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MEDICAID

State Financing Schemes Again Drive Up Federal Payments

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Medicaid: State Financing Schemes Again Drive Up Federal Payments

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you discuss the federal government's role in helping pay for Medicaid. The Congress has structured Medicaid as a federal/state partnership that provides federal matching funds and gives states considerable flexibility in deciding what medical services and individuals to cover, as long as certain basic requirements are met. Over the years, the Congress has also attempted to make the program easier for states to administer and to provide more flexibility in how they may distribute funds to Medicaid providers. However, several times in the 1990s reports surfaced that some states were abusing this flexibility through various financing schemes that increased the federal share of program costs beyond what the partnership agreement calls for. When these practices came to light, laws or regulations were rewritten to stop or restrict them. Now there are reports that a number of states are engaging in a practice that is a variant of previous practices. Limiting this practice would involve taking similar action to what has been done in the past.

In my testimony today, I will (1) describe how this current financing scheme works and (2) discuss how it compromises the agreement for federal/state sharing of Medicaid financing. We have reviewed state plans describing this financing arrangement and have discussed the issue with officials of the Health Care Financing Administration (HCFA) and other agencies. We have not yet identified the extent to which these schemes have been implemented or the amount of money involved, but at the request of the Committee, we will be continuing our work in this regard. Because this scheme is so similar to some practiced previously, I will also draw on our prior work.[1]

In brief, the current scheme inappropriately increases federal Medicaid payments by paying certain providers more than they would normally receive and then having the providers return the bulk of the extra monies to the state. By making an excess payment, the state generates additional federal matching funds, which can be used to pay its share of future Medicaid payments—thus generating even more federal matching funds—or spent however the state determines. The providers receiving the inflated payments and passing back the excess to the state are entities owned by local governments—for example, county-owned nursing homes and local hospital districts. According to HCFA, as of late July, 17 states have state plans that could allow them to use this practice, and 11 other

[1]See the list of related GAO products at the end of this statement.

states have drafted plans for doing so. The exact amount of additional federal Medicaid dollars generated through this process is unknown, but it is in the billions of dollars and growing. While most states do not specifically acknowledge how they will use the money that makes the round-trip back to their treasuries, intended uses reported by elected officials in some states include funding other health-care or education programs, as well as subsidizing a state tax cut.

In our view, this financing practice violates the integrity of Medicaid's federal/state partnership. By receiving part of the money back from the provider and keeping the federal share associated with it, the state is—in effect—able to lower its own Medicaid contribution substantially below the share specified in federal law. We have not yet been able to specifically determine how much of an effect this current practice will have in any one state. However, our analysis of previous financing schemes showed that the effect can be substantial. For example, in 1994 we analyzed Michigan's use of similar funding mechanisms (including excessive payments to county nursing homes) and found they had the effect of raising the federal share for Medicaid expenditures from 56 percent to 68 percent. When related schemes came to light in years past, steps were taken to curtail them and restore the federal/state partnership as intended. HCFA has drafted a regulation that would curtail this scheme, but the draft has not moved far in the rulemaking process. We urge the Administration to finalize this regulation and reiterate a recommendation to the Congress, first made in 1994, that would close the door on financing practices that inflate the federal share by making excessive payments to government-owned facilities.

Background

The federal and state governments' shares in the cost of Medicaid are based on a statutory formula designed to reflect differences in each state's program needs and capacity to finance them. At a minimum, the federal government pays 50 percent of the cost. However, poorer states—those with a low per capita income—receive federal contributions at a higher matching rate. The aim is to reduce differences among the states in medical care coverage for the poor and distribute fairly the burden of financing program benefits among the states. Under this statutory formula, the federal payment for the poorest states can be up to 83 percent of the program's cost.

Within a broad legal framework, each state designs and administers its own Medicaid program, including deciding how much to pay providers for a particular service. Each state operates its program under a plan that

HCFA must approve for compliance with current federal law and regulations. In addition, HCFA must approve any amendments to this plan.

