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Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

August 1994

MEDICAID

States Use Illusory Approaches to Shift Program Costs to Federal Government

GAO/HEHS-94-133

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

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August 1, 1994

The Honorable John D. Dingell
Chairman, Subcommittee on Oversight
and Investigations
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

Because of increasing health care costs over the past decade, states have been searching for new ways to help finance the $125 billion Medicaid program, a jointly funded federal/state entitlement program that provides medical assistance to low-income people.[1] For example, states have used provider donations and imposed provider health care taxes to obtain matching federal funds to help pay for services to Medicaid patients.

Since the late 1980s, the Health Care Financing Administration (HCFA) has been concerned that the use of such funding mechanisms is reducing the states' percentage share of Medicaid spending and, thus, placing an inappropriately large share of the cost of the Medicaid program on the federal government. As a result, the Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (1991 amendments). These amendments severely restricted the use of provider-specific taxes and donations as a source of state matching funds. However, recent concerns have been raised in the media and by others that states continue to benefit from similar financing arrangements.

Because of your concerns, we sought to (1) determine if states are using financial arrangements that inflate the federal share of Medicaid program expenditures, (2) describe various techniques that states use to obtain federal funds for their basic Medicaid and disproportionate share hospital (DSH) programs, and (3) determine if states are using their federal matching funds to provide medical services to Medicaid patients.

As agreed with your office, we reviewed Medicaid records in Michigan, Tennessee, and Texas. In fiscal year 1993 these states accounted for about 11 percent of federal and state Medicaid medical expenditures. In addition, we interviewed officials from HCFA, the three state Medicaid offices, and

[1]Included in these expenditures are payments made under the disproportionate share hospital (DSH) program that have increased dramatically, from about $1.1 billion in fiscal year 1991 to about $16.6 billion in fiscal year 1993. This program provides supplemental payments to hospitals that serve large numbers of Medicaid and other low-income patients.

the Prospective Payment Assessment Commission (PROPAC).[2] In each state, we focused primarily on financing practices that were allowed after the effective dates of the 1991 amendments. Our work was performed between June 1993 and March 1994 in accordance with generally accepted government auditing standards.

Results in Brief

On October 2, 1993, the state of Michigan made a Medicaid payment of $489 million to the University of Michigan hospital that included $276 million in federal matching funds. Within hours, the entire $489 million was returned to the state by the hospital. In fiscal year 1993, this and other such financial arrangements enabled Michigan, Tennessee, and Texas to obtain about $800 million in federal Medicaid funds without effectively committing their share of matching funds.

These types of transactions, which affect the amount of federal dollars provided to match state funds in the Medicaid program, effectively increased the federal share of Medicaid expenditures in the three states. In Michigan, for example, the federal share of Medicaid expenditures effectively increased from 56 percent to 68 percent in 1993. Although we concentrated our work in these three states, HCFA and PROPAC officials told us that such practices are also occurring in other states.

Although the various financial arrangements generated about $1.3 billion in federal and state Medicaid funds, each state treated these funds differently. In Michigan and Texas, funds totaling about $1.2 billion were used to finance the states' Medicaid programs. Without these funds, the states would have had to appropriate additional state funds or, given reduced federal funds, make cuts in their Medicaid program. In Tennessee, over $110 million went into the state treasury where it lost its identity.

HCFA has been concerned about these practices for several years and has requested Michigan and Tennessee to provide additional information on several of their financing arrangements. Further, recently enacted legislation will limit some of these practices. However, Michigan has already taken steps to ensure continuation of its current federal Medicaid funding levels in 1995. Rather than making a single payment to the University of Michigan, the state is proposing to make payments totaling about $590 million to over 90 government-owned hospitals and community

[2]PROPAC, established by the Social Security Act Amendments of 1983, advises the Congress and the Secretary of Health and Human Services on Medicare and Medicaid issues.

health boards and have these entities transfer almost all the funds back to the state.

In our view, the Medicaid program should not allow states to benefit from illusory arrangements where federal funds purported to be used to benefit providers are given to providers with one hand only to be taken back with the other. Prohibiting such arrangements would direct federal funds intended to cover costs of medical care to those medical facilities that provide the care.

Background

In 1965, Medicaid was established as a jointly funded federal/state program providing medical assistance to qualified low-income people. At the federal level, the program is administered by HCFA, an agency within the Department of Health and Human Services (HHS). Within a broad legal framework, each state designs and administers its own Medicaid program. States decide whether to cover optional services and how much to reimburse providers for a particular service.

States continue to face challenges in funding their Medicaid program. Increases in Medicaid costs have been attributed to several factors, including high inflation in medical costs, new medical technologies, expanded eligibility, increases in the use of services, and growth in the number of poor and unemployed people. In addition, almost all states are required to balance their budgets.

