" financing mechanisms by states to generate additional federal spending; (2) growth in medical costs and wages; (3) increased spending on prescription drugs; (4) increased use of long-term care services at home or in the community by individuals with disabilities; and (5) administrative costs for computer systems and Medicaid services provided in schools. In the long run, CBO expects federal Medicaid spending to be driven by (1) growth in medical costs and wages; (2) increased use of long-term care services at home or in the community by individuals with disabilities; (3) increases in reimbursement rates to managed care plans; (4) continuing efforts by states to convert state-funded programs into programs that qualify for federal Medicaid matching funds; and (5) increased enrollment as states expand coverage.[45] There is, of course, a good deal of uncertainty associated with these estimates. Even if they prove to be accurate with respect to federal Medicaid spending, CBO's estimates will not necessarily track the Medicaid spending trends in any particular state over the next decade.

As uncertain as ten-year spending projections may be, estimates for the longer term are even more precarious. While CBO has not published projections of annual federal Medicaid spending beyond FY 2011, it has observed that "[t]he major fiscal problem for the Medicaid program will occur around 2030—when the boomers begin to join the ranks of the 'old old' (those age 85 or older) and many of them begin to need long-term care services."[46] In FY 2001, CBO expects the federal government to spend $39.5 billion, or about 38 percent of federal spending on Medicaid benefits, buying nursing facility services, home- and community-based services, and other long-term care on behalf of aged and disabled beneficiaries. In the nearer (ten-year) future, CBO expects this spending to grow at about nine percent per year, the same rate as overall Medicaid benefits are projected to increase.[47] How these spending trends play out over the longer run will depend not only on demographic and long-term care cost factors; but also on policy choices relating to eligibility, benefits, and reimbursements made by states in Medicaid and by the federal government in Medicaid and Medicare.

**Figure 3-5: Federal Budget Outlays, FY 2000**




SOURCE: CBO, January 2001.

## IV. MEDICAID'S MATCHING RULES

Medicaid is a voluntary, open-ended federal-state matching program. If a state elects to participate in Medicaid, it is entitled to have the amount of state funds it spends to purchase covered services on behalf of eligible individuals matched by the federal government. These federal matching payments are known as federal financial participation (FFP). As seen in Figure 3-5, they account for about seven percent of the federal government's spending in FY 2000.

The rate at which state spending is matched by the federal government, known as the federal medical assistance percentage (FMAP), is determined through a statutory formula. For almost all covered services received by almost all eligible individuals, this rate currently varies from 50 to as much as 77 percent; on average, the federal government nominally pays 57 percent of the cost of the program. For administrative costs, federal matching rates vary by function, not from state to state. This section describes the way in which each state's FMAP is calculated as well as the types of state spending that will qualify for FFP.

***Federal Matching Rates for Services.*** The statutory formula for calculating each state's federal matching rate, or FMAP, is:

$$1-\left[\left(\frac{(\text{State Per Capita Income})^2}{(\text{National Per Capita Income})^2}\right) * 0.45\right]$$

Under this formula, a state's federal Medicaid matching rate is based on the ratio of its per capita income, squared, to the U.S. per capita income, squared. States with per capita incomes above the national level receive a lower federal matching percentage; states with per capita incomes below the national level receive higher percentages. A state with average per capita income will have an FMAP of 55 percent. The effect of the square is to increase the range of the matching percentages. The percentages are recalculated each federal fiscal year based on state and national income data from the most recent three-year periods. It is not unusual for any given state's FMAP to change by a percentage point or two from year to year due to changes in personal income.[48] The operation of the formula is bounded by a statutory provision specifying that no state can have a matching rate lower than 50 percent or higher than 83 percent.

The FMAP produced by this formula applies to a state's spending for almost all covered services on behalf of almost all Medicaid beneficiaries. In the case of family planning services and supplies, however, each state's costs are matched at 90 percent, regardless of its normal FMAP. Similarly, when a state buys any covered service—hospital care, physician services, etc.—on behalf of a Native American or Alaska Native beneficiary from a facility run by the Indian Health Service (IHS) or a tribal contractor to the IHS, the federal matching rate is 100 percent. In 1997, Congress set the District of Columbia's FMAP permanently at 70 percent, even though, by operation of the formula, the District's FMAP would be 50 percent.

Table 3-3 at right shows each state's FMAP for FY 2001. Nine states have federal matching rates of 50 percent: Colorado, Connecticut, Delaware, Illinois, Maryland, Massachusetts, New Hampshire, New Jersey, and New York. All of these states would have FMAPs lower than 50 percent if it were not for the statutory floor constraining the operation of the formula.[49] At the other end of the formula, 12 states (and the District of Columbia) have FMAPs of 70 percent or more: Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Montana, New Mexico, North Dakota, Oklahoma, South Carolina, Utah, and West Virginia.

The premise of the current matching formula is that a state's per capita income is a reasonable indicator of the economic well-being of its residents, and that states with lower per capita incomes would have a greater demand for Medicaid services but less ability to finance this coverage. This premise has been challenged by the General Accounting Office, among others. GAO argues that per capita income is not the best measure of a state's

## TABLE 3-3: FY 2001 FMAP

| State | FMAP |
|---|---|
| Alabama | 70.0% |
| Alaska | 56.0% |
| Arizona | 65.8% |
| Arkansas | 73.0% |
| California | 51.3% |
| Colorado | 50.0% |
| Connecticut | 50.0% |
| Delaware | 50.0% |
| District of Columbia | 70.0% |
| Florida | 56.6% |
| Georgia | 59.7% |
| Hawaii | 53.9% |
| Idaho | 70.8% |
| Illinois | 50.0% |
| Indiana | 62.0% |
| Iowa | 62.7% |
| Kansas | 59.9% |
| Kentucky | 70.4% |
| Louisiana | 70.5% |
| Maine | 66.1% |
| Maryland | 50.0% |
| Massachusetts | 50.0% |
| Michigan | 56.2% |
| Minnesota | 51.1% |
| Mississippi | 76.8% |
| Missouri | 61.0% |
| Montana | 73.0% |
| Nebraska | 60.4% |
| Nevada | 50.4% |
| New Hampshire | 50.0% |
| New Jersey | 50.0% |
| New Mexico | 73.8% |
| New York | 50.0% |
| North Carolina | 62.5% |
| North Dakota | 70.0% |
| Ohio | 59.0% |
| Oklahoma | 71.2% |
| Oregon | 60.0% |
| Pennsylvania | 53.6% |
| Rhode Island | 53.8% |
| South Carolina | 70.4% |
| South Dakota | 68.3% |
| Tennessee | 63.8% |
| Texas | 60.6% |
| Utah | 71.4% |
| Vermont | 62.4% |
| Virginia | 51.9% |
| Washington | 50.7% |
| West Virginia | 75.3% |
| Wisconsin | 59.3% |
| Wyoming | 64.6% |
| **U.S. Average** | **60.8%** |

SOURCE: http://aspe.os.dhhs.gov/health/fmap01.htm

ability to finance Medicaid because it does not adequately reflect the greater tax burden of states with high proportions of needy residents. GAO suggests revising the formula by substituting two factors, total taxable resources and people in poverty, for per capita income.[50]

A state's statutory FMAP applies to the costs of most covered services purchased for most eligible populations. The principal exceptions are the cost of family planning services and supplies (90 percent in all states), and the cost of covered services provided to Medicaid-eligible Native Americans and Alaska Natives by facilities of the Indian Health Service or of tribes contracting with the IHS (100 percent in all states). In addition, in states that take up the option of covering uninsured women who need treatment for breast or cervical cancer, the costs of the treatment are matched at the same enhanced FMAP that the state receives under the State Children's Health Insurance Program (SCHIP).[51]

***Federal Matching Rates for Administration.*** As a general matter, costs incurred by states in administering the Medicaid program rather than paying for covered services are matched at a 50 percent rate by the federal government. There are, however, a number of costs for administrative functions that are matched at higher or "enhanced" rates. These include: operation of a Medicaid management information system (75 percent); survey and certification of nursing facilities (75 percent); operation of a state fraud and abuse control unit (75 percent); performance of utilization and quality review of services provided by hospitals or managed care plans (75 percent); and operation of a system for verifying the status of immigrants (100 percent). For a detailed discussion of these tasks, see the *Medicaid Administration* chapter.

***State Share.*** Under the FMAP formula, some states pay as much as 50 percent of the costs, while others pay shares as small as 23 percent. On average under the formula, states contribute no more than 43 percent of the costs of the Medicaid program.

The state share of Medicaid spending presents more complex issues than the federal share. Most importantly, state budgeting occurs in a different context than does federal budgeting. According to the National Association of State Budget Officers (NASBO), "… states operate within stricter revenue/expenditure limitations than the federal government … States are required to make spending choices within available resources and must reduce spending when revenues come in under estimates. For the most part, states cannot incur a deficit, and must monitor their debt financing in order to avoid jeopardizing their bond ratings."[52] Thus, when revenues fall short in periods of economic downturn, many states look for ways to limit the rate of increase in (or reduce) their Medicaid spending. For example, a NASBO survey of states in 2001 found that "states are proposing measures to contain [Medicaid] cost drivers, such as pharmaceutical costs, long-term care, and higher utilization of services in general. These proposed measures include home- and community-based alternatives to institutional long-term care, procuring private pharmacy contacts to manage drug utilization, reducing reimbursements for prescription drugs and nursing homes, promoting managed care, and eliminating coverage of certain optional services."[53]

Medicaid's importance to both the spending and revenue sides of state budgets makes it a focal point of debate over policy priorities. The state perspective is reflected in the following observation of a former state Medicaid director: "While Medicaid represents about 20 percent of all state spending, at the margin it is much more than that. According to the National Commission on the State and Local Public Service, 'Approximately 50 cents of every dollar of increased revenue is spent on the Medicaid program.' While there are many reasons for this, including the rapid rise in caseloads during this period, federal mandates clearly played a role. The result was less money for other programs. The rapid growth of Medicaid is diverting funds from other priorities, like public health and education."[54]

Another point of view is that Medicaid is not a mandate but an option, and that states have elected to participate in the program (and continue to do so) because it represents an important source of non-state revenues. A July 2000 Urban Institute analysis found that over the ten-year period 1988–1997, real per capita spending by states for all purposes increased by 30 percent, much faster than the growth in real per capita income (nine percent) or the growth in gross domestic product (16 percent). Almost half of this increase was due to spending for public welfare, most of which in turn was attributable to Medicaid. During this same period, the analysis found, federal intergovernmental revenues to states (on a real per capita basis) grew by 52 percent; nearly all of this growth was due to growth in federal Medicaid revenues.[55] Proponents of this viewpoint note that nearly two-thirds of state Medicaid spending is for enrollees and services that are optional; in other words, states are not required to cover these enrollees or services as a condition of participating in the program.[56]

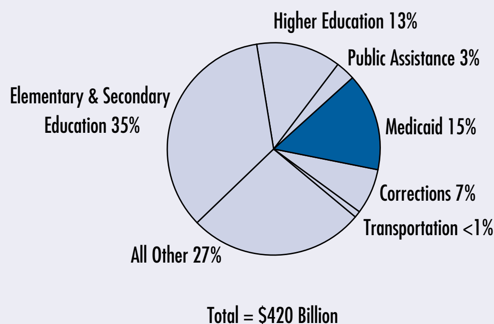
Whatever one's perspective on Medicaid's role in state budget priorities, it is indisputable that state funding of

Medicaid is a significant budget item in almost all states. In 1999, states spent an average of 12.2 percent of their own total funds (general funds plus other funds) on Medicaid; these percentages ranged from 4 percent in Utah to 25 percent in New Hampshire. If federal grant-in-aid spending (including Medicaid FFP) is treated as part of a state's budget, then Medicaid spending represented an average of 19.8 percent of state spending that year, ranging from 8.2 percent in Nevada to 32.2 percent in New York.[57] The difference in the two percentages—12.2 versus 19.8—largely reflects the treatment of federal grant-in-aid dollars. If these federal funds are viewed as state funds and included in the computation of state spending, then the result is the higher percentage. If these funds are viewed as federal intergovernmental payments that are revenues to the states, then only state tax and other non-federal revenues are included in the computation, and the lower percentage applies.

Figure 3-6 shows state general fund spending on Medicaid in relation to other types of general fund expenditures for 1999. In this figure, federal grants, including federal Medicaid matching payments, as well as other state funding sources, have been excluded. The figure shows that, on average, states spent about 15 percent of their general fund dollars on Medicaid in 1999; in contrast, they spent a total of 48 percent of their general fund dollars on elementary, secondary, and higher education. Thus, while Medicaid is certainly an important factor in state budgets, it trails significantly behind education as a priority for state general funds.

While Medicaid is a federal-state matching program, participating states are not required to finance the entire amount of the state share from state funds. As much as 60 percent of a state's share of Medicaid spending may be derived from local funds—i.e., those raised by cities, counties, hospital districts, or other localities. In a number of states, localities are required to contribute toward the state matching amount, but in no state does the percentage of the local contribution approach 60 percent. Although the great majority of states do not require local financing, counties in New York, for example, are required to finance 20 percent of the nonfederal share of long term care services, and 50 percent of the nonfederal share of all other Medicaid services.[58] As discussed in Part VII, local funding is also a common source of the state share with respect to federal Medicaid matching payments flowing to DSH hospitals.

**Figure 3-6: Medicaid Spending as a Percentage of State General Fund Expenditures, FY 1999**




Total = $420 Billion

SOURCE: National Association of State Budget Officers, 1999 State Expenditure Report, June 2000.

Whether the state share of Medicaid spending derives from state funds or from local funds, federal law stipulates that these funds not be federal funds (Medicaid or otherwise).[59] That is, the funds a state spends on Medicaid will not qualify for federal matching payments if they are federal funds. Obviously, if states were to use federal funds to pay for part or all of their share of Medicaid program costs, the federal government would finance most or all of the program, and matching rates that were nominally 50 percent or 70 percent would in reality be considerably higher. The fewer state or local dollars that are spent on Medicaid health or long-term care services for low-income people, the more these funds are freed up for other purposes ranging from education to corrections to highway construction to state or local tax reductions. In recent years, a number of financing arrangements have emerged in which states have substituted federal funds for their own state matching funds. These arrangements, and the federal government's responses to them, are discussed in Part VII.