To control federal expenditures, HCFA established a set of upper payment limits on the total amount it would agree to pay states for a variety of services. For example, one upper payment limit sets a maximum amount of federal payments for all nursing homes in a state.[2] The upper limits are based on the payment amount allowed under the Medicare program, which is the federal government's program for providing medical services for the elderly and the disabled. The upper limit is not a price to be paid for each service provided, but rather a ceiling on Medicaid expenses above which the federal government will not share.

The flexibility states have to set Medicaid's payment rates has provided them the opportunity to develop various financing schemes in the past that effectively changed what the federal government paid (see table 1). Most of these financing schemes have subsequently been restricted by law or regulation. While such restrictions curtailed the specific schemes that had been brought to light, the restrictions did not extend to transactions with certain government health care providers, such as local- and county-level providers. To address this problem, in 1994 we recommended that the Congress enact legislation to prohibit Medicaid payments that exceed costs to any government-owned facility. That recommendation remains outstanding.

[2]Upper payment limits currently exist for different classes of services, including inpatient hospital services, outpatient hospital services, nursing facility services, and intermediate care services for the mentally retarded. Separate upper payment limits are set for state-operated facilities that provide each of these services, with the exception of outpatient hospital services, which have no upper payment limit.

Table 1: Examples of Previous Medicaid Financing Schemes for Generating Federal Funds Without Committing a Corresponding State Contribution

Financing practice	Summary	How subsequently restricted
Excessive payments to state facilities	Excessive payments were made to state-owned facilities, increasing federal payments.	HCFA promulgated regulations in 1987 that established payment limits for state-operated inpatient and institutional facilities.
Provider taxes and contributions	Revenues from provider-specific taxes or donations were used to increase state Medicaid spending. The taxes and contributions were matched with federal funds and paid to the providers. These providers then returned most of the federal monies to the state.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 essentially banned provider donations, placed a series of restrictions on provider taxes, and set certain other restrictions for each state.
Excessive disproportionate share hospital (DSH) payments	DSH payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the state and federal funds to the state.	The Omnibus Budget Reconciliation Act of 1993 limited which hospitals could receive DSH payments, capped the amount of DSH payments individual hospitals could receive, and capped states' total DSH payments. The Balanced Budget Act of 1997 further reduced state-specific DSH allotments for fiscal years 1998-2002.
Excessive DSH payments to state mental hospitals	A large proportion of state DSH payments were directly returned to the state treasury or were paid to state-operated psychiatric hospitals to indirectly cover the cost of services provided to patients that Medicaid cannot directly pay for.	The Balanced Budget Act of 1997 limited the proportion of a state's DSH payment that can be paid to state psychiatric hospitals.

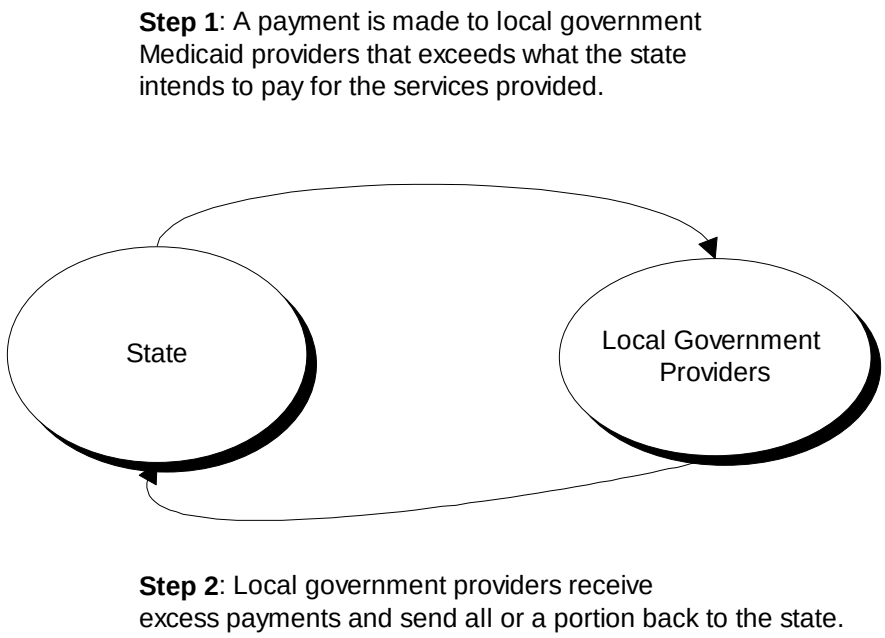
To better ensure that federal Medicaid dollars are used for Medicaid services, in the Balanced Budget Act of 1997 the Congress explicitly banned the use of federal matching funds for any non-health-related items or for any item or service not covered by a state's Medicaid plan.

