# Moving Beyond the Tug of War: Improving Medicaid Fiscal Integrity

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# BACKGROUND

For at least the last 25 years, state governments and federal regulators have been involved in a high-stakes struggle about how Medicaid programs are financed. Given the essential nature of Medicaid as a federal-state matching program, and the lack of a clear regulatory framework about what states may use for their portion of the pie, disputes over state funding practices have arisen regularly.

From the states' perspective, financing guidelines have become murkier still in recent years even as the Centers for Medicare & Medicaid Services (CMS) has worked to eliminate gray areas in state financing. In order to serve certain federal policy goals, the federal government has allowed and even encouraged state fiscal practices that it later determines are problematic. It has made decisions for individual states that seemed inconsistent or in conflict with the decisions for other states. The rules about what is acceptable often change in midstream – a state can be told one year that its practices are fine, while the next year the state is told that its actions are not permitted.

From the federal perspective, states are engaged in a constant game of "catch-me-if-you-can" in an effort to maximize receipt of federal matching funds. Some state efforts have enabled states to increase their receipt of federal funds without putting up additional state funds, thereby thwarting the intent of the federal-state matching structure. Once states implement these efforts, their Congressional delegations often oppose efforts to undo them, no matter how egregious the practices may appear.

This cycle of action and response has been repeated many times in the last 20 years, each time poisoning the critical intergovernmental relationship necessary for successful delivery of health services to our poorest citizens. The most recent clashes have perhaps been the fiercest, as the serious fiscal downturn of 2001 through 2004 led states and the federal government to search for revenues and reduce expenditures with renewed vigor.

## The NASHP Fiscal Integrity Project

The goal of the NASHP fiscal integrity project was to bring participants with different perspectives together to find common ground and generate ideas about improving Medicaid fiscal integrity. NASHP convened a Medicaid Fiscal Integrity Work Group, which met for a day of facilitated discussion on November 1, 2005, in Washington, DC. Some members submitted additional comments, and all were given an opportunity to review and comment on a draft of this paper. The group of fourteen people (listed in Appendix IV) included Congressional staff, state Medicaid officials, health financing experts, a hospital executive, representatives of the National Conference of State Legislatures and the National Governors Association, and current and former federal health officials. No statements in this report are meant to be attributed to any member of the Work Group. Views expressed in this report are NASHP's, rather than a consensus of the group.

## What is Fiscal Integrity in Medicaid?

Fiscal integrity in Medicaid means a fiscal relationship between the states and the federal government that is sound. Integrity has a moral meaning; fiscal integrity in Medicaid implies a standard of appropriateness from the perspective of both parties to the relationship.

Fiscal integrity should be distinguished from "program integrity," which generally refers to efforts to avoid fraud by providers or beneficiaries. While fiscal integrity can promote program integrity, the two terms focus in different areas. Program integrity is currently a major priority for CMS. Some efforts in this area have implications for the fiscal relationship between the federal government and states, but they do not address the core challenges of achieving a system of fiscal integrity.

Meeting participants expressed a range of views about the scope and definition of fiscal integrity:

> "To states, Medicaid fiscal integrity is a sustainable source of financing for the program."
>
> "The federal view of fiscal integrity is knowing what you pay for, and states adhering to the rules of what is matchable and what is not."

Ultimately, the discussion of fiscal integrity focused on two components. First, every dollar paid should be for a person, for a service, and at a price that is defensible. The second is that there are no virtual or illusory transactions—the state and federal contributions to their respective share of the program should be real.

Meeting participants also discussed what fiscal integrity is not. It was suggested that fiscal integrity is not states constantly under-budgeting the program, borrowing long-term to finance the operations, or raising provider rates using one-time sources of funds. Fiscal integrity is also not individual CMS regional offices allowing different financing arrangements for different states, or the federal government approving a financing arrangement and then changing its mind.

## Why Care About Medicaid Fiscal Integrity?

Improving fiscal integrity in Medicaid is an important end in itself because public programs that spend public dollars should operate with transparency, integrity, and accountability. Many participants also felt strongly that resolving the fiscal integrity problem in Medicaid is a first step toward ultimately resolving many of the program's larger struggles and helping to ensure sustainable sources of financing for providing health and long-term care coverage. Participants thought that taking fiscal integrity off the table as a problem would allow policymakers to move on and focus on Medicaid's more fundamental financial concerns: improving efficiency and working relationships

between states and the federal government; minimizing funding and other program inequalities among states; and ultimately improving states' resource allocations for the program.

