

Testimony of:
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Good morning Mr. Chairman and Members of the Committee. I am here today to discuss States' use of financing mechanisms to shift the cost of Medicaid to the Federal Government, contrary to statutory Federal and State sharing formulas. In particular, I will discuss how States use their intergovernmental transfer (IGT) authority with regard to certain enhanced payments and the negative implications such transfers may have for the quality of care for Medicaid beneficiaries residing in local public nursing facilities. I will describe how States divert funds away from their original purpose once the Federal share is received, leaving poorly performing public nursing facilities under-funded. Then, referencing previous audits, I will summarize some problems we uncovered over the years with respect to tax and donation programs and disproportionate share hospital payments. Finally, I will discuss some concerns emerging from our recent work in other Medicaid benefit areas and outline some accountability issues and basic principles to be followed in ensuring the financial integrity of the program.

We have found that current policies and practices severely limit the ability of Congress, the Department of Health and Human Services, and State and local governments to manage, account for, and assess the benefits of Medicaid dollars. Some financing mechanisms are designed solely to maximize Federal reimbursements to States, contrary to Federal and State cost-sharing principles, and serve to disguise the source and final use of both Federal and State funds.

THE MEDICAID FEDERAL/STATE PARTNERSHIP

Since the inception of the Medicaid program, the Federal Government and the States have shared in the cost of the program. Each State Medicaid program is administered by the State in accordance with a State plan approved by the Centers for Medicare & Medicaid Services (CMS). While the States have considerable flexibility in designing their State plans and operating their Medicaid programs, they must comply with broad Federal requirements. The Federal Government pays its share of medical assistance expenditures to the States according to a defined formula, which yields the Federal medical assistance percentage (FMAP). The FMAP can range from 50 percent to 83 percent, depending on each State's relative per capita income. My testimony deals with practices that circumvent these Federal/State matching requirements and cause the Federal Government to pay disproportionately more, without a corresponding benefit to the intended beneficiaries.

ENHANCED PAYMENTS UNDER UPPER PAYMENT LIMIT RULES

Intergovernmental transfers are transfers of non-federal public funds between State and/or local public Medicaid providers and the State Medicaid agency. This is the most common

method we have noted by which States divert funds from an intended purpose after drawing down the Federal share of the benefit.

States' use of IGTs to divert funds has the following consequences: a State's share of its Medicaid program inappropriately declines; Federal taxpayers pay more than their statutory share; and the increased Federal Medicaid funding derived from these financing mechanisms becomes comingled in general revenue accounts, where it can be used for purposes unrelated to Medicaid, including as the State's match to draw down more Federal dollars for Medicaid and other federally matched grant programs.

I would like to point out that there is virtually no need for a State to transfer funds to be used for another Medicaid purpose because States can simply claim Federal funding for any valid Medicaid expenditure. States have the option of managing their Medicaid transactions in ways that are straightforward and auditable. Generally, accountability is lost at the point that Medicaid funds are transferred into general revenue accounts, thereby placing the funds at risk of misuse.

The most conspicuous use of the IGT mechanism in recent years has centered on enhanced payments available under upper payment limit (UPL) rules. The UPL is an estimate of the maximum amount that would be paid to a category of Medicaid providers (usually hospitals and nursing homes) under Medicare payment principles. The difference between the State's reimbursement rate and the UPL is called an enhanced payment. Generally, State payments that exceed UPLs do not qualify for Federal matching funds. In short, the States' use of IGTs as part of the UPL enhanced payment program has been primarily a financing mechanism designed to maximize the Federal share of Medicaid while effectively avoiding the Federal/State matching requirements.

Medicaid regulations allow State Medicaid agencies to pay different rates to the same class of providers as long as the payments, in aggregate, do not exceed what Medicare would pay for the services. Before new regulations took effect on March 13, 2001, State Medicaid agencies were able to calculate the total enhanced payment amount (the difference between the regular Medicaid payment and the Medicare payment amount for a similar service) on the basis of the aggregate of all private, State-operated, and city- or county-operated facilities. The entire amount could then be distributed to only city- and county-owned facilities. The State could even direct the entire amount to only one such facility if it chose to do so. The results of OIG audits demonstrated that billions of dollars were at risk and would continue to be at risk in the future unless substantive changes were made in the program.