Additional Federal Funds Are Obtained Through Excessive Payments to Local Government Providers

The current practice is a variation of past practices in which federal dollars make a round-trip from the state, to a Medicaid provider, and then back to the state. Under the current scheme, excessive payments are made to health facilities owned by local governments. Such providers include county-owned nursing homes, local hospital districts, and county hospitals. Unlike schemes involving other types of providers, which have been addressed through legislation or changes in regulation, restrictions on excessive payments to local government providers are fewer. The

round-trip arrangement that maximizes federal dollars for the state essentially involves two steps, as shown in figure 1.

Figure 1: Overview of Process for Maximizing Federal Medicaid Dollars



In the first step, states make a payment to certain Medicaid providers over and above the amount that Medicaid actually intends to pay them. States determine the amount of the excess payment by computing the difference between the upper payment limit (that is, the maximum amount of total Medicaid expenses eligible for federal matching payments) and the total amount the state would normally pay to Medicaid providers using its payment rates. Local government health care facilities such as nursing homes and hospitals constitute good candidates for these excessive payments because states are not limited in how much they may pay local government providers, as long as their total payments to that provider group as a whole fall below the upper limit for that category of provider. For example, if actual Medicaid payments to all nursing homes in a state were $100 million under normal Medicaid rates, and the upper payment

limit was $120 million, the amount available for the excessive payment to county-owned nursing homes would be $20 million.[3] Assuming a 50-percent federal matching rate, the federal share of the aggregate payments would thus be driven from $50 million to $60 million.

The second step is the transfer of all or an agreed-upon share of the excess payments from the local government providers back to the state treasury. Without this step, the local providers would benefit, but the states would realize no financial benefit. In fact, the state would actually lose from the arrangement, because it would simply be paying more than normal for the same services. However, once a payment is made to a local government provider, the funds become local government funds, and the local government is free to make any intergovernmental transfer of the funds. Thus, the states can receive the transfer and reap the financial benefit of the federal share of the excess payment.

While most states are silent on the distribution of excessive payments once the local government providers are paid, some states are quite clear that the money is intended to complete the round-trip and be returned to the state (see table 2 for examples).

[3]When the excess payments are made, they are a combination of federal and state funds.