Each state operates its Medicaid program under a state plan that HCFA must approve for compliance with current law and regulations. States also must obtain HCFA approval for any amendments to their plans. However, a state can operate under a proposed amendment and receive federal matching funds for distribution to Medicaid providers pending HCFA's final approval.

Besides payments to reimburse medical providers for services rendered, states are required to make additional Medicaid payments to hospitals that serve large numbers of Medicaid and other low-income patients. Within federal guidelines, states determine if a hospital qualifies for additional Medicaid DSH payments. There are no federal restrictions on how hospitals may use the DSH payments.

The federal and state governments share in the cost of Medicaid—including DSH payments—with the federal government paying

at least 50 percent and no more than 83 percent of a state's costs, as determined by a formula. This formula considers a state's average per capita income against the national per capita income and is intended to reduce differences among the states in medical care coverage to the poor and distribute fairly the burden of financing program benefits among the states. The formula-derived rate that the federal government pays for Medicaid reimbursement is called the federal medical assistance percentage (FMAP). In fiscal year 1993, federal Medicaid payments accounted for 58 percent of all Medicaid medical expenditures.

States Use Circuitous Financing Arrangements to Obtain Federal Matching Funds

Michigan, Texas, and Tennessee used several financing approaches to maximize federal Medicaid contributions without effectively committing their share of matching funds. Under these approaches, facilities that received increased Medicaid payments from the states, in turn, paid the states almost as much as they received. Consequently, the states realized increased revenue that was used to reduce their state Medicaid contributions, fund other health care needs, and supplement general revenue funding.

Michigan obtained federal Medicaid matching funds of over $430 million by (1) increasing payments to certain county nursing homes, (2) making DSH payments to a state university in excess of the university's charges for charity care, and (3) increasing payment rates for hospital outpatient services. In Texas, funds provided by three state-owned universities were used to obtain $271 million in federal matching funds. In Tennessee, taxes paid to the state by providers for nursing home beds and hospital services were considered as an allowable Medicaid cost and resulted in federal expenditures of $75 million. We describe these financial practices below.

Medicaid Payments to Michigan Nursing Homes Returned to the State

Michigan nursing homes that received increased Medicaid payments of $277 million in fiscal year 1993[3] returned $271 million to the state. To make the payments to the nursing homes, Michigan obtained about $155 million in federal Medicaid funds by increasing Medicaid reimbursement payments to county nursing facilities[4] by about 200 percent. Due to this rate increase, the state paid $122 million as its share of the increased reimbursement.

[3]Throughout this report, any reference to years relates to a state's fiscal year.

[4]In addition to 41 county nursing facilities, 4 other local government long-term care facilities are also included.

On July 20, 1993, the state transferred the combined federal and state funds of $277 million to the county nursing facilities. Later that day, however, the county facilities wired $271 million back to the state. The county nursing homes were allowed to keep a total of $6 million. A state document indicated that this financial arrangement would produce a significant benefit to the state—funds returned to the state would reduce the state's Medicaid appropriations.

In originally seeking HCFA's approval for the increased rates, Michigan did not have to justify that the county nursing facilities needed increased reimbursements. However, Michigan did have to show that the increase would not exceed the upper limit of what Medicare would pay for nursing home services.[5] Although the average daily Medicaid payment for the affected nursing facilities in Michigan increased from $90 to $269, the average rate of all nursing homes in the state remained below the Medicare upper limit of $99. This was accomplished because reimbursements to all other nursing facilities, that accounted for 86 percent of all Medicaid inpatient days, remained the same.

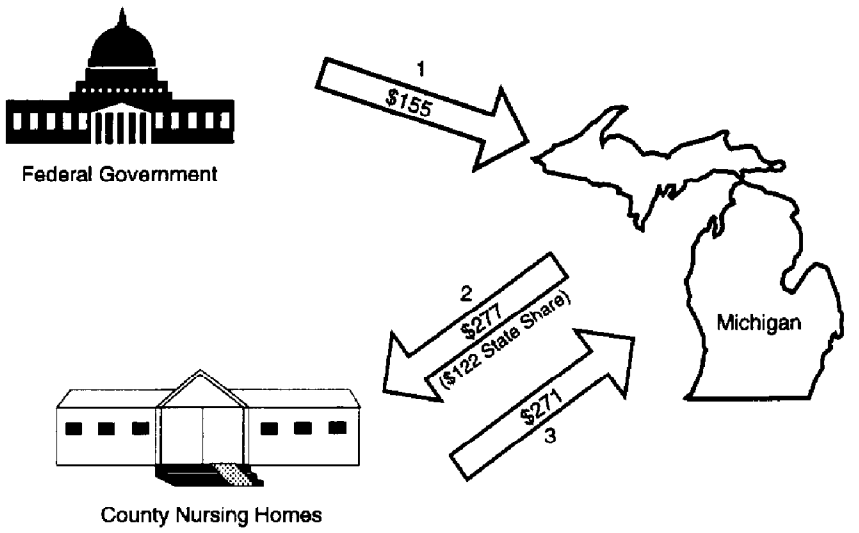
Michigan was able to benefit from this transaction because after a state provides its share of Medicaid funds and makes payments to providers for their Medicaid services, HCFA does not look at subsequent transactions between the state and such providers. There appears to be at least three reasons that led HCFA to this approach. First, no restriction prohibits nursing homes or health facilities from transferring funds back to the state; second, tracing funds through intergovernmental transfers is difficult because such funds lose their identity; and last, the congressional conference report for the 1991 amendments directs HCFA not to change its treatment of intergovernmental transfers, such as this, without going through a lengthy administrative process.

