Discussion Papers

States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences

Teresa A. Coughlin
Stephen Zuckerman

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Assessing the New Federalism

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Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states. It focuses primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. Alan Weil is the project director. In collaboration with Child Trends, the project studies changes in family well-being. The project provides timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia. Publications and database are available free of charge on the Urban Institute's web site: http://www.urban.org. This paper is one in a series of discussion papers analyzing information from these and other sources.

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CONTENTS

Medicaid is the nation's major public source of financing of health insurance for low-income families and long-term care services for the elderly and disabled. Policymakers designed Medicaid so that both the federal government and the states share in program financing as well as in setting major program policies. Medicaid financing rules require states to spend their own funds to receive a federal financial match for Medicaid services, but there are no federal limits on program spending. This open-ended commitment of federal resources invites states to be generous in designing their programs. At the same time, because states share in the costs, it encourages states to use federal Medicaid dollars judiciously. State cost-sharing is also a way to assure federal policymakers and taxpayers that Medicaid spending is valuable because a state is willing to spend money on the program.

Within broad federal guidelines, states are given considerable discretion about specific groups of people and services that they want to cover through their Medicaid programs. In addition, states, to a large extent, determine how they raise their share of program costs and how much they pay Medicaid providers. While decisions about eligibility and the benefit package have tended be less controversial, how states raise their share of Medicaid costs and provider payment has been an area of federal-state conflict, especially over the past decade.

Much of the controversy surrounding provider payments and states' funding sources centers around states figuring out ways, all allowed within Medicaid law, to claim as many federal Medicaid dollars as possible. The practice of implementing program policies designed to expand the federal financing role in Medicaid is commonly referred to as "Medicaid maximization." Some forms of maximization are actively encouraged and were intended, given the structure of the program. Others, however, are not, which sometimes has made maximization a contentious issue. These revenue maximization strategies have brought about several changes

to the structure and character of the Medicaid program. These include increasing federal spending with no real state match contribution; creating inequities in the distribution of Medicaid funds among states; distorting program spending; and heightening tensions between federal and state governments.

In this paper, we provide a brief background on Medicaid financing and general program design. Then we discuss some of the maximization strategies states have used and how these strategies may have affected the Medicaid program. We conclude with some policy issues related to Medicaid maximization and consider options that could address state actions and their impact on the federalist structure of the program.

Background on Medicaid Program Design and Financing

The Medicaid statute sets out basic guidelines about which populations and services states are required to cover. Federal Medicaid guidelines also impose some limitations on how providers are paid and how services are delivered to beneficiaries. Beyond these basics, however, Medicaid law provides states with considerable latitude in the design of their Medicaid programs. States, for example, have the option to cover a wide range of additional populations—such as the medically needy, the working disabled, and low-income working parents. They can also elect to offer a broad range of services; states can add up to 34 optional services to their programs. Both how and how much Medicaid providers are paid is also almost entirely left up to the discretion of each state.

State policymakers thus make a range of important decisions in piecing together their Medicaid programs: Which populations are they going to cover? What services are going to be included in their benefit package? Should service limitations be imposed? How should care be

delivered—managed care or fee-for-service? At what level should provider reimbursement be set? Owing to the federal promise to pay for a share of all Medicaid costs, states have an incentive to assess opportunities for Medicaid maximization when designing their programs. Indeed, a primary goal of the federal Medicaid match is to lower states' costs of providing coverage to low-income residents, thereby encouraging states to undertake initiatives that they would not have done otherwise or to go beyond what they would have done on their own. The match rate basically "discounts" the price states would otherwise face when deciding how much to spend on health care programs for their low-income population. The federal match also makes it less attractive for states to cut Medicaid during economic downturns when need is great but state revenues are low.

The federal share of Medicaid spending is determined according to a formula—called the Federal Medical Assistance Percentage or FMAP—under which the poorest states (based on average per capita income) receive a higher federal matching rate. By law, a state's FMAP cannot be lower than 50 percent or greater than 83 percent. In 2000, nine states received the minimum 50 percent FMAP, while Mississippi had the highest match, 76 percent. Of the roughly $206 billion spent on Medicaid in 2000, almost 57 percent ($117 billion) was from the federal government, with the remainder from states and localities (CMS 2000).

States recognize that the federal funding available through Medicaid allows them to finance health care for the poor with less of their own funds, and all states participate in the program. In fact, states quickly recognized the value of Medicaid. By 1971, five years after the program was implemented, Medicaid costs totaled $6.5 billion, more than twice initial expenditure projections. Analysts attributed the unanticipated growth in Medicaid's early days largely to an underestimate of the extent to which states would cover optional eligibility groups

and optional services (Klemm 2000). Medicaid is now one of the largest expenditure items in most states' budgets and, in the federal budget, one of the fastest growing components.

Clearly, the structure of the match rate contains incentives that influence state behavior in the direction of Medicaid maximization. If a state is going to provide a service to its low-income population funded with state or local dollars, it is to their benefit to include the service in its Medicaid package. Similarly, the federal-state partnership encourages states to cover people through Medicaid as opposed to local or state health programs. The match also provides incentives to pay Medicaid providers generously as it can help offset potential state or local health care outlays. For example, broad Medicaid eligibility rules and generous provider payment rates can offset state or local health expenditures for the uninsured or help cover providers' uncompensated care costs.

Recognizing the potential pressure to expand Medicaid along these various dimensions—which can cause program costs to spiral upward—the federal government retains the right to review and approve states' Medicaid plans and changes to those plans. Further, in some cases, if a state wants a major exception to Medicaid eligibility, payment, or service coverage rules, the federal government can require the state to seek a research and demonstration, freedom-of-choice, or a home- and community-based service waiver. Not all states, however, are inclined to "maximize" Medicaid to the same degree. Economic resources as well as underlying population differences that affect health care needs (such as the number of uninsured residents) play important roles in determining how a state designs its Medicaid program and the extent to which it maximizes Medicaid. A state's political cultural as well as the level of sophistication and expertise among state Medicaid officials and legislators regarding the many nuances of the Medicaid program are also very important factors.

Ways That States Have Maximized Medicaid

The structure of the federal match coupled with the program flexibility under Medicaid has provided states both the opportunity and the incentive to leverage federal funds. Over the years, maximization strategies have come in various forms. Some entail shifting previously state-funded health programs into Medicaid. Others involve making extra Medicaid payments to selected health care providers with states putting up little to no real state tax dollars. All of these strategies are fully allowable under Medicaid law. Indeed, in many instances, such as expanding program eligibility and service coverage, the federal government actively encouraged states to undertake the initiatives. By contrast, some of the varied Medicaid financing strategies states have used over the years have stirred considerable debate between states and the federal government.

In this section we describe some important ways states have maximized Medicaid. We grouped maximization strategies into two broad categories, Medicaid program expansions and Medicaid revenue expansions. Under the former, states maximize Medicaid by expanding eligibility and services. These efforts generally operate within the basic Medicaid principles that states get more by spending more on more or better services. Thus with program expansions a state can choose to "maximize" federal support by operating a more generous Medicaid program. States can undertake program expansions by electing the various options allowed under the program or by seeking special Medicaid waiver.

The second group of maximization strategies is Medicaid revenue expansions. As we discuss below, these have been much more controversial compared to program expansion strategies. Under the revenue expansions, which take various forms, increased federal spending takes place with limited or no state contribution. Further, in some instances, federal Medicaid

dollars that are paid do not go to cover or improve health care services or expand coverage to new populations.

Medicaid Program Expansions

Shifting of State-Funded Health Services into Medicaid. A common practice among states has been to reconfigure state-funded services so that they are in keeping with Medicaid standards and regulations. By shifting services into Medicaid, states can get federal dollars to help pay for the services that previously had been financed just with state funds. Shifting of services into Medicaid really took hold among states in the mid- to late- 1980s. Among others, Medicaid has become an important source of revenue for many public health programs, particularly maternal and child health services and home health (Coughlin et al. 1999). Another area in which states pursued Medicaid maximization is mental health care. Beginning in the mid-1980s, states increasingly moved patients out of state psychiatric hospitals, where adults age 22 to 64 are generally ineligible for Medicaid, into the community, where they are eligible for Medicaid (Manderscheid et al. 2000). Likewise, over the years some states—for example, Wisconsin, California, and Washington—have shifted state-funded home care services into Medicaid. Moving state and locally funded school-based services is another area where states have shifted programs into Medicaid.

Expanding Populations Served under Medicaid. More recently several states have increased the flow of federal dollars by expanding Medicaid eligibility to populations that were either uninsured or had been covered by state-funded programs. The vehicle by which many states undertook this type of eligibility expansion was through the Medicaid Section 1115

demonstration waiver authority.[1] Though 1115 waivers had been available for many years, prior to the early 1990s they had not been used widely, in part because of the fear among federal policymakers that program costs might increase under waivers and because states viewed the federal review process as too burdensome and lengthy. Soon after then-President Clinton assumed office in 1993, his administration allowed some new assumptions about program costs under the waiver that made it easier for some states to meet the budget neutrality provisions required by 1115 waivers (Holahan et al. 1995).[2] In addition, the Clinton administration made a commitment to states to streamline the waiver process. States rapidly embraced the new flexibility: Between 1993 and 1995 alone, thirteen states received 1115 waivers. Before 1993, Arizona was the only state with a statewide 1115 waiver demonstration.

