Memorandum

Date FEB -9 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of the Commonwealth of Pennsylvania's Use of Intergovernmental Transfers to Finance Medicaid Supplementation Payments to County Nursing Facilities (A-03-00-00203)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

Attached are two copies of a final report that presents the results of an Office of Inspector General review of the Commonwealth of Pennsylvania's use of intergovernmental transfers (IGT) to finance enhanced Medicaid payments to county nursing facilities. An IGT represents a transfer of funds from one level of government to another. This is one in a series of reports involving enhanced payments made in six States. At the completion of all the reviews, we will issue a summary report to the Health Care Financing Administration (HCFA) that will consolidate the results of the six States and include additional recommendations addressing enhanced payments financed through the IGT process.

The objectives of our review were to analyze the Pennsylvania Department of Public Welfare's (DPW) use of IGTs to finance enhanced payments to county-owned nursing facilities as part of its compliance with Medicaid upper payment limit regulations, and to evaluate the financial impact of these transfers on the Medicaid program. Under upper payment limit rules, States are permitted to establish payment methodologies that allow for enhanced payments to non-State owned government providers, such as county nursing facilities. In Pennsylvania, these enhanced payments are called supplementation payments. The supplementation payments, which trigger a Federal matching payment, are over and above the regular Medicaid payments made to nursing facilities.

In our opinion, DPW's use of the IGT as part of the supplementation payment program is a financing mechanism designed solely to maximize Federal Medicaid reimbursements without providing either additional funds to the participating county nursing facilities or additional medical services to their Medicaid residents. Under the program, counties obtained bank loans and transferred the borrowed funds to DPW, which immediately transferred the funds back to the counties as Medicaid supplementation payments. The counties used their supplementation payment to pay the bank loans that initiated the transaction. The DPW claimed, received, and kept Federal matching funds based on the supplementation payments. The participating county-owned nursing facilities received no direct supplementation payments for increasing services to Medicaid residents.

During the period State Fiscal Year (SFY) 1992 to SFY 1999, DPW reported $5.5 billion in supplementation payments, none of which was ever paid to participating county nursing facilities. These reported supplementation payments generated $3.1 billion in Federal matching funds without any corresponding increase in services to the Medicaid residents of the participating county nursing facilities. Further, in the last 3 years (SFYs 1997-1999) about 21 percent of the Federal financial participation generated by the IGT transactions was not even budgeted for Medicaid purposes, and another 29 percent remained unbudgeted and available to Pennsylvania for non-Medicaid related use.

The supplementation payments and the Federal match increased significantly over the past several years. The HCFA recognized that more States are starting to adopt aggressive payment methodologies for public providers using the flexibility of the upper payment limit rules and the IGT funding mechanism in order to maximize Federal reimbursement. In response, HCFA proposed regulatory changes aimed at limiting the amount available to State Medicaid programs through enhanced payments to public providers. We estimated that the regulatory changes HCFA proposed would have reduced the amount available for DPW to fund supplementation payments to county-owned nursing facilities from about $1.7 billion to $237 million for SFY 1999, resulting in savings of about $731 million in Federal matching funds and reducing the average supplementation payment from $425.93 to $66.32 per Medicaid resident day.

In our draft report, we recommended that HCFA move as quickly as possible to issue regulatory changes involving the upper payment limit calculations. We also recommended that HCFA take additional action to require that supplementation payments to Pennsylvania's county-owned facilities are based on financial need and paid directly to the targeted nursing facility for direct health care services of its Medicaid residents.

In response to our draft report, HCFA agreed to our recommendation to place a control on the overall funding mechanisms being used by the States. The HCFA noted that it published, on October 10, 2000, proposed regulations to close the loophole in Medicaid regulations that costs Federal taxpayers billions of dollars without commensurate increases in coverage or improvements in the care provided to Medicaid beneficiaries. The HCFA also agreed in principle with our second recommendation to require that supplementation payments be need based and paid directly to the targeted nursing facilities for health care services of Medicaid residents. However, HCFA believed that a new regulation would be required which would force it to divert resources away from its current upper payment limit initiatives.

We commend HCFA for taking action to change the upper payment limit regulations. In December 2000, Congress passed legislation that the President signed, instructing HCFA to implement a transition period for States with plans approved or in effect before October 1, 1992. On January 5, 2001, HCFA finalized revisions to the upper payment limit regulations, and included the transition period passed by Congress. During the transition, the financial

impact of the new regulations will be gradually phased in and become fully effective on October 1, 2008. Pennsylvania is among the States eligible to receive the benefit of this transition period. In Pennsylvania alone, we estimate savings to the Federal Government of $2.4 billion during the transition period. Once the regulatory changes are fully implemented, we estimate additional savings to the Federal Government of $731 million annually, totaling a savings of $3.7 billion over 5 years. We, therefore, recommend that HCFA take action to ensure that Pennsylvania complies with the phase in of the revised regulations.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at 410-786-7104.

To facilitate identification, please refer to Common Identification Number A-03-00-00203 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE COMMONWEALTH OF PENNSYLVANIA'S USE OF INTERGOVERNMENTAL TRANSFERS TO FINANCE MEDICAID SUPPLEMENTATION PAYMENTS TO COUNTY NURSING FACILITIES

Inspector General

JANUARY 2001
A-03-00-00203

Memorandum

Date FEB -9 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of the Commonwealth of Pennsylvania's Use of Intergovernmental Transfers to Finance Medicaid Supplementation Payments to County Nursing Facilities (A-03-00-00203)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

This final report provides the results of our review of the Commonwealth of Pennsylvania's use of intergovernmental transfers (IGT)[1] to finance Medicaid supplementation payments to county nursing facilities. This is one in a series of reports on enhanced payments made in six States. At the completion of all the audits, we will issue a summary report to the Health Care Financing Administration (HCFA) that will consolidate the results of the six States and include additional recommendations addressing enhanced payments financed through the IGT process.

The objectives of our review were to analyze the Pennsylvania Department of Public Welfare's (DPW) use of IGTs to finance enhanced payments to county-owned nursing facilities as part of its compliance with Medicaid upper payment limit regulations and to evaluate the financial impact of these transfers on the Medicaid program. Under upper payment limit rules, States are permitted to establish payment methodologies that allow for enhanced payments to non-State owned government providers, such as county nursing facilities. In Pennsylvania, these enhanced payments are called supplementation payments. The supplementation payments, which trigger a Federal matching payment, are over and above the regular Medicaid payments made to nursing facilities.