***Administering Federal Matching Payments.*** Federal Medicaid matching payments, technically referred to as federal financial participation (FFP), are available for state expenditures for services and administration on a quarterly basis. The state expenditures must be pursuant to a state Medicaid plan that has been approved by the Centers for Medicare and Medicaid Services (CMS). Based on quarterly estimates and expenditure reports submitted by each state, CMS calculates the amount of a quarterly payment to the state, which is made in the form of a grant. The quarterly grant award authorizes the state to "draw down," through a commercial bank, the funds it needs to pay the federal share of the state's Medicaid expenditures. (Technically, the "draw" is against a continuing letter of credit certified to the Secretary of Treasury in favor of the state payee.)

In order to qualify for FFP, state Medicaid expenditures must be "allowable." For example, a state expenditure on behalf of an ineligible individual, or for an uncovered service, would not be allowable. Similarly, a state claim for FFP based on an expenditure of federal dollars rather than state or local dollars would also not be allowable. If CMS is uncertain as to whether a particular state expenditure is allowable, it may defer payment of the state's claim until the issues have been resolved.[60] If CMS determines that a state expenditure is not allowable, it notifies the state of its intent to disallow FFP for that expenditure.[61] The state may appeal the disallowance to the Departmental Appeals Board and may seek federal court review of a DAB decision upholding the disallowance. Once a final decision has been made, either sustaining or reversing the disallowance, a subsequent quarterly grant award to the state is increased or decreased, as appropriate. During the four federal fiscal years from 1997 to 2000, CMS disallowed only about $170 million of Medicaid spending that totaled nearly $740 billion (i.e., a mere 0.02 percent of funds claimed were disallowed).[62]

The Secretary of HHS has the statutory authority to withhold FFP from a state if she determines the state is out of compliance with federal Medicaid requirements, even if the state has not submitted an unallowable claim for FFP.[63] For example, the Secretary could in theory withhold FFP from a state that failed to process applications for Medicaid eligibility in a timely manner as required under federal regulations, even though the state never claims FFP for the individuals it has not enrolled in Medicaid. However, this remedy for noncompliance, which can be imposed only after a hearing and is subject to judicial review, is rarely invoked. No state has been subject to a withholding of FFP due to noncompliance with federal Medicaid requirements for at least the last decade.

## V. MEDICAID FINANCING WAIVERS

There are certain categories of individuals, and certain types of services, for which federal Medicaid matching funds are not ordinarily available. As a general rule, states may cover these individuals and pay for those services through their Medicaid programs if they so choose, but they must do so entirely with their own funds. For example, FFP is not normally allowable for the costs of providing services to low-income adults who have no dependent children and are not elderly, disabled, or pregnant. Similarly, FFP is not ordinarily available for the costs of providing certain long-term care services outside of a nursing home to eligible aged or disabled Medicaid beneficiaries.[64]

### The Basic Math of Federal Matching Payments

At a 50 percent matching rate, a state that expends $2 receives $1 in Federal Financial Participation (FFP) from the federal government. In other words, the state draws down one federal dollar for each state dollar it spends. At a 70 percent matching rate, a state that spends $2 receives $1.40 in FFP. In effect, the state draws down $2.33 in FFP for every $1 it spends. At an 80 percent matching rate, a state that spends $2 receives $1.60 for every $1 it spends. In effect, the state draws down $4 for every $1 it spends.

The Secretary of HHS has authority to grant exceptions to these limitations on FFP on a state-by-state basis through two statutory waivers. These are the statewide demonstration waiver authority under section 1115 of the Social Security Act and the home and community-based services waiver authority under section 1915(c) of the Act. Of the $130 billion that the federal government is projected to spend in FY 2001 making Medicaid matching payments to the states, over one fifth will flow through these two waiver authorities for populations or services that would not otherwise be allowable.[65]

### Statewide "Section 1115" Waivers

Section 1115 of the Social Security Act is a broad demonstration authority that allows the Secretary of HHS to permit a state to use federal Medicaid matching funds to pay for expenditures that would otherwise not be allowable under the Medicaid statute (Title XIX of the Act). These expenditures could be for populations not otherwise allowable, services not otherwise allowable, or both. A state seeking FFP under a section 1115 waiver must show that its demonstration will be "budget neutral" to the federal government. That is, the state must show that, over the five-year period of the waiver, federal Medicaid spending under the waiver will not exceed what the federal government would have spent in the absence of the waiver.[66] In addition, the state's demonstration is subject to an independent evaluation.

As of July 2001, 13 states (Arkansas, Delaware, Hawaii, Massachusetts, Minnesota, Missouri, New Mexico, New York, Oregon, Rhode Island, Tennessee, Vermont, and Wisconsin) were operating statewide section 1115 demonstration waivers under which they receive federal

matching funds for the costs of Medicaid coverage for "waiver only" beneficiaries—i.e., individuals who would not be eligible for Medicaid in the absence of the waiver. An additional five states (Arizona, Kentucky, Maryland, Ohio, and Oklahoma) were operating section 1115 demonstration waivers affecting only beneficiaries who qualify for Medicaid without regard to the waiver. As of June 2000, a total of 7.6 million beneficiaries (both waiver-only and non-waiver), or about one sixth of all Medicaid beneficiaries nationwide, were covered through these waivers.[67] In total, these 18 statewide demonstration waivers accounted for over $27 billion in federal matching payments in FY 2001, or about one fifth of the total amount the federal government spent on Medicaid that year.[68] As Lambrew notes, "The amount of Medicaid demonstration spending exceeds the discretionary funding for 23 of the 27 federal cabinet-level agencies, including the FY 2001 discretionary budgets for the Departments of Agriculture, Justice, Labor, and Veterans Affairs."[69]

States propose to meet the federal "budget neutrality" requirement in different ways. In some cases, budget neutrality is to be achieved in large measure by offsetting the costs of "waiver-only" populations with savings derived from enrolling ordinarily eligible, or "nonwaiver" populations in managed care.[70] In other cases, budget neutrality is to be achieved in part by reducing Medicaid payments to disproportionate share (DSH) hospitals (discussed in Part VII) and using the associated FFP to offset the costs of the "waiver-only" populations.[71]

Section 1115 waivers have also been granted (as of August 2001) to 15 states to enable them to receive federal matching funds for the costs of extending coverage for family planning services and supplies to low-income women who would not otherwise be eligible for Medicaid. In eight of these states (Alabama, Arizona, Florida, Maryland, Missouri, New York, Rhode Island, and South Carolina) coverage is provided under the waiver to low-income women who were eligible for Medicaid during their pregnancies but whose eligibility has ended with the expiration of the 60-day post-partum period. Delaware uses its waiver to extend family planning coverage to women losing Medicaid for any reason. Finally, Alabama (which is also in the first group) and six other states (Arkansas, California, New Mexico, Oregon, South Carolina, and Washington) use section 1115 waivers to extend coverage to women based on their low income, whether or not they have previously been eligible for and lost Medicaid.[72] It is anticipated that, by reducing the number of unintended pregnancies, the provision of family planning services to this population will reduce the number of Medicaid-financed pregnancies. The resulting federal savings, it is estimated, will offset the additional costs of providing family planning services to this otherwise ineligible population.[73]

The section 1115 demonstration authority has also been used to target federal Medicaid matching funds directly on a "safety net" public health care system. In 1995, the Secretary of HHS approved a section 1115 waiver for the Los Angeles County Department of Health Services (LACDHS) system of six public hospitals and 45 health centers. The purpose of the waiver was to provide immediate federal fiscal relief for the LACDHS system to avoid closures and service cutbacks, as well as to help finance a restructuring of the system so as to reduce inpatient capacity and expand ambulatory care capacity.[74] In January, 2001, the Secretary approved a five-year extension of this waiver designed to gradually phase-out federal matching payments for costs incurred by LACDHS in delivering outpatient care that would not otherwise be matchable.[75] The waiver extension will bring $900 million in federal matching payments, $150 million in state matching payments, and additional county funding into the LACDHS system over the five-year period.[76] The $900 million represents a net increase in federal spending.[77]

As of July 2001, Maine, Massachusetts, and the District of Columbia have received section 1115 waivers to extend Medicaid coverage to low-income individuals with HIV who do not otherwise qualify for Medicaid because their disease has not progressed to the point where they are considered disabled (and therefore categorically eligible for Medicaid). Services covered for this population include the administration of antiretroviral therapy, as well as mental health and substance abuse treatment, together with a range of other Medicaid benefits. The Maine demonstration will test whether making these services available to HIV-positive individuals with incomes at or below 300 percent of the federal poverty level ($25,050 for an individual in 2000) can forestall the onset of AIDS and avoid the Medicaid costs associated with its treatment.[78] The state may limit the number of individuals made eligible through the waiver.

## Health Insurance Flexibility and Accountability (HIFA) Waivers

In August 2001, in response to a Medicaid restructuring proposal by the National Governors' Association,[79] the Bush Administration announced a new format for the use of the section 1115 waiver authority and federal Medicaid and SCHIP matching funds. The "primary goal" of the Health Insurance Flexibility and Accountability

(HIFA) demonstration is to "increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources."[80] Under the HIFA waivers, states will have the flexibility to reduce the amount, scope, or duration of optional benefits like prescription drugs and increase cost-sharing requirements for optional Medicaid eligibility groups such as children six and over in families with incomes above 100 percent of the FPL. States will be able to use savings achieved by these reductions to expand coverage to the uninsured or for other purposes. Under traditional section 1115 waiver criteria, states seeking to expand Medicaid coverage to uninsured residents could not do so by reducing covered services to current eligible populations.[81]

The HIFA demonstration waivers place "particular emphasis" on "broad statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with income below 200 percent of the federal poverty level (FPL)." These approaches could take the form of "premium assistance"—that is, subsidies for the purchase of private health insurance coverage offered by employers. Under Medicaid law, states have the option (without the need for a waiver) to use federal matching funds to pay the premiums (and related deductibles and other cost-sharing) for Medicaid beneficiaries whose employers offer health insurance coverage in cases where it is "cost-effective" to do so.[82] As of 2000, five states were operating premium assistance programs using federal Medicaid matching funds, either under the state option (Iowa) or a section 1115 waiver (Massachusetts, Minnesota, Vermont, and Wisconsin).[83]

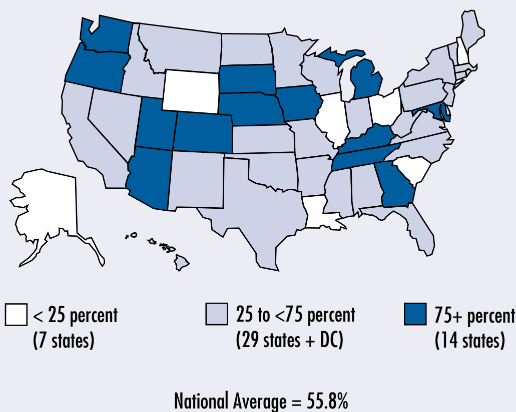
## Home and Community-Based Services (HCBS) Waivers

Section 1915(c) of the Social Security Act allows the Secretary of HHS to approve federal Medicaid matching payments for certain long-term care services that would not otherwise qualify for FFP. Unlike the broad section 1115 demonstration waivers, these section 1915(c) waivers focus on a cluster of home- and community-based services. The 1915(c) waiver authority is used to authorize FFP for certain services, not to create a new "waiver-only" eligibility group, as can be done under section 1115. (States may cover individuals receiving only these HCBS services as an optional eligibility group.)[84] As in the case of the section 1115 waiver, states seeking a section 1915(c) waiver must demonstrate "budget neutrality" from the federal government's standpoint.[85]

Under a section 1915(c) waiver, a state may, subject to the federal budget neutrality requirement, cover one or more of the following "home- and community-based" services: case management services, homemaker/home health aide services, personal care services, adult day health services, habilitation services, respite care, and, for individuals with chronic mental illness, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services. These HCBS services may be provided to Medicaid beneficiaries who, but for the provision of such services, would require the level of care provided in a hospital or nursing facility or intermediate care facility for the mentally retarded (ICF/MR). The state may limit the categories of individuals for whom it will cover HCBS services and the areas of the state in which such individuals reside. It may also limit the number of "waiver slots"—i.e., the number of eligible individuals in each category or area whom it is willing to cover for HCBS services. Note that some of these HCBS services, such as personal care services, are also statutory Medicaid benefit categories and could therefore be covered by a state as an optional benefit with FFP for all eligible Medicaid beneficiaries. The waiver authority gives the state the additional option of covering these services with FFP for a targeted numerically bounded population on less than a statewide basis, e.g., 300 elderly individuals living in a particular county at risk of nursing facility care.[86]

Every state except Arizona operates at least one HCBS waiver (Arizona covers home- and community-based services under its section 1115 waiver).[87] As of 1997, a total of 561,500 Medicaid beneficiaries, ranging from individuals with mental retardation to individuals with physical disabilities, from the aged to children with special needs, received services under 224 HCBS waivers. The total federal and state expenditure for these services that year was $7.9 billion, or 13.5 percent of the $58.7 billion in total Medicaid long-term care spending that year.[88] The large majority of the HCBS waiver spending that year—77 percent—purchased services for individuals with mental retardation or developmental disabilities. This spending trend reflects a 16 percent reduction in the number of Medicaid beneficiaries with mental retardation and related conditions receiving services in institutions (ICFs/MR) between 1993 and 1998 and a dramatic 175 percent increase in the number of such beneficiaries receiving HCBS services over that same period.[89] It is anticipated that the federal Medicaid matching funds available through the HCBS waiver authority will play an important role in the resolution of litigation under the Americans with Disabilities Act (ADA) by individuals with disabilities seeking to avoid institutionalization.[90]

**Figure 3-7: Medicaid Managed Care Enrollment, by State, 2000**




Note: Includes full-risk and PCCM arrangements.
SOURCE: HCFA, 2001.

## VI. MEDICAID PROVIDER PAYMENT POLICIES

Medicaid is a "vendor payment" program. That is, state Medicaid programs make payments not to beneficiaries, but to the providers or managed care plans that furnish services to beneficiaries.[91] It is those payments to providers or plans that constitute the state expenditures that are subject to federal matching at each state's FMAP. Understanding Medicaid provider payment methodologies is essential to understanding the manner in which Medicaid is financed in some states.

States have broad discretion in establishing payment methodologies and setting payment amounts. They have the flexibility to purchase covered services on a fee-for-service basis, on a capitation basis from managed care plans, or through a combination of both. While Medicaid spending nationally remains predominantly fee-for-service, Medicaid payments flowing to managed care plans are nonetheless significant.[92] CBO estimates that in FY 2001, federal Medicaid payments to managed care plans will total $16.5 billion, or 25 percent of the $65.3 billion in total federal Medicaid spending on acute care services that year.[93] Medicaid managed care spending and enrollment vary considerably from state to state. As shown in Figure 3-7, the extent of Medicaid managed care enrollment in 2000 averaged 56 percent nationally and ranged from less than 25 percent in 7 states to over 75 percent in 14 states.