While each of the 1115 programs implemented in the mid- and late-1990s is unique, a common feature shared by many, especially the early ones, was the expansion of coverage beyond the traditional Medicaid eligibility categories to include the uninsured or individuals enrolled in state-funded health programs (Holahan et al. 1995).[3] Key examples of these programs include the Oregon Medicaid demonstration, which, among other things, expanded Medicaid eligibility to individuals with incomes less than 100 percent of the federal poverty level. Tennessee's TennCare waiver also included a broad eligibility expansion to uninsured individuals: When first established, TennCare was open to all uninsured persons, regardless of employment status or income level.

[1] Section 1115 of the Social Security Act authorizes waivers of specified provisions of Medicaid law allowing states to test a range of policy ideas, including how the program is financed, how services are delivered, and what populations are served under the waiver.

[2] One of the requirements of Section 1115 waiver programs is that they be "budget neutral." That is, over the life of the waiver, the costs of the waiver program to the federal government cannot be more that they would have been without the waiver.

[3] See Holahan and Pohl (2002) for details on these waiver programs.

Using somewhat of a different approach, several states now receive federal Medicaid matching dollars through 1115 waivers for health insurance programs that had been funded exclusively with state dollars. Examples of such waivers include Minnesota's Prepaid Medical Assistance Program demonstration, where the state now receives Medicaid funds to help finance its subsidized health insurance program, MinnesotaCare. Likewise, New York under its Partnership Plan waiver gets federal Medicaid matching funds for its general assistance population, which it previously covered under the state and local Home Relief program.

Medicaid Revenue Expansions

Medicaid Funding of General Safety Net Programs. Some states have used the Section 1115 authority to secure new federal funds to help finance their general health care safety net programs (Coughlin and Liska 1998). California and New York are among the states that have used this maximization strategy. In 1995 and in 2000, Los Angeles County received 1115 waivers that provided additional federal dollars to the county health care system, on the condition that the system be restructured to have more of an emphasis on ambulatory care (Long and Zuckerman 1998; Zuckerman and Lutzky 2001). The initial purpose of this waiver was to financially stabilize a system that was experiencing a serious fiscal crisis in 1995 and was considering closing its largest public hospital and privatizing others. Despite the promise for restructuring, the waiver was viewed by many as a "bailout" of the county health system and was reported as such in the media (American Health Line 1995). Over the seven-year waiver period, Los Angeles received more than $1 billion in federal Medicaid money. The state match required to receive these federal payments was financed with intergovernmental transfers, or IGTs (see discussion below), from Los Angeles County, so that the county was helped without any additional expenditure on the part of the state of California.

Similarly New York, as part of its Partnership Plan 1115 waiver, was granted additional federal funds to help safety net hospitals make the transition to a more competitive marketplace. With heavy promotion by hospital union officials, over the five-year waiver, New York hospitals will get $1.25 billion in federal funds. The funds can be used for a wide range of activities including worker retraining and investing in management information systems; funds do not have to be used for direct patient services. The state was able to secure these federal funds through the budget neutrality provisions provided under the 1115 waiver authority. That is, as long as states can show that expenditures under the waiver are no more than they would have been without the waiver, then states—with federal approval—can get Medicaid matching funds.

Financing and Payment Policies. Without doubt, the most controversial Medicaid revenue strategy has been the combination of the financing policies and payment policies that states have used in recent years to maximize federal Medicaid matching funds. Often this type of maximization strategy is done without spending from state general revenue. We begin with a discussion of the financing policies, followed by one of payment policies. However, it should be noted that to make maximization work, the financing and payment policies must work in tandem.

Financing policies aimed at maximizing Medicaid began with provider taxes and donations, which were widely used by states beginning in the mid-1980s. Ironically, provider taxes and donations were initially approved by the Health Care Financing Administration (HCFA, now called the Centers for Medicaid and Medicare Services or CMS). In an effort to afford states greater flexibility in raising Medicaid funds, HCFA issued a rule in 1985 allowing states to use donations from private medical care providers as part of their Medicaid match. West Virginia was the first state to use provider donations for this purpose. In 1986, West Virginia, facing major fiscal problems, did not have state funds to pay hospitals for Medicaid services and

thus could not draw federal Medicaid matching dollars. Hospitals helped the state by "donating" money to the state. Then the state paid back the hospitals with the donated funds, earning federal Medicaid match. Thus, by paying hospitals with donated funds, West Virginia was able to receive the federal match without, in fact, having to spend any state dollars. Although the federal dollars may not have fully covered hospitals' costs in treating Medicaid patients, the donation program allowed hospitals to receive at least partial payment.

Also in the mid-1980s, some states adopted provider tax programs, which operated along the same principle as donation programs. Under provider tax programs, states would collect tax revenue from providers, often hospitals, and use these funds as the state share for making Medicaid payments, especially Medicaid disproportionate share hospital payments (see discussion below). Typically, the payments were issued to the providers that had been taxed. So, at the end of the transaction, the hospital was fully reimbursed for their tax contribution. In other words, providers were held harmless. Florida was the first state to establish a provider tax program in 1984.

Using provider tax and donation programs as a way to raise the state share became a common practice among states in the early 1990s. In 1990 just six states had tax and donation programs; by 1992, 39 states had them (Ku and Coughlin 1995). While the bulk of the provider tax and donations programs involved hospitals, other providers including intermediate care facilities for the mentally retarded (ICF/MRs), nursing homes, and physicians were also sometimes involved. To deal with the rapid rise in provider tax and donation programs, Congress enacted legislation in 1991 that essentially banned states' use of provider donations and imposed restrictions on provider taxes so that taxes now have to be a "real" assessment and providers could not be guaranteed a payback of their tax contribution. As a result of the Medicaid

Voluntary Contribution and Provider-Specific Tax Amendments of 1991, states had trouble enacting provider taxes that complied with the new law.

Because of these difficulties, many states turned to intergovernmental transfer (IGTs) programs as a way to raise their state Medicaid share. As the name implies, intergovernmental transfers are fund exchanges among or between different levels of government, and are a common feature in state finance. For example, a state transfer of money to a county to support primary education constitutes an IGT. Beginning in early 1990s, many states began to use IGTs as a way to leverage federal Medicaid dollars, and IGT programs became a variant of provider tax and donation programs. Though IGTs in and of themselves are a legally acceptable means of raising the state's share for Medicaid,[4] they are not in keeping with the spirit of how Medicaid was to be financed: Since IGTs often do not represent a true expenditure for health care services, states are not fully financing their share of Medicaid costs as was intended.

To understand how states benefit from financing policies involving IGTs (or earlier, tax and donation programs), we show a typical transaction in Figure 1. The transaction might begin with a state receiving $10 million in revenue—in the form of an IGT, tax, or donation—from a hospital. The state would then make a $12 million Medicaid payment back to the hospital. Assuming the state has a 50 percent federal matching rate, the state would get $6 million in federal Medicaid funds. At the end of the transaction, the provider would have netted $2 million ($12 million minus $10 million) in Medicaid payments, all from federal funds. The federal government has paid $6 million in Medicaid payments, of which $4 million went to the state where the money could be used for various purposes—health or general state expenditures. At

[4] Indeed, several states have long used IGTs from local governments to help pay the state's share of Medicaid. New York, for example, requires counties to pay 20 percent of the nonfederal share of Medicaid long-term care expenses and 50 percent of the nonfederal share of all other Medicaid services.

the end of the transaction, neither the state nor the locality expended any funds; only the federal government did. That the state or locality made no financial contribution is contrary to a basic tenet of Medicaid: That is, it is a program in which the federal government and states or localities share the financial burden.

These financing policies have enormous advantages for states. Each dollar of revenue raised—from either a tax or donation program or an IGT—could generate one to three federal Medicaid matching dollars, depending upon the state's match rate. Again, depending upon the specifics of the program, the federal dollars could be generated without the state using any of its own money.

Although many states generated revenues through provider taxes, donations, and IGTs, states had to spend this revenue because federal Medicaid matching payments are based on expenditures not revenues. States have used two basic payment programs to spend the revenues generated under provider tax and donation programs and through IGTs: the Medicaid disproportionate share hospital (DSH) program and, more recently, upper payment limit (UPL) programs.

In an effort to maintain access to health care, in the Omnibus Reconciliation Act of 1981, Congress mandated that states consider the special payment needs of hospitals that serve a high proportion of Medicaid and uninsured patients. These special payments came to be known as hospital disproportionate share or DSH payments.[5] Although these payments were mandated in the early 1980s, states were initially slow to act. By 1989 only a handful of states were making

[5] The rationale behind the special payments was that hospitals that provide high volumes of care to low-income Americans often lose money as a result of low Medicaid reimbursement rates. They also lose money because these same hospitals generally render high volumes of care to indigent patients and thus had high levels of uncompensated care. In addition, hospitals with large caseloads of low-income patients frequently had low private caseloads and thus were less able to shift the cost of uncompensated care to privately insured patients.

