

GAO

Report to the Committee on Finance,
U.S. Senate

February 2004

MEDICAID

Improved Federal Oversight of State Financing Schemes Is Needed



Highlights of [GAO-04-228](#), a report to the Committee on Finance, U.S. Senate

Why GAO Did This Study

For years, some states have taken advantage of a loophole in Medicaid law that allows them to claim billions of dollars in excessive federal matching funds by exploiting the “upper payment limit” (UPL), which is intended to be a ceiling on federal cost sharing. Congress and the Centers for Medicare & Medicaid Services (CMS) acted to curtail UPL financing schemes through law in 2000 and regulation in 2001. CMS recognized that some states had developed a long-standing reliance on UPL funds. The law and regulation authorized transition periods of up to 8 years for states to phase out excessive UPL claims.

GAO was asked to examine CMS’s oversight of nursing home UPL arrangements, including the status of and the basis for transition period decisions.

What GAO Recommends

CMS concurred with GAO’s recommendations that the agency improve its oversight of UPL arrangements, including expediting its financial reviews, establishing uniform guidance for states, and improving state reporting. CMS, Nebraska, and Wisconsin disagreed with GAO’s recommendation that CMS reassess its decisions to grant those two states an 8-year transition period. GAO is suggesting that Congress consider ending, under certain circumstances, the 8-year transition periods for states with excessive nursing home UPL arrangements.

www.gao.gov/cgi-bin/getrpt?GAO-04-228.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

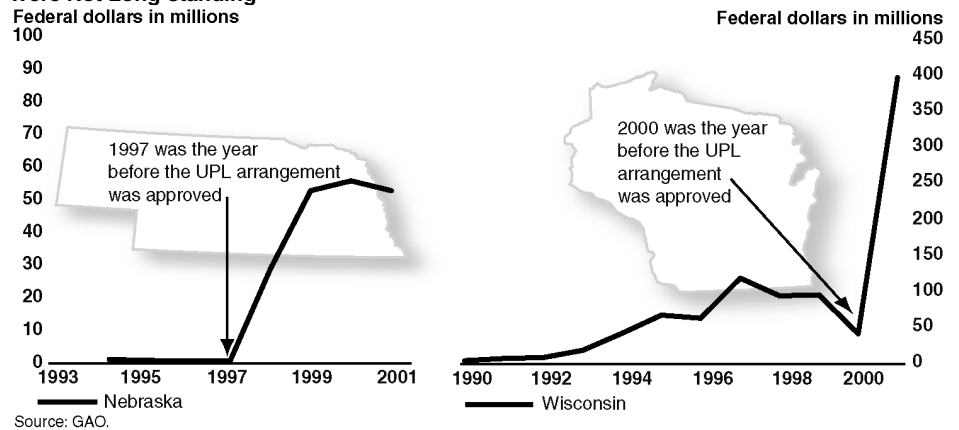
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Improved Federal Oversight of State Financing Schemes Is Needed

What GAO Found

CMS has granted transition periods to 18 states for phasing out excessive claims for federal Medicaid funds obtained through UPL financing schemes. Eight states were granted 1- or 2-year transition periods, seven were granted 5-year transitions, and three states—Nebraska, Pennsylvania, and Wisconsin—were granted the maximum of 8 years. The law permits 8-year transition periods for qualifying states with UPL financing schemes relating to a payment provision established on or before October 1, 1992. Although permissible under the law, CMS’s decisions to grant 8-year transition periods to two of the three states were not consistent with the agency’s stated purpose for the UPL regulation and transition policy, which targeted arrangements with problematic characteristics and states with a long-standing budgetary reliance on excessive federal funds. Neither Nebraska nor Wisconsin had such arrangements or budgetary reliance until after 1997 and 2000, respectively (see figure). Under their 8-year transition periods, these states can claim about \$633 million more in federal matching funds than they could have claimed under shorter transition periods consistent with the stated purpose of CMS’s regulation and transition policy.

Nebraska’s and Wisconsin’s UPL Financing Schemes and Claims for Excessive Payments Were Not Long-standing



CMS has strengthened its oversight of state UPL schemes, including forming a team to coordinate its reviews, drafting internal guidelines for reviewing state methods, and conducting financial reviews that have identified hundreds of millions of dollars in improper claims. CMS has not focused its reviews on the states with the largest arrangements, however, or instructed states on appropriate methods for calculating their UPLs. GAO’s analysis of six states’ UPL methods found variations and concerns suggesting that states may be overstating their UPL claims. Although efforts by Congress and CMS have narrowed the UPL loophole, it has not been eliminated. States can and do continue to claim excessive federal matching funds through UPL arrangements, using them for non-Medicaid purposes or to inappropriately increase the federal share of Medicaid program expenditures.

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Abbreviations

BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CBO	Congressional Budget Office
CMS	Centers for Medicare & Medicaid Services
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IGT	intergovernmental transfer
OIG	Office of Inspector General
NIRT	National Institutional Reimbursement Team
SFY	state fiscal year
UPL	upper payment limit

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United States General Accounting Office
Washington, DC 20548

February 13, 2004

The Honorable Charles Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

In searching for ways to generate additional revenues, many states have turned to certain creative financing schemes for Medicaid, the federal-state partnership that finances health care for an estimated 53 million low-income people. Although each state must pay a share of Medicaid expenditures, the federal government pays the larger share—on average, 57 percent—calculated according to a matching formula defined in statute.¹ Over the years, some states have taken advantage of the flexibility built into the Medicaid program by devising financing schemes that inappropriately boost the federal share of program expenditures, through use of Medicaid upper payment limit (UPL) provisions, resulting in excessive federal payments. The UPL is the upper bound on what the federal government will pay as its share of the Medicaid costs for different classes of covered services, and it often exceeds what states actually pay providers for services. Some states exploited the UPL loophole by paying nursing homes and hospitals owned by local governments much more than the established Medicaid payment rate, and requiring the providers to return the excess payments to the state. States that used the UPL loophole have collected billions of excessive federal dollars since the mid- to late 1990s. Few states specifically acknowledged how they spent these funds, but officials in some states have reported uses including education or health care programs besides Medicaid.

Over the years, we and others have reported concerns with states' ability to take advantage of the UPL loophole and other financing schemes.² As

¹In fiscal year 2002, the latest year for which data are available, the federal government paid \$139 billion of the \$244 billion spent on Medicaid. For each state, the federal and state shares are derived from a formula known as the federal medical assistance percentage, which is designed to reflect each state's capacity to finance Medicaid services. The federal share of each state's expenditures ranged from 50 percent to 76 percent in 2002.

²A list of related GAO products is provided at the end of this report.

the UPL financing schemes came to light, Congress and the Health Care Financing Administration (HCFA), the federal agency administering the Medicaid program, took action through statute and regulation to curtail states' ability to claim excessive federal funds through these UPL financing schemes.³ HCFA initiated policy changes to restrict states' UPL arrangements in an October 2000 proposed regulation.⁴ The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) directed HCFA to issue a final regulation to limit states' ability to claim excessive federal matching funds through UPL arrangements.⁵ BIPA also required that HCFA's final regulation—established in January 2001⁶—allow for transition periods as long as 8 years, during which time excessive UPL payments would be phased out. Because some states may have come to rely on these excessive federal funds, the length of a state's transition period was based in part on how long the state had in place a UPL arrangement meeting certain specified criteria.

This report addresses your questions about the criteria and process used by the agency, renamed the Centers for Medicare & Medicaid Services (CMS), to authorize transition periods. You asked us to examine states' UPL payment schemes that received the maximum transition period of 8 years and involved payments to nursing homes, which generally represent the highest-cost UPL arrangements.⁷ In addition, you raised questions about CMS's monitoring of the UPL arrangements still allowed under the new 2001 regulation. In response to your request, this report addresses the following questions:

- What is the status of CMS's activity in establishing transition periods for states to phase out UPL arrangements involving excessive payments to nursing homes?

³In June 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS). We continue to refer to HCFA where agency actions were taken under its former name.

⁴See 65 Fed. Reg. 60,151 (2000).

⁵See Pub. L. No. 106-554, App. F, §705(a), 114 Stat. 2763A-463, 575-576 (2000).

⁶See 66 Fed. Reg. 3148 (2001) (codified at 42 C.F.R. Part 447 (2002)).

⁷The other major UPL payment schemes funneling excessive federal matching funds to states involved hospitals.

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- Did CMS have a sound basis for its decisions to grant maximum-length (8-year) transition periods for UPL arrangements involving excessive payments to nursing homes?
 - Is CMS's continuing oversight of UPL arrangements sufficient to ensure that claims submitted by states are calculated appropriately and comply with Medicaid requirements?

To determine the status of CMS's actions in establishing transition periods, we interviewed CMS and state officials and reviewed documents pertaining to CMS's criteria, calculation, review, and preliminary decisions for the 18 states granted transition periods to phase out their nursing home UPL payment arrangements. To evaluate CMS's basis for approving maximum-length transition periods for arrangements involving payments to nursing homes, we reviewed the statutory language that authorized the 8-year transition period and related CMS regulations, policies, and memoranda, discussed transition period decisions with CMS officials, and reviewed CMS documentation, including written responses to our questions about specific transition period decisions. We also reviewed the nursing home UPL arrangements in the three states that received 8-year transition periods: Nebraska, Pennsylvania, and Wisconsin. To assess CMS's efforts to oversee state UPL arrangements, we analyzed the UPL calculations of six states. Four of these states—Michigan, New York, Oregon, and Washington—received 5-year transition periods, and two states—Pennsylvania and Wisconsin—received 8-year transition periods. We selected these states because, of the 10 states with 5- or 8-year transition periods, these six have the largest nursing home UPL arrangements. Finally, we used our past work to provide historical information on the nature of state financing schemes, and reviewed studies conducted by CMS, the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS), state auditors, and others. We conducted our work from October 2002 through January 2004 in accordance with generally accepted government auditing standards.

Results in Brief

CMS has granted provisional transition periods to 18 states for phasing out UPL schemes involving excessive federal payments for nursing homes. Of the 18, CMS determined that 3 states were eligible for the maximum 8-year transition period, 7 for 5-year transitions, and 8 for 1- or 2-year transitions. CMS determined that UPL arrangements in 8 other states were not eligible for any transition period because the arrangements were too recent. CMS officials told us that none of these decisions were final and that all were subject to continuing review. CMS has had to rely on limited historical

information on states' arrangements to assign transition periods, and on state-provided information to determine how much federal funding each state would be allowed to claim during the transition periods. On the basis of data submitted by states, we estimate that the 10 states with nursing home UPL arrangements that have 5- or 8-year transition periods could receive about \$9 billion in excessive federal matching funds during their transition periods. CMS's reviews of the validity of states' claims have been hampered by states' slow and incomplete responses to the agency's requests for information. Transition periods have already ended in 8 states, and 5-year transition periods are scheduled to end in 2005.

CMS's decisions to grant 8-year transition periods to two of the three states that received them—Nebraska and Wisconsin—were not consistent with the purpose the agency identified for the UPL regulation and for transition periods in the preamble to the January 2001 final rule. Although these decisions were permissible under the statute, neither Nebraska nor Wisconsin had the type of long-standing arrangement in place that the agency said the regulation was designed to curtail or a long-standing budgetary reliance on excessive payments. In Wisconsin's case, CMS's action is particularly troublesome because, as we earlier reported, Wisconsin's UPL financing scheme, established in 2001, should not have been approved.⁸ Wisconsin's arrangement was established after the agency had already taken action to curtail such practices. Over the 8-year transition periods, Nebraska and Wisconsin are eligible to receive about \$633 million more in excessive federal matching funds than they would have been eligible for under shorter transition periods based on the purposes of CMS's regulation and transition period policy as discussed in the preamble. In contrast to Nebraska and Wisconsin, the third state granted an 8-year transition period, Pennsylvania, had a long-standing UPL arrangement that has generated large federal payments for the state and, therefore, had in place the type of problematic arrangement CMS described.

CMS has taken a number of steps to strengthen its oversight of state UPL arrangements, including forming a team to coordinate and bring uniformity to the agency's review of the arrangements, and drafting internal guidelines for reviewing state UPL calculations. CMS's newly established financial management reviews have identified hundreds of

⁸U.S. General Accounting Office, *Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes*, GAO-02-147 (Washington D.C.: Oct. 30, 2001).

millions of dollars in improper UPL payments, allowing the agency either to avoid paying states inappropriately or to recoup the overpayment from states in those cases where the state had already been paid. For example, CMS has begun action to recoup over \$200 million from Louisiana and Missouri because financial reviews determined that these states had claimed more in federal matching funds through their UPL arrangements than allowed under the 2001 regulation. Despite these positive results from its financial reviews, CMS has not focused its reviews on the states with the largest UPL arrangements. Furthermore, although CMS established internal guidelines for its financial management reviews, it has not issued guidance for states' use on appropriate methods for calculating their UPLs, contributing to the possible overstatement of states' claims for federal matching funds under the 2001 UPL regulation. The agency has also not developed a process that will assure states' compliance with its requirement that states report UPL payments made to individual nursing homes and other facilities. Despite CMS's new regulation, states still can—and do—claim excessive federal matching funds and use them for non-Medicaid purposes or to inappropriately increase the federal share of Medicaid program expenditures.

We believe Congress and CMS should continue legislative and administrative efforts to preclude states' ability to claim excessive federal Medicaid payments and to inappropriately shift Medicaid costs to the federal government. We suggest that Congress consider a recommendation that remains open from our prior work, that is, to prohibit Medicaid payments to government-owned facilities that exceed costs. Further, in light of concerns that CMS's current policy for granting states an 8-year transition period could further erode the fiscal integrity of the Medicaid program and significantly increase future Medicaid expenditures, we also suggest that Congress consider ending the 8-year transition period for states with excessive nursing home arrangements, with a consideration for states that have demonstrated a long-standing budgetary reliance on excessive federal funds. This report also contains recommendations for the Administrator of CMS to take actions to improve the agency's oversight of state Medicaid financing arrangements. These actions include reassessing its decisions granting 8-year transition periods to Nebraska and Wisconsin, establishing guidance for states on appropriate methods for calculating their UPLs, improving its requirements for states to report on UPL arrangements, and giving priority to financial management reviews for states with the largest UPL arrangements and active transition periods.

In commenting on a draft of this report, CMS did not concur with our recommendation that it reconsider its initial decisions to grant Nebraska and Wisconsin 8-year transition periods. CMS believes that its current policy supports the intent of the UPL regulations regarding appropriate federal Medicaid spending as well as congressional intent to allow for an 8-year transition period. While we acknowledge that CMS's current transition period policy and decisions are legally permissible, we do not believe they are consistent with the objectives the agency identified when it issued the regulations. Because CMS is maintaining that its 8-year transition period policy and decisions are appropriate, we have elevated this issue for Congress to consider, as indicated above. Other than those recommendations related to its transition period policy and decisions, CMS generally concurred with our recommendations to improve its oversight, including to establish guidance for states and to improve its requirements for state reporting on their UPL arrangements.

We also provided a draft of this report to the states of Michigan, Nebraska, New York, Oregon, Pennsylvania, Wisconsin, and Washington. All the states but Washington provided comments. Nebraska and Wisconsin disagreed with our recommendation that CMS reconsider its initial 8-year transition period decisions. Nebraska stated that it complied in good faith with the Medicaid regulations and that reinterpreting the decision to grant the state an 8-year transition period would be unacceptable. Wisconsin stated that it was eligible for an 8-year transition period under the criteria established by BIPA and provided extensive comments explaining the basis for this view. We acknowledge that CMS's current transition period decisions are permissible under the statute, and have clarified our report accordingly. However, because of the fiscal impact of these decisions and concerns that CMS's policy could open the door for other states to claim that they qualify for an 8-year transition period, we maintain that CMS should reconsider its decisions to grant 8-year transition periods to these states.

Michigan, New York, Oregon, and Pennsylvania provided more limited comments and did not take issue with our recommendations. These states also provided technical comments on their specific UPL methodologies, which we incorporated as appropriate.

Background

Title XIX of the Social Security Act authorizes federal funding to states for Medicaid, which finances health care for certain low-income, aged, and disabled individuals. States have considerable flexibility in designing and operating their Medicaid programs, but they must comply with federal

requirements specified in Medicaid statute, regulations, and program directives. Each state administers its Medicaid program in accordance with a state plan approved by the Secretary of HHS, who has delegated approval authority to CMS. States' Medicaid plans specify, for example, the services to be provided and how the state will calculate the amount it will pay for these covered services. Any program changes a state wishes to make, including establishing UPL arrangements, must be submitted for CMS approval as a state plan amendment. The Social Security Act requires state plans to meet various requirements related to payments for Medicaid-covered care and services. Among other things, plans are to ensure that payments are consistent with efficiency, economy, and quality of care.⁹ The federal government pays a specified share of each state's Medicaid payments on the basis of a cost-sharing formula established under the Social Security Act.

UPLs Set Maximum Federal Cost Sharing for Medicaid Services

UPLs are the federal government's way of placing ceilings on federal financial participation in a state's Medicaid program.¹⁰ The UPL is tied to the amount that Medicare, the federal program that provides health coverage for seniors and some disabled persons, pays for comparable services. Thus, if the average Medicare rate for 1 day's care in a nursing home were \$150, and a state provided a total of 10,000 days of nursing home care under its Medicaid program, the UPL for that service would be \$1.5 million. If the Medicaid cost-sharing formula called for the federal government to provide 60 percent of this state's Medicaid expenditure, the maximum the federal government would pay would be \$900,000. In this way, the UPL places an upper limit beyond which federal matching funds will not be provided.

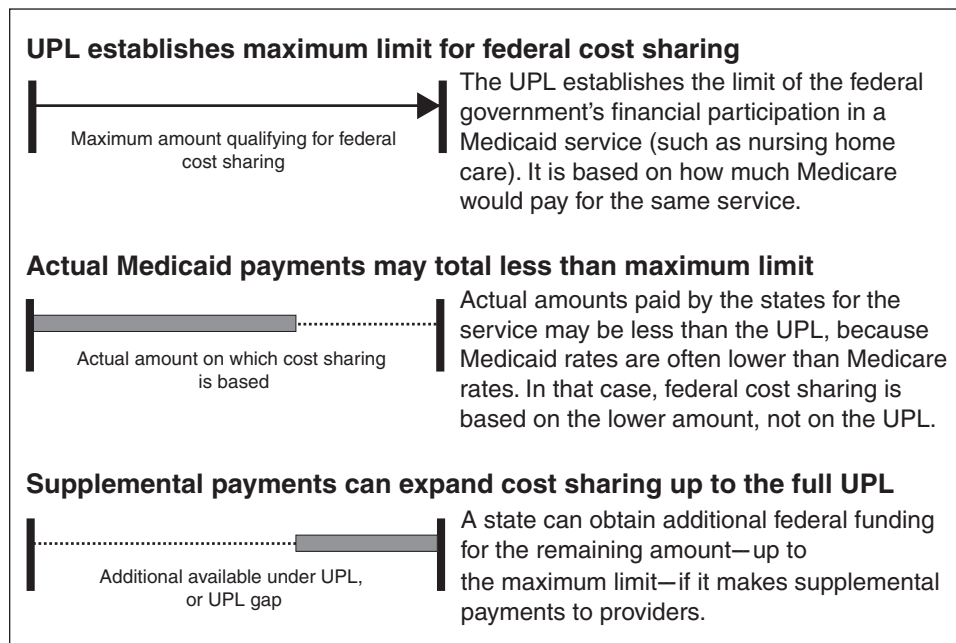
In practice, states' Medicaid rates are often lower than Medicare rates, creating a potential gap between the UPL and the amount states actually spend to provide services to Medicaid beneficiaries. For example, if a state actually paid for Medicaid-covered nursing home care at \$100 per day instead of the \$150 per day Medicare rate, the state's actual spending for 10,000 days of nursing home care would total \$1 million, not \$1.5 million. Under the Medicaid cost-sharing formula, the state would therefore

⁹42 U.S.C. §1396a(a)(30)(A).

¹⁰HCFA established UPLs in response to the Omnibus Budget Reconciliation Act of 1980 and the Omnibus Budget Reconciliation Act of 1981. See 46 Fed. Reg. 47,964 (1981); 48 Fed. Reg. 56,046 (1983).

receive federal matching funds for 60 percent of \$1 million, not 60 percent of \$1.5 million. Under the Medicaid program, however, states may make payments to providers separate from and in addition to those made using standard Medicaid rates, and the federal government will share in those payments up to the maximum allowed under the UPL. Such supplemental payments might be made, for example, to compensate a specific facility for higher-cost patients or for meeting an important community need, such as providing a high volume of care to people on Medicaid (see fig. 1).

