

Good morning Mr. Chairman and Members of the Committee. I am here today to discuss intergovernmental transfers of Medicaid funds. We have found that current policies and practices severely limit the ability of the Congress, the Department of Health and Human Services, and State and local governments to manage, account for, and assess the benefits of Medicaid dollars. Some fund transfers and financing mechanisms are designed solely to maximize Federal reimbursements to States and serve to obfuscate the source and final use of both Federal and State funds. Action by the Congress and the Centers for Medicare and Medicaid Services (CMS), through issuance of revised regulations in 2001, has helped to curb the effect of such practices, but significant vulnerabilities remain.

First, I will describe the Federal/State Medicaid partnership and accountability principles. Then, based on audits we have completed over the years, I will summarize some serious problems we uncovered with respect to taxes and donations, enhanced payments to certain health care providers, and disproportionate share hospital payments. I will specifically describe how States use intergovernmental transfers to divert funds away from their agreed upon purpose once the Federal share is received. Finally, I will discuss some newer concerns arising from our most recent work related to school based health services, state-employed physicians, and hospital graduate medical education payments.

THE MEDICAID FEDERAL/STATE PARTNERSHIP

The Social Security Act authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy persons. Since the inception of the Medicaid program, the Federal Government, through CMS, and the States have shared in the cost of the program. Each State Medicaid program is administered by the State in accordance with an approved State plan. While the States have considerable flexibility in designing their State plans and operating their Medicaid programs, they must comply with broad Federal requirements. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid-eligible individuals. The Federal Government pays its share of medical assistance expenditures to the States according to a defined formula, which yields the Federal medical assistance percentage. This percentage ranges from 50 percent to 83 percent, depending on each State's relative per capita income. My testimony deals with practices that distort these Federal/State matching requirements and cause the Federal Government to pay disproportionately more, without a corresponding benefit to the intended beneficiaries.

ACCOUNTABILITY OF MEDICAID FUNDS

Effective use of State and Federal Medicaid funds depends on the consistent application of the following widely-accepted accountability principles:

- There should be assurance that the funds paid are actually used for the intended purposes. For example, if disproportionate share payments (payments to hospitals that provide care to large numbers of Medicaid and uninsured patients) are made, they must be used to reimburse hospitals for their uncompensated care costs.
- The management oversight structure should be adequate to ensure that Medicaid funds are paid only for health care services and products that are appropriate and necessary.
- There should be a clear trail of responsibility within the State as to who is accountable for the proper expenditure of Medicaid funds.
- The State Medicaid agency must ensure that quality and timely healthcare services are being delivered to properly eligible beneficiaries.

Our studies raise serious concerns that some or all of these aspects of accountability are lacking in some State Medicaid programs.

STATE ABUSES OF MEDICAID PAYMENT SYSTEMS

The Office of Inspector General (OIG) has focused considerable audit resources over the last several years on enhanced Medicaid payments made to hospitals and nursing facilities. Although these have proven to be troublesome areas, they are but a continuation of creative financing mechanisms that States began to use extensively starting over 15 years ago.

States first used provider donation and tax programs to increase Federal Medicaid matching funds while at the same time reducing the use of State resources in the Medicaid program. States would either arrange for providers to donate funds to the Medicaid program or certain provider groups would be levied special taxes. States were allowed by Federal regulations to use these funding sources as the State share of Medicaid expenditures. These collected funds were then repaid to the providers by increasing the total Medicaid reimbursement. As the reimbursements were raised, the providers recouped their donations or taxes, and the State could then use the Federal matching funds for whatever purpose it decided. The provider tax and donation programs were generally not about increasing services to Medicaid beneficiaries, nor about improving the quality of care provided to these beneficiaries. Rather, they were carefully crafted financing techniques that allowed States to reduce their share of Medicaid costs and force the Federal Government to pay significantly more.

While both congressional and regulatory action has curtailed most of these problems with taxes and donations, the new uses of intergovernmental transfers in areas such as upper payment limits and disproportionate share hospital payments have opened new venues for States to employ creative financing mechanisms. States' use of intergovernmental transfers in certain ways has the same consequences as the old taxes and donations schemes: a State's share of the cost of its Medicaid program declines; Federal taxpayers in other States pay more than their share of Medicaid; and the increased Federal Medicaid

funding derived from these financing mechanisms is often diverted to commingled accounts, where it can be used for purposes unrelated to Medicaid.