## Allowing policymakers to focus on the real Issues

Many participants were concerned that fiscal integrity problems are distracting policymakers from resolving the program's other fundamental financing issues. In other words, the "micro" fiscal integrity problem in Medicaid prevents us from solving some of the program's most critical "macro" financing problems. By solving the fiscal integrity problem and moving these concerns off the table, participants felt that we could focus on the bigger, and more serious financial concerns.

Some of these "macro" concerns include the lack of federal matching funds to cover key low-income populations such as childless adults and legal immigrants, finding sustainable funding streams for the program, and the funding of long-term care. Participants recognized that the failure to address these larger fiscal problems is part of what is fueling states' use of financial schemes that have come under federal scrutiny.

## Improving efficiency and working relationships between states and the federal government.

State participants felt that attacks and counterattacks over fiscal integrity issues and questions have soured state/federal relations and drained time and resources away from administrators at both levels. Negotiations to resolve disputes over fiscal integrity take time away from administrators at both levels that could be used to solve other important problems.

Two recent examples illustrate this point. First, CMS approved California's Hospital Financing waiver in August 2005, and set a September 30, 2005, deadline for a protocol on certified public expenditures (CPE). Since the state is moving away from intergovernmental transfers (IGT), the CPE agreement is a critical element in the waiver. As of fall 2005, months had passed since the waiver was approved, California and CMS were still in negotiations, and no agreement had been reached on the CPE protocol.

Second, in Florida, the state sought a budget neutrality agreement in its waiver that would preserve its upper payment limit (UPL) arrangement (renamed the Low Income Pool in the waiver application) with a growth factor as mandated by state law.[1] The approved waiver did not include a final agreement about federal funding for the UPL arrangement, and the waiver's Terms and Conditions establish only vague benchmarks that the state will need to meet within six months of implementing the waiver in order to receive $1

[1] Joan Alker, *Understanding Florida's Medicaid Waiver Application* (Winter Park Health Foundation: September 2005).

billion in UPL funding.[2] State officials have publicly expressed their concerns over the ability of the state to receive adequate financial terms.[3]

In both of these instances, disputes between the state and CMS revolved around financing issues even after the substantive terms of the waiver had been settled. Resolving these disputes took administrative time and energy that could have been spent more appropriately on implementing the plans, and delayed implementation unnecessarily.

### Minimizing funding and other program inequalities among states.

Some participants from state agencies felt that the lack of clear rules applied consistently across states leaves states operating in the dark, and creates funding inequalities among states. In the absence of a clear fiscal structure, CMS is using administrative discretion and waiver and plan amendment negotiations to tackle fiscal integrity problems one-by-one. Several participants mentioned concerns that arise from this approach. First, states do not know what has been accepted or rejected in other states' negotiations, so they cannot plan or anticipate acceptable approaches. Second, CMS may be unfairly "trading" fiscal integrity for other policy goals (for example, allowing inappropriate state financing schemes to continue in return for achieving a CMS policy goal in a waiver). And third, states may be banking on inappropriate state financing schemes by using "bad money" in the pre-waiver baseline calculation. Ultimately, all of these problems add up to opportunities for inequitable treatment across states as the federal government exercises its discretion differently in its negotiations with individual states.

For example, under Iowa's recent Section 1115 waiver, the state promised to eliminate certain inter-governmental transfers (IGTs), prohibit new provider taxes, and limit the rates paid to public institutions to actual Medicaid costs. In addition, an outside evaluator will perform an annual audit to ensure state compliance. In exchange, Iowa will receive federal matching funds to provide a limited benefits package to some non-custodial adults and parents and fold some state-only programs into Medicaid. In Massachusetts, the MassHealth waiver phases out IGTs that the state had previously used as non-federal share and replaces them with CPEs. In exchange, it establishes a Safety Net Care Pool to enable the state to pay for services to the uninsured and other un-reimbursed Medicaid costs. If Massachusetts can raise the non-federal share under the new requirements, the Pool will provide an estimated $650 million in federal funds per year (from DSH and other existing sources). The waiver also offers new flexibility in distributing these funds. For example, the hospital funds no longer have to be used for hospitals only. The Safety Net Care Pool has recently been used as a building block for universal coverage in Massachusetts.

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[2] CMS, Special Terms and Conditions, Number 11-W-00206/4, Title: Medicaid Reform Section 1115 Demonstration, Awardee: Agency for Health Care Administration (FL) available online at http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/waiver/pdfs/cms_special_terms_and_conditions.pdf

[3] Joan Alker, *Understanding Florida's Medicaid Waiver Application* (Winter Park Health Foundation: September 2005).

