

# fiscal forum

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## MEDICAID SPECIAL FINANCING PAYMENTS AND INTERGOVERNMENTAL TRANSFERS

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The federal Health Care Financing Administration (HCFA) recently proposed new Medicaid requirements that would put further limits on Medicaid special financing payments.<sup>1</sup> The new rules would have a significant negative financial impact on Michigan and other states that have implemented supplemental Medicaid payments to earn additional federal matching funds and reduce the amount of state funding needed to operate the Medicaid program. The widespread use of these special financing arrangements has become controversial because they are being used to shift a greater percentage of Medicaid program costs from the states to the federal government.

The proposed new limits on such payments could lead to the potential loss of up to \$700 million in revenue that is currently used to fund Michigan's Medicaid program.<sup>2</sup> This amount is equivalent to more than 12% of the Medicaid budget in the state. Because of the way that Medicaid payments are matched with federal funds, it is estimated that Michigan would ultimately have to allocate approximately \$300 million from other state sources to maintain the Medicaid program at current levels. Without replacement revenue, Medicaid program expenditure reductions of up to \$700 million would be necessary due to the corresponding loss of federal matching funds.

The draft federal regulations have not been finalized yet, and there are transition provisions in the proposed rules designed to phase in the new payment limits. This approach is intended to gradually reduce each state's reliance on the special Medicaid payments over a five-year period.

Under the proposal, approximately one-half (\$350

million) of the funding loss to Michigan would occur in FY 2001-02. The remaining reductions would be phased in over a four-year period.

This report will briefly describe the special Medicaid financing payments, explain how they affect Michigan's bottom line, and discuss the potential effects of the federal changes now under consideration.

### *Background*

Medicaid is a joint federal and state program providing health care coverage for low-income persons. Each year, over one million Michigan residents obtain medical services that are paid for through the program. State expenditures for Medicaid services, excluding the special financing payments, currently exceed \$5.5 billion annually.<sup>3</sup>

Financial responsibility for the Medicaid program is

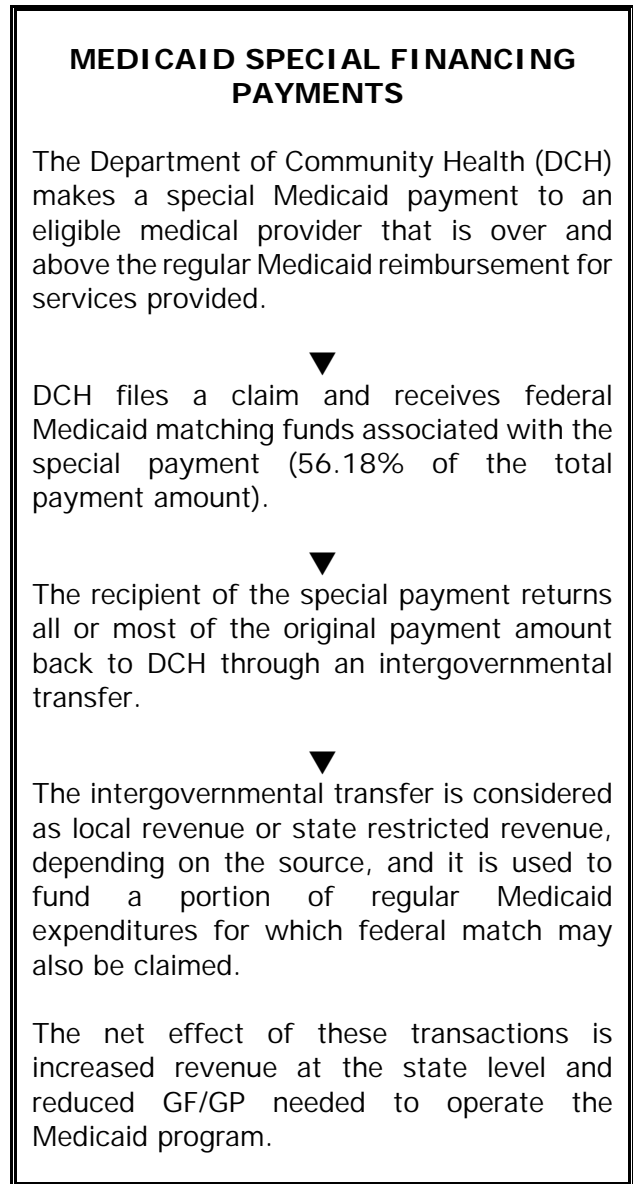
shared between the state and federal government. Currently, the federal government pays about 56% of Medicaid costs in Michigan. Nationally, the federal Medicaid matching rate varies from a low of 50% to a high of 77%.