Table 2: Examples of State Plan Descriptions of Disposition of Excess Payments

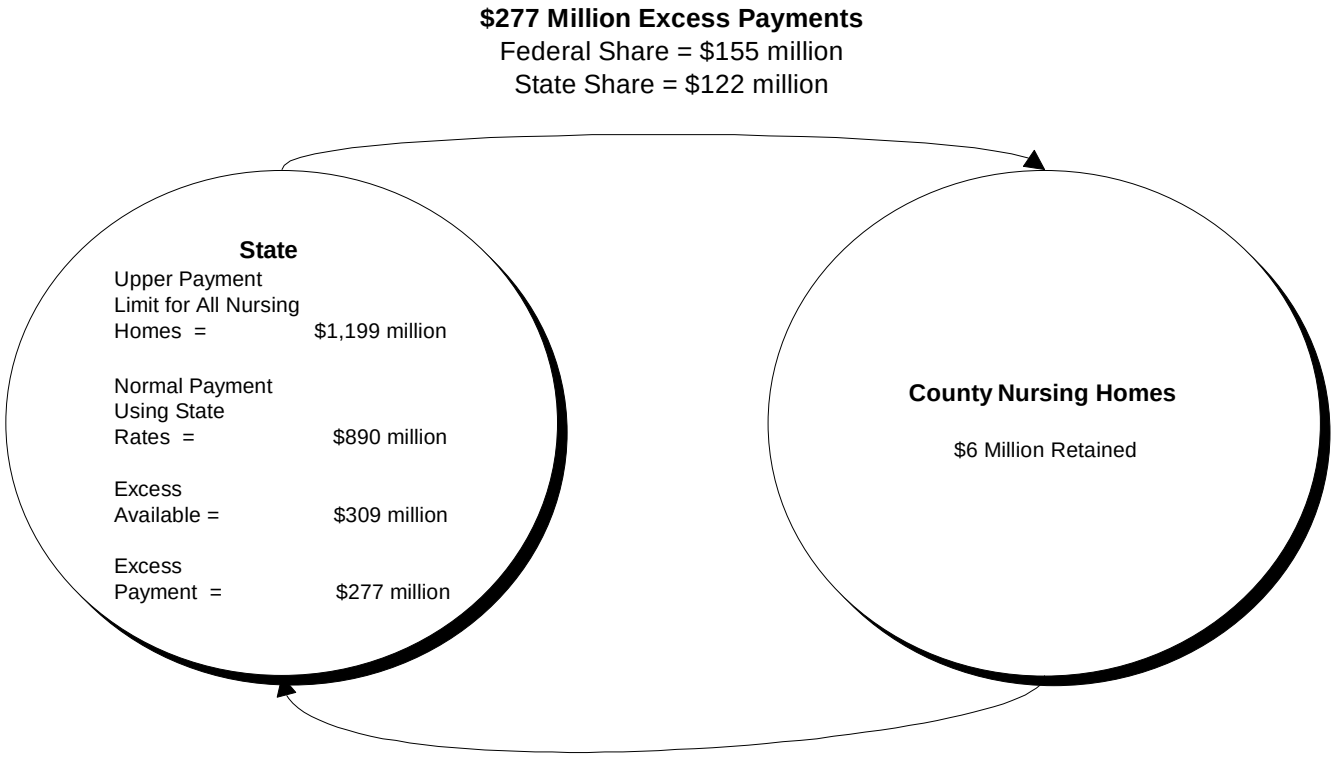
State	Excerpts from state plan amendments	Status[a]	Effective date
Alaska	"While it is probable that some portion of the payments will be retained by the publicly owned and operated hospitals, Alaska intends that the largest share of the payments will be returned to the State through an intergovernmental transfer."	Pending	Deemed approval estimated for November 2000
South Dakota	"A government nursing facility funding pool is created to increase payments to nursing facilities that are owned by political subdivisions of the state (publicly owned). . . Each publicly owned nursing facility, upon receiving a distribution of the funding pool, remits the amount of that payment, less a transaction fee, to the Department of Social Services thereby creating an intergovernmental transfer of funds."	Pending	Deemed approval estimated for September 2000
Tennessee	". . .(B)ased upon an executed intergovernmental transfer agreement and subsequent transfer of funds, qualifying Medicaid level II nursing facilities shall receive a Medicaid nursing facility level II disproportionate share payment one time each fiscal year."	Deemed approved	July 2000
Washington	"The supplemental payments made to public hospital districts are subject to. . .a contractual commitment by each hospital district to return a minimum of 82% by intergovernmental transfer to the state treasurer. . ."	Approved	September 1999

[a]By law, if HCFA neither denies nor approves plan amendments submitted by the states within 90 days, the amendments automatically become accepted and approved. In some cases, HCFA does not have grounds to deny the state proposals but will not officially approve them. As a result, these proposals become "deemed approved" after 90 days. In some cases, this process extends up to 180 days if additional information is requested from the state.