Figure 1: Overview of How States Can Use the UPL to Make Supplemental Payments beyond Actual Medicaid Payments



Source: GAO.

Some States Have Exploited UPLs to Inappropriately Increase Federal Matching Funds

Over the years, some states exploited UPLs to claim excessive federal matching funds by paying government-owned facilities at rates much higher than established Medicaid rates. States used a method known as “aggregation,” whereby they estimated the UPL for a given class of service, such as nursing home care, on the basis of all facilities in the state that provided that service, including state-owned, local-government-owned, and private facilities. By combining, or aggregating, the UPL for services provided by nursing homes in all three categories of ownership, for example, and determining the difference between the combined UPL and what a state actually paid for Medicaid-covered nursing home services

statewide, the state could pay this large difference to only a few government-owned facilities, claim federal matching dollars for the payment, and require those facilities to return most or all of the excessive payment.¹¹ If, for example, the difference between the standard Medicaid payment rate and the UPL for private nursing homes was \$100 million, \$20 million for local-government-owned nursing homes, and \$50 million for state-government-owned nursing homes, the state could make a payment equaling the aggregated difference of \$170 million to a few government-owned nursing homes and then claim federal matching funds for the aggregated amount. Although, in some cases, states agreed to let the nursing homes keep a portion of the excess funds, typically the nursing homes were required to return the bulk of the payments to the state.

In 1987, HCFA acted to limit states' ability to use the UPL loophole. In response to states' manipulation of the UPL to make extremely large payments to state-owned facilities, HCFA created a separate UPL for state-owned facilities. HCFA's regulation, however, allowed states to aggregate the UPLs of local-government¹² and private facilities. Abusive arrangements involving local-government-owned facilities, like the prior abusive arrangements with state-owned facilities, became prominent in the mid-1990s and shared three characteristics:

- **The basis of the states' payment was the combined UPL for private and local-government facilities.** The states aggregated the dollar amounts in the UPL gap—that is, the difference between states' Medicaid payments for a class of services and Medicare's payments for the same services—for all local-government-owned and privately owned facilities providing, for example, nursing home services. Similar to the arrangements involving state-owned facilities, the states then paid one or more counties, on behalf of a few local-government nursing homes, a sum based on the UPL gap, in addition to and separate from payments at the states' standard Medicaid payment rates, which allowed the states to claim excessive federal matching dollars.

¹¹Until 1987, separate UPLs existed for different classes of services (such as nursing home or inpatient hospital care), but within a service category, separate UPLs were not set for different types of providers; that is, local government-owned and private nursing homes qualified for the same UPL for a given service.

¹²Throughout this report we refer to local-government facilities to identify a general ownership group. When discussing certain state UPL arrangements involving only nursing homes owned by county governments, however, we use the term county nursing homes.

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- **States' payments for the aggregated UPL gap resulted in total payments that were much higher than the facilities' actual costs.** Since UPL arrangements were based on an aggregated UPL gap for all private and local-government facilities, but payments were made to only a few facilities, the payments have been huge—vastly higher than the payments those facilities would have received under the standard Medicaid payment rate. For example, our earlier work found that in one state, the average daily federal matching payment for a Medicaid patient in a county nursing home increased by 17 fold, from \$54 per day to about \$969 per day.¹³ Such UPL arrangements resulted in sums that were many times greater than the facilities' actual costs of providing Medicaid services.
 - **States' payments for the aggregated UPL gap were temporary because most or all of the excessive payments were immediately returned to the state.** Because they are public entities, local-governments (typically counties) could return the payment to the state through what is known as an intergovernmental transfer.¹⁴ In some instances, the temporary payment was made through a bank transaction between the state and local government, with the “round-trip” of funds (from the state, to the local government, and back to the state) completed within a few hours.¹⁵ The local governments were in many cases allowed to keep a small portion of the UPL payment.

Establishing UPL arrangements using local-government and private facilities allowed states to claim billions of dollars in excessive federal Medicaid matching funds, without any increase in state Medicaid expenditures. States used the additional federal dollars for non-Medicaid purposes and for financing the states' share of Medicaid expenditures. The total dollars involved were substantial: the Congressional Budget Office (CBO) concluded in January 2001 that UPL schemes were the principal

¹³U.S. General Accounting Office, *Medicaid: State Financing Schemes Again Drive Up Federal Payments*, [GAO/T-HEHS-00-193](#) (Washington D.C.: Sept. 6, 2000).

¹⁴Intergovernmental transfers are an authorized financing mechanism in which states may use revenue from local governments to help fund the state share of allowable Medicaid expenditures.

¹⁵In a variant of this practice, some states required one or a few counties to send the state an amount equal to the total amount the state determined it could pay under the UPL for nursing home services. The state then sent the money back to the counties as a Medicaid payment, claimed the federal share of the payment, and then kept those federal dollars for its own purposes.

factor behind the 9 percent growth in Medicaid spending in 2000, the largest spending increase of the previous 7 years.¹⁶

HCFA and Congress Took Steps to Limit States' UPL Schemes

Responding to escalating costs from such arrangements, HCFA in October 2000 proposed a regulation that would eliminate states' ability to aggregate UPLs across private and local-government providers. Under this regulation, a separate UPL was proposed for nonstate government facilities (those owned by local governments), a limit that would effectively end states' ability to aggregate UPLs for local-government and private providers.

For UPL schemes that were already in place, HCFA's proposed October 2000 regulation contained transition periods that would phase out prohibited payments over time rather than eliminate them immediately. HCFA proposed such transition periods because it recognized that some states, as part of their overall state budgets, had come to rely on the additional money they were receiving through these schemes. The proposed transition periods extended payments to states for as long as 5 years. The length of the transition period a state would receive was based on how long it had operated the type of UPL arrangement that would be prohibited under the proposed regulation, with the longest-standing arrangements receiving the 5-year transition time. During the transition, states could continue to receive excessive federal matching funds from these arrangements—those prohibited by the 2001 UPL regulation—at a gradually declining rate.

BIPA directed HCFA to finalize its October 2000 proposed regulation and also established an 8-year transition period,¹⁷ which states could receive if they met two conditions. First, a state must have had a Medicaid plan payment arrangement (specifically, a provision or methodology) in place

¹⁶See Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2002–2011* (Washington D.C.: 2001).

¹⁷On the basis of elapsed time between September 30, 2002, and an ending date of September 30, 2008, BIPA describes the longest transition period as a 6-year transition. CMS, however, officially refers to this transition as an 8-year transition period because the agency measures from the passage of BIPA to the end of the transition period and rounds up to 8 years. In this report, we also refer to this transition period as an 8-year period.

on or before October 1, 1992.¹⁸ Second, the payment provision or methodology must have provided for payments in excess of the new UPL limits under certain identified time periods.¹⁹

HCFA issued its final UPL regulation on January 12, 2001. The regulation narrowed the UPL loophole by establishing separate UPLs for private, state, and local-government facilities. The January 2001 regulation also created three transition periods—8 years, 5 years, and 2 years. The agency later added a 1-year transition period for states with arrangements established around the same time as the regulation was published.²⁰ Transition periods were based on the date the state’s payment provision or methodology went into effect, with long-standing arrangements (those with earlier effective dates) receiving longer transitions. During its transition period, a state must gradually phase out excessive payments. The length of the transition period is important, because a state granted an 8-year transition period receives substantially more federal funding than it would receive under shorter periods. Figure 2 compares the amounts for a hypothetical excessive federal payment of \$100 million that is now prohibited. In this example, a state would receive a total of \$575 million in excessive federal funds under an 8-year period, \$350 million under a 5-year period, \$200 million under a 2-year period, and \$100 million under a 1-year period. Amounts are greatest under the 8-year period because the state

¹⁸Under the first BIPA requirement, a state must have had a Medicaid plan payment provision or methodology that “was approved, deemed to have been approved, or was in effect on or before October 1, 1992 (including any subsequent amendments or successor provisions or methodologies and whether or not a State plan amendment was made to carry out such provision or methodology after such date) or under which claims for Federal financial participation were filed and paid on or before such date” See section 705(b)(3)(A), 114 Stat. 2763A-576.

¹⁹Under the second BIPA requirement, the state’s Medicaid plan payment provision or methodology must have provided “for payments that are in excess of the upper payment limit test established under the final regulation . . . (or which would be noncompliant with such final regulation if the actual dollar payment levels made under the payment provision or methodology in the State fiscal year which begins during 1999 were continued).” See section 705(b)(3)(B), 114 Stat. 2763A-576. States’ fiscal years are set by states and do not necessarily align with the federal fiscal year. Most state fiscal years start July 1 and end June 30. In applying this requirement, CMS determined whether states made excessive payments during two different time periods. The first period was the effective date of the January 12, 2001 final regulation, which was March 13, 2001, and the second was the state fiscal year that began during 1999 (SFY 2000).

²⁰On September 5, 2001, CMS established a 1-year transition period for states that submitted plan amendments before March 13, 2001, that did not comply with the final regulation’s new UPLs. See 66 Fed. Reg. 46,397 (2001).

receives 3 full years of payment at 100 percent of the excessive amount, plus decreasing payments for 5 additional years. HCFA estimated that, even with such transition periods, its 2001 regulation would reduce payments to all states with any existing UPL arrangement (nursing home, inpatient hospital, or outpatient hospital) by \$55 billion over a 10-year period.²¹

Figure 2: What Happens to an Excessive UPL Claim of \$100 Million a Year under Each of the Four Transition Periods

Transition period	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Total
1 year	100% \$100								\$100
2 years	100% \$100	100% \$100							\$200
5 years	100% \$100	100% \$100	75% \$75	50% \$50	25% \$25				\$350
8 years	100% \$100	100% \$100	100% \$100	85% \$85	70% \$70	55% \$55	40% \$40	25% \$25	\$575

Source: GAO.

Note: All dollar figures are in millions. Percentages of excessive federal payments are those allowed under the 2001 UPL regulation. Percentages for 2-year, 5-year, and 8-year transition periods were established on January 12, 2001, and the percentage for the 1-year transition period was established on September 5, 2001.

Even under the January 2001 regulation, however, states can generate excessive federal matching payments beyond what they would claim using their established Medicaid payment rates. States can do this by aggregating the payments for all local-government nursing homes under one UPL, making payments to one or more counties on behalf of just a few

²¹This estimate did not take into account a later revision of the UPL regulation to reduce the upper limit for local-government hospitals from 150 percent to 100 percent, a reduction that CMS estimated would save an additional \$9 billion in federal expenditures over 5 years.

nursing homes, and requiring that the excessive payments be returned to the state. States' use of such arrangements for nursing homes continues to grow, even though the newer arrangements involve fewer dollars because UPL aggregation is limited to local-government facilities. CMS has reported a more than fivefold growth in the number of states with UPL nursing home arrangements, from 5 states before 1999 to 26 states as of January 2003.

Eighteen States Have Received Transition Periods, with Three States Receiving the Maximum of 8 Years

As of October 2003, CMS had determined that 18 of the 26 states with UPL arrangements involving nursing homes were eligible for transition periods to phase out excessive payments. CMS determined that 3 of the 18 states were eligible for the maximum 8-year transition period, 7 were eligible for 5-year transitions, and 8 were eligible for 1- or 2-year transitions. Eight additional states were found not eligible for transition periods because their UPL arrangements were too new to qualify (see table 1).

Table 1: Transition Period Assignments for States' Nursing Home UPL Arrangements

8-year	5-year	2-year	1-year	Not eligible
Nebraska	Alabama	Iowa	Virginia	Arkansas
Pennsylvania	Michigan	Kansas		Colorado
Wisconsin	New Hampshire	Louisiana		Georgia
	New York	Missouri		Indiana
	North Dakota	New Jersey		Kentucky
	Oregon	South Dakota		Mississippi
	Washington	Tennessee		Montana
				South Carolina

Source: CMS.

Until 2001, the agency did not require states to specifically report how many federal dollars they claimed through UPL arrangements. Also, while states needed to obtain HCFA regional office approval for their payment methodologies, these payment provisions were not necessarily identified in the state plan amendments submitted by states, or by HCFA, as a "UPL arrangement." Consequently, CMS had limited historical information on states' UPL arrangements to use to assign transition periods and to determine how much in federal funds each state would be allowed to claim. To supplement the information it had, CMS requested documentation from states on how they calculated their UPLs and on their estimates of what they could claim during their transition periods. This information was requested when CMS informed states in early spring 2002 of the transition periods it had assigned them.

CMS's reviews of state UPL payment calculations took months to complete, and some were still under way as of October 2003, in part because some states' responses to CMS's requests were not received for weeks or even months.²² For example, one state did not respond to CMS's February 2002 letter and data request until July 16, 2003—more than a year later. According to CMS officials, state responses were often incomplete or failed to provide the detailed information the agency requested, which also delayed CMS reviews of state UPL calculations and excess payment estimates. As of January 2004, CMS had not completed reviews of UPL calculations for 3 of the 18 states with nursing home UPL arrangements and an assigned transition period. These included 2 that had active transition periods and large UPL arrangements, New York and Oregon.

CMS officials told us that they consider all the transition period decisions provisional and subject to revision based on the findings of continuing reviews. CMS officials stated that they do not intend to issue final transition period determinations; instead, through ongoing reviews of state UPL calculations and estimated transition period payments, the agency will communicate directly with states to make any necessary changes. CMS also intends to monitor actual state spending and recoup any payments beyond the allowable limits. According to preliminary UPL estimates submitted by 10 states with UPL arrangements and either 5- or 8-year transition periods, these states expect to claim a total of about \$9 billion in excessive federal matching funds during their transition periods.²³

By October 2002, transition periods for eight states had ended, even though CMS had not completed its initial reviews of all these states' UPL methodologies and transition period assignments.²⁴ The transitions of the eight states granted 1- or 2-year transition periods were mandated to end

²²When CMS asked a state to provide information related to its transition period, the state was under no requirement to reply within any specified time frame.

²³This estimate is based on states with 5-year transition periods (Alabama, Michigan, New Hampshire, New York, North Dakota, Oregon, and Washington) and 8-year transition periods (Nebraska, Pennsylvania, and Wisconsin). As of October 2003, CMS had not reviewed all the states' estimated claims during their transition periods; some of these estimates may therefore change after review.

²⁴In commenting on a draft of this report, CMS told us in January 2004 that its reviews of 7 of the 8 states were completed. CMS's initial transition period decisions did not change as a result of these reviews being completed.

on September 30, 2002, or earlier.²⁵ The seven states with 5-year transition periods must be in compliance with the 2001 regulation by state fiscal year (SFY) 2006; thus, SFY 2005 will be the last year that these states can claim a portion of the excessive amount that they have claimed in the past. The three states granted 8-year transition periods must be in compliance by October 1, 2008.

CMS's Basis for Granting 8-Year Transition Periods to Two States Was Not Consistent with Its Stated Objectives

CMS's basis for granting 8-year transition periods to two of three states—Nebraska and Wisconsin—was not consistent with the objectives the agency identified for the UPL regulation and transition periods in the preamble to the January 2001 regulation. When developing and issuing its January 2001 UPL regulation, the agency repeatedly stated that transition periods were to address states with UPL arrangements with certain problematic characteristics and a long-standing budgetary reliance on excessive federal funds. Yet neither Nebraska nor Wisconsin had long-standing problematic arrangements or a long-standing budgetary reliance on excessive UPL payments from them. In contrast, the decision to grant Pennsylvania an 8-year transition period was consistent with the purpose described by CMS of the UPL regulation and transition periods. CMS made its initial transition period decisions without establishing and conveying how it would interpret the statutory language for granting states an 8-year transition period. Granting Nebraska and Wisconsin 8-year transition periods will result in significant federal government outlays. Under the 8-year phase-out, Nebraska and Wisconsin are slated to receive about \$633 million more in federal matching funds than they would have received under shorter transition periods more consistent with the agency's stated objectives. As of September 2003, the states had already claimed about \$497 million of these excessive federal funds.

²⁵Specifically, states granted a 1-year transition period could exceed the UPL until the later of two dates: either November 5, 2001, or 1 year from the approved effective date of the state plan provision authorizing the UPL arrangement. States granted a 2-year transition period were allowed to exceed the UPL until September 30, 2002. See 42 C.F.R. §§ 447.272(e)(2)(ii)(A) and (D).

CMS's Transition Period Decisions for Nebraska and Wisconsin Are Inconsistent with Stated Regulatory Objectives

Although permissible under the law, CMS's granting 8-year transition periods to Nebraska and Wisconsin is not consistent with the objectives the agency identified in the preamble to its January 2001 regulation, as neither state had in place the type of long-standing excessive payment arrangement the agency intended to curtail.²⁶ In explaining the basis for the changes imposed by the final regulation, HCFA emphasized that a key objective of the regulation was to limit states' ability to gain excessive federal matching payments through their UPL arrangements, specifically on the basis of aggregating UPLs of private and local-government facilities. The regulation was needed, according to HCFA, because

[i]t had become apparent that the existing regulations created a financial incentive for States to overpay non-State government-owned or operated facilities because, through this practice, States, counties, and cities were able to effectively lower net State or local expenditures for covered services and gain extra Federal matching payments.

The agency further explained that

[b]y developing a payment methodology that set rates for proprietary and nonprofit facilities at lower levels, States were able to set rates for county or city facilities at substantially higher levels and still comply with the existing aggregate upper payment limit. The Federal government matched these higher payment rates to public facilities. Because these facilities are public entities, funds to cover the State share were transferred from those facilities (or the local government units that operate them) to the State, thus generating increased Federal funding with no net increase in State expenditures.²⁷

According to HCFA, such practices contributed to rapid growth in Medicaid spending and were not consistent with the statutory requirements that Medicaid payments be economical and efficient.²⁸ In the preamble to the regulation, HCFA also stated that its paramount interest for issuing the regulation was protecting the fiscal integrity of the Medicaid program and that its proposed transition periods balance state budget issues with that protection. HCFA also emphasized that a transition

²⁶Although not legally binding, the preamble to a federal regulation is a valuable tool for determining the meaning or underlying purposes of an agency's regulation. See *Conn. Gen. Life Ins. Co. v. Commissioner*, 177 F.3d 136 (3d Cir. 1999).

²⁷See 66 Fed. Reg. 3149-3150 (2002).

²⁸HCFA provided the same description of the UPL problem in a July 26, 2000, letter to all state Medicaid directors and in the preamble to its October 10, 2000, proposed regulation, which Congress, through BIPA, instructed CMS to finalize.

policy was needed to recognize (1) that immediate implementation of the new UPLs could disrupt budget arrangements for states that had relied on the federal funds generated by such arrangements, and (2) that the length of the transition period should be based on how long a state had had an excessive UPL payment arrangement in place. HCFA reported that Congress affirmed in BIPA the use of budgetary reliance as the basis for granting transition periods of different lengths. Specifically, in response to commenters' opposition to having different transition periods based on the effective date of a state plan amendment, the agency stated in the preamble to its regulation that

[t]he reliance concept is applicable because these funds have been built into State and provider budgets for longer periods of time. We note also that in enacting a third transition period for States with excessive payment methodologies in place on or before October 1, 1992, the Congress has ratified our approach to establish transition periods based on a "reliance concept."²⁹

Although Nebraska and Wisconsin did have supplemental payment arrangements for nursing homes in place as of October 1, 1992, neither state had an arrangement that aggregated UPLs of local-government and private nursing homes, made extremely large payments to units of local governments on behalf of a few locally owned nursing homes, or required the local governments to return the bulk of payments to the state.³⁰ In contrast, Pennsylvania did have a long-standing UPL arrangement, that is, an arrangement that aggregated payments and resulted in large payments to local providers that exceeded their costs.

Nebraska's UPL History

Nebraska did not establish the type of UPL arrangement considered problematic until January 1998. CMS nonetheless determined that the state qualified for an 8-year transition period on the basis of a supplemental payment provision that the state established in September 1992.³¹

²⁹See 66 Fed. Reg. 3161-3162 (2002).

³⁰It is important to identify the type of supplemental payment arrangement a state had in place on or before October 1, 1992, because states may have had approved supplemental payment arrangements that did not have the characteristics of problematic UPL arrangements, such as extremely large payments to just a few local-government facilities. For example, states may have made small supplemental payments to local-government facilities to compensate them for higher-cost patients or for meeting an important community need, such as providing a high volume of care to Medicaid beneficiaries.

³¹Although the supplemental payment provision was effective September 1992, the state did not make supplemental payments until July 1993.

