kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

April 2004

Current Issues in Medicaid Financing – An Overview of IGTs, UPLs, and DSH

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Since its enactment in 1965, Medicaid has been a joint venture between the states and the federal government. While each state administers its own Medicaid program within broad federal guidelines, the federal government provides the majority of the program's financing. As a result, Medicaid is not only one of the largest budget items in each state, it is also the single largest source of federal grant funds to the states. This shared financing structure, with its guarantee of federal matching funds for state expenditures for beneficiaries, is the foundation of the individual entitlement to coverage through which Medicaid pays for health and long-term care services for more than 50 million our nation's sickest and poorest individuals.[1]

As might be expected, shared financing has at times produced tension over each level of government's appropriate share of the cost of the Medicaid program. By statutory formula, the federal government pays between 50 and 77 percent of all the costs incurred by states in purchasing covered services on behalf of Medicaid beneficiaries. Matching rates vary by state, with states that have lower per capita incomes receiving higher federal matching rates. On average, the nominal federal share is 57 percent.

States have only recently begun to emerge from one of the worst fiscal situations they have faced since World War II.[2] At the same time, the federal government has increased its scrutiny of several controversial mechanisms states have employed in recent years to finance their share of Medicaid expenditures. The purpose of this paper is to explain briefly the mechanisms at issue and present the most recent available data on the states most affected. As discussed below, although these transactions involve large sums, they represent only a small part of a much larger Medicaid program that directly benefits over 50 million low-income Americans and the health care providers that serve them. Similarly, the challenge to Medicaid financial management extends beyond these transactions.[3]

Background and Overview

The financing mechanisms in question involve highly technical issues relating to IGTs (intergovernmental transfers), UPLs (upper payment limits), DSH (disproportionate share hospital) payments, and provider taxes. In and of themselves, all of these are legal under federal law and regulation and do not change the nominal federal share. However, in certain configurations, transactions involving IGTs, UPLs, and DSH payments are designed to increase the federal share of Medicaid costs above a state's statutory matching rate. These transactions are problematic for two reasons. First, they raise the federal matching rate without authorization by the Congress through a change in the matching formula.[4] And second, in some cases, states apply these additional federal funds to purposes other than health or long-term care services for low-income residents.[5]

Federal and state disagreements about the use of such mechanisms are not new. As disputes have surfaced periodically over the last two decades, however, Congress and the Administration have addressed and resolved each of these debates without fundamentally altering the basic federal-state matching structure. Figure 1 on the next page provides a timeline of these federal responses.

Several events in 2004 have precipitated the latest iteration of these disagreements. First, the Bush Administration's FY 2005 budget proposes to achieve $9.6 billion in savings to the federal government over the next 5 years by restricting the use of certain IGTs and limiting payments to state and local hospitals and nursing homes to the cost of services provided to Medicaid patients.[6] According to the Administration's budget, "Medicaid's open-ended financing structure encourages efforts to draw down Federal matching funds in any way possible, some of which are not appropriate. These financing practices undermine the Federal-State partnership and jeopardize the financial stability of the Medicaid program."[7] The Senate Budget Committee directed a $3.4 billion reduction in federal Medicaid spending over 5 years in its FY 2005 budget resolution, attributing these savings to unspecified "waste and abuse in the system."[8] Additionally, the controversy has been fueled by a proposal by the Centers for Medicare and Medicaid Services (CMS) to modify an obscure reporting form (CMS-37) in order to require states to identify more fully the revenue sources used to pay their share of Medicaid expenditures.[9] This change has been seen by some as presaging a fundamental shift in the current federal-state matching arrangement, with the federal government asserting a right through its regulatory authority to prospectively approve state Medicaid budgets and to subject federal matching payments to prior approval, which is unprecedented in the program's nearly 40 year history.[10] The Administration has indicated it plans to pursue such a change, after consultation with the governors and appropriate time for public comment.[11]

Figure 1
A Summary Timeline for Federal Action on DSH, IGTs, Provider Taxes, and UPLs

1981 Congress requires states to make additional payments to DSH hospitals for inpatient services *(Omnibus Budget Reconciliation Act of 1981)*

1987 Congress establishes a minimum federal standard for qualifying as a DSH hospital *(Omnibus Budget Reconciliation Act of 1987)*
CMS (then HCFA) issues UPL regulation limiting aggregate payments to state-operated hospitals and nursing facilities and all other hospitals and NFs *(52 Fed. Reg. 28141, July 28, 1987)*

