Memorandum

Date FEB 22 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of Medicaid Enhanced Payments to Public Providers and the Use of Intergovernmental Transfers by the State of Nebraska (A-07-00-02076)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of Medicaid Enhanced Payments to Public Providers and the Use of Intergovernmental Transfers by the State of Nebraska." This is one in a series of reports on enhanced payments made in six States. The objectives of our review were to analyze the State of Nebraska's use of enhanced payments and evaluate the financial impact of intergovernmental transfers on the Medicaid program. This report only includes information on Medicaid enhanced payment transactions resulting from the upper payment limit calculations. These enhanced payments are separate and apart from the basic payment rates for Medicaid providers. The basic Medicaid payments were not included as part of our review.

Based on our review for Fiscal Years (FY) 1998 through 2000, we found that Nebraska made enhanced payments to public nursing facilities totaling $227 million, generating about $139 million in Federal financial participation. Of the $227 million, providers retained about $1.5 million and about $225.5 million was returned to the State for other uses. For the funds transferred back to the State ($225.5 million), the State share of the enhanced payments, totaling about $88 million, was returned to the Nebraska General Fund and the remaining $137.5 million in Federal matching funds was designated for the Nebraska Health Care Trust Fund.

We also found that the Medicaid enhanced payments to city and county owned nursing facilities were not based on the actual cost of providing services to Medicaid beneficiaries or were not directly related to increasing the quality of care provided by public facilities.

In our draft report, we recommended that the Health Care Financing Administration (HCFA) move as quickly as possible to issue regulatory changes involving the upper payment limit calculations. In response to our draft report, HCFA concurred with our recommendation. On October 10, 2000, HCFA issued a Notice of Proposed Rulemaking in the Federal Register to address the issue. The proposed regulations limited the aggregate Medicaid payments to locally owned government facilities to the amount that would have been paid under Medicare payment principles. Using these proposed regulations, in Nebraska, for FY 1998 through 2000, the enhanced payment funding pools would have been reduced from $227 million to $52 million, a reduction of $175 million (Federal share $107 million).

We commend HCFA for taking action to change the upper payment limit regulations. In December 2000, Congress passed legislation that the President signed, instructing HCFA to implement a transition period for States with plans approved or in effect before October 1, 1992. On January 12, 2001, HCFA issued revisions to the upper payment limit regulations, and included the transition period passed by Congress. During the transition, the financial impact of the new regulations will be gradually phased in and become fully effective on October 1, 2008. Nebraska is among the States eligible to receive the benefit of this transition period. In Nebraska alone, we estimate that during the transition period the Federal Government will save $142 million. Once the regulatory changes are fully implemented, we estimate additional savings to the Federal Government of $44 million annually, totaling a savings of $220 million over 5 years. We, therefore, recommend that HCFA take action to ensure that Nebraska complies with the phase-in of the revised regulations.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions, please contact 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-07-00-02076 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID ENHANCED PAYMENTS TO PUBLIC PROVIDERS AND THE USE OF INTERGOVERNMENTAL TRANSFERS BY THE STATE OF NEBRASKA

FEBRUARY 2001
A-07-00-02076

Memorandum

Date FEB 22 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of Medicaid Enhanced Payments to Public Providers and the Use of Intergovernmental Transfers by the State of Nebraska (A-07-00-02076)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

This final report provides the results of our review of Medicaid enhanced payments to public providers and the use of intergovernmental transfers (IGT) in the State of Nebraska by the Nebraska Department of Health and Human Services (NDHHS). The objectives of our review were to analyze the use of enhanced payments and evaluate the financial impact of IGTs on the Medicaid program. This is one in a series of reports involving enhanced payments made to public providers in six States. At the completion of all the audits, we will issue a summary report to the Health Care Financing Administration (HCFA) that will consolidate the results of our reviews in the six States and include additional recommendations addressing enhanced payments and the use of IGTs.

This report only includes information on Medicaid enhanced payment transactions resulting from the upper payment limit calculations. These enhanced payments are separate and apart from the basic payment rates for Medicaid providers. The basic Medicaid payments were not included as part of our review.