In order to obtain federal matching funds, each state's Medicaid program must meet a wide range of requirements related to who is eligible for Medicaid, what services are covered, and how medical providers are reimbursed. Although states do have the ability to determine the payment amount for covered services, there is a provision that prohibits aggregate payments for services that would exceed the amount that would be paid each year under the federal Medicare program providing health insurance to the elderly. This is referred to as the federal upper payment limit (UPL). Because the Medicaid program generally reimburses health care providers at rates that are below Medicare levels, there is room under the federal upper limit to make additional payments to medical providers without violating the federal UPL requirements.

In the early 1990s, Michigan began to take advantage of the flexibility available under federal Medicaid provisions to enhance its Medicaid payments and earn additional matching funds. Initially, the state developed a plan that increased payments to hospitals serving large numbers of Medicaid patients. The additional \$438 million distributed under this arrangement was financed with \$200 million in voluntary hospital contributions which allowed the state to obtain \$238 million in federal Medicaid matching funds. The net savings to the state, after paying \$238 million to the contributing hospitals, was \$200 million. Shortly thereafter, Congress adopted legislation that prohibited states from using medical provider donations to earn additional federal Medicaid funds.<sup>4</sup>

Even though federal restrictions were imposed during the last decade, the state developed alternative methods of making extra payments to government-operated health care facilities that complied with federal regulations.<sup>5</sup> Annually, such payments now exceed \$1.0 billion. The savings to the state is over \$565 million per year.

The box below describes how these Medicaid special payments result in savings to the state.



It is important to keep in mind that these financing arrangements involve payments to government-owned public hospitals and county-run medical care facilities. While the federal government does not allow for contributions from private health care institutions, the same restrictions do not apply to intergovernmental transfers by medical care institutions that are owned and operated by state and local governments.

**Medicaid Payments and**

The key factor in determining the allowable amount of special financing payments is based on the Medicare upper payment limit (UPL) referred to earlier in this report. The Medicare UPL is the amount that the health care services provided through Medicaid in a given year would cost if they were paid using Medicare payment principles.

The method used to determine compliance with the Medicare upper payment limit is based on aggregate payments to medical providers in a particular service category, such as hospitals or nursing homes. Consequently, Michigan is able to increase payments to state or county health facilities as long as total payments to public and private medical providers in each class are less than what Medicare would pay for such services.

The FY 2000-01 Department of Community Health appropriation for Medicaid special financing payments and the anticipated GF/GP savings are summarized below. These payments and the potential effects of the proposed federal regulations are described on the following pages. A history of Medicaid special payments since 1991 is included at the end of the report.

***Disproportionate Share Payments to Hospitals (DSH)***

Because of existing federal limits on disproportionate share payments to public hospitals, these payments are not directly affected by the new proposed federal regulations. Nonetheless, the reduction of other Medicaid special payments could affect decisions about the continuation of certain DSH funds that are used to

help finance indigent medical care in Michigan.

As the term implies, disproportionate share payments are allocations to hospitals that serve a disproportionate number of low-income patients with special needs. In the 1980s, the federal government required states to take hospital payment rates into account when addressing the situation of hospitals serving a high percentage of Medicaid patients. As an incentive to states, Congress enacted a law that allows Medicaid reimbursement rates to qualifying hospitals to exceed the comparable Medicare rates.<sup>6</sup>

Disproportionate share funds are currently allocated to large public hospitals such as University of Michigan Hospital and Hurley Hospital, state-owned psychiatric hospitals operated by the Department of Community Health, and a number of smaller community-run hospitals throughout the state. Over the years, the amount of DSH payments in Michigan has been reduced, in part, due to restrictions imposed by the federal Balanced Budget Act of 1997.

In Michigan, there is a separate pool of \$45 million in DSH payments that is distributed to hospitals serving a high percentage of Medicaid patients. Unlike the other DSH payments, the institutions that receive these payments keep them and do not return the funds to the state through an intergovernmental transfer. Michigan also makes DSH payments to help finance the cost of indigent care to non-Medicaid eligible persons through the State Medical Program and county-operated indigent medical programs in Wayne, Ingham, and Muskegon counties.<sup>7</sup> Over \$80 million was expended for these programs in FY 1999-2000.