In both of the examples described above, the state received permission to spend federal funds in a manner not permissible under Medicaid rules in exchange for accepting limits on funding. It is, of course, possible that these waivers would have been approved even if the funding components were not present. However, the terms of these waivers and the manner in which they are negotiated gives the impression that different states can be subject to different program and financing rules depending upon the desires of CMS.

### Improving state resource allocations for Medicaid.

Finally, a few participants thought that resolving the fiscal integrity problem would allow states, and state legislators in particular, to more appropriately fund the Medicaid program. Under the current system, states are not sure about how the financing rules may change or how the rules may be applied to their unique circumstance, so it is difficult to plan ahead and budget accordingly. Without the ability to plan, states may fail to make appropriate investments. States may also be less willing to cover needy populations if they are not sure that the funding streams they have dedicated to this coverage will persist into the future.

## Perceptions of the Current Absence of Fiscal Integrity

The federal government and the states have very different perceptions of the magnitude of and reasons for fiscal integrity problems.

In recent years, CMS has increasingly drawn attention to the fiscal integrity problem. Tom Scully, former CMS administrator, often voiced his strong views about the subject. For example, at a Congressional hearing in 2003, he testified[4]:

> Through complex, creative financing schemes, States have artificially maximized Federal Medicaid matching funds. This practice is simply unacceptable. The Medicaid program must be a Federal-State partnership, not an exercise in financing gamesmanship. We must continue to ensure that beneficiaries receive the high quality care they deserve, and that we are appropriately matching State Medicaid funds. The last two decades have demonstrated that States can be extremely resourceful in creating innovative funding mechanisms that do not comply with the intent of the Medicaid program, which requires States to certify that they have the appropriate funding to pay their matching Medicaid share.

Many state officials acknowledge that states seek to maximize federal funding, but their view of what is needed to restore fiscal integrity is different. For example, the National Conference of State Legislatures enacted a new policy in 2005 on Medicaid that includes a section on ensuring program integrity: "NCSL supports the use of audits to ensure program integrity. Where states have made honest errors in interpretation, this

[4] Testimony of Thomas Scully, Administrator, Centers for Medicare & Medicaid Services, "Challenges facing the Medicaid Program in the 21st Century," Before the House Energy and Commerce Committee Subcommittee on Health, (October 8, 2003). Available at http://www.cms.hhs.gov/apps/media/press/testimony.asp?Counter=882.

information should be shared so that other states might benefit. In cases where an infraction was procedural in nature and did not affect the quality of care, medical necessity or the appropriateness of services, NCSL urges CMS to impose compliance on a prospective basis." On October 25, 2005, Senator Dennis Byars, Chair of the NCSL Standing Committee on Health, wrote to the Senate Finance Committee, saying "As both the states and the federal government struggle to balance their budgets and to support all the critical functions of government, it is important to review the state/federal partnership. NCSL looks forward to having an opportunity to discuss Medicaid reform and how the state/federal partnership can be sustained and improved and to explore ways to provide predictability in program financing and administration."

## Brief History of Fiscal Integrity Policies

In any program that shares funding and administration between the federal government and the states, the two governments will struggle over who is paying for what expense. From the state perspective, drawing down additional federal funds allows states to provide more services or serve more of their vulnerable populations. From the federal perspective, however, if states inappropriately draw down additional federal funds—and they incur no added costs—it distorts the federal/state partnership at the heart of Medicaid and puts undue burdens on the federal government.

This inconsistency between state and federal views has resulted in a policy environment that can be characterized as a "tug-of-war," with states discovering, expanding, or changing legal mechanisms in the financing of the program, and the federal government eventually reacting by restricting these practices through legislative or regulatory actions.[5] (See Appendix I for detailed timelines of each mechanism's use and the regulatory response.) All of the mechanisms that states use to generate funds—provider donations and taxes, IGTs, DSH payments, and UPLs—have a basis in law or regulation. However, federal efforts to restrict states from using these mechanisms have been sporadic.

One of the earliest strategies used by states to obtain federal matching funds without a contribution of state general revenues involved the use of provider donations and taxes. In 1985, a regulatory change by the Health Care Financing Administration (now CMS) allowed states to use provider donations to fund all or part of the state share of Medicaid. (Using state and local tax revenues from health care providers, among other sources, in funding the state share was already permitted.) States began to use these provider donations and taxes to make Medicaid payments to the donating or taxed parties, thereby resulting in no net cost to the provider or state but generating a federal match. The new federal matching funds were then used to support Medicaid and other state non-health programs.