On July 30, 1993, HCFA requested more information from Michigan to explain its computation showing that the increase was within the Medicare upper limit test. HCFA received a response from Michigan on March 1, 1994, and additional information on April 8, 1994. HCFA approved the practice on May 20, 1994, effective to June 10, 1993. However, the arrangement with the county nursing homes would not be allowed were these state-owned facilities. Federal regulations do not allow reimbursements to state facilities to be averaged with reimbursements for

[5]While states set Medicaid reimbursement rates, they must assure HCFA that such rates are reasonable and adequate and do not exceed what Medicare would pay for the service. Medicare is a federal health insurance program for people 65 years of age or older, certain disabled persons, and most persons with end-stage renal disease.

nonstate facilities. Figure 1 illustrates the flow of monies between the nursing homes and the state.

Figure 1: Transactions Relating to Increased Reimbursement Rates for County Nursing Homes (Dollars in millions)



Michigan DSH Payments Transferred to State

Michigan has also used other financing arrangements to generate additional federal matching funds, including making payments to hospitals through its DSH program. While legislation has prohibited certain financing mechanisms, Michigan has adjusted its program to meet new legislative requirements, and its 1995 program is still expected to generate an estimated $335 million in federal funds.

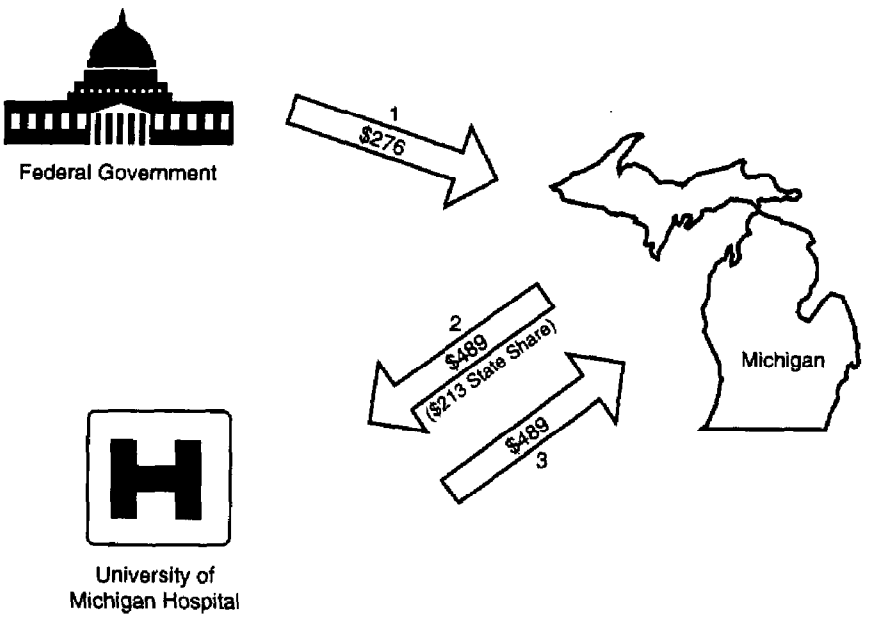
In fiscal year 1993, Michigan used hospital donations to help raise funds for its Medicaid program. Michigan made DSH payments of $458 million, including $256 million in federal matching funds to 53 hospitals; however, the hospitals returned all but $6 million to the state. As a result, the state received a $250 million net benefit from the federal share of the DSH payments. Michigan stopped this practice because the 1991 amendments, which took effect in Michigan on January 1, 1993, severely limited provider donations.

In response to these limitations, Michigan's 1994 DSH program included $489 million for those hospitals that provide many medical services to the state's indigent population. To be eligible for 1994 DSH payments, hospitals had to provide at least 6 percent of inpatient services to indigent patients

in the state. State-owned mental hospitals were not eligible for this payment.