In our opinion, DPW's use of the IGT as part of the supplementation payment program is a financing mechanism designed solely to maximize Federal Medicaid reimbursements, thus effectively avoiding the Federal/State matching requirements. These supplementation payments were not provided directly to the participating county-owned nursing facilities for Medicaid residents' medical services.

During the period State Fiscal Year (SFY)[2] 1992 to SFY 1999, DPW, under its IGT program, reported $5.5 billion in supplementation payments, none of which was ever paid

[1]Intergovernmental transfers are fund exchanges among or between different levels of government. For example, a State transfer of money to a county to support primary education constitutes an IGT.
[2]Pennsylvania's fiscal year is July 1 through June 30. The SFY 1992 began July 1, 1992.

directly to participating county nursing facilities. These reported supplementation payments generated $3.1 billion in Federal matching funds without any corresponding increase in services to the Medicaid residents of the participating county nursing facilities. In fact, we noted that of the $1.9 billion generated by the IGT program within the last 3 years of our review period, only 50 percent of the Federal matching funds were budgeted for Medicaid related activities. About $407 million was budgeted for various non-Medicaid health and welfare programs, and $557 million remained unbudgeted and available for other uses. Under the program, counties obtained bank loans and transferred the borrowed funds to DPW, which immediately transferred the funds back to the counties as Medicaid supplementation payments. The counties used their supplementation payments to pay the bank loans that initiated the transactions. The DPW claimed, received, and kept Federal matching funds based on the supplementation payments. The participating county-owned nursing facilities received no direct supplementation payments to increase services to Medicaid residents.

The supplementation payments and the Federal match increased significantly over the past several years. The HCFA recognized that more States are starting to adopt aggressive payment methodologies for public providers using the flexibility of the upper payment limit rules and the IGT funding mechanism in order to maximize Federal reimbursement. In response, HCFA proposed regulatory changes aimed at limiting the amount available to State Medicaid programs through enhanced payments to public providers. We estimated that the regulatory changes HCFA proposed would have reduced the amount available for DPW to fund supplementation payments to county-owned nursing facilities from about $1.7 billion to $237 million for SFY 1999, resulting in savings of about $731 million in Federal matching funds and reducing the average supplementation payment from $425.93 to $66.32 per Medicaid resident day.

In our draft report, we recommended that HCFA move as quickly as possible to issue regulatory changes involving the upper payment limit calculations. We also recommended that HCFA take additional action to ensure that claims for supplementation payments to Pennsylvania's county-owned facilities are based on financial need and paid directly to the targeted nursing facilities for direct health care services for Medicaid residents.

In response to our draft report, HCFA agreed to our recommendation to place a control on the overall funding mechanisms being used by the States. The HCFA noted that it published, on October 10, 2000, proposed regulations to close the loophole in Medicaid regulations that costs Federal taxpayers billions of dollars without commensurate increases in coverage or improvements in the care provided to Medicaid beneficiaries. The HCFA also agreed in principle with our second recommendation to require that supplementation payments be need based and paid directly to the targeted nursing facilities for health care services of Medicaid residents. However, HCFA believed that a new regulation would be required which would force it to divert resources away from its current upper payment limit

initiatives. The HCFA comments to our draft report are included in their entirety in **APPENDIX E.**

We commend HCFA for taking action to change the upper payment limit regulations. However, we believe the transition period applicable to Pennsylvania is excessive. On December 15, 2000, Congress passed legislation that instructed HCFA to implement a transition period for States with plans approved or in effect before October 1, 1992. During the transition, the financial impact of the new regulations will be gradually phased in and become fully effective on October 1, 2008. Pennsylvania is among the States eligible to receive the benefit of this transition period. While we disagree with the need for such an extensive transition, in Pennsylvania alone, we estimate savings to the Federal Government of $2.4 billion during the transition period. Once the regulatory changes are fully implemented, we estimate additional savings to the Federal Government of $731 million annually, totaling a savings of $3.7 billion over 5 years (see **APPENDIX D** for additional details). We, therefore, recommend that HCFA take action to ensure that Pennsylvania complies with the phase in of the revised regulations.

Although no recommendations were directed towards DPW, we requested and received a prompt response from DPW to our draft report. The DPW responded that the IGT program was created with the express authorization and approval of HCFA and Congress to help States offset the costs of unfunded Medicaid mandates. The DPW also believed that a number of factual statements in our draft report were inaccurate.

INTRODUCTION

BACKGROUND

Title XIX of the Social Security Act (Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy people. Each State Medicaid program is administered by the State in accordance with an approved State plan. While the State has considerable flexibility in designing its State plan and operating its Medicaid program, it must comply with Federal requirements. In Pennsylvania, DPW administers the Medicaid program.

The Federal Government and the States share in the cost of the program. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid beneficiaries. The Federal Government pays its share of medical assistance expenditures to a State according to a defined formula. The Federal share of medical cost, referred to as Federal financial participation (FFP), ranges from 50 percent to 83 percent, depending upon each State's relative per capita income. The FFP rate in Pennsylvania is about 54 percent.

The Act requires a State Medicaid plan to meet certain requirements in setting payment amounts. In part, this provision requires that payment for care and services be consistent with efficiency, economy, and quality of care. Essentially, funds are to be used to pay for daily needs of Medicaid recipients in nursing facilities, including medical services, room and board expenses, personnel salaries, etc. This provision also provides authority for specific upper limits set forth in Federal regulations relating to different types of Medicaid covered services. These regulations stipulate that aggregate State payments for each class of service (for example, inpatient hospital services, nursing facility services, etc.) may not exceed a reasonable estimate of the amount the State would have paid under Medicare payment principles. In addition, aggregate payments to each group of State operated facilities may not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles. The FFP is not available for State expenditures that exceed the applicable upper payment limits.