Our review found that the Medicaid enhanced payments to city and county owned nursing facilities were not based on the actual cost of providing services to Medicaid beneficiaries, or directly related to increasing the quality of care provided by public facilities. We also found that a large portion of the enhanced payments was not being retained by the facilities to provide services to Medicaid beneficiaries. For Fiscal Years (FY) 1998 through 2000, Nebraska made enhanced payments to public nursing facilities totaling $227 million, generating about $139 million in Federal financial participation (FFP). Of the $227 million, providers retained about $1.5 million and about $225.5 million was returned to the State for other uses. For the funds transferred back to the State ($225.5 million), the State share of the enhanced payments, totaling about $88 million, was returned to the Nebraska General Fund and the remaining $137.5 million in Federal matching funds was designated for the Nebraska Health Care Trust Fund.

Because the $225.5 million was returned to the State, it appears that the State did not incur an expenditure for which Federal matching funds may be claimed. This condition draws into question whether the amounts returned to the State agency constitute a refund required

to be reported as other collections and consequently offset against expenditures on HCFA Form 64.

In addition, if Federal regulations were changed to include a separate aggregate upper limit applicable to payments made to local government owned providers, the amount of funds available to Nebraska for enhanced payments would be significantly reduced. Thus, the amount of Federal Medicaid funds that public providers are able to transfer to the State for other uses would be limited. As previously stated, the combined enhanced payments made during FYs 1998 through 2000 totaled $227 million. If the regulations had included a separate upper payment limit applicable to local government owned providers, in Nebraska, for FYs 1998 through 2000, the enhanced payment funding pools would have been reduced from $227 million to $52 million, a reduction of $175 million (Federal share $107 million).

In our draft report, we recommended that HCFA move as quickly as possible to issue regulatory changes involving the upper payment limit calculations. In response to our draft report, HCFA concurred with our recommendation. On October 10, 2000, HCFA issued a Notice of Proposed Rulemaking in the Federal Register to address the issue. The proposed regulations limited the aggregate Medicaid payments to locally owned government facilities to the amount that would have been paid under Medicare payment principles. The HCFA comments to our draft report are included in their entirety in **APPENDIX B**.

We commend HCFA for taking action to change the upper payment limit regulations. In December 2000, Congress passed legislation that the President signed, instructing HCFA to implement a transition period for States with plans approved or in effect before October 1, 1992. On January 12, 2001, HCFA issued revisions to the upper payment limit regulations, and included the transition period passed by Congress. During the transition, the financial impact of the new regulations will be gradually phased in and become fully effective on October 1, 2008. Nebraska is among the States eligible to receive the benefit of this transition period. In Nebraska alone, we estimate that during the transition period the Federal Government will save $142 million. Once the regulatory changes are fully implemented, we estimate additional savings to the Federal Government of $44 million annually, totaling a savings of $220 million over 5 years (see **APPENDIX A** for details). We, therefore, recommend that HCFA take action to ensure that Nebraska complies with the phase-in of the revised regulations.

We are including two additional recommendations for HCFA to require State plans to contain assurances that enhanced payments will be retained by the providers and used to provide services to Medicaid eligible individuals. In addition, all Medicaid payments returned by providers to the State should be treated as refunds and reported as other collections and consequently offset against expenditures on HCFA Form 64.

Although no recommendations were directed towards NDHHS, we requested and received a prompt response to our draft report. The State agency agreed with our financial computation, but declined further comment.

BACKGROUND

Title XIX of the Social Security Act authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy persons. Each State Medicaid program is administered by the State in accordance with an approved State plan. While the State has considerable flexibility in designing its State plan and operating its Medicaid program, it must comply with broad Federal requirements. The Medicaid program is administered by the State, but is jointly financed by the Federal and State governments. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid eligible individuals. The Federal Government pays its share of medical assistance expenditures to a State according to a defined formula.

States establish their own methodologies for reimbursing providers of Medicaid services. However, Federal regulations (42 CFR 447.272) require that the aggregate Medicaid payments to each group of health care facilities (that is: hospitals, nursing facilities, or intermediate care facilities for the mentally retarded) may not exceed the amount that can be reasonably estimated would have been paid for those services under Medicare payment principles.