1991 Congress
(1) establishes detailed rules for provider taxes used to generate revenues as state share of Medicaid spending,
(2) prohibits CMS from restricting IGTs of state or local tax revenues, and
(3) limits DSH spending in each state to 12 percent of total Medicaid spending *(Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991)*

1993 Congress imposes facility-specific ceilings on the amount of DSH payments states may make to DSH hospitals *(Omnibus Budget Reconciliation Act of 1993)*

1997 Congress specifies and phases down over FY 1997 – FY 2002 allotments of federal DSH funds for each state *(Balanced Budget Act of 1997)*

2000 Congress
(1) increases state-specific allotments of federal DSH funds for FY 2001 and FY 2002, and
(2) requires CMS to issue final regulations applying UPLs to providers owned or operated by local governments and allowing for a transition period of up to 8 years *(Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000)*

2001 CMS issues final regulations establishing UPLs for local public providers and transition periods *(66 Fed. Reg. at 3154, 3173, January 12, 2001)*

2003 Congress increases state-specific allotments of federal DSH funds for FY 2004 by 16 percent *(Medicare Prescription Drug, Improvement, and Modernization Act of 2003)*

IGTs

As the name implies, IGTs, or intergovernmental transfers, are transfers of public funds between governmental entities. The transfer may take place from one level of government to another – e.g., counties to states – or within the same level of government, from one agency to another – e.g., from a state university hospital to a state Medicaid agency. The federal Medicaid statute expressly recognizes the legitimacy of IGTs involving tax revenues.[12] IGTs made by

localities from their own tax revenues to help fund a state's Medicaid program are a legitimate way for a state to pay its share of Medicaid spending. Current law stipulates that no more than 60 percent of the state share may be from local funds.[13] While some states require their localities to contribute toward the cost of Medicaid, only New York even remotely approaches this limit as it requiring its counties to contribute 50 percent of the state share.[14]

The controversy surrounding IGTs centers around what qualifies as the state share of Medicaid spending. Under current law and regulation, the state share of Medicaid spending must consist of public funds.[15] These funds may not be federal funds, unless, as in the case of the federal share of the tobacco settlement payments, they are expressly authorized to be used as the state share.[16] The controversy arises when the funds involved in these IGTs come from specific types of provider taxes or donations, or when they are the means through which UPL arrangements are implemented (see below).

UPLs

While IGTs relate to what qualifies as the state share of Medicaid spending, UPLs, or upper payment limits, have to do with the amounts state Medicaid programs can pay to providers for covered services. These limits are creatures of federal regulations, not statute.[17] Current UPL regulations limit Medicaid payments, in the aggregate, for inpatient services provided by three classes of hospitals, three classes of nursing homes, three classes of intermediate care facilities for the mentally retarded (ICFs/MR), and for outpatient services provided by three classes of hospitals and clinics. In each case, the provider classes are defined on the basis of ownership or operation by the state, by localities, and by private entities.[18]

The limit applied by UPLs is the estimated amount that would be paid for Medicaid-covered services under Medicare payment principles. This limit applies to the entire class of providers (e.g., all private hospitals in a state); thus, an individual facility could be paid more by Medicaid than what Medicare would have paid so long as at least some other facilities in the same class were paid sufficiently less to offset the overpayment. These limits went into effect on March 13, 2001; however, some states have qualified for "transition periods" through as long as 2008 that exempts them from these regulations.

The key to UPL arrangements prior to the 2001 regulations was to (1) create a gap between the upper payment limit and regular Medicaid reimbursements by underpaying private facilities relative to Medicare rates; (2) then to make a payment or payments to public facilities in the amount of this gap; (3) to claim federal matching funds on this excess payment; (4) and finally, to return some or all of the funds from the public facilities to the state treasury though an IGT.