Under upper payment limit rules, States are permitted to establish payment methodologies that allow for enhanced payments to non-State owned government providers, such as county-owned nursing facilities. The enhanced payments are over and above the regular Medicaid payments made to nursing facilities. States are not required to justify to HCFA the details of why these enhanced payments are needed.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objectives of our audit were to analyze the DPW's use of IGTs to finance supplementation payments to county nursing facilities as part of its compliance with Medicaid upper payment limit regulations and to evaluate the financial impact of these transfers on the Medicaid program. Our audit was made in accordance with generally accepted government auditing standards. To accomplish our objectives, we reviewed DPW's use of IGTs as part of their supplementation payment program during SFYs 1997, 1998, and 1999. We interviewed DPW officials and others responsible for the implementation and operation of the supplementation payment and IGT process. These included officials from the offices of long-term care, budget, and controller. We also met with officials of the County Commissioners Association of Pennsylvania (CCAP) to gain their perspective on how supplementation payments were made and how the IGT process worked.

The DPW used a funding pool to determine the amount available to make supplementation payments to county nursing facilities. We reviewed DPW's computation of the IGT funding pool and attempted to track the dollars that were transferred between DPW and county governments. We estimated the financial impact of the DPW's use of IGTs on the Medicaid program as well as the potential impact of HCFA's regulatory changes on the DPW's IGT program.

The documentation we reviewed included: (1) Pennsylvania Medicaid State Plan Amendments (SPA) for payments to nursing facilities; (2) the DPW/CCAP agreement that implemented the IGT process; (3) DPW voucher and revenue transmittals; (4) bank statements and bank transaction forms associated with the IGT activity; (5) county resolutions and/or ordinances authorizing and coordinating the IGT process; and (6) Medicaid cost reports for several county nursing facilities filed with DPW for Calendar Years 1997, 1998, and 1999. The cost reports contained data used in the IGT pool computation. We also obtained HCFA data on DPW's IGT activity in SFYs 1992 through 1996. Our review was conducted in Harrisburg, Pennsylvania between May 2000 and July 2000.

RESULTS OF REVIEW

DPW'S IGT PROGRAM IS DESIGNED SOLELY TO MAXIMIZE FEDERAL FUNDING

DPW generated $3.1 billion in Federal Medicaid matching funds based on $5.5 billion in supplementation payments to county nursing facilities that, in reality, never received these payments. In the last 3 years, at least 21 percent of the FFP was budgeted for non-Medicaid purposes.

The DPW's IGT program, in our opinion, was designed solely to maximize Federal Medicaid reimbursements but did not provide either additional funds to the participating county-owned nursing facilities or additional medical services to the Medicaid residents of these nursing facilities. Since SFY 1992, DPW received $3.1 billion in Federal matching funds based on a reported $5.5 billion in supplementation payments to county nursing facilities, payments that never left the bank that processed the supplementation payment transactions. It is clear that the reported supplementation payments were never directly made to the county nursing facilities that supposedly were to receive these payments for medical services provided to their Medicaid residents. In the last 3 years (SFYs 1997-1999), about 21 percent of the FFP generated by the IGT transactions was not even budgeted for Medicaid purposes, and another 29 percent was unbudgeted and available to Pennsylvania for non-Medicaid related use. The HCFA made regulatory changes that, when fully implemented, will significantly reduce the Federal share generated by supplementation payments. We commend HCFA for issuing these regulatory changes and believe HCFA should consider further action to ensure that supplementation payments intended for specific facilities are retained by these facilities to provide care to their Medicaid residents.

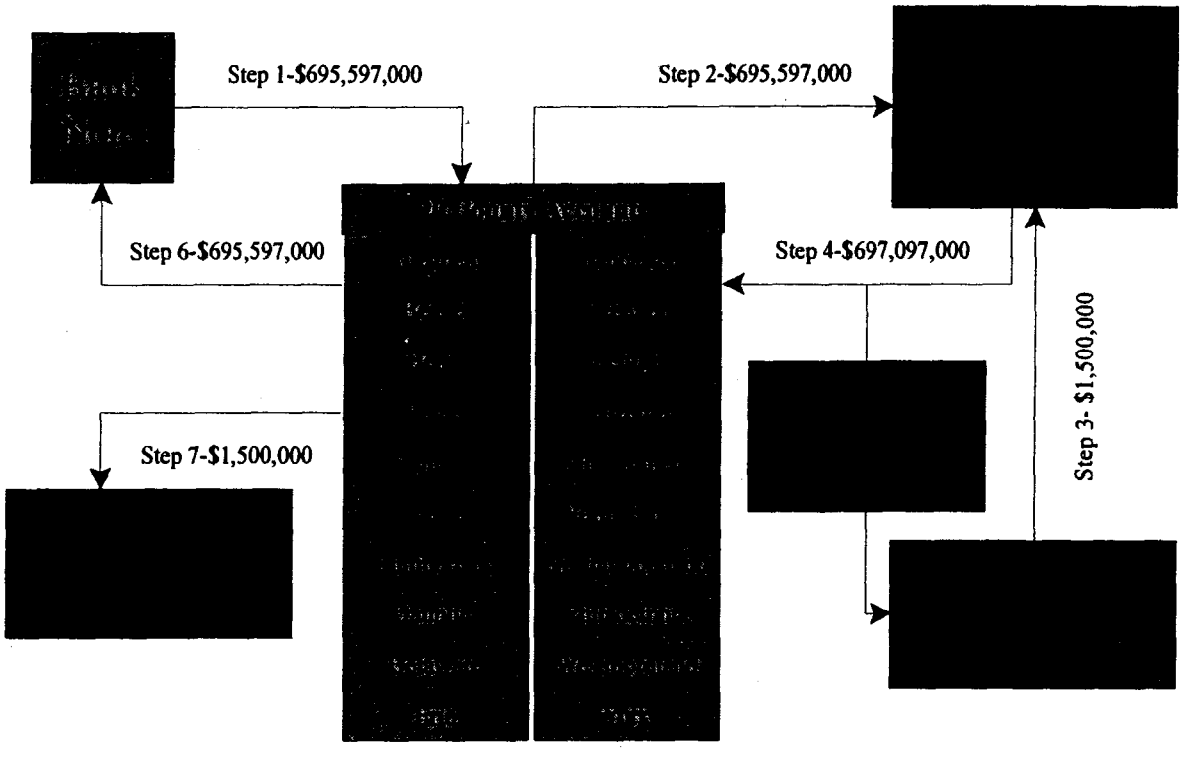
Implementation of the DPW IGT Program

Supplementation payments purportedly for county-owned nursing facilities never left the bank that processed the IGT transactions.