One widely-reported incident traced the funding of roads and bridges back to the Medicaid program. These sorts of practices prompted Congressional action. The use of

[5] Matherlee, K. "Issue Brief: The Federal-State Match: An Ongoing Tug-of-War over Practice and Policy." *National Health Policy Forum*. December 2000.

provider donations to finance the state share of Medicaid was effectively prohibited in 1991. The use of provider taxes was limited, with Congress imposing a statutory definition on such taxes and detailing specific requirements in order for those taxes to be applied—particularly that providers cannot be "held harmless" against the cost of the tax. These statutory requirements have successfully curtailed the inappropriate use of provider taxes.

The same legislation contained language specifically prohibiting CMS from restricting the states' use of certain public funds to finance the state share of Medicaid. In a 1992 regulation, HCFA delineated what constitutes permissible public funds, which included those transferred from other public agencies to the state or local agency and under its administrative control. These are known as intergovernmental transfers, or IGTs. The advent of the Disproportionate Share Hospital payment program in 1981, followed in 1987 by Upper Payment Limit rules, ushered in another period in which states used legal mechanisms to obtain federal funds. The IGT provided a source of funds, with those funds returned to the public agency though DSH payments or payment rates inflated according to the UPL standards.

Although authorized in 1981, few DSH payment programs were established until 1987, when further legislation was passed that required states to submit Medicaid state plan amendments describing their DSH policies. States were afforded considerable discretion in determining which hospitals qualified for these additional payments and how much each facility would receive. DSH spending rose substantially when it became a mechanism for returning provider donations and taxes. Subsequently, a series of caps on DSH funding was mandated. State and facility caps were put in place (although some states were subject to less restrictive caps) and DSH funding allotments were also reduced. These restrictions have controlled DSH payment growth, but using the DSH program as a payment mechanism still remains a legal strategy for maximization of federal funding. And, as the fiscal picture improved in the late 1990s, some of these restrictions were relaxed. In 2000 and 2003, Congress increased the facility-specific cap and state-specific allotments. A recent study in *Health Affairs* suggests that these federal DSH reforms have been successful.[6] However, a recent audit of selected states' DSH programs by the HHS Office of Inspector General, found that nine out of ten states reviewed did not meet the hospital-specific DSH limits.[7]

States also discovered they could generate additional federal funds at no net cost under current UPL rules. Historically, the UPL was based on the aggregate amount that could be paid to an entire class of providers, assuming that every provider in that class would be paid the same rate for all services it provided to Medicaid recipients. States found that they could establish a certain payment rate for the majority of providers within a class and a significantly higher rate for one or a few providers within the same class and still

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[6] Teresa A. Coughlin, et al, "States' Use Of Medicaid UPL And DSH Financing Mechanisms," Health Affairs, 23, (2004), p. 245-257.
[7] Health and Human Services, Office of Inspector General, "Audit of Selected States' Medicaid Disproportionate Share Hospitals," (March 2006).

satisfy the UPL rules. By overpaying a public facility and then requiring it to return some or all of the overpayment to the state through an IGT, states found they could obtain additional federal funds without a new financial contribution. The federal government sought to mitigate this practice through further regulatory action, creating three classes of providers and separate UPLs for each class. These regulatory changes are being phased-in over eight years, with full compliance expected from all states in 2008.

Efforts to improve the integrity of Medicaid continue. The Deficit Reduction Act (DRA) of 2005 included increased federal funding to focus on program—not fiscal—integrity, through hiring contractors; combating waste, fraud and abuse; and requiring states to cooperate with such efforts. While the main focus of this comprehensive plan is on program integrity – for example, fraud and abuse by providers, MCOs, and administrative contractors – it also offers the federal government an opportunity to improve the transparency of its fiscal integrity policies. The Senate version of the DRA also limited contingency fees for consultants, but that provision was dropped in conference.

**Deficit Reduction Act Requirement for Medicaid Integrity Program**

Under the Deficit Reduction Act of 2005,[8] CMS will have increased funding to hire contractors to combat waste, fraud, and abuse.

HHS will increase its staffing of FTEs to work on fiscal integrity by 100 people and is required to submit a report to Congress annually. States are required to comply with any requirements that HHS determines are necessary to carry out this program.