DSH payments. To encourage states to make Medicaid DSH payments, Congress passed several provisions during the mid-1980s. A key provision, which was included in the Omnibus Reconciliation Act of 1986, allowed states to pay hospitals rendering high volumes of care to low-income patients rates above those paid by Medicare and exceed the so-called "upper payment limit."[6]

The combination of raising revenue without state expense (via provider taxes, donations and IGTs), coupled with the ability to make virtually unlimited DSH payments was central to the extraordinary increase in Medicaid DSH expenditures in the early 1990s. Between 1990 and 1992, DSH payments (federal and state) grew from $1.4 billion to $17.5 billion and were a major reason for the rapid growth in overall Medicaid expenditures in early 1990s (Holahan et al. 1993; Coughlin and Liska 1997). By 1996, DSH payments accounted for 1 of every 11 dollars spent on Medicaid. The extent to which states use the DSH maximization strategy varies widely (Table 1). In 1998, for example, DSH spending accounted for 22 percent of Louisiana's total Medicaid spending and nearly 20 percent of Missouri's and South Carolina's. By contrast, DSH accounted for less than 1 percent of many states' programs spending, including Arkansas's, Nebraska's and Wisconsin's.

Importantly, some of the gross DSH payments do not represent real additional dollars to help cover hospitals' uncompensated care costs because provider taxes or IGTs are used to pay the state share of DSH payments. Although some of the IGTs may represent local funds that are retained by providers and ultimately used to fund health care services, only the federal share of

[6] As a way to limit federal Medicaid expenditures, over the years HCFA established a set of upper payment limits on the total amount it would agree to pay states for certain services. The payment limits are based on service payment allowed under the Medicare program. The payment limit is not a price to be paid for each service provided, but rather a ceiling on total Medicaid expenses above which the federal government will not match. Further, upper payment limits are set for different classes of services (such as nursing home care, inpatient hospital services, and ICF/MRs).

the gross DSH payments represents new funds to providers. However, some states retain most of the federal share of DSH payments so that hospitals actually received little, if any, additional Medicaid revenue under the DSH program. Further, state and local subsidies to public hospitals may be reduced in anticipation of the inflow of federal funds and these cutbacks may offset any new revenue received under the DSH program. A 1997 survey revealed that only about 40 percent of total DSH expenditures in that year went to help hospitals' cover their costs of caring for Medicaid and uninsured individuals (Coughlin, Ku, and Kim 2000). Thus the bulk of DSH spending in 1997 was not going to cover safety net hospitals' uncompensated care costs as was the original intent behind the special payments. Not surprisingly, as discussed below, Medicaid DSH payments have been a highly contentious issue between the states and the federal government, and on three separate occasions Congress enacted legislation to curtail DSH spending.

More recently states have developed UPL programs as a way to draw down extra federal matching dollars (Coughlin et al. 2000; Ku 2000; U.S. GAO 2000, 2001). These programs are essentially a variant of the DSH program: A state makes an additional Medicaid payment (that is, payment that is over and above regular Medicaid reimbursement) to a targeted group of providers—such as nursing homes or hospitals—that are typically owned by a county or local government. (States generally use county and locally owned providers in UPL programs because they can make IGTs to fund the state share.) The enhanced payments are well in excess of the actual cost of medical services provided to Medicaid beneficiaries. The state claims federal Medicaid funds for the enhanced payments and then requires the providers to give back much or all of the enhanced payment to the state in the form of IGTs. Thus, similar to DSH financing, the state receives federal matching dollars without putting up any real state funds.

Though Medicaid law grants states broad discretion in setting provider reimbursement levels, mentioned above, it does impose the Medicare upper payment limit where Medicaid payments (except hospital DSH payments) can be no higher than the amount that Medicare would have paid for the same service. Importantly, whether Medicaid payments exceed the UPL is not determined by Medicare payment for a single procedure or even on payment for all Medicaid services a provider renders. Rather, the UPL is based on the *aggregate* amount that can be paid to an entire class of providers if every provider in that class were paid the Medicare rate for all services it provided to Medicaid beneficiaries. Until 2001, when the federal government issued regulations establishing three classes of providers (see discussion below),[7] there were two classes of providers—state-owned and non-state-owned. The latter class includes both local publicly owned facilities and private providers.

Prior to the new 2001 regulation, a state could thus determine its UPL for, say, nursing homes by calculating, on a statewide basis, the difference between its total Medicaid payments to all county-owned nursing homes and private nursing homes and what Medicare would have paid. To use the UPL maximization strategy, the state would then pay the entire difference, in supplemental Medicaid payments, to the publicly owned nursing homes. States were allowed to pay the full UPL difference to just the public nursing homes because, as noted in the proceeding paragraph, public and private providers were in the same provider class for UPL determination purposes. Given that the Medicaid payment levels historically have been considerably lower than Medicare levels, the potential for gaining additional federal dollars through UPL arrangements was enormous.

[7] In brief, the January 2001 UPL regulation separated local publicly owned facilities from private providers. So now the UPL is determined across a narrower range of providers.

As an example of how an UPL program works, in figure 2 we describe Pennsylvania's nursing home program as reported by HHS's Office of the Inspector General (OIG) (Mangano 2001). On June 14, 2000, Pennsylvania paid $697.1 million in supplemental payments to 23 county nursing homes. With its 54 percent FMAP, the state received $393.3 million in federal matching funds. On the same day, the nursing homes returned $695.6 million (of the $697.1 million in supplemental payment) to the state. At the end of the transaction, the nursing homes had a small ($1.5 million) net gain whereas the state of Pennsylvania gained $392 million. Further, while the federal government had paid $393.3 million in Medicaid nursing home reimbursement, no new Medicaid services appeared to have been provided with the funds. Other states' UPL programs highlighted in the OIG report operated along a similar vein.

Systematic information on what states do with the federal funds obtained under UPL programs is limited. However, the 2001 report by the OIG found that in some states the federal UPL funds are effectively "recycled" to generate additional federal Medicaid matching funds (Mangano 2001). Alabama and Pennsylvania were among the states that were cited as having UPL programs in which the federal dollars gained were used as the state match to make subsequent Medicaid payments and, in the process, drawing another match. In short, the state is earning "match on the match."

While some states have had UPL programs for many years, the number of programs has grown dramatically in recent years (Ku 2000; U.S. GAO 2000, 2001). One survey showed that in 1995 states spent $313 million on UPL programs; by 1998, states spent $1.4 billion. Two years later, in 2000, 28 states had at least one UPL program and, nationwide, an estimated $10 billion in Medicaid UPL expenditures were made (Mangano 2001).

Implication of Maximization Strategies

The matching rate mechanism that is central to Medicaid financing encourages states to spend more on health care for low-income populations through Medicaid than they would have on their own. However, Medicaid maximization strategies have implications that go beyond merely elevating spending. These range from increasing state variation in Medicaid benefit packages and eligibility to altering provider and health plan payments to disrupting the intended balance between federal and state payments toward program costs. With all the various options, the federal government allowed for some program variation in Medicaid. Therefore, that differences across states exist is not a major implication of Medicaid maximization.

States have used Medicaid program maximization strategies in the areas of service coverage and eligibility in ways that have made Medicaid a bigger and more costly program, and a source of funding for many health care services that had been or could have been financed with just state and local dollars. Washington's Basic Health Plan, New York's Home Relief Program, California's In-Home Support Services, Tennessee's TennCare, and Vermont's Pharmacy Assistance Program are all examples of existing or new programs that states run but whose funding is dependent on federal Medicaid dollars. However, and perhaps the critical element shaping federal attitudes in this area, the state share in the costs of adding beneficiaries or services is generally paid for from state general funds. In this way, the federal policymakers know that states are taxing their residents, in part, to raise their share of Medicaid program costs and, therefore, putting real dollars into this health care program. Thus these efforts represent real opportunity costs for the states; state spending on Medicaid program expansions come at the expense of state spending on other objectives, including tax cuts. This is in stark contrast to Medicaid revenue programs, where states often view the federal Medicaid match as a funding

source that can be used to offset rising health care costs, the costs of non-health programs or to eliminate the need to raise taxes.

Provider and Health Plan Payments

Provider payments made through DSH and UPL programs are viewed as a central component of Medicaid maximization. Especially for DSH payments, the development of these programs has caused dramatic state payment differences. For example, although DSH payments are intended to offset uncompensated costs that hospitals incur on behalf of treating Medicaid and uninsured patients, data on variation in DSH spending (table 2) show that payments go well beyond state variation in uninsurance rates: In 1998, 17 states reported less than $100 in DSH payments per uninsured person, while 12 made payments in excess of $500 per uninsured person. In short, Medicaid DSH payments are not equitably distributed across states based on population needs. Instead, differences in Medicaid DSH primarily reflect the creativity of state policymakers and a state's willingness to engage in this form of Medicaid maximization.

Program Financing

When states have used strategies to fundamentally change the financing of Medicaid, federal concerns developed relatively quickly—but not immediately. Through the use of IGTs, in conjunction with DSH and UPL programs, states have increased the federal share of Medicaid program costs beyond the share dictated by the matching rate. To the extent that these practices are used, they altered the intended balance of Medicaid dollars between the federal government and the states as well as the distribution of federal matching dollars across the states. In turn, this affects the integrity of the federal matching rate structure that is designed to have states contribute a pre-determined share of Medicaid costs.