The DPW began the supplementation payment program in the early 1990s. The SPA provided for supplementation payments to county-owned nursing facilities with more than 270 beds if their Medicaid resident days accounted for at least 80 percent of their total resident days. There are 20 counties operating 23 nursing facilities that met the SPA requirements and qualified for supplementation payments. The SPA also specified that supplementation payments were subject to the availability of sufficient county, State, and Federal funds based upon an executed IGT agreement and subsequent transfer of funds. The SPA was updated several times since 1991 but still provides for enhanced payments to county nursing facilities.

As part of the supplementation payment process, each year DPW determined the available funding pool by calculating the amount of Medicaid funds available under the upper limit regulations. It then entered into an agreement with CCAP whereby the counties borrow funds from a single bank (referred to as the transaction bank) using tax and revenue anticipation notes which may be equal to the total amount of the funding pool. The county funds maintained at the transaction bank were then transferred to a DPW bank account, also at the transaction bank, as the initial source to fund the pool. Within 24 hours of receipt, DPW transferred the amount received from the counties, plus a $1.5 million program implementation fee, back to the county bank accounts maintained at the transaction bank as Medicaid supplementation payments for nursing facility services. The counties used the supplementation payments to pay the bank notes. The counties then forwarded the program implementation fee to CCAP. The DPW reported the supplementation payments to HCFA as county nursing facility supplementation payments and claimed FFP. As demonstrated, the reported supplementation payments to the county nursing facilities were not really payments at all. They were merely transfers of funds between county bank accounts and the account maintained by DPW. The transactions were generally completed within one banking day, and except for the $1.5 million program implementation fee, the funds never left the bank that maintained the accounts for DPW and the counties. The chart below illustrates the flow of funds for the most recent IGT transaction of June 14, 2000.

INTERGOVERNMENTAL TRANSFER
JUNE 14, 2000

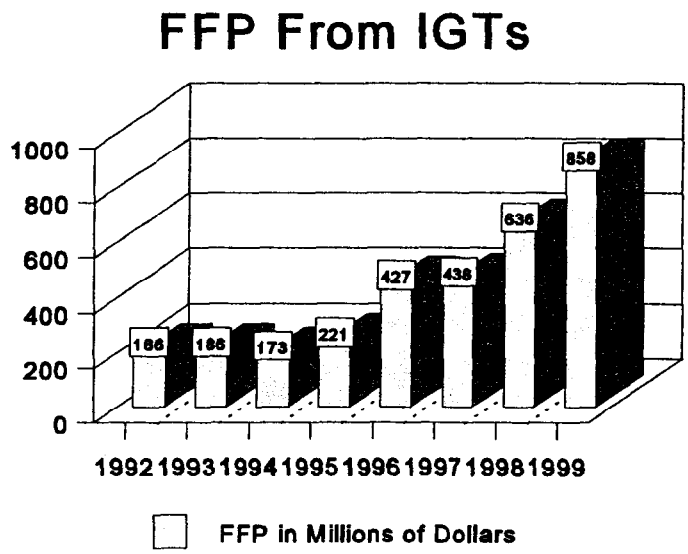


As shown in the illustration, the counties borrowed $695,597,000 (Step 1) and transferred it to the DPW transaction account (Step 2). The DPW added the $1,500,000 transaction implementation fee to the DPW transaction account (Step 3), transferred $697,097,000 as Medicaid supplementation payments to the county bank accounts (Step 4), and claimed $393,342,145 in FFP (Step 5). The counties used the supplementation payments to satisfy the bank loans (Step 6) and transferred the transaction implementation fee to CCAP (Step 7). None of the supplementation payments reached the participating nursing facilities, and the Medicaid residents received no additional services. Pennsylvania retained the entire $393,342,145 in FFP to use as it pleased.

This was the second of two IGT transactions processed in SFY 1999. The first IGT provided for supplementation payments of $823,907,000, generating $464,793,744 in FFP. **APPENDIX A** shows supplementation payments and FFP resulting from IGT activity for SFYs 1992 to 1999.

The Growth of the Supplementation Payment Program and Use of the FFP Generated by It

The supplementation payment program grew significantly in Pennsylvania, and the original FFP generated by this growth was used by DPW to generate additional FFP which, in some cases, was budgeted for non-Medicaid related health activities. Since SFY 1992, the growth in DPW's supplemental payments generated corresponding increases in FFP. For example, the FFP generated from this financing technique doubled from $221 million in SFY 1995 to $438 million in SFY 1997 and nearly doubled again to $858 million in SFY 1999.



The net effect of DPW's IGT financing mechanism was that the Federal Government paid significantly more for the same level of Medicaid services, while the DPW paid significantly less. By first deducting the supplementation payments from DPW's total medical assistance expenditures, we determined that for Federal Fiscal Year (FFY) 2000, the effective FFP matching rate was about 65 percent of total Medicaid expenditures, or 11 percent higher than the 54 percent average FFP rate under the statutory formula **(See APPENDIX B)**.

Regarding how the FFP generated by the supplementation payment program was to be used, DPW entered into an agreement with CCAP that detailed the intended use of the FFP. For the past 3 years, DPW reported supplemental payments to county nursing facilities totaling $3.4 billion, with the Federal share totaling approximately $1.9 billion. The DPW provided us with a schedule showing how it budgeted these Federal matching funds. The DPW budgeted about $968.6 million of the FFP, or about 50 percent, as DPW's State matching share to draw down an additional $1.3 billion in Federal matching funds to pay for various Medicaid health care services. In effect, Federal funds were used to obtain additional funds. The remaining $964.4 million in FFP was budgeted for various non-Medicaid health and welfare programs ($406.9 million, or 21 percent) or remained unbudgeted and available for other uses ($557.5 million, or 29 percent). **APPENDIX C** shows the budgeted uses for FFP generated from IGT activity for SFYs 1997 to 1999.

Since the inception of the Medicaid program, the fiscal responsibility and integrity of the program were to be shared by the Federal and State governments. However, even though some of the FFP received on the supplementation payments might have been used for health

care purposes, the funds consist of only Federal dollars. Thus, the use of the funds for an otherwise worthwhile health care purpose resulted in a wholly Federal-funded activity rather than the shared Federal/State activity intended by the Medicaid program.

