Memorandum

Date MAR - 8 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of Medicaid Supplemental Payments to Public Hospital District Nursing Facilities and the Use of Intergovernmental Transfers by Washington State (A-10-00-00011)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

Attached are two copies of a final report entitled, "Review of Medicaid Supplemental Payments to Public Hospital District Nursing Facilities and the Use of Intergovernmental Transfers by Washington State." This is one in a series of reports on audits of supplemental payments made in six States. At the completion of all the audits, we will issue a summary report that will consolidate the results of our reviews in the six States and will include additional recommendations addressing supplemental payments and the use of intergovernmental transfers (IGT).

The objectives of our review were to analyze the State's use of supplemental payments and to evaluate the financial impact of IGTs on the Medicaid program. This report only includes information on Medicaid supplemental payment transactions, which are separate and in addition to the basic payment rates for Medicaid providers. The basic Medicaid payments were not included as part of our review.

We found that less than 7 percent of the supplemental payments distributed by the State was retained by Public Hospital District (PHD) nursing facilities to help provide services to Medicaid beneficiaries. For State Fiscal Year (SFY) 2000, the State made supplemental payments, totaling approximately $147 million, to PHD nursing facilities meeting certain eligibility criteria, resulting in Federal matching funds of $76.2 million. Of the $147 million distributed, we found that:

- $127 million was transferred back to the State.
- $10.2 million was shared with three health-related organizations.
- $9.8 million was retained by 14 eligible PHD nursing facilities.

A large portion of the supplemental payments was not retained by the PHD nursing facilities. However, it appeared that most of the funds was either designated or used for State health care needs, regardless of a person's Medicaid eligibility.

Because $127 million was returned to the State, it appeared that the State did not incur an expenditure for which Federal matching funds may be claimed. This situation raises a question as to whether the amounts returned to the State constitute a refund required to be reported as other collections and, consequently, offset against expenditures reported to the Health Care Financing Administration (HCFA). As is, the State developed a mechanism to obtain Federal Medicaid funds without committing its share of required matching funds.

The HCFA has issued regulatory changes aimed at limiting the amount of supplemental payments available to State Medicaid programs. Full implementation of the regulations would limit the supplemental payments available to States. The corresponding amount of Federal Medicaid funds that are returned to the State for other purposes would also be limited. For SFY 2000, we estimated that the regulatory changes would have reduced the State's funding pool from $147 million to about $5.3 million, resulting in Federal matching funds of $2.8 million or $73.4 million less than what was claimed by the State.

In our draft report, we recommended that HCFA move as quickly as possible to issue regulatory changes involving the upper payment limit calculations. We are pleased to note that HCFA concurred with our recommendation and has taken action to change the upper payment limit regulations. On January 12, 2001, HCFA issued revisions to the upper payment limit regulations which precludes States from aggregating payments across private and public facilities to calculate upper payment limits, and creates new payment limits for local government-owned providers. The regulations also provide States a transition period, which is dependent upon the effective date of the State plan amendment, to comply with the new payment limits. The financial impact of the new regulations will be gradually phased in over a transition period and become fully effective on October 1, 2008. The complete text of HCFA's comments can be found in APPENDIX A to the attached report.

States such as Washington with approved amendments in effect prior to October 1, 1999 have been provided a 3-year transition period, beginning in SFY 2003, to comply with the new payment limits. APPENDIX B to the attached report illustrates the estimated savings to the Federal Government for Washington State. We estimate savings to the Federal Government of $110 million during the transition period in Washington alone. Once the regulatory changes are fully implemented, we estimate additional savings to the Federal Government of $73 million annually, totaling a savings of $365 million over 5 years. We, therefore, recommend that HCFA take action to ensure that Washington complies with the phase-in of the revised regulations.

