

Dennis Barry's

# Reimbursement Advisor

DOU E —  
ART L —  
MARIA D —  
NORA W —  
JUDY A —  
GUY L —

OCTOBER 2004 • VOLUME 20, NO. 2



## CMS Targets Intergovernmental Transfers

*Significant reimbursement ramifications, legal challenges may loom*

By Charles A. Luband

Medicaid is a program of shared responsibility. Each state independently administers its own Medicaid program within broad federal parameters.<sup>1</sup> Eligibility and coverage can vary widely from state to state.

Although the federal government pays for at least half of the Medicaid expenditures, states are required to provide a "non-federal share" of all Medicaid expenditures. The matching rate for most Medicaid expenditures is determined by the Federal Medical Assistance Percentage (FMAP), which is set for each state according to a formula in federal law.<sup>2</sup> States use a variety of methods for providing the non-federal share, including state general revenues, provider taxes, and intergovernmental transfers (IGTs). The Medicaid statute explicitly requires only that "not less than 40 per centum" of the non-federal share be provided by the state itself.<sup>3</sup>

This article describes apparent changes by the Centers for Medicare and Medicaid Services (CMS<sup>4</sup>) with regard to regulation of IGTs as they are used by states to provide the non-federal share of Medicaid expenditures. CMS is engaged in a broad review of financial arrangements used by states, and IGTs have been an important focus.

CMS appears to have significantly changed its policy regarding when and which IGTs are allowable. This change has serious implications for state Medicaid programs and for providers that rely on Medicaid reimbursement. Furthermore, CMS's new policy, as expressed in a letter to the Chair of the Senate Finance Committee, appears to conflict with prior policy in ways that leave the new policy open to legal challenges.

### Background

Intergovernmental transfers are public funds transferred from one governmental entity to another. In the Medicaid context, this usually involves a transfer from a governmental agency to the state Medicaid agency, which then uses those transferred funds as the required non-federal share of a Medicaid expenditure by the Medicaid agency. These are often used in the context of states provid-

#### INSIDE THIS ISSUE

<i>CMS revises MSP requirements for reference lab services</i>	3
<i>Top 10 billing errors</i>	8
<i>Tracking expenses relating to investigations</i>	10
<i>Effect of discounting charges for non-Medicare patients</i>	11

ASPEN  
PUBLISHERS

CMS—from page 1

ing supplemental payments to providers, most notably Medicaid disproportionate share hospital (DSH) payments and supplemental Medicaid payments, often involving the Medicaid upper payment limit (UPL).

Since the original enactment of the Medicaid statute in 1965, the statute has required that the state provide its share of the financing of the program. The state, however, has never been required to provide its share strictly from state funds. The Medicaid statute has always authorized states to use local government funds as a source of financing for the program, explicitly requiring that only “financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan . . . .”<sup>6</sup>

In other words, states may derive up to 60 percent of the non-federal share from sources other than state general revenues. “Local sources” are specifically mentioned. It is not insignificant that the statute refers to the “non-Federal share” and not the “State share” of Medicaid expenditures.

Pursuant to this statutory authority, CMS has regulations in place (essentially unchanged since 1977<sup>6</sup>) allowing states to use “public funds” as a source of Medicaid financing:

1. Public funds may be considered as the State’s share in claiming FFP [Federal Financial Participation] if they meet the conditions specified in paragraphs (b) and (c) of this section.
2. The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.
3. The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.<sup>7</sup>

Despite its long-standing acceptance as part of the Medicaid program, the non-federal share has occasionally caused controversy. For example, in 1985, CMS permitted state expansion of “provider donations.”<sup>8</sup> Through this mechanism, states could request that providers “donate” money to the

Medicaid program, which the states then used to finance Medicaid payments. This mechanism, combined with disproportionate share hospital (DSH) payments, led to some excesses, since states could guarantee that the providers would not be harmed and states were able to generate large amounts of federal financial participation (FFP). By 1990, CMS was struggling to control what they saw as “the potential for use of these revenues to affect unfairly the Federal share of Medicaid expenditures.”<sup>9</sup>

In 1991, Congress passed legislation to limit voluntary donations and provider taxes but specifically preserved IGTs.<sup>10</sup> The 1991 legislation, in fact, explicitly restricted CMS from regulating many IGTs:

[T]he Secretary may not restrict States’ use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures . . . regardless of whether the unit of government is also a health care provider. . . .<sup>11</sup>