HCFA's Regulatory Change to the Upper Payment Limit Rule

HCFA's regulatory changes would have saved $731 million of FFP in SFY 1999.

The HCFA has taken action to change the upper payment limit regulations which, when fully implemented, will significantly reduce DPW's funding pool and, correspondingly, decrease the FFP generated by it. However, we believe HCFA should consider further steps to ensure that supplementation payments are actually retained by the facility for which they were intended.

The DPW determined the available funding pool for supplementation payments by calculating the amount of Medicaid funds available under upper payment limit regulations. These regulations specified that aggregate State payments for each class of services--in this case, nursing facility services--may not exceed a reasonable estimate of the amount the State would have paid under Medicare payment principles. First, DPW estimated the amount it would have incurred under Medicare payment principles related to skilled nursing facilities. Next, it determined how much it paid in regular Medicaid nursing facility payments. The difference between these two amounts represented the potential funding pool for supplementation payments to county nursing facilities. The funding pool represented the maximum amount that may be used for enhanced supplementation payments (over and above regular nursing facility payments) to nursing facilities without exceeding upper payment limit regulations.

The HCFA allowed the States to determine how their specific nursing facility enhanced payments were to be calculated for purposes of determining upper payment limit related funding pools. The DPW computed its funding pool by multiplying the annual medical assistance days per facility by the difference between Medicare and Medicaid per diem rates. The DPW's funding pool calculation was based on 604 nursing facilities in SFY 1997, 627 in SFY 1998, and 670 in SFY 1999.

The HCFA has taken action to make regulatory changes that would require States to modify which facilities are a part of specific categories against which the upper payment limit rule would be applied. The upper payment limits would continue to be based on Medicare skilled nursing facility payment principles. From discussions with HCFA officials, we determined that the effect on DPW's program would be to reduce the pool of nursing facilities from 670 to 41. Currently there are 41 county-owned nursing facilities in Pennsylvania, of which 23 qualify for supplementation payments.

We recalculated DPW's IGT pool for SFY 1999 limiting the nursing facilities to the 41 county-owned facilities. We determined that the regulatory changes would have reduced DPW's funding pool from about $1.7 billion to $237 million for SFY 1999. The change would limit FFP to about $127 million per year if DPW made supplementation payments equal to the IGT pool. This represents a reduction of $731 million in FFP from the $858 million in FFP claimed for SFY 1999.

We also estimated the effect of HCFA's regulation changes to DPW's supplementation payment program on a per diem basis. For SFY 1999, the regular Medicaid payments to the 23 participating county-owned nursing facilities averaged $146.59 per Medicaid resident day. The supplementation payments (over and above the regular Medicaid payments) averaged $425.93 per Medicaid resident day. The regulatory changes would reduce the average supplementation payment to $66.32 per Medicaid resident day, a reduction of $359.61.

Based on HCFA's fully implemented revisions to the upper payment limit rules, DPW's supplementation payment program would continue to generate about $127 million of FFP every year. We believe that this amount remains excessive considering that supplementation payments are not based on need, the funds are not paid to the targeted county-owned nursing facilities, and the Medicaid residents receive no additional benefits. In addition, DPW would still be able to use Federal funds to obtain additional Federal funds without a joint Federal/State expenditure.

CONCLUSION AND RECOMMENDATIONS

Our review found that DPW's supplementation payment program was a financing mechanism designed to maximize Federal Medicaid reimbursements without providing either additional funds to the participating county-owned nursing facilities or additional medical services to the Medicaid residents of these nursing facilities. Since SFY 1992, DPW reported to HCFA $5.5 billion in supplementation payments to county-owned nursing facilities, payments that never left the bank that processed the IGT supplementation transactions. The reported supplementation payments were never directly made to the county nursing facilities that supposedly receive these payments for medical services provided to their Medicaid residents. The DPW received $3.1 billion in FFP for the supplemental payments that were never received by the nursing facilities. Further, in the last 3 years (SFYs 1997-1999), about 21 percent of the FFP generated by the IGT transactions was not even budgeted for Medicaid purposes, and another 29 percent remained unbudgeted and available to Pennsylvania for non-Medicaid related use.

The supplementation payments and the Federal match increased significantly over the past several years. The DPW's supplementation payment program generated $858 million in FFP during SFY 1999. Based on fully implemented revisions in the calculation of the upper payment limit rule, the FFP received by DPW would have dropped from $858 million in

SFY 1999 to about $127 million, a savings to the Federal Government of $731 million and a reduction of the average supplementation payment from $425.93 to $66.32 per Medicaid resident day.

Once the upper payment limit revisions are fully implemented, the DPW will continue to receive about $127 million per year in FFP generated by the supplementation payments. This continues to be excessive considering supplementation payments are neither based on need nor paid to the county-owned nursing facilities. The FFP generated by these payments could be budgeted for non-Medicaid related activities.

In our draft report, we recommended that HCFA move as quickly as possible to issue regulatory changes involving the upper payment limit calculations. We are pleased to note that HCFA has taken action to change the upper payment limit regulations. However, we believe the transition period applicable to Pennsylvania is excessive. On December 15, 2000, Congress passed legislation that instructed HCFA to implement a transition period for States with plans approved or in effect before October 1, 1992. During the transition, the financial impact of the new regulations will be gradually phased in and become fully effective on October 1, 2008. Pennsylvania is among the States eligible to receive the benefit of this transition period. While we disagree with the need for such an extensive transition, in Pennsylvania alone, we estimate savings to the Federal Government of $2.4 billion during the transition period. Once the regulatory changes are fully implemented, we estimate additional savings to the Federal Government of $731 million annually, totaling a savings of $3.7 billion over 5 years (see **APPENDIX D** for additional details). We, therefore, recommend that HCFA take action to ensure that Pennsylvania complies with the phase in of the revised regulations.

We continue to recommend that HCFA take additional action to require that claims for supplementation payments to Pennsylvania's county-owned facilities be based on financial need and paid directly to the targeted nursing facilities for direct health care services for Medicaid residents.

