

Oral Testimony

Charles Milligan
Senate Finance Committee
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Chairman Grassley, Ranking Member Baucus, and distinguished members of the committee, thank you for inviting me to appear before you today to discuss state Medicaid financing arrangements, such as intergovernmental transfer (IGT) and upper payment limit (UPL) financing arrangements, as well as Medicaid school-based reimbursement. My name is Charles Milligan, and I am the executive director of the Center for Health Program Development and Management at the University of Maryland, Baltimore County. I am a former state Medicaid director from the State of New Mexico.

In my remarks I will focus on IGT and UPL arrangements, but I am happy to answer any questions involving school-based reimbursement.

I would like to make four major points in my testimony today.

First, it is quite likely that the vast majority of current inter-governmental Medicaid financing arrangements—IGTs, UPLs, school-based services, and other examples—not only comply with federal laws and regulations, but also comply with the terms of state Medicaid plans that have been approved by CMS.

Second, these arrangements clearly give rise to the risk for fraud, waste, and abuse. Because state and local governmental entities act as both payer and provider, the normal safeguards involved in a true arms-length relationship between an insurer and a health care provider do not exist. However, the scale of the potential problem is not known. I urge Congress not to extrapolate from a few anecdotes to assume that all arrangements are inappropriate.



Third, as I note in more detail in my written testimony, it will be exceptionally difficult for the federal government to enforce certain reforms aimed at cracking down on potential IGT and UPL abuse. To prevent the IGT abuse that is sometimes called the “recycling” of funds, the federal government would need to trace the flow of dollars after they have been received by public providers. In all likelihood this is not possible. To alter the UPL test to add a factor related to provider costs, a new process of audited cost reporting would be required, which would be expensive, and administratively burdensome, and it would punish efficient providers. A cost-based UPL test may create an incentive for providers to grow their costs, which would not generate any federal savings.

Fourth, I would like to suggest a potentially better approach that would both protect the integrity of the federal funds and ensure that the safety-net providers can fulfill their missions to Medicaid beneficiaries, the uninsured, and others who depend on these providers.

The incentive that may exist for states and local governments to create IGT and UPL arrangements would be reduced if programs like the disproportionate share hospital payments, otherwise known as DSH, were indexed to the actual Medicaid enrollment and the number of uninsured. At present, DSH payment levels have not kept up with the rapid growth in Medicaid enrollment, nor with the number of uninsured. Indexing DSH to Medicaid enrollment and the uninsured would use an appropriate financing mechanism, one designed to subsidize Medicaid and indigent care, in a targeted way. For hospitals, this would eliminate the need for IGT and UPL arrangements.

Simultaneous with indexing DSH in this way, Medicaid agencies could be required to pay public providers, such as hospitals, using the same provider fee schedule that they use to pay private providers. This would prevent the current system of two fee systems—one public, one

private—that underlie UPL arrangements. If the DSH level was sized correctly, I believe states and local governments would accept this type of reform.

I am happy to answer any questions you may have. Thank you.