As mentioned, the federal government pays almost 57 percent of Medicaid program costs. The implications of UPL programs on the effective matching rate in selected states have been explored recently by both the Inspector General (IG) of DHHS and the General Accounting Office (Mangano 2001; U.S. GAO 2000). In its study, the GAO concluded that the basic UPL programs currently being used in some states "inappropriately increases federal Medicaid payment …and violates the integrity of Medicaid's federal/state partnership" (U.S. GAO 2000). For example, GAO reported that its 1994 analysis of a UPL program run through county nursing homes in Michigan raised the federal share of Medicaid program expenditures from 56 percent (the statutory rate) to 68 percent. A study of a similar UPL program in Pennsylvania conducted by the IG of DHHS found that the state was able to achieve a matching rate of 65 percent instead of the official rate of 54 percent. To the extent that DSH programs affect financing similarly to UPL programs, they also increase the effective matching rate.

Although it is not possible to precisely assess the impact of DSH and UPL programs across *all* states with the available data, we were able to estimate the effective match rate for 23 states that were included in the DHHS Inspectors General's report and that responded to a 1998 Urban Institute survey on the Medicaid DSH program (Coughlin et al. 2000). In basic terms, we lowered the reported amount of state Medicaid spending to reflect the fact that some portion of that money was raised through IGTs and, as such, does not represent real health care spending. (The details of this estimation are discussed in Appendix A.) Table 3 shows Medicaid spending as reported by the states in claiming federal matching funds (first three columns), adjusted Medicaid spending using information on IGTs from the DHHS IG report on UPL programs and a Medicaid DSH survey (second three columns), the FMAP calculated from the reported expenditure data, and the effective FMAP calculated from the adjusted data. The last column

shows the difference between the calculated and adjusted FMAP. Based on this analysis, we concluded that these 23 states were able to increase their average match rate for federal fiscal year (FFY) 2000 from approximately 56 percent based on reported Medicaid expenditures to an effective rate of 59 percent.

To understand the financial impact of this seemingly small change in the FMAP, it is necessary to recall how the match rate affects federal spending. At a 50 percent matching rate, for every state dollar spent the federal government spends one dollar. However, at a 56 percent matching rate, each state dollar requires the federal government to spend $1.27 (= federal share/(1-federal share) = 0.56/(1-0.56)). Shifting the effective matching rate to 59 percent through the use of IGTs means that the federal government would spend $1.43 for each dollar of state spending (rather than $1.27) financed out of general revenues. Therefore, across the 23 states for which we have relatively complete data, federal spending per dollar of state general revenue spending, on average, was increased by about 13 percent as a result of IGT financing. In the state of New Jersey, where our estimates suggest that the matching rate was effectively increased from 50 to 57 percent, federal spending per dollar of state general revenue increased by almost 33 percent.

In addition to altering the effective match rate, UPL and DSH programs financed through IGT mechanisms also obscure actual levels of program spending. A recent review of UPL programs in 28 states conducted by the IG of DHHS showed that, as a group, spending through these programs totaled $10.3 billion in 2000, with $5.8 billion coming from the federal government and $4.5 billion from the states (Mangano 2001). However, if the states' share of $4.5 billion was paid with IGTs that were ultimately returned to the local governments to use as they pleased, then it is wrong to view these UPL payments as having increased aggregate

Medicaid spending by $10.3 billion. That would overstate aggregate program spending. In reality, Medicaid expenditures only increased by the amount of federal outlays, or $5.8 billion rather than $10.3 billion. The same 28 states also spent $11.3 on Medicaid DSH payments in 2000, but only $6.3 billion of this amount was derived from federal funds with $5 billion from state funds. However, like the states' UPL programs, the vast majority of the state share for DSH was financed by IGTs or analogous mechanisms. Taken together, in 2000 the 28 states' DSH and UPL programs recorded $21.6 billion in Medicaid spending, but actual spending—net of the state component—may have been as little as the $12.1 billion that was the federal share.

Moreover, there is no reason to believe that all of this $12.1 billion in federal spending was used to pay for the costs of Medicaid-covered or health-related services. Some states have been able to increase federal payments through Medicaid UPL and DSH programs to such a degree that they have been able to use these dollars as the state share for other Medicaid spending—termed "recycling the match," as discussed earlier—or to direct these dollars to non-health areas of their budgets (Ku 2000; Rein 2001; U.S. DHHS OIG 2001).

State Health Care Policymaking

While difficult to fully assess, maximization has also likely affected state health care policy and the general budget making process. The influx of federal dollars and the growing reliance on Medicaid to fund health care programs or, in some cases, general budget items may allow states to delay tough decisions such as raising taxes or cutting back on programs. To the extent that states can implement new maximization strategies in the face of a downturn in overall state revenues or higher-than-expected Medicaid costs, states may be able to avoid or delay tax increases. By lowering state spending on health care, maximization can also protect spending on non-health programs.

A recent response to a budget crisis in the state of Washington, a revamped supplemental nursing home payment system in Wisconsin, and an ongoing supplemental hospital payment program in California are all examples of how the ability to think creatively and draw in federal dollars can influence state health care policy. During Washington state's fiscal year 2002–2003 budget debate, the legislature was facing serious financing problems as a result of growing costs in a number of health care programs (Holahan and Pohl 2002). Although significant Medicaid cutbacks were considered, the state realized that it could legally alter the way it sets the upper payment limits in its county nursing home UPL program and generate $450 million in additional federal Medicaid dollars. The state took this route and made only limited cuts in health care spending.

Similarly, in preparing its 2001–03 biennial budget, Wisconsin replaced a supplemental payment program that was designed to cover the unreimbursed costs of only county and municipal nursing homes with a program that applies the Medicare upper payment limit to all nursing homes to maximize federal dollars (Bruen and Wiener 2002). The state estimated that this could generate approximately $604 million in federal dollars between 2001 and 2003 and that this could be used to fund the state share of future Medicaid payments. However, federal rule changes may limit the ability of the state to continue this approach. Although other strategies—such as raising taxes or making Medicaid cuts—were available, the UPL approach was described as being the only politically feasible option that could generate enough funds to finance the reimbursement increase.

In an even bigger effort to draw federal dollars into a state, California's Medicaid program has used supplemental payments as part of a response to hospital complaints that its selective hospital contracting program had enabled the state to establish payments that were too

low to adequately compensate providers (CMAC 2001). Rather than adopt a major across-the-board change in the rates paid to all contract hospitals, California developed a more targeted approach that cost the state nothing from its general fund revenues. The state agreed to a supplemental payment program that paid extra amounts to contract hospitals that operated emergency rooms and qualified for Medicaid DSH payments. The state share of these supplemental payments was funded entirely with IGTs from county and University of California hospitals. The program has grown from under $100 million in federal payments in state fiscal year 1992–93 to over $650 million in state fiscal year 2000–01.

Conflicts between States and the Federal Government

Perhaps the most visible consequence of maximization is the heightened tension between states and the federal government over the Medicaid program. Over the past decade, that tension has brought about several pieces of federal legislation and regulation aimed at curbing maximization, especially the DSH and UPL strategies. Mentioned earlier, federal policymakers began to intervene in 1991 when Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments—after the Bush administration and the National Governors' Association reached an agreement—which sought to reform the DSH program along several dimensions. In addition to greatly restricting the use of provider donations and taxes, the 1991 law—the first time in the program's history that a stand-alone Medicaid law was enacted—also severely limited the growth in DSH spending by imposing state DSH expenditure caps. However, the law did not attempt to impose cuts to the DSH program. It also did not address any of the underlying inequities in the DSH program across states—for example, the unevenness in DSH spending among states. Instead, it more or less "froze" the program circa 1992.

Federal concerns about the DSH program persisted. In particular, federal policymakers wanted to regulate how payments were made to individual hospitals. A major issue was that many states were making DSH payments that exceeded hospitals' uncompensated care costs associated with serving the Medicaid and uninsured populations. To address this, Congress included a provision in the Omnibus Reconciliation Act of 1993 limiting DSH payments to a single hospital to no more than 100 percent of the unreimbursed costs of providing care to Medicaid and uninsured patients. This limit has become known as the "hospital-specific cap."

Controversy around the DSH program again surfaced during the 1997 federal budget debate. This time Congress undertook substantial cutbacks in federal DSH spending as part of the Balanced Budget Act (BBA). Indeed, of the $17 billion in gross Medicaid reductions contained in the BBA over the 1998–2002 time period, about $10 billion or 60 percent were attributed to cuts in federal DSH payments (Schneider, Chan, and Elkin 1997). The BBA set out state-specific DSH allotments for each year in 1998 to 2002 time period, which were lower than what had been allowed under previous law.[8]

However, the BBA contained no formula for distributing federal DSH payments based on specific criteria, e.g., in accordance with low-income uninsurance rates. Instead, the state-specific allotments, which were based on historical state DSH spending patterns, have been described as "a classic compromise" between the House and Senate versions of the DSH provisions (Schneider et al. 1997), sometimes reflecting a state's political influence. Under the final BBA legislation states received the higher of the DSH amounts allowed under the Senate bill and those allowed under the House bill. An additional constraint was imposed in which no

[8] The BBA contained several other important DSH provisions, including a provision requiring that DSH payments made on behalf of Medicaid beneficiaries enrolled in managed care must be paid directly to hospitals rather than managed care plans. Finally, the BBA contained some longer-term DSH spending limits which are scheduled to take effect in 2002.

state's federal DSH funding in any year could be reduced by more than 3.5 percent of a state's total 1995 federal Medicaid payments. This limit helped several states including Alabama, Connecticut, and Kansas. Further, some specific states—such as Louisiana and New Jersey—received more favorable treatment in their BBA allotments. In a separate provision, BBA also made a special exception for California: For 1998 and 1999, California's hospital-specific cap was increased from 100 percent (as mandated under OBRA 1993) to 175 percent. (In subsequent legislation, this exception was made permanent for California.) Thus while Congress as a whole was interested in cutting federal DSH expenditures, individual representatives sought to protect their states.