### Fee-for-Service

With the enactment of the 1997 Balanced Budget Act (BBA), very few federal rules remain vis-a-vis state payment policies toward fee-for-service providers. In general, federal Medicaid law does not establish specific floors or ceilings on the payment rates for any individual provider, whether the provider is an institution or a practitioner. In the case of institutional services, there are some minimal procedural requirements and some aggregate payment ceilings. In the case of both institutional and practitioner services, a requirement that payments be "sufficient" to ensure "equal access" to providers applies. The only services that are still subject to minimum federal payment standards are federally-qualified health center (FQHC) services, rural health center (RHC) services, and hospice services.[94]

***Hospital Services.*** Prior to the enactment of the BBA, state Medicaid programs were required, under the terms of the "Boren" amendment, to pay for nursing home services (1980) and inpatient hospital services (1981) using "reasonable and adequate" rates.[95] States criticized this requirement, and its enforcement by federal courts, as leading to an institutional bias in Medicaid spending.[96] In 1997 Congress repealed the "Boren" payment standard and substituted a "public process" requirement. States must now publish their proposed rates for hospital services (both inpatient and outpatient), the methodologies on which the rates are based, and justifications for the rates. States must give providers and beneficiaries a "reasonable opportunity for review and comment" and must publish the final rates, methodologies, and justifications.[97]

While the rates that the states establish for hospital services no longer have to be "reasonable" or "adequate," they are subject to the general statutory requirement that they be "consistent with efficiency, economy, and quality of care."[98] CMS has interpreted this statutory language as giving it the authority to impose upper payment limits, or UPLs, on state Medicaid payments for hospital services. By regulation, CMS has established such UPLs not on payments to each individual facility, but on aggregate state Medicaid payments to all hospitals within each of the following three groups: state government-owned or operated; local government-owned or operated; and privately-owned or operated.[99] In general, the UPL is "a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles."[100] Finally, CMS has also imposed a separate UPL on payments for outpatient hospital and clinic services.[101] As discussed in Part VII, use of intergovernmental transfers in connection with

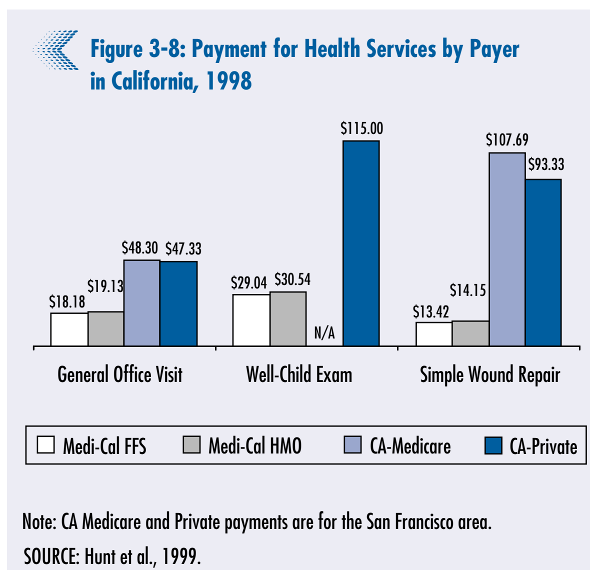
UPLs has led to the diversion of federal Medicaid matching funds from their intended purposes.

There is one hospital payment standard that was not repealed in BBA 1997: the requirement that state payment rates for inpatient services "take into account … the situation of hospitals which serve a disproportionate number of low-income patients with special needs."[102] Unlike other Medicaid payments to hospitals, these Medicaid "DSH" (disproportionate share hospital) payments are not subject to the aggregate UPLs that apply to state, local public, or private hospitals. Instead, three separate caps on federal matching funds—two state-specific and one facility-specific—apply to Medicaid DSH payments. These are discussed in Part VII.

***Nursing Facility Services.*** The federal rules governing state Medicaid payments to nursing facilities are generally comparable to those governing payments to hospitals. As a result of BBA 1997, there is no longer a requirement that rates paid to nursing facilities for caring for Medicaid patients be "reasonable and adequate." Instead, as in the case of inpatient hospital services, nursing facility payment rates are subject to a "public process" requirement, including publication of proposed rates and methodologies and an opportunity for review and comment by providers and beneficiaries.[103] And, as in the case of inpatient hospital services, Medicaid payments to nursing facilities are subject to an aggregate UPL based on a reasonable estimate of what Medicare would pay, applied to each of three groups of facilities: state-owned or operated; local government-owned or operated; and privately-owned or operated.[104] In contrast to hospital reimbursement policy, there is no federal requirement that states make additional payments to nursing facilities serving a "disproportionate share" of Medicaid residents.

***Physician Services.*** States have even more discretion with respect to payment rates and methodologies for services of physicians (and other practitioners) than they do for hospital or nursing facility services. No "public process" requirement applies, and CMS has imposed no UPLs. Payments to physicians must, however, be "sufficient to enlist enough providers so that care and services are available under [the state's Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area."[105] While this statutory standard applies to hospitals, nursing facilities, and other institutional providers as well as individual practitioners, in most states it tends to have more relevance to practitioners.[106] BBA 1997 repealed a statutory provision designed to implement this standard with respect to physicians (and other practitioners) delivering obstetrical or pediatric services.[107]

**Figure 3-8: Payment for Health Services by Payer in California, 1998**




Note: CA Medicare and Private payments are for the San Francisco area.
SOURCE: Hunt et al., 1999.

A study of Medicaid physician fees in 1993 and 1998 found wide variations in payment levels from state to state. It also found that in 1998 the ratio of Medicaid fees to Medicare fees was about 64 percent, down from 75 percent in 1993.[108] While not all state Medicaid programs pay physicians less than two thirds of what Medicare pays, some pay rates that are substantially lower.[109] Figure 3-8 shows the disparities in payment for three procedures—general office visit, well-child exam, and simple wound repair—in the San Francisco area in 1998. California's Medicaid payment for well-child exam was $29.04, or 25 percent of the $115 a physician would receive for a well-child exam from a private insurer. Low payment rates create incentives for physicians to limit the number of Medicaid beneficiaries they will treat or to decline participation in the program altogether. A subsequent fee increase raised Medicaid payment rates for physicians' services in California from 58 percent to 65 percent of the average Medicare payment rates for all physician services in the state in 2000. This increase was viewed as "probably not sufficient to bring physicians into the Medi-Cal program who are not currently participating (or who participate on a limited basis)," but it "may have been of substantial short-term value in encouraging physicians to continue accepting Medi-Cal patients."[110]

Federal Medicaid law is more specific in addressing the timeliness of payment than it is in addressing its adequacy. States must pay 90 percent of the "clean claims" they receive—i.e., claims for which no further

written information or substantiation is required—within 30 days of receipt, and 99 percent of such claims within 90 days of receipt.[111] These timeliness standards apply to services furnished by physicians and other practitioners being paid on a fee-for-service basis. They also apply to health care providers contracting with Medicaid managed care plans, unless the provider and the plan agree to a different schedule.[112]

***Federally-qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services.*** FQHCs and RHCs have a special status under federal Medicaid law, which specifies the manner in which they are to be reimbursed. FQHCs are primary care providers that receive grant funds under section 330 of the Public Health Service Act, providers that meet the qualifications for grant funds but don't receive them, and tribal or urban Indian clinics.[113] RHCs are facilities located in rural areas with shortages of primary health care practitioners that meet Medicare requirements for providing outpatient physician services. For Medicaid purposes, however, FQHCs and RHCs are not just classes of participating providers: the services they deliver are benefits categories that all states must offer and for which states must pay in a specified manner. When reimbursed on a fee-for-service basis, FQHCs and RHCs are entitled to payment through a prospective payment system under which per-visit payment amounts are based on the reasonable costs incurred by a center in providing Medicaid-covered services during a base period (FY 1999 and FY 2000), adjusted annually for inflation and changes in the scope of services provided.[114] If an FQHC or RHC subcontracts with a Medicaid MCO, the state Medicaid agency must make the center whole for any difference between the amount the center would receive under the prospective payment system for serving the MCO's enrollees and the amount it actually receives from the MCO.[115]

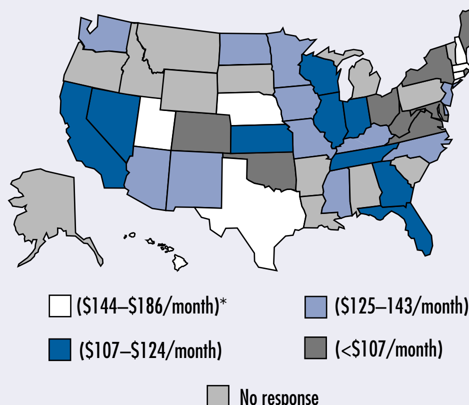
## Capitation

States have the option of purchasing Medicaid services for the same beneficiaries through managed care plans rather than on a fee-for-service basis. Over the past decade, most states have elected to do so. Between 1991 and 2000, the number of Medicaid beneficiaries enrolled in either managed care organizations (MCOs) or primary care case management programs (PCCMs) increased from 2.7 to 18.8 million;[116] as of 1999, an estimated 11.4 million of these beneficiaries were enrolled in 316 full-risk managed care plans.[117] As of June 2000, 43 states had more than one-quarter of their beneficiaries enrolled in managed care.[118] CBO estimates that federal Medicaid matching funds for payments to managed care plans will grow at an average annual rate of 11 percent from $16.5 billion in FY 2001 to $25.1 billion in FY 2005. This projection assumes a rate of growth higher than the nine percent average annual rate of growth projected for federal Medicaid fee-for-service spending.[119] CBO assumes that over the next ten years, "states will likely have to pay higher rates to managed care organizations to maintain their participation in the program."[120]

States that elect to enroll Medicaid beneficiaries in full-risk MCOs are required to pay the MCOs on "an actuarially sound basis."[121] The federal Medicaid statute does not define this term. Although this requirement was enacted in 1981, CMS had not issued any detailed administrative guidance to states[122] and did not propose implementing regulations until early 2001.[123] CMS did, however, issue a regulation in 1983 imposing a ceiling on Medicaid payments flowing under managed care risk contracts in the form of an upper payment limit (UPL). The UPL, which applies not in the aggregate but on an MCO-by-MCO basis, is set at the cost of purchasing, on a fee-for-service basis, the same services being purchased from the MCO for a population that is actuarially equivalent to that enrolled in the MCO.[124] As discussed above, there is no corresponding statutory or regulatory requirement that the state's fee-for-service rates be adequate, reasonable, or actuarially sound. As a result, according to PriceWaterhouseCoopers, "[a] state's Medicaid fee-for-service payment level in large part determines the approximate level of capitation rates. States with generally high Medicaid payment levels will have the opportunity to pay capitation rates that are relatively high, while states with low fee-for-service payment levels will have capitation rates that are also low."[125] An analysis of capitation rates paid by California in 1999 found them to be lower on average than those of other purchasers (after adjusting for differences in health status of enrollees and benefits covered), due in part to "the low fee schedule that underlies the capitation rates."[126]

State payment rates to Medicaid managed care plans vary substantially. The extent of this variation during 1998 can be seen in Figure 3-9. The survey on which this figure is based found "more than a twofold variation in rates among states for reasonably homogeneous populations" (e.g., low-income children and adults).[127] The national average capitation rate among the 36 states providing data was $129.32 per member per month. In California, the average rate was calculated to be $85.09; for Massachusetts, $179.78. The variation was attributed to a number of factors, including previous fee-for-service spending; differing state policy objectives (e.g., controlling spending, increasing access, encouraging plan

**Figure 3-9: Medicaid Capitation Rates, by State, 1998**



($144–$186/month)*
($125–143/month)
($107–$124/month)
(<$107/month)
No response

*Includes the District of Columbia
Note: Includes full-risk and PCCM arrangements. The capitation rates were standardized for age, sex, benefits and DSH/GME payments.

SOURCE: Holahan et al., 1999.

participation); the effect of the UPLs; and the distribution of the eligible population (e.g., urban vs. rural).

The shift of state Medicaid payment policies from fee-for-service to managed care, discussed above, has important implications for "safety-net" hospitals and clinics serving large numbers of Medicaid patients.[128]

Payments that these providers used to receive directly from the state Medicaid program in the form of fees for providing covered services to program beneficiaries no longer flow directly to them (unless these providers themselves organize as MCOs). Instead, the state makes monthly capitation payments (matched with FFP) on behalf of Medicaid enrollees to the MCO or MCOs operating in the provider's service area. The state has the flexibility to allow the MCOs and affected providers to negotiate among themselves the terms of the provider's participation (if any) in the MCO's provider network and the related payment arrangements, subject to limits on the degree of risk that participating physicians may be required to assume.[129]

There are three federal statutory provisions designed to address concerns specific to these hospitals and clinics. First, states must make Medicaid DSH payments directly to qualifying hospitals rather than route the funds through MCOs.[130] Second, MCOs must pay for emergency services received by a "prudent" Medicaid enrollee whether or not the hospital or other emergency care provider is affiliated with the MCO and whether or not the MCO has approved the services in advance.[131] Finally, as noted above, if the MCO contracts with an FQHC or RHC for the provision of services, the MCO must pay the FQHC or RHC at the same level and amount that it would pay to any provider furnishing the same services. In addition, the state Medicaid program is required to make up the difference, if any, between what the FQHC or RHC receives from the MCO, and the amount to which the FQHC or RHC would be entitled on a fee-for-service basis under the prospective payment system.[132]

In some communities, "safety net" hospitals and FQHCs have responded to the conversion of Medicaid from fee-for-service to managed care by establishing and operating their own MCOs.[133] These MCOs are able to return any surpluses achieved on their Medicaid business to individual hospitals or FQHCs to subsidize their costs of care to the uninsured.[134]

## VII. SPECIAL MEDICAID FINANCING ISSUES

A central issue of Medicaid financing is: what is an allowable state expenditure? If a state expenditure is allowable for FFP purposes, then the state making the expenditure is entitled under Medicaid law to federal matching payments of at least 50 percent and as much as 83 percent. If the expenditure is not allowable, then the federal government will not share in the cost. States are therefore highly concerned about the allowability of any change they consider making in their Medicaid program's eligibility, coverage, payment, or administrative policies.