Nebraska's 1992 supplemental payment provision was designed to allow certain local-government-owned nursing homes to receive payments exceeding the state's normal cap on Medicaid nursing home payments, although payments under this arrangement could not exceed the nursing homes' costs of providing Medicaid services. Nebraska's 1992 payment provision differed significantly from the UPL arrangement that HCFA was trying to curtail in that it did not aggregate UPLs across local-government and private nursing homes. It also did not make large payments to a few nursing homes and require that they be returned to the state. Using the January 1998 UPL arrangement as the basis for the transition period decision, Nebraska would have qualified for a 5-year transition period.

Wisconsin's UPL History

Although Wisconsin did not establish the type of UPL arrangement considered problematic until 2001, in February 2002 CMS determined that the state qualified for an 8-year transition period on the basis of a small supplemental payment provision the state established in SFY 1985. Wisconsin's 1985 payment provision enabled the state to claim federal matching funds for some expenditures made by county nursing homes for Medicaid patients that were not covered by the state's standard Medicaid payment rates. These supplemental payments were relatively small. For example, in SFY 1992, Wisconsin's supplemental payments totaled \$15 million—resulting in a federal matching share of about \$9 million—and when combined with standard Medicaid payments to the nursing homes still totaled less than the nursing homes' costs for their Medicaid patients. Moreover, the 1985 payment provision did not aggregate UPLs across nursing homes as the basis for the nursing homes' payments; rather, the state capped total payments and payments to individual nursing homes at an amount set annually, typically far below the Medicaid upper limit. Finally, county nursing homes were not required to return supplemental payments to the state, and the state did not retain any of the federal funds claimed through the 1985 provision.³² In 2001, however, Wisconsin established a UPL arrangement that did aggregate the UPLs of local-government and private nursing homes in order to make extremely large payments to three counties on behalf of five nursing homes—totaling \$637

³²In 1994, Wisconsin changed how it claimed federal matching funds under its supplemental payment provisions. It did not, however, incorporate methods identified in the preamble to the January 2001 regulation; that is, the state did not identify the maximum amount allowed by aggregating payments of county and private nursing homes or make extremely large payments to only a few county nursing homes. In 2001, CMS reviewed the state's 1994 method (and the associated claims for federal funds based on that method), found the state's method to be inappropriate, and prohibited its use.

million—which allowed the state to generate and retain about \$373 million in federal funds.³³ As a result, before 2001 Wisconsin had no reliance on excessive UPL payments that would justify an 8-year transition period, given the purpose stated by CMS.

In 2001, we reported that HCFA should not have approved Wisconsin’s 2001 arrangement because the state did not seek approval for the arrangement until after the agency had taken steps to curtail such arrangements through regulation.³⁴ In September 2001, HCFA determined that the arrangement it approved for Wisconsin should receive a 16-month transition period, because the state’s arrangement was recently established.³⁵ But in February 2002, the agency determined that Wisconsin qualified for an 8-year transition period. CMS officials indicated that they changed their position on Wisconsin’s transition because the state had informed them, in November 2001, that the new arrangement continued a provision that had been in place before October 1992. After discussions with the state, CMS agreed that the 2001 UPL arrangement continued the state’s 1985 payment arrangement and that Wisconsin therefore had a long-standing UPL arrangement that would qualify the state for an 8-year transition. In our view, Wisconsin’s 2001 UPL arrangement differs substantially from the 1985 arrangement, and granting the state an 8-year transition period is inconsistent with the agency’s stated objectives in curtailing excessive UPL schemes.

³³Wisconsin first proposed its UPL arrangement on February 7, 2001, almost a month after the January 12, 2001, regulation was published. Even though this arrangement mimicked the practices that HCFA was explicitly working to limit, the agency approved the arrangement on May 8, 2001. In Wisconsin’s arrangement, three counties wired a total of \$637 million to the state, and the state then wired most of the money back to the counties, creating an illusion of a Medicaid payment. The wire transfers were completed in one day—March 12, 2001—the day before the effective date of the new UPL regulation, which is one of the dates for a state to qualify for an 8-year transition period. Further, because the state retained \$373 million of the federal funds generated and then used them as the state share of other Medicaid expenditures, we estimate that the state generated \$222 million more in federal funds. The payment transactions were wired to the three counties on behalf of five county nursing homes. Of the federal funds generated, about \$150,000 was paid to consultants and banks as transaction fees and charges related to the wire transfer; the remainder was retained by the state.

³⁴[GAO-02-147](#).

³⁵In September 2001, HCFA established a UPL regulation specifically for several states with newly established UPL arrangements, including Wisconsin, which shortened the time they could operate these arrangements. See 66 Fed. Reg. 46,397 (2001). For a further discussion, see [GAO-02-147](#).

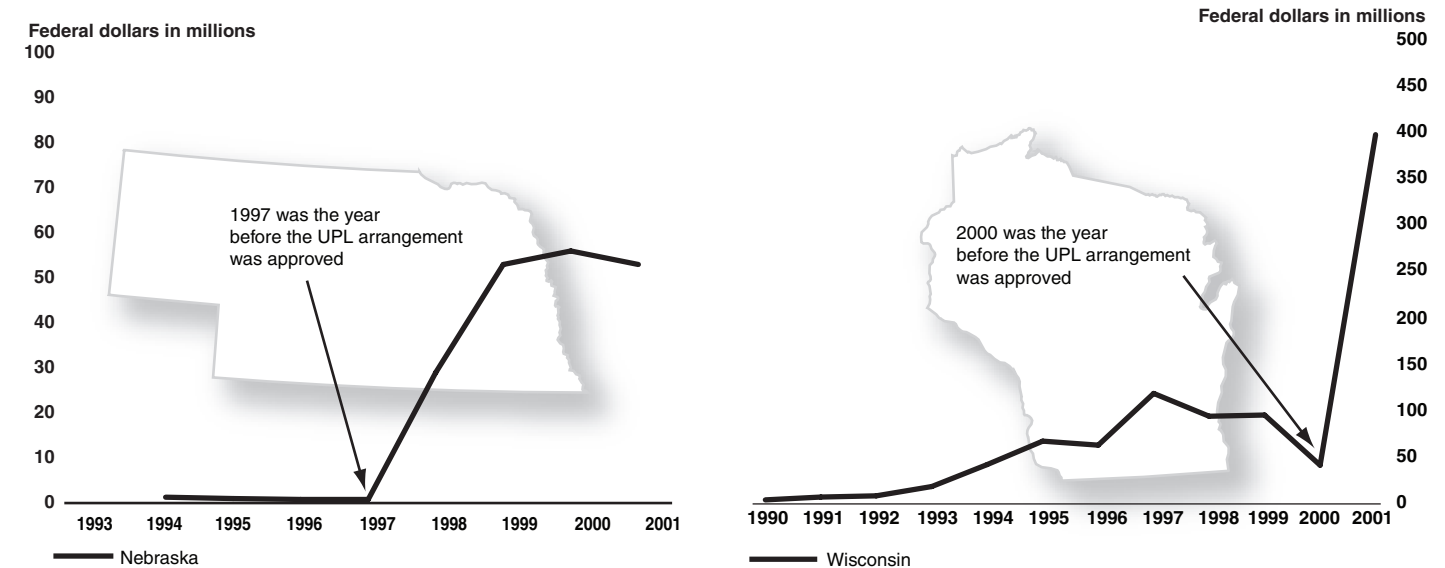
Pennsylvania's UPL History

In contrast to Nebraska and Wisconsin, Pennsylvania had the type of UPL arrangement identified as problematic by CMS that predated October 1992. As a result, CMS's granting an 8-year transition period to Pennsylvania is consistent with the objectives for the UPL regulation and transition periods that the agency identified when issuing the final regulation. The state provided information that described a 1992 arrangement and showed that Pennsylvania claimed federal matching funds based on an aggregated UPL for public and private providers, and made unusually large payments to 23 of the state's 47 county-operated nursing homes in amounts that exceeded their Medicaid costs.

Recent Payment Spikes Reflect a Lack of Long-standing Budgetary Reliance on UPL Arrangements

Given that Nebraska and Wisconsin started their aggregated UPL arrangements in 1998 and 2001, respectively, these states lacked long-standing budgetary reliance on excessive UPL funds. The date when a state first established an aggregated UPL arrangement is important, because the beginning of such an arrangement typically produces a sharp increase, or spike, in supplemental payments made on behalf of local-government nursing homes and, consequently, in the federal matching share of such payments. Such an increase represents the earliest point, in our view, that a state could have established a budgetary reliance on excessive matching dollars from UPL arrangements. For example, federal payments for supplemental payments to local-government nursing homes in Nebraska increased from about \$830,000 in 1997 to nearly \$53 million in 1999—the first full-year of the state's UPL arrangement. Indeed, the federal share of state supplemental payments to county nursing homes spiked dramatically in both Nebraska and Wisconsin long after 1992, in 1998 and 2001, respectively (see fig. 3).

Figure 3: Federal Share of Supplemental Payments in Nebraska and Wisconsin through SFY 2001



Source: GAO.

Note: Nebraska established its supplemental payment provision in September 1992 (SFY 1993), but did not make payments until SFY 1994. Wisconsin started its supplemental payment provision in SFY 1985, and we obtained payment information back to SFY 1990.

Because of the 8-year transition periods granted to Nebraska and Wisconsin, these two states can obtain more in federal matching payments during their transition periods than they had received before the 2001 regulation. In our view, this is further evidence that the states did not have long-standing budgetary reliance on excessive federal funds and that 8-year transition periods are not warranted. Our analysis of historical and projected claims data estimates that, together, Nebraska and Wisconsin are eligible for at least \$490 million more in federal matching funds during their transition periods than they actually obtained in the 9 years before the January 2001 regulation. Specifically, Wisconsin is eligible for \$936 million in excessive federal matching funds from UPL payments during its 8-year transition period, which is \$385 million more than the \$551 million it obtained from SFY 1992 through SFY 2000. Similarly, Nebraska is eligible for \$248 million in federal matching funds from excess UPL payments

during its 8-year transition period, which is \$105 million more than it obtained from SFY 1994 through SFY 2000.³⁶

CMS Made Transition Period Decisions without Establishing How It Would Apply Broad Statutory Language

Before making its initial transition period decisions, CMS did not establish or convey to the states how it would interpret and apply the statutory criteria for a state to receive an 8-year transition period. According to the agency, its policy for making this determination was still being developed during the course of our review. Under BIPA, a state could qualify for an 8-year transition period if the UPL payment provision that resulted in a state's not complying with the January 2001 regulation was in place on or before October 1, 1992, including a "successor" or "subsequent amendment" to an earlier payment provision or methodology. To qualify for an 8-year transition period, CMS informed us that states must have had a supplemental payment provision in place on or before October 1, 1992—that is, a provision allowing for enhanced or supplemental payments to providers. CMS officials made initial transition period decisions by assessing how long the UPL payment arrangements known to exist in 2000 or 2001 had been in place. Thus, CMS's 8-year transition period determinations depended on whether a current UPL payment provision was a "successor" or "subsequent amendment" to a 1992 supplemental payment provision or methodology. Before it notified states of their assigned transition periods in early spring 2002, CMS did not establish how it would determine whether a state's latest UPL arrangement was a "successor" of an arrangement the state had had in place on or before October 1, 1992.³⁷

During our review, CMS's explanation of how the agency determined whether a provision was a "successor" changed. In March 2003, CMS officials advised us that they considered a state's latest UPL payment provision to be a successor of an earlier qualifying payment provision if changes made by the state in later years were consistent with the basic payment principles of the provision in place on or before October 1, 1992,

³⁶Through SFY 2003, Wisconsin had already obtained \$895 million, which is \$344 million more than it obtained the 9 years before January 2001. Nebraska had already obtained \$120 million through SFY 2003, and this year will surpass the \$143 million it obtained in the years its arrangement was in place before the 2001 regulation (from when payments were first made under the arrangement in SFY 1994 through SFY 2000).

³⁷CMS allows states to qualify for an 8-year transition period on the basis of payment provisions in place in SFY 2000 or SFY 2001. We use the term "latest" to refer to provisions in either of these state fiscal years.

and that payment methodologies that were not identical to the original methodology might not be considered successors. CMS stated in writing that the agency would consider changes updating the state's Medicaid plan for inflation and other cost factors to be successor provisions. CMS officials informed us that other changes, including changes in payment provisions, would not qualify as successor provisions. This interpretation, however, was not consistent with the agency's initial decisions to grant Nebraska and Wisconsin 8-year transition periods, because in 1992 these states had payment provisions in place that differed significantly from the UPL arrangements that they established in 1998 and 2001, respectively.

When we asked for clarification, CMS stated that the agency was still evaluating its definition of a successor provision. In August 2003, CMS officials informed us in writing that the description it gave us earlier was too restrictive. Instead, CMS wrote that provisions for payments to the same provider *type* would embody the same basic principles as the original provision and that any modification to the original supplemental payment provision would constitute a successor, as long as payments were made to the same *type* of provider. CMS further explained its evolving policy and interpretation of the law. The agency said that its preliminary interpretation of BIPA potentially disqualified any amendments from consideration as successors and could potentially "render meaningless" BIPA's provisions creating the 8-year transition period. CMS officials indicated that as the agency developed its interpretation, officials considered various interpretations including those that, when applied consistently to all states, resulted in no states qualifying for an 8-year transition period and in all states qualifying. We find the approach adopted by CMS troublesome because it links current problematic UPL arrangements with significantly different payment provisions that may not have been problematic.

Shorter Transition Periods Would Have Resulted in Less Federal Spending

Under the regulation allowing a state with an 8-year transition period to claim its full 2001 UPL payment until 2004, Nebraska and Wisconsin have been able to generate significantly more in excessive federal UPL payments than they could have under shorter transition periods consistent with CMS's stated purpose for the 2001 regulation. Had CMS based transition periods on the date that a state actually established a problematic UPL arrangement, the transition periods assigned would have been shorter, and allowable federal matching dollars would have totaled \$551 million, which is \$633 million less than the nearly \$1.2 billion that CMS is allowing the two states to claim. Through SFY 2003, the two states had already claimed about \$497 million more than they would have been

able to receive under shorter transition periods. The two states are eligible to claim a total of about \$135 million more in federal matching funds during the remaining years of their 8-year transition periods that they would not be able to claim under shorter transition periods.

Nebraska would have received \$102 million less in federal funding under a 5-year transition period, during which the state would have had to reduce its excessive payments (by 25 percent per year over 4 years, instead of 15 percent per year over 6 years). The payments allowed in Wisconsin are even more troubling, because in 2001 we found HCFA's approval of Wisconsin's UPL arrangement unjustified. In approving the arrangement, and then granting Wisconsin an 8-year transition period, the agency made the state eligible for about \$936 million in excessive federal funds. Most of the federal funds have already been claimed.³⁸ (See app. I for a more detailed description of the year-to-year differences in excessive federal payments.)

A review by the HHS OIG concluded that long transition periods were not needed, and estimates by CBO point to significant federal savings if transition periods were ended sooner. On the basis of its reviews of UPL arrangements in six states in 2000, the OIG concluded that transition periods in HCFA's January 2001 regulation were longer than needed for states to adjust their spending to achieve the lower UPL ceilings established by the new regulation.³⁹ The OIG recommended that CMS seek authority to eliminate or reduce transition periods, but CMS did not concur. Savings from shortening transition periods could be significant. According to estimates from CBO in 2003, the federal government could save \$2.8 billion in 2004 and \$7.3 billion over 5 years if transition periods

³⁸In Wisconsin, federal funding declined dramatically when the phase-out portion of the transition period began on July 1, 2003.

³⁹HHS, Office of the Inspector General, *Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers*, A-03-00-00216 (Washington, D.C.: 2001).

were stopped after 2003 and all states were required to comply with the January 2001 regulation beginning in 2004.⁴⁰

CMS Has Strengthened Its Oversight of UPL Arrangements, but Concerns Remain

CMS has taken action to improve its oversight of state UPL arrangements, but its efforts do not go far enough to ensure that states' claims are for Medicaid-covered services provided to eligible beneficiaries. Such oversight is important because, even though CMS's regulations significantly narrow the UPL loophole, states can still claim excessive federal matching dollars for nursing home payments that exceed the facilities' actual costs. CMS's recent efforts include forming a team to centralize and coordinate the review of state UPL arrangements, bringing more uniformity to the process. The agency has also conducted financial management reviews of some states' UPL arrangements and identified and disallowed some inappropriate claims. CMS has not, however, completed detailed financial management reviews of states with the largest UPL arrangements or issued guidance instructing states how to appropriately calculate the UPL. Our review of UPL estimates in six states found wide variances in calculations and identified concerns about the accuracy of state estimates. Further, all six states are still using federal Medicaid funds obtained through UPL arrangements for non-Medicaid purposes or to increase the federal share of Medicaid expenditures over the established federal matching rate.

UPL Loophole Has Narrowed, but States Can Still Generate Excessive Federal Funds

Because states can aggregate payments to all local-government nursing facilities under one UPL, they can still generate substantial excessive federal matching payments beyond their standard Medicaid claims. Our analysis of CMS estimates indicates that under the January 2001 regulation, states could still generate about \$2 billion annually in federal matching funds through UPL arrangements with nursing homes by making payments that are substantially higher than a facility's cost of providing services. In Wisconsin, for example, CMS's January 2001 regulation would still allow the state to claim federal matching funds on the basis of the UPL

⁴⁰According to CBO, supporters of such an action argue that the reduction would treat states more equitably by not allowing some states to obtain more federal Medicaid funds than intended by statute; opponents counter that requiring faster compliance would cut federal payments to some states when they are already facing budgetary difficulties. Congressional Budget Office, *Budget Options* (Washington, D.C.: 2003), 133, <http://www.cbo.gov/showdoc.cfm?index=4066&sequence=0&from=0> (downloaded Oct. 6, 2003).

for all county-owned nursing homes in the state. The state could continue to make large UPL payments to a few counties participating in its UPL arrangement and generate federal matching funds for as much as \$41 million more than the nursing homes' actual cost of providing services.

CMS Has Strengthened Oversight, but Issues Remain in Four Areas

CMS has taken a variety of actions to strengthen its oversight of state UPL nursing home arrangements (see table 2).⁴¹ It has, for example, formed a special team to coordinate review of UPL transition periods and other UPL arrangements, drafted guidelines for internal use in reviewing UPL arrangements, conducted financial management reviews in a few states to help ensure UPL payments were proper, and established some UPL-reporting requirements. Although these actions demonstrate CMS's efforts to curb UPL abuses, our review of several state UPL programs identified areas where stronger agency oversight is needed. For example, CMS has not issued guidance to states to help ensure that they use appropriate methods to calculate their UPLs, and it has not completed financial reviews of some states with the largest arrangements and longest transition periods. CMS also has not standardized its reporting requirements, but instead has asked states to provide information as part of its ongoing transition period reviews.

⁴¹CMS has also taken action to curb excessive UPL arrangements involving hospitals. For example, CMS's January 2001 regulation also established transition periods to phase out excessive UPL payments for inpatient and outpatient hospital services.

Table 2: Benefits and Shortcomings of CMS Actions to Strengthen Oversight of UPL Arrangements

CMS action	Benefit	Shortcomings
Formed National Institutional Reimbursement Team	Coordinates CMS review and approval of initial UPL applications and amendments, conducts reviews of states' claims for federal matching funds during transition periods	The volume and complexity of UPL submissions and related workload has resulted in delayed reviews and questionable decisions
Developed draft guidelines for reviewing UPL methodology	Establishes guidelines and some consistent standards that CMS reviewers can use to assess state UPL methods and calculations	Guidelines not finalized and similar guidance not yet provided to states
Conducted financial management reviews	Verifies the accuracy of state UPL claims; identifies flaws in states' methods for calculating their UPLs and recommends corrective action	Reviews limited in number and conducted mainly in smaller states, rather than in states with large UPL claims and long transition periods
Established annual and quarterly UPL reporting requirements	Provides information that could be used to better monitor state UPL programs	Annual reporting requirement not yet implemented; quarterly reports provide only aggregate data, rather than facility-specific information needed to monitor payment levels

Source: GAO analysis of CMS actions.

National Institutional Reimbursement Team

To promote more timely and consistent review of state UPL arrangements, CMS formed the National Institutional Reimbursement Team (NIRT) in July 2002. This reimbursement team centralizes the reviews and approvals of state proposals to change or institute new payment methods for institutions, including nursing homes and hospitals. As of September 2003, the centralized team consisted of six members from CMS headquarters and four from its regional offices. Its major responsibilities are to make transition period decisions and reviews and to validate states' claims for federal matching funds during their transition periods.