Under these broad parameters, Nebraska established rates for nursing home care that were less than the Medicare rates, using a cost report system for establishing interim payments with final settlement after submission of the cost report. However, because the regulations allow for aggregate payments up to the Medicare limit, Nebraska also established a proportionate share funding pool to make enhanced payments to city and county owned nursing facilities. The funding pool was established by computing the total estimated amount that would have been paid under Medicare payment rates for all nursing facilities (public and private) and comparing the amount to the total estimated Medicaid payments to nursing facilities. The difference (both Federal and State share) was then transferred (paid) to public nursing facilities. The facilities were required to transfer those funds back to the State on the same day, except for a provider participation fee. The State match was restored to the State general fund. The net gain to the State was the Federal share, less the provider participation fee. Through the enhanced payment process, the State obtained Federal funding without a net increase in State expenditures. For FYs 1998 through 2000, Nebraska made enhanced payments totaling $227 million. The Federal share of those payments was about $139 million.

SCOPE OF REVIEW

Our audit was conducted in accordance with government auditing standards. The objectives of our review were to analyze the use of Medicaid enhanced payments to public providers and evaluate the financial impact of IGTs on the Medicaid program. We reviewed enhanced payments totaling $226,919,676, (FFP $138,805,345) which were made to providers for State FYs 1998 through 2000 as a result of the March 1998 and December 1999 amendments to the State plan.

To evaluate the initial estimated funding pools for the period April 1, 1998 through April 30, 2000, we reviewed the Nebraska general fund and Medicaid fund accounting transactions. We determined the balances for the Nebraska trust funds which received funding directly or indirectly through IGTs, and obtained financial records from three providers that received enhanced payments. We also visited the three providers to determine the use of the enhanced payments.

We reviewed State plan amendments (SPAs) that addressed the nursing facility payment rates for public providers and the State statutes that created the accounts to which the enhanced payments were transferred. Medicare upper payment limit regulations, the Provider Reimbursement Manual and Federal Register publications relating to calculations of Medicare rates for skilled nursing facilities (SNFs) in Nebraska were also reviewed. We relied on calculations by Mutual of Omaha, the fiscal intermediary for Nebraska, for the Medicare SNF routine cost limits and prospective payment rates for FYs 1998 and 1999.

We obtained the computations of the estimated funding pools and evaluated them with respect to the provisions included in the approved State plan and related Federal regulations. During the period of our field work, NDHHS was in the process of revising the FY 1998 and 1999 pools to reflect actual Medicaid payments and dates of service. We traced the revised data to summary documentation maintained by the Department. However, because NDHHS had not submitted an FFP claim based on the revision, we did not evaluate the accuracy of the detail.

The enhanced payments made in FY 2000 are included in our audit results as a part of the impact of the enhanced payment process. These payments were based on estimates. While we were able to trace the amounts transferred back to NDHHS records, we were not able to evaluate the assumptions underlying the estimates. The pool calculation was dependant, in part, on comparing Medicare levels of care to Medicaid levels of care, and involved making clinical judgements.

Our field work was conducted during May and June 2000 at the NDHHS offices in Lincoln, Nebraska and at three public providers located throughout the State.

RESULTS OF REVIEW

For FYs 1998 through 2000, Nebraska made enhanced payments to public nursing facilities totaling $227 million, generating about $139 million in FFP. Of the $227 million, providers retained about $1.5 million and about $225.5 million was returned to the State for other uses. For the funds transferred back to the State ($225.5 million), the State share of the enhanced payments, totaling about $88 million, was deposited into the Nebraska general fund and the remaining $137.5 million was designated for the Nebraska Health Care Trust Fund.

In addition, we determined that if Federal regulations were revised to include a separate aggregate limit for payments to local government providers, the amount available for enhanced payments would be reduced. As previously stated, the combined enhanced payments for FYs 1998 through 2000 totaled $227 million. Under a change in regulations, the $227 million in enhanced payments would have been reduced to about $52 million (Federal share $32 million), a reduction of $175 million (Federal share $107 million).

History of Nebraska's Enhanced Payment Program

Effective September 1, 1992, Nebraska implemented a limited program which made payments to public providers who met specific eligibility requirements. These payments were always made after the cost report was finalized. On March 9, 1998, HCFA approved SPA 97-10, which greatly expanded Nebraska's proportionate share funding pool for enhanced payments to public nursing facilities.