In accordance with our early findings and with the Benefits Improvement and Protection Act of 2000, CMS issued a final rule in 2001, which modified the UPL regulations. The regulatory action created three aggregate upper payment limits—one each for private, State, and non-State government-operated facilities. The creation of a separate aggregate payment limit for non-State government-owned facilities effectively reduces the amount of funds that States can gain by requiring public providers to return Medicaid payments through IGTs. The new regulations are being phased in gradually and will become fully effective on October 1, 2008.

When fully implemented, these changes will dramatically limit this State manipulation of the Medicaid program. However, the changes will not entirely eliminate this problem because the regulation still does not require that the enhanced funds be retained by the targeted facilities to provide covered services to Medicaid beneficiaries. Thus, States continue to divert enhanced payments to other purposes.

STATES' USE OF IGTs: EFFECT ON NURSING FACILITIES

Some of our recent audits have explored States' use of IGTs in which some or all of the Medicaid funds that were directed to local public nursing facilities as enhanced payments made under UPL rules were returned to the States instead of being retained at the facilities for the care of patients. The Medicaid funding for such facilities is composed of per diem payments and enhanced payments. When the State's per diem rate is less than the UPL, some States provide enhanced payments to make up all or a portion of the difference.

In the sections that follow, I will describe the results of audits covering various 3-year periods ending in 2001 or 2002. Although the audit periods in some cases included enhanced payments made both before and after the new regulations, the new rules continue to allow States to require providers to return their Medicaid enhanced funds to the State. The nursing facilities were selected for review because State survey and certification reviewers had identified them as having serious deficiencies in patient care. Our objectives were to ascertain whether Medicaid payments to the nursing facilities were adequate to cover their operating costs and whether a link could be drawn between the quality of care of patients and the amount of Medicaid funding received.

In every case, we found that the gross Medicaid per diem and enhanced payments were sufficient to cover operating costs, but the net payments were not. The nursing facilities were all required to return substantial portions of their enhanced payments to the States to be used for other purposes. As a result, the facilities were under funded. We believe this under funding had a negative impact on quality of care. In all four reports, we recommended that the State allow the facility administrators to retain sufficient funding to cover the costs of providing an adequate level of care to its residents.

Generally, once the payments that had been directed to these facilities for patient care were returned to the States, the States were able to use the funds for any purpose, including to draw down new Federal matching funds for Medicaid or other Federal programs.

State of New York: Albany County Nursing Home¹

The Medicaid combined per diem and enhanced payments made to Albany County Nursing Home in New York for our 3-year audit period were more than adequate to cover its operating costs. However, after the nursing home returned 90 percent of its enhanced funds to the county and State, the net Medicaid payment retained by the facility was \$22 million less than the facility's total Medicaid operating costs for the period.