I will discuss upper payment limits first.

Enhanced Payments Available under Upper Payment Limits.

The Medicaid regulations allow State Medicaid agencies to pay different rates to the same class of providers as long as the payments, in aggregate, do not exceed what Medicare would pay for the services. This is known as the “upper payment limit.” Federal regulations in effect before March 13, 2001, established two separate aggregate limits within a State applicable to each group of health care facilities (i.e., nursing facilities, hospitals, and intermediate care facilities for the mentally retarded). For each group, the first limit applied to all providers in the State (private, State operated, and city or county operated). The second limit applied to only State-operated facilities. There was no separate aggregate limit that applied to non-State-owned public providers, such as city- and county-owned facilities. Therefore, State Medicaid agencies were able to calculate the total enhanced payment (the difference between the regular Medicaid payment and the Medicare payment amount for a similar service) amount to those providers on the basis of all private, State operated, and city or county operated facilities. The entire amount could then be distributed to only city- and county-owned facilities.

Based on audit results in six States, we found that:

- **Payments were not related to costs.** In general, enhanced payments to city- and county-owned providers were not based on the actual cost of providing services to Medicaid beneficiaries or were without a specific intent to increase the quality of care provided by the public facilities that received the enhanced payments.
- **Facilities surrendered upper payment limit dollars to the State.** City and county nursing homes and hospitals did not always retain all the enhanced payments that were intended for them. Instead, billions of Federal Medicaid dollars were returned by these providers to the States through intergovernmental transfers.
- **Medicaid funds were used for non-Medicaid expenditures.** Some of the money sent back to the State governments through use of intergovernmental transfers were deposited in the general fund or earmarked for use in health-related service areas, but not necessarily for the Medicaid services approved in the State plan.
- **Federal funds were used for State matching payments.** Those funds that were used for Medicaid purposes were used as the States’ share to match more Federal funds. That is, Federal funds were diverted from their intended purpose to generate still more Federal funds.

In short, the States' use of intergovernmental transfers as part of the enhanced payment program was only a financing mechanism designed to maximize the Federal share of Medicaid while effectively avoiding the Federal/State matching requirements.

An example of how a State used the upper payment limit rules, in conjunction with intergovernmental transfers, to their advantage is as follows:

The State creates a State-maintained funding pool to increase reimbursement to county government-owned nursing homes. The State calculates the funding pool by determining the difference between the upper payment limit (based on Medicare payment principles) and the regular allowable Medicaid payments made to all these facilities. The combined total of the differences for all facilities in the State represents the funding pool. The initial source of the State's share of the funding pool is the State's general fund. With the State's share available, Federal matching funds are claimed. The funds in the pool, including Federal and State share, are then transferred to the county providers as a Medicaid enhanced payment. Within a short time frame, using intergovernmental transfers, the nursing facilities return the majority of the enhanced payment to the State.

Little or none of the funds are retained by the nursing facilities for the benefit of their Medicaid residents. The gain from this financing mechanism accrues to the State government, not the Medicaid facilities or beneficiaries. The State commingles the Federal matching funds generated by these enhanced payments with its general fund, in effect making them available for any purpose, including the State share of payments needed to obtain additional Federal funds.

CMS's Actions to Curb Upper Payment Limit Abuses

In an effort to curb these abuses and ensure that State Medicaid payment systems promote economy and efficiency, CMS issued a final rule in 2001 which modified upper payment limit regulations in accordance with the Benefits Improvement and Protection Act of 2000. The regulatory action created three aggregate upper payment limits – one each for private, State, and non-State government-operated facilities. The creation of a separate aggregate payment limit for non-State government-owned facilities effectively reduces the amount of funds that States can gain by requiring public providers to return Medicaid payments through intergovernmental transfers. The new regulations will be gradually phased in and become fully effective on October 1, 2008.