The purpose of the proportionate share pool, according to the SPA, was to increase reimbursement to city and county owned facilities. For each nursing facility provider in the State, NDHHS computed the difference between the NDHHS estimated Medicaid rate and the applicable Medicare SNF rate. For FYs 1998 and 1999, the Medicare SNF rate was the routine cost limit or prospective payment rate applicable to the facility. The NDHHS multiplied the difference between the rates by their estimate of the facility's inpatient Medicaid days to determine the dollars included in the pool. The total estimated pool was then distributed to city and county owned nursing facilities only, based on their proportionate share of Medicaid patient days. The SPA was silent regarding the NDHHS requirement that participating facilities return their enhanced payment, less a participation fee, to the State the same day as received.

The NDHHS submitted supporting worksheets for its calculation of the estimated payments to HCFA when the SPA was filed. Nebraska determined the funding pool for a full year was $90.6 million. The amendment was effective January 1, 1998, which was the midpoint for the State FY of July 1, 1997 through June 30, 1998. Consequently, the initial funding pool was prorated and the distribution of $45.3 million was made in April 1998 for one half of the year. The NDHHS based its FY 1999 funding pool on the same calculation, and a distribution of $90.6 for a full year was made in October 1998.

The SPA required a reconciliation of the funding pool by using actual Medicaid payments based on finalized cost reports and claims payment activity. During our field work, the State Medicaid agency was in the process of performing this reconciliation for 1998 and 1999.

On December 29, 1999, Nebraska amended its State plan to revise the methodology used to calculate the enhanced payment funding pool. This amendment, SPA 99-08, was approved effective October 1, 1999. The SPA revised section 12-011.07F of the State plan for payment rates for nursing facility services. The change was necessary due to the

implementation of a case-mix payment methodology under Medicare for SNF services as promulgated in the Federal Register on July 30, 1999. This change in Medicare payment methodology was retroactive to July 1, 1998 for Medicare SNF payments. However, Nebraska did not retroactively revise its State plan for the FY 1999 calculation based on these revisions. Rather, the State plan was amended effective October 1, 1999 for the FY 2000 funding pool calculation.

Nebraska contracted with a consultant for assistance in comparing Medicaid levels of care to Medicare under the case mix payment methodology and prepared supporting documentation to estimate the FY 2000 funding pool.

Enhanced Payment Funding Pool Distribution Methodology

In FYs 1998 through 2000, Nebraska claimed FFP for enhanced payments totaling $227 million under SPA 97-10. The Nebraska general fund and Federal Medicaid funds financed the total payments in the amounts of $88 million and $139 million, respectively. The payments were made by wire transfer to public providers, who then immediately refunded the amounts to the State, less a total participation fee of $1.5 million ($10,000 per facility per enhanced payment). No guidelines existed for the facilities' use of participation fees. Of the three facilities we visited, two used the participation fees for special projects and one commingled the funds in its general fund for operating costs.

Of the $225.5 million ($227 million - $1.5 million) transferred back to NDHHS, the State share of $88 million was returned to the Nebraska general fund. The remaining $137.5 million, ($139 million - $1.5 million) was transferred to the Nebraska Health Care Trust, which was the superfund for all IGTs retained by the State. The $88 million that was returned to the State's General Fund could be churned repeatedly to gain additional Federal funds for future enhanced payments. The net result is that the same State funds that were never used to actually pay for services to a Medicaid beneficiary could be used multiple times to generate Federal funds.

Use of Intergovernmental Transfer Funds

Nebraska Legislative Bill 1070 effective January 12, 1998, authorized the use of IGTs retained by the State. The State law provided for the creation of the Nebraska Health Care Trust Fund to receive payments from public providers through IGTs. Additionally, the law created the Nursing Facility Conversion Cash Fund, the Children's Health Insurance Fund, and the Excellence in Health Care Trust Fund which received a portion of the funds originally received by the Nebraska Health Care Trust Fund.

According to the State law, the funds were to be distributed as follows:

State Directed Funds	Amount received from Nebraska Health Care Trust Fund	Purpose
Nursing Facility Conversion Cash Fund	First $40 million plus interest accruing prior to transfer	Capital or one-time expenditure grants and loan guarantees, less administrative expenses, for alternatives to nursing care services, including home and community-based waiver services for aged persons or adults or children with disabilities under Medicaid, conversions to accommodate assisted-living facility or alternative to nursing facility care.
Children's Health Insurance Cash Fund	Next $25 million, plus interest accruing prior to transfer	Provided for the State's matching share for children's health insurance under Title XXI of the Social Security Act, and for administrative expenses of the program.
Excellence in Health Care Trust Fund.	Interest accruing on funds in excess of the first $65 million (beginning January 15, 1999)	Awards or loan guarantees similar to the Nursing Facility Conversion Cash Fund, and awarding grants for a variety of public health services.