More recently, the federal government has turned its attention to controlling UPL programs. In the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act (BIPA) of 2000, Congress directed the Secretary of Health and Human Services to issue regulations that would revise Medicaid UPL policies with the aim of limiting spending. A final regulation was issued in January 2001 which, among other things, created aggregate upper payment limits by three types of inpatient services (hospital, nursing facility, and intermediate care facility for the mentally retarded) and by three types of provider classes—state-owned facilities, local publicly owned facilities, and private providers. Noted earlier, previously the last two facility types—local publicly owned and private—had been grouped together for purposes of calculating the UPL, and it was this grouping that allowed states to make excess payments to locally owned providers, leveraging federal match in the process.

Importantly, the January 2001 rule created two levels of UPLs. For state facilities and private facilities (nursing homes or hospitals), and for local publicly owned nursing homes, the

UPL is set at 100 percent of the amount that Medicare would have paid for the service. However, in recognition of the "higher costs of …services in public hospitals," for local publicly owned hospitals, the UPL limit was set at 150 percent. (*Federal Register* 2001). In other words, a state could pay a local public hospital as much as 50 percent more than what Medicare would have paid for the collective services the hospital have provided to Medicaid patients. Thus with the increased limit, more federal funds are provided to states, via their public hospitals. In sum, with the 2001 rule, the federal government took important steps in controlling UPL programs but weakened that initiative in making the 150 percent payment exception for local public hospitals.

This payment exception, which was issued in the last few days of the Clinton administration, stirred considerable controversy among the incoming Bush appointees (Combs and Gilroy 2001; *Washington Health Beat* 2001). In 2002, in an effort to "restore fiscal integrity to the Medicaid program and to reduce the opportunity for abusive funding practices," a new rule removing the 150 payment exception for public hospitals was issued (*Federal Register* 2002). Similar to other Medicaid financing strategies, the administration's concern was that more federal dollars were going to states technically to pay for hospital care, but with no assurances that the dollars stayed at the hospitals.

The repeal of the 2001 regulation has sparked strong reaction among state and local officials (Pear 2002). States claim that the new rule will create significant financial hardship and aggravate their budget problems. States also claim that their efforts to provide services to Medicaid beneficiaries and to the uninsured will be affected (Ku 2001; Pear 2002). Interestingly, in somewhat of an about face, members of Congress of both parties have also objected to the new rule.

In the BIPA of 2000, Congressional policymakers also backtracked on some of their efforts to reduce DSH spending. As a way to offset revenue losses due to the closing of the UPL loophole, Congress postponed the 1997 BBA DSH cuts for 2001 and 2002.[9] BIPA also included DSH provisions allowing states to increase the amount of DSH payments that public hospitals could receive. Modeled after the California DSH payment exemption, beginning in 2002, all states can pay public hospitals 175 percent of uncompensated care costs rather than 100 percent as stipulated by OBRA 1993 (see above). This payment exemption is for a two-year period; California's exemption, however, is indefinite.

Thus the federal-state tug-of-war over both Medicaid UPL and DSH programs will likely be a continuing area of conflict. Further, the battle lines have become somewhat blurred in that Congress at one point enacted DSH spending cuts and then postponed them. Likewise, with UPL programs, Congress passed provisions to limit spending under these programs, but now appears to be backing away from this position and, in some cases, supporting the UPL strategy. Over time, through the various pieces of federal legislation and regulations, the federal government has helped to legitimize the states' Medicaid revenue strategies. Further, the back and forth between the two layers of government reflects an important political reality of the Medicaid program. Congress wants to be fiscally responsible and close financial loopholes. However, at the same time, members of Congress want to protect the states that they are elected to represent.

[9] In 2003, however, the BBA DSH cuts are scheduled to go in effect.

The Future of Medicaid Financing

The structure of Medicaid, with its often vague federal rules and considerable state flexibility, all but guarantees states will have the opportunity to maximize federal matching funds.[10] However, in considering changes that might alter financing incentives, it is important to recognize that the current system has both strengths and weaknesses depending on one's perspective. As intended, the matching rate approach encourages states to spend more than they would otherwise. At the same time, the match provides incentives for state and local officials to find financial "loopholes." With over $200 billion spent each year on Medicaid, the financial stakes are high. As discussed, states have found loopholes in Medicaid financing and have used them very effectively. In addition to driving up program costs, these types of Medicaid gaming have caused tension between federal and state policymakers. However, after both states and health care providers become accustomed to the additional federal dollars, it is very difficult for congressional policymakers—who simultaneously represent federal interests and their respective states—to eliminate the loopholes. Even with these flaws, the current federal matching system seems to encourage states to undertake health care initiatives that they may not have if they had to rely solely on state dollars.

However, some of the recent Medicaid financing arrangements raise fundamental questions about the future of Medicaid financing. To the extent that federal policymakers view using Medicaid for revenue maximization as a problem, are there ways to prevent states from engaging in these strategies that alter the program's financing? Or, is the federal-state financing partnership inherently flawed? Are there ways to ensure that states and localities are financial

[10] Other federal assistance programs—such as social services block grants and federal manpower programs—have experienced similar issues with states successfully leveraging federal funds or finding a loophole that allowed them to use federal dollars for unintended purposes (Anton 1997).

partners in Medicaid to the degree that program rules require? More broadly, does it make sense to maintain the current structure of Medicaid or would another approach, such as federalizing the program or using a block grant, be better?

Although current financing methods have both negative and positive attributes, it seems that some changes in the program are needed to address the conflicts that have surfaced in recent years—especially with respect to the development of UPL programs, where large payments to a range of providers are involved. As we have discussed, UPL programs, as well as other creative financing arrangements, have had important and far-reaching implications for Medicaid. Perhaps most importantly, states' actions have fundamentally changed how Medicaid is financed: To varying degrees, the bulk of states now draw down some federal matching dollars with little to no state contribution. As a result, the FMAP formula has been altered and, moreover, overall Medicaid spending has been distorted.

These creative financing arrangements raise issues not only about the shared federal-state responsibility for Medicaid, but about whether and how the financial integrity of Medicaid can be restored. In the past, the federal government has sought to limit these abuses through various laws or regulations. For example, when states started using DSH payments to draw down extra federal funds, Congress on several occasions during the 1990s passed legislation to bring the payments under control. While DSH expenditure growth was curtailed, the provisions did not attempt to reshape the DSH program into one that provided subsidies for uncompensated care built on a rational foundation. Instead, the measures allowed the program to stay largely intact with many states drawing federal match dollars with little to no state or local contribution. Further, over the last couple years, federal policymakers seem to be backtracking on their efforts to reform the DSH program. In short, the DSH program had become part of the Medicaid

financial landscape and was too politically difficult to undo it. In the current UPL financing debate, a similar situation appears to be taking shape.

If federal policymakers are interested in restoring greater control over Medicaid financing, there are several alternative approaches that could be used. One is to work within the current Medicaid program design but to reduce the degree of state discretion. Among other things, federal policymakers could develop a new formula that would more equitably distribute DSH funds. They could also decrease the DSH payment allowance for public hospitals from 175 percent to 100 percent of uncompensated care costs. More fundamentally, akin to the DSH law passed in 1991, the federal government could identify specific revenue sources that they would and would not match. For example, the federal government could no longer match expenditures in which the state share is financed with intergovernmental transfers. This would help ensure that states are truly paying their share of program costs.

Alternatively, the federal government could assume greater financial responsibility for Medicaid. This would mean reducing the states' contribution, increasing the federal match, and providing greater incentives for states to finance creatively and maximize federal dollars. In return for increased funding, the federal government would have to be given more control over Medicaid. With this broader authority, the federal government could, for example, define more uniformly who should be covered, what types of services should be included in the benefit structure, and how providers should be paid. It could also eliminate or overhaul the Medicaid DSH program.

However, if federal policymakers conclude that DSH and UPL programs financed with IGTs cannot be eliminated or if states continue to develop new creative approaches that further compromise the design of Medicaid financing, then solutions completely outside the current

system may be necessary. For example, Medicaid could be federalized and financed just with federal dollars, like Medicare. It may be that the loopholes available under the current federal-state arrangement can only be closed by eliminating the financing partnership entirely. Another reason that this more radical approach might be needed is that the level of tension between federal and state policymakers over program financing has escalated under both Democratic and Republican administrations and it may be very difficult, if not impossible, to restore a sense of trust. A federalized Medicaid program would also reduce interstate variation in eligibility rules and service coverage and would promote greater horizontal equity across low-income individuals. For people in some states this might lead to a less generous program, while for others eligibility and service coverage could be expanded.