We also recommend that HCFA require State plans to contain assurances that supplemental payments will be retained by the providers and used to provide services to Medicaid eligible individuals.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-10-00-00011 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID SUPPLEMENTAL PAYMENTS TO PUBLIC HOSPITAL DISTRICT NURSING FACILITIES AND THE USE OF INTERGOVERNMENTAL TRANSFERS BY WASHINGTON STATE

MARCH 2001
A-10-00-00011

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Subject Review of Medicaid Supplemental Payments to Public Hospital District Nursing Facilities and the Use of Intergovernmental Transfers by Washington State (A-10-00-00011)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

This final report provides the results of our review of Medicaid supplemental payments to Public Hospital District (PHD) nursing facilities and the use of intergovernmental transfers[1] (IGT) by Washington State. This is one in a series of reports on audits of supplemental payments made in six States. At the completion of all the audits, we will issue a summary report that will consolidate the results of our reviews in the six States and will include additional recommendations addressing supplemental payments and the use of IGTs.

The objectives of our review were to analyze the State's use of supplemental payments and to evaluate the financial impact of IGTs on the Medicaid program. This report only includes information on Medicaid supplemental payment transactions which are separate and in addition to the basic payment rates for Medicaid providers. The basic Medicaid payments were not included as part of our review.

We found that less than 7 percent of the supplemental payments distributed by the State was retained by PHD nursing facilities to help provide services to Medicaid beneficiaries. For State Fiscal Year (SFY) 2000, the State made supplemental payments, totaling approximately $147 million, to PHD nursing facilities meeting certain eligibility criteria, resulting in Federal matching funds of $76.2 million. Of the $147 million distributed, we found that:

- $127 million was transferred back to the State.
- $10.2 million was shared with three health-related organizations.
- $9.8 million was retained by 14 eligible PHD nursing facilities.

A large portion of the supplemental payments was not retained by the PHD nursing facilities. However, it appeared that most of the funds was either designated or used for State health care needs, regardless of a person's Medicaid eligibility.

[1]Intergovernmental transfers are exchanges of funds among or between different levels of government.

Because $127 million was returned to the State, it appeared that the State did not incur an expenditure for which Federal matching funds may be claimed. This situation raises a question as to whether the amounts returned to the State constitute a refund required to be reported as other collections and, consequently, offset against expenditures reported to the Health Care Financing Administration (HCFA). As is, the State developed a mechanism to obtain Federal Medicaid funds without committing its share of required matching funds.

The HCFA has issued regulatory changes aimed at limiting the amount of supplemental payments available to State Medicaid programs. Full implementation of the regulations would limit the supplemental payments available to States. The corresponding amount of Federal Medicaid funds that are returned to the State for other purposes would also be limited. For SFY 2000, we estimated that the regulatory changes would have reduced the State's funding pool from $147 million to about $5.3 million, resulting in Federal matching funds of $2.8 million or $73.4 million less than what was claimed by the State.

In our draft report, we recommended that HCFA move as quickly as possible to issue regulatory changes involving the upper payment limit calculations. We are pleased to note that HCFA concurred with our recommendation and has taken action to change the upper payment limit regulations. On January 12, 2001, HCFA issued revisions to the upper payment limit regulations which precludes States from aggregating payments across private and public facilities to calculate upper payment limits, and creates new payment limits for local government-owned providers. The regulations also provide States a transition period, which is dependent upon the effective date of the State plan amendment (SPA), to comply with the new payment limits. The financial impact of the new regulations will be gradually phased in over a transition period and become fully effective on October 1, 2008. The complete text of HCFA's comments are included as APPENDIX A to this report.

Washington is among the States eligible to receive the benefit of a transition period. Under the regulations, the State would phase in the new aggregate upper payment limit over a 3-year period beginning in SFY 2003. We estimate the Federal Government will save $110 million during the transition period. Once the regulatory changes are fully implemented, we estimate additional savings to the Federal Government of $73 million annually, totaling a savings of $365 million over 5 years (see APPENDIX B for details). We, therefore, recommend that HCFA take action to ensure that Washington complies with the phase-in of the revised regulations.

We also recommend that HCFA require State plans to contain assurances that supplemental payments will be retained by the providers and used to provide services to Medicaid eligible individuals.

BACKGROUND

Title XIX of the Social Security Act authorizes Federal grants to States for Medicaid programs to provide medical assistance to persons with limited income and resources. Each State Medicaid program is administered by the State in accordance with a State Plan approved by HCFA. Although the State has considerable flexibility in designing its State Plan and operating its Medicaid program, it must comply with broad Federal requirements.