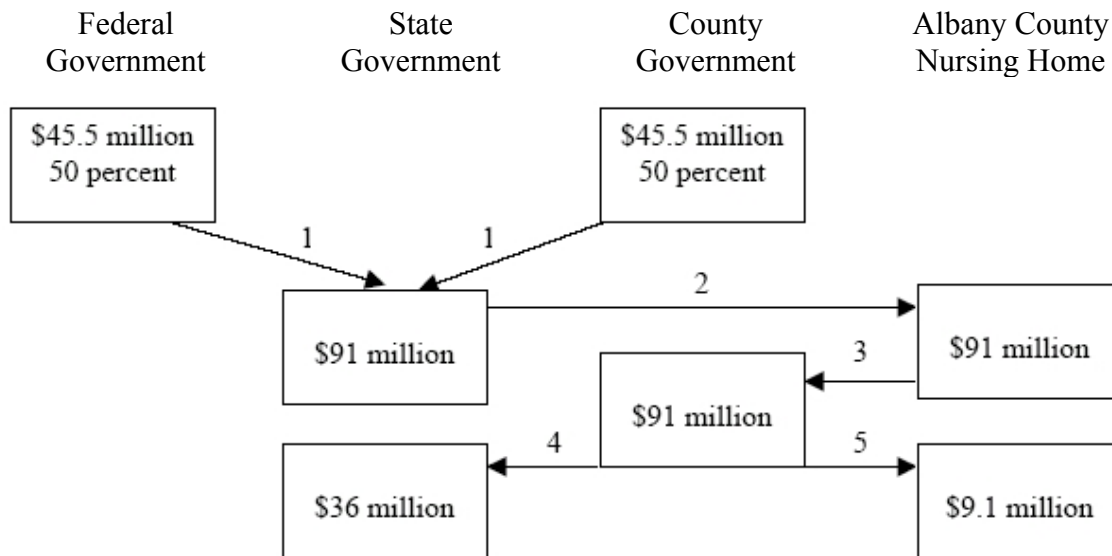
¹ Report A-02-02-01020

This diversion of funds took place despite the fact that the nursing home had received an immediate jeopardy rating from the State Department of Health. An immediate jeopardy rating is the most unfavorable rating that can be issued. The net Medicaid funding fell short of operating costs, and the nursing home did not fill all of its nursing positions. This condition may have affected the quality of care provided to its residents. During our audit period, the nursing home was significantly understaffed compared to the minimum number of positions specified in its budget.

Of the \$132 million total payments made to the facility during the period we reviewed, \$91 million was from UPL enhanced payments. In New York, the State's agreement with the counties only allowed the counties' nursing homes to retain 10 percent of the UPL enhanced payments that were designated for them. After a trail of transactions, the nursing home retained only \$9.1 million of its \$91 million in enhanced payments, as illustrated in the following chart:

Flow of Medicaid Funds to/from Albany County Nursing Home

Amounts shown are rounded.



1. Drawdowns by State from Federal Government and county to holding account.
2. State payment to county nursing home operating bank account.
3. County transfer from nursing home operating account to county general fund.
4. State withdrawal from county general fund.
5. Amount designated through county budget for nursing home

Note: The chart represents the totals of funds that were contributed, drawn down, and moved over a period of 3 years.

The \$9.1 million in enhanced payments, combined with the total per diem payments of \$41 million totaled only about \$50 million, which was about \$22 million less than the facility's total operating costs of about \$72 million for the period reviewed.

The county and State divided the remaining \$82 million (90 percent of the enhanced payment amount) between them. The State received \$36.4 million, which fully reimbursed the State

for its per diem contribution of \$16 million and provided a surplus of \$20 million that the State could use for any purpose. The county was reimbursed 100 percent for its upper payment limit contribution. The Federal Government, in effect, provided almost all of the nursing home's Medicaid funding, contrary to the principle that Medicaid is supposed to be a shared responsibility of the Federal and State Governments.

State of Washington: Newport Community Hospital, Long Term Care Unit²

Total Medicaid payments made to the Newport Community Hospital's long term care unit (nursing facility) during the audit period were adequate to cover its operating costs. However, after using IGTs to divert almost all of the enhanced payment funds to other purposes, the Medicaid amount that the State allowed Newport to retain was \$290,000 less than Newport's total Medicaid operating costs. During the same period, the nursing home was understaffed, which may have affected the quality of care provided to its residents. Newport officials believed that they could improve quality of care if they had more funds to hire additional staff, provide more training, improve the facility, and purchase safety equipment.

In addition to the State's requiring Newport to return about 94 percent of its enhanced funding to the State, the State directed Newport to pay about 3 percent of its enhanced funding to other health organizations as well. In effect, the Federal Government provided almost all of the nursing home's Medicaid funding, contrary to Federal/State cost-sharing principles.

State of Tennessee: Nashville Metropolitan Bordeaux Hospital, Long Term Care Unit³

We found that the Medicaid payments made to Bordeaux Hospital's long term care unit were adequate to cover Medicaid-related costs, but net payments after IGTs were \$22.8 million less than the facility's total Medicaid operating costs for the audit period.