Figure 2 shows how the round-trip payment process works in one state we examined in prior work, illustrating how long the practice has prevailed. The illustration is based on a financing arrangement between the state of Michigan and some county nursing homes. We first reported on it in 1994.[4] As illustrated, the state determined that it could pay an additional $277 million to county nursing homes and still stay under the upper payment limit for all nursing homes. Michigan then made a payment of $277 million, which included $155 million in federal matching funds, to the homes. On the same day that the county facilities received the money, they wired $271 million of the payment back to the state. None of these funds were returned to the federal government but instead were intended to reduce the state's share of Medicaid payments.

[4]See *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government* (GAO/HEHS-94-133, Aug. 1, 1994).)

Figure 2: Michigan's Excessive Payment Arrangement With County Nursing Homes, 1993



Several variations to this basic approach exist among state plans. For example, in one state, county-owned nursing homes obtain the equivalent of a bank loan to finance both the state and federal shares of the excessive payment. The county-owned nursing homes transfer the total amount borrowed to the state, which returns all the funds plus a transaction fee to the county-owned nursing homes as a Medicaid payment for nursing services. The nursing homes use the payment to pay off their loans. The net result of this variation is the same: hundreds of millions of dollars in federal funds are generated with ultimately no state contribution.

The exact amount of additional federal Medicaid matching dollars generated from states' use of these practices is unknown, but it is likely

substantial and increasing. HCFA estimates that of a $3.4 billion increase in its fiscal year 2000 spending above earlier projections, $1.9 billion was likely due to the circulation of funds through round-trip arrangements with local government providers. According to HCFA, as of July 26, 2000, 17 states had approved state plans that would permit the use of this reimbursement practice, and another 11 states have submitted proposed plan amendments for approval to do so. The quick and dramatic increase in Medicaid expenditures that accompanied the adoption of schemes involving DSH payments in the early 1990s shows the potential of the current financing arrangement to increase expenditures. In that earlier set of schemes, DSH payments increased from $1 billion in 1990 to over $17 billion in 1992.

Because HCFA regulations currently allow excessive payments as long as they do not exceed the upper payment limit, HCFA's position is that it has no grounds to deny these plans. A review of just a few of the proposals, approved plan amendments, and various media reports shows the potential for generating a significant amount of additional Medicaid federal matching dollars without assurances that the money will be spent on Medicaid services and beneficiaries.

- Iowa's plan, which took effect last year, pays county nursing homes this year about $95 million and will pay an estimated $125 million in 2001 in additional federal dollars.[5] These payments will result in average federal spending of about $969 daily per Medicaid bed in county nursing homes, or a 1,700-percent increase from the current federal spending level of $54 per bed per day. While Iowa's plan does not specify how these funds will be spent, a state Medicaid official told us the funds will be returned to the state to create a trust fund that will be spent on assisted living for the elderly, which may or may not be related to covered Medicaid services or beneficiaries.

- New Jersey's plan, which lapsed into effect September 1, will generate an additional federal payment of about $500 million over a 15-month period by increasing payments to county nursing facilities by $999 million. The counties initiate the excess payment by transferring the total expected excess payment amount, both state and federal shares, to the state. The state immediately sends the money back to the county facilities as a Medicaid payment. This state payment triggers the federal share of the payment, which it can then spend at its discretion.

[5] This year's excess payment amount is based on a 9-month period. In 2001, the payment amount will be based on a full 12 months, which is the basis for our estimate.

- Media reports from some other states have cited elected officials' plans to use the federal funds for state education programs or to subsidize a state tax cut.

Financing Scheme Undermines Congressionally Determined Federal Share of Medicaid Expenditures

The fiscal integrity of the Medicaid program is a shared federal/state responsibility. As such, states have considerable programmatic flexibility but also the fiduciary responsibility to manage program finances efficiently and economically and to make responsible spending decisions. Because states share in the program costs, they have a strong incentive to contain health care costs through prudent program decisions.

The current funding arrangements with local government health providers undermine this incentive and circumvent the federal and state funding balance that is set by law. These funding arrangements effectively increase the federal matching rate by increasing federal expenditures, while total state contributions remain unchanged or even decrease. For example, we reported in 1994 that the state of Michigan increased its federal matching rate from 56 percent to 68 percent by reducing state payments by $773 million through several different funding practices. These practices included the funding arrangement explained in figure 2.