While Medicaid programs are administered by the States, they are jointly financed by the Federal and State governments. States incur expenditures for medical assistance payments to providers which furnish medical services to Medicaid-eligible individuals. The Federal Government pays its share of these medical assistance expenditures to each State according to a prescribed formula. The Federal financial participation (FFP) amount for each State is derived by applying the applicable Federal medical assistance percentage to the total medical assistance expenditures paid by that State which are in accordance with the approved State Plan.

Under Federal regulations in effect during our review, two separate aggregate upper payment limits were applicable to each group of health care providers. The first limit applied to all facilities in the State (i.e., private, State, city, and county-operated). The second limit applied to only State-operated facilities. The FFP is not available on State aggregate expenditures that exceed the amount that can reasonably be estimated would have been paid for those services using Medicare payment principles.

Under the upper payment limit rules, States are permitted to establish payment methodologies that allow for enhanced payments to local government-owned providers, such as PHD nursing facilities. In Washington, these enhanced payments are called supplemental payments. The supplemental payments, which are eligible to receive Federal matching funds, are separate and in addition to the regular Medicaid payments made to nursing facilities.

The widespread use of supplemental payments and the Federal matching funds being claimed have increased significantly over the past several years. The HCFA recognized that more States are starting to adopt aggressive payment methodologies for public providers using the flexibility of the upper payment limit rules and the IGT funding mechanism in order to maximize Federal reimbursement. In response, HCFA has issued regulatory changes aimed at limiting the amount available to State Medicaid programs through supplemental payments to public providers.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our audit was conducted in accordance with generally accepted government auditing standards. The objectives of our review were to analyze the State's use of supplemental payments to PHD nursing facilities and to evaluate the financial impact of the IGTs on the Medicaid program. We reviewed the State's supplemental payments, totaling $147 million, that were distributed to PHD nursing facilities during the period July 1, 1999 through June 30, 2000 as a result of an amendment in 1999 to the State Plan.

This report only includes information on Medicaid supplemental payment transactions, which are separate and in addition to the basic payment rates for Medicaid providers. The basic Medicaid payments were not included as part of our review.

To accomplish our objectives, we reviewed the SPA and other applicable criteria on the computation and use of IGTs. We met with HCFA regional office staff to discuss their role and review their records pertaining to the State's Medicaid program. We interviewed key personnel with the State and reviewed applicable State records supporting the funding pool calculations, supplemental payments, and IGTs. We visited 4 and contacted by telephone 10 PHD nursing facilities which received supplemental payments to verify payment amounts provided by the State and determine how the payments were used. We also discussed the use of funds with the officials of other organizations which received part of the supplemental payments either through an intermediary or directly from PHD nursing facilities.

We reviewed only those internal controls considered necessary to achieve our objectives. Our review was limited to gaining an understanding of the processes for supplemental payments and IGTs and did not include a review of the State's internal controls concerning its ability to safeguard Federal funds.

We discussed the results of our review with State officials to the extent necessary to satisfy ourselves as to the accuracy and validity of our facts and conclusions. Our field work was conducted primarily at the State Medicaid agency offices in Olympia, Washington during the period of June through August 2000.

RESULTS OF REVIEW

In SFY 2000, the State distributed supplemental payments of $147 million to PHD nursing facilities meeting certain eligibility criteria, resulting in Federal matching funds of $76.2 million. We found that $127 million of the distribution was returned to the State by

the PHD nursing facilities in the form of an IGT. The remaining $20 million was shared among 14 eligible PHD nursing facilities and other health-related organizations. The PHD nursing facilities retained only a small portion of the supplemental payments to improve access to the services of these facilities (Figure 1). However, it appeared that most of the funds was either designated or used for State health care needs, regardless of a person's Medicaid eligibility.