Whether or not the current federal-state partnership is overhauled in any way will be directly related to how seriously policymakers view the problems created by the current financing schemes. To date, most changes have not fundamentally altered states' incentives or ability to draw down some share of federal Medicaid dollars without spending from state general revenues. Given that Medicaid program spending is now more than $200 billion, it is likely that the matter of what to do about Medicaid financing will remain at the center of the nation's health policy debates into the future.

References

American Health Line. 1995. "Statelines-California: L.A. County Receives Bailout from Washington," http://nationaljournal.com, September 22.

Anton, T. J. 1997. "New Federalism and Intergovernmental Fiscal Relationships: The Implications for Health Policy." *Journal of Health Politics, Policy, and Law* 22(3):691-720.

Bruen, Brian K. and Joshua M. Weiner. 2002. "Recent Changes in Health Policy for Low-Income People in Wisconsin." Washington, D.C.: The Urban Institute's *Assessing the New Federalism*, State Update #25.

California Medical Assistance Commission (CMAC). 2001. *Annual Report to the Legislature*, Sacramento, CA.

Centers for Medicare and Medicaid Services (CMS). 2000. *Financial Management Report, FY 2000*. The Center for Medicaid and State Operations. http://www.hcfa.gov/Medicaid/ofs-64.html (Accessed April 10, 2002).

Combs, Jennifer V. and Thomas Gilroy. 2001. "CMS Still Working on UPL Rule Eliminating Leeway for Public Hospitals, Official Says." *Health Care Policy Report*, 9(37):1423-5.

Coughlin, Teresa A., Stephen Zuckerman, Susan Wallin, and John Holahan. 1999. "A Conflict of Strategies: Medicaid Managed Care and Medicaid Maximization." *Health Services Research*, 34(1):281-93.

Coughlin, Teresa A., and David Liska. 1997. "The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues." Urban Institute's *Assessing the New Federalism* Series A, No. A-14, Washington, D.C., October.

———. 1998. "Changing State and Federal Payment Policies for Medicaid Disproportionate-Share Hospitals." *Health Affairs*, 17(3):118-36.

Coughlin, Teresa A., Leighton Ku, and Johnny Kim. 2000. "Reforming the Medicaid Disproportionate Share Program in the 1990s." *Health Care Financing Review*, 22(2):137-57.

Federal Register. 2001. January 12, 2001. 66(9):3147-77.

Federal Register 2002. January 18, 2002. 67(13):2602-11.

Holahan, John and Mary Pohl. 2002. "States as Innovators in Low-Income Health Coverage," The Urban Institute's *Assessing the New Federalism* Discussion Paper 02-08, June.

Holahan, John and Mary Pohl. 2002. "Recent Changes in Health Policy for Low-Income People in Washington," The Urban Institute's Assessing the New Federalism, State Update, No.26, February.

Holahan, John, Suresh Rangarajan, and Matthew Schirmer. 1999. "Medicaid Managed Care Rates in 1998," *Health Affairs*, 18(3):217-27.

Holahan, John, Teresa A. Coughlin, Leighton Ku, and Shruti Rajan. 1995. "Insuring the Poor through Medicaid 1115 Waivers." *Health Affairs*, 14(1):200-17.

Holahan, John, Dianne Rowland, Judy Feder, and David Heslam. 1993. "Explaining the Recent Growth in Medicaid Spending." *Health Affairs*, 12(3):178-93.

Klemm, John. 2000. "Medicaid Spending: A Brief History." *Health Care Financing Review*, Vol. 22: 1, pp. 105-112.

Ku , Leighton. 2000. "Limiting Abuses of Medicaid Financing: HCFA's Plan to Regulate the Medicaid Upper Payment Limit." Center on Budget and Policy Priorities, Washington, DC, September.

———. 2001. "Administration's Regulation to Reduce Medicaid "Upper Payment Limit" would Further Worsen State Budget Crises," Center on Budget and Policy Priorities, Washington, DC, December.

Ku, Leighton and Teresa A. Coughlin. 1995. "Medicaid Disproportionate Share and Other Special Financing Programs." *Health Care Financing Review*, 16(3)27-54.

Long, Sharon and Stephen Zuckerman. 1998. "Urban Health Care in Transition: Challenges Facing Los Angeles County," *Health Care Financing Review*, Vol. 20: 1.

Manderscheid, Ronald W., Joanne E. Atay, María del R. Hernández-Cartagena, Pamela Y. Edmond, Alisa Male, Albert C. E. Parker, and Hongwei Zhang. 2000. "Highlights of Organized Mental Health Services in 1998 and Major National and State Trends." In *Mental Health, United States, 2000*, edited by R.W. Manderscheid and M.J. Henderson. DHHS Pub. No. (SMA) 01-3537. Washington, DC: Superintendent of Documents, U.S. Government Printing Office.

Mangano, Michael F. 2001. "Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers." Memo from principal deputy directory of U.S. DHHS OIG to Thomas Scully, September 11.

Pear, Robert. 2002. "Budget Would Cut Medicaid Payments." *New York Times*, Saturday February 3.

Rein, Lisa. 2001. "Virginia Tries Medicaid Maneuver: Federal Funds Would Help Cover Tax Shortfall." *Washington Post*, November 3.

Schneider, Andy, Stephen Cha and Sam Elkin. 1997. “Overview of Medicaid DSH Provisions in the Balanced Budget Act of 1997, P.L. 105-33.” Center on Budget and Policy Priorities, Washington, D.C., September.

U.S. Department of Health and Human Services Office of Inspector General (U.S. DHHS OIG). 2001. “Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers.” Washington, D.C., September.

U.S. General Accounting Office (U.S. GAO). 2000. “Medicaid: State Financing Schemes Again Drive Up Federal Payments.” GAO/T-HEHS-00-193, September.

———. 2001. “Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes.” GAO-02-147, October.

Washington Health Beat. 2001. “A Fast-Paced Session With Straight-Talking Tom,” editor John Reichard, October 15.

Zuckerman, Stephen and Amy Lutzky. 2001. “The Medicaid Demonstration Project for Los Angeles County, 1995-2000: Progress, But Room For Improvement.” Final Evaluation Report to Center for Medicare and Medicaid Services, available at http://urban.org/pdfs/mdp_la_FINAL.pdf.

Table 1. Medicaid DSH Expenditures by State, 1998

State	Medicaid DSH Payments (in millions)	DSH as a Share of Total Medicaid Spending
United States	$14,997.6	8.5%
Alabama	393.7	16.6
Alaska	15.4	3.9
Arizona	123.4	6.2
Arkansas	1.7	0.1
California	2,450.7	12.5
Colorado	174.8	10.3
Connecticut	370.1	12.7
Delaware	8.0	1.8
District of Columbia	32.9	3.6
Florida	370.5	5.6
Georgia	409.6	11.0
Hawaii	—	0.0
Idaho	2.2	0.5
Illinois	269.6	3.8
Indiana	194.7	7.3
Iowa	19.8	1.4
Kansas	45.0	3.9
Kentucky	194.7	7.3
Louisiana	738.3	22.6
Maine	122.4	10.9
Maryland	136.0	4.9
Massachusetts	497.3	8.8
Michigan	319.3	5.1
Minnesota	56.3	1.8
Mississippi	183.9	10.7
Missouri	666.1	19.6
Montana	0.2	0.1
Nebraska	5.9	0.7
Nevada	73.6	13.6
New Hampshire	128.4	16.6
New Jersey	1,020.4	17.8
New Mexico	9.4	0.9
New York	1,860.4	6.6
North Carolina	354.1	7.5
North Dakota	1.2	0.3
Ohio	657.0	9.6
Oklahoma	22.7	1.6
Oregon	27.0	1.5
Pennsylvania	546.3	6.2
Rhode Island	56.0	5.6
South Carolina	445.7	18.9
South Dakota	1.1	0.3
Tennessee	—	0.0
Texas	1,438.9	13.9
Utah	4.1	0.6

Vermont	22.3	5.2
Virginia	160.7	6.5
Washington	332.8	9.3
West Virginia	21.9	1.6
Wisconsin	11.2	0.4
Wyoming	0.1	0.1

Source: Spending data are from the HCFA-64 and enrollee data from the HCFA-2082. Both enrollee and spending data are for federal fiscal year 1998.