HCFA Comments

In its general comments to our draft report, HCFA noted that it received a number of proposals from States that target payment increases to county nursing facilities. These excessive payments raise serious and troubling policy considerations. The practice appears to be creating a rapid increase in Federal Medicaid spending with no commensurate increase in Medicaid coverage, quality, or amount of services provided to Medicaid beneficiaries. While States claim these payment expenditures are for Medicaid nursing facility services furnished to an eligible individual, these payments may ultimately be used for a number of purposes, both health care and non-health care related. In many cases, IGTs are used to finance these payments.

With respect to our specific recommendations, HCFA agreed to place a control on the overall funding mechanisms being used by the States. The HCFA noted that it published, on October 10, 2000, proposed regulations to close the loophole in Medicaid regulations that costs Federal taxpayers billions of dollars without commensurate increases in coverage or improvements in the care provided to Medicaid beneficiaries. The proposed regulation, which included a gradual transition policy[3], would create a new reimbursement limit for local government providers, and in the case of outpatient hospital services and clinic services, an additional upper limit for State-operated facilities. The HCFA believed that the proposed change would significantly reduce the amount of excessive payments that can and are being paid under the current upper payment limit regulations.

The HCFA also agreed in principle with our second recommendation to require that supplementation payments be need based and paid directly to the targeted nursing facilities for health care services of Medicaid residents. However, HCFA believed that a new regulation would be required which would force it to divert resources away from its current upper payment limit initiatives. The HCFA comments to our draft report are included in their entirety in **APPENDIX E**.

OIG Comments

We commend HCFA for taking action to control these costly financing mechanisms used by States to maximize Federal Medicaid reimbursements. However, the regulations limit but do not end this practice. When HCFA's changes to the upper payment limit rules become fully implemented, DPW's supplementation payment program would continue to generate at least $127 million each year in excessive Federal Medicaid reimbursements. These reimbursements result from a financing mechanism that does not provide either additional funds to the participating county-owned nursing facilities or additional medical services to the Medicaid residents of these nursing facilities. Moreover, the Federal funds derived from these financing methods may continue to be used for non-Medicaid purposes.

Therefore, we believe that HCFA should take the necessary action to implement our recommendation to require that claims for supplementation payments to Pennsylvania's county-owned facilities be based on financial need and paid directly to the targeted nursing facilities for direct health care services for their Medicaid residents.

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[3]For States with approved SPAs before October 1, 1999, HCFA is proposing a 3-year transition period beginning in the SFY that begins in Calendar Year 2002. In effect, HCFA's proposal would result in a 5-year transition period except for those States with SPAs approved after October 1, 1999 which would have a transition period ending September 30, 2002. In addition, Congress passed legislation instructing HCFA to implement an 8-year transition period for States with plans approved or in effect before October 1, 1992. Pennsylvania is among the States receiving the benefit of the longer transition period.

DPW Comments

Although no recommendations were directed towards DPW, we requested and received a prompt response from DPW to our draft report. The DPW responded that the IGT program was created with the express authorization and approval of HCFA and Congress to help States offset the costs of unfunded Medicaid mandates. The DPW cited expansion of long-term care services for the elderly, the Early Periodic Screening, Diagnosis and Treatment Program for children, and the Medicaid managed care patient bill of rights as specific examples of unfunded Medicaid mandates. The DPW added that the reason that neither Congress nor HCFA acted to limit IGTs was that all parties recognize that it was unfair to withdraw this source of relief to the States without addressing the larger problem of how to fund the expanding list of Federal mandates imposed on States through Medicaid legislation.

The DPW also believed that a number of factual statements in our draft report were inaccurate. The DPW presented a detailed critique of our description of its IGT process. It argued that the account into which the program supplementation payment was made was the one designated by the county nursing facility, therefore, DPW did make a payment to the participating nursing facility. The DPW added that Federal law allows providers to use Medicaid payments in any manner they choose. Referring to its latest IGT transaction (described on pages 6 and 7), the DPW disagreed with our statement that, "Pennsylvania retained the entire $393,342,145 in FFP to use as it pleased." The DPW contended that it retained approximately $393 million in county-provided funds, not $393 million in FFP. The DPW, in a footnote, said it was merely using the term "county-provided funds" to distinguish these funds from Federal funds. The "county-provided funds" are, in fact, funds in the State Treasury and, therefore are "State funds" for the purpose of the IGT transaction. The DPW stated that the $393 million in FFP was included in the $697 million supplementation payment. Therefore, the DPW contended that our statements concerning the uses of Federal funds were incorrect.

Additional OIG Comments

The DPW in its response did not provide any additional information that would cause us to change our findings and recommendations. The DPW's comment that the IGT program was implemented to help pay for unfunded Federal Medicaid mandates was contrary to its HCFA approved SPA which stated that DPW would pay supplementation payments to county nursing facilities. The SPA made no mention of using Federal matching funds to offset the costs of unfunded Federal Medicaid mandates. In addition, our review found that during the last 3 years DPW's IGT program generated $1.9 billion in FFP. The DPW provided us with a schedule showing how it budgeted these Federal matching funds. The DPW budgeted about $968.6 million of the FFP, or about 50 percent, as DPW's State matching share to draw down an additional $1.3 billion in Federal matching funds to pay for various Medicaid health care services. In effect, Federal funds were used as the State's share to obtain additional Federal funds. The remaining $964.4 million in FFP was budgeted for various

non-Medicaid health and welfare programs ($406.9 million, or 21 percent) or remained unbudgeted and available for other uses ($557.5 million, or 29 percent). The DPW's schedule did not identify any of the programs as unfunded Federal Medicaid mandates.

We strongly disagree with DPW's criticism of our description of its IGT financing mechanism. We believe that DPW's argument was a matter of semantics. We clearly and accurately described the circle of transactions involved in this financing mechanism which allow DPW to get Federal matching funds and effectively avoid Medicaid's State matching requirement.

Also, DPW's contention that the supplementation payments reached the nursing facilities was not correct. The DPW provided no documentation to prove that the participating nursing facilities own, control, or had access to the county bank accounts used in the IGT transactions. In fact, DPW's agreement with CCAP specified that the county bank accounts maintained at the transaction bank shall be used solely and exclusively for IGT undertakings. The agreement went on to state that upon payment of the supplementation payment into the county bank account, the county must take all actions necessary to assure that the bank loan was repaid and the implementation fee was paid to CCAP. These two payments consume the entire supplementation payment and there were no funds remaining for distribution to the participating nursing facilities.