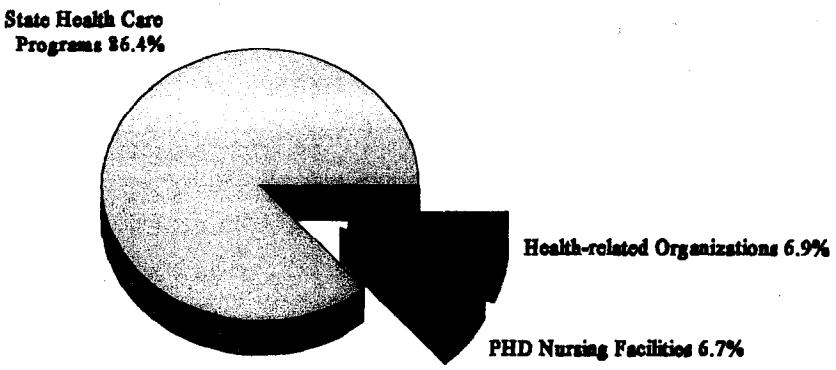

Figure 1

At the time of our review, HCFA discussed changes to the upper payment limit regulations which would significantly reduce the State's funding pool and the corresponding Federal matching funds. For SFY 2000, we estimated that the potential regulatory changes would have reduced the State's funding pool from $147 million to about $5.3 million, resulting in Federal matching funds of $2.8 million. We recommended that HCFA move as quickly as possible to issue regulatory changes involving the upper payment limit calculations.

SUPPLEMENTAL PAYMENT PROGRAM

The State's supplemental payment program was established in September 1999 through an SPA that provided for supplemental payments to PHD nursing facilities meeting established criteria. The supplemental payments made to PHD nursing facilities were subject to prior Federal approval and the availability of State matching funds.

In SFY 2000, the State's supplemental payment program originated in the State legislature. Funds were appropriated by the legislature to specifically provide supplemental payments to nursing facilities operated by rural PHDs. Once the funds were made available for use, the State calculated a funding pool which was distributed to eligible nursing facilities in the form of supplemental payments. After receiving the payments, PHD nursing facilities were required to transfer a portion of the funds back to the State Treasurer in the form of an IGT.

Supplemental Payments

In SFY 2000, the State distributed more than $147 million in supplemental payments to PHD nursing facilities for which the State received $76.2 million in Federal matching

funds. The following table identifies the three supplemental payments and the corresponding Federal share as determined by the State.

Payment Date	Supplemental Payment	Federal Share Claimed[2]
September 20, 1999	$ 60,434,015	$ 31,727,858
November 15, 1999	47,614,563	24,678,628
June 19, 2000	38,974,465	19,795,557
Totals	**$ 147,023,043**	**$ 76,202,043**

The State included the supplemental payments in its quarterly expenditure reports to HCFA.

Funding Pool

For SFY 2000, we determined the State's funding pool computation for the supplemental payments complied with Federal regulations. Using facility Medicaid cost report data, the State determined that the funding pool was $147 million. However, we estimated that Federal regulations would have allowed the funding pool to be as high as $195 million using Medicare payment principles.

States have been allowed the flexibility to determine the methodologies used to calculate the funding pool for supplemental payments. However, the supplemental payments eligible for FFP are limited by Federal regulations which state that aggregate payments for each class of services – in this case, nursing facility services – may not exceed a reasonable estimate of the amount the State would have paid under Medicare payment principles. Therefore, the maximum allowable funding pool is the difference between what Medicaid paid and what Medicare would have paid for the same services.

The funding pool was calculated by the State as the difference between Medicaid costs and payments for all nursing facilities in the State. The Medicare upper payment limit was not used to determine the funding pool, except as a ceiling for Medicaid nursing facility costs. In other words, because Medicaid costs did not exceed what Medicare would have paid for the services, the Medicare upper payment limit was not used to compute the funding pool.

The calculation of the funding pool included a comparison of three components:

[2]The State miscalculated the Federal share for the third supplemental payment which resulted in the State claiming less Federal share than allowed.

- **Medicare Upper Payment Limit.** The State calculated its Medicare upper payment limit using the formula prescribed for freestanding skilled nursing facility inpatient routine costs published in the October 1, 1997 Federal Register and adjusted it for inflation. The limit was computed by the State for each county and summarized into a statewide weighted average per Medicaid patient day.