States face competing demands for public services such as education, corrections, transportation, and health care that exceed their fiscal capacities, especially in times of economic downturn. The competition among these service needs for available state revenues gives states a fiscal incentive to substitute federal (or local) funds for state funds. This substitution enables states to free up their own funds for other needs or to enact tax cuts. Because federal Medicaid matching funds are available to states on an open-ended, entitlement basis for allowable state expenditures, many states have looked to Medicaid as a source of federal funds to help finance a range of mental health, public health, education, and other programs. This is known as "Medicaid maximization."[135]

Some types of Medicaid maximization are approved and even encouraged by federal policy. For example, federal law expressly allows states to cover services that have traditionally been state or local responsibilities and to receive federal matching funds for the costs of furnishing these services to Medicaid beneficiaries. Examples are

institutional services like intermediate care facilities for the mentally retarded (ICF/MR) and public health services such as immunizations for children. By billing Medicaid, states are able to replace some of their funds with federal matching funds; the higher the state's matching rate, the greater the replacement potential. In addition, states have the flexibility to import federal Medicaid dollars into state-run institutions through reimbursement methodologies, such as graduate medical education (GME) payments to state university teaching hospitals.[136] Finally, as discussed below, federal law allows states to retain the federal share of the payments that tobacco manufacturers make to them each year to settle claims for the costs of treating the smoking-related illnesses of Medicaid beneficiaries.

Other types of Medicaid maximization are problematic. This section discusses the major maximization strategies that have emerged over the past decade and that raise questions as to the integrity of Medicaid's federal/state matching arrangements. In some cases—DSH payments and provider taxes, and state settlements with tobacco manufacturers—the issues have been largely resolved through legislation. In the others—administrative claiming for school-based services and upper payment limits (UPLs)—the Medicaid statute does not expressly speak to the issue, and regulatory solutions are being developed.

## Tobacco Settlement Funds

On November 23, 1998, 46 states and the District of Columbia agreed to settle pending litigation against the tobacco manufacturers for Medicaid and other costs incurred by states as the result of tobacco-related illnesses. Prior to this master settlement agreement, four states (Florida, Mississippi, Texas, and Minnesota) had individually settled their respective lawsuits for $40 billion over 25 years. In exchange for the states' agreements not to pursue litigation, the manufacturers agreed under the master settlement to make annual payments to the other 46 states and the District of Columbia that the parties at the time estimated will amount, in total, to $36.3 billion through 2002 and $239.5 billion through 2025 (the payments are to run in perpetuity). As of December 2000, the states had received payments from the manufacturers totaling nearly $10 billion (see Table 3-4).[137]

Although the state lawsuits involved a number of different legal theories, central to all of them were the costs attributable to state Medicaid programs for the treatment of tobacco-induced illnesses.[138] The manufacturers' payments are thus intended to offset at least in part these Medicaid expenditures, both in the past and in the future. Under long-established Medicaid policy, the recovery

### Table 3-4: Cumulative Tobacco Settlement Funds, 2000

| | Dollars (millions) |
|---|---|
| **United States** | **$9,907** |
| Florida | $2,294 |
| New York | $668 |
| New Jersey | $553 |
| California | $475 |
| Texas | $458 |
| Massachusetts | $450 |
| Illinois | $437 |
| Michigan | $352 |
| Wisconsin | $293 |
| Minnesota | $287 |
| Ohio | $276 |
| Maryland | $266 |
| Connecticut | $261 |
| Alabama | $233 |
| Tennessee | $180 |
| Virginia | $180 |
| Colorado | $176 |
| Kentucky | $175 |
| Washington | $168 |
| South Carolina | $159 |
| Georgia | $145 |
| Arizona | $118 |
| Iowa | $116 |
| Mississippi | $115 |
| Indiana | $105 |
| New Hampshire | $97 |
| Nevada | $93 |
| Louisiana | $77 |
| Maine | $74 |
| Kansas | $67 |
| Rhode Island | $67 |
| West Virginia | $58 |
| Vermont | $57 |
| Alaska | $51 |
| Hawaii | $49 |
| North Carolina | $37 |
| Oklahoma | $36 |
| Utah | $36 |
| Delaware | $32 |
| North Dakota | $30 |
| South Dakota | $28 |
| New Mexico | $24 |
| Wyoming | $19 |
| Montana | $19 |
| Nebraska | $14 |
| Idaho | $2 |
| Arkansas | NA |
| District of Columbia | NA |
| Missouri | NA |
| Oregon | NA |
| Pennsylvania | NA |

Note: As of December 31, 2000, these states had received tobacco settlement funds but had not yet decided how to appropriate or allocate them.

SOURCE: National Conference of State Legislatures, Health Policy Tracking Service, 2001.

from a third party of the costs of care is one of the states' administrative responsibilities, and any amounts recovered are shared between the states and the federal government in proportion to their respective shares of Medicaid spending under the FMAP formula.[139] While the recovery of "third-party liability" (TPL) commonly involves efforts to collect from health or automobile accident insurers, in this instance the liable third parties are the tobacco manufacturers. Thus, the federal government would normally receive, on average, 57 percent of the portion of the settlement payments that represents Medicaid recoveries.

In the Emergency Supplemental Appropriations Act for FY 1999, the Congress carved out an exception to this general rule. States and localities are allowed to retain all of the federal share of their tobacco settlement payments and may use these funds for almost any purpose they choose, including the funding of the state share of Medicaid spending.[140] The federal government will also continue to pay its share of each state's Medicaid costs of treating tobacco-induced illnesses among program beneficiaries. Under the terms of the settlement, the federal government is foreclosed from recovering its share of these costs directly from the tobacco manufacturers; their settlement payments to the states satisfy their liability to both the state and federal governments for all past, present, and future treatment costs.

In ceding its share of the tobacco settlement payments to the states, the federal government effectively transfers tens of billions of federal Medicaid funds to states each year. According to the estimates developed by the states' own experts in the course of the tobacco litigation, the federal share of the Medicaid cost of treating tobacco-induced illnesses ranged between $8.9 and $13.2 billion in FY 2000 alone.[141] The mid-point of this range—$11 billion—is a fair estimate of the order of magnitude of the annual resource transfer from the federal government to the states potentially resulting from this transaction.[142] As of December 30, 2000, 46 states had disbursed a cumulative total of $9.9 billion in settlement payments for state FYs 2000 and 2001; of this amount, five percent was allocated to tobacco use prevention, and 38 percent was allocated to reserve funds or uses unrelated to prevention or cessation of smoking, children and youth, health or long-term care, health research, or education.[143]

### The Basic Math of the Tobacco Settlement.

Assume that a state with a 50 percent federal matching rate incurs $300 in paying for hospital and physician services to treat the smoking-induced lung cancer of a Medicaid beneficiary. Assume further that the state, through the tobacco litigation, has settled with the manufacturers for 66 cents on the dollar, or $200. Under normal Medicaid "third party liability" (TPL) rules, the state and the federal government would share in this $200 recovery in proportion to their share of the costs; thus, the state would keep $100, and the federal government $100. Thus, of the $300 cost of the services, $200 would be paid by the tobacco manufacturers, $50 by the state, and $50 by the federal government. Under the 1999 Congressional exception to the normal TPL rules, the state keeps the $200 in payments from the tobacco manufacturers and receives its 50 percent match on the $300 cost of services, or $150, from the federal government. The state may elect to use the $200 in tobacco settlement payments to pay its normal 50 percent share of the $300 cost, or $150. This would effectively raise the state's federal matching rate on this transaction to 100 percent and leave it with an additional $50 for other purposes.

## Introduction to "Creative" Financing Mechanisms

While large in scale, the transfer of the federal share of tobacco settlement payments is straightforward. Each state is expressly authorized by federal law to retain the share of the payments it receives from the manufacturers that would otherwise go to the federal government and to use those funds for almost any purpose, including the state's share of Medicaid spending. The states do not have to claim Medicaid matching funds from the federal government in order to secure these federal resources; they simply need to collect the settlement payments from the manufacturers.

The Medicaid maximization strategies discussed below are not nearly so straightforward. In each case, in order to receive federal matching payments, states must file claims with the federal government for expenditures made on behalf of Medicaid beneficiaries for Medicaid covered services. And in each case, the state (or the locality) does not ultimately spend its own general funds in order to satisfy its state matching requirement. Instead, through various mechanisms, some or all of the state matching requirement is ultimately paid by the federal government, and the effective federal matching rate is higher than the nominal matching rate specified in the FMAP formula described in Part IV.

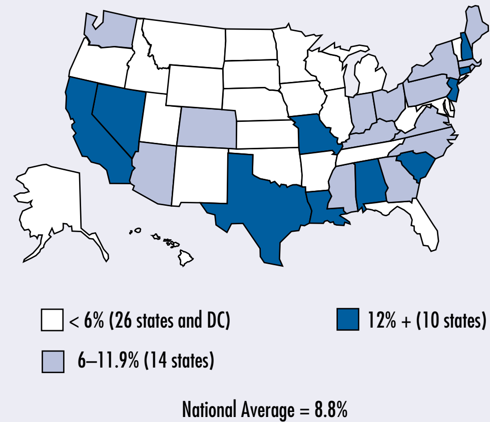
The amounts of federal funds at issue in these arrangements are not trivial. For example, CBO projects that the federal government will pay out $36.3 billion over the five years between FY 2001 and FY 2005 under UPL arrangements alone. This is more than one and one half times the amount CBO projects the federal government will spend on SCHIP over that same period ($20.6 billion).[144] These arrangements also have an important impact on federal Medicaid cost growth. In explaining why the rate of increase in federal Medicaid spending in 2000 exceeded its projection by two full percentage points, CBO concluded that state use of UPL financing mechanism was "the most notable factor."[145] And, as noted by Ku and Guyer, these financing arrangements have led to higher rates of growth in federal Medicaid spending than in state Medicaid spending from state general funds (7.3 percent versus 5.6 percent, respectively, in state FY 1999).[146]

Because revenues flowing into state treasuries are fungible, it can be difficult to determine the ultimate disposition of these federal Medicaid matching funds. They can be used by states for a wide range of purposes: to expand Medicaid eligibility, to raise provider payment rates, to expand the scope of covered benefits, to increase the federal government's share of Medicaid costs, to finance other state activities such as road or prison construction, to reduce state taxes, or to balance state budgets. On the federal government's books, however, they are presented as purchasing health and long-term care for low-income Americans.

## Disproportionate Share Hospital (DSH) Payments

In 1981, federal Medicaid law was amended to repeal the requirement that states pay for inpatient hospital services using the same "reasonable cost" methodology as the Medicare program used at the time. States were instead given the flexibility to pay for such services using rates that were, under the terms of the "Boren" amendment discussed in Part VI, "reasonable and adequate." Recognizing that this change would result in a reduction in Medicaid payment rates for inpatient hospital care in many states, and that such a reduction would have a more severe impact on those hospitals treating large numbers of Medicaid and uninsured patients, Congress required that the payment rates "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs." This provision, which became known as the Medicaid "disproportionate share hospital" (DSH) requirement, survived the repeal of the "Boren" amendment in the

**Figure 3-10: Medicaid Disproportionate Share Hospital Payments as a Percent of Total Medicaid Spending, 1998**




SOURCE: Urban Institute estimates, 2001.

Balanced Budget Act of 1997.[147] Federal Medicaid DSH payments are projected to total $8.4 billion in FY 2001, or about 6.5 percent of all federal Medicaid spending that year and slightly more than the $7.6 billion in projected UPL payments.[148]

Unlike other federal Medicaid matching payments, federal Medicaid DSH payments do not flow to states on an open-ended basis. Instead, these payments are allocated among states in amounts specified in a table set forth in federal statute.[149] States may claim federal matching funds for DSH payments made to qualifying hospitals up to these ceilings. The state-specific DSH payment ceilings reflect state DSH spending at the time the ceilings were imposed by the Congress; they do not reflect the number of Medicaid beneficiaries, the number of uninsured, the number of DSH hospitals, or the number of inpatient hospital days provided to Medicaid beneficiaries. As shown in Figure 3-10 and Table 3-5 on the right, state Medicaid DSH payments as a proportion of total Medicaid spending ranged from under six percent in 26 states and the District of Columbia to twice that percentage (or more) in ten states in 1998. Looking at this variation in another way, total (federal and state) Medicaid DSH payments per Medicaid or uninsured individual averaged $219 in 1997 but ranged from a low of less than $1 in Montana, Nebraska, West Virginia, and Wyoming, to a high of $648 in New Hampshire and $690 in Connecticut.[150]

There is wide variation from state to state in the definition of hospitals that qualify for DSH payments and in the amounts of Medicaid DSH payments that are made to qualifying facilities. Beyond certain minimum standards,

## TABLE 3-5: MEDICAID DSH EXPENDITURES, 1998

| | Expenditures (millions) | | |
|---|---|---|---|
| | Total | DSH | (%) |
| **United States** | **$169,316** | **$14,962** | **(8.8%)** |
| Alabama | 2,330 | 394 | (16.9%) |
| Alaska | 370 | 15 | (4.2%) |
| Arizona | 1,858 | 123 | (6.6%) |
| Arkansas | 1,416 | 2 | (0.1%) |
| California | 18,383 | 2,451 | (13.3%) |
| Colorado | 1,590 | 139 | (8.7%) |
| Connecticut | 2,895 | 370 | (12.8%) |
| Delaware | 422 | 8 | (1.9%) |
| District of Columbia | 742 | 33 | (4.4%) |
| Florida | 6,617 | 371 | (5.6%) |
| Georgia | 3,598 | 410 | (11.4%) |
| Hawaii* | 594 | 0 | (0.0%) |
| Idaho | 449 | 2 | (0.5%) |
| Illinois | 6,648 | 270 | (4.1%) |
| Indiana | 2,600 | 195 | (7.5%) |
| Iowa | 1,447 | 20 | (1.4%) |
| Kansas | 1,070 | 45 | (4.2%) |
| Kentucky | 2,615 | 195 | (7.4%) |
| Louisiana | 3,200 | 738 | (23.1%) |
| Maine | 1,112 | 122 | (11.0%) |
| Maryland | 2,667 | 136 | (5.1%) |
| Massachusetts | 5,601 | 497 | (8.9%) |
| Michigan | 5,663 | 319 | (5.6%) |
| Minnesota | 2,938 | 56 | (1.9%) |
| Mississippi | 1,689 | 184 | (10.9%) |
| Missouri | 3,320 | 666 | (20.1%) |
| Montana | 405 | < 1 | (0.1%) |
| Nebraska | 847 | 6 | (0.7%) |
| Nevada | 528 | 74 | (13.9%) |
| New Hampshire | 768 | 128 | (16.7%) |
| New Jersey | 5,451 | 1,020 | (18.7%) |
| New Mexico | 1,019 | 9 | (0.9%) |
| New York | 26,993 | 1,860 | (6.9%) |
| North Carolina | 4,689 | 354 | (7.6%) |
| North Dakota | 340 | 1 | (0.4%) |
| Ohio | 6,729 | 657 | (9.8%) |
| Oklahoma* | 1,339 | 23 | (1.7%) |
| Oregon | 1,729 | 27 | (1.6%) |
| Pennsylvania | 8,522 | 546 | (6.4%) |
| Rhode Island | 973 | 56 | (5.8%) |
| South Carolina | 2,319 | 446 | (19.2%) |
| South Dakota | 360 | 1 | (0.3%) |
| Tennessee | 3,758 | 0 | (0.0%) |
| Texas | 9,752 | 1,439 | (14.8%) |
| Utah | 688 | 4 | (0.6%) |
| Vermont | 401 | 22 | (5.5%) |
| Virginia | 2,324 | 161 | (6.9%) |
| Washington | 3,345 | 333 | (10.0%) |
| West Virginia | 1,279 | 22 | (1.7%) |
| Wisconsin | 2,719 | 11 | (0.4%) |
| Wyoming | 201 | < 1 | (0.1%) |

*Denotes states where significant amounts of expenditures were either missing or categorized as “unknown” (no reported enrollee group or cash assistance status) in the original data released from HCFA. The estimates shown here rely heavily on supplemental data.