We found that the Nebraska Health Care Trust Fund transferred funds to the subsidiary trust funds in accordance with the law as follows:

State Directed Funds	FY	Amount Transferred	Source
Nursing Facility Conversion Cash Fund	1999	$40,611,766 (1)	Direct payment
Children's Health Insurance Cash Fund	1999	$25,050,744 (1)	Direct payment
Excellence in Health Care Trust Fund	1999	$698,683	Interest income
Excellence in Health Care Trust Fund	2000	$1,880,778	Interest income

(1) There were no additional transfers made to these funds in FY 2000, as of April 30, 2000.

As of April 30, 2000, the balances of the four Trust Funds were as follows:

State Trust Funds	Current Balance
Nebraska Health Care Trust Superfund:	$ 72,355,344
Nursing Facility Conversion Cash Fund:	36,291,808
Children's Health Insurance Cash Fund:	24,783,790
Excellence in Health Care Cash Fund:	3,092,502
Total:	$136,523,444

Unless the legislature approves additional uses of the proceeds, we believe these fund balances will continue to grow. The Nursing Facility Conversion Cash Fund and Excellence in Health Care Trust Funds are required to submit annual reports regarding grand awards to the legislature.[1] The December 31, 1999 Nursing Facility Conversion Cash Fund report listed grant awards of $35 million for the creation of assisted living facility (ALF) units. Of the 707 ALF units, an estimated 354 will be for Medicaid eligible clients. For the Medicaid beneficiaries residing in ALFs rather than in nursing facilities, the State projected annual Medicaid savings of $2.7 million.

Furthermore, the potential exists where the Federal monies used to establish these Trust Funds could be used to generate additional Federal funds if used for expenditures that cover approved Medicaid services.

The fiscal responsibility of the Medicaid program is to be shared by the Federal and State governments. However, even though the Nebraska enhanced payments might be used for health care purposes, the funds consist of only Federal dollars. Thus, the use of the funds for an otherwise worthwhile health care purpose results in being a totally Federally funded activity rather than the shared activity required of the Medicaid program. And, as stated, the health care activity may not be approved as a Medicaid covered service.

Impact of Revisions to the Upper Payment Limit Regulations

Presently, 42 CFR 447.272 does not allow aggregate Medicaid reimbursements to nursing facilities above the amount that can reasonably be estimated to have been paid for those services under Medicare payment principles. This limit also applies more narrowly to the State-operated facilities in States which own nursing facilities. However, all the publicly owned facilities in Nebraska are owned by cities or counties. Consequently, Nebraska may subsidize public providers to the extent that the State, as a whole, had aggregate payments equal to total payments which would have been reimbursed under Medicare payment

[1]The Excellence in Health Care Trust Fund had not submitted an annual report because it had not awarded grant funds during the audited period.

principles. As a result, Nebraska included the difference between the Medicaid payments made to private providers, and what would have been paid these providers under Medicare, in the enhanced payment funding pool.

The HCFA has taken action to change the upper payment limit regulations to include a separate aggregate upper limit applicable to payments made to local government owned providers. The effect of this change will be to limit the amount of the funding pool calculated for only public providers. If this rule had been in effect in Nebraska during our audit period, the funding pools would have been $52 million as shown below:

	Total Funding Pool	Federal Share
FY 1998	$11 million	$ 7 million
FY 1999	23 million	14 million
FY 2000	18 million	11 million
TOTAL	$52 million	$32 million

The total Federal share of enhanced payments distributed to public providers was $139 million. Therefore, if the above regulations had been in effect when the funding pools were estimated, the Federal share of the pools would have been reduced by $107 million.

CONCLUSIONS AND RECOMMENDATIONS

Enhanced payments and IGTs have become a financial windfall for Nebraska. Our review showed that Nebraska's enhanced payments was a financing mechanism designed to maximize Federal Medicaid reimbursements while providing only minimal additional funds to the city and county owned facilities. Since 1998, Nebraska reported to HCFA $227 million in enhanced payments to city and county owned nursing facilities. These payments were made directly to the nursing facilities and immediately returned back to the State, less a total participation fee of $1.5 million. Of the $225.5 million ($227 million less $1.5 million) transferred back to the State, the State's share of $88 million was returned to the Nebraska General Fund. The remaining $137.5 million was transferred to the Nebraska Health Care Trust Fund.