- **Medicaid Nursing Facility Costs.** To calculate the funding pool, the State used costs and patient days reported in the PHD nursing facilities' Medicaid cost reports. For the first supplemental payment, the State used Medicaid costs and Medicaid patient days included in the 1997 Medicaid cost reports. For the remaining supplemental payments, the State used total costs and total patient days included in the 1998 Medicaid cost reports. Based on the reported number of patient days, a weighted average cost per patient day was calculated for all nursing facilities in the State. The weighted average cost per patient day was then adjusted for inflation.

- **Medicaid Nursing Facility Payments.** The State's Medicaid payment computation was based on a case-mix payment system. Nursing facility residents were categorized into groups[3] based on their characteristics and clinical needs. Each nursing facility was assigned a prospective payment rate based upon facility-specific adjusted cost data obtained from Medicaid cost reports. The cost data used for rate setting was subject to limits based upon the median costs of nursing facilities located in and outside of metropolitan statistical areas. Payment rates were adjusted annually by certain other factors to account for economic trends and conditions. The first supplemental payment was calculated using a statewide weighted average payment rate. For the remaining supplemental payments, an average maximum statewide payment rate was provided by legislative staff.

Distribution of Funds

Approximately $127 million of the $147 million in supplemental payments distributed to PHD nursing facilities in SFY 2000 was transferred, through the Association of Washington Public Hospital Districts (AWPHD), to the State Treasurer for deposit into the State's health services account. Of the remaining $20 million, $10.2 million was shared with the (i) AWPHD, (ii) Washington State Hospital Association (WSHA), and (iii) Washington Health Foundation (WHF). Even though the PHD nursing facilities were the intended recipients of the payments, they only retained $9.8 million, or 6.7 percent, of the $147 million in supplemental payments. (See Figure 2.)

[3]Resident classifications were based on the 44 Resource Utilization Groups, Version III, which was implemented for the Medicare skilled nursing facility prospective payment system after July 1, 1998.