SOURCE: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports. Does not include administrative costs, accounting adjustments, or the U.S. Territories. Total spending including these additional items was about $176.9 billion in FY 1998.

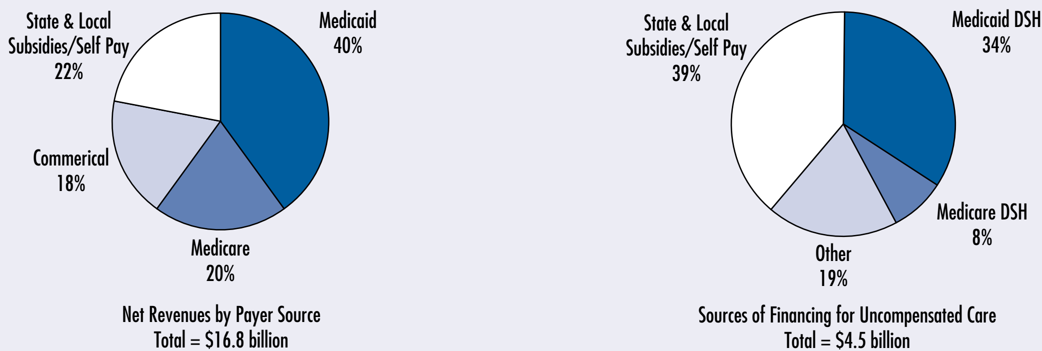
states have wide discretion.[151] For example, some states make large amounts of Medicaid DSH payments to state mental institutions; others make none.[152] This is in sharp contrast to Medicare’s DSH program, under which payments are made following a nationally standardized formula tied to the number of inpatient days attributable to Medicare patients eligible for Supplemental Security Income (SSI) and to the number of Medicaid patients. The national formula ensures that, within classes of hospitals (e.g., urban with 100 or more beds, rural with under 100 beds), similarly-situated hospitals in different states are treated similarly.[153]

Medicaid DSH payments were intended to supplement regular Medicaid payments for inpatient services to public or private hospitals serving large numbers of Medicaid and uninsured patients. (Although DSH payments are tied to Medicaid inpatient services, they may be used by hospitals to help defray the costs of providing outpatient services to Medicaid and uninsured patients.) For many of these “safety net” hospitals, these payments represent a revenue stream critical to their operation. For example, a 1998 survey of 84 public hospitals found that, on average, Medicaid DSH payments accounted for 34 percent of the facilities’ subsidies for uncompensated care. As shown in Figure 3-11 on the next page, the comparable figure for Medicare DSH payments that year was eight percent.

In other instances, however, high percentages of federal Medicaid DSH funds are retained by the states for their general treasuries. A recent Urban Institute survey of 40 states found that, in fiscal year 1997, of the $8 billion in Medicaid DSH payments, only $4.7 billion, or about 60 percent, went to private or local public facilities; the remaining $3.3 billion were either paid to state facilities or withheld by the state. Four states (California, Massachusetts, Missouri, and Texas) retained over $1 billion in federal DSH funds that year.[154]

Medicaid DSH payments are subject to the same federal-state matching rules as apply to Medicaid payments for inpatient hospital, outpatient hospital, or other services. Generally, states contribute the bulk of the non-federal share of Medicaid spending from state general revenues. With respect to DSH payments, however, the sources of non-federal financing differ substantially. Coughlin et al. found that, in state FY 1997, only 19.5 percent of DSH revenues derived from state funds (including transfers from state hospitals). Almost the same proportion—19.0 percent—of DSH revenues came from county or local funds (including transfers from county or local hospitals), and 10 percent came from provider taxes.[155] In some states, such as California and Texas, the entire state share

**Figure 3-11: Net Revenues and Sources of Uncompensated Care for Safety-Net Hospitals, 1998**




Note: Data based on survey of member hospitals of the National Association of Public Hospitals and Health Systems, with 84 hospitals (82% of total membership) responding.
SOURCE: National Association of Public Hospitals and Health Systems: America's Safety Net Hospitals and Health Systems, 1998. October 2000.

of the Medicaid DSH program derives from transfers from counties, special districts, and university hospitals.[156]

As a general rule, Medicaid DSH payments to any particular facility cannot exceed 100 percent of the hospital's costs of treating Medicaid and uninsured patients on an inpatient or outpatient basis, net of any non-DSH Medicaid revenues the hospital receives.[157] The purpose of this cap, which applies in addition to the state-specific allotment for a particular fiscal year, is to limit the ability of states to use DSH hospitals as conduits for the intergovernmental transfer of federal Medicaid funds to state treasuries. Under this cap, a state may cover 100 percent of a facility's cost of treating uninsured patients who are not eligible for Medicaid, as well as any shortfall the hospital experiences in regular Medicaid reimbursement for inpatient or outpatient services provided to program beneficiaries. A state may not, however, pay a facility more than its uncompensated care costs so that the facility may then transfer the excess back to the state at federal expense.

In California, the facility-specific DSH payment cap is set by statute at 175 percent of a facility's Medicaid and uncompensated care costs, net of non-DSH Medicaid revenues. This 175 percent ceiling allows the counties to recover not just their intergovernmental transfers to the state but also most or all of their uncompensated care costs. The ceiling also enables the state to avoid putting any of its own tax revenues into Medicaid DSH payments and instead to use funds transferred from the counties as its share of Medicaid DSH payments to both public and private DSH hospitals.[158] In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Congress extended this policy to all states, raising the facility-specific cap from 100 percent to 175 percent for state and local public hospitals for two state fiscal years beginning after September 30, 2002.[159] This policy change will enable states other than California with county or other local public hospitals to withdraw their own funds as the state share of Medicaid DSH payments and substitute intergovernmental transfers from the counties or localities, at least during this two-year period. The Office of Inspector General has recommended that CMS seek legislation "to at least delay, if not repeal, the implementation of the increase in the DSH limit from 100 to 175 percent of uncompensated care costs until the need for and use of DSH funds for actual direct care of uninsured patients can be sufficiently reviewed."[160]

## Provider Taxes and Donations

Thousands of non-public hospitals, nursing facilities, physicians, and other providers participate in Medicaid, as do hundreds of managed care plans. Until the early 1990s, states were permitted to use revenues derived from special taxes imposed upon, or donations received from, these providers and plans as their state share of Medicaid spending. The details of these provider tax and donation arrangements varied from state to state, but they shared a common characteristic: states reduced their own spending, providers increased their revenues, and the federal government's Medicaid outlays grew.

Commonly, hospitals and nursing facilities would either "donate" funds to state Medicaid programs or agree to be

## The Basic Math of DSH Payments.

Assume that in a state with a 50 percent Medicaid matching rate, a county hospital transfers $10 million to the state Medicaid agency, to which the state adds $2 million and then returns to the hospital in the form of a $12 million DSH payment. The hospital's net gain in DSH payments—that is, actual new resources available to the hospital to cover the unreimbursed costs of serving Medicaid and uninsured patients—is $2 million. The state then claims $6 million from the federal government in DSH matching funds (the 50 percent federal share of the $12 million payment). After reimbursing itself $2 million for the portion of its $12 million DSH payment to the hospital that the county did not transfer to it initially, the state has a gain of $4 million in federal matching funds. The state can apply this $4 million to the state share of payments to private DSH hospitals that cannot make intergovernmental transfers, to the state share of payments to other Medicaid providers such as physicians or MCOs, or to non-Medicaid purposes.

In this scenario, the hospital has benefited less than the state at the expense of the federal government. To increase the hospital's net benefit, without making any contribution of its own, the state could increase the hospital's DSH payment to, say, $20 million. (Under federal law, the state's payment to the hospital is subject to a facility-specific cap as well as a statewide cap; assume for this scenario that the $20 million payment complies with both.) The hospital would then receive a net gain of $10 million (the $20 million payment less its $10 million transfer from the county). The state would receive $10 million in federal Medicaid matching funds on the $20 million payment to the hospital. Unlike the first scenario, the state would not have an extra $4 million in federal DSH matching funds in its general treasury, but it would not incur any cost in making the DSH payment to the hospital ($10 million would come from the county's intergovernmental transfer and $10 million from the federal government). For its part, the federal government would face an increased outlay of $4 million, but all of the increase would flow through to the hospital rather than be retained in the state's treasury.

"taxed" (or subjected to "fees" or "assessments"). States would use the resulting revenues as the state share of expenditures that would qualify for federal Medicaid matching. They would then reimburse the hospitals and nursing homes to compensate them for some or all of the costs of furnishing services to Medicaid beneficiaries in such a way as to hold them harmless for the costs of their "donations" or "taxes." Any residual federal matching funds would be retained by the states and used for other purposes. In the case of hospitals, these transactions were often implemented through DSH payment adjustments.

Not all states engaged in these transactions. Some, however, were particularly aggressive. New Hampshire received about $360 million in federal Medicaid DSH payments in 1991; of this amount, $320 million was diverted to other parts of the state budget, forestalling the need for a state tax increase.[161] A state legislator said, "It was a scam, no question about it. We're funding our judicial system, our highway program, and everything else out of a Medicaid loophole."[162]

In 1991, federal law was amended in an effort to curb such diversion of federal Medicaid matching funds. The amendments focused on greatly restricting the use of revenues from provider taxes or donations as the state share of Medicaid spending. Under the 1991 limitations, states and localities may impose whatever taxes and accept whatever contributions they wish under state law. However, federal Medicaid matching payments will be reduced dollar for dollar by the amount of revenues received by a state or locality from provider taxes or donations that do not meet certain requirements.[163] The requirements that apply to provider donations restrict their use in financing state Medicaid spending to extremely limited situations.[164]

While there is no limit on the amount of revenues a state may receive from provider taxes in order to finance its share of Medicaid costs, such taxes must meet stringent federal statutory requirements designed to ensure that they are legitimate.[165] The federal statute defines a tax or licensing fee, assessment, or other mandatory payment as a "provider tax" if 85 percent or more of its burden falls upon health care providers. In order to be allowable as a Medicaid revenue source, a provider tax must be "broad based," (i.e., it must cover at least all non-federal, non-public providers in a class, such as hospitals, nursing homes, etc.) and it must be imposed uniformly upon every provider in the class. In addition, the state must not have in effect a "hold harmless" provision with respect to the tax (i.e., the state or locality does not provide, directly or indirectly, a payment or offset that holds the provider harmless for any portion of the cost of the tax).

During FY 1995, 34 states and the District of Columbia reported receiving revenues from provider taxes or donations (no information was available with respect to five states). On average, about eight percent of all state

Medicaid spending was raised from provider taxes or donations that year, according to the state reports. There was considerable variation among the states in the degree of reliance on these financing arrangements. In six states (Colorado, Georgia, Kentucky, Missouri, Ohio, and West Virginia), revenues from provider taxes and donations accounted from more than 20 percent of all state Medicaid spending. In contrast, 11 states (Alaska, Arizona, California, Delaware, Idaho, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, and Wyoming) reported no revenues from either of these sources.

State compliance with the federal requirements relating to revenues generated from provider taxes continues to be a matter of dispute between the federal government and certain states. In BBA 1997, the Congress deemed certain taxes, fees, or assessments collected by New York from health care providers prior to June 1, 1997 to be permissible, at an estimated cost to the federal budget of $200 million.[166] In September 1999, CMS notified six states (Hawaii, Illinois, Louisiana, Maine, New York, and Tennessee) that one or more of their provider taxes violated federal law. On June 15, 2000, CMS notified nine states (Alabama, Connecticut, Florida, Hawaii, Massachusetts, Nevada, New Hampshire, New York, and Utah) that certain provider taxes they had imposed could be impermissible and therefore "may operate to shift some of a state's responsibility for a state Medicaid program to the federal government."[167] On November 29, 2001, CMS notified the state of Missouri that a draft audit had found that the state's "Federal Reimbursement Allowance Tax" did not comply with the "hold harmless" requirement of federal law, putting the state at risk for a potential disallowance of more than $1.6 billion.[168]

### The Basic Math of Provider Donations and Taxes

Assume that, before 1991, a state with an FMAP of 57 percent (the national average) imposes a $43 licensing fee exclusively on Medicaid DSH hospitals with the revenues from the fee to be earmarked for Medicaid. It then pays the hospital $100 in DSH payment adjustments. The state claims federal Medicaid matching on the $100 expenditure, and the federal government pays it $57. The state has incurred no net cost (it received $43 from the hospital and $57 from the federal government). The hospital has gained $57 (the $100 DSH payment less its $43 licensing fee). The federal government has paid out $57. If the hospital is a state-owned or operated-facility, part or all of the $57 can be transferred back to the state general treasury. As state funds, the $57 could then be used to make other state Medicaid expenditures that could in turn qualify for additional FFP.