The following year, in the context of issuing regulations regarding the new legislation, CMS specifically said that, “until the Secretary adopts regulations changing the treatment of intergovernmental transfer, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds from any governmental source . . . .”<sup>12</sup> CMS has repeatedly stated in various regulatory issuances that it has limited authority to regulate transfers and has declined to exercise its limited authority.<sup>13</sup>

Despite the statutory restriction, CMS has periodically targeted payments that use IGTs, including DSH payments and certain targeted supplemental Medicaid payments. CMS’s concern is the same concern that it had with regard to donations and taxes in the early 1990s: Because the structure of the Medicaid program allows states flexibility, CMS is concerned that states may misuse federal funds. For example, CMS claimed that the “continued flexibility that states had to abuse IGTs” was part of the reason for UPL regulation revisions in 2001.<sup>14</sup> Congress and CMS have undertaken a number of legislative and regulatory actions to try to curtail abuse in both DSH payments and other Medicaid payments.<sup>15</sup>

### CMS Action and Congressional Questions

CMS appears to be currently focused on Medicaid financing, including IGTs. At some point in 2003,

CMS—on page 6

*CMS—from page 2*

CMS began to ask states a standard set of questions that must be answered before a state plan amendment (SPA) will be approved, including questions about financing.<sup>15</sup> CMS also began making demands on state Medicaid agencies, including the demand that “all intergovernmental transfers” be eliminated before an SPA would be approved.<sup>17</sup>

In early 2004, a number of members of Congress and congressional delegations wrote letters to CMS requesting clarification about how the policy would impact their state. In particular, the Iowa congressional delegation, led by Senate Finance Committee Chairman Charles Grassley, wrote a letter to Acting CMS Administrator Dennis Smith on March 12, 2004, with regard to two pending state plan amendments for Iowa. The letter specifically requested six pieces of information:

1. The number and names of states currently undertaking corrective action pursuant to an agreement with CMS.
2. The terms of completed corrective action agreements.
3. The specific criteria for determining whether an IGT conforms to the requirements of § 1903(w)(6).
4. Whether CMS is requiring, as a condition of approval of new SPAs a phase-out of all IGTs that do not conform to the requirements of § 1903(w)(6).
5. Assurances that the terms of the phase-outs of IGTs are being uniformly applied to all states involved in such phase-outs.
6. A copy of the guidelines CMS is providing to states currently undergoing, or that have completed, corrective action.<sup>18</sup>

### The CMS Letter

In a letter dated April 28, 2004 (the CMS letter), new CMS Administrator Mark McClellan responded to Grassley’s questions. The CMS letter makes a number of distinct points in responding to Grassley’s request for information. In addition to providing information about the number of state plan amendments that it has reviewed and asserting that “questions and remedies (if needed)” have been applied equally across states, CMS states that it distinguishes:

a true, protected IGT, in which a state shares its cost of the Medicaid program with local units of government, from an unprotected

“recycling” mechanism under which payments to providers for services are returned to the state. “Recycling” has the effect of shifting the cost of the program from state/local governments to the Federal Government, thereby increasing the Federal match rate. A true IGT does not have this effect.<sup>19</sup>

CMS goes on to state that it is not approving SPAs that would create new recycling mechanisms and is working with states cooperatively to terminate existing recycling mechanisms. At the same time, CMS states that it “does not intend to pursue issues related to” IGTs in prior years.

CMS also defines the criteria for whether an IGT conforms to § 1903(w)(6)(A), which is the 1991 provision prohibiting CMS from restricting IGTs.<sup>20</sup> CMS labels as “protected” those IGTs which it is prohibited from restricting.

Finally, CMS announces a distinction between entities considered “public” and the statutory term “unit of state or local government,” which is used in § 1903(w)(6)(A). As stated in the letter:

Defining an entity as public does not, by itself, prove that an entity is in fact a unit of government. As discussed above, entities eligible to make protected IGTs/CPEs must be units of state or local government, which means that such an entity embodies the same characteristics as the applicable unit of government within the state.<sup>21</sup>

### The CMS Letter Represents a Change in Policy

The CMS letter reflects a number of changes in CMS policy regarding IGTs. Although much of the letter explicitly defines what is “protected” under § 1903(w)(6)(A), CMS has never before explicitly defined this category. CMS’s new interpretation of the statutory language is not reflected in, and at times conflicts with, the existing regulation regarding IGTs. Furthermore, CMS’s decision to not approve SPAs that involve (presumably only “unprotected”) recycling mechanisms and to terminate existing recycling mechanisms “on a prospective basis” represents an explicit break in prior policy regarding IGTs. As CMS has not sufficiently defined “recycling,” there is uncertainty regarding the full scope of the policy implications.