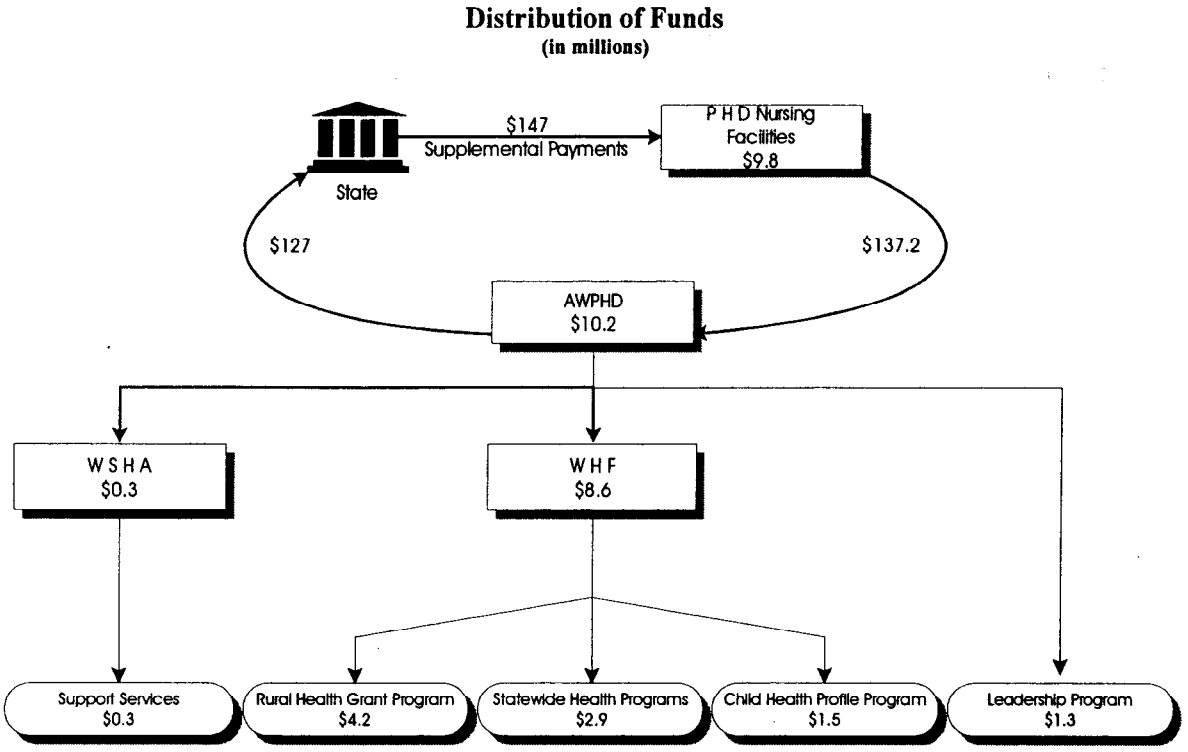

Figure 2

State officials distributed the funding pool to 14 of the State's 52 PHDs based on criteria pertaining to (i) financial viability, (ii) urban or rural status, (iii) competition in providing Medicaid subsidized services, and (iv) operation of a nursing facility. The payments were distributed to each of the eligible PHD nursing facilities based upon their proportion of Medicaid days of care provided relative to the total Medicaid days of care provided by all 14 PHDs during the same year.

USE OF FUNDS

Although a majority of the supplemental payments was not retained by the PHD nursing facilities to improve access to the services of these facilities as intended, it appeared most of the funds was either designated or used for State health care needs, regardless of a person's Medicaid eligibility.

Washington State

The State Plan required that Federal matching funds resulting from the supplemental payments to PHD nursing facilities be used for important State health care needs. The funds returned to the State Treasurer, as well as any corresponding Federal matching amounts calculated from the supplemental payments, were deposited in the State's health services account. According to State administrative code, funds in this account were to be expended for (i) maintaining and expanding access for low-income residents to health care

services, (ii) maintaining and improving the capacity of the health care system, (iii) containing health care costs, and (iv) regulating, planning, and administering the health care system.

PHD Nursing Facilities

According to the State Plan, funds retained by PHD nursing facilities (and amounts passed on to other health-related organizations) must be used to improve access for Medicaid beneficiaries to health care services in rural area nursing facilities. Information provided to us indicated that the 14 eligible PHD nursing facilities utilized the $9.8 million to cover operating expenses or offset losses.

AWPHD

The AWPHD is an association organized and operated to (i) serve the collective needs of the PHDs and (ii) assist the PHDs in addressing the health care needs of their residents and other persons. The AWPHD represents the unique political, educational, and program concerns of the PHDs in the State.

In addition to serving as an intermediary for the IGT from the PHD nursing facilities to the State Treasurer, the AWPHD received just over $10.2 million from the PHD nursing facilities. Of the $10.2 million received, $8.9 million was distributed to the WSHA and WHF. With the remaining $1.3 million, the AWPHD indicated a leadership program was sponsored to create more effective models of leadership and governance for the elected and appointed officials of PHDs. More specifically, the leadership program educated new commissioners about (i) their role as public officials and (ii) legal issues that may impact their oversight of PHDs.

WHF

The WHF is a nonprofit charitable foundation organized and operated to promote, sponsor, conduct, and implement research and education programs designed to improve the health of and health care for the people of the State. In SFY 2000, WHF received $8.6 million from AWPHD. Based on information provided by WHF, the funds were either set aside or utilized for a series of programs that benefit State residents as follows:

- **Rural Health Grant Program:** The WHF sponsored a $4.2 million Rural Health Grant program to assist the 38 PHDs that did not meet all the State's criteria to be eligible for supplemental payments, but who may have also faced financial difficulties. Grants were awarded to PHDs based on WHF-established criteria relating to their short-term financial condition as well as long-term community access to services. Approximately $0.6 million was awarded in SFY 2000 with another $2 million planned for award in SFY 2001. According to WHF officials, the remaining $1.6 million will be awarded in future years based on the success of the program.

- **Child Health Profile Program:** The WHF awarded a $1.5 million grant to further the statewide implementation of the Child Profile Immunization Tracking project. The funds were required to be used for staffing, technology, operating expenses, and general administrative expenses in support of the statewide expansion of immunization tracking.