In addition to the shortfall, Bordeaux did not retain enough Medicaid funding to fill all of its nursing positions, which may have affected the quality of care provided to its residents.

During the audit period, Bordeaux's Medicaid operating costs were about \$62.5 million. During the same period, initial Medicaid payments to the facility totaled \$139.8 million. However, the State and the county required Bordeaux to return about 96 percent of its enhanced payments to the State. We were concerned that the Federal Government effectively provided all of Bordeaux's Medicaid funding, contrary to Federal/State cost-sharing principles. The long term care facility was ultimately under funded, and the transferred funds were available to be used for other purposes.

² Report A-10-04-00001.

³ Report A-04-03-03023.

State of New York: A. Holly Patterson Extended Care Facility⁴

OIG found that the total Medicaid payments to A. Holly Patterson Extended Care Facility were adequate to cover Medicaid-related costs for the audit period, but net payments after IGTs were \$25 million less than Patterson's total Medicaid operating costs. Patterson was also understaffed during the audit period, which may have affected the quality of care provided to its residents. Patterson officials believed that they could improve quality of care if they had more funds. Patterson's Medicaid operating costs for the period were about \$190 million. During the same period, Medicaid's initial payments to Patterson totaled \$348 million in per diem and enhanced payments. The State and county required Patterson to return about 90 percent of its enhanced payments. As with the other audits, OIG concluded that the Federal Government, in effect, provided almost all of the facility's Medicaid funding, contrary to the Federal/State cost-sharing principle, and the facility, which had been identified by the State as having problems with patient care, was under funded. The amount that was returned to the State and county was merged into general revenues and could no longer be tracked.

RECOMMENDATIONS TO IMPROVE ENHANCED PAYMENTS UNDER UPL RULES

Some recommendations from our audits involving enhanced payments made under UPL rules have not yet been implemented. Following are recommendations that, in combination, we believe would curb the inappropriate transactions that inflate the Federal share.

- Use facility-specific limits to cap the amount of enhanced payments that could be sent to any one facility. These limits should be based on the cost of providing services in that facility by using the facility's actual cost reports.
- Require States to allow public providers to retain their enhanced payments to provide health care services to Medicaid beneficiaries.
- Declare any Medicaid enhanced payments that are returned to the State by public providers to be refunds, with the Federal share of the refund returned to the Federal Government.
- States should calculate per diem rates that more closely reflect operating costs. In the States we reviewed, per diem rates were not sufficient to cover costs.
- Perform annual audits of the States' enhanced payment calculations to ensure compliance with the UPL rules. We are finding incorrect calculations in some States.

⁴ Report A-02-03-01004.

- Shorten the transition periods included in the final upper payment limit regulation since, currently, there are no formal controls to ensure that these added funds are actually used for their purported Medicaid purpose.

OTHER USES OF INTERGOVERNMENTAL TRANSFERS TO INCREASE THE FEDERAL SHARE OF MEDICAID

The State manipulations of the Medicaid UPL enhanced payments are but a continuation of creative financing mechanisms that States began to use extensively starting over 15 years ago. I would like to mention the provider tax and donation programs, disproportionate share hospital payments, and some new areas where similar financing schemes are emerging.

Provider Tax and Donation Programs

Several years ago, States used provider tax and donation programs to increase Federal Medicaid matching funds while at the same time reducing the use of State resources in the Medicaid program. Subsequent congressional and regulatory action helped curtail the earlier problems with provider taxes and donations to a great extent. The taxation matter has, however, continued to be of concern as efforts are made to ensure they are properly implemented. At the request of CMS, our office has begun a new review of the Medicaid provider tax programs that are in use today.

In the earlier tax and donation programs, States would either arrange for providers to donate funds to the Medicaid program or certain provider groups would be levied special taxes. States were allowed by Federal regulations to use these funding sources as the State share of Medicaid expenditures. These collected funds were then repaid to the providers by increasing the total Medicaid reimbursement. As the reimbursements were raised, the providers recouped their donations or taxes, and the State could then use the Federal matching funds for whatever purpose it decided. The Omnibus Budget Reconciliation Act of 1990 affirmed that States were permitted to use provider tax revenues as their share of Medicaid expenditures.