State officials determined that only one hospital would qualify—the state-owned University of Michigan hospital. On October 2, 1993, Michigan made a DSH payment of $489 million to the University of Michigan hospital. This included $276 million in federal matching funds and $213 million in state funds. Later that day, the hospital returned the entire payment to the state through an intergovernmental transfer. As a result, the state realized a net benefit from the federal share of the DSH payment equal to $276 million. Figure 2 shows the transactions related to the 1994 DSH payment to the University of Michigan.[6]

Figure 2: Transactions Relating to the University of Michigan Hospital DSH Payment (Dollars in millions)



Beginning in 1995, the University of Michigan DSH payment will be severely restricted by the 1993 Omnibus Budget Reconciliation Act (OBRA-93). This legislation limits such payments for 1995 to 200 percent of each qualifying

[6]HCFA approved the DSH payment because the proposed payments and other DSH spending did not exceed the state's DSH spending limit. However, the DSH payment of $489 million is 79 percent of the state's total preliminary 1994 DSH allocation of $622 million. At the time, HCFA officials said that they did not know how many hospitals would qualify for the payments.

hospital's costs for Medicaid and uninsured patients, less the hospital's total Medicaid reimbursement and payments received from the uninsured. State officials have calculated that the state can make a 1995 DSH payment to the University of Michigan hospital of $136.3 million.[7] In subsequent years, OBRA-93 limits DSH payments to 100 percent of a hospital's uncovered costs.

To make up for the shortfall from the restrictions on the payments to the University of Michigan in 1995, the state has proposed making payments of about $590 million, including federal funds of $335 million, to 92 government-owned hospitals and community health boards. According to the proposal, these governmental entities will then make intergovernmental transfers back to the state, thereby allowing the state to continue to benefit from federal Medicaid matching funds.

Medicaid Funds Used to Finance a Michigan Indigent Care Program for People Not Eligible for Medicaid

In 1992, the Director of Michigan's Department of Social Services advised HCFA that the department planned to increase Medicaid payments to seven hospitals, which in turn would make payments to a nonprofit organization to purchase managed-care coverage for people not eligible for Medicaid. In 1993, the seven hospitals were paid $51 million, which included $28.5 million in federal funds, $7 million in state funds, and $15.5 million contributed by Wayne County.[8] In prior years, a similar program was funded entirely by the state and county.

In response to HCFA's request for more information, Michigan documented that the total payments to 190 providers, including the increased payments, would not exceed what Medicare would pay for such services. However, our analysis of the state's data for the seven hospitals showed that the increased payments were 146 percent of the hospitals' estimated costs, which were already substantially covered by Medicaid reimbursements. HCFA approved the program on November 16, 1992.

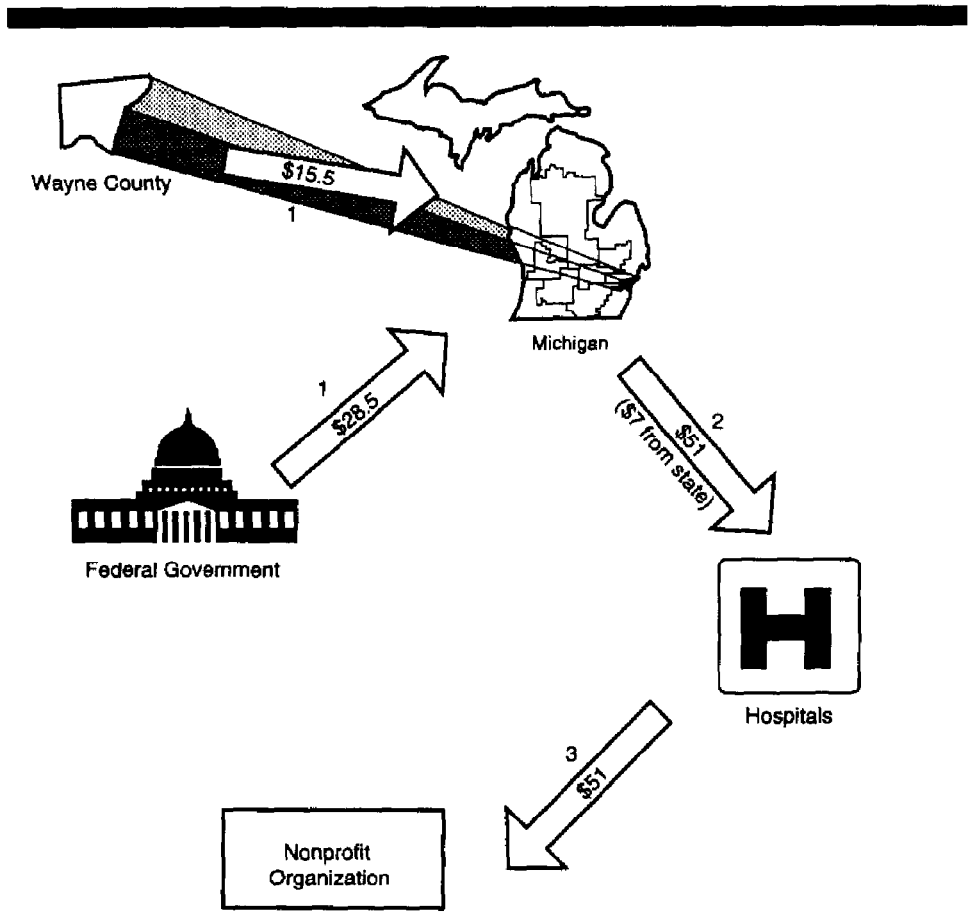
On July 27, 1993, HCFA requested more information on the relationship between the increased payments and the Medicare payment limit, but as of