As a result of the 1991 law, the licensing fee would be an illegal provider tax because it is not broad-based and the hospital is held harmless against its cost. The federal government would therefore reduce the state's expenditure ($100) by the revenues from the improper fee ($43) before applying its matching percentage (57 percent). As a result, the federal matching payment on the $100 expenditure would be 57 percent of $57 ($100 minus $43), or $32.50.

## Administrative Claiming for School-Based Services

Most of the 23 million children enrolled in Medicaid in 2001 were of school age. This basic demographic fact gives rise to a number of different interactions between Medicaid and schools. First, schools may be the sites for the delivery of services such as physical, speech, and occupational therapy that they are required provide to children with Individual Education Plans (IEPs) under the Individuals with Disabilities Education Act (IDEA).[169] Second, schools and the school lunch programs they administer may offer a mechanism for identifying and enrolling eligible children in Medicaid.[170] Finally, schools may provide sites for access to preventive and primary care, including health supervision, reproductive health care, and mental health services through school-based health centers.[171] Although school-based services are not a Medicaid benefit category per se, federal Medicaid matching funds are available for the costs of many of the services that school-based health centers (SBHCs) provide to eligible children through benefits categories such as EPSDT, physician, and clinic services.

In recent years, some state and local school districts have billed Medicaid programs not just for primary care or other health services but also for administrative costs. In some instances, state Medicaid programs made "bundled" payments for these services—i.e., a fixed payment for all services assumed to be furnished to a child during a specified period. The absence of sufficient documentation for such payments led CMS in 1999 to restrict the use of "bundled" rate methodologies.[172] Of greater concern, however, was claiming of Medicaid administrative costs by school districts. In ten states reviewed by the General Accounting Office (GAO), state

claims for school-related administrative costs grew from $82 million to $469 million between 1995 and 1998. In some states, the federal administrative matching payments are returned to the school districts that incurred the costs; in others, some of the federal payments are allocated to the state's general treasury. For example, GAO found that since 1996, Michigan has retained for its treasury $106 million of the federal matching funds it has claimed in connection with the provision of school-based services to Medicaid-eligible children.[173] GAO concluded that "… some school district and state practices appear intent on maximizing their receipt of Medicaid funds through suspect financing mechanisms."[174] An Office of Inspector General review of administrative costs claimed by the Florida Medicaid agency based on costs reported by school districts (which are reported as the state's share for purposes of drawing down federal matching payments) found that the amounts claimed included "unallowable costs, unsupported costs, and costs based on improper documentation."[175]

## Intergovernmental Transfers (IGTs) and Upper Payment Limits (UPLs)

In many states, public hospitals play a critical role in delivering covered services to Medicaid beneficiaries. These facilities, whether owned by states or by localities, also often serve as providers of last resort for low-income individuals who are not eligible for Medicaid and who have no other source of coverage.[176] Although they account for only two percent of all hospitals in the country, these facilities provide roughly one-quarter of all uncompensated care nationally and are under enormous financial pressures, especially during periods of economic downturn.[177] The payments that Medicaid makes to these "safety net" providers for treating program beneficiaries—both regular payments for inpatient or outpatient services as well as DSH and other supplemental payments—represent a crucial revenue stream for these institutions (39 percent of net revenues in 1999).[178] The adequacy of Medicaid payments can determine the quality and accessibility of services for both Medicaid beneficiaries and uninsured patients alike.

In recent years, however, a number of states have used local public institutions as conduits for importing federal Medicaid matching dollars into their general funds. Under these arrangements, a hospital operated by a county or other locality was reimbursed by the state Medicaid agency for treating program beneficiaries in amounts that substantially, and in some cases vastly, exceeded the costs of treatment. So long as the payments to a particular facility did not result in the breach of an aggregate upper payment limit (UPL) applicable to all hospitals, the federal government would match the full amount of the reimbursement at the state's regular Medicaid matching rate. The state, after paying the local provider, would retain some of the federal government's share for its own uses. In some states, local public nursing homes were the conduits rather than hospitals. In either case, these arrangements came under intense criticism from the GAO[179] and the HHS Office of Inspector General (OIG).[180] As CBO observed, the number of states with such arrangements "grew rapidly in 2000 as more states learned about UPL financing mechanisms and hurried to enact them—and received additional federal funds—before the federal government moved to curb the practice."[181]

The amounts at issue are substantial. In January 2001, 2001, CMS promulgated a regulation establishing new rules for applying aggregate UPLs.[182] The new rules took effect on March 13, 2001. CBO estimated that, in the absence of the regulation, UPL-related federal Medicaid spending would have totaled $160 billion over the 2001-2010 period.[183] Although the new rules will significantly reduce this outflow,[184] they continue to allow for a large amount of additional federal expenditures. CBO estimates that, over the five-year period FY 2001–FY 2005, $36.3 billion in federal funds will flow through these arrangements. In comparison, federal Medicaid DSH payments over this same period are projected to total $42.3 billion.[185]

There are two features of Medicaid law that, in combination, enabled such arrangements prior to the January 2nd regulation. The first was the recognition of transfers of funds from localities to the state—IGTs—as a legitimate source of the state share of Medicaid expenditures. The second was the authorization that the amount of Medicaid payment to individual public hospitals or nursing homes could exceed the costs of providing services at particular facilities, so long as an aggregate ceiling on payments was not breached. (With the repeal of the "Boren" amendment in 1997, the federal government no longer requires that Medicaid payment rates for inpatient hospital and nursing facility services be "reasonable").

IGTs made by localities from their own tax revenues to a state's Medicaid program are a legitimate way for a state to pay its share of Medicaid expenditures for covered services on behalf of eligible beneficiaries. As a legal matter, localities are generally creatures of state government and derive their taxing authorities from the state. Local tax revenues are therefore of the same character as state tax revenues from the standpoint of a

federal-state matching program like Medicaid. This is recognized in the federal Medicaid statute, which expressly exempts IGTs derived from permissible state or local taxes from the restrictions it imposes on provider taxes and donations.[186] It is also recognized in federal regulations, which authorize the use of public funds as the state share of Medicaid spending if the funds are "transferred from other public agencies (including Indian tribes) to the state or local [Medicaid] agency and under its administrative control …"[187]

The second enabling element was the manner in which the aggregate upper payment limits (UPLs) on Medicaid reimbursements were applied. Prior to March 13, 2001, CMS regulations imposed a UPL on aggregate payments to all hospitals (state, county, and private) as a group; a UPL on aggregate payments to all nursing homes (state, county, and private) as a group; and a UPL on outpatient hospital services and clinic services. In each instance, the UPL was the amount "that can reasonably be estimated would have been paid under Medicare payment principles." In addition, an UPL was imposed on aggregate payments to state-operated hospitals for inpatient services and a separate UPL was imposed on aggregate payments to state-operated nursing homes. However, no UPL applied to aggregate payments to county-operated hospitals and no UPL applied to aggregate payments to county-owned nursing homes.

In combination, the IGT authority and the absence of an aggregate UPL on Medicaid payments to county-operated hospitals or to county-owned nursing homes enabled states to generate federal Medicaid matching funds for their treasuries.[188] States were able to pay county-operated facilities far in excess of their costs of serving Medicaid patients so long as the total payments did not exceed the amount of "room" available under the aggregate UPLs to all non-state facilities. This "room" results from state Medicaid payment rates far below rates that would be paid under Medicare payment principles. These excess payments to county-owned facilities could then be returned to the state treasury via an IGT.[189]

***Implications for Medicaid Financing.*** These UPL arrangements distort Medicaid financing in four important ways. First, they make federal matching funds available for purposes other than purchasing covered health and long-term care services for eligible low-income individuals. A number of states have used some or all of the federal Medicaid matching funds received through UPL transactions for general state budgetary purposes. For example, the *Wichita Eagle* reported on February 19, 2000, that the Governor of Kansas had announced his intention to seek federal Medicaid matching funds precisely for this purpose:

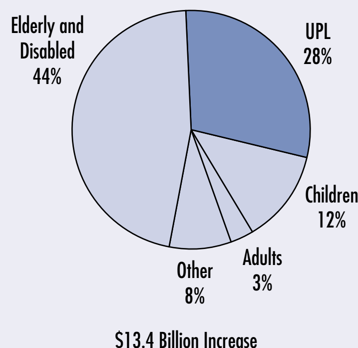
> "The federal government may provide the money to solve the state's budget woes, Gov. Bill Graves said Friday. State bureaucrats learned of a little-known federal program that could provide Kansas with more than $100 million, Graves said. The money would come from the Health Care Financing Administration—the same agency that runs Medicare and Medicaid. The money Graves wants to tap is usually earmarked by the federal government for nursing home care. But an accounting trick used by other states could allow Kansas to send the money to nursing homes on the condition that they send it back so the state can spend it elsewhere. Staff members of the Department of Aging became aware of the strategy from Nebraska colleagues while attending a conference a couple of months ago, department officials said."[190]

Many of the states with UPL arrangements (including Kansas) enacted tax cuts prior to 2001. According to the Center on Budget and Policy Priorities, 16 of the 28 states using or proposing to use UPL arrangements as of September 2000 cut taxes for that year.[191]

The second important distortion is that federal Medicaid spending on UPL programs inflates the rate of overall Medicaid spending growth without a commensurate increase in spending for services provided to Medicaid enrollees. As shown in Figure 3-12, nearly 30 percent of the growth in federal Medicaid spending between 2000 and 2001 was attributable to growth in UPL spending. In contrast, spending for children accounted for only 12 percent of spending growth, even as 1.6 million additional children were enrolled in the program during that year.[192] If there had been no increase in UPL spending that year, overall federal Medicaid spending would have grown by 8.3 percent, not 11.4 percent, while actual spending on covered services for eligible individuals would likely not have increased at all.

The third distortion created by UPL arrangements is the incentive for states and localities to reduce their own funding for the hospitals and nursing homes they operate and to replace their funds with federal dollars. For example, Cook County, Illinois operates one of the largest "safety net" hospitals in the country. An audit by the OIG found that from 1991 until 2000, UPL transactions between the state Medicaid agency and Cook County resulted in the payment of $2.9 billion in federal matching funds at no cost to the state. Of this amount, $867 million was deposited in the state's General Revenue Fund, while the remaining $2.0 billion was

**Figure 3-12: Sources of Growth in Federal Medicaid Expenditures, 2000–2001**




Note: Federal Medicaid expenditures grew from $117.3 billion in FY 2000 to $130.7 billion in FY 2001, an increase of $13.4 billion. These calculations exclude SCHIP expansion payments and reconciliation with SCHIP.

SOURCE: KCMU analysis of CBO Medicaid baseline fact sheet issued in April, 2001.

retained by the County. The audit noted that, although the County had opened an additional hospital and several new clinics in the 9 years since the UPL transactions began, the County's annual tax-levy contribution to all of its hospitals and clinics dropped from $296 million in 1991 to $247 million in 2000, or 16 percent.[193]

Finally, states are able to use UPL arrangements to raise the federal share of total Medicaid funding far above their nominal, statutory federal matching rate. For example, the OIG estimates that the effect of the UPL transactions in Pennsylvania during 1999 was to raise that state's actual matching rate for FY 2000 from 54 percent under the statutory formula to 65 percent.[194] Similarly, OIG auditors estimated that, in Alabama, UPL transactions involving county-owned nursing facilities effectively increased the federal matching rate from the statutory 70 percent to about 78 percent through the following mechanism: "The state initially received approximately 70 percent of federal matching dollars when it made the enhanced payments to the nursing facilities and reported them as program expenses. When [almost all] of the enhanced payments came back to the state from the nursing facilities, the state used those funds for other Medicaid expenditures. These expenses were reported, and in turn, the state received federal matching funds. Thus, there was a federal match on the original enhanced payments and a Federal match on the second use of the enhanced payments. This recycling of the funds had the effect of increasing the overall Federal share."[195] Increasing the federal share means increasing federal Medicaid outlays without a corresponding increase in the number of Americans enrolled, the scope of services covered, or the adequacy of provider reimbursement levels.

A number of states argue that federal Medicaid matching funds received through UPL transactions are used for general health care needs of state residents who are not Medicaid beneficiaries. For example, an OIG audit concluded that in Washington state, "it appeared that most of the [federal matching funds retained by the state] were either designated or used for state health care needs, regardless of a person's Medicaid eligibility."[196] In many cases, however, it is not possible to determine the disposition of the federal Medicaid dollars transferred back to the state treasury. For example, the OIG audit of the Illinois UPL arrangements concluded: "At the state level, we could not determine how the windfall revenues were used. The $866.6 million returned to [the state Medicaid agency] by Cook County was deposited directly to the state's General Revenue Fund and traceability of these funds was lost. Although [state Medicaid agency] staff strongly contend that the deposits to the General Revenue Fund resulted in corresponding increases in spending for health care programs, there was no assurance that the funds were used in this manner."[197] Overall, the OIG has identified 28 states using UPL arrangements as of October 2000 (Table 3-6).

***Federal Policy Changes: March 13, 2001 and Beyond.*** In BIPA 2000, the Congress directed the Secretary of HHS to issue a final regulation revising the agency's UPL policies.[198] The regulation was to establish UPLs for payments made for inpatient hospital services, nursing facility services, and outpatient hospital and clinic services to government facilities that are not state-owned or operated. The regulation was to contain a transition period to give those states with UPL arrangements in place since 1992 until the end of FY 2008 to bring themselves into full compliance with the new UPLs.