In 1990, the then Health Care Financing Administration (HCFA) asked our office to audit the taxation and donation programs because of HCFA's concern that the use of such taxes and donations had the potential to significantly alter the real rate of the Federal share of Medicaid expenditures. We issued three reports over the next year describing the serious negative impact of these practices. We reported that the potential increase in the Federal share was inestimable and was limited only by the collective ability of institutional providers to participate in the programs. We urged HCFA to propose legislation to close the loopholes. In a 1991 Management Advisory Report to HCFA, we stated: "Provider tax and donation programs are generally not about increasing services to Medicaid recipients; nor are they about improving the quality of care provided to these recipients. They are, in our opinion, carefully crafted financing techniques that allow States to reduce their share of Medicaid costs and force the Federal Government to pay significantly more." We further stated: "Provider programs differ in some respects, but the Federal Government always loses, and States always profit."

Disproportionate Share Hospital Payments

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

Our work⁵ has shown that the States can divert these funds in ways similar to the enhanced payments provided under the UPL rules. Audits in two States show that public hospitals that received disproportionate share hospital payments returned large portions (80 to 90 percent) of the payments to State Medicaid agencies. Here is an example:

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

Once payments are returned, the States are able to use the funds for any purpose. We believe the return of these funds contradicts the stated purpose of assisting these public safety-net hospitals to pay for uncompensated care costs. In many States, the use of enhanced payments under the upper payment limit regulations and the disproportionate share program are combined to increase Federal reimbursements. The financial relationship involves some States allowing hospitals to retain upper payment limit funds but requiring the return of disproportionate share hospital funds through IGTs. In other cases, the reverse occurs—hospitals retain disproportionate share hospital funds but return upper payment limit funds.

Just as we recommend for enhanced payments made under the UPL rules, we also believe that disproportionate share hospital funds should remain at the hospitals to provide care to vulnerable populations, rather than being returned to the States through IGTs. We believe that any Medicaid payment returned by a provider to the State should be treated as a refund applicable to the Medicaid program, with a corresponding adjustment to the Federal share.

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

⁵ Reviews in Alabama, North Carolina, and California.

New Vulnerabilities Are Being Identified

We foresee the possibility that all types of public Medicaid providers could be used by States to maximize Federal revenues, circumventing the statutory Federal/State sharing formulas. We are finding other Medicaid program areas where States are manipulating Federal financing sources with little regard for program accountability.

State-employed Physicians and Hospital Graduate Medical Education Payments.

Both State-employed physicians and hospital graduate medical education providers could be paid an enhanced payment that could serve as a mechanism for inflating the Federal share of payments for Medicaid services above the statutory Federal matching percentage. The additional payment amount made to public providers could then be returned to the State by the provider with the effect similar to what we have observed in the UPL enhanced payment process at hospitals and nursing homes.

Medicaid School-based Health Services

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

We have identified instances⁶ in which States take back funds from the school districts as part of the contractual arrangements or require the districts to return a portion of the Medicaid payment to the State through intergovernmental transfers, thus reducing the State's share of the original payment and possibly resulting in a net gain for the State.

Although not the subject of this hearing, we have found numerous errors in billings for Medicaid services to children by school districts. In many instances, OIG found that school districts billed their States for services that were not supported by documentation, were medically unnecessary, coded incorrectly, or were not covered by the program. In some cases, the school districts billed for services allegedly performed on days the children were not in school. There were also errors in related administrative costs. CMS has begun to recover from some of the States the Federal share of the payments OIG questioned.

Most recently, we released a report of our review of Medicaid speech claims made by the New York City Department of Education.⁷ Our objective was to determine whether Federal Medicaid payments for speech services claimed by New York City Department of Education were in compliance with Federal and State requirements. Eighty-six of 100 speech claims in our sample did not comply with requirements and 68 of the sampled claims contained more

⁶ Reviews in Washington, Oregon, and New York.

⁷ Report A-02-02-01029.

than 1 deficiency. As a result, we estimate that the State improperly claimed \$435,903,456 in Federal Medicaid funding during our audit period.