[7]HCFA has not yet determined whether the 200 percent should be computed by (1) first reducing hospital costs incurred by Medicaid and uninsured patients by payments received from these patients and then multiplying by 200 percent or (2) multiplying the hospital costs incurred by Medicaid and uninsured patients by 200 percent and then reducing this amount by payments received from these patients. Michigan's calculation is based on the latter. Using the first method would result in a DSH payment of $69.8 million or $66.5 million less than what the state calculated.

[8]Wayne County includes the city of Detroit.

May 3, 1994, Michigan had not yet responded. Figure 3 traces the flow of monies for the indigent care program for Wayne County.

Figure 3: Medicaid Funding of Michigan's Indigent Care Program in Wayne County (Dollars in millions)



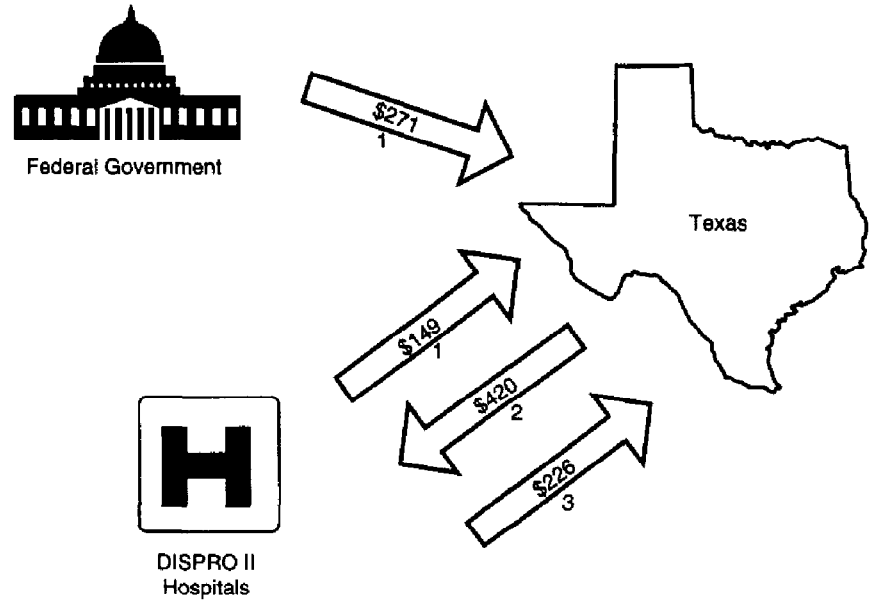
Majority of Texas DSH Payments to State-Owned Teaching Hospitals Returned to State Treasury

In 1993, under the Texas Disproportionate Share Program for State-Owned Teaching Hospitals (DISPRO II), actual charity care charges at three state-owned university hospitals were considered as state expenditures and, therefore, eligible for federal matching funds. The hospitals transferred $149 million (representing their charity care charges) to the Texas Department of Human Services, which received another $271 million in federal matching funds. The entire $420 million was then used to make monthly DSH payments to the three hospitals; however, a large part of these funds was subsequently returned to the state.

The hospitals returned to the state that part of their DSH payments that exceeded their charity care charges, minus any amount authorized by the state legislature. In 1993, the hospitals kept $194 million of the DSH payments, which included $45 million more than their actual charity care charges.[9] The hospitals returned the remaining $226 million to the state general revenues, through intergovernmental transfers, to be appropriated for health care services to low-income individuals. Under OBRA-93, beginning in 1996, Texas will not be allowed to make DSH payments in excess of 100 percent of a hospital's unreimbursed cost of providing care to Medicaid recipients and the uninsured.

Figure 4 illustrates the flow of funds under this financial arrangement.