On January 12, 2001, the Secretary issued a final regulation that revised the previous UPL policy effective March 13, 2001.[199] As directed by the Congress, the regulation established a UPL on aggregate payments to county-owned or operated nursing homes and hospitals. It did so by establishing separate UPLs for inpatient hospital services with respect to 3 groups of facilities: hospitals owned or operated by a state; hospitals owned or operated by a locality (or other non-state governmental entity); and hospitals that are privately owned or operated.[200] As under current law, the UPL on inpatient hospital services would not apply to Medicaid DSH payments. The regulation also imposed separate UPLs on payments for nursing facility services, on payments for intermediate care facility (ICFs/MR) services for the mentally retarded, and on payments for outpatient

## TABLE 3-6: MEDICAID UPPER PAYMENT LIMIT PROGRAMS BY TYPE AND FISCAL IMPACT, FY 2000

| State[1] | Program Types: Inpatient Hospital | Outpatient Hospital | Nursing Facility | Annual Federal Fiscal Impact* |
|---|---|---|---|---|
| Alabama | ✓ | ✓ | ✓ | $141,600,000 |
| Alaska | ✓ | | | $12,000,000 |
| Arkansas | | ✓ | | $40,700,000 |
| California | ✓ | | | $754,300,000 |
| Georgia | ✓ | ✓ | | $402,500,000 |
| Illinois | ✓ | ✓ | | $569,500,000 |
| Indiana | ✓ | ✓ | | $136,400,000 |
| Iowa | | | ✓ | $127,500,000 |
| Kansas | | | ✓ | $77,800,000 |
| Louisiana | | | ✓ | $483,000,000 |
| Michigan | ✓ | ✓ | ✓ | $306,200,000 |
| Minnesota | | | ✓ | $4,800,000 |
| Missouri | ✓ | | ✓ | $76,300,000 |
| Montana | ✓ | | | $700,000 |
| Nebraska | | | ✓ | $55,400,000 |
| New Hampshire | | | ✓ | $14,200,000 |
| New Jersey | | | ✓ | $448,000,000 |
| New Mexico | ✓ | | | $31,300,000 |
| New York | | | ✓ | $495,800,000 |
| North Carolina | ✓ | | | $149,600,000 |
| North Dakota | | | ✓ | $25,900,000 |
| Oregon | ✓ | | ✓ | $48,700,000 |
| Pennsylvania | | | ✓ | $858,100,000 |
| South Carolina | ✓ | | | $48,600,000 |
| South Dakota | | | ✓ | $20,500,000 |
| Tennessee | | | ✓ | $248,300,000 |
| Washington | ✓ | | ✓ | $91,500,000 |
| Wisconsin[2] | | | ✓ | $105,000,000 |
| Total (28 States) | 14 | 6 | 18 | $5,774,200,000 |

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

[2] Wisconsin also received approval for an additional UPL program after the publication of the OIG report. GAO estimates that this program will result in $504 million in additional federal payments to Wisconsin over FY 2000 to FY 2002.

*These estimates represent only the annual initial federal payment under each state's plan amendment(s) as of October 2000. States may use these funds as their state share of Medicaid expenditures, drawing down additional federal matching funds.

SOURCE: *OIG Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers* (September 2001), A-03-00-00216, Appendix B.

hospital and clinic services, in each case using the tripartite framework of state, non-state public, and privately owned and operated facilities.[201]

Although the stated effective date of the final regulation was March 13, 2001 CMS approved state plan amendments after that date that reflected the previous UPL policy. CMS approved Wisconsin's UPL arrangement, which involves additional federal payments estimated at $504 million, on May 8; it approved Virginia's UPL arrangement on June 4 at a cost to the federal treasury of an estimated $218 million. In reviewing these approvals at the request of the Senate Finance Committee, the GAO found CMS' actions "troubling: at the same time that [CMS] was attempting to close a glaring loophole, it allowed additional states to engage in the very schemes it was trying to shut down, at a substantial additional cost".[202]

Even for state UPL arrangements approved before January 12, 2001, the stated effective date of March 13, 2001 is modified by transition rules. The regulation contains the 8-year transition period specified by BIPA 2000 for Pennsylvania and other states with UPL arrangements approved prior to October 1, 1992 to bring themselves into compliance with the new UPLs. The regulation also provides for a 5-year transition period allowing states with UPL arrangements effective before October 1, 1999 to gradually bring themselves into full compliance by state FY 2006. For UPL arrangements effective on or after October 1, 1999, and approved before January 22, 2001, the regulation provides a transition period extending through September 30, 2002. A subsequent regulation provided yet another transition period for states with UPL arrangements submitted to CMS prior to March 13, 2001 and approved on or after January 22, 2001.[203]

These transition periods apply regardless of a state's fiscal circumstances and regardless of the purposes for which a state uses the federal Medicaid matching funds it receives through its UPL arrangements. The HHS Office of Inspector General estimates that these transition periods will allow Pennsylvania to receive an additional $5.4 billion in unrestricted federal matching payments and Illinois $3.8 billion.[204]

The January 12, 2001, regulation created two tiers of UPLs. In the case of nursing facilities (whether state, county, or private), and in the case of state and private hospitals, the UPL is a reasonable estimate of 100 percent of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles. However, in the case of county hospitals or other public hospitals not owned or operated by states, the UPL is set at 150 percent of a reasonable estimate of the amount that would be paid for the services furnished by the hospitals under Medicare payment principles. This 150 percent limit applies to the inpatient hospital UPL and to the outpatient hospital and clinic UPL. Thus, a state may pay a local public hospital as much as 50 percent more than its costs of providing both inpatient and outpatient care to Medicaid patients and receive federal matching funds for these payments. As under current law, the hospital may be allowed to retain the payments or it may transfer some or all of the funds back to the state treasury.

This creates a very attractive refinancing opportunity for states. Assume that a public hospital's costs of providing inpatient services to Medicaid patients are $100, and that the state's matching rate is 50 percent. Assume further that the hospital makes an intergovernmental transfer of $50 to the state, and the state then pays the hospital $150. The state may then claim $75 in federal Medicaid matching payments. The hospital nets $100 from the transaction, or 100 percent of the hospital's costs of treating Medicaid patients. The state pays only 25 percent of these costs, not 50 percent, while the federal government picks up 75 percent. If the federal matching rate for this state were 70 percent instead of 50 percent, the state could claim $105 in federal matching payments. This would allow the hospital to net $100 entirely at federal expense. Not only would the state not contribute any of its own funds to the hospital's costs of treating Medicaid patients, but the federal government would in effect pay it an additional $5 for its unrestricted use.

CMS justified the 150 percent UPLs, which it estimated would cost the federal government $4 billion in Medicaid matching payments through 2006, on the basis of "the special mission of these public hospitals and their important role in serving the Medicaid population."[205] At the same time, it acknowledged its "concerns as to whether these higher payments would, in fact, be retained by these hospitals to allow them to provide needed services to the Medicaid population."[206] The National Association of Public Hospitals and Health Systems (NAPH) argues that the 150 percent limit "allows Medicaid payments to more fully reflect the value of public hospitals' services and to assist with the extreme stresses and uncertainties in the financing of public hospitals."[207] NAPH also points out that the January 12 regulations require that states using the 150 percent UPLs report annually to CMS (1) the amount of Medicaid payments they make to each local public hospital and (2) a reasonable estimate of the amount that would be paid for each hospital's services under Medicare principles.[208]

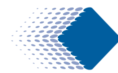
On January 18, 2002, CMS published a final rule prohibiting states from using the 150 percent UPL for local public hospitals contained in the January 12, 2001 rule. The new regulation takes effect in all states as of March 19, 2002.[209] CMS estimates that the new policy will result in federal savings of $9 billion over the 5-year period FY 2002–2006.[210] CMS justified the rule as "part of this Administration's efforts to restore fiscal integrity to the Medicaid program and reduce the opportunity for abusive funding practices based on payments unrelated to actual covered Medicaid services."[211]

## VIII. CONCLUSION

The defining characteristic of Medicaid's financing structure is its open-ended federal matching arrangement. This financing structure enables states at their option to draw down federal funds without limit to help pay the costs they incur in providing basic medical care and

long-term care services for their low-income populations. States facing increased program costs due to rising caseloads resulting from an economic downturn can rely on the additional federal Medicaid funds to pay a large part of the cost of this increased caseload. States seeking to reduce the number of uninsured residents can receive additional federal Medicaid funds to match the costs of liberalizing eligibility rules or increasing enrollment rates among eligible individuals. States that want to improve payment rates to providers or managed care plans to enable them to furnish services of acceptable quality may obtain federal matching funds for the costs of these enhancements. In each case, the state may draw down these resources without seeking a special appropriation from Congress or a waiver from the Secretary of HHS.

In order to take advantage of Medicaid's federal financing opportunity, states must fund their share of Medicaid's cost from state or local funds. Over time, however, many states have turned to "Medicaid maximization" strategies to draw down additional federal funds. Although some forms of Medicaid maximization fulfill federal policy goals, others are more problematic, and some states have exploited Medicaid's financing structure in order to draw down federal matching funds without spending their own. This can divert federal funds intended for coverage of low-income Americans to other uses and generally makes the program appear more costly than it actually is.



# Endnotes

1 Section 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. 1396a(a)(30)(A).

2 CBO projections are for federal fiscal year 2002. Federal Medicaid outlays are projected to be $130 billion; total federal on-budget outlays (discretionary and mandatory spending) are projected to be $1,491 billion. Accessed on www.cbo.gov on April 1, 2002, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2002,* Congressional Budget Office, May 2001, Tables 5 and 10.

3 A survey of direct personal health expenditures by the states in 1999 found that Medicaid accounted for 73 percent of state health care spending, followed by spending for state employees (8%), public health services (6%), community-based services (6%), state facility-based services (3%), higher education health care (2%), corrections (1%), and state insurance and access expansion (< 1%)., National Association of State Budget Officers, *1998–1999 State Health Care Expenditure Report,* Milbank Memorial Fund, 2001, p. 3.

4 For a brief overview of Medicaid, see *Medicaid: A Primer,* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, March 2001. Accessed on www.kff.org on April 1, 2002.

5 See *The Uninsured: Briefing Charts,* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, The Henry J. Kaiser Family Foundation, April 2001; and *In Their Own Words: The Uninsured Talk about Living Without Health Insurance,* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, September 2000. Accessed on www.kff.org on April 1, 2002.

6 Spillman, "Public Health Coverage for Adults: How States Compare," *New Federalism: National Survey of America's Families,* July 2000, Series B, No. B-22, p. 2. Accessed on www.urban.org on April 1, 2002.

7 In 1999, 36 percent of the uninsured had incomes below 100 percent of the federal poverty level and 29 percent had incomes between 100 and 200 percent of poverty. *The Uninsured: Briefing Charts,* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, April 2001, p. 1.

8 *Health Insurance Coverage in America—1999 Data Update,* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, December 2000.

9 *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures: Findings from a 50-State Survey,* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, October 2000, Table 1. Accessed on www.kff.org on April 1, 2002.

10 The Urban Institute estimates that in 1998, 71 percent of all non-elderly individuals nationwide had private or other non-Medicaid coverage, that 10 percent had Medicaid coverage, and that the remaining 18 percent were uninsured. *Uninsured in America: A Chart Book,* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, May 2000, 2nd Ed., pp. 47–51. Accessed on www.kff.org on April 1, 2002.

11 Ibid, pp. 47-51

12 For state-by-state Medicaid data, including data on expenditures and managed care, see the State Health Facts, Henry J. Kaiser Family Foundation website at www.statehealthfacts.kff.org/. Accessed on April 1, 2002.

13 For a discussion of Medicaid eligibility for various populations, see Chapter 1, *Medicaid Eligibility.*

14 See Chapter 2, *Medicaid Benefits.*

15 For a discussion of the "race-to-the-bottom" theory in the context of Medicaid, see Thompson, F., and Dilulio, J. (eds.), *Medicaid and Devolution: A View from the States,* Brookings Institution, 1998, pp. 271–274.

16 Kates, J., *Financing HIV/AIDS Care: A Quilt with Many Holes,* October 2000, The Henry J. Kaiser

Family Foundation, p. 4. Accessed on www.kff.org/content/2000/1607/ on April 1, 2002.

17 Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid,* 1974, pp. 57–61.

18 This requirement, originally in section 1903(e) of the Social Security Act, was repealed by the 1972 Social Security Act Amendments.

19 Holahan, Weiner, and Wallin, *Health Policy for the Low-Income Population: Major Findings from the Assessing the New Federalism Case Studies,* The Urban Institute, November 1998, Occasional Paper Number 18, p. 53.

20 Holahan, *op. cit.,* note 27.

21 For a discussion of the factors explaining the differences in per beneficiary spending between California and New York, see Sparer, M., *Medicaid and the Limits of State Health Reform,* Temple University Press, 1996.

22 See Boyd, D., "Medicaid Devolution: A Fiscal Perspective," *Medicaid and Devolution: A View from the States,* Brookings Institution, 1998, pp. 76–90.

23 *Medicaid Coverage During A Time of Rising Unemployment,* December 2001, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation. Accessed on www.kff.org/content/2001/4026/4026.pdf, on April 1, 2002.

24 See Guyer, J., *The Role of Medicaid in State Budgets,* October 2001, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation. Accessed on www.kff.org/content/2001/4024/4024.pdf on April 1, 2002.

25 Section 2102(b)(4) of the Social Security Act provides that "[n]othing in this title shall be construed as providing an individual with an entitlement to [services covered under a state's CHIP program]." An analysis of SCHIP enabling legislation in 34 states found no individual entitlement. See Rosenbaum, S. and Smith, B., *Policy Brief #1: State SCHIP Design and The Right To Coverage,* GW Center for Health Services Research and Policy, 2001. Accessed on www.gwhealthpolicy.org on April 1, 2002.

26 *April 2001 Baseline Medicaid and State Children's Health Insurance Program,* Congressional Budget Office, May 18, 2001.

27 Wachino, V. and Schlobohm, A., *Federal Budget Chart Book 2001,* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, June 2001, p. 11. Accessed on www.kff.org on April 1, 2002.

28 *Budget of the United States Government, Fiscal Year 2001: Historical Tables,* Office of Management and Budget, Table 12–3.

29 Ibid.

30 The other sources of state general revenues are taxes, current charges (e.g., tuition revenues from state universities), and other (e.g. net lottery receipts). Merriman, "What Accounts for the Growth of State Government Budgets in the 1990s?" *New Federalism: Issues and Options for States,* Urban Institute, July 2000, Series A, No. A-39, pp. 2–5.

31 Leonard, Walder, and Acevedo, *The Federal Budget and the States: Fiscal Year 1998,* 1999, pp. 5 and 38. Accessed on www.ksg.harvard.edu/taubmancenter on April 1, 2002.

32 Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, 45 C.F.R. 80.1 et seq.

33 Title VII of the Civil Rights Act of 1964, 42 U.S.C. 2000e.

34 Age Discrimination Act of 1975, 42 U.S.C. 6101 et seq., 45 C.F.R. Part 91.

35 Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. 12132 (Title II), 28 C.F.R. Parts 35 and 36.

36 Rosenbaum, *The Olmstead Decision: Implications for Medicaid,* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, March 2000. Accessed on www.kff.org on April 1, 2002.

37 The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, analysis is based on data provided in Tables 14 and 41 of the National Association of State Budget Officers' (NASBO) *1998–1999 State Health Care Expenditure Report,* co-published by NASBO, the Milbank Memorial Fund, and the Reforming States Group, March 2001, available at www.milbank.org. Accessed on April 1, 2002. This disparity reflects clear differences in policy preferences detailed in Sparer, *Medicaid and the Limits of State Health Reform,* Temple University Press, 1996.