APPENDIX A

PENNSYLVANIA NURSING FACILITY
SUPPLEMENTATION PAYMENTS
SFYs 1992 - 1999

State Fiscal Year	Supplementation Payments	State Share
1999	$1,521,004,000	$858,135,889
1998	$1,128,818,000	$636,385,542
1997	$783,011,000	$438,487,474
Total SFYs 1997-1999	$3,432,833,000	$1,933,008,905
1996	$769,114,996	$426,582,090
1995	$397,144,466	$220,514,302
1994	$304,071,438	$172,927,545
1993	$323,596,000	$185,686,355
1992	$320,676,000	$186,200,700
Total SFYs 1992-1996	$2,114,602,900	$1,191,911,992
Total SFYs 1992-1999	$5,547,435,900	$3,124,920,897

[4]The 1992 through 1996 figures were provided by HCFA.

APPENDIX B

COMMONWEALTH OF PENNSYLVANIA
EFFECTIVE FFP RATE
FEDERAL FISCAL YEAR 2000

Form HCFA-64, Quarterly Report of Expenditures
Line 30, Total Current Expenditures

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1st Qtr	$1,270,070,140	$2,358,940,341	53.84%	$215,952,118	$2,142,988,223	59.27%
2nd Qtr	$1,242,560,070	$2,307,884,460	53.84%	$215,952,118	$2,091,932,342	59.40%
3rd Qtr	$1,695,427,778	$3,149,153,782	53.84%	$946,799,658	$2,202,354,124	76.98%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

[5]Expenditures for first three quarters of FFY October 1999 through June 2000. Pennsylvania's fiscal year began July 1, 1999.

PENNSYLVANIA'S PLANNED BUDGET FOR THE USE OF THE FEDERAL PORTION OF SUPPLEMENTATION PAYMENTS

	[illegible]	[illegible]	[illegible]
Medicaid Services Eligible for FFP	$968,593,000	$1,120,618,000	$2,089,211,000
State Only Programs Not Eligible for FFP	$406,926,000	$0	$406,926,000
Unallocated Funds	$557,489,905	$194,961,000	$752,450,905
[illegible]	[illegible]	[illegible]	[illegible]

[1]Original Federal money received from supplementation payments that is now being used as the State share for the identified services.

[2]New Federal funds resulting from the use of the original Federal share of the supplementation payments, where applicable.

[3]Total State Budget plan for the identified services which consist of only Federal funds.

PENNSYLVANIA'S PLANNED BUDGET FOR THE USE OF THE FEDERAL PORTION OF SUPPLEMENTATION PAYMENTS FOR MEDICAID SERVICES

[illegible]	[illegible]	[illegible]	[illegible]
Regular Medical Assistance Payments to County Nursing Facilities	$745,170,000	$862,761,000	$1,607,931,000
Aging Services	$62,180,000	$71,779,000	$133,959,000
DPW Litigation - DME Supplies in Nursing Facilities	$44,163,000	$51,170,000	$95,333,000
Disproportionate Share Incentive Payments	$24,235,000	$28,158,000	$52,393,000
Nursing Facility Transition Payments	$19,379,000	$22,311,000	$41,690,000
Services for Disabled	$17,568,000	$20,300,000	$37,868,000
Alternate Long-Term Care Services	$16,186,000	$18,695,000	$34,881,000
Home and Community Based Services	$15,455,000	$17,318,000	$32,773,000
Managed Care Demonstration Project	$15,022,000	$17,469,000	$32,491,000
Supplemental Home & County Based Waiver	$5,372,000	$6,235,000	$11,607,000
Contracts/EDP Costs	$3,863,000	$4,422,000	$8,285,000
[illegible]	[illegible]	[illegible]	[illegible]

[1]Original Federal money received from supplementation payments that is now being used as the State share for the identified services.

[2]New Federal funds resulting from the use of the original Federal share of the supplementation payments, where applicable.

[3]Total State Budget plan for the identified services which consist of only Federal funds.

PENNSYLVANIA'S PLANNED BUDGET FOR THE USE OF THE FEDERAL PORTION OF SUPPLEMENTATION PAYMENTS FOR STATE ONLY PROGRAMS NOT ELIGIBLE FOR FFP

[illegible]	[illegible]	[illegible]	[illegible]
10% County Share Medical Assistance Payments to Nursing Facilities	$216,286,000	$0	$216,286,000
SSI Domestic Care Payment Support	$80,955,000	$0	$80,955,000
Behavioral Health Services Payments	$46,214,000	$0	$46,214,000
Additional Payments to Certain Nursing Facilities	$14,600,000	$0	$14,600,000
Community Mental Health/Mental Retardation Services	$14,249,000	$0	$14,249,000
Contracts/EDP Costs	$8,559,000	$0	$8,559,000
Program Implementation Fee	$7,500,000	$0	$7,500,000
Final Hospital Cost Settlements	$6,400,000	$0	$6,400,000
County Invoicing Fees	$4,063,000	$0	$4,063,000
Substance Abuse Research	$2,600,000	$0	$2,600,000
Managed Care Risk Pool	$2,500,000	$0	$2,500,000
Home Modification Program	$2,000,000	$0	$2,000,000
County Nursing Facility Case-Mix Rate Payments	$1,000,000	$0	$1,000,000
[illegible]	[illegible]	[illegible]	[illegible]

[1]Original Federal money received from supplementation payments that is now being used as the State share for the identified services.

[2]New Federal funds resulting from the use of the original Federal share of the supplementation payments, where applicable.

[3]Total State Budget plan for the identified services which consist of only Federal funds.

PENNSYLVANIA'S PLANNED BUDGET FOR THE USE OF THE FEDERAL PORTION OF SUPPLEMENTATION PAYMENTS FOR UNALLOCATED FUNDS

To be Allocated for Medicaid Programs in SFY 1999	$167,370,000	$194,961,000	$362,331,000
To be Allocated for State Programs in SFY 1999 (Not Medicaid Approved)	$261,721,000	$0	$261,721,000
To be Allocated for County Programs in SFY 1999 (Not Medicaid Approved)	$37,954,000	$0	$37,954,000
Not Budgeted	$90,444,905	$0	$90,444,905
[illegible]	[illegible]	[illegible]	[illegible]

[1]Original Federal money received from supplementation payments that is now being used as the State share for the identified services.