The team has uncovered a number of inappropriate UPL claims. For example, in New Jersey, the team determined that the state's 2-year transition period ended in September 2002, but the state continued to make UPL payments above the limits established by the January 2001 rule and claimed \$238 million in UPL payments that the team denied. In addition, the team identified and rejected a number of states' claims for

retroactive payments. Some states attempted to retroactively change the way they calculated their UPLs so they could increase payments for prior periods, specifically for SFY 2000, the base year for transition periods. If such changes were made to the base year, increased payments would also carry forward and enable the states to make higher payments throughout their transition periods. But changes that do not comply with the state's current Medicaid plan are prohibited. The team prevented three states—New Hampshire, Oregon, and Washington—from claiming \$30 million, \$46 million, and \$265 million, respectively, in federal matching funds for prohibited retroactive payments.⁴²

Although NIRT has brought greater consistency to the oversight process and identified a number of unallowable UPL claims, it has been challenged by the volume, complexity, and variety of state UPL methodologies, as well as by its other responsibilities to review all changes that states propose involving payments to institutional providers, including hospitals and nursing homes.⁴³ The team's heavy workload has contributed to delays and raises concern about the comprehensiveness of CMS's review and approval of states' claims during transition periods. For example, despite the team's reviews, we identified concerns with two states' methodologies that the team's review did not challenge. Our analysis of Pennsylvania's UPL methodology found shortcomings in the state's calculations; specifically, the state had overestimated its base-year ceiling by about \$11 million, which could allow the state to claim more than \$55 million in excess federal matching funds during its 8-year transition period.⁴⁴ In Michigan, NIRT reviewers did not identify an error in the state's 2000 UPL methodology, which used a higher wage index (from 2001) than the index that was actually in place for 2000. This error increased Michigan's UPL

⁴²In January 2003, the Departmental Appeals Board upheld a CMS decision to disallow \$30 million (federal share) of New Hampshire's SFY 2002 UPL claims. CMS determined that the state improperly used a payment calculation methodology that was inconsistent with its approved state plan. See New Hampshire Department of Health and Human Services., DAB No. 1862 (2003).

⁴³Before establishing NIRT, review and approval of state plan amendments related to institutional payment provisions, including UPL arrangements, were primarily a CMS regional office responsibility.

⁴⁴An earlier OIG audit identified about \$155 million in unallowable UPL claims because the state had claimed matching funds for UPL payments that were not supported by actual expenditures. HHS, Office of Inspector General, *Review of Medicaid Claims for County Nursing Facility Supplementation Payments by the Commonwealth of Pennsylvania*, A-03-00-00211 (Philadelphia, PA: 2001).

estimate by more than \$8 million, allowing the state to claim almost \$5 million more in federal matching funds in SFY 2000.

During our review, team officials told us that they had a new effort under way to hold states more accountable for how the federal funds are spent. Starting in August 2003, for any state plan amendments that proposed changing how the state would pay nursing homes or other institutions, the team requested information that had not previously been required. According to officials, the reimbursement team began asking states with proposed state plan amendments to provide detailed descriptions of the state's payment provision, including sources of state matching funds for supplemental payments; the extent that total payments under the new payment provision would exceed providers' costs; how the state would use the additional funds; and whether the state required payments to providers to be returned to the state (and if so, how the state planned to spend such funds). Team officials indicated that they would disapprove any proposed plan amendments from states that did not adequately respond to the team's requests for this information. As of October 2003, the team had asked 30 states with proposed state plan amendments to provide additional information, and the agency was in the process of receiving and reviewing states' initial responses. At that time, decisions about whether to approve or disapprove the plan amendments had not yet been made. CMS officials said that all states would be asked to provide detailed information on their payment provisions—irrespective of whether the state had qualified for a transition period.

Guidelines for Calculating a UPL

CMS has developed draft internal guidance for reviewing state UPL arrangements, but it has not finalized it or issued guidance for states, setting out acceptable methods for states to calculate their UPLs. Under the Medicaid reimbursement process, the federal contribution to a state's UPL payments is based on the state's estimate of its UPL; inflating the UPL, whether intentional or not, could bring a state a financial windfall. In August 2002, CMS's Division of Financial Management issued a draft UPL financial management review guide for the agency's internal use when auditing state UPL arrangements. The guide was designed to provide some instructions on performing a financial management review of Medicaid supplemental payments, and related UPL arrangements, and has been used by NIRT and reviewers who have examined states' UPL arrangements. The reimbursement team prepared a section of the guide on suggested approaches for calculating a UPL. According to the guide, unique circumstances could require the use of additional methods and procedures, determined by the reviewer's professional judgment and reviewed by the team.

To determine their UPLs, states are required to make reasonable estimates of what Medicare would pay for similar services. Although CMS allows states some flexibility in how they calculate their UPLs, its financial management review guide states that, generally, any methodology states elect to use should incorporate at least three factors: (1) consideration of any geographic variation within the state in Medicare rates, (2) determination of the appropriate Medicare payment rate for the medical and resource needs of comparable Medicaid patients, and (3) adjustment for the different services covered by Medicaid and Medicare. To determine if states were using UPL methodologies that incorporated such factors, we applied Medicare payment principles as well as standards from CMS's financial management review guide to review the UPL calculation methodologies used by six states that operate large UPL arrangements and have long transition periods.

Our examination of methodologies in the six states—Michigan, New York, Oregon, Pennsylvania, Washington, and Wisconsin—revealed concerns with UPL calculations in each state, including widely varying and potentially inaccurate calculation methods. In our view, these variations and potential inaccuracies can result in overestimates of the UPL. Concerns we identified with states' methods included overestimates of the number of Medicaid residents served and the use of incorrect Medicare rates for service locations. Oregon, for example, projected and used in its SFY 2000 UPL calculation about 163,000 more nursing home resident days than nursing homes actually provided. As a result, we estimate that the state's claim for SFY 2000 was inflated by \$6 million. If this overestimate is not corrected, the state may receive at least another \$22 million during its transition period, because SFY 2000 establishes the excessive payment amount allowed during that transition period. We also found that states used a variety of different approaches to estimate their UPLs. For example, states used different methodologies in calculating appropriate Medicare rates to account for changes that occurred when Medicare

moved from a cost-based reimbursement system to a prospective payment system starting in 1998.⁴⁵

In addition, five of the six states we reviewed did not use a method for determining the appropriate Medicare payment rate, based on the medical and resource needs of comparable Medicaid patients, that was consistent with CMS's guide.⁴⁶ Our analysis of the one state that did comply with CMS's method found that this approach, as expected, resulted in a lower and more accurate estimate of the UPL than the approach used by the other five states. Requiring states to follow a standard methodology could have helped prevent many of the discrepancies we identified. Appendix II summarizes our analysis of the methods that the states in our review used to calculate their UPLs.

Financial Management Reviews

CMS has also improved its ability to monitor state UPL programs by conducting a number of financial management reviews. CMS's Division of Financial Management, in conjunction with the regional offices, conducts annual audits, also known as financial management reviews, of state Medicaid expenditures and claims. Although examining UPL arrangements is not a mandatory item for every financial management review, in recent years CMS selected a number of states for focused UPL audits.⁴⁷ Regional

⁴⁵Over the 3 years following Medicare's implementation of prospective nursing home payments in 1998, many nursing homes were paid an amount that blended prior cost-based rates with new prospective per diem rates. Two states (Washington and Pennsylvania) blended Medicare facility-specific cost-based rates with their estimated Medicare prospective payment rates for Medicaid residents. In contrast, two other states (New York and Wisconsin) took a more conservative approach, blending Medicaid facility-specific cost-based rates with their estimated Medicare prospective payment rates. For Wisconsin in SFY 2000, this conservative methodology was to the state's advantage, because by this method, the state's small supplemental payment exceeded the new UPL, thus appeared to meet one condition for an 8-year transition period. Had the state, like Washington and Pennsylvania, used the less conservative approach approved by CMS, the result would have been a payment below the new UPL, not qualifying the state for an 8-year transition period.

⁴⁶These states calculated their UPL by using, as a basis for their estimate, the number of residents that each nursing home served, rather than the number of resident days for each level of service. CMS's draft guidance maintains that, if states use a weighted average methodology, UPLs should be calculated on the basis of patient days, by level of service, rather than the number of patients, which can result in overestimates of what Medicare would have actually paid for those services.

⁴⁷At CMS's request, the HHS OIG in 2003 began conducting UPL financial reviews in seven states with nursing home UPL arrangements (transition period in parenthesis): Alabama (5 years), Colorado (none), Kansas (2 years), Michigan (5 years), Indiana (none), New York (5 years), and Oregon (5 years). According to officials, the reviews were limited to SFY 2003 payments, and no review had been completed as of October 2003.

financial auditors familiar with states' financial management systems and expenditure levels perform these reviews. The reviews conducted to date have identified millions of dollars in unallowable UPL claims, and CMS has begun to recover improperly paid federal matching funds. For example, to prevent state UPL payments from escalating during transition periods, CMS's January 2001 regulation limited payments to SFY 2001 levels. Recent financial management reviews in Louisiana and Missouri have identified federal matching payments of \$116 million and \$87 million, respectively, that CMS has determined were improper increases over their maximum allowed payments. CMS has initiated action to recoup these excessive payments.

Although these financial reviews have identified millions of dollars in potentially unallowable payments, CMS's financial management reviews have not been targeted to those states with the longest transition periods and largest claims. As of October 2003, reviewed states were those with 1- or 2-year transition periods. None of the 10 states with transition periods of 5 or 8 years had been reviewed (see table 3). While there is merit to focusing reviews on those states whose transition periods ended first, it is also important to ensure that states claiming large amounts of excessive funds for a long period of time—in particular states with 8-year transition periods that can claim 100 percent of their excessive payments for the first 3 years of the transition—have their UPL payment methods and claims reviewed for accuracy.

Table 3: Status of CMS Financial Management Reviews of Nursing Home UPL Arrangements, as of October 2003

Transition period	State	Financial management review of nursing home arrangement		Federal share of state UPL payments in SFY 2001 (dollars in millions)
		Yes	No	
8-year	Nebraska		✓	\$55
	Pennsylvania		✓	\$816
	Wisconsin		✓	\$355
5-year	Alabama		✓	\$51
	Michigan		✓	\$402
	New Hampshire		✓	\$16
	New York		✓	\$496
	North Dakota		✓	\$26
	Oregon		✓	\$96
	Washington		✓	\$87
	Virginia	✓		\$179
2-year	Iowa	✓		\$190
	Kansas	✓		\$101
	Louisiana	✓		\$415
	Missouri	✓		\$134
	New Jersey	✓		\$445
	South Dakota		✓	\$32
	Tennessee		✓	\$76
1-year	Virginia	✓		\$179
None ^a	Arkansas		✓	\$9
	Colorado		✓	\$6
	Georgia		✓	\$68
	Indiana		✓	\$7
	Kentucky		✓	\$17
	Mississippi		✓	\$11
	Montana		✓	\$4
	South Carolina		✓	\$0.1

Source: CMS.

^aThese states' UPL arrangements were too new to qualify for a transition period; federal share applies to federal fiscal year 2001, 2002, or 2003.

Annual and Quarterly UPL Reporting Requirements

Until recently, states were not required to report separately on the amount of Medicaid funds they were claiming for nursing home UPL arrangements. As a result, information on the number of states with such arrangements and on the total amount of funds claimed through these arrangements has not been readily available. Starting in 2001, CMS established two reporting requirements to help remedy this lack of information. First, as of October 2001, CMS required all states with UPL arrangements to report quarterly the total amount they were claiming in Medicaid funds for their arrangements. Second, to facilitate the monitoring of UPL programs in states with transition periods, CMS incorporated into a January 2002 regulation an annual UPL reporting requirement for the duration of each state's transition period. Specifically, states that are eligible for a transition period are required to report to CMS the total Medicaid payments made to each facility, as well as a reasonable estimate of the amount that would be paid for the services under Medicare payment principles.⁴⁸

Under the October 2001 reporting requirement, states are reporting the total amount of their UPL claims on a quarterly basis. Although these reports provide summary information on a statewide basis, they do not identify the amount paid to each nursing home—important information that could help CMS oversee changes in claimed amounts and in the potential for continued aggregated payments to a few nursing homes. Quarterly reporting on payments made to each nursing home could also allow CMS to detect dramatic changes in supplemental payments, conduct a more timely review of states' payments, and take more immediate action than waiting for the results of annual reports.

As of October 2003, CMS had not taken steps to implement the 2002 reporting requirement to collect facility-specific information on a consistent and continuing basis from states with transition periods. For example, CMS has not provided guidance to states as to the required format for these reports or the time frames for reporting. According to CMS officials, the agency has gathered some payment information on individual nursing homes as part of its transition period decision-making process, but it has not established a standard format or reporting time frames. Such an ad hoc approach does not ensure that CMS gathers the

⁴⁸CMS's January 2001 regulation contained reporting requirements applicable to hospitals that were non-state government owned or operated. Subsequently, a January 18, 2002, regulation expanded the reporting requirements to all facilities, including nursing homes that receive payments during transition periods. See 67 Fed. Reg. 2602 (2002).

information it needs to monitor states' UPL arrangements during transition periods.

Some States Use Funds from UPL Arrangements for Non-Medicaid Purposes or to Inappropriately Increase the Federal Share of Medicaid Expenditures

Despite efforts to improve oversight of state UPL schemes, there is no assurance that states are not using excessive federal Medicaid UPL matching funds for non-Medicaid purposes or to inappropriately increase the federal share of Medicaid expenditures. Federal Medicaid matching funds are intended for Medicaid-covered services for eligible individuals on whose behalf payments are made.⁴⁹ But states reported continuing to use UPL arrangements to obtain federal matching funds that are spent for non-Medicaid purposes or to effectively increase those states' federal matching rates. Each of the six states we examined with large UPL arrangements reported using the proceeds from its UPL arrangement for a variety of Medicaid and non-Medicaid purposes. Similar to past reported uses of UPL funds,⁵⁰ some states in our review put excessive funds from UPL arrangements into the state's general fund, which the state may or may not use for Medicaid purposes. States also used excessive federal funds obtained through UPL arrangements to pay for the state's share of its Medicaid program. In this way, federal funds are "recycled" to generate additional federal funds, effectively increasing those states' federal match rate. In Wisconsin, for example, we estimate that by obtaining excessive federal matching payments and using these funds as the state share of other Medicaid expenditures, the state effectively increased the federal matching share of its total Medicaid expenditures from 59 percent to 68 percent in SFY 2001. States often provide a small amount of the total federal UPL match to the county nursing homes on whose behalf it was claimed but retain the majority of the funds. Table 4 provides further information on the reported uses of UPL funds in the six states we reviewed.

⁴⁹See 42 U.S.C. § 1396.

⁵⁰See, for example, HHS, A-03-00-00216, 2001; Teresa A. Coughlin and Stephen Zuckerman, *States' Use of Medicaid Maximization Strategies to Tap Federal Revenues* (Washington, D.C.: Urban Institute, 2002); Andy Schneider and David Rousseau, *Upper Payment Limits: Reality and Illusion in Medicaid Financing* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2002).

Table 4: Selected States' Use of Funds Generated through UPL Arrangements

State	Use
Michigan	Funds generated by the state's UPL arrangement are deposited in the state's general fund but are tracked separately as a local fund source. These local funds are earmarked for future Medicaid expenses and used as the state match, effectively recycling federal UPL matching funds to generate additional federal Medicaid matching funds.
New York	Funds generated by the state's UPL arrangement are deposited into its Medical Assistance Account. Proceeds from this account are used to pay for the state share of the cost of Medicaid payments, effectively recycling federal funds to generate additional federal Medicaid matching funds.
Oregon	Funds generated by the state's UPL arrangement are being used to finance education programs and other non-Medicaid health programs. UPL matching funds recouped from providers are deposited into a special UPL fund. Facing a large budget deficit, a February 2002 special session of the Oregon legislature allocated the fund balance, about \$131 million, to finance kindergarten to 12th grade education programs. According to state budget documents, the UPL funds are being used to replace financing from the state's general fund.
Pennsylvania	Funds generated by the state's UPL arrangement are used for a number of Medicaid and non-Medicaid purposes, including long-term care and behavioral health services. In SFY 2001–2003 the state generated \$2.4 billion in excess federal matching funds, of which 43 percent was used for Medicaid expenses (recycled to generate additional federal matching funds), 6 percent was used for non-Medicaid purposes, and 52 percent was unspent and available for non-Medicaid uses (does not total 100 percent because of rounding).
Washington	Funds generated by the state's UPL arrangement are commingled with a number of other revenue sources in a state fund. The fund is used for various state health programs, including a state-funded basic health plan, public health programs, and health benefits for home care workers. A portion of the fund is also transferred to the state's general fund. The fund is also used for selected Medicaid services and the state's SCHIP program, which effectively recycles the federal funds to generate additional federal Medicaid matching funds.
Wisconsin	Funds generated by the state's UPL arrangement are deposited in a state fund, which is used to pay for Medicaid-covered services in both public and private nursing homes. Because the state uses these payments as the state share, the federal funds are effectively recycled to generate additional federal Medicaid matching funds.

Sources: CMS and states.

Further Action Would Help Address Continuing Concerns with UPL Schemes

Although Congress and CMS have taken significant steps to help curb inappropriate UPL arrangements, the growing use of state UPL nursing home arrangements poses continuing concerns about states' ability to aggregate payments under the UPL. An outstanding recommendation from an earlier GAO report would, if implemented, strengthen CMS oversight of UPL programs and help mitigate these concerns. In August 1994, we recommended that Congress consider prohibiting Medicaid payments that exceeded actual costs for any government-owned facility.⁵¹ The recommendation was aimed at eliminating states' ability to aggregate payments to multiple nursing homes (regardless of category of ownership) under one UPL and to make large payments that exceed a facility's costs, by essentially creating facility-specific limits. In September 2001, the OIG made a similar recommendation, that CMS implement facility-specific upper limits based on facility costs. At that time, CMS agreed that facility-specific limits may be the most effective approach to ensure that UPL payments are reasonable, but the agency also stated that, if possible, it wanted to maintain states' flexibility in how they paid facilities. CMS indicated that it did not want to impose facility-specific limits until it was clear that its January 2001 regulation had not solved the problem. CMS indicated that if this approach proved inadequate, it would consider additional measures, such as facility-specific limits.

Conclusions

The actions that Congress and CMS have taken to limit states' ability to inappropriately claim federal Medicaid funds through UPL financing schemes have helped strengthen the fiscal integrity of Medicaid's state and federal partnership. With BIPA, and CMS's implementing regulation, the UPL loophole has been narrowed. CMS has subsequently further strengthened its oversight of states' continuing UPL arrangements, including launching a major initiative in August 2003 aimed at holding states more accountable for using Medicaid funds only for Medicaid purposes.

At the same time, problems with federal oversight of state financing schemes remain. Although CMS described transition periods as a mechanism for assisting states that had relied on excessive UPL funds to adjust to the new and reduced limits, CMS had little historical information

⁵¹U.S. General Accounting Office, *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*, [GAO/HEHS-94-133](#) (Washington D.C.: Aug. 1, 1994).

on, and uncertain criteria for, its decisions before it assigned states their transition periods. We found that, while permissible under the statute, CMS's decisions to grant Nebraska and Wisconsin an 8-year transition period were inconsistent with the agency's stated objectives because neither state's circumstances suggest a budgetary reliance on excessive UPL funds for long periods. In our view, these decisions did not reflect a balancing of Medicaid's fiscal integrity with the state budget issues as cited by CMS. Further, CMS's current transition period policy raises broader concerns about the program's fiscal integrity in the future, as states without any long-standing budgetary reliance on federal funds from UPL arrangements may claim that they qualify for an 8-year transition period and continue to submit claims for excessive funds from the federal government. These decisions establish a questionable precedent with unknown ramifications for the Medicaid budget.

In addition to the lack of information CMS has on states' UPL arrangements and concerns about its transition period policy and decisions, our work points to other concerns with current financing arrangements and the limits of CMS's ability to oversee them. Our work and the financial reviews CMS has conducted indicate that states continue to submit improper claims for federal matching funds. Claims are based on widely varying and sometimes inaccurate methods for estimating what Medicare would pay, a problem stemming from the agency's lack of guidance to states on allowable methods for calculating their UPLs. Although our work identified some overpayments to states based on inappropriately calculated UPLs, the full extent of problems with states' methods is unknown, in part because CMS has not completed its reviews of all states with long transition periods and with large claims for federal matching payments. In addition, although CMS has improved UPL reporting requirements, such reporting is still limited. This dearth of information and the complexities of states' financing schemes are likely to continue to challenge and complicate the agency's oversight role.