For example, assume a state has 10 nursing facilities – 9 private and 1 owned and operated by a county. Assume further that each facility has 100 Medicaid residents, and that the state pays a hypothetical Medicare rate of $150 per resident per day to the county facility, but only 2/3 of the Medicare rate, or $100 per resident per day, to each of the private facilities. Prior to the 2001 regulations, the UPL applied to all 10 facilities, yielding an aggregate upper limit of $150,000 ($150 times 1000 residents). However, because the state had only paid $90,000 to the private facilities ($100 times 900 residents) and $150,000 to the county facility ($150 times 100 residents), it had generated a gap of $45,000 under its UPL. The state could then make a supplemental payment from state funds to the county facility of $45,000. If the state's federal matching rate were 50 percent, the payment would yield $22,500 in federal matching payments. The county facility could then transfer the entire amount back to the state through an IGT. As a result, the state would have effectively generated an additional $22,500 in new federal dollars without any actual outlay of its own funds. This transaction could also be structured to rely entirely on county funds, with an IGT of $45,000 from the county to the state prior to the state's supplemental payment of $45,000 to the county. In this variation, the county gets its money back, and the state draws down $22,500 in federal matching funds on the $45,000 payment to the county and retains the federal funds for its own use.

The 2001 regulations apply the UPL separately to state, private, and county-owned facilities. Therefore, after March 2001, the $45,000 aggregate gap in payments to private facilities described in the example above could only be used to make supplemental payments to private facilities. Because the county facility is paid at Medicare rates, there is no gap under the UPL for this class of providers, and the state could not generate any additional federal funds from supplemental payments to these facilities. For this reason, the 2001 federal regulations greatly limited the ability of states to draw down additional federal funds from such transactions.

Because those states that had received federal approval to conduct these transactions during the 1990s had come to rely on them to help fund their health care programs, the federal government allowed these states to phase out their UPL payments over transition periods lasting as long as 8 years. According to the Administration's FY 2005 budget, the federal cost of UPL arrangements over the next 5 years is $9.2 billion.[19] While this amount of spending is significant, it represents less than one percent of projected federal Medicaid spending over that period.[20] The General Accounting Office, among others, has questioned the validity of several of these transition periods.[21]

DSH

DSH, or "disproportionate share" hospitals are hospitals that serve a large number of Medicaid and low-income uninsured patients. Under federal law, state

Medicaid programs must "take into account the situation of" these hospitals in setting payment rates for inpatient services.[22] This requirement has come to mean making a payment supplemental to the reimbursement a hospital would normally receive under the Medicaid program for inpatient services. The hospitals qualifying for these additional payments are generally determined by each state (subject to federal minimum standards), and the amount of additional payments made to each facility is set by each state (subject to federal maximum limits). In many states, these DSH payments have been crucial to the financial stability of "safety net" hospitals.[23] Federal DSH payments are estimated to total $8.2 billion in FY 2004.[24]

While states have considerable discretion in determining the amount of DSH payments to each DSH hospital, their discretion is bounded by two caps – one at the state level, and the other at the facility level. At the state level, the total amount of federal funds that each state can spend on DSH payments to all of its DSH hospitals each fiscal year from FY 1997 on has been fixed in statute.[25] Congress recently increased these state-specific DSH allotments for FY 2004 by 16 percent across-the-board in the Medicare drug legislation at a federal cost of $6.4 billion over the next ten years.[26] At the facility level, the total amount of Medicaid DSH payments that a state can make to an individual hospital is limited to 100 percent of the costs incurred by a hospital for serving Medicaid and uninsured patients for which it has not been compensated by Medicaid.[27] For the two state fiscal years beginning after September 30, 2002, Congress raised this limit to 175 percent of such uncompensated costs.[28]