We commend CMS for changing the upper payment limit regulations. The CMS projected that these revisions would save \$55 billion in Federal Medicaid funds over a 10-year period. However, as part of the regulatory changes, CMS increased the enhanced payments that States may pay public hospitals from 100 percent to 150 percent of the amount that would be paid under Medicare payment principles. We had recommended that the payments continue to be limited to 100 percent, and CMS subsequently took that action at an additional savings of \$24.3 billion over 10 years.

These regulatory changes have been a positive step in controlling the States' ability to use financing mechanisms that violate the Federal/State Medicaid partnership agreement.

When fully implemented, these changes will dramatically limit, though not entirely eliminate, State manipulation of the Medicaid program because the regulation still does not require that the enhanced funds be retained by the targeted facilities to provide medical services to Medicaid beneficiaries. Thus, Federal funds continue to be vulnerable to diversion, especially through the use of intergovernmental transfers.

OIG’s Additional Planned Work Involving Upper Payment Limits

We are continuing our work in the area of States’ use of upper payment limit regulations as a financing mechanism to increase Federal reimbursement. Our work is focused on three areas:

- States’ adherence to the transition periods under the new regulations.
- Application of the new aggregate limits by States that have just begun to use the upper payment limit funding mechanisms.
- The possible impact on public nursing homes if the funds paid as part of the upper payment limit regulations were left at the facilities rather than being sent back to the States as part of an intergovernmental transfer transaction.

For example, we are currently performing audit work at a county nursing facility in a State that makes enhanced payments to public nursing facilities. During our three-year audit period, \$132 million in Medicaid payments was directed to the nursing facility from the Federal Government, the county, and the State, using the upper payment limit provision. The county and State purported to contribute \$66 million, generating a matching Federal share of \$66 million (the State and Federal matching rate in 50%/50%).

Preliminary work indicates, however, that of the \$132 million, the nursing facility retained only \$50 million. The remaining \$82 million was returned to the county and State through intergovernmental transfers for discretionary use.

| <i>Government Payer</i> | <i>Total Payment to Nursing Facility (A)</i> | <i>Amount of Payment Returned to Payer by Nursing Facility (B)</i> | <i>Net Payment (A – B)</i> |
|-------------------------|--|--|--------------------------------|
| Federal | \$66 million | \$0 | \$66 million |
| County | \$50 million | \$46 million | \$ 4 million |
| State | \$16 million | \$36 million | (\$20 million) Gain |
| Total | \$132 million | \$82 million | \$50 million |

As summarized in the table above, the Federal Government contributed \$66 million and the County government contributed \$4 million towards the care of residents of the nursing facility, while the State was able to make a profit of \$20 million.

The nursing facility returned \$82 million of the \$132 million to the county and State through the use of intergovernmental transfers, despite the fact that during our audit period State surveyors had rated the nursing facility as in immediate jeopardy for a

pattern of deficiencies and substandard care that constituted actual harm and required significant corrections. If the nursing home had retained more of its upper payment limit funding, it might have provided better quality of care.

We plan to review additional individual nursing homes as part of our continuing work in the upper payment limit area.

Disproportionate Share Hospital Program

Another financial mechanism that can be the source of both benefit and abuse is known as Medicaid disproportionate share hospital payments. Under this program, enhanced payments are made to financially assist hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients. These payments are important because public “safety net” hospitals face special circumstances and play a critical role in providing care to vulnerable populations.

Our work has shown that the States can divert these funds in ways similar to upper payment limit funds. Audits in two States show that public hospitals, that received disproportionate share hospital payments, returned large portions (80 to 90 percent) of the payments back to State Medicaid agencies through intergovernmental transfers. Here is an example of one of those States:

- During fiscal years 1999 and 2000, the State made disproportionate share hospital payments of approximately \$738 million to acute care hospitals.
- Approximately \$632 million of the \$738 million was transferred back to the State.
- The result was that approximately 86 percent of the total disproportionate share hospital payments were returned to the State via an intergovernmental transfer.

Once payments were returned, the States were able to use the funds for any purpose deemed appropriate. We believe the return of these funds contradicts the stated purpose of assisting these public safety-net hospitals to pay for uncompensated care costs.