Table 2. Medicaid DSH Expenditures per Program Enrollee and per Uninsured by State, 1998

State	DSH Expenditures	
	Per Medicaid Enrollee	Per Uninsured Person
United States	$371.40	$345.35
Alabama	626.73	589.28
Alaska	174.79	132.52
Arizona	190.05	110.10
Arkansas	3.89	3.32
California	395.83	344.05
Colorado	503.86	276.19
Connecticut	919.47	978.69
Delaware	76.08	79.70
District of Columbia	236.86	393.33
Florida	181.57	134.32
Georgia	334.77	311.47
Hawaii	0.00	0.00
Idaho	18.14	9.38
Illinois	151.09	159.65
Indiana	319.04	272.18
Iowa	61.78	70.91
Kansas	182.53	151.51
Kentucky	297.89	343.93
Louisiana	1,019.89	847.87
Maine	625.17	743.95
Maryland	225.30	193.18
Massachusetts	521.55	734.89
Michigan	235.73	266.62
Minnesota	100.96	132.57
Mississippi	349.18	353.07
Missouri	862.07	1,167.42
Montana	2.36	1.26
Nebraska	28.17	34.59
Nevada	562.98	201.45
New Hampshire	1,305.79	947.65
New Jersey	1,189.42	818.80
New Mexico	27.71	22.36
New York	531.51	594.04
North Carolina	294.67	311.87
North Dakota	19.24	13.72
Ohio	468.52	530.80
Oklahoma	49.44	38.68
Oregon	50.32	57.18
Pennsylvania	317.63	459.31
Rhode Island	376.26	643.38
South Carolina	679.12	700.68
South Dakota	12.93	12.01
Tennessee	0.00	0.00
Texas	536.78	300.19
Utah	20.80	14.11

Vermont	169.11	355.43
Virginia	233.01	174.23
Washington	363.65	442.24
West Virginia	58.65	72.83
Wisconsin	20.77	20.86
Wyoming	2.39	1.56

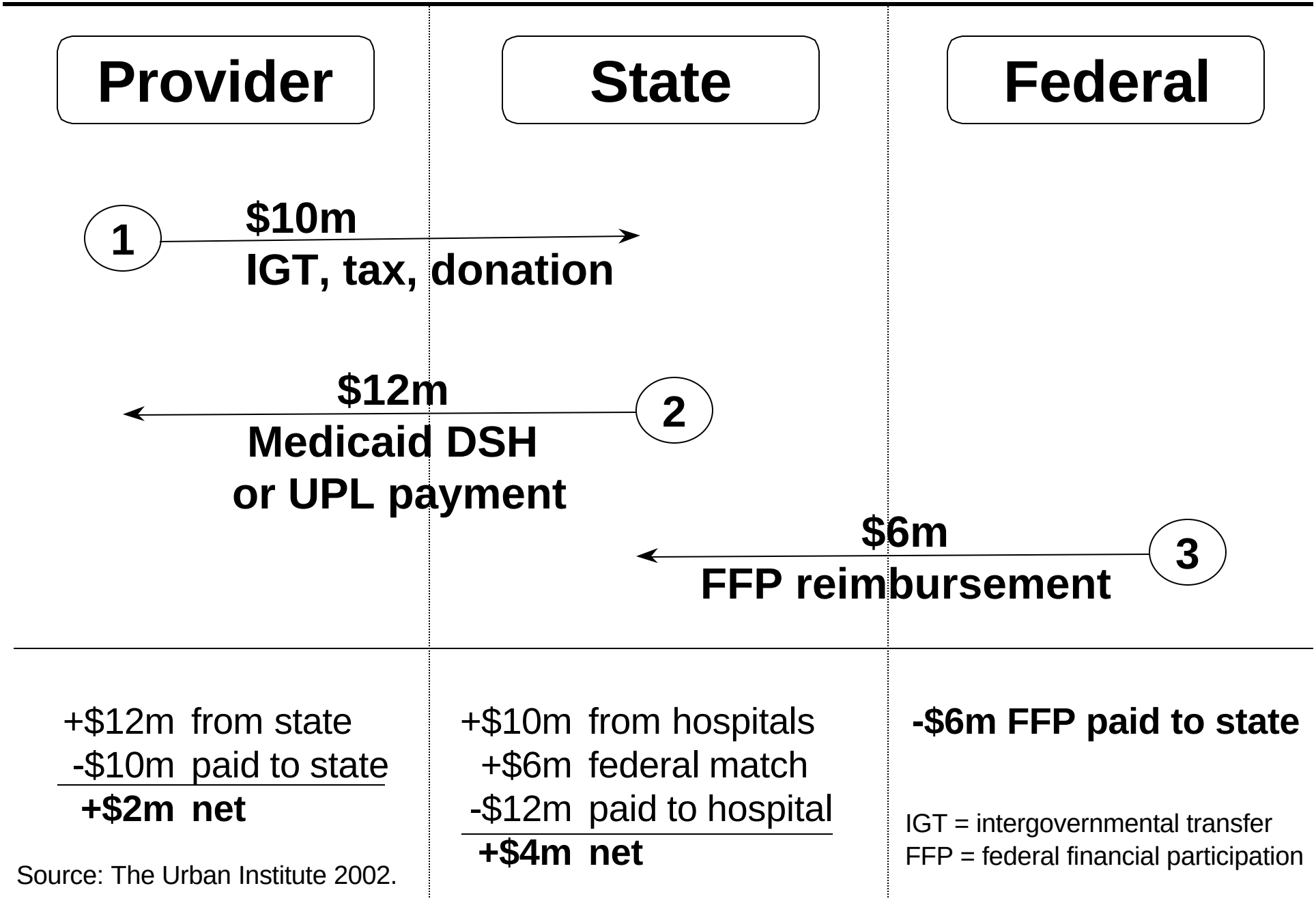
Source: Spending data are from the HCFA-64 and enrollee data from the HCFA-2082. Both enrollee and spending data are for federal fiscal year 1998. Estimates of the uninsured are derived from a 3-year merge of the Current Population Survey for 1997-1999.

Table 3
Medicaid Enhanced Payments, Total Expenditures, and Effective FMAPs, FFY 2000

State	Medicaid Expenditures			Adjusted Expenditures			Calculated FMAP	Effective FMAP	Difference Between Calculated and Effective FMAP
	Total	Federal	State	Total	Federal	State			
Alabama	$2,696.4	$1,877.4	$819.0	$2,557.4	$1,877.4	$680.0	0.6963	0.7341	0.0378
Alaska	$481.3	$322.8	$158.5	$473.3	$322.8	$150.5	0.6707	0.6821	0.0113
Arkansas	$1,579.7	$1,154.8	$424.8	$1,564.5	$1,154.8	$409.6	0.7311	0.7382	0.0071
California	$21,150.6	$11,002.9	$10,147.7	$19,510.4	$11,002.9	$8,507.6	0.5202	0.5639	0.0437
Georgia	$4,321.2	$2,592.5	$1,728.7	$3,890.2	$2,592.5	$1,297.7	0.5999	0.6664	0.0665
Illinois	$7,487.7	$3,754.3	$3,733.4	$6,751.3	$3,754.3	$2,997.1	0.5014	0.5561	0.0547
Indiana	$3,470.0	$2,145.2	$1,324.8	$3,191.6	$2,145.2	$1,046.4	0.6182	0.6721	0.0539
Iowa	$1,637.9	$1,034.3	$603.7	$1,563.3	$1,034.3	$529.1	0.6314	0.6616	0.0301
Kansas	$1,410.8	$847.7	$563.0	$1,359.0	$847.7	$511.2	0.6009	0.6238	0.0229
Louisiana	$3,443.3	$2,422.7	$1,020.6	$3,241.3	$2,422.7	$818.6	0.7036	0.7474	0.0438
Minnesota	$3,322.3	$1,717.4	$1,604.9	$3,317.8	$1,717.4	$1,600.4	0.5169	0.5176	0.0007
Missouri	$3,939.5	$2,386.1	$1,553.3	$3,708.7	$2,386.1	$1,322.6	0.6057	0.6434	0.0377
Montana	$450.2	$335.4	$114.9	$449.9	$335.4	$114.6	0.7449	0.7454	0.0005
New Jersey	$6,069.8	$3,038.5	$3,031.4	$5,345.0	$3,038.5	$2,306.5	0.5006	0.5685	0.0679
New York	$30,186.3	$15,124.3	$15,062.0	$28,611.2	$15,124.3	$13,486.9	0.5010	0.5286	0.0276
North Carolina	$5,464.9	$3,421.1	$2,043.8	$5,209.9	$3,421.1	$1,788.8	0.6260	0.6566	0.0306
North Dakota	$428.7	$304.2	$124.4	$417.8	$304.2	$113.5	0.7097	0.7282	0.0185
Oregon	$2,110.8	$1,275.2	$835.7	$2,076.6	$1,275.2	$801.5	0.6041	0.6141	0.0099
South Carolina	$2,664.6	$1,869.2	$795.4	$2,533.4	$1,869.2	$664.2	0.7015	0.7378	0.0363
South Dakota	$395.7	$281.2	$114.5	$386.4	$281.2	$105.2	0.7106	0.7277	0.0171
Tennessee	$4,941.6	$3,122.7	$1,818.9	$4,799.2	$3,122.7	$1,676.5	0.6319	0.6507	0.0188
Washington	$3,962.5	$2,062.7	$1,899.8	$3,750.5	$2,062.7	$1,687.8	0.5206	0.5500	0.0294
Wisconsin	$3,266.9	$1,923.4	$1,343.5	$3,193.3	$1,923.4	$1,269.9	0.5888	0.6023	0.0136
Total	$114,882.5	$64,015.9	$50,866.6	$107,902.0	$64,015.9	$43,886.1	0.5625	0.5933	0.0307