38 See *Medicaid: A Primer,* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, March 2001. Accessed on www.kff.org on April 1, 2002.

39 In a 1992 analysis, the Congressional Research Service identified the first three of these periods: the early years (1966–1974); spending growth without beneficiary increases (1975–1981); a moderate period of program spending growth (1982–1988). *CRS, Medicaid Source Book: Background Data and Analysis (A 1993 Update),* Committee on Energy and Commerce Print 103-A, January 1993, pp. 82–90.

40 See *The Medicaid Cost Explosion: Causes and Consequences,* The Kaiser Commission on the Future of Medicaid, 1993.

41 *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government,* General Accounting Office, August 1994, (GAO/HEHS-94-133).

42 See Bruen and Holahan, *Medicaid Spending Growth Remained Modest in 1998, But Likely Headed Upward,* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, February 2001.

43 *April 2001 Baseline Medicaid and State Children's Health Insurance Program,* Congressional Budget Office, May 18, 2001.

44 Estimates from CMS. See www.hcfa.gov/stats/NHE-Proj/proj2000/tables/. Accessed on April 1, 2002.

45 *The Budget and Economic Outlook: Fiscal Years 2002–2011,* Congressional Budget Office, January 2001, pp. 81–82, www.cbo.gov.

46 *Long-Term Budgetary Pressures and Policy Options,* Congressional Budget Office, May 1998, p. 46.

47 *April 2001 Baseline Medicaid and State Children's Health Insurance Program,* Congressional Budget Office, May 18, 2001.

48 Vic Miller projects that in 22 states, FMAPs will increase between FY 2002 and FY 2003, while in 18 states FMAPs will decline, due to changes in personal income for calendar year 2000 and the April 2000 decennial census count. *Issue Brief 01-24: Preliminary 2003 FMAPs,* Federal Funds Information for States, April 25, 2001, Table 2.

49 Vic Miller has estimated that for FY 2003, these same states would have the following FMAPs but for the 50 percent floor: C0 (46.3%); CT (15.5%); DE (49.1%); IL (46.1%); MD (41.3%); MA (29.6%); NH (44.9%); NJ (30.3%); NY (39.0%). *Issue Brief 01-24: Preliminary 2003 FMAPs,* Federal Funds Information for States, April 25, 2001, Table 2.

50 *Changing Medicaid Formula Can Improve Distribution of Funds to States,* General Accounting Office, March 9, 1983, (GAO/GGD-83-27); *Medicaid:Alternative for Improving the Distribution of Funds,* General Accounting Office, May 20, 1991, (GAO/HRD-91-66FS).

51 Section 1905(b)(4) of the Social Security Act, 42 U.S.C. 1396d(b)(4). The enhanced rate under SCHIP is calculated by reducing the state's share under its Medicaid FMAP by 30 percent; the highest possible enhanced matching rate is 85 percent. Section 2105(b) of the Social Security Act, 42 U.S.C. 1397ee(b). Thus, the enhanced FMAP in a state with a 50 percent Medicaid FMAP is 65 percent; in a state with a 70 percent FMAP, 79 percent.

52 *State Expenditure Report 1999,* National Association of State Budget Officers, June 2000, p. 4.

53 *The Fiscal Survey of States: June 2001,* National Association of State Budget Officers, August 2001, p. 2. Accessed on www.nasbo.org/Publications/PDFs/FSJUN2001.pdf on April 1, 2002.

54 Offner, *The Devolution Revolution: Medicaid and the States,* A Century Foundation Report, 1999, p. 14.

55 Merriman, "What Accounts for the Growth of State Government Budgets in the 1990s?" *New Federalism: Issues and Options for States,* Urban Institute, July 2000, Series A, No. A-39.

56 *Medicaid "Mandatory" and "Optional " Eligibility and Benefits,* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, June 2001, Figure 11.

57 The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, analysis is based on data provided in Tables 14 and 41 of NASBO's *1998–1999 State Health Care Expenditure Report,* co-published by NASBO, the Milbank Memorial Fund, and the Reforming States Group, March 2001, available at www.milbank.org. Accessed April 1, 2002.

58 Unpublished data from the National Association of Counties, 2001.

59 42 CFR 433.51(c).

60 42 C.F.R. 430.40.

61 42 C.F.R. 430.42.

62 The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, analysis is based on CMS-64 financial management reports and unpublished data provided by CMS's Division of Financial Management, 2001.

63 42 C.F.R. 430.60 et seq.

64 See chapter 1, *Medicaid Benefits.*

65 See Lambrew, J., *Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program,* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, July 2001. Accessed on www.kff.org/content/2001/4001/ on April 1, 2002.

66 This budget neutrality requirement is regulatory, not statutory, in origin. CMS, "Budget Neutrality of Comprehensive Section 1115 Waiver Demonstrations" (December 1996) states, "To ensure budget neutrality, CMS places a limit on the amount of Federal Financial Participation (FFP) that the state can receive during the demonstration period. … States must choose one of two methods for calculating the expenditure limit—the per capita method or the aggregate method. The per capita method allows the benefits component of the expenditure limit to vary depending on actual enrollment during the demonstration (the DSH component is calculated separately) … . Under the aggregate method, the expenditure limit does not vary with actual enrollment … the expenditure limit is a fixed amount."

67 Letter of Secretary Thompson to Representative Waxman, House Committee on Government Reform, July 25, 2001, *Responses to Questions for the Department of Health and Human Services,* Enclosure 1.

68 Lambrew, *op cit.,* Figure 3.

69 Lambrew, *op. cit.,* p. 11.

70 Examples include Maryland and Oregon. See Gold et al., *Managed Care and Low-Income Populations: A Case Study of Managed Care in Maryland,* May 1999; and Mittler et al., *Managed Care and Low-Income Populations: Four Years' Experience with the Oregon Health Plan,* May 1999. Accessed on www.kff.org on April 1, 2002.

71 Examples of this approach include New York and Tennessee, although both waivers also involve reliance on managed care. See Aizer et al., *Managed Care and Low-Income Populations: Four Years' Experience with Tenncare,* May 1999. Accessed on www.kff.org on April 1, 2002.

72 *State Policies in Brief: Medicaid Family Planning Waivers,* Alan Guttmacher Institute, August 1, 2001. Accessed on www.agi-usa.org/pubs/spib_MFPW.pdf on April 1, 2002.

73 See Health Systems Research, *Medicaid Coverage of Family Planning Services,* The Henry J. Kaiser Family Foundation, September 2000. Accessed on www.kff.org on April 1, 2002.

74 Long and Zuckerman, "Urban Health Care in Transition: Challenges Facing Los Angeles County," *Health Care Financing Review,* Fall 1998, pp. 45–58.

75 Accessed on www.hcfa.gov/medicaid/1115/statesum.pdf on April 1, 2002.

76 Brennan, N., Guterman, S., and Zuckerman, S., *The Health Care Safety Net: An Overview of Hospitals in Five Markets,* April 2001, p. 9. Accessed on www.kff.org/content/2001/2250/2250.pdf on April 1, 2002.

77 Lambrew, op. cit., Figure 3 Note.

78 Letter to State Medicaid Directors, May 31, 2000. Accessed on www.hcfa.gov/medicaid/letters/smd531a0.htm on April 2, 2002. See Kahn J.G., Haile B., Kates J., Chang S. "Health and Federal Budgetary Effects of Increasing Access to Antiretroviral Medications for HIV by Expanding Medicaid." *American Journal of Public Health,* 2001; 91: 1464–1473. Note that at the time of publication, only Massachusetts had implemented its waiver and that Georgia had submitted a waiver proposal that had not yet been approved.

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80 *Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative,* CMS, August 2000, Accessed on www.hcfa.gov/medicaid/letters/smd531a0.htm on April 2, 2002.

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84 42 C.F.R. 435.217.

85 Section 1915(c)(2)(D) of the Social Security Act, 42 U.S.C. 1396n(c)(2)(D), specifies that budget neutrality for purposes of an HCBS waiver means that the "average per capita expenditure under the waiver in a fiscal year for individuals receiving waiver services does not exceed 100 percent of average per capita expenditure for individuals receiving waiver services if waiver had not been granted." 42 C.F.R. 441.300-441.310.

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90 Rosenbaum, *The Olmstead Decision: Implications for Medicaid,* March 2000, p. 6.

91 The HHS Assistant Secretary for Planning and Evaluation is testing the effects of "cashing out" personal assistance services for Medicaid beneficiaries in three states (Arkansas, Florida, and New Jersey). Under this "cash and counseling" demonstration, beneficiaries are randomly assigned to one of two groups: one in which beneficiaries receive case-managed personal care services in traditional fashion from providers and agencies that are reimbursed by Medicaid, the other in which participants receive a monthly cash payment to purchase services on their own. Accessed on www.aspe.hhs.gov/daltcp/projects.htm#Umd1. on April 2, 2002.

92 Note that, in terms of enrollment, Medicaid is predominantly a managed care program; CMS reports that as of 1999, 17.8 million Medicaid beneficiaries, representing 55.6 percent of all Medicaid beneficiaries were enrolled in managed care plans (both risk-based managed care organizations and fee-for-service primary care case management arrangements). *Medicaid and Managed Care.* The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, February 2001. Accessed on www.kff.org on April 1, 2002.

93 CBO projects a total of $65.3 billion in federal Medicaid acute care spending in FY 2001 (other than for Medicare premium subsidies), of which $48.8 is fee-for-service payments. *April 2001 Baseline Medicaid and State Children's Health Insurance Program,* Congressional Budget Office, May 18, 2001.

94 Section 1902(a)(13)(B) of the Social Security Act, 42 U.S.C. 1396a(a)(13)(B), requires that states offering hospice benefits pay for those services in amounts "no lower than," and using the same methodology as, under Medicare. For a discussion of Medicaid hospice payment, see Tilly, J., and Wiener, J., *Medicaid and End-of-Life Care,* Spring 2001, pp. 14–16. Accessed on www.lastacts.org/files/publications/medicaid.pdf on April 2, 2002.

95 The "Boren" Amendment required states to pay for inpatient hospital and nursing facility services "through the use of rates … which the State finds,

and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards … ."

96 One former Medicaid director writes, "In preparing state Medicaid budgets, the 'Boren' Amendment became the overriding concern. Since institutional costs (covered by 'Boren') constituted over half of most states' Medicaid budgets, and these had to rise at something resembling the inflation rate, that is where the money went. Usually, there was little left over for noninstitutional practitioners like doctors, dentists, and community clinics, which provided much of the primary care." Offner, *The Devolution Revolution: Medicaid and the States,* A Century Foundation Report, 1999, pp. 16–17.

97 Section 1902(a)(13)(A)(i), (ii), (iii) of the Social Security Act, 42 U.S.C. 1396a(a)(13)(A)(i), (ii), (iii).

98 Section 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. 1396a(a)(30)(A).

99 42 C.F.R. 447.272(a). as revised at 66 Fed. Reg. 3175,January 12, 2001.

100 42 C.F.R. 447.272(b), as revised at 66 Fed. Reg. 3175, January 12, 2001.

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102 Section 1902(a)(13)(A)(iv) of the Social Secuirty Act, 42 U.S.C. 1396a(a)(13)(A)(iv).

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107 Section 4713(a) of P.L. 105-33 repealed section 1926 of the Social Security Act, "Assuring Adequate Payment Levels for Obstetrical and Pediatric Services."

108 Norton and Zuckerman, "Trends in Medicaid Physician Fees, 1993–1998," *Health Affairs,* July/August 2000, p. 229.

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111 Section 1902(a)(37)(A) of the Social Security Act, 42 U.S.C. 1396a(a)(37)(A).

112 Section 1932(f) of the Social Security Act, 42 U.S.C. 1396u-2(f).

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131 Section 1932(b)(2) of the Social Security Act.

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Medicaid; But It Might Be Too Late For LA To Get On Board," *Times-Picayune,* April 2, 2000.

182 66 Fed. Reg. 3148 (January 12, 2001).

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184 For requiring the issuance of a final regulation curbing the use of UPL arrangements, Congress was credited by CBO as saving the federal government $77.3 billion in Medicaid matching payments over the 2001–2010 period. These savings were applied not to Medicaid program improvements or expansions but to offset the costs associated with the restoration of payments to Medicare providers adversely affected by the 1997 BBA. *Ibid.* at p. 3. Subsequent to the enactment of BIPA, actions taken by CMS in approving additional UPL arrangements had the effect of reducing these savings: "Several states had amendments to their Medicaid plans that would establish or expand UPL mechanisms pending with CMS. CBO assumed that CMS would not approve these plan amendments until they were revised to comply with the new UPL regulation. However, the Administration has approved these amendments without changes, so these states will be eligible for a two-year transition period before they have to comply with the new UPL regulation. As a result, federal Medicaid spending related to UPL mechanisms will be higher in 2001 and 2002, and the cost savings associated with BIPA will be lower, than CBO had anticipated." *Ibid.* at 18.

185 *April 2001 Baseline Medicaid and State Children's Health Insurance Program,* Congressional Budget Office, May 18, 2001.

186 Section 1903(w)(6) of the Social Security Act states that "the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes … transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title … unless the transferred funds are derived by the unit of government from donations or taxes that [are impermissible under the provider tax and donation rules]."

187 42 C.F.R. 433.51(b).

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197 OIG, *op. cit.,* p. 6.

198 Section 705 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), enacted by section 1(a)(6) of the Consolidated Appropriations Act for FY 2001, P.L. 106-554, December 21, 2001.

199 66 *Fed. Reg.* 3148, January 12, 2001; Letter to state Medicaid Directors, CMS, March 13, 2001 SMDL#01-017, www.hcfa.gov/medicaid/letters/smd31301.htm

200 42 C.F.R. 447.272(b)

201 42 C.F.R. 447.342(b).

202 *Medicaid: CMS Reversed Its Position and Approved Additional State Financing Schemes,* General Accounting Office, October 2001, GAO-02-147, p. 14.

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210 67 *Fed. Reg* at 2610 (January 18, 2002).

211 67 *Fed. Reg* at 2602 (January 18, 2002). The Administrator of the CMS characterized the original January 12, 2001, final rule as "the single biggest outrage I have ever seen in the history of government finance." See Riccardi, N., "Bush Plan May Close Some Public Hospitals," *Los Angeles Times* (September 6, 2001), Part 2, p. 3.