Under this program, HHS will contract with entities to: 1) review actions of individuals or entities receiving payment by Medicaid for goods and services, 2) audit claims for payment for items and services furnished or admin services rendered, and 3) educate service providers, managed care entities, beneficiaries, and others about payment integrity and quality assurance issues.

Appropriations for this program are $5 million in FY 2006, $50 million in FY 2007 and FY 2008, and $75 million thereafter.

Also, the President's FY 2007 Budget proposes two major fiscal integrity changes: 1) a provision that would reduce the maximum amount states can tax providers from 6 percent to 3 percent (although this rule change is being proposed for budgetary reasons, not because of fiscal integrity concerns);[9] and 2) a provision that would cap Medicaid

[8] Budget Reconciliation Act, Sec. 6035.

[9] There are already detailed regulations on this subject, and no evidence from the Administration that these provider tax arrangements are abusive. By reducing the amount states can tax providers, it reduces the amount the Federal Government must contribute toward Medicaid, and federal Medicaid spending declines.

payments to government providers and cap DSH funding. Similar proposals have been made in previous years, but have not moved forward.

On this tug-of-war in Medicaid financing, one commentator has concluded: "Although the federal government has ultimately responded when different creative financing strategies have emerged, it has frequently been slow to do so, failing to act until the amount of federal financial liability and consequent public attention are substantial. Frequently, the federal government has been either unable or unwilling to use administrative means to reject claims for federal matching for these transactions; at times, it has tacitly encouraged or allowed the practice to bail out states facing significant budget shortfalls. Meanwhile, the practices spread quickly through the states once it became apparent the federal government was going to allow the practice."[10]

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[10] Penny Thompson, "Medicaid's Federal-State Partnership: Alternatives for Improving Financial Integrity," Kaiser Family Foundation, (February 2004).

# WHAT WOULD FISCAL INTEGRITY IN THE MEDICAID PROGRAM LOOK LIKE?

## Clear Rules from the Federal Government, Applied Equally

Participants generally agreed that clear federal rules about fiscal integrity that are fair to the federal government and states are needed to guide state fiscal practices. There was consensus among participants that clear, fair federal rules would help states comply with federal law, and protect states from hardship that could be caused by waiver negotiations or retrospective disallowances.

As mentioned earlier, there are two key parts to a definition of fiscal integrity in Medicaid. The first relates to revenues: as long as every dollar in Medicaid is a real state dollar, it provides a strong incentive for states not to be more expansive than the statute. A second relates to expenditures: if every dollar paid out goes for covered services (including necessary administrative costs) at a reasonable price for an eligible person, the money would only go where it is allowed to go.

Clear definitions of permissible revenues and expenditures are particularly important to improving fiscal integrity. However, participants had different ideas about what concepts require a specific definition and how they would be defined.

### Revenues

There was also discussion of how to define state revenue. Participants suggested that states need to show that matching funds come from state or local sources that could have otherwise gone to other programs in order to show that they are not recycled.

One participant suggested that there should be a clear definition (in regulation) of what are allowable sources of state funds to be spent on Medicaid and then a separate process to track them. The regulation would be based on an analysis of how states characterize funds, how state budget processes work, and when a federal dollar, provided to a state in the form of a grant, loses its character as a federal dollar. Work could be done with academics who know state budget and revenue policy, with additional conversations among state officials, in order to generate an appropriate definition.

Another state participant said that it would be important to define state general revenue, and what taxes are allowable. Although it would be impossible for states to track a dollar from a taxpayer to when it ends up in a program, if it comes from a tax source that a state is allowed to collect, then it should be considered as the equivalent of general revenue.

Some states are wary of embracing the revenue model out of concern that they will lose vital dollars that are used to serve needy people generated through their existing UPL and DSH programs.

### Expenditures

Participants had different ideas about how to define appropriate state Medicaid expenditures and what needed to be done to certify their accuracy.

One view was that appropriate expenditures have been made when providers have been approved, claims paid are for eligible people, needed services are covered, and reimbursement is consistent with defined payment methodologies. Another view was that definitions of certified public expenditures must be commonly agreed upon and consistent across states. One participant also stressed that the federal government should not be approving provider-specific rate methodologies.

One participant raised the issue of what constitutes medical services. Over time, states have recognized that some services previously paid for with 100 percent state funds have a medical component. States then have sought to "Medicaid-ize" those services—or move them to Medicaid to secure federal matching funds. The participant suggested that there needs to be a common understanding, defined in regulation, of what constitutes a medical service. States felt that the location where the service is provided (institution, home, school, or other program) should not be a factor. Instead, it should be dependent upon *who* provides the service, for example if it is provided by or under the supervision of a doctor, dentist, or other licensed provider acting within his or her scope of practice.