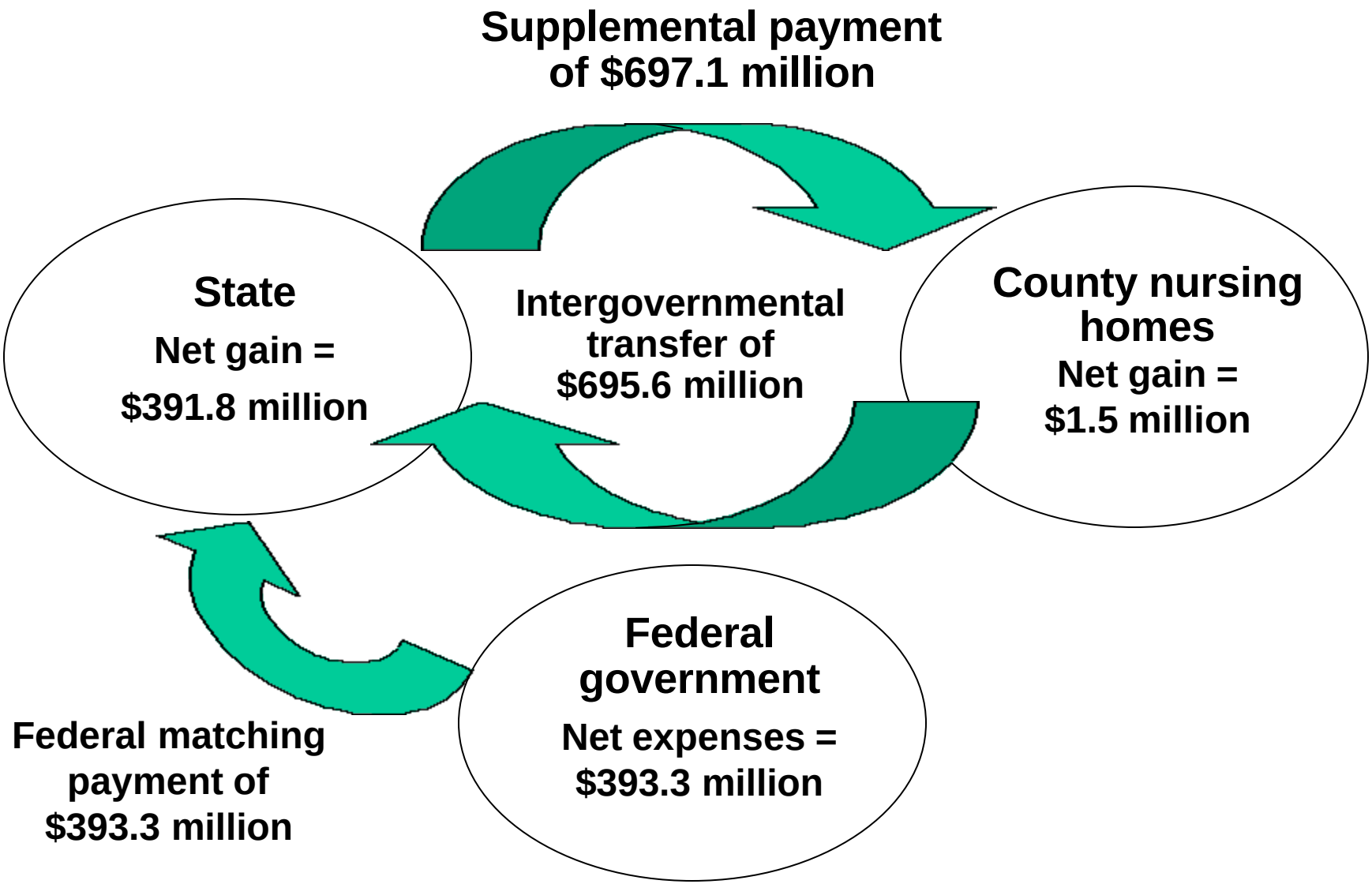
Source: Urban Institute estimates based on data from HCFA-64 reports and information in Coughlin, et al. (2000) and U.S. DHHS OIG (2001).

Figure 1. How a DSH or UPL Program Can Work



Source: The Urban Institute 2002.

Figure 2. Flow of UPL Funds in Pennsylvania, June, 2000



Source: Urban Institute, based on data from Mangano 2000; adapted from Ku 2000.

Appendix A

Estimating the Effective Match Rate

To assess the potential impact of states' use of intergovernmental transfers (IGTs), certified public expenditures (CPEs), and provider taxes to fund Medicaid DSH and UPL programs on the Federal Medical Assistance Percentage (FMAP), we computed the FMAP under two alternative sets of assumptions. For the first set, we assume that all of the state Medicaid spending reported on the Financial Management Reports represent a real expenditure of state general funds. For the second set, we account for states' use of IGT, CPEs and providers taxes to finance their DSH and UPL program and re-estimate the FMAP using state expenditures net of these funds. By netting out IGTs, CPEs and taxes we are assuming that these financing sources do not represent a real state outlay.

Our first FMAP calculation is based on Medicaid Financial Management Reports from the Centers for Medicare and Medicaid Services (CMS).[1] These reports are annual summaries of data from quarterly expenditure reports (Form CMS-64) submitted by states to show the distribution of Medicaid spending for the quarter being reported and corrections for previous quarters and fiscal years. From these reports, we obtain total federal and state Medicaid expenditures for medical services and disproportionate share hospital (DSH) programs for federal fiscal year (FFY) 2000. We then use these data to calculate the FMAP for each state according to the following formula:

$$Calculated\ FMAP = \frac{Total\ Federal\ Expenditures}{Total\ Federal\ Expenditures + Total\ State\ Expenditures}$$

The calculated FMAP for each state based on the federal and state expenditures reported in CMS data are shown in table 3 in the main body of this chapter. The calculated match rate

often differs from the official match rate for each state printed in the *Federal Register*. Reasons for the discrepancies are most likely higher match rates for certain services (such as family planning) and adjustments for amounts reported for prior fiscal years when the state may have had a different match rate. We feel that the calculated FMAP is a more accurate than the published rate as it fully accounts for actual state and federal spending and adjustments to Medicaid spending.

The calculated FMAP assumes that all state Medicaid expenditures represent actual outlays by state governments. However, expenditures financed with IGTs, CPEs, and provider taxes generally do not represent real state outlays and our second match rate calculation—which we call the effective FMAP—addresses this issue by employing an alternative formula,

$$Effective\,FMAP = \frac{Total\ Federal\ Expenditures}{Total\ Federal\ Expenditures + Adjusted\ State\ Expenditures}$$

where "adjusted state expenditures" are the reported amount of state expenditures minus state Medicaid DSH and UPL expenditures funded with IGTs, CPEs, and provider taxes. The effective FMAP is shown in the second to last column in table 3.

The first step in calculating the adjusted state expenditures is to subtract the state share of DSH expenditures funded by IGTs, CPEs, and provider taxes. Because the Federal Management Reports data only provide total state Medicaid DSH expenditures, we used DSH revenue data for state fiscal year 1997 (collected and reported by Urban Institute researchers) as the source of the state share of DSH expenditures in each state funded by IGTs, CPEs, and provider taxes. (Coughlin et al. 2000). Implicit in this calculation is that states' funding of DSH has not fundamentally shifted between 1997 and 2000.

[1] Formerly the Health Care Financing Administration (HCFA).

The second step in calculating adjusted state expenditures is to subtract the entire state share of Medicaid UPL payments from state spending. A report on UPL programs released by the Department of Health and Human Services' Office of Inspector General (OIG) in September 2001 shows that 28 states made or planned to make at least $10.3 billion in Medicaid enhanced payments in FFY 2000, including $5.8 billion in federal funds (U.S. DHHS OIG 2001). We used the total and federal enhanced payments for the states in the OIG report to calculate the state share, which was then subtracted from total state Medicaid expenditures.

Ideally, we would have liked to use an adjustment for UPL that counted state Medicaid enhanced payments financed with outlays from state general funds as actual expenditures, particularly if the state did not recoup its general fund expenditures (for example, by requiring hospitals to return DSH funds or some portion of the UPL payment to the state).[2] However, we were unable to identify an analysis of enhanced payment programs that provided sufficient data for this task. As a result, we may overestimate the amount of state funding for enhanced payments that comes from non-state sources which, in turn, results in a higher estimated effective FMAP for states that fund enhanced payments with state general fund dollars and do not recoup these funds at a point later in the process.

Table 3 in the main body of this paper shows the results of this analysis for 23 states that were included in both the Urban Institute's DSH survey and also the OIG data. Although not shown, the first adjustment reduced state Medicaid DSH expenditures for FFY 2000 (obtained from Federal Management Reports) in these 23 states from $4.5 billion to $1.0 billion. The second adjustment, which removed the entire state share of UPL payments (as reported by the OIG) lowered reported state expenditures in these 23 states by another $3.5 billion. In total, the

adjustments lowered state Medicaid expenditures in these 23 states from $50.9 billion to $43.9 billion, a 13.8 percent reduction. The effective match rate in these 23 states changed from 56 percent before the adjustment to 59 percent after the adjustment.

[2] The OIG study cited earlier in this appendix found that states sometimes use UPL payments in place of DSH payments to certain hospitals, or require hospitals receiving both UPL and DSH payments to return some of the DSH payments to the state through IGTs.