- **Statewide Health Programs:** We found that WHF had set aside $2.9 million for various statewide health programs. At the time of our review, only $0.6 million of that amount was specifically designated by WHF for programs aimed to (i) promote greater dialogue among health care advocates and interest groups, (ii) increase children's health coverage, (iii) enhance health care quality improvement activities, and (iv) create healthier communities through partnerships. The remaining $2.3 million was set aside as undesignated funds awaiting the WHF Board's decision as to how the funds should be used.

The WHF is under contractual agreement with the AWPHD to sponsor these programs while following general guidelines as to how the funds are expended.

WSHA

The WSHA represents the broad political, legal, educational, and program concerns of all hospitals in Washington and maintains a professional staff to provide these services. In SFY 2000, the WSHA received $0.3 million from the AWPHD for duties and responsibilities which included the following:

- Provide a focal point for information affecting the PHDs.
- Provide staff, clerical, and accounting support to AWPHD.
- Represent and advocate on behalf of AWPHD.
- Conduct special projects.

In consideration of the services provided by WSHA, AWPHD agreed to pay the full costs of (i) salaries and benefits of an Executive Director, an Assistant Director, and a Program Assistant, (ii) accounting services, (iii) specialized lobbying services, (iv) insurance, (v) rent, and (vi) other overhead costs.

IMPACT OF ISSUED REGULATORY CHANGES

The HCFA has taken action to modify the upper payment limit regulations to include a separate aggregate upper limit applicable to payments made to local government-owned nursing facilities. Full implementation of the regulations will significantly reduce the State's funding pool and the corresponding Federal matching funds. For SFY 2000, we estimated that the regulatory changes would have reduced the State's funding pool from $147 million to $5.3 million. As a result, Federal matching funds available to the State

would have been only $2.8 million, or $73.4 million less than the State actually claimed that year.

Upper payment limit regulations allowed the State flexibility to include Medicaid payments to all government-owned and privately-owned nursing facilities in the funding pool calculation. In SFY 2000, this included payments to more than 300 nursing facilities. The regulatory changes will limit the funding pool calculation to include Medicaid payments to only 21 local government-owned nursing facilities. The upper payment limit would continue to be based on Medicare payment principles.

RECOMMENDATION

In our draft report, we recommended that HCFA move as quickly as possible to issue regulatory changes involving the upper payment limit calculations. We are pleased to note that on January 12, 2001, HCFA issued revisions to the upper payment limit regulations which created a separate aggregate payment limit for local government-owned providers. The regulations included several transition periods, one of which applied to Washington. Using the transition period applicable to Washington, the financial impact of the revised regulations will be gradually phased-in and become fully effective on July 1, 2005. We recommend that HCFA take action to ensure that Washington complies with the phase-in of the revised regulations.

We also recommend that HCFA require State plans to contain assurances that supplemental payments will be retained by the providers and used to provide services to Medicaid eligible individuals.

HCFA's COMMENTS

In response to our draft report, HCFA concurred with our recommendations to take immediate action to issue regulatory changes involving the upper payment limit calculations. On January 12, 2001, HCFA issued final regulations which precludes States from aggregating payments across private and public facilities to calculate upper payment limits, and creates new payment limits for local government-owned providers. The complete text of HCFA's comments are included in APPENDIX A to this report.

OIG's RESPONSE

We commend HCFA for taking action to control these costly financing mechanisms used by States to maximize Federal Medicaid reimbursements. Under the regulations, Washington State would phase-in the new aggregate upper payment limit over a 3-year period beginning in SFY 2003. We estimate the Federal government will save $110 million during the transition period alone. Once the regulatory changes are fully implemented, we estimate

additional savings to the Federal government of $73 million annually, totaling a savings of $365 million over 5 years (see APPENDIX B for details).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: JAN 18 2001

TO: June Gibbs Brown
Inspector General

FROM: Robert A. Berenson, M.D. Robert A. Berenson M.D.
Acting Deputy Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Review of Medicaid Supplemental Payments to Public Hospital District Nursing Facilities and the Use of Intergovernmental Transfers by Washington State," (A-10-00-00011)

Thank you for the opportunity to comment on the use of Medicaid upper payment limits (UPL). The information you have provided in the related draft reports is very useful to us as we develop new Medicaid payment policies. We look forward to receiving the audit reports in the remaining States and your summary report and recommendations.