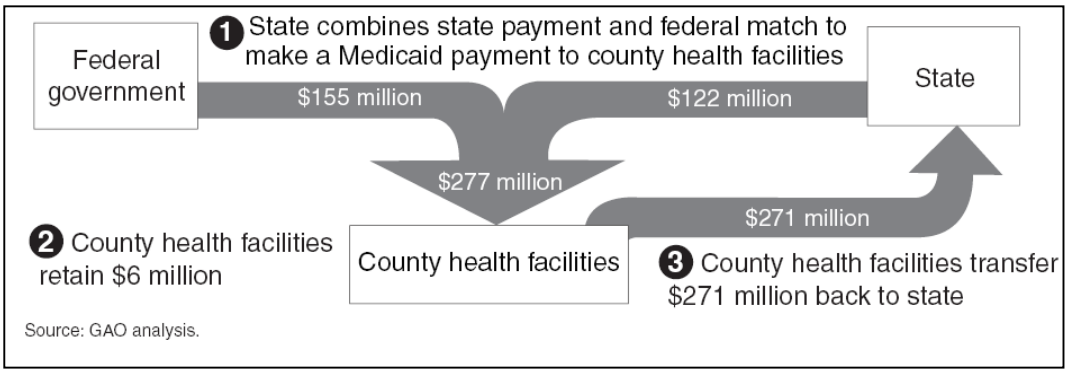
Provider Taxes

The revenues that states use as their share of Medicaid costs come from a variety of sources, including income, sales, property, and estate taxes. States may also use revenues from the imposition of fees, assessments, or other types of taxes on health care providers, but only if the tax meets detailed requirements specified in federal law and regulation. These laws and regulations resulted, in part, from widespread use of licensing fees and other specific taxes in the 1980s that effectively lowered the real state share of Medicaid spending, increased provider revenue, and increased federal Medicaid outlays. As shown previously in Figure 1, Congress acted in 1991 to regulate the use of these taxes. Under these new requirements, if 85 percent or more of the burden of a tax falls on health care providers, the tax must be imposed uniformly on all non-Federal, nonpublic providers in the class (e.g., hospitals, nursing facilities, etc.) and providers paying the tax must not be held harmless for the costs of the tax through offsetting payments or credits.[29] In the past few years, as revenue pressures have mounted, states have turned to revenues from taxes on hospitals, nursing homes, and managed care organizations to help finance their share of Medicaid program costs.[30] Because these taxes are broad- based and the taxed amounts are not directly returned to the providers, they do not violate the current federal regulations regarding such taxes.

Use of IGTs, UPLs, and DSH to Increase a State's Effective Matching Rate

In and of themselves, IGTs, UPLs, and DSH payments are not improper. In fact, as noted above, they are expressly authorized (and in the case of DSH) required by federal Medicaid statute or regulations. However, they can be (and have been) combined in such a way as to increase a state's federal Medicaid matching rate. For example, Figure 2 below presents one state's use of these mechanisms to increase federal Medicaid matching funds with no outlay of state dollars.[31] As described in a recent General Accounting Office report, a state first made Medicaid payments totaling $277 million to certain county health facilities where aggregate Medicaid spending was bellow the upper payment limit based on Medicare payment levels. These payments included $155 million in federal funds at a matching rate of 56 percent (step 1). Immediately upon receiving these funds, the county health facilities transferred through an IGT all but $6 million of the excess payments back to the state, which retained $271 million for a net gain of $149 million in new federal funding (steps 2 and 3).

Figure 2: General Accounting Office's Example of One State's Arrangement to Increase Federal Medicaid Payments



Similarly, some states have used their DSH programs to make unusually large payments to government-owned facilities, which then used IGTs to return the bulk of the federal and state funds to the state treasury. A recent survey of DSH and UPL financing mechanisms in 34 states found, however, that in 2001 most of the gains under DSH accrued to providers, while under UPL programs the bulk of the gains were returned to the state treasury. Nevertheless, such transactions involving both UPL and DSH were estimated to have increased the average federal matching rate by three percentage points in the 29 states that provided data in 2001.[32]

State-by-State Distribution of IGTs, UPLs, and DSH

There is no national public database on the use of IGTs in Medicaid. There are, however, data available to the public on the expenditures under UPLs and for DSH hospitals. These data, while limited, show that the current controversy over UPLs affects just under half the states.

On October 8, 2003, the CMS Administrator testified before a House Subcommittee that "States often find ways to use IGTs to avoid paying the statutory match rate and effectively shift a larger portion of Medicaid costs to the Federal government."[33] While the Administrator did not present any state-by-state data at that time, in response to Member questions, CMS subsequently produced the data presented in Table 1 below.

Table 1: Estimated Total UPL Transition Payments

(as of 1/22/2004)