Figure 4: Transactions Relating to Texas DISPRO II (Dollars in millions)



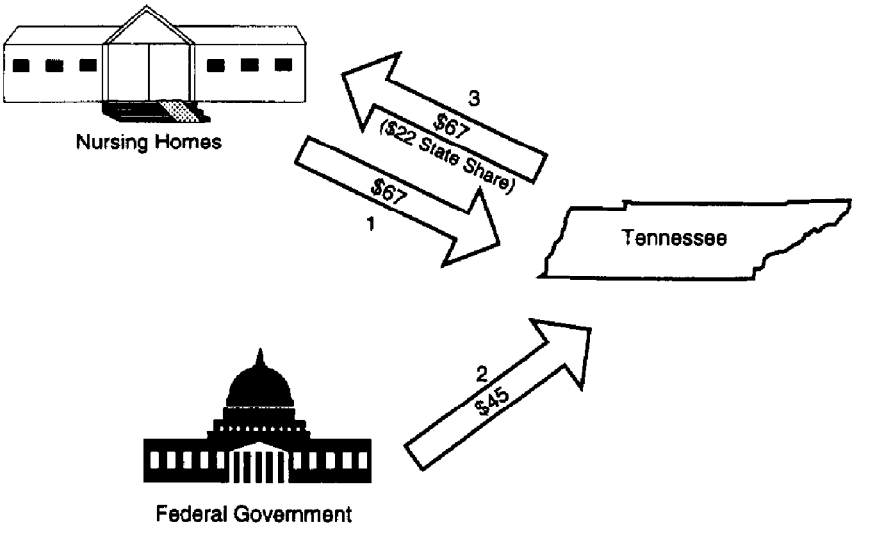
[9]Texas legislation authorizing the hospitals to keep the $45 million, in addition to the actual charity care charges, expired at the end of the state's 1993 fiscal year.

Tennessee Taxes Health Services, Allowing the State to Receive Federal Medicaid Contributions as Tax Revenue

In Tennessee, certain medical providers were required to pay state taxes on their nursing home beds and hospital services. However, that portion of the taxes related to Medicaid patients was considered as a reimbursable Medicaid expenditure,[10] which cost the federal government an estimated $75 million in 1993. These federal funds, along with $37 million in state funds, were, in effect, used to reimburse medical providers for their state taxes. These taxes went into the state's treasury where they were commingled with other state funds.

In 1993, Tennessee enacted a nursing home tax of $2,600 per bed on all beds—both Medicaid and non-Medicaid—that provided the state with $93 million in tax revenues. Tennessee estimates that it reimbursed nursing homes $67 million in federal and state funds for the portion of the taxes related to their Medicaid patients. This reimbursement included an estimated $45 million in federal dollars. Figure 5 shows the flow of Medicaid funds associated with these transactions.

Figure 5: Transactions Relating to Tennessee's Nursing Home Tax
(Dollars in millions)



HCFA approved the nursing home tax on June 22, 1993, effective retroactively to July 1, 1992. Despite this, HCFA is still reviewing the state's

[10]Under the Omnibus Budget Reconciliation Act of 1990, taxes imposed by the state solely on hospitals, nursing facilities, and intermediate care facilities for the mentally disabled were not a reimbursable Medicaid cost. However, the 1991 amendments repealed this provision and allowed such taxes to be included as reimbursable costs for Medicaid.

nursing home tax for compliance with the hold-harmless provisions of the 1991 amendments. These provisions reduce federal reimbursements by the amount of the tax revenues when a state directly or indirectly guarantees reimbursement of any part of a tax to medical providers or patients not related to Medicaid.

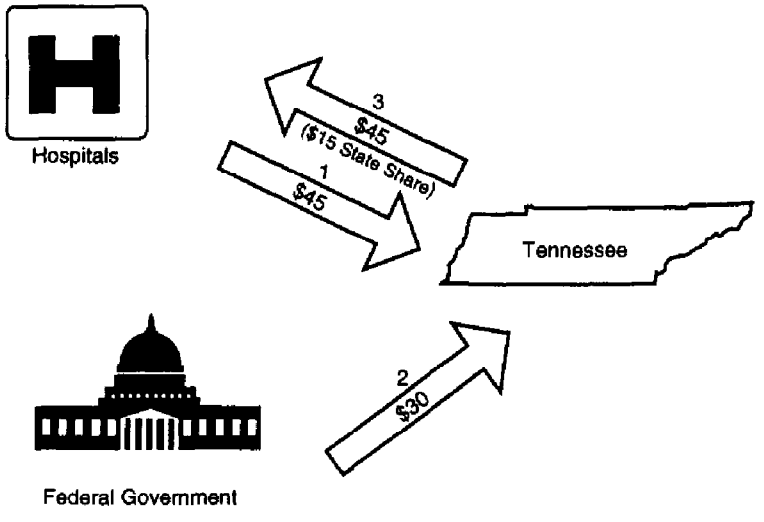
The focus of HCFA's review is Tennessee's granny grant program, which provides payments to indigent nursing home patients. These payments are slightly less than the tax that the nursing homes pay.[11] According to HCFA, because nursing homes can effectively pass on the tax to their patients and some patients receive grants for amounts almost equal to the tax, the nursing homes are virtually guaranteed a return of a major portion of the cost of the tax. The Tennessee Medicaid director stated that the granny grant was never designed as an offset to the nursing home tax and would have been implemented even if there was no nursing home tax.