<b>MEDICAID SPECIAL FINANCING PAYMENTS</b>	<b>FY 2000-01 Appropriation</b>	<b>FY 2000-01 GF/GP Savings</b>
1. Disproportionate Share Payments to Public Hospitals	\$258,628,200	\$144,336,400
2. Long Term Care Adjustor Payments to County Medical Care Facilities and Hospital LTC Units	\$350,000,000	\$188,510,000
3. Outpatient Adjustor Payments to Public Hospitals	\$280,675,000	\$151,227,700
4. School-Based Services Payments to Local School Districts	<u>\$142,782,300</u>	<u>\$81,470,700</u>
<b>TOTAL</b>	<b>\$1,032,085,500</b>	<b>\$565,544,800</b>

The DSH funds from the \$45 million pool and the \$80 million for indigent care are not included in the special financing totals above. However, funding

for these programs may be at risk if the proposed federal regulation is adopted and alternative sources of revenue cannot be identified to cover

the shortfall.

### **Long Term Care Adjustor Payments**

Medicaid Long Term Care Adjustor payments would be significantly reduced if the proposed federal rules take effect, but the reductions would be phased in over a five-year period.

The Long Term Care Adjustor payments in Michigan are made to county-owned medical care facilities and hospital chronic care units. The method used to calculate the Medicare upper payment limit for nursing facility services takes into account the care provided by public and private nursing homes in Michigan, as well as the Home and Community Based Services (HCBS) Waiver Program.<sup>8</sup>

Since total Medicaid expenditures for these services are less than would be paid at Medicare reimbursement rates, there is room under the upper payment limit to make additional payments to the county-operated long term care facilities. As is the case with other Medicaid special payments, an amount equal to most of the additional monies provided is subsequently returned to state coffers through intergovernmental transfers under an agreement with the facilities involved.

It is estimated that the Long Term Care Adjustor could be reduced as much as 90% by the revised federal Medicaid regulation. Under the transition provisions in the proposed rules, the Long Term Care Adjustor would not be affected until FY 2002-03. The payment would be lowered by 25% of the excess amount, or approximately \$75 million, in each subsequent year.

An alternative method of calculating the Medicare upper limit for long term care services, based on recent Medicare reimbursement changes, may be available to minimize the adverse financial impact in Michigan of the proposed HCFA rule changes over the next five years.

### **Outpatient Hospital Adjustor**

Most of Michigan's \$350 million special adjustor payments for outpatient hospital services could be eliminated under the proposed federal requirements. The financial impact would likely occur in FY 2001-02.

The Outpatient Hospital Adjustor payment is calculated based on the difference between the amount that Medicaid and Medicare would pay for the same outpatient hospital services. The entire amount of the Outpatient Hospital Adjustor is allocated to Hurley Hospital in Genesee County, which returns most of the monies to the state through an intergovernmental transfer.

This payment is one that has grown significantly in recent years even though the state's Medicaid plan amendment for this payment has not been officially approved. At issue is the inclusion of outpatient hospital services provided through qualified health plans in determining the upper payment limit.

Under the proposed federal regulation, this payment is most at risk. It would be reduced to a small fraction of the current amount if the rule goes into effect.

### **School-Based Services**

School-Based Services payments are not directly affected by the proposed federal regulation. In a separate action, however, the federal government recently disallowed more than \$100 million of Michigan's Medicaid claims for administration-related School-Based Services over the last three years. Such payments in the future will be substantially below the appropriated level. These reductions are in addition to the potential loss of \$700 million associated with the draft HCFA rule. The state appealed the federal disallowance of School-Based Services payments, but the outcome of the appeal remains in doubt.

The School-Based Services line in the DCH Budget represents the federal Medicaid matching funds paid to local school districts for certain special education services provided to Medicaid eligible children. These services include health screening services; language, hearing, and speech services; nursing, psychological, and counseling services;

and non-routine transportation. Schools may also receive reimbursement for the costs of performing administrative activities related to Medicaid services such as outreach, application assistance, and coordination of health services.

Historically, most of the costs of special education services, including those provided to Medicaid eligible children, were paid for with state and local funds. Beginning in FY 1993-94, Michigan developed an arrangement with participating school districts to claim federal Medicaid match for covered services provided to children who qualify for Medicaid. The federal revenue associated with these services has grown over the years and now exceeds \$200 million. Under the arrangement with the local school districts, the state retains 40% of the federal Medicaid funds received while the local school district receives the remaining 60% of the monies.

In FY 1998-99, the federal Medicaid revenue paid to local districts for School-Based Services was approximately \$122.4 million. The state's 40% share of the additional federal funds was \$81.5 million, which was used to offset the GF/GP that otherwise would be required to support the current level of Medicaid services in Michigan.