State	UPL Type[1]	Transition Period	Total Payments	Comments[2]
Alabama	IH	5	--	May not qualify for Transition
	OH	5	--	May not qualify for Transition
	NF	5	--	May not qualify for Transition
Alaska	IH	2	$36,851,234	
Arkansas	OH	2	$56,500,000	
California	IH	8	$3,853,398,807	
Georgia	IH	5	--	May not qualify for Transition
Illinois	OH	8	$981,077,623	
	IH	8	$3,410,932,473	
Iowa	NF	2	$148,923,590	
Kansas	NF	2	$46,854,572	
Louisiana	NF	2	$1,166,666,296	
Michigan	OH	1	--	UPL calculations not complete
	OH	5	--	UPL calculations not complete
	NF	5	$2,262,265,250	
Missouri	IH	1	--	
	NF	2	$433,014,424	
Nebraska	NF	8	$363,772,160	
New Hampshire	NF	5	$82,070,559	
New Jersey	NF	2	$920,000,000	
New York	NF	5	$2,809,851,503	
North Carolina	IH	5	$0	Did not qualify for Transition
	OH	5	$0	Did not qualify for Transition
North Dakota	NF	5	$128,312,825	
Oregon	NF	5	$187,869,560	
Pennsylvania	NF	8	$6,479,520,523	
South Dakota	NF	2	$90,800,000	
Tennessee	NF	2	$199,261,426	
Virginia	NF	1	$477,405,016	
Washington	IH	1	--	UPL calculations not complete
	NF	5	$493,627,778	
Wisconsin	NF	2	$1,014,868,858	
	NF	8	$122,839,917	
Total (24 States)	33		$25,766,684,393	

[1] IH = inpatient hospital services; OH = outpatient hospital services; and NF = nursing facility services.

[2] CMS indicated that some programs may not qualify under existing federal regulations for the transition period indicated.

Source: CMS Administrator Tom Scully's written response to questions before the House Energy and Commerce Health Subcommittee on October 13, 2003, submitted Friday, February 13, 2004.

As shown in Table 1, CMS has preliminarily determined that 24 states may qualify for transition periods under existing UPL regulations and that the estimated total computable amount of funds (federal and state share) each state will receive over their entire transition period for each type of UPL arrangement (inpatient hospital, outpatient hospital and nursing facility) will total more than $25 billion. Transition periods for 1-year and 2-year transition states have expired. However, CMS indicated that four states with 2-year UPL transition periods – Arkansas, Kansas, Louisiana, and Missouri – have spent beyond what CMS believes was their allowable UPL transition amount. All of the 5-year and 8-year UPL transition periods remain active.

In December, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (P.L. 108-173). Title X of the MMA provides for a one-time increase in state-specific Medicaid DSH allotments of 16 percent across the board in FY 2004.[34] As shown in Table 2 on the next page, this change increased total federal DSH allotments from $8.7 billion in FY 2003 to $10.1 billion in FY 2004. Table 2 also demonstrates the large variation in DSH spending as a percent of total Medicaid spending in each state. DSH accounted for 6.4% of Medicaid spending nationally in 2002, ranging from less than 1% of total Medicaid spending in Wyoming and Montana to more than 17% of spending in Louisiana and New Hampshire.[35]

Conclusion

No figures are available on the total amount of IGTs used by states as their share of Medicaid spending. The amount of federal DSH and UPL payments in FY 2004 are estimated to total $13.4 billion, or 8 percent of federal Medicaid spending.[36] This is a significant commitment of federal resources and the federal government must ensure accountability for the use of these funds, as well as the remaining 92 percent of federal Medicaid funds.[37] A recent report prepared for the *Kaiser Commission on Medicaid and the Uninsured* by a former federal Medicaid official identified some significant improvements that CMS could undertake within Medicaid's existing financing structure to improve financial management and promote accountability for use of federal funds.[38] Such changes undertaken to improve accountability should both support the program's existing health and long term care coverage goals and help it meet the many challenges it faces, including the growth in the number of low-income uninsured Americans,[39] and the rapid increases in the cost of prescription drugs and other health and long-term care services.[40] Moreover, states continue to face significant budget shortfalls because of declining tax revenues, and will be even more challenged as the temporary fiscal relief provided by the Jobs and Growth Act of 2003 expires at the end of June 2004.[41]