In 1993, Tennessee also enacted a service tax or privilege tax of 6.75 percent on the purchase of services, including medical services. According to Tennessee officials, this new tax replaced a prior tax on hospitals that was based on Medicaid utilization and did not meet the conditions for an allowable tax under the 1991 amendments. Besides medical services, the privilege tax was levied on motels, theaters, amusements, and auto repair shops. These nonmedical services had been taxed in the prior year at the same rate under what was then called a sales tax.

The medical or hospital component of the privilege tax raised $365 million from both Medicaid and non-Medicaid services. In 1993, Tennessee used federal and state funds of $45 million to make interim payments to hospitals to reimburse them for their part of the tax on Medicaid patients. These payments were based on 1991 hospital Medicaid utilization rates and will be adjusted as more current information is provided by the hospitals. The federal government paid an estimated $30 million as its share of the reimbursement of the privilege tax on Medicaid patients. Figure 6 shows the flow of Medicaid funds involved in these transactions.

[11]Depending on state eligibility criteria, the granny grant payments are either $6.00 or $6.50 a day. The annual nursing home tax of $2,600 a bed is equivalent to a $7.12 a day tax.

Figure 6: Transactions Relating to Tennessee's Hospital Tax (Dollars in millions)



HCFA is reviewing the state's privilege tax to determine if it qualifies as a nonhealth-care-related tax. HCFA is concerned that the tax may not treat health and nonhealth entities the same and, thus, may not qualify as a nonhealth-care-related tax. If the tax does not meet this and other conditions, HCFA may retroactively disallow federal reimbursement. Tennessee officials said that they do not consider this tax to be subject to the 1991 amendments because it is not limited to hospitals, nor does the tax revenue raised from hospitals qualify the tax as health-care-related tax as defined by law. Despite this, the state stopped the tax January 1, 1994, to coincide with the implementation of a statewide program—TennCare—that largely replaced Tennessee's Medicaid program.

Financial Arrangements Increase Federal Share of Medicaid Costs

The financing arrangements and medical service taxes in the three states effectively increased the federal percentage share of total Medicaid payments in the states. Our analysis shows that for 1993, the federal share of total Medicaid expenditures in Michigan effectively increased from 56 percent to 68 percent (see app. I for details). In Texas and Tennessee the increase in the effective federal share of total Medicaid expenditures was less, increasing from 65 to 67 percent and 68 to 71 percent, respectively.

HCFA officials told us that although they do not know the exact number of states involved, the financing arrangements are not limited to the three states we reviewed. Our review of HCFA preliminary data on states' health-care-related taxes shows that 21 states and the District of Columbia had such taxes as of December 31, 1993. Further, in January 1994, PROPAC reported that some states are using financing arrangements involving DSH payments to obtain federal Medicaid funding that is used to supplant state-only spending.

Conclusions

Michigan, Tennessee, and Texas obtained hundreds of millions of dollars in federal matching Medicaid funds through a variety of financial arrangements without effectively contributing their share of funds. Our computation of effective FMAP rates shows that the federal government pays more Medicaid costs than its established formula rate because some providers return increased reimbursements and DSH payments to the states.

The practices in Michigan and Texas that involve DSH payments to state-owned facilities will be restricted by OBRA-93 provisions that limit DSH payments to unreimbursed Medicaid and uninsured costs. However, states can use other financial arrangements to help assure the continuation of their current federal funding levels. States could continue to make DSH payments to local-government-owned facilities and have the facilities return the payments to the states. Further, states can continue to reimburse selected local-government-owned facilities in excess of the cost of specific services and have the facilities return the excess payments. States are not required to justify the need for increased reimbursements, nor is HCFA required to verify that monies are used for the purpose for which they were obtained. Federal Medicaid funds should only be used to help cover the costs of medical care incurred by those medical facilities that provide the care.

Recommendation to the Congress

The Congress should enact legislation to minimize the likelihood that states can develop illusory financing mechanisms whereby providers return Medicaid payments to the states, thus effectively reducing the states' share of Medicaid funding. This legislation should prohibit Medicaid payments that exceed costs to any government-owned facility.

Comments From HCFA and the States

We discussed a draft of this report with HCFA headquarters officials and Michigan, Tennessee, and Texas Medicaid officials. HCFA officials, reacting to the draft report's recommendation that the Congress require the Secretary of Health and Human Services to develop regulations limiting the subject financing mechanisms, suggested that the matter, in their view, would require legislation. State officials said that the report accurately reflects the various funding mechanisms they use and that these mechanisms were in compliance with federal laws. We have incorporated the states' and HCFA's comments where appropriate.