The current excessive payment rates used or proposed by states have the same potential. For example, under New Jersey's excessive payment plan to county nursing facilities, an additional $500 million in federal funds will be paid over a 15-month period. While the state has not indicated how much of this payment it will ultimately retain, keeping all additional federal funds would have the effect of increasing the federal share from 50 percent to 62 percent. HCFA is aware of 15 other similar plan amendments involving local government nursing homes. Together, these 16 state funding arrangements, if they all take effect, could result in over $2 billion in annual excessive federal payments.

Restricting the Size of Excessive Payments Can Limit Financing Schemes

In the past, efforts to curtail round-trip financing schemes have focused on restricting the size of the excessive payments. The same approach can be taken for the current scheme. More specifically, in 1987, in response to some states' excessive Medicaid payments to state-operated facilities, HCFA promulgated regulations that established separate upper payment limits for state-owned facilities in certain provider categories. Expanding this approach to include all government-owned Medicaid providers would essentially shrink the upper payment limit loophole and reduce the financial benefit of current financing arrangements with local government providers. For example, if an upper payment limit was established for

payments to all government providers, the federal share of the excessive payment amount in Iowa could be reduced from over $95 million to less than $3 million. This decline would occur because the excess amount available for payment would be reduced from $151 million for all nursing homes to about $4 million for nursing homes operated by local governments.

Some action on this front is under way. In response to the increasing magnitude of the current payment schemes, HCFA has drafted regulations that, if put into effect, would curtail excessive payments to local government providers in the same manner as for state-owned facilities. HCFA officials acknowledged that they had been aware that some states have been using the current scheme for a number of years. They said they had become more motivated to take action because of the increasing number of states submitting plans to use the scheme and the drain of federal dollars as a result. HCFA's draft regulations are awaiting approval from the Office of Management and Budget (OMB). If OMB approves them, the regulations must undergo a public comment period before they can take effect. HCFA officials were unable to definitively estimate when proposed regulations would be issued for public comment.

Conclusions and Previous Recommendation

The financing scheme that states are increasingly using is basically no different from the schemes that have been identified and subsequently prohibited in the past. The current schemes take advantage of a technicality that allows states to, in effect, supplant state Medicaid dollars with federal Medicaid dollars. In so doing, states violate the basic integrity of Medicaid as a joint federal/state program.

HCFA's proposed regulatory change, which would impose an upper payment limit on providers owned by local government entities, would extend the existing limits on payments to state-owned facilities. While such a change would probably not discourage other attempts to find ways to increase federal payments, it would at least curtail the scheme now in widest use. Because of the potential for excessive payments to persist in other forms, the Congress should consider implementing a recommendation that remains outstanding from our 1994 work to enact legislation to prohibit Medicaid payments that exceed costs to any government-owned facility. Finally, continuing attempts to exploit program loopholes also point to the need to be ever vigilant to identify the next innovative arrangement before it reaches such financial magnitude that it becomes both a staple of state financing and a potential threat to the integrity of the funding partnership.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Committee may have.

GAO Contact and Staff Acknowledgments

For future contacts regarding this testimony, please call Kathryn G. Allen at (202) 512-7118. Frank Pasquier, Tim Bushfield, Robert Crystal, Evan Stoll, and Stan Stenersen also made key contributions to this testimony .

Related GAO Products

Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit (GAO /T-HEHS/OSI-00-87, Apr. 5, 2000).

Medicaid in Schools: Improper Payments Demand Improvement in HCFA Oversight (GAO/HEHS/OSI-00-69, Apr. 5, 2000).

Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals (GAO/HEHS-98-52, Jan. 23, 1998).

State Medicaid Financing Practices (GAO/HEHS-96-76R, Jan. 23, 1996).

Michigan Financing Arrangements (GAO/HEHS-95-146R, May 5, 1995).

Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994).

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