Table 2

Federal Medicaid DSH Allotments

State	DSH as % of Total Medicaid Spending 2002	(Federal Allotments in Millions) Pre-MMA 2003	Post-MMA 2004	Post-MMA 2005
United States	**6.4%**	**$8,748**	**$10,148**	**$10,187**
Alabama	12.0	250	290	290
Alaska*	2.7	9	11	12
Arizona	2.5	82	95	95
Arkansas*	0.6	19	22	26
California	5.0	890	1,033	1,033
Colorado	6.9	75	87	87
Connecticut	6.7	162	188	188
Delaware*	0.5	4	5	5
District of Columbia	3.9	32	38	38
Florida	3.9	162	188	188
Georgia	6.8	218	253	253
Hawaii	--	--	--	--
Idaho*	1.3	7	9	10
Illinois	4.2	175	203	203
Indiana	8.9	174	201	201
Iowa*	1.1	18	20	24
Kansas	2.2	33	39	39
Kentucky	5.2	118	137	137
Louisiana	17.3	631	732	732
Maine	3.5	85	99	99
Maryland	3.7	62	72	72
Massachusetts	7.9	248	287	287
Michigan	5.3	215	250	250
Minnesota*	1.3	33	39	45
Mississippi	6.5	124	144	144
Missouri	9.9	385	446	446
Montana*	0.1	5	6	7
Nebraska*	0.8	13	15	17
Nevada	9.4	38	44	44
New Hampshire	17.7	132	153	153
New Jersey	15.5	523	606	606
New Mexico*	0.7	9	11	12
New York	7.8	1,304	1,513	1,513
North Carolina	6.6	240	278	278
North Dakota*	0.5	4	5	6
Ohio	6.7	330	383	383
Oklahoma*	1.0	16	19	22
Oregon*	0.9	20	24	27
Pennsylvania	6.4	456	529	529
Rhode Island	6.4	53	61	61
South Carolina	11.6	266	308	308
South Dakota*	0.2	5	6	7
Tennessee	--	--	--	--
Texas	10.4	776	901	901
Utah*	1.2	9	10	12
Vermont	4.3	18	21	21
Virginia	4.7	71	83	83
Washington	6.9	150	174	174
West Virginia	5.2	55	64	64
Wisconsin*	1.2	42	49	57
Wyoming*	0.1	0	0	0

* "Low-DSH State" These states continue to receive 16% increases through FY 2008.

NOTE: MMA refers to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173). DSH provisions are contained in Title X, Section 1001 of the MMA. 2002 data represent actual DSH spending as a percent of total program spending.

SOURCE: 2002 data from KCMU and Urban Institute analysis of CMS-64 data. 2003 and 2004 allotments are from Fed Reg. Vol 69, No. 59., p. 15861 and p. 15863, March 26, 2004. 2005 allotments are estimates prepared by KCMU, 2004.

Medicaid's current federal-state matching structure enables states and the federal government to respond flexibly and quickly to changes in the health care system, to emerging public health threats, and to changes in the location or needs of the nation's low-income population.[42] As attempts are made to strengthen program integrity and accountability by curtailing or modifying the use of IGTs, UPLs, DSH, or provider taxes, care should be taken to do so in a way that does not jeopardize the many benefits the program brings to low-income Americans, states, the local health safety net, and the nation's health care system as a whole.