Given the continuing oversight challenges and significant financial risks to the federal government that remain through these arrangements, the UPL loophole should be closed altogether. Although the federal government may need to have an upper payment limit or some other means to help ensure that Medicaid payments are economical and efficient, any limit should be just that: an upper bound to what states can pay to individual facilities for Medicaid-covered services and for which they can receive federal reimbursement. Consistent with this approach and with sound fiscal policy, federal matching payments should be based on the lower of the established limit or facilities' actual Medicaid costs. Because the UPL

provision continues to allow states to claim hundreds of millions of dollars above what they actually pay for care, we believe the earlier action we recommended to Congress—that it consider prohibiting Medicaid payments that exceed costs to any government-owned facility—is still valid and would help to further safeguard federal Medicaid funds.

Matter for Congressional Consideration

We believe Congress should continue its efforts to close the UPL loophole and prevent further claims from arrangements that undermine the fiscal integrity of the Medicaid program. In addition to reiterating our previous recommendation to Congress to limit Medicaid payments to providers' costs, we believe action is required to address the impact of CMS's transition policy and decisions on program integrity. We suggest that Congress consider ending the 8-year transition periods for states with excessive nursing home UPL arrangements, with a consideration for any state that has demonstrated a long-standing budgetary reliance on the federal funds.

Recommendations for Executive Action

To protect the fiscal integrity of the Medicaid program, we recommend that the Administrator of CMS take the following two actions:

- establish criteria for making transition period decisions that are consistent with the objectives described in CMS's January 2001 UPL regulation, and
- reconsider the agency's initial decisions to grant Nebraska and Wisconsin 8-year transition periods.

To further improve UPL oversight, we also recommend that the Administrator of CMS take the following three actions:

- establish uniform guidance for states, which would set forth acceptable methods to calculate UPLs;
- expedite the financial management reviews of states with UPL arrangements, assigning high priority to reviews of states with 5- and 8-year transition periods, including those we identified as having methodological problems; and
- improve state reporting on UPL arrangements, such as implementing the current requirement for states with transition periods to report payments on a facility-specific basis, and requiring such reports for all states with a UPL arrangement.

Agency and State Comments and Our Evaluation

We provided a draft of this report for comment to CMS and the states of Michigan, Nebraska, New York, Oregon, Pennsylvania, Wisconsin, and Washington. CMS and all the states except Washington provided comments. Pennsylvania provided a technical comment. Comments from Michigan, Nebraska, New York, Oregon, and Wisconsin are found in appendixes IV through VIII, respectively.

CMS's Comments and Our Evaluation

CMS generally concurred with our recommendations to improve its UPL oversight, including establishing uniform guidance for states to calculate their UPL and strengthening its requirements for states to report UPL activity. CMS concurred in part with our recommendation to expedite financial management reviews of states with 5- and 8-year transition periods, indicating that it had made more progress than our draft reflected, but also agreeing to review those states that it had not yet reviewed. CMS concurred with our recommendation that it establish criteria for making transition period decisions that are consistent with the objectives described in issuing its January 2001 UPL regulation, but the agency also commented that it had already done so. CMS did not concur with our recommendation that it reconsider its initial decisions to grant Nebraska and Wisconsin 8-year transition periods. CMS stated that its current policy and transition period decisions reflect both the intent of the UPL regulation and congressional intent to allow for an 8-year transition period.

CMS also stated that its transition period policy and decisions are legally supportable and, in summarizing its concerns, provided a detailed explanation of the legal basis for its current policy and decisions. We acknowledge that CMS's 8-year transition period policy and its initial transition period decisions are permissible under the statute, and we have clarified our report accordingly. CMS also stated, however, that it considered various interpretations of BIPA's provisions for an 8-year transition period, suggesting that the provisions were susceptible to alternative interpretations. We disagree that CMS has already established transition period criteria in a manner consistent with the objectives it identified in the preamble to the regulation implementing BIPA to help ensure the fiscal integrity of the Medicaid program. We note that, although CMS maintains that it has applied its current policy consistently in making its decisions, its decisions were made before the agency defined key provisions of its interpretation—in particular, what constitutes a “successor” payment provision. We are concerned that CMS's current policy could invite more states to claim that they qualify for an 8-year transition period, because they had a supplemental payment provision in

place on or before October 1, 1992, particularly given the scant information CMS has available on states' historical payment arrangements. Because CMS disagrees with our view, we believe Congress should consider addressing this issue.

CMS also commented on our draft report's treatment of the agency's basis for and explanations of its transition period policy and decisions. CMS expressed concerns that the draft report ignored, almost entirely, the basis for and explanations of CMS's policy interpretations and decisions. CMS also stated that the report inaccurately suggested that the agency changed policy interpretations in the middle of UPL implementation in order to provide preferential treatment to certain states. We do not believe or report that CMS changed its policy to favor certain states. Moreover, we did not ignore CMS's explanations of its evolving policy; in fact, as CMS pointed out, we obtained and analyzed considerable oral and written documentation throughout our review in order to understand CMS's position. Further, we believe that it was appropriate to report on the evolution of CMS's policy during our review. CMS's policy development occurred months after states had been informed of their transition periods, and more than 2 years after BIPA was enacted. Our review, and CMS's evolving policy and interpretations, took place months after the agency had sent letters to Nebraska, Wisconsin, and Pennsylvania, notifying them that they would receive an 8-year transition period.⁵² Our concern was, and remains, that the agency was developing key aspects of its policy, such as the definition of a "successor" provision, after it notified states about their transition periods. We acknowledge that CMS staff had a very complex challenge in making transition period decisions. But we suggest that, given the substantial financial impact of these decisions, CMS should have developed its policy position and obtained and reviewed states' documentation before it notified states of their initial transition periods and allowed states to claim funds based on these decisions. In response to CMS's concern that we do not adequately reflect the agency's current policy, we have modified the report to do so.

⁵²For example, letters to Nebraska and Wisconsin, with the stated purpose of notifying the state of its transition period, were sent in February 2002. We began our fieldwork in December 2002.

In its cover letter, CMS also expressed four general concerns:

- **The stated objectives included in the draft report differ from those in the letter notifying the Secretary of the initiation of the assignment.** Our final reporting objectives differed from the questions posed at the start of our assignment because we agreed with our congressional requesters, soon after we initiated work, to broaden the scope of work to include additional states and to provide a broader perspective on CMS’s oversight of state UPL arrangements. We communicated these revised objectives to CMS staff at the time these revisions occurred and at meetings held during our review.
- **The illustrations in the draft report of UPL-related spending in Nebraska and Wisconsin do not fairly and accurately represent the amounts allowed by CMS.** The illustrations of Nebraska and Wisconsin’s past payment levels (figure in “Highlights” and fig. 3 in the report) are based on payment amounts reported to us by the states and CMS. Consequently, we believe our illustrations are fair and accurate in the context they are presented—to summarize the federal share of states’ historical supplemental payments.
- **The report does not consider the limited CMS resources available to determine transition periods and amounts.** We believe our report captures the challenges faced by CMS staff responsible for making UPL transition period decisions and policy and for reviewing state plan amendments—including tremendous workload and limited personnel (see pp. 28–29). We also report that CMS had limited historical information on states’ UPL arrangements for assigning transition periods and determining how much in federal funds each state would be allowed to claim, and that some states’ responses to CMS’s requests for information were not received for weeks or months (see p. 14–15).
- **The report does not acknowledge that GAO staff told CMS officials that the agency’s interpretation of two statutory terms was reasonable and legally supportable.** We have clarified our report to explicitly acknowledge that, while CMS’s policy and decisions were permissible under BIPA, they departed significantly from the stated objectives of the agency’s UPL regulations.

CMS’s written comments appear in appendix III. CMS also provided technical comments, which we considered and incorporated as appropriate.

Nebraska's and Wisconsin's Comments and Our Evaluation

Nebraska and Wisconsin also disagreed with our recommendation that CMS reconsider its initial 8-year transition period decisions. Nebraska stated that it complied in good faith with the Medicaid regulations and that reinterpreting the decision to grant the state an 8-year transition period would be unacceptable. Wisconsin stated that it was eligible for an 8-year transition period under the criteria established by BIPA and provided an extensive explanation of the basis for this view. (Nebraska's comments appear in app. V, and Wisconsin's comments and our detailed response appear in app. VIII.)

In addition to disagreeing with our position that its 8-year transition period was unjustified, Wisconsin commented on our approach for estimating the state's UPL payments during state fiscal year 2000, stating that its methodology was appropriate and that the one we used was flawed. We disagree that our methodology was in error, since other states had taken the same approach and CMS had approved their methodologies. We agree, however, that Wisconsin's methodology could also be considered reasonable, and we have revised our report accordingly. Our concern remains that, because CMS has not defined what constitutes a "reasonable" methodology, states' methods vary widely, and states are free to use methods designed to maximize their UPL payments. This lack of consistency formed the basis for our recommendation that CMS establish uniform guidance for states that would set forth acceptable methods to calculate UPLs, and CMS concurred. Wisconsin also disagreed with our concern that HCFA should not have approved the state's UPL arrangement when it was initially proposed in 2001. The state asserts that its 2001 state plan amendment was legal and appropriate and disagrees with the conclusion of our 2001 report that CMS's approval of the arrangement was unjustified.⁵³ We disagree, and refer to our response to the state's comments in our 2001 report.

New York's Comments and Our Evaluation

New York's comments discussed the concept of local-government cost sharing through intergovernmental transfers (IGT). New York explained that its Medicaid state plan has, since its inception, included local government cost sharing and that IGTs of local-government funds to finance Medicaid services is integral to the state's Medicaid financing statutes. We agree that IGTs are a legitimate tool used by state and local governments to carry out their shared governmental functions, including

⁵³ [GAO-02-147](#).

collecting revenues and making expenditures for government services. Moreover, the Medicaid statute allows local governments to contribute up to 60 percent of the state's share of Medicaid expenditures. We do not take issue with New York's use of IGTs to enable local governments to transfer funds to the state. We do, however, disagree with the state's implication that its UPL financing scheme is appropriate simply because the IGT mechanism is legally established. New York also provided several technical comments that we incorporated where appropriate. New York's comments appear in appendix VI.


Other States' Comments and Our Evaluation

Three other states (Michigan, Oregon, and Pennsylvania) provided comments summarized below.

- Michigan expressed concern that the error in its UPL methodology that we report is not substantive and said that the error has been corrected for subsequent years; it recommended deleting the audit finding. Michigan further said that its methodology did not account for an increase in Medicare rates in SFY 2000 that would have offset the overestimated claim based on its calculation. While we agree that this error did not have a substantial impact on the state's claims, we maintain that the state's error was relevant to our report, which includes concerns with CMS's oversight of the accuracy of states' claims for UPL-related payment.
- Oregon did not take issue with the report's general substantive findings, except for the characterization that states were engaged in unauthorized activities. The state commented that CMS's oversight of state UPL arrangements was consistent with the regulations because it afforded states some flexibility in calculating a reasonable estimate of what Medicare would have paid for Medicaid services. We acknowledge that state flexibility is an integral aspect of the Medicaid program, allowing states broad discretion to establish priorities to cover and pay for populations and services.
- Pennsylvania provided a single technical comment about the number of county-owned nursing homes, which we incorporated into our final report.

As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution of this report until 30 days after its issuance date. At that time, we will send copies of this report to the Secretary of Health and Human Services, the Acting Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions, please contact me at (202) 512-7118. Another contact and other major contributors are included in appendix IX.



Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

Appendix I: Comparison of Federal Funds under 8-Year and Shorter Transition Periods

We assessed the difference between what Nebraska and Wisconsin are slated to receive under the 8-year transition periods they have been granted, and what they would have received under shorter transition periods consistent with CMS's stated objectives for the 2001 regulation. Specifically, we compared annual federal matching funds claimed by Nebraska and Wisconsin under 8-year transition periods with those the states would have received had CMS based its decisions on when the states actually started the arrangements giving rise to excessive federal payments (see table 5).

Because Nebraska's upper payment limit (UPL) arrangement started in 1998, the state would qualify for a 5-year transition period. Under this transition period, the state would have 1 year less than under the approved 8-year transition period to claim the full excessive payment before starting to phase it out, and the state would have to phase out the excessive payment more quickly. As a result, the state would be eligible for \$102 million less in federal matching payments.

On the basis of when Wisconsin's UPL arrangement began, its transition period would decrease from 8 years to 16 months. Because the state did not have a problematic UPL arrangement on or before October 1, 1992, and given CMS's stated objectives for the January 2001 regulation and transition periods, in our view the state should have received no more than the 16-month transition period.¹ In that event, the state would have had to stop claiming federal matching funds from its UPL arrangement on November 5, 2001, making it eligible for about \$531 million less in federal matching funds.²

Wisconsin had, as of the end of state fiscal year (SFY) 2003, already claimed most of the excessive funds it can claim during its transition period—more than \$895 million in federal matching funds—for the 3-year period from SFY 2001 through 2003. As illustrated in table 5, the amount in excessive federal payments drops for Wisconsin after SFY 2003 and continues to decline in subsequent years. This large drop occurs because

¹We reported in 2001 that HCFA's approval of Wisconsin's 2001 proposed transition period was unjustified ([GAO-02-147](#)).

²Furthermore, on the basis of our analysis of the state's 2000 UPL calculation, we determined that had the state not used a conservative approach in estimating its SFY 2000 UPL it would have no excess UPL payments from SFY 2000 to phase out between SFY 2004 and 2009, even under an 8-year transition period.

**Appendix I: Comparison of Federal Funds
under 8-Year and Shorter Transition Periods**

excessive payments through SFY 2003 are based on the amount of excessive payments in SFY 2001, the first year of Wisconsin's UPL arrangement. In contrast, starting in SFY 2004, the allowed excessive payment amount is a percentage of excessive payments in SFY 2000, the year that Wisconsin had a much smaller supplemental payment arrangement.

Table 5: Excessive Federal Payments, State Fiscal Years 2001–2009, for Two States under Different Transition Periods

Dollars in millions

State	Transition period	State fiscal year									Total
		2001	2002	2003	2004	2005	2006	2007	2008	2009	
Nebraska	8-year assigned by CMS	\$45	\$45	\$30	\$38	\$31	\$25	\$18	\$11	\$4	\$248
	5-year ^a	45	45	23	22	11	0	0	0	0	146
	Difference ^b			8	16	20	25	18	11	4	\$102
Wisconsin	8-year assigned by CMS	300	298	297	13	10	8	6	4	0.4	936
	16-month ^c	300	105	0	0	0	0	0	0	0	405
	Difference ^b		194	297	13	10	8	6	4	0.4	\$531
Total^d	8-year assigned by CMS	345	343	327	51	42	33	24	15	5	1,184
	Shorter	345	149	23	22	11					551
	Difference ^b	0	194	304	28	31	33	24	15	5	\$633

Source: GAO analysis of state payment data and estimates of UPL payments during transition periods.

^aThe 5-year transition period is based on GAO analysis showing that the state established a UPL arrangement on January 1, 1998, which qualifies it for a 5-year transition period under CMS's UPL regulation.

^bDifferences based on numbers before rounding.

^cThe 16-month transition period is based on GAO analysis showing that the state established a UPL arrangement on February 7, 2001, which indicates that the originally assigned 16-month transition period should be maintained.

^dTotals may not add because of rounding.

Appendix II: Scope, Methodology, and Analysis of Selected State UPL Calculations

An upper payment limit (UPL) represents the maximum amount the federal government will pay as its share of a state's Medicaid expenditures.¹ Because UPLs are based on the amount Medicare would pay for similar services, a state must develop a reasonable methodology to (1) identify nursing home services provided to Medicaid residents, (2) generate a reasonable estimate of what Medicare would have paid for equivalent services, and (3) account for differences in covered services between Medicaid and Medicare and determine the payment adjustments needed. Because an inflated UPL can generate excessive federal matching funds, it is important that states use sound methods for calculating their UPLs. Although CMS has developed a draft financial review guide as a basis for the agency's audits of state calculations, it has not prescribed a standard UPL methodology that states must use. According to agency officials, CMS deliberately decided to recognize the variation among state approaches and to allow states some flexibility to develop methods appropriate to their situations. With this flexibility in mind, we examined the extent to which states used appropriate methods to calculate their UPLs. We made this assessment by comparing states' methodologies and results with Medicare payment principles and with CMS's draft internal UPL review guide.

For our analysis, we obtained data and documentation from six states that have large nursing home UPL arrangements and received either an 8-year or a 5-year transition period—Michigan, New York, Oregon, Pennsylvania, Washington, and Wisconsin. We generally focused our review on state methods for state fiscal year (SFY) 2000 because it is the base year for determining the sum of excessive payments that will be phased out during the transition period, but we also reviewed SFY 2001 methods to determine whether selected states had made changes. Methods used in SFY 2001 are important because that particular year established the amount that certain states—those with long transition periods—could claim before the phase-out of excessive payments began. We based our analysis on the information that was provided to us by states and CMS during our review.

We found widely varying methods, potentially inaccurate UPL calculations, and other errors as well. Some states, for example, used

¹Under the 2001 regulation, UPLs exist for different types of services, such as inpatient hospital, outpatient hospital, and nursing home services, as well as for different facility ownership types, such as private, state owned, and local-government owned.

incorrect Medicare rates, such as rates from the wrong year, when computing their UPL; another potentially overstated the number of Medicaid nursing home resident days by using estimates that were higher than the actual days provided. These methods could have inflated states' UPLs—and subsequent claims for federal matching funds—by tens of millions of dollars. Further, because SFY 2000 errors applied to states' base year for their transition periods, excessive federal claims could continue throughout their transition periods, leading to continued excessive federal outlays for those states with UPL arrangements in place.

Incorrect Medicare Payment Rates

All six states we examined adopted methods that, in our view, were not consistent with Medicare payment principles. Under Medicare, nursing homes receive a prospective daily rate to cover most services provided to a resident during each day of a covered stay. The rate is adjusted for the resident's expected care needs and therapy, as determined by the resident's assignment to one of Medicare's 44 different payment groups. In addition, Medicare payment rates are adjusted by area wage indexes to account for geographic variations in costs. For UPL purposes, an accurate Medicare equivalent should be based on the number of Medicaid resident days in each of Medicare's 44 payment groups. States should also adjust their UPL calculations by the appropriate Medicare wage index. In all six states we examined, we identified instances in which states' UPL methodologies made general assumptions that, in our view, raised concerns and potentially resulted in inaccurate Medicare equivalents and inflated UPLs.

- Five states we examined did not use Medicaid resident days—the most precise method for determining a Medicare equivalent—in their UPL calculations. Only one state, Washington, calculated a weighted Medicare rate using Medicaid resident days. The five remaining states used less accurate measures, either the number of Medicaid residents or the number of Medicaid nursing home beds. In our view (and suggested by CMS's internal financial review guide), the use of Medicaid resident days is a more accurate basis for determining the weighted Medicare payment rate because it accounts for different lengths of stay in each of the payment groups. In addition, one state, Wisconsin, inappropriately changed its UPL methods in SFY 2001, by estimating its UPL on the assumption that all Medicaid residents fell into a single Medicare payment group. This approach was problematic because the state selected a higher payment group (indicating that all residents needed skilled care) even though state data showed that 60 percent of Medicaid residents actually required lower levels of care.

- Another error we identified involved the use of incorrect Medicare payment data, such as Medicare wage indexes in different areas. Each year, CMS updates Medicare nursing home data and determines a wage index for each geographic area in a state.² Three states — Michigan, Wisconsin, and Washington—did not correctly apply updated Medicare payment data in their UPL estimates. In Michigan’s SFY 2000 estimate, the state’s UPL methodology adjusted Medicare payment rates using federal fiscal year 2001 wage indexes, rather than the lower wage indexes applicable in SFY 2000. As a result, Michigan’s UPL estimate was inappropriately inflated by more than \$8 million, allowing the state to claim almost \$5 million more in federal matching funds than it should have in SFY 2000 and, if the error is not corrected, more than \$17 million more during its 5-year transition period. In Wisconsin, the state’s SFY 2000 estimate used outdated Medicare payment data, which lowered the state’s UPL estimate by about \$3 million. In Washington, the state’s SFY 2001 estimate used the wage index and Medicare payment rates applicable in rural areas for nursing homes located elsewhere, which had a different index and payment rates.