BILLING CONSULTANTS

The use of consultants on a contingency fee basis has become a major influence in helping States to maximize their Medicaid revenue from the Federal government. Although there is nothing wrong with States obtaining such consultant help, it is important that States maintain vigilance over the consultant work to ensure the accuracy of the outcomes. We have noted that selected States have incorrectly billed CMS for claims developed by consultants and for the fees paid to these consultant firms.

In the State of New Jersey, we found that over \$22 million in improper Medicaid claims (Federal share of over \$11 million) were submitted for prison inmates' inpatient and outpatient health care costs under the Medicaid disproportionate share hospital program. The New Jersey State plan explicitly excluded any Federal funding for the cost of health services provided to prison inmates, and an August 16, 2002, policy clarification by CMS further prohibited Federal disproportionate share reimbursement for prison inmate costs. We found that the State agency relied solely on a consultant's work to prepare claims and, contrary to Federal requirements, failed to ensure the veracity of the claims before submitting them for Federal reimbursement.

The problem in New Jersey was not limited to the prison inmate reimbursement issues noted above. For a 4-year period ending June 30, 2001, this same consultant erroneously duplicated almost \$55 million (Federal share over \$27 million) in disproportionate share acute care hospital claims that the State submitted to CMS for reimbursement without validating the dollar value. The duplication error by the consultant occurred because their computer system had an error. But the major problem was that the State agency relied solely on the consultant's work to prepare and document the additional disproportionate share acute care hospital claims without validating the consultant's work.

We have also noted instances in which States have claimed unallowable contingency fee payments made to consulting firms for providing Federal revenue maximization services. Such findings were noted in both Virginia and Colorado. Such payments are not allowable for Medicaid reimbursement because the amounts were contingent upon the recovery of costs from the Federal Government, which does not comply with the requirements of Office of Management and Budget Circular A-87.

ACCOUNTABILITY OF MEDICAID FUNDS

As I mentioned at the beginning of this testimony, the financing mechanisms that are designed to circumvent Federal and State cost-sharing principles serve to disguise the source and final use of both Federal and State funds. Such manipulation undermines the ability of Congress and the Department to exercise responsible stewardship of Federal funds and distorts efforts to measure and estimate the true Federal cost of the Medicaid program.

The problems I have described in this statement are just one side of the coin. Not only does the Federal Government pay more than its statutory share of Medicaid because of States' financial manipulations, the Federal Government pays too much for Medicaid as a result of less than optimum State management of other aspects of the program as well.

For example, the Inspector General mentioned a problem with third-party liability claims. Medicaid is supposed to be the payer of last resort. When States pay a claim that should have been paid by another program or insurer, the States have not had great success in recouping those funds. Yet, instead of focusing on cost avoidance, many States pursue a pay-and-chase method of dealing with third-party liability. I am raising these examples here because, when a State pays more for a benefit than it should or pays a claim that some other program or insurer should be paying, not only does the State waste its own tax dollars, the Federal share of that improper payment may be lost as well.

We are in the process of conducting a series of audits of State's accounts receivable systems for Medicaid provider overpayments to determine whether the States reported overpayments to the Federal Government as required. The Social Security Act requires CMS to adjust reimbursements to a State for any overpayment or underpayment and generally requires States to report overpayment adjustments within 60 days from the date of discovery. In the few States reviewed so far, we have identified millions of dollars in provider overpayments for which the States failed to follow reporting rules. Therefore, there were no corresponding adjustments to restore the Federal share of those overpayments.

Effective use of State and Federal Medicaid funds depends on the consistent application of the following widely-accepted accountability principles. Our studies raise serious concerns that some or all of these aspects of accountability are lacking in many State Medicaid programs.

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

CONCLUSION

Our overarching concern is to ensure that Federal matching payments are in proper proportion to States' shares and that the funds are used to provide the intended health care services, in the intended facility, to the intended beneficiaries. Changes are needed to resolve

some of the more obvious shortcomings of the Medicaid program that are the subject of this hearing. This concludes my testimony, and I welcome your questions.