The federal government's disallowance of a substantial portion of Michigan's Medicaid claims for School-Based Services is based on objections to the method Michigan is using to claim federal matching funds for administration, outreach, and family planning activities. As a result, approved payments in FY 1999-2000 passed on to local school districts were \$43.4 million while the amount retained by the state was \$28.9 million.

The latter amount is \$56.9 million less than the amount assumed in the budget. While the state has appealed the federal disallowances for School-Based Services, it is unlikely that the appropriated levels in FY 2000-01 will be attained.

***Proposed Changes to Federal Medicaid Regulations***

As indicated earlier, there have been longstanding concerns at the federal level about the way supplemental Medicaid payments were being made

<b>Medicaid Special Payments</b>	<b>Impact of Proposed Federal Changes</b>
Disproportionate Share Payments to Hospitals (DSH)	No direct effect on DSH payments, but changes could lead to less funds available to finance indigent care programs
Long Term Care Adjustor Payments	Long Term Care Adjustor payments reduced from \$350 million to about \$50 million through a phase-in of new rules beginning in 2002-03
Outpatient Hospital Adjustor Payments	Outpatient Hospital Adjustor Payments reduced from \$350 million to about \$50 million beginning in FY 2001-02
School-Based Services Payments	Disallowance of over \$100 million in previous claims for federal Medicaid matching funds and future payments to be sharply reduced

to maximize federal revenue and reduce state Medicaid costs. These concerns were heightened by recent proposals from more and more states to set up or expand these financing mechanisms.

On July 26, 2000, the Director of the Health Care Financing Administration, the federal agency with responsibility for the Medicaid program, wrote a letter to State Medicaid Directors announcing the agency's intent to issue a proposed rule to modify the current upper payment limit policy as it relates to Medicaid. The letter stated that the flexibility provided for setting maximum rates based on the upper payment limit is being used to pay

government-owned facilities at a rate far exceeding their cost of serving Medicaid beneficiaries in order to gain federal Medicaid matching payments without new state contributions.

In September, the U.S. Senate Finance Committee conducted a hearing to take testimony on the issue. Comments were provided by an official from the Government Accounting Office (GAO), the Deputy Inspector General for the U.S. Department of Health and Human Services, and the HCFA Director. All three spoke in favor of the need to close the loophole in federal Medicaid policy that allowed such payments to be made.

The proposed rule changes were published in the Federal Register on October 10, 2000. Under these provisions, states would no longer be allowed to group payments to private and non-state owned public health care facilities together in each category (i.e. hospital services, and nursing facility services) for the purpose of determining the difference between Medicaid and Medicare payment rates. Instead, there would be a separate upper payment limit for state-run facilities and another payment limit for other government-owned facilities.

If payments to private facilities are not included in the calculation of the Medicare upper payment limit, the amount of the enhanced payments to government-owned health care providers would be limited to the difference between Medicaid and Medicare rates to the publicly-owned or -operated facilities in each category. The bulk of Medicaid spending used to determine the extent to which the state's costs are below the Medicare cap involves payments to private health care providers. Without such payments, the net effect would be a substantial reduction in the amount of special financing payments that can be made in Michigan. Public comments on the proposed regulations were due November 9, 2000. It is uncertain when the final rules will be published, or if any further changes will be forthcoming. Some observers anticipate that the federal government will finalize the policy in January 2001, before the current Administration in Washington, D.C. leaves office.

## ***Fiscal Impact on Michigan***

While many questions remain to be answered regarding the proposed federal regulations, Michigan stands to lose as much as \$700 million in federal, state, and local revenue that is now used to fund Medicaid services. This represents over 12% of the total monies allocated to the program. The full impact of the loss of funds would not be felt until FY 2005-06 if the transition provisions in the rules are promulgated as proposed.

Most of the \$350 million in Long Term Care Adjustor payments would be phased out between FY 2002-03 and FY 2005-06. Michigan's \$350 million in Outpatient Hospital Adjustor payments would be sharply curtailed in FY 2001-02.

The potential loss of funding has already spurred action at the state level. In September, the Department of Community Health indicated that it was freezing new enrollments in the Home and Community-Based Services Waiver Program (HCBS) to limit participation (and costs) below the funded level in the FY 2000-01 budget. The Department took this action due to the perceived risk that the Long Term Care Adjustor Payments would be adversely affected by the soon-to-be-released federal regulations.

After the draft federal rules were issued and it became apparent that Medicaid funding for FY 2000-01 was more secure, the action was reversed. On October 16, 2000, DCH Director James Haveman announced that the freeze on new enrollments for the HCBS program would be lifted to allow the program to serve the 15,000 persons as funded in the DCH budget.