Overstated Medicaid Nursing Home Resident Days

Although most states we examined did not use the number of resident days in calculating the Medicare payment rates for the Medicaid nursing home residents served, states did incorporate an estimate of resident days in determining the amount of the aggregate UPL and the amount available for an excessive UPL payment. Specifically, after the states calculated the difference between Medicare and Medicaid per diem rates, they multiplied this difference by an estimate of the number of Medicaid resident days provided by nursing homes in the states to determine the amount they could pay and claim under their UPL arrangement. While states may have used the best available data at the time, changes in the actual number of resident days provided could lead to inflated UPL estimates. For example, we found that one state—Oregon—determined its UPL claims on the basis of an estimated number of Medicaid resident days that was significantly higher than the actual number of days provided by nursing homes that year. In its base year estimate, Oregon relied on an estimated number of Medicaid nursing home resident days that was nearly 163,000 days more

²For Medicare nursing home payment purposes, each state is divided into specific urban areas, and a different adjustment is calculated for each area on the basis of each area’s labor costs. In addition, areas not falling into one of the urban areas are classified as rural and have a separate wage index.

than the actual provided days, allowing that state to claim more than \$6 million in additional federal matching funds. If this error is not corrected, Oregon could claim another \$22 million during its 5-year transition period.³

³Another state—New York—relied on an estimated number of Medicaid nursing home resident days from 2 years earlier. Our analysis of information provided by the state indicated that New York’s estimate was overstated, however, the state provided subsequent information that suggested its estimate was conservative. We were unable to reconcile the difference in time to be included in this report.

Appendix III: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JAN 14 2004

DATE:

TO: Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues
General Accounting Office

FROM: Dennis G. Smith *Dennis G. Smith*
Acting Administrator
Centers for Medicare & Medicaid Services

SUBJECT: *MEDICAID: Improved Federal Oversight of State Financing Schemes Is Needed (GAO-04-228)*

We appreciate the opportunity to respond to the November 25, 2003, draft report entitled, *MEDICAID: Improved Federal Oversight of State Financing Schemes Is Needed (GAO-04-228)*. The General Accounting Office (GAO) provided this draft report to the Centers for Medicare & Medicaid Services (CMS) for review and comment prior to issuing the report in final form. You indicated that the comments would be reflected in the final report. Upon review of the November 25, 2003, draft report, CMS is very concerned with GAO's findings regarding CMS' implementation of the upper payment limit (UPL) Federal regulations.

The findings and recommendations included in this draft report are based on the GAO's unique interpretation of the statutory language included in Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) and the GAO's inference of preamble language included in the UPL regulations. Moreover, the GAO's findings and recommendations ignore, almost entirely, the basis for and explanations of CMS' policy interpretations and decisions, which were provided to you both orally and in writing over the 13 months that you investigated CMS implementation of the UPL regulations. The only reference to CMS policy interpretation included in this draft report suggests that CMS changed policy interpretations in the middle of the UPL implementation in order to provide preferential treatment to certain states. We believe this assertion is an inaccurate statement and does not take into account any of the explanation provided to you both orally and in writing. Finally, we note the following general observations:

Page 2 - Kathryn G. Allen

- (i) The stated objectives included in this draft report are different from the objectives stated at the October 1, 2002, entrance conference and included in the September 11, 2002, letter sent by the GAO to the Secretary of Health and Human Services, yet the draft report contains no explanation of such change in objectives;
- (ii) The illustrations included in the draft report of UPL-related spending in Nebraska and Wisconsin do not fairly and accurately represent the amounts allowed by CMS;
- (iii) To the extent that the draft report criticizes CMS for the length of time taken in determining UPL transition periods and transition amounts, GAO fails to consider the limited resources available to CMS in administering the UPL regulations; and,
- (iv) The draft report fails to acknowledge that GAO's own audit staff stated during the November 4, 2003, exit conference, that CMS' interpretation of the statutory phrase, "Medicaid payment provision in place prior to October 1, 1992," and of the statutory terms "successor provisions" and "subsequent amendments" were both reasonable and legally supportable.

Consequently, we have several significant comments with regard to the findings and recommendations included in this draft report. Upon your consideration of such comments, we urge you to re-consider your conclusions and recommendations regarding qualification for the 8-year transition under the UPL regulations.

Attachments

OVERVIEW

The CMS is concerned about GAO's apparent misunderstanding of CMS implementation of the new UPL regulation. The CMS has been clear with GAO staff regarding the evolution of CMS policy development during our UPL implementation and GAO's concurrent investigation. The rationale behind the evolution of CMS policy during implementation of the UPL rules was openly shared with, and carefully explained to, GAO staff via numerous e-mail communications, conference calls, and formal written communications.

It is important to note that this review took place simultaneously to CMS' development and implementation of the UPL regulations. These provisions are highly complex in both the areas of policy and information gathering. In addition, as you are aware from the internal status reports provided by CMS, we have had to request additional information on several occasions and in several states in order to fully evaluate the states' UPL calculations. The data gathering has been a lengthy process and often includes the collection and evaluation of significant amounts of data.

In the draft report, GAO has asserted that CMS changed its policy interpretations when in fact CMS was simply undertaking the process to develop its policy interpretation. In response to the substantial number of questions raised by the GAO during your review, CMS explained that we continue to develop policy to implement the UPL regulations. The detailed information provided to CMS under the UPL transition review has assisted in developing legally supportable policies. Specifically, in response to the questions raised during the March 18, 2003, conference call with your staff (see Attachment 1), CMS explained the basis for the evolution of CMS policy regarding the definition of "subsequent amendments/successor provisions." As we continued to review Medicaid institutional reimbursement state plan language, we informed GAO staff that our internal, preliminary interpretation potentially disqualified any amendments from being considered successors and had the potential to render meaningless the BIPA 2000 provision on the 8-year transition period. This explanation was formally provided to you on August 14, 2003, in response to your July 7, 2003, request for confirmation of how CMS is implementing the UPL transition periods (see Attachment 2).

The policy interpretation that CMS has now adopted interprets the terms "successor provisions" and "subsequent amendments" consistently with the interpretation of what constitutes a payment provision in place prior to October 1, 1992. Specifically, CMS interprets the BIPA 2000 phrase, "payment methodology in place prior to October 1, 1992" to mean an "enhanced" Medicaid payment provision or a "supplemental" Medicaid payment provision. The CMS does not consider a regular Medicaid payment rate provision to qualify under this statutory phrase. In addition, CMS interprets the BIPA 2000 phrases "successor provisions" and "subsequent amendments" to mean "enhanced" or "supplemental" Medicaid payment provisions to the same type of providers as the qualifying payment methodology in place prior to October 1, 1992. Specifically, a successor provision and a subsequent amendment must be an enhanced or supplemental Medicaid payment provision to the same provider type (e.g., county nursing

Attachments not printed.

facilities) that was eligible for an enhanced or supplemental Medicaid payment prior to October 1, 1992. Under CMS' current interpretation, successor provisions and subsequent amendments do not have to contain reimbursement formulas that are identical to the payment methodology in place prior to October 1, 1992.

We believe that our current policy supports the intent of the UPL regulations regarding appropriate Federal Medicaid spending as well as Congressional intent to allow for an 8-year transition period. Moreover, CMS has uniformly applied this policy to all states. Based on our preliminary review of historical state spending, we had indicated that we believed there were five states (including hospital and nursing home UPL arrangements) that had the potential to qualify for 8-year transition periods. As we developed our interpretation of both the "payment provision in place prior to October 1, 1992," language and the "successor provision" language, we considered various interpretations including those that when applied consistently to all states, resulted in no state qualifying for an 8-year transition and those that resulted in every state qualifying for an 8-year transition period. Based on the information we have received from states to date, we believe a consistent application of our current policy would likely result in five states qualifying for 8-year transition periods through either a hospital or nursing facility supplemental payment program. This represents neither a significant expansion nor reduction from our initial estimate of the number of states qualifying for an 8-year transition period.

Your report recommends that CMS reassess its decision to grant 8-year transition periods to Nebraska and Wisconsin, establish guidance for states on appropriate methods for calculating their UPLs, and give priority to financial management reviews for states with the largest UPL arrangements. As will be explained in detail under the "TECHNICAL CORRECTIONS/COMMENTS" and "RECOMMENDATIONS" sections of this response, we believe:

- (i) The CMS has developed sound, legally supportable policies with regard to the 8-year transition under the UPL regulations and has appropriately determined that Nebraska, Pennsylvania, and Wisconsin as qualify for an 8-year transition period, based on a nursing facility supplemental payment provision in place prior to October 1, 1992;
- (ii) The CMS has been providing on-going and direct guidance to all states through the implementation of the UPL regulations and through CMS' Medicaid institutional reimbursement state plan amendment review process;
- (iii) In allocating resources to the determination of transition periods and amounts, the CMS has directed its staff, whenever possible, to give priority to the determination of these issues for states with the largest UPL arrangements, to ensure that these states can incorporate CMS findings into their budgeting plans.

Technical comments not printed.

RECOMMENDATIONS

GAO Recommendation

The Administrator of CMS establish criteria for making transition period decisions that are consistent with the objectives described in its January 2001 UPL regulation.

CMS

We concur. As carefully detailed in the response to this draft report, CMS has already done so.

GAO Recommendation

CMS reconsider its initial decisions to grant Nebraska and Wisconsin 8-year transition periods.

CMS

We do not concur. The CMS has developed a reasonable and legally supportable interpretation of 8-year transition qualification under the statute and UPL regulation and GAO has stated that both Wisconsin and Nebraska meet those criteria.

GAO Recommendation

CMS establish uniform guidance for states, which would set forth acceptable methods to calculate their UPLs.

CMS

We concur. The CMS does not necessarily agree with the GAO's definition of a reasonable estimate of the UPL. Nor does CMS believe that an exhaustive "laundry" list of acceptable methods can be compiled that would address every payment methodology to every provider in every state. Hence, CMS will issue guidance on the characteristics and principles underlying acceptable methods of calculating UPLs, along with extensive examples. However, CMS believes a certain degree of state flexibility is warranted.

GAO Recommendation

CMS expediting the financial management reviews of states with UPL arrangements, with a high priority on reviews of states with 5- and 8-year transition periods, including those we identified as having methodological errors.

CMS

We concur in part. The CMS has made significantly more progress than is articulated by the GAO in this draft report. However, CMS agrees to perform financial management reviews in the 5-year and 8-year states not currently under review by the HHS OIG.

GAO Recommendation

CMS improving its requirements for states for reporting UPL arrangements, such as implementing its current requirement for states with transition periods to report payments on a facility-specific basis, and requiring such reports for all states with a UPL arrangement.

CMS

We concur. The CMS will re-evaluate current UPL reporting requirements and CMS will further consider GAO's recommendation for improved UPL reporting requirements.

Appendix IV: Comments from the State of Michigan



JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

December 23, 2003

Ms. Kathryn G. Allen, Director
Health Care -- Medicaid and Private Health Insurance Issues
United States General Accounting Office
Washington, DC 20548

Dear Ms. Allen:

Pursuant to your letter of December 1, 2003, I am submitting comments on the GAO report entitled "MEDICAID -- Improved Federal Oversight of State Financing Schemes is Needed".

On pages 26 and 39 it was noted that Michigan "made adjustments for geographic variations in labor costs that incorporated inappropriately high wage rates. The higher rates overstated the state's UPL by more than \$8 million, allowing excess federal claims of almost \$5 million."

We have reexamined our long term care upper payment limit (UPL) calculation for fiscal year 2000 (the year on which the phase-out amounts were based) and have determined that our initial calculations were substantially correct. There was a labeling problem in our spreadsheet where the label describing the wage index number was incorrect as stated in the GAO analysis. However, the column of figures which drove the UPL calculations contained (with one minor exception) the correct wage index numbers and, therefore, there was no substantial error in Michigan's UPL calculation for fiscal year 2000. This same labeling error was discovered by an OIG audit of our fiscal year 2003 calculation but, again, the column driving the calculations contained the correct number. These labels have been corrected for our 2003 and 2004 submissions to CMS.

It should also be noted that the Medicare RUGS rates were raised significantly by CMS for the period covering the final six months of fiscal year 2000. If those changes had been factored into the Michigan UPL calculation, the Medicare upper payment limit for fiscal year 2000 would have increased by about \$65 million.

Given our analysis of the two points discussed above, I recommend that the audit findings related to Michigan in the GAO report be deleted. There was no error of substance and a disallowance or reduction in federal funding is not appropriate. Thank you for the opportunity to review and comment on the draft report.

Sincerely,

Handwritten signature of Janet Olszewski in cursive script.
Janet Olszewski
Director

LEWIS CASS BUILDING • 320 SOUTH WALNUT STREET • LANSING, MICHIGAN 48913
www.michigan.gov • (517) 373-3500

Now pages 29, 30 and 51.

Appendix V: Comments from the State of Nebraska

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

STATE OF NEBRASKA
MIKE JOHANN, GOVERNOR

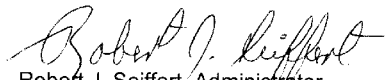
December 8, 2003

Kathryn G. Allen, Director
Health Care – Medicaid and Private Health Insurance Issues
United States General Accounting Office
Washington, D.C. 20548

Dear Ms. Allen:

We have reviewed draft report GAO-04-228 entitled "MEDICAID: Improved Federal Oversight of State Financing Schemes Is Needed" as requested in your correspondence of December 1, 2003. The report reviews the actions of the federal Centers for Medicare & Medicaid Services (CMS) in determining the transition period for phase-out of state Upper Payment Limit (UPL) arrangements. The Nebraska Medicaid Program has complied in good faith with regulations established by the federal Department of Health and Human Services and administered by CMS. A reinterpretation of the federal decision to grant Nebraska an eight-year transition period would be unacceptable.

Sincerely,



Robert J. Seiffert, Administrator
Medicaid Division

CC: Stephen B. Curtiss

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Appendix VI: Comments from the State of New York



STATE OF NEW YORK DEPARTMENT OF HEALTH

Coming Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

January 8, 2004

Ms. Kathryn G. Allen
Director, Health Care - Medicaid
and Private Insurance Issues
United States General Accounting Office
Washington, DC. 20548

Dear Ms. Allen:

Thank you for submitting a draft copy of the GAO report, *Medicaid: Improved Federal Oversight of State Financing Schemes is Needed*, for our review and comment.

Enclosed are our comments on the report and an overview of New York's upper payment limit calculation. Please note that our comments refute many of the report's findings regarding New York State. Therefore, we expect that the final GAO report will more accurately reflect the State's calculation and use of its nursing home Upper Payment Limit.

If you have any questions concerning our comments, please contact Mark H. Van Guysling, Assistant Director, Division of Health Care Financing at (518) 474-6350.

Sincerely,

A handwritten signature in cursive script that reads 'S. Pettinato'.

Sandra Pettinato
Deputy Director
Office of Medicaid Management

Enclosures

**NEW YORK STATE RESPONSE TO THE GENERAL ACCOUNTING OFFICE (GAO)
DRAFT REPORT #04-228**

GAO Finding: Funds generated by New York's UPL arrangement are deposited into its Medical Assistance Account. Proceeds from this account are used to pay for the state share of the cost of Medicaid payments; effectively recycling federal funds to generate additional federal Medicaid matching funds.

NYS Response:

Since its inception New York's Medicaid State Plan has included local government cost sharing. Intergovernmental transfers (IGTs) from counties and the City of New York to the State are integral to New York's Medicaid financing statutes. This form of financing of the non-federal share of Medicaid expenditures is permitted by federal law (Section 1902(a)(2) of the Social Security Act (SSA)) as long as the State dollars make up, in the aggregate, at least 40 percent of the non-federal share of expenditures for which federal financial participation is sought under SSA Section 1903. The State and local shares of Medicaid payments vary by category of service and by certain recipient-specific factors. Further, State statutes sometimes establish state and local funding arrangements that are specific to particular payments under the State Plan. For the payments that are the subject of the GAO finding, State statute provides that local governments will assume 100 percent of the non-federal cost, which is derived from funds appropriated by local governments' legislative bodies. This expenditure is clearly eligible for federal matching funds pursuant to 42 CFR 433.51(b) and is entirely consistent with the Congressional intent to permit States to fund a portion of the non-federal share of Medicaid expenditures with funds appropriated by local governments. State statute establishing these payments also requires an additional transfer of funds from local governments to the State's local assistance medical assistance account. These funds represent a Medicaid shares adjustment between the State and local governments that complies with the non-federal share local government contribution limitations established by Section 1902(a)(2). Transfer of these funds in no way negates the initial local government expenditure that is eligible for federal matching funds.

The State makes payments for services under the approved State Plan directly to providers. State laws create no repayment obligation on the part of nursing facilities with regard to funds received under the approved State Plan, though associated transactions between some public providers and their local governments were noted in their audited annual financial statements in previous years. The State is not authorized or required to monitor the financial relationships that may exist between local governments and their public nursing facilities. Further, we believe it would be inappropriate to do so for the purpose of Medicaid claiming.

GAO Finding: The federal share of New York State UPL payments in SFY 2001 was \$520,000,000, which has not been subject to a financial management review by CMS.

NYS Response:

While the room under the upper payment limit for SFY 2001 was calculated to be in excess of \$1 billion, only \$991.5 million in payments were made to county sponsored nursing facilities for IGT. Therefore the federal share of the New York State IGT payments was only \$495.75 million. It is unclear where the \$520 million was derived from.

GAO Finding: For example, none of the states accurately determined Medicare rates when calculating their UPLs, because they did not correctly account for changes that occurred when Medicare moved from cost based reimbursement to prospective rates starting in 1998.

NYS Response:

New York's UPL calculations have been based on the formula as described in the Federal Registers beginning with the interim final rule published 5/12/98 which includes changes that occurred when Medicare moved from cost based reimbursement to prospective rates.

GAO Finding: The methodology for New York's SFY 2000 UPL estimate was also inaccurate because it used Medicare, not Medicaid, residents to calculate a weighted Medicare payment rate; this substitution likely inflated the calculated Medicare equivalent and the estimated UPL because Medicare patients generally fall into higher Medicare payment groups than do Medicaid residents

NYS Response:

New York's UPL calculation utilizes only patient data for Medicaid residents in determining the number of residents that fall into each of the 44 PPS payment groups. The only place Medicare residents were used was in determining the Medicare Federal rate, which was needed in the calculation to estimate the facility specific rate. (See attached explanation of the 2000 Upper Payment Limit Calculation.)

GAO Finding: None of the six states we examined accounted correctly for Medicare's move from retrospective cost-based reimbursement to prospective rates. Over the three years following Medicare's implementation of prospective nursing home payments in 1998, many nursing homes were paid an amount that blended prior cost-based rates with new prospective per diem rates. None of the six states' methodologies properly accounted for the transition by using facility specific blending rates specified by Medicare regulations. Some states applied a single blending factor for all nursing homes, and others made improper adjustments in applying blending rates. New York and Pennsylvania, for example, selectively blended rates only for those nursing homes

that would generate higher Medicare payment rates - regardless of whether or not the facility was actually blending.

NYS Response:

Following the formula as published in the 5/12/98 Federal Register, New York used facility specific blended rates for the three years following the implementation of the Prospective Payment System. The Federal Register published 7/30/99 specified that for any facility that was advantaged, an immediate transition to the Federal rate for those facilities was allowed. The full Federal rate was used instead of the blended rate. NYS made the assumption that all facilities that were advantaged moved to the Federal rate.

GAO Finding: We identified two states, New York and Oregon, which developed their UPL based on an estimate of the number of Medicaid resident days that was significantly higher than the actual number of days that were provided by nursing homes that year. While the states may have used the best available estimates at the time, in our view, states should be held accountable for reconciling estimates with the actual services provided. Left uncorrected, this error could increase their federal claims throughout their transition periods. New York relied on an estimate of the number of Medicaid nursing home resident days that was nearly 600,000 higher than the actual number of days where residents were served in the state's nursing homes, allowing the state to claim more than \$9 million in additional federal matching funds. If the discrepancy is not corrected, the state could claim an additional \$35 million over its five-year transition period.

NYS Response:

We do not have enough information to accurately respond to this finding. Specifically, we need more information regarding the 600,000 patient day discrepancy. What period does it relate to and how does it relate to the \$9 million overage?

GAO Finding: Our estimate of overstated claims are conservative for both states. Even with the corrections we made, we believe the states' methodologies continue to overstate UPLs in New York and Oregon because they assume that all residents stay in nursing homes for an entire year. The discrepancies would be greater had more accurate information been available on the residents' actual average length of stay.

NYS Response:

New York State uses actual patient days reported in certified cost reports. These days take into consideration length of stay.