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 has taken action to change the upper payment limit regulations. In December 2000, Congress passed legislation that the President signed, instructing HCFA to implement a transition period for States with plans approved or in effect before October 1, 1992. On January 12, 2001, HCFA issued revisions to the upper payment limit regulations, and included the transition period passed by Congress. During the transition, the financial impact of the new regulations will be gradually phased in and become fully effective on

October 1, 2008. Nebraska is among the States eligible to receive the benefit of this transition period. In Nebraska alone, we estimate that during the transition period the Federal Government will save $142 million. Once the regulatory changes are fully implemented, we estimate additional savings to the Federal Government of $44 million annually, totaling a savings of $220 million over 5 years (see **APPENDIX A** for details). We, therefore, recommend that HCFA take action to ensure that Nebraska complies with the phase in of the revised regulations.

We also recommend that HCFA require State plans to contain assurances that enhanced payments will be retained by the providers and used to provide services to Medicaid eligible individuals. In addition, all Medicaid payments returned by providers to the State should be treated as refunds and reported as other collections and consequently offset against expenditures on HCFA Form 64.

HCFA's Comments

In response to our draft report, HCFA concurred with our recommendation to take immediate action to issue regulatory changes involving the upper payment limit calculations. On October 10, 2000, HCFA issued a Notice of Proposed Rulemaking in the Federal Register to address the issue. The proposed regulations would limit the aggregate Medicaid payments to locally owned government facilities to the amount that would have been paid under Medicare payment principles. The complete text of HCFA's comments are included as **APPENDIX B**.

OIG's Response

We commend HCFA for proposing changes to the current upper payment limit regulations. For States with plan amendments approved before October 1, 1992, the financial impact of the revised regulations will be gradually phased in and become fully effective on October 1, 2008.

State Agency's Comments

Although no recommendations were directed towards NDHHS, we requested and received a prompt response to our draft report. The State agency agreed with our financial computation, but declined further comment.

APPENDIX A

SCHEDULE OF FEDERAL SAVINGS IN NEBRASKA BASED ON IMPLEMENTATION OF REVISED UPPER PAYMENT LIMIT REGULATIONS (INCLUDING TRANSITION PERIOD)

State Fiscal Year	Fiscal Period	Federal Savings (Millions)	
2001	07/01/00 - 06/30/01	$ 0	
2002	07/01/01 - 06/30/02	0	
2003	07/01/02 - 06/30/03	0	
2004	07/01/03 - 06/30/04	7	**Savings during the transition period equals $142 million**
2005	07/01/04 - 06/30/05	13	
2006	07/01/05 - 06/30/06	20	
2007	07/01/06 - 06/30/07	26	
2008	07/01/07 - 06/30/08	33	
2009	07/01/08 - 06/30/09	43	
2010	07/01/09 - 06/30/10	44	**5-year savings after the regulations have been fully implemented equals $220 million**
2011	07/01/10 - 06/30/11	44	
2012	07/01/11 - 06/30/12	44	
2013	07/01/12 - 06/30/13	44	
2014	07/01/13 - 06/30/14	44	

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

IG	✓
EAIG	
PDIG	✓
DIG-AS	✓
DIG-EI	
DIG-OI	
DIG-MP	
OCIG	
ExecSec	✓
Date Sent	11-9

DATE: NOV - 7 2000

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Acting Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Review of Medicaid Enhanced Payments to Public Providers and the Use of Intergovernmental Transfers by the State of Nebraska," (A-07-00-02076)

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 are 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.

Earlier this month, we proposed regulations 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. The proposed regulation would revise 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 would be phased in to allow States time to adjust their Medicaid programs to meet the new requirements. In addition, the proposal 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. In the NPRM, we proposed to preclude States from aggregating payments across private and public facilities to calculate UPLs. We further proposed to create a new payment limit for local governmental providers, and in the case of outpatient hospital and clinic services, an additional UPL for State-operated facilities. These changes would 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, we have proposed 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 have solicited comments on our proposed changes to the UPL policy, as well as the transition provisions, and we are open to other courses of action that will accomplish the same goals set out in the proposed rule.