Endnotes

[1] For more on Medicaid financing issues, see Wachino, Schneider, and Rousseau, "Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds," *The Kaiser Commission on Medicaid and the Uninsured* (January 2004).
[2] See Boyd and Wachino, "Is the State Fiscal Crisis Over? A 2004 State Budget Update," *The Kaiser Commission on Medicaid and the Uninsured* (January 2004).
[3] See Thompson, P, "Medicaid's Federal-State Partnership: Alternatives for Improving Financial Integrity," *The Kaiser Commission on Medicaid and the Uninsured* (February 2004).
[4] Researchers at the Urban Institute have estimated that in state fiscal year 2001 these transactions increased the average federal matching rate by three percentage points in the 29 states for which they had data; see Coughlin et al., "States' Use of Medicaid UPL and DSH Financing Mechanisms," *Health Affairs*, Vol. 23, No. 2, March/April 2004. See also, GAO, "Major Management Challenges and Program Risks: Department of Health and Human Services," (January 2003), GAO-03-101, pp. 27- 29.
[5] GAO, "Medicaid: Improved Federal Oversight of State Financing Schemes is Needed," (February 2004), GAO-04-228, p. 1.
[6] Centers for Medicare and Medicaid Services FY 2005 Budget in Brief (January 2004), p. 66.
[7] OMB, *The Budget for Fiscal Year 2005*, p. 149.
[8] Committee Print, *Concurrent Resolution on the Budget – Fiscal Year 2005* (March 5, 2004), p. 28, available at www.senate.gov/~budget/republican/pressarchive/CommitteePrint2005.pdf. The House Budget Committee's report was silent on the issue of Medicaid cuts related to "waste and abuse."
[9] 69 *Fed. Reg.* 922 (January 7, 2004).
[10] Miller, V, "Cash Ceilings May be Placed on Medicaid Drawdowns," Federal Funds Information for States, Issue Brief 04-02 (February 4, 2004).
[11] Pear, Robert. "Bush to Revisit Changes in Medicaid Rules, *The New York Times* (February 23, 2004).
[12] Section 1903(w)(6) of the Social Security Act, 42 U.S.C. 1396b(w)(6).
[13] Section 1902(a)(2) of the Social Security Act, 42 U.S.C. 1396a(a)(2).
[14] CMS Survey of Regional Medicaid Offices, April 2001, as cited by the New York State Association of Counties.
[15] 42 CFR 433.51
[16] Kaiser Commission on Medicaid and the Uninsured, The Medicaid Resource Book (July 2002), p. 105.
[17] 66 *Fed. Reg* at 3154, 3173 (January 12, 2001) and 67 *Fed. Reg* at 2610 (January 18, 2002).
[18] See Schneider and Rousseau, "Upper Payment Limits: Reality and Illusion in Medicaid Financing," *The Kaiser Commission on Medicaid and the Uninsured* (February 2002).
[19] Budget of the United States FY 2005, Analytical Perspectives, Table 24-5.
[20] Budget of the United States FY 2005, Analytical Perspectives, Table 24-1.
[21] See GAO, "Medicaid: Improved Federal Oversight of State Financing Schemes is Needed," (February 2004), GAO-04-228.
[22] Section 1902(a)(13)(A)(iv) of the Social Security Act, 42 USC 1396a(a)(13)(A)(iv).
[23] Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* (2000), pp. 87-102, www.nap.edu.
[24] CBO, March 2004 Medicaid Baseline, 3/3/2004.
[25] Section 1923(f) of the Social Security Act, 42 U.S.C. 1396r-4(f).
[26] Informal HHS estimates from November 2003. It should be noted, however, that a letter from CBO Director Douglas Holtz-Eakin to the Honorable Bill Thomas, Chairman of the House Committee on Ways and Means, dated November 20, 2003, estimated the federal impact of the MMA's DSH provisions at $3.0 billion over ten years, apparently assuming that states will not draw down their full allotments over the next decade.
[27] Section 1923(g) of the Social Security Act, 42 U.S.C. 1396r-4(g).
[28] See BIPA (P.L. 106-554), section 701(c); in California the 175 percent limit applies indefinitely.

[29] Section 1903(w) of the Social Security Act, 42 U.S.C. 1396b(w).
[30] See Smith et al. "States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004 – Results from a 50 State Survey," *The Kaiser Commission on Medicaid and the Uninsured* (September 2003).
[31] General Accounting Office, "Major Management Challenges and Program Risks – Department of Health and Human Services", January 2003, p. 27, GAO-03-101.
[32] Coughlin et al., 2004.
[33] Testimony of Thomas Scully, Administrator, Centers for Medicare & Medicaid Services before the Subcommittee on Health of the House Committee on Energy and Commerce (October 8, 2003), p. 2.
[34] MMA also contained special provisions for the 16 states with DSH expenditures between 0% and 3% of total (state and federal) Medicaid spending in FY 2000, defined as "low DSH states." The allotment for these states increases by 16% *each year* from FY 2004 through FY 2008, and by the CPI-U thereafter.
[35] Both Hawaii and Tennessee do not have separate DSH allotments as they have incorporated these into their section 1115 Medicaid waiver programs.
[36] CBO, March 2004 Medicaid Baseline, 3/3/2004.
[37] See CBO, March 2004 Medicaid Baseline, 3/3/2004, and Thompson, P, "Medicaid's Federal-State Partnership: Alternatives for Improving Financial Integrity," *The Kaiser Commission on Medicaid and the Uninsured* (February 2004).
[38] Thompson, P, "Medicaid's Federal-State Partnership: Alternatives for Improving Financial Integrity," *The Kaiser Commission on Medicaid and the Uninsured* (February 2004).
[39] See "The Uninsured: A Primer – Key Facts About Americans Without Health Insurance," *The Kaiser Commission on Medicaid and the Uninsured* (December 2003).
[40] See Holahan and Bruen, "Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?" *The Kaiser Commission on Medicaid and the Uninsured* (September 2003).
[41] See Smith et al. "States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions," *The Kaiser Commission on Medicaid and the Uninsured* (January 2004).
[42] See Wachino, Schneider, and Rousseau, "Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds," *The Kaiser Commission on Medicaid and the Uninsured* (January 2004).

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