Michigan officials provided additional comments relating to its Medicaid program. They commented that Michigan, like most states, devoted a significant and growing portion of its discretionary revenue to the Medicaid program and that a principal reason for the growth was unfunded federal mandates.[12] They added that should Michigan be denied access to intergovernmental funding sources, it would need to commit nearly 25 percent of its discretionary revenue to subsidize the current Medicaid program, equal to a state funding increase of about $500 million.

Michigan officials also noted that terminating funding for other state programs to support the Medicaid program is highly unlikely; most likely, Medicaid eligibility and services would be severely restricted. Michigan officials do not believe that additional constraints on states' use of Medicaid funds are necessary. However, they added that changes to the federal medical assistance percentage formula should be considered by the Congress. They commented that a prior GAO report suggested alternatives to the current FMAP formula that would provide Michigan with additional federal Medicaid funds.[13]

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to interested congressional committees; the Secretary of Health and Human Services; the Administrator of HCFA; the Medicaid directors in Michigan, Tennessee, and Texas; and other interested parties. We will also make copies available to others upon request.

[12]While these mandates do increase state costs, they are not funded differently than other Medicaid benefits. The federal government pays its share of the increased costs based on FMAP.

[13]Medicaid: Alternatives for Improving the Distribution of Funds to States (GAO/HRD-93-112FS, Aug. 20, 1993)

This report was prepared under the direction of Sarah F. Jaggar, Director, Health Financing and Policy Issues. Please contact Robert F. Hughes, Assistant Director, at (202) 512-7203 or Daniel S. Meyer, Policy Analyst, at (312) 220-7683 if you have any questions about this report. Other contributors to this report include Robert T. Ferschl, Julian P. Klazkin, Alfred R. Schnupp, and Karin A. Van Egmond.

Sincerely yours,

Leslie G. Aronovitz
Associate Director, Health
Financing Issues

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Abbreviations

DISPRO II	Disproportionate Share Program for State-Owned Teaching Hospitals
DSH	disproportionate share hospital
FMAP	federal medical assistance percentage
FY	fiscal year
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OBRA-93	1993 Omnibus Budget Reconciliation Act
PROPAC	Prospective Payment Assessment Commission

States' Financing Practices Effectively Increase the FMAP and Overstate the Total Cost of Medicaid

As described in this report, financing mechanisms used in each of the three states we reviewed effectively increased the federal percentage share of Medicaid medical assistance payments in each state. Although federal Medicaid payments were made according to the federal medical assistance percentage rates, as established by law, our analysis shows that the federal dollars account for a greater share of Medicaid expenditures that ultimately benefited providers in these states. The financial arrangements we have highlighted resulted in providers only receiving a net benefit from Medicaid payments, because they either returned the payments to the state treasury or directed the payments for use in a non-Medicaid program.

In calculating an adjusted FMAP, we reduced total Medicaid expenditures for a state by the dollar amount of Medicaid funds returned to the state treasury. This includes the state's benefit from federal matching funds plus the amount of the state funds that providers returned. We also reduced the total state share of Medicaid expenditures by the same amount because these practices reduced the amount of money the state had to contribute to Medicaid expenditures. We made similar reductions for Medicaid payments that were ultimately used to fund a program for non-Medicaid patients. Using the new figures for total Medicaid medical assistance and the state's contribution, we then recomputed the federal and state shares of total Medicaid medical assistance payments in the state.

As an example, the calculation for Michigan and supporting data for the adjustments follow. Note that the federal contribution percentage of reported fiscal year (FY) 1993 Medicaid expenditures, 56.00 percent, differs slightly from the FY 1993 official FMAP of 55.84 percent. This is because it includes some services that are reimbursed at different rates.

Table I.1: Adjusted FMAP Computation for FY 1993 Medicaid Medical Assistance Expenditures in Michigan (Dollars in millions)

	Total payments	Federal payments	Percent	State payments	Percent
FY 1993 Medicaid medical assistance payments	$4,403	$2,466	56	$1,938	44
Adjustments for Medicaid financing practices	–773	0		–773	
Adjusted FY 1993 Medicaid medical assistance payments	3,630	2,466	68	1,165	32

Table I.2: Adjustment Used in the Adjusted FMAP Computation for Michigan Medicaid Financing Practices in FY 1993 (Dollars in millions)[a]

Description	Increased funding	Net benefit to providers	Funding not kept by providers
Hospital contributions	$458	$6	$452
County medical care	277	6	271
Outpatient services	51	0	51
Total	$786	$12	$773

[a]Totals may not add due to rounding.

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