In many States, the use of enhanced payments under the upper payment limit regulations and disproportionate share program are combined to increase Federal reimbursements. The financial relationship involves some States allowing hospitals to retain upper payment limit funds but requiring the return of disproportionate share hospital funds through intergovernmental transfers. In other cases, the reverse occurs – hospitals retain disproportionate share hospital funds but return upper payment limit funds.

EMERGING VULNERABILITIES

The concerns we have had with States’ use of intergovernmental transfers involving upper payment limit rules and disproportionate share payments extend beyond these areas. We foresee the possibility that all public provider types could be used by States to maximize Federal revenues without ensuring that the integrity of the basic Federal/State

sharing of Medicaid costs is met. We are finding areas where States can manipulate Federal financing sources and neglect accountability over the payment of Medicaid funds. One of these areas concerns school based health services.

States are permitted to use their Medicaid programs to help pay for certain health care services delivered to children in schools, such as physical and speech therapy services. Schools may also receive Medicaid reimbursement for the costs of administrative activities, such as Medicaid outreach activities, application assistance, and coordination and monitoring of health services.

We have identified instances where States require the school districts to return a portion of the Federal funds back to the State through intergovernmental transfers, thus resulting in a net gain for the State government.

In addition, we are beginning audit work involving States' potential use of intergovernmental transfers in two additional areas: state-employed physicians and hospital graduate medical education payments. Both of these provider types could be paid an enhanced payment that could serve as a mechanism for inflating the Federal share of payments for Medicaid services above the statutory Federal matching percentage. The additional payment amount made to public providers could then be returned to the State in a mechanism similar to what we have observed in the upper payment limit process at hospitals and nursing homes. Our concern is that any payment above a public provider's cost could become a part of a financing mechanism that would not ensure that the funds were used for the medical care to which they were intended. We have not yet issued any audit reports on these payment areas, but increasingly we are focusing on them.

ENSURING THAT MEDICAID FUNDS ARE USED FOR MEDICAID SERVICES

We are continuing our work in the areas noted above and plan to provide CMS with additional recommendations on how to help ensure that Medicaid expenditures are in fact used for medical care to Medicaid beneficiaries.

The Administration's fiscal year 2005 proposed budget includes two actions that should help improve the integrity of the Medicaid program. First, the budget proposes to restrict the use of certain intergovernmental transfers that are in place solely to undermine the statutorily determined Federal matching rate. Second, the budget proposes to cap Medicaid payments to individual State and local government providers to no more than the cost of providing services to Medicaid beneficiaries. We have not yet had a chance to discuss these proposals with the Department but welcome their efforts to ensure better control of the benefit.

In addition, some recommendations from our prior work involving upper payment limits and disproportionate share hospital payments have not yet been implemented. We believe they should be. Here is a summary of them.

Upper payment limits. The following additional steps are important because the total number of States now making enhanced payments as part of the upper payment limit process has increased in recent years. We have and continue to recommend that:

1. The transitions periods included in the final upper payment limit regulation be shortened since the controls are not in place to ensure that these added funds are actually used for Medicaid health care services.
2. Annual audits be performed of the States' upper payment limit calculations to ensure compliance with the upper limits.
3. Facility-specific limits be used that are based on the cost of providing services to Medicaid beneficiaries.
4. States be required to allow public facilities to retain upper payment limit funding to provide health care services to Medicaid beneficiaries.
5. Medicaid payments returned by public providers to the State be declared a refund of those payments and used to offset the Federal financial participation generated by the original payment.

Disproportionate share hospital payments. We continue to recommend that steps be taken to ensure that disproportionate share hospital funds remain at the hospitals to provide care to vulnerable populations, rather than being returned to the States through intergovernmental transfers. We believe that any Medicaid payment returned by a provider to the State should be treated as a credit applicable to the Medicaid program.

Disproportionate share hospital payments serve an important purpose in trying to help hospitals cover their uncompensated care costs. But, without States being required to leave the funds at the hospitals, there is no assurance that the intended purposes of disproportionate share payments is being met.

CONCLUSION

Our overarching concern is to ensure that Federal matching payments are in the proper proportion to States' shares and that the funds are used to provide the intended health care services in the intended facility to the intended beneficiaries. Changes are still needed to enable the Congress and the Department to be responsible stewards of Federal funds and measure the true cost and benefits of the Medicaid program.