Although there is not an explicit connection between the Long Term Care Adjustor and the \$126 million of HCBS funding in the budget approved by the Legislature, it is an area that could be considered if expenditure cuts are required. Cost containment measures for the Medicaid program could include elimination of non-mandatory covered services and/or eligibility restrictions on population groups for whom coverage is considered optional by the federal government. Reductions in medical provider

reimbursement levels is another possibility. Achieving the necessary savings from such actions would have a substantial effect on the beneficiaries and the providers of health care services. Budget reductions in areas outside of the Medicaid program could be used to offset some or all of the potential losses.

In previous years, when federal restrictions have reduced various special financing amounts, the state has been successful in developing alternative strategies to maintain or increase the level of federal earnings through special financing arrangements. It remains to be seen if any further options exist to make up all or part of the losses that otherwise would occur in the years ahead.

Recent changes in Medicare nursing home reimbursement may raise the upper payment limit for Michigan. This would allow the state to

temporarily increase its Long Term Care Adjustor payments and earn additional revenue before the federal restrictions take effect in FY 2002-03.

A "Medicaid Benefits Trust Fund" was recently added to Senate Bill 882 by the House Appropriations Committee. This provision would allow the state to retain the extra revenue from the additional special Medicaid payments and use them in the future to offset the federal reductions over a period of several years. It is unknown whether the federal government will take any further action to challenge or disallow the additional Long Term Care Adjustor payments.

Until the many issues related to the federal upper payment limit regulation are resolved, there is likely to be considerable uncertainty regarding the availability of Medicaid funding.

### SUMMARY OF MEDICAID SPECIAL FINANCING PAYMENTS IN MICHIGAN

Fiscal Year	DSH Payments	Long Term Care Adjustor	Outpatient Hospital Adjustor	School Based Services Payments	Community Mental Health Adjustor	State GF/GP Savings
1991	\$438,400,500	\$0	\$0	\$0	\$0	\$200,000,000
1992	\$489,081,400	\$0	\$0	\$0	\$0	\$233,500,000
1993	\$496,100,000	\$277,089,800	\$0	\$0	\$0	\$419,100,000
1994	\$570,700,000	\$277,089,799	\$40,000,000	\$20,416,094	\$6,400,000	\$493,900,000
1995	\$390,781,800	\$262,000,000	\$66,300,000	\$25,578,000	\$102,092,700	\$497,705,500
1996	\$302,503,600	\$292,000,000	\$212,000,000	\$106,366,000	\$41,730,820	\$507,764,200
1997	\$257,978,200	\$295,000,000	\$204,000,000	\$175,918,400	\$103,446,300	\$522,939,800
1998	\$340,043,700	\$270,000,000	\$234,738,800	\$106,370,000	\$75,639,100	\$544,206,800
1999	\$340,913,500	\$300,000,000	\$280,945,300	\$122,206,100	\$20,735,400	\$564,169,400
2000	\$304,401,800	\$325,000,000	\$350,000,000	\$43,400,000	\$0	\$551,466,100
2001	\$258,628,200	\$350,000,000	\$280,675,000	\$142,782,300	\$0	\$565,544,800

## ENDNOTES

- 1 Notice of Proposed Rulemaking: Revision to Medicaid Upper Payment Limit for Hospital Services, Nursing Facility Services, Intermediate Care Facility Services for the Mentally

Retarded, and Clinic Services, Department of Health and Human Services, Health Care Financing Administration.

2 The funding loss estimate is based on the projected amount of Long Term Care Adjustor payments (\$350 million) and Outpatient Hospital Adjustor payments (\$350 million) that would no longer qualify for federal Medicaid matching funds. A relatively small special payment would continue in both areas, but the specific amount has not been calculated.

3 The Medicaid spending amount reflects regular payments for Medicaid services. It excludes over \$1 billion in the Medicaid special financing payments that are the subject of this report.

4 The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991.

5 Additional federal restrictions on Disproportionate Share Payments to Hospitals were enacted as part of the Omnibus Budget Reconciliation Act of 1999 and the Balanced Budget Act of 1997.

6 The Omnibus Reconciliation Act of 1986 allows states to pay hospitals that serve a high volume of low income persons at rates above the Medicare upper payment limit.

7 The State Medical Program pays for limited outpatient care primarily to single adults and childless couples with extremely low incomes who do not qualify for Medicaid. Until recently, it was entirely funded with state GF/GP funds.

8 The Home and Community Based Services Waiver Program, also known as MIChoice, provides care management, personal care, and a range of other home and community services to aged and disabled persons over the age of 18 who are Medicaid eligible and would otherwise require a nursing home level of care.