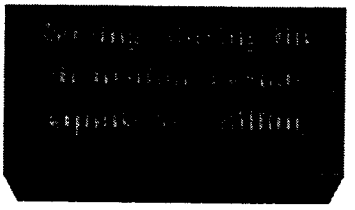
[2]New Federal funds resulting from the use of the original Federal share of the supplementation payments, where applicable.

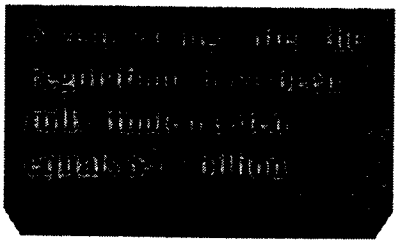
[3]Total State Budget plan for the identified services which consist of only Federal funds.

APPENDIX D

SCHEDULE OF FEDERAL SAVINGS IN PENNSYLVANIA BASED ON IMPLEMENTATION OF REVISED UPPER PAYMENT LIMIT REGULATIONS (INCLUDING TRANSITION PERIOD)

State Fiscal Year	Fiscal Period	Federal Savings
2000	07/01/00 - 06/30/01	$ 0
2001	07/01/01 - 06/30/02	0
2002	07/01/02 - 06/30/03	0
2003	07/01/03 - 06/30/04	110
2004	07/01/04 - 06/30/05	219
2005	07/01/05 - 06/30/06	329
2006	07/01/06 - 06/30/07	439
2007	07/01/07 - 06/30/08	548
2008	07/01/08 - 06/30/09	713
2009	07/01/09 - 06/30/10	731
2010	07/01/10 - 06/30/11	731
2011	07/01/11 - 06/30/12	731
2012	07/01/12 - 06/30/13	731
2013	07/01/13 - 06/30/14	731





DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

IG ✓
EAIG
PDIG ✓
DIG-AS ✓
DIG-EI
DIG-OI
DIG-MP
OCIG
ExecSec ✓
~~Date~~ Sent 11-9

DATE: NOV - 7 2000

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Acting Administrator

Michael M. Hash

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of the Commonwealth of Pennsylvania's Use of Intergovernmental Transfers (IGTs) to Finance Medicaid Supplementation Payments to County Nursing Facilities," (A-03-00-00203)

Thank you for the opportunity to review and comment on the above-referenced draft report. We appreciate the work OIG is doing in this area. The information that OIG has provided in this draft report is very useful to us as we develop new Medicaid payment policies.

Under current Medicaid requirements, States have considerable flexibility in setting payment rates for nursing facility services. States are permitted to pay in the aggregate up to a reasonable estimate of the amount that would have been paid using Medicare payment principles. This payment restriction is commonly referred to as the Medicare upper payment limit (UPL). This UPL permits States to set higher rates for services furnished in public facilities.

Within the last year, the Health Care Financing Administration (HCFA) has received a number of proposals from States that target payment increases to county and or municipal nursing facilities. The amount of payment is not directly related to cost of services furnished by the facilities, but on the aggregate difference between Medicaid payments and the maximum amount allowed under the Medicare UPL. While these types of proposals fit within current rules, HCFA became concerned when our review found that payments to individual public facilities were excessive, often many times higher than the rate paid private facilities or above the cost incurred by the public facility.

These excessive payments raise serious and troubling policy considerations. The practice appears to be creating a rapid increase in Federal Medicaid spending with no commensurate increase in Medicaid coverage, quality, or amount of services provided to Medicaid beneficiaries. While States claim these payment expenditures are for Medicaid

nursing facility services furnished to an eligible individual, these payments may ultimately be used for a number of purposes, both health care and non-health care related. In many cases, IGTs are used to finance these payments.

Earlier this month, we proposed regulations to close the loophole in Medicaid regulations that costs Federal taxpayers billions of dollars without commensurate increases in coverage or improvements in the care provided to Medicaid beneficiaries. The proposed regulation would revise Medicaid's "upper payment limit" rules, stopping States from using certain accounting techniques to inappropriately obtain extra Federal Medicaid matching funds that are not necessarily spent on health care services for Medicaid beneficiaries. The changes would be phased in to allow States time to adjust their Medicaid programs to meet the new requirements. In addition, the proposal also allows a continued higher limit on payments for public hospitals in recognition of their critical role in serving low-income patients.

We appreciate the effort that went into this report and the opportunity to comment on the issues raised. Our detailed comments on the OIG's recommendations follow.

OIG Recommendation

HCFA should take quick action to place a control on the overall financing mechanisms being used by States to circumvent the Medicaid program requirement that expenditures be a shared Federal/State responsibility.

HCFA Response

We concur. The Department published a Notice of Proposed Rulemaking (NPRM) on October 10. In July, we issued a letter to State Medicaid Directors outlining our concerns and informing them of our intent to issue the NPRM. The NPRM invited public comment on our proposal to preclude States from aggregating payments across private and public facilities. The proposed regulation would create a new reimbursement limit for local government providers, and in the case of outpatient hospital services and clinic services, an additional upper limit for State-operated facilities. This change would significantly reduce the amount of excessive payments that can and are being paid under the current UPL regulations.

To help States that have relied on UPL financing arrangements, our proposal includes a gradual transition policy. Recognizing the need to preserve access by Medicaid beneficiaries to public hospitals, we also included provisions to ensure adequate reimbursement rates for such facilities. We have solicited comments on our proposed changes to the UPL policy, as well as the transition provisions, and we are open to other courses of action that will accomplish the same goals set out in the proposed rule.

OIG Recommendation

Pending the national improvements expected through regulatory action, OIG recommends that HCFA take additional action to require that claims for supplementation payments to county owned facilities be based on financial need and paid directly to the targeted nursing facilities for direct health care services for Medicaid residents.

HCFA Response

While we concur in principle with this recommendation, outside of the regulatory process itself we believe we lack the authority to require States to make payments that are reflective of a facility's financial need with respect to services furnished to Medicaid residents. Having to promulgate a new regulation at this time would force us to divert resources away from our current UPL reform initiatives. However, as we indicate above, we are open to other courses of action and will give further consideration to this recommendation, but we believe our current proposal will most immediately curtail excessive spending.