Much of the letter interprets the language of § 1903(w)(6)(A), which places limits on CMS’s ability to restrict IGTs. With regard to the statutory language regarding “units of government within a

State," however, CMS provides more detail than it ever has previously. The CMS letter states explicitly that this language does not mean "any entity considered 'public' by the state." In addition, the letter places a number of conditions on transfers by providers that are "units of government" in order to be "protected."

In particular, the governmental provider must "have access to state or local tax revenues," which means that "the provider must either have direct taxing authority or must be able to access funding as an integral part of a governmental unit with taxing authority . . . so that no contractual arrangement with the state or local government is necessary in order for the health care provider to receive tax revenues."<sup>22</sup>

This is in direct conflict with the existing regulations, which state simply that "public funds may be considered as the State's share in claiming FFP if . . . appropriated . . . or transferred from other public agencies . . . , or certified by the contributing public agency . . . ."<sup>23</sup> Never before has CMS provided additional conditions on the regulatory language regarding the definition of a public agency.

It is possible to read the language of the CMS letter as providing only additional detail regarding protected IGTs and, therefore, not conflicting with the broader regulatory language. In preamble language in 1991, however, CMS appears to recognize that it could make a regulatory distinction between certain types of transfers and those not to do so.<sup>24</sup>

In the 1991 preamble, CMS makes no distinction between the statutory language of "unit of government" and "public." The preamble, in reaffirming regulatory language using the term public, says that states may continue to use funds transferred or certified funds from any "governmental" source. Furthermore, if the language in the CMS letter provides only additional detail regarding the protected category of IGTs, the language is meaningless, since CMS has not made any regulatory distinction between protected and unprotected IGTs.

Similarly, CMS's decision to not approve SPAs that involve recycling mechanisms and to terminate existing recycling mechanisms on a prospective basis is an explicit break in prior policy regarding IGTs. Although the regulations do require that public funds being transferred or certified not be federal funds,<sup>25</sup> CMS has never provided any definition of this requirement. CMS recognizes that its new statement is a change in policy by agreeing not to pursue related to prior years. Furthermore, CMS's cursory description in its letter does not provide sufficient certainty for states regarding what is and is not permitted.

CMS states that "[R]ecycling' has the effect of shifting the cost of the program from state/local governments to the Federal Government, thereby increasing the Federal match rate."<sup>26</sup> Although this statement describes the impact of a recycling mechanism, it fails to actually define the characteristics of a recycling mechanism. Given the longstanding acceptance of intergovernmental transfers in the Medicaid statute and in the administration of the program, this description is not enough.

## Implications and Conclusion

As demonstrated in the April letter to Grassley, CMS has clearly changed its policy regarding intergovernmental transfers. Given the longstanding acceptance of IGTs in the Medicaid statute and the reliance of many states on IGTs, particularly for financing supplemental payments to certain groups of providers, this may have significant ramifications on reimbursement. At the same time, there are aspects of CMS's new policy that appear to conflict with existing regulations and guidance and which thus may leave CMS open to legal challenges.

### ABOUT THE AUTHOR

**CHARLES A. LUBAND** is a partner in the Washington, DC, office of Powell, Goldstein, Frazer & Murphy, LLP. Mr. Luband's practice focuses on health care policy, with a particular focus on issues concerning safety net hospitals, including Medicaid and Medicare disproportionate share hospital (DSH) and graduate medical education (GME) payment issues, Medicaid upper payment limit (UPL) payments, intergovernmental transfers (IGTs) and provider taxes, the State Children's Health Insurance Program (SCHIP) and the Emergency Medical Treatment and Labor Act (EMTALA). For more information, contact Mr. Luband at 1001 Pennsylvania Ave NW, Washington, DC 20001; telephone: (202) 624-7215; email: [cluband@pgfm.com](mailto:cluband@pgfm.com). Address effective November 5: 901 New York Avenue NW, Washington, DC, 20001

### Notes

1. See 42 U.S.C. § 1396a(a) (state plan requirements).
2. 42 U.S.C. § 1396d(b). The FMAP must be between 50 percent and 83 percent.
3. 42 U.S.C. § 1396a(a)(2).
4. Prior to 200X, CMS was referred to as the Health Care Financing Administration (HCFA). For ease of reference, CMS is used to refer to both CMS and its predecessor HCFA.
5. See 42 U.S.C. § 1396a(a)(2).
6. See 42 Fed. Reg. 60564 (Nov. 28, 1977).
7. 42 C.F.R. § 433.51.