2000 UPPER PAYMENT LIMIT CALCULATION

The upper payment limit calculation determines how much lower the Medicaid rates being paid in New York State are than what they would have been if they had been calculated using Medicare principles.

MEDICAID RATE:

The Medicaid rates used in this calculation were the January 1, 2000 Medicaid rates.

MEDICAID RATE USING MEDICARE PRINCIPLES:

The rates used in this calculation are 50 percent of the federal rate plus 50 percent of the facility-specific rate.

FEDERAL RATE:

The federal rate is based on the new Medicare Prospective Payment System (PPS). National prices for 44 PPS RUG groups were first wage adjusted for New York State areas. The prices and the wage indices used are contained in the Federal Register published 7/30/99. Patient data from nursing facilities' 1997 MDS+ data was then matched to patient data from the second quarter 1997 PRI data to determine which patients in the MDS+ file were Medicaid residents. 1997 data was chosen to use since it was the most complete set of both MDS+ and PRI data that was available at the time. It has been found that using the case mix from 1997 instead of a more current period does not materially affect the calculation. Once the Medicaid residents were determined, the Medicaid residents for each facility were then categorized into one of 44 RUG groups. Each facility's federal rate was calculated by multiplying the number of Medicaid residents in each RUG group by the applicable price for each group, then dividing the sum of the 44 groups by the total number of Medicaid residents. An inflation factor was then applied to adjust for the 4.5 month difference in the midpoints between the period the initial prices were based on (7/1/98 – 9/30/99) and the period the initial Medicaid rates were based on (1/1/99 – 12/31/99). The inflation factor used was 1.00675, calculated as $[4.5/12 \times (\text{the revised 1999 market basket of 2.8 percent from the 7/30/99 Federal Register minus 1 percent})]$.

FACILITY-SPECIFIC RATE:

In general, the facility-specific rate is:

A) For facilities participating in the Nursing Home Case Mix and Quality (NHCMQ) demonstration project, it is the rate paid under the demonstration project.

B) For facilities not participating in the demonstration project, it is the rate calculated under the previous routine ceiling methodology.

Since these rates were calculated for Medicare, New York State did not have a Medicaid equivalent. An assumption was made that the percentage relationship between the Medicare facility-specific rate and the Medicare federal rate would be the same in the Medicaid calculation. Therefore, a Medicaid facility-specific rate had to be estimated by using this relationship and applying it to the Medicaid federal rate. A facility-specific rate percentage was calculated by dividing the 1999 Medicare facility-specific rate (see below) by the 1999 Medicare federal rate (see below). This percentage was then multiplied by the 1999 Medicaid federal rate, calculated in accordance with applicable regulations, to arrive at the estimated 1999 facility-specific rate for Medicaid. The 2000 facility-specific rate was then calculated by multiplying the 1999 facility-specific rate by the full 2000 market basket rate of 2.9 percent as published in the 7/30/99 Federal Register. If a facility-specific rate percentage could not be determined for a particular facility due to the unavailability of data, an average facility-specific rate percentage was used. The average facility-specific rate percentage used depended on whether or not the facility participated in the demonstration project. The average for facilities participating in the demonstration project was 1.1158. The average for facilities not participating in the demonstration project was .9738.

1999 Medicare facility-specific rate:

Facilities **participating** in the demonstration project –

If the Medicare Part A Intermediary was Empire Medicare Services, the rate used was the facility-specific per diem rate on Line 5 of the 1997 NHCMQ demonstration computation. The rate on Line 5 includes an inflation factor of 1.031532. If the Medicare Part A Intermediary was United Health Care, the rate used was the total amount reimbursed on Line 25 divided by the total demonstration program days on Line 2 of the 1997 calculation of the NHCMQ demonstration reimbursement settlement. This per diem was then multiplied by an inflation factor of 1.031532.

Facilities **not participating** in the demonstration project –

If the Medicare Part A Intermediary was Empire Medicare Services, the rate used was the facility-specific per diem rate on Line 20 of the 1995 rate computation. The rate on Line 20 includes an inflation factor of 1.071430. If the Medicare Part A Intermediary was United Health Care, (or Empire Medicare Services and the 1995 computation of the facility-specific per diem rate was not available) the rate used was the 1995 Part A Medicare rate trended to 1999 using an inflation factor of 1.071430.

1999 Medicare federal rate:

The Medicare federal rate was calculated exactly the same as the federal rate in the 1999 Upper Payment Limit calculation, except that Medicare residents were used instead of Medicaid residents.

CALCULATION OF UNADJUSTED ROOM UNDER THE UPPER PAYMENT LIMIT:

The Medicaid rates were weighted by estimated 2000 Medicaid days to develop a 2000 statewide average Medicaid rate. The Medicare rates were weighted by estimated 2000 Medicaid days to develop a 2000 statewide average Medicare rate. The 2000 statewide average Medicaid rate was \$166.56 and the 2000 statewide average Medicare rate was \$200.51. The difference of \$33.95 was multiplied by total Medicaid days to arrive at the unadjusted room under the limit of \$1,097.5M. The methodology in this analysis has been applied to all Nursing Facilities in New York State.

Appendix VII: Comments from the State of Oregon



Oregon

Theodore R. Kulongoski, Governor

**Department of Human Services
Health Services**

Office of Medical Assistance Programs

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December 19, 2003



Kathryn G. Allen
Director, Health Care-Medicaid
and Private Health Insurance Issues
United States General Accounting Office
Washington, D.C. 20548

RE: GAO-04-228 Oversight of State Financing Schemes

Dear Ms. Allen:

Thank you for the opportunity to comment on the above reference draft report entitled *MEDICAID: Improved Federal Oversight of State Financing Schemes is Needed*.

Oregon does not take issue with the general substantive findings delineated in the report except the general characterization that states were engaged in unauthorized activities regarding transactions in the Nursing Facility Proportionate Share (PPS) program. Findings in the report state that the PPS program was casually overseen by CMS. Implementation by CMS had been done consistent with the preamble statement of the implementing regulations to the program.

"The new UPL regulations afford states some flexibility in calculating a reasonable estimate of what Medicare would have paid for Medicaid services. In formulating their own approach to computing the UPL, State have flexibility to use either Medicare principles of cost reimbursement or prospective payment systems as the foundation of their estimates." 66 Fed. Reg. 3148 (January 12, 2001)

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OMAP 3213 (02/03)

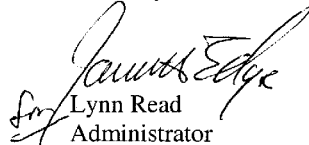
Kathryn G. Allen
December 19, 2003
Page 2

States remitted their State Plan Amendments, methodologies and claims to CMS within prescribed protocols, and these were reviewed and acted upon by CMS within that defined framework. While we understand that GAO now believes that framework to be flawed, it was the correct framework to be followed by states. Hence, the characterization that states actions were outside of authority we find to be inaccurate.

Pursuant to existing rules, Oregon filed a required State Plan Amendment and received approval of that amendment. In accordance with the methodology approved, Oregon estimated its entitlement to PPS and requested reimbursement from CMS. CMS reviewed the requests and rendered payment without issue.

Again, we want to thank you for the opportunity to comment on this report.

Sincerely,


Lynn Read
Administrator

Appendix VIII: Comments from the State of Wisconsin and GAO's Response

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

Jim Doyle
Governor

Helene Nelson
Secretary



State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

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December 23, 2003

Kathryn G. Allen, Director
Health Care - Medicaid
and Private Health Insurance Issues
United States General Accounting Office
Washington, DC 20548

Dear Ms. Allen:

On December 1, 2003, the Wisconsin Medicaid Program received from the General Accounting Office (GAO) a draft report entitled *MEDICAID: Improved Federal Oversight of State Financing Schemes is Needed (GAO-04-228)*. In its cover letter, GAO indicated it wished to receive comments regarding the draft report by December 23, 2003. Enclosed please find Wisconsin's comments regarding the GAO draft report.

The GAO draft report concludes that Wisconsin should be subject to an Upper Payment Limit transition period of only 16 months rather than the 8 years granted by CMS. As a result, GAO asserts that Wisconsin is not entitled to receive over \$500 million in federal Medicaid funds it would have received under the 8-year transition period. GAO is incorrect on both counts, as further explained in Wisconsin's comments.

These comments are being sent via email, fax and first class mail. Please note there are four enclosures that you will receive with the faxed and mailed versions. Because the enclosures are not available in electronic format, you will not receive them with the emailed version.

Thank you for the opportunity to review and comment on GAO's draft report.

Sincerely,

A handwritten signature in black ink that reads "Mark B. Moody".

Mark B. Moody
Administrator

MBM:dd
DO12100

Enclosures

Wisconsin.gov

See comment 1.

WISCONSIN'S COMMENTS REGARDING GAO-04-228

The GAO report (GAO-04-228) concludes that Wisconsin should be subject to an Upper Payment Limit transition period of only 16 months rather than the 8 years granted by CMS. As a result, GAO asserts that Wisconsin is not entitled to receive over \$500 million in federal Medicaid funds it would have received under the 8-year transition period. GAO is incorrect on both counts, as further explained below.

Wisconsin is entitled to "Tier 3" transition status under BIPA.

See comment 2.

In October 2000 HHS published a proposed rule changing the upper payment limit (UPL) test for Medicaid payments to local government institutional facilities. The proposed new UPL measure would be the aggregate of what would be paid under Medicare payment principles for services provided in local government facilities. The existing UPL measure was the aggregate of what would be paid under Medicare payment principles for services provided in all facilities. HHS believed that states were taking advantage of the existing UPL measure to make unduly large Medicaid payments to local government facilities, and claiming the federal share for those payments. The proposed new UPL rule contained two transition provisions, one allowing payments exceeding the new UPL measure until September 30, 2002, and the other allowing payments exceeding the new UPL measure, in declining amounts, through state fiscal year 2005.¹

In December 2000 Congress enacted BIPA.² In BIPA, Congress directed HHS to adopt a new UPL rule based on the October 2000 proposed rule, but further required that the rule provide for a third transition period. The third transition provision would allow certain states to make payments exceeding the new UPL measure, in declining amounts, until September 30, 2008.³ BIPA describes a state qualifying for this transition period as follows:

A State described in this paragraph is a State with a State Medicaid plan payment provision or methodology (including a payment provision or methodology approved under a waiver of such plan) which--

(A) was approved, deemed to have been approved, or was in effect on or before October 1, 1992 (including any subsequent amendments or successor provisions or methodologies and

¹ 65 FR 60151, October 10, 2000.

² The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106-554.

³ This transition period is now commonly referred to as "Tier 3."

Appendix VIII: Comments from the State of Wisconsin and GAO's Response

whether or not a State plan amendment was made to carry out such provision or methodology after such date) or under which claims for Federal financial participation were filed and paid on or before such date; and

(B) provides for payments that are in excess of the upper payment limit test established under the final regulation required under subsection (a) (or which would be noncompliant with such final regulation if the actual dollar payment levels made under the payment provision or methodology in the State fiscal year which begins during 1999 were continued).⁴

There are thus two conditions a state must meet to qualify for the Tier 3 transition period. The first is that the state must have had a payment methodology in effect on or before October 1, 1992. The second condition is that that methodology or a successor to that methodology must have provided for payments exceeding the UPL under HHS' new rule at the time the new UPL rule takes effect.

A "State medicaid plan payment provision or methodology" within the meaning of the first Tier 3 condition is a provision or methodology for making supplemental payments to local government facilities that complied with the then-existing UPL measure but might have exceeded the UPL measure under the rule proposed by HHS in October 2000. Wisconsin meets the first condition because it has had a provision for making supplemental payments to local government nursing homes in its state plan since 1986.

It is clear from correspondence between HCFA and Wisconsin Medicaid relating to Wisconsin's state plan for state fiscal year (SFY) 1987 (July 1, 1986 – June 30, 1987) that section 3.775 of Wisconsin's nursing home payment methodology meets the first condition for Tier 3 status under BIPA. In particular, a January 30, 1987, letter⁵ from Wisconsin to HCFA indicated that a HCFA central office employee had

... expressed concern that under the terms of the amendment, Wisconsin's payments to nursing homes could approach the Medicare upper limit. He suggested that, as an assurance that the Medicare upper limit not be exceeded, the State compute the supplemental funds under this provision and provide that the facility's Medicaid rate including the supplemental payment cannot exceed the payment it would receive under Medicare principles. [He] would also approve a system wherein *the state computes the aggregate payment to government facilities under Medicare principles and assures that total rates of facilities receiving payments under this program does not exceed the Medicare aggregate payment amount.*

⁴ Public Law 106-554, section 705 (b) (3).

⁵ A copy is enclosed. This letter and the rest of the correspondence relating to the 1986 version of section 3.775 was provided to GAO during its investigation.

See comment 3.

Appendix VIII: Comments from the State of Wisconsin and GAO's Response

[Wisconsin] *cannot make either of these changes* to the amendment for the reasons outlined below:

1. Wisconsin determines the Medicare upper limit in the aggregate, and not on a facility-by-facility *or category-of-ownership* basis. This approach is justified under 42 CFR 447.253(b)(2), which reads: "The Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services or long term care facilities services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement." (emphasis added). We have not, and do not intend to apply the Medicare upper limit on a facility-specific *or ownership-specific* basis.

[Emphasis by underscoring in 1987 letter; emphasis by italics added.]

Based on the above passages from correspondence regarding Wisconsin's SFY 1987 state plan, it is clear that the only limit on total Medicaid payments to local government nursing facilities recognized under the SFY 1987 version of section 3.775 is what all facilities, government-owned and privately owned, would have been paid in the aggregate under Medicare principles. Wisconsin rejected HCFA's request for an assurance that supplemental payments to government facilities would not exceed what government facilities alone would have been paid under Medicare principles. Ultimately, the only UPL assurance Wisconsin made in this regard was that

... rates under the Wisconsin Medical Assistance Program for 1985-86 including supplements paid under s. 3.775 of the Nursing Home Methods paid no more in the aggregate for long term care facility services than we reasonably estimate would be paid for the services under Medicare principles of reimbursement.⁶

Notably, Wisconsin did not make the assurance requested by HHS that aggregate Medicaid payments to government facilities would not exceed what government facilities would have been paid in the aggregate under Medicare principles. This approach of using the aggregate Medicare upper limit for all facilities, private and government, as the Medicaid UPL for payments to local government facilities is precisely what HHS intended to prohibit in its proposed new UPL rule in October 2000.

In numerous passages in the report, GAO suggests that in order for a state to have a "State Medicaid plan payment provision or methodology" (and thus meet the first Tier 3 condition) the state must have had a long-standing practice of making extremely large supplemental payments to

⁶ March 17, 1987 letter from Christine Nye to Judith Stec, enclosed.

See comment 4.

Appendix VIII: Comments from the State of Wisconsin and GAO's Response

local government facilities.⁷ There is no support for this view in the language of BIPA that establishes the eligibility criteria for the Tier 3 transition period. Congress expressly required HHS to issue a final UPL rule that is based on the October 2000 proposed rule and that “provides for a transition period in accordance with subsection (b).”⁸ In turn, subsection (b) provides that

The final regulation ... shall provide that, with respect to a State described in paragraph (3), the State shall be considered to be in compliance with the final regulation ... so long as, for each State fiscal year [that begins after September 30, 2002, and ends on September 30, 2008], the State reduces payments ... by 15 percent in the first such State fiscal year, and by an additional 15 percent in each of the next 5 State fiscal years.⁹

As noted at page 1, above, a “State described in paragraph (3)” under BIPA is a State with a payment provision or methodology which “was approved, deemed to have been approved, or was in effect” on or before October 1, 1992 and “provides for payments that are in excess of the upper payment limit test established under the final regulation ...”¹⁰ The use of the past tense in the first clause and present tense in the second clause of this provision makes clear Congress’ intent not to limit Tier 3 transition status in the way suggested by GAO. Had Congress intended to limit Tier 3 to States with a longstanding practice of making supplemental facility payments that would have exceeded the new UPL test, it would not have used the present tense in clause (B). The BIPA Tier 3 language in no way suggests that in order to qualify for the Tier 3 transition period a State must have had a payment provision or methodology that, on or before October 1, 1992, provided for payments that would have exceeded the new UPL test.

Had Congress intended to require a state, in order to qualify for Tier 3, to have had a long-standing practice of making supplemental payments to local government facilities that in fact exceeded what would be permitted under the new UPL rule, it would have done so expressly. The GAO report makes repeated reference to CMS’ stated objectives for granting transition periods,

⁷ See, e.g., p. 14: “CMS’ granting 8-year transition periods to Nebraska and Wisconsin is not consistent with the objectives that the agency published in the preamble to its January 2001 regulation, as neither state had in place the type of longstanding excessive payment arrangement the agency intended to curtail.” Page 15: “Although Nebraska and Wisconsin did have supplemental payment arrangements for nursing homes in place as of October 1, 1992, neither state had an arrangement that ... made extremely large payments to units of local governments on behalf of a few locally-owned nursing homes...” [Also see accompanying footnote.] Page 16: “...Wisconsin had no reliance on excessive UPL payments prior to 2001 that would justify an 8-year transition period given the purpose stated by CMS.” Page 17: “... Wisconsin’s 2001 UPL arrangement differs substantially from the 1985 arrangement, and granting the state an 8-year transition period is inconsistent with the agency’s stated objectives in curtailing excessive UPL schemes.”

⁸ BIPA, sec. 705 (a) (2).

⁹ BIPA, sec. 705 (b) (1). [Emphasis added.]

¹⁰ BIPA, sec. 705 (b) (3) (A) and (B). [Emphasis added.]

Now page 16.

Now page 18.

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Now page 20.

Appendix VIII: Comments from the State of Wisconsin and GAO's Response

as indicated in the preamble to the final regulations.¹¹ However, CMS' objectives in creating the original 2 transition periods are not relevant in determining Congress' intent in mandating the Tier 3 transition period. The federal legislation is clear on its face in this regard.

Moreover, even were the BIPA Tier 3 language not clear on its face, the legislative history of the provision makes Congress' intent plain:

The provision [BIPA sec. 705] also requires the final regulation to stipulate a third set of rules governing the transition period for certain states. This additional set of rules would apply to states with payment arrangements approved or in effect on or before October 1, 1992, or under which claims for federal matching were paid on or before that date, and for which such payments exceed the UPLs established under the final regulation. For these states, a 6-year transition period would apply ...¹²

The passage "such payments exceed the UPLs established under the final regulation" underscores Congress' directive to CMS' to apply the new UPL test to State supplemental payment methodologies that were in effect at the time the new UPL rule took effect. Otherwise, the passage would have read "such payments would have exceeded the UPLs established under the final regulation," or words to similar effect.

Finally, subsequent Congressional pronouncements admonish CMS not to stray from a literal interpretation of BIPA Tier 3 language. During 2001 budget deliberations, the Senate Committee on Appropriations noted that the BIPA UPL provisions,

... which included reasonable transition periods for States to adopt a revised standard for treatment of their programs, were adopted after intense bipartisan negotiations among the House, Senate, and administration. ... The Committee is pleased that the administration, in January and September 2001, supported this Medicaid upper payment limit agreement in the promulgation of Medicaid upper payment limit regulations. Further, the Committee

¹¹ See, e.g., p. 4: "Over the 8-year transition periods, Nebraska and Wisconsin are eligible to receive about \$633 million more in excessive federal matching funds than they would have been eligible for under shorter transition periods based on the stated purpose of CMS's regulation and transition policy." Page 9: "HCFR proposed such transition periods because it recognized that some states, as part of their overall state budgets, had come to rely on the additional money they were receiving through these schemes." Page 14: "CMS's granting 8-year transition periods to Nebraska and Wisconsin is not consistent with the objectives that the agency published in the preamble to its January 2001 regulation, as neither state had in place the type of longstanding excessive payment arrangement the agency intended to curtail." Page 16: "... Wisconsin had no reliance on excessive UPL payments prior to 2001 that would justify an 8-year transition period given the purpose stated by CMS." Page 17: "... [G]ranteeing [Wisconsin] an 8-year transition period is inconsistent with the agency's stated objectives in curtailing excessive UPL schemes." Page 20: "Under the final rule allowing a state with an 8-year transition period ..., Nebraska and Wisconsin have been able to generate significantly more in excessive federal UPL payments than they could have under shorter transition periods consistent with the purpose of the 2001 regulation as stated by CMS."

¹² House Report 106-1033, Committee on Conference, December 15, 2000; See also House Report 106-1004, Committee on Conference, October 26, 2000.

Now page 11.