Under current Medicaid requirements, States have considerable flexibility in setting payment rates for nursing facility services. States are permitted to pay in the aggregate up to a reasonable estimate of the amount that would have been paid using Medicare payment principles. This payment restriction is commonly referred to as the Medicare UPL. This UPL permits States to set higher rates for services furnished in public facilities.

Within the last year, the Health Care Financing Administration (HCFA) has received a number of proposals from States that target payment increases to county and/or municipal nursing facilities. The amount of payment is not directly related to cost of services furnished by the facilities, but on the aggregate difference between Medicaid payments and the maximum amount allowed under the Medicare UPL. While these types of proposals fit within current rules, HCFA became concerned when our review found that payments to individual public facilities were excessive, often many times higher than the rate paid private facilities or above the cost incurred by the public facility.

These excessive payments raise serious and troubling policy considerations. The practice appears to be creating a rapid increase in Federal Medicaid spending with no commensurate increase in Medicaid coverage, quality, or amount of services provided to Medicaid beneficiaries. While States claim these payments expenditures for Medicaid nursing facility services furnished to an eligible individual, these payments may

ultimately be used for a number of purposes, both health care and non-health care related. In many cases, intergovernmental transfers (IGTs) are used to finance these payments.

On October 10, 2000 we proposed a regulation to close the loophole in Medicaid regulations that costs Federal taxpayers billions of dollars without commensurate increases in coverage or improvements in the care provided to Medicaid beneficiaries. This regulation was finalized and displayed at the Federal Register on January 5, 2001. It revises Medicaid's UPL rules, stopping States from using certain accounting techniques to inappropriately obtain extra Federal Medicaid matching funds that are not necessarily spent on health-care services for Medicaid beneficiaries. The changes will be phased in to allow States time to adjust their Medicaid programs to meet the new requirements. In addition, the final rule also allows a continued higher limit on payments for public hospitals in recognition of their critical role in serving low-income patients.

OIG Recommendation
HCFA should take immediate action to place a control on the overall financing mechanisms being used by States to circumvent the Medicaid program requirement that expenditures be a shared Federal/State responsibility.

HCFA Response
We concur. In July, we issued a letter to State Medicaid Directors outlining our concerns about excessive payments to public providers and setting forth our intent to propose new rules to address the issue. HCFA published a Notice of Proposed Rulemaking (NPRM) on the subject on October 10, 2000. The NPRM was finalized on January 5, 2001. In the final rule, we amend our regulations to preclude States from aggregating payments across private and public facilities to calculate UPLs. We also create new payment limits for local governmental and private providers, and in the case of outpatient hospital and clinic services, an additional UPL for State-operated facilities. These changes will significantly reduce the amount of excessive payments that currently can and are being paid under the current UPL regulations.

To help States that have relied on UPL financing arrangements and in accordance with the recently enacted Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) (P.L. 106-554, December 21, 2000) we have instituted a gradual transition policy. In addition, recognizing the need to preserve access by Medicaid beneficiaries to public hospitals, we have included provisions that would ensure adequate payment rates for such facilities.

We solicited comments on our proposed changes to the UPL policy, as well as the transition provisions, and we incorporated changes to this regulation in the final rule.

APPENDIX B

Schedule of Federal Savings in Washington State Based on Implementation of Revised Upper Payment Limit Regulations

(in millions)

SFY	Fiscal Period	Federal Savings	
2001	07/01/00 - 06/30/01	$ 0	
2002	07/01/01 - 06/30/02	0	
2003	07/01/02 - 06/30/03	18	*Savings during transition period*
2004	07/01/03 - 06/30/04	37	
2005	07/01/04 - 06/30/05	55	
		$ 110	
2006	07/01/05 - 06/30/06	$ 73	
2007	07/01/06 - 06/30/07	73	
2008	07/01/07 - 06/30/08	73	*Savings after full implementation of regulations*
2009	07/01/08 - 06/30/09	73	
2010	07/01/09 - 06/30/10	73	
		$ 365	