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Appendix VIII: Comments from the State of Wisconsin and GAO's Response

reiterates its commitment to both the letter and spirit of this agreement, and directs the administration to maintain its course in complying with congressional intent. Any subsequent modifications should be done only after the administration has had an opportunity to assess the implementation of the new regulations and only in consultation with the States and their Medicaid programs, as well as the other stakeholders.¹³

For the reasons stated above, Wisconsin meets the first condition, set forth in BIPA section 705 (b) (3) (A), to qualify for Tier 3 transition to compliance with the new UPL rule.

Wisconsin also meets the second condition for qualifying for the Tier 3 transition period. Under BIPA section 705 (b) (3) (B), there are two alternative ways to meet this second condition. Wisconsin meets it both ways.

One way to meet the second Tier 3 condition is to have a payment methodology that, at the time the new UPL rule took effect, provided for payments that are in excess of the UPL under the new rule. The new UPL rule took effect March 13, 2001.¹⁴ Wisconsin's state Medicaid plan for SFY 2001 (effective July 1, 2000 – June 30, 2001), which was in effect with respect to payments made on March 13, 2001, provided for payments to local government facilities substantially exceeding the UPL provided for in the new rule that took effect on that date. (Indeed, GAO appears to concede this point in its draft report.)

The other way for a State to meet BIPA's second Tier 3 condition is for the State to have made payments for "the State fiscal year which begins during 1999" that would have exceeded the UPL under the new rule if the payments had been continued to the effective date of the new rule. In Wisconsin, "the State fiscal year which begins during 1999" is SFY 2000 (July 1, 1999 – June 30, 2000). The September 23, 2002 letter from Wisconsin Medicaid Director Peggy Handrich to CMS' Cheryl Harris (see enclosed) establishes that Wisconsin Medicaid payments to local government facilities for Wisconsin SFY 2000 would have exceeded the UPL under the new rule by over \$25,000,000.

Though CMS accepted Wisconsin's calculations as to what the UPL under the new rule would have been in Wisconsin SFY 2000, GAO asserts in its draft report that Wisconsin underestimated this figure. GAO concludes that had Wisconsin accurately estimated this figure, Wisconsin's

¹³ Senate Report 107-84, Senate Committee on Appropriations, October 11, 2001.

¹⁴ Final Rule, 66 *FR* 3148 at 3148.

See comment 5.

See comment 6.

actual payments to local government facilities during SFY 2000 would not have exceeded the UPL. GAO estimates that payments under Medicare payment principles would have been at least \$162.77 per bed day, as opposed to the \$133.50 per bed day estimated by Wisconsin. This difference would more than offset the \$25,000,000 excess calculated by Wisconsin for SFY 2000.

Because it was unclear from GAO's draft report the basis upon which GAO arrived at its estimate of \$162.77 per bed day, Wisconsin requested that GAO provide Wisconsin all computations and other analysis leading to this estimate. GAO's response to this request demonstrates that in arriving at the \$162.77 per bed day estimate GAO fundamentally misapplied applicable methodology for establishing UPLs. [GAO's response is attached as an appendix to this document.]

The fundamental flaw in GAO's approach to estimating Wisconsin's SFY 2000 UPL relates to that part of the UPL calculation in which GAO used Medicare *rates* rather than Medicare *rate-setting methodology* in approximating what Medicare would have paid for Medicaid recipients residing in Wisconsin nursing homes. The governing federal rule provides, in pertinent part:

... aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (a) of this section may not exceed a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter.¹⁵

During Wisconsin's SFY 2000 Medicare reimbursed skilled nursing facilities for services provided to Medicare residents under the transition provisions of its new prospective payment system (PPS). During PPS transition, a facility's Medicare payment was computed as a weighted average of a "Federal payment" and a "facility-specific payment." The Federal payment was computed by applying a published schedule of 44 per diem rates varying according to the intensity of service needs of the facility's Medicare residents. The facility-specific payment was computed by applying the facility's own historical average Medicare cost per diem to the current population of Medicare residents. The historical average cost was taken from the facility's 1995 Medicare cost report inflated to the payment period. In this manner, Medicare payment principles at that time based a portion of the payment on each facility's historical cost per diem for the population being served (the facility-specific payment), with the remaining portion based upon a pricing schedule dependent upon the population's service needs (the Federal payment).

¹⁵ 42 CFR § 447.272 (b) [emphasis added].

To apply this Medicare payment principle to a population of Medicaid residents in calculating the UPL for SFY 2000, Wisconsin computed a Medicaid Federal payment and a Medicaid facility-specific payment. Wisconsin computed the Medicaid Federal payment by applying the published Medicare rate schedule to the population of Medicaid residents according to each resident's service needs classification. GAO did not challenge this portion of the Wisconsin UPL calculation for SFY 2000.

Wisconsin computed the Medicaid facility-specific payment using the same methodology used to compute the Medicare facility-specific payment at that time.¹⁶ Specifically, Wisconsin derived the Medicaid facility-specific average costs using 1995 Medicaid cost report information (adjusted to remove non-Medicaid and developmentally disabled resident costs) inflated to the payment period.

Rather than applying Medicare payment principles to estimate the facility-specific payment component of Wisconsin's UPL, GAO used "actual rates used by Medicare to pay Wisconsin nursing homes in SFY 2000." [Appendix, p. 1, par. 3. (Emphasis added.)] In applying Medicare payment principles to Medicaid residents, it is inappropriate to use actual Medicare facility-specific rates, since these rates are derived from average Medicare resident costs. Medicare resident costs per diem are typically much greater than Medicaid costs per diem. This is true because, in order to qualify for Medicare payment for nursing home care, a resident must have been admitted following an inpatient hospital stay, and the services the patient receives in the nursing home must have been necessitated by the condition for which the patient was hospitalized.¹⁷ Moreover, Medicare generally only covers the kinds of services in a nursing home that would be covered if furnished to a hospital inpatient.¹⁸ Medicare payment is made for a maximum of 100 days of post-hospitalization nursing home care.¹⁹ Unlike Medicaid, Medicare does not cover long-term care services in nursing homes. Thus, GAO's use of actual Medicare facility-specific rates results in an upper payment limit for Medicaid residents that is excessive.

¹⁶ (See 63 *FR* 26251 at 26286, May 12, 1998.)

¹⁷ 42 U.S.C. §1395x (i).

¹⁸ 42 U.S.C. §1395f (a) (2) (B).

¹⁹ 42 U.S.C. §1395d (a) (2).

Now page 32.

Appendix VIII: Comments from the State of Wisconsin and GAO's Response

Wisconsin was reasonable and consistent in applying Medicare payment principles to the population of Medicaid residents. The resulting upper limit of \$133.50 per patient day results from a direct application of those principles to the best available information about Medicaid nursing home residents. GAO's recomputed value of \$162.77 results from a facility-specific component that is based upon Medicare resident average per diem costs. GAO's approach does not yield a reasonable payment for Medicaid residents, and, contrary to federal rules, is not based on Medicare payment principles.

While, as GAO notes, CMS has never published detailed guidance with respect to the Medicare UPL calculation, what federal guidance exists is consistent with Wisconsin's approach to calculating the UPL for SFY 2000. The *State Medicaid Manual* emphasizes that federal UPL rules

... permit a State greater discretion in determining if the requirement has been met and emphasize the State's flexibility to develop procedures for applying the upper limit test. They relieve the State of the burden of having to use the detailed cost finding principles required by Medicare or of complying with a prescriptive formula approach in ascertaining what would have been paid for such services under the Medicare principles of reimbursement.²⁰

That section goes on to state that "in determining if you meet the test of the upper payment limit, your estimate must use the Medicare principles in effect at the time," and that,

[i]n determining whether you comply with the Medicare upper limit ... you need not follow exactly every detailed procedure used to implement either of these principles in the Medicare program, so long as the principles are satisfied.

The repeated references in the *State Medicaid Manual* section to application of Medicare *principles* in calculating the UPL belies GAO's mechanistic approach of simply substituting Medicare facility-specific *rates* for Medicaid services, regardless of the applicability of those rates to the services received or the people who receive them. That GAO's approach is inconsistent with Medicare principles becomes even clearer when one considers that the UPL applies as well to Medicaid payments for services for which Medicare does not pay at all, such as the services provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Clearly, the UPL rule does not envision using a Medicare payment rate as the UPL measure for services Medicare does not cover.

²⁰ State Medicaid Manual, § 6005.

For all of the reasons set forth above, GAO's conclusion that Wisconsin was overpaid by over \$500 million in Federal Medicaid funds is incorrect.

Other Issues

Wisconsin's SFY 2001 Supplemental Payment Methodology was Legal and Appropriate. At page 4 and again at pages 16 and 20, GAO contends that HCFA "should not have approved" Wisconsin's SFY 2001 methodology for making supplemental Medicaid payments to local government nursing homes. GAO bases its position in this regard on the fact that Wisconsin's SFY 2001 state plan was amended to include the supplemental payment methodology on February 7, 2001, while HCFA had published a rule which would prohibit such payments on January 12, 2001. GAO omitted the fact that the new rule did not take effect until March 13, 2001, and applied only to state plan amendments submitted on or after that date.²¹ State plan amendments, like Wisconsin's, that were submitted prior to March 13, 2001 were reviewed by HCFA under the former UPL rule, which aggregated the UPL measure across government and non-government facilities. Under that rule, HCFA had no alternative but to approve Wisconsin's SFY 2001 supplemental payment methodology.

Supplemental Payments to Nursing Homes in Wisconsin were Lawfully Financed. At pages 7 and 8 and elsewhere in its report GAO notes that "typically" supplemental Medicaid payments to local government facilities are returned to the state. Wisconsin does not engage in this practice. In Wisconsin, supplemental payments to local government facilities have been financed through a combination of certified public expenditures by the counties that operate the facilities and by intergovernmental transfers of public funds from the counties to the state. Both of these methods of funding Medicaid payments are expressly authorized in federal law.²² Indeed, Congress has expressly prohibited HHS from restricting States' use for Medicaid expenditures of funds derived from local taxes that are transferred from local units of government to the state.²³

²¹ See State Medicaid Directors Letter #01-017.

²² 42 CFR § 433.51 (b); 42 USC § 1396a (a) (2).

²³ 42 USC Sec. 1396b (w) (6) (A).

See comment 7.
Now pages 4, 20 and 24.

See comment 8.
Now pages 9 and 10.

See comment 9.
Now page 32.

Wisconsin Acted Reasonably in Estimating the UPL during the Transition from Cost-Based to Prospective Medicare Reimbursement. At page 26 GAO asserts that “none of the states accurately determined Medicare rates when calculating their UPLs, because they did not correctly account for changes that occurred when Medicare moved from cost based reimbursement to prospective rates starting in 1998.” In a footnote to that text, GAO states that “[s]ome states applied a standard blending rate to all nursing homes, not accounting for the different blended rates that were specific to each facility. Two states selectively chose to use a standard rate only when it would generate the most federal dollars.”

Wisconsin's SFY 1999 and 2000 UPL calculations took into account Medicare's transition from a cost-based to a prospective rate system. In both years, facilities were grouped according to their status under the transition rules to the new payment system, some using 100% of the Federal PPS rate and others following the phase-in schedule from facility-specific rates to the Federal rate. The SFY 1999 calculation blended the old three-part upper limit (i.e., the minimum of routine service limit, allowable cost and private-pay rates) with the FFY 1999 PPS rates. The FFY 1999 rates for the phase-in facilities were, in turn, 75% of facility-specific rate and 25% of the Federal rate.

For SFY 2000, the upper limit was a blend of the FFY 1999 and the FFY 2000 PPS rates. For the phase-in facilities, the weights on the facility-specific rates were 75% in FFY 1999 and 50% in FFY 2000. The BBRA 1999 provision to allow the phase-in facilities to elect to move to 100% of the Federal rate starting with the cost report year on or following 1/1/2000 was also incorporated in the FFY 2000 portion of the upper limit calculation.

Using Federal Matching Funds for Other Medicaid Services is Legal and Appropriate. At pages 29 to 30, GAO asserts that states' use of federal matching funds to pay for additional Medicaid services “effectively increas[es] those states' federal match rate.” In particular, GAO notes that

In Wisconsin, for example, we found that, by obtaining excessive federal matching payments and using these funds as the state share of other Medicaid expenditures, the state effectively increased the federal matching share of its total Medicaid expenditures from 59 percent to 68 percent in SFY 2001.

States routinely use claimed federal Medicaid funds to pay for additional Medicaid services. This is entirely consistent with principles of federal Medicaid claiming. When a State makes a Medicaid expenditure with state and local public funds and claims its proportionate federal match for that expenditure, the federal matching funds received by the State are deposited in state appropriation accounts and may be expended in any manner directed by the state legislature. Spending those matching funds as state Medicaid expenditures for additional services is in no way inappropriate, and it has never been held that this practice affects the state's overall federal matching share.

Wisconsin Uses Federal Funds Generated by Supplemental Local Government Facility Payments Exclusively to Pay for Medicaid-Covered Services. In the chart on page 31 of the report GAO indicates that “[f]unds generated by the State’s UPL arrangement are deposited in a state fund, which is used primarily to pay for Medicaid-covered services ...” [Emphasis added.] Under Wisconsin law, federal Medicaid funds claimed based on supplemental payments to local government facilities are deposited in a trust fund and may only be used to pay for Medicaid services.

See comment 11.
Now pages 34.

The following is our response to the State of Wisconsin's comments provided on December 23, 2003.

GAO's Response to the State of Wisconsin's Comments

Our responses to Wisconsin's comments are numbered below to correspond with the state's various points. Wisconsin generally contends that (1) the state's arrangement met the first BIPA condition required to receive an 8-year transition period (see Wisconsin's comments 1 through 4 and our corresponding response), (2) the state's arrangement met the second BIPA condition required for an 8-year transition period (see Wisconsin's comments 5 and 6 and our corresponding response), and (3) the state's arrangement is legal and appropriate (see Wisconsin's comments 7 through 11 and our corresponding response). In view of the evidence we reviewed, we continue to believe that CMS's decision to grant Wisconsin an 8-year transition period was not consistent with the objectives stated in the preamble to the agency's final UPL rule.

1. We disagree with Wisconsin that we incorrectly concluded that a 16-month transition period—rather than an 8-year transition period—was warranted for the state, with the result that the state was not entitled to receive more than \$500 million in federal Medicaid funds. We continue to maintain that, because the state's 2001 UPL arrangement was established after HCFA had taken action to limit the arrangements, Wisconsin's arrangement should not have been approved in the first place. In addition, we did not conclude that CMS's decision was unlawful. Rather, we believe that if CMS's transition period decisions had been more consistent with the objectives stated in the preamble to the agency's January 2001 regulation, CMS's decisions would have better protected the fiscal integrity of the Medicaid program.
2. Wisconsin also explained at length the legal basis for its 8-year transition period in terms of the two conditions set forth in BIPA, including an interpretation of BIPAs reference to a "payment provision or methodology" that defines the phrase as a provision or methodology for making supplemental payments. We have revised the report to expressly acknowledge that CMS's transition period decision with respect to Wisconsin was permissible given the statutory language. But we disagree with the state's position that BIPA defines a "payment provision or methodology" as a supplemental payment provision. Neither the plain language of BIPA nor its legislative history refers to "supplemental payments" or otherwise provides a basis for the state's definition.

3. We disagree with the state's contention that correspondence between HCFA and Wisconsin's Medicaid program relating to the state's plan for state fiscal year (SFY) 1987 provides evidence that the state's methodology (and the supplemental arrangement it established) was the type of arrangement that the agency described in its proposed UPL rule in October 2000. The state implied that it had a problematic UPL arrangement before October 1992 because it used an aggregated UPL test in providing HCFA with the required assurance that state Medicaid payments did not violate the UPL requirement. From our review of the actual payment methodology that Wisconsin had in place in 1992, however, we concluded that the state's supplemental payment was small and not the type of arrangement HCFA said it was trying to address with its UPL regulation.
4. We disagree with Wisconsin regarding the factors we weighed in assessing CMS's decision to grant the state an 8-year transition period: first, that we erred in considering whether the state had a long-standing practice of making extremely large supplemental payments to local government facilities; and second, that we erred in considering the objectives identified by CMS for the new UPL regulation in the preamble to the final rule. Wisconsin stated that BIPA provides no support for our position. We acknowledge that BIPA does not refer to these specific factors, but both are key to determining whether a state had developed budgetary reliance on the excessive federal funds as a result of using UPL arrangements over a number of years—CMS's stated reason for granting transition periods.
5. We do not dispute that Wisconsin may have met BIPA's second condition for qualifying for an 8-year transition period. Regarding the first way to meet this condition—having payments that exceeded the UPL under the new regulation as of its effective date, March 13, 2001—we agree that the state made a substantial UPL payment before that date. In fact, the state completed a \$637 million electronic transfer of funds to participating counties on March 12, 2001. Although this transfer for a Medicaid payment clearly exceeded the new UPL regulation and took place before the March 13, 2001, effective date, we question CMS's decision to treat this payment arrangement as a successor to a significantly different and smaller supplemental payment arrangement in place on or before October 1, 1992.
6. Regarding the second way for a state to meet BIPA's second condition—to have made payments for the state fiscal year beginning in 1999 that would have exceeded the UPL under the new rule had the payments been continued—we disagree with Wisconsin's assertion

that our approach to estimating the state's SFY 2000 UPL was fundamentally flawed. Our approach to estimating Wisconsin's UPL, which shows that the state complied with the new UPL and would not qualify for a transition period, applied the same types of principles used by other states whose UPL estimation methods were approved by CMS. We agree, however, that Wisconsin's methodology, while more conservative, could be considered reasonable. We have revised our report to recognize that either the state's approach or the one we used could be considered reasonable, given the lack of CMS guidance for appropriate methods for calculating the UPL.

7. Wisconsin asserts that its SFY 2001 supplemental payment methodology was legal and appropriate and disagrees with the conclusions from our earlier report that HCFA's approval of this arrangement was unjustified.¹ We disagree with the state's contention that the agency's approval of the state's arrangement was appropriate given its stated objectives and regulation to limit such arrangements; we explained our position in greater detail in our previous report.
8. We disagree with Wisconsin's assertion that—because the supplemental payments were lawfully financed through the use of intergovernmental transfers (IGTs) and certified public expenditures (CPEs) from local governments such as cities and counties—the UPL payments are appropriate. We agree that IGTs and CPEs are appropriate and legal mechanisms for the transfer of funds between government entities. In addition, we found that the state's UPL arrangement serves to increase federal Medicaid matching payments without a commensurate increase in state expenditures, which in our view is not appropriate or consistent with the goals and fiscal integrity of the Medicaid program. We also find Wisconsin's description of its UPL arrangement misleading. Wisconsin maintains that it does not require the local government facilities to return the supplemental Medicaid payments to the state. While technically correct, Wisconsin counties first transfer the total amount of the UPL payment (federal and state share) to the state and then the state transfers the funds back to the county—with the same result that the state does not increase its share of Medicaid expenditures.
9. As stated in comment 6, we have revised our report to acknowledge that Wisconsin's method for accounting for the Medicare's transition from a retrospective cost-based reimbursement system to a

¹[GAO-02-147](#).

prospective rate system may be considered reasonable in light of CMS's lack of guidance on how states should calculate their UPL.

10. We disagree with Wisconsin's contention that using federal matching funds obtained through UPL arrangements as the state's share of other Medicaid expenditures is appropriate. Under Wisconsin's arrangement, the state is not seeking federal reimbursement for payments made to local governments for Medicaid services provided to Medicaid-covered beneficiaries, as the state implies. Instead, the state is seeking reimbursement for a same-day wire transfer of a bank loan between county and state. As the state acknowledges, the claimed federal funds are placed in a trust fund, from which they are drawn upon as the state share for other Medicaid payments. The state thus increases federal Medicaid payments without a commensurate increase in its own payments. This practice effectively raises the federal government's share of Medicaid expenditures beyond the state's Medicaid-formula-based matching rate.
11. We have revised our report to incorporate Wisconsin's clarification that it uses the federal funds generated by its UPL arrangement to pay for Medicaid-covered services. It is important to clarify, however, that the funds are likely not being used for the Medicaid services provided to the Medicaid beneficiaries on whose behalf the funds are claimed. Rather, as we point out in comment 10, the federal funds are being used to effectively replace state funding for other Medicaid services and beneficiaries.

Appendix IX: GAO Contact and Staff Acknowledgments

GAO Contact

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Michigan Financing Arrangements. [GAO/HEHS-95-146R](#). Washington D.C.: May 5, 1995.

Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government. [GAO/HEHS-94-133](#). Washington, D.C.: August 1, 1994.

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