## Structure for Implementing New Rules

As mentioned above, participants generally agreed that clear federal rules should be developed in conjunction with states to guide states' fiscal practices. Participants also preferred formal rulemaking because it would give them notice of impending changes in policy and an opportunity to comment before the agency's position is crystallized. Participants also discussed the need for federal monitoring, and accountability mechanisms, to make sure these new rules are followed.

### The Medicaid architecture: Federal statute, regulations, guidance, waivers, and state plan amendments

A review of the federal Medicaid program architecture reveals that it is equipped to guide state policy on fiscal integrity issues. However, this architecture has not been used consistently. Like other federal entitlement programs, Medicaid is governed by statute, regulations, a program manual (with program transmittals which are used to communicate new or changed policies, and/or procedures that are incorporated into a specific CMS program manual),[11] "Dear State Medicaid Director" letters to clarify pressing issues, and additional communications between CMS regional offices and states. Similar to the federal structure, states also have their own Medicaid statutes, regulations,

[11] Program transmittals used to be called program memos.

and policy manuals that reflect their programs, and include information about fiscal practices.[12]

## Federal statute

Participants generally agreed that the current Medicaid statute provides varying degrees of specificity on fiscal integrity policy. It provides broad language about CMS's authority to deal with fiscal integrity. The statute says that a state plan must "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan… as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care."[13] CMS cites this statutory provision on "efficiency, economy and quality of care" as giving it broad discretion to stop states from using certain financing arrangements. CMS continues to view this discretion as valid since the 9th Circuit Court of Appeals recently upheld a ruling favorable to CMS on Alaska's financing arrangements.[14] In addition, the statute requires state Medicaid agencies to make reports, in such form and containing such information as the Secretary of HHS may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports.[15]

Since the 1980s, Congress has passed at least 11 distinct amendments to the Medicaid statute which attempt to address fiscal integrity problems, [see Appendix I], but no comprehensive statutory reform has been attempted. GAO has recommended that Congress enact legislation to prohibit Medicaid payments that exceed costs to any government-owned facility.[16] This would minimize the likelihood that states could develop financing mechanisms whereby providers return Medicaid payments to the states, thus effectively reducing the states' share of Medicaid funding. Congress has not acted on this recommendation.

## Federal rulemaking

There was consensus among participants that the Medicaid regulations on the topic of fiscal integrity have generally tackled only one particular fiscal integrity issue at a time and some more completely than others. There are extensive regulations on UPL and provider donations and taxes, but not on DSH, IGTs, and CPEs. (See Appendix I.) This

[12] The National Health Law Program and the National Association of Community Health Centers have published a state-by-state guide to institutional procedures to State Plan Amendments and Waivers. See, "Role of State Law in Limiting Medicaid Changes," April 2006, available at www.healthlaw.org.
[13] 42 U.S.C. S. 1396(a)(30)(A).
[14] Alaska v. CMS, No. 04-74204, HHS No. CMS 2003-14 (U.S. Court of Appeals for the Ninth Circuit, September 12, 2005).
[15] 42 U.S.C. S. 1396(a)(6).
[16] See GAO, "Medicaid: States Use Illusory Approaches to Shift Program Costs to the Federal Government," August 1994, p. 14. GAO/HEHS-94-133. See also, GAO, "Medicaid Financing: States Use of Contingency Fee Consultants to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight," June 2005, p. 44 GAO-05-748.

piecemeal regulatory approach has allowed states to turn from one mechanism to another in order to fund their programs. Without a broader fiscal integrity regulatory framework or a more comprehensive set of policies and practices, many questions remain unanswered and terms remain undefined.

Participants generally recommended that Congress, the Administration, and states work to define fundamental concepts like "public expenditure," "allowable expenditure," "state matching dollar," and "state general revenue" in regulation. Many participants agreed that states could begin this process by giving the basic parameters to Congress and the Administration so they can debate the issues, consider whether legislation is needed, and then issue proposed rules, definitions, examples, and approaches on fiscal integrity.

## Dear State Medicaid Director letters

Dear State Medicaid Director (DSMD) letters, which could be a mechanism to clarify gray areas and share information with all states, generally have not been used to create clear policy on fiscal topics. CMS's use of these letters in general, and to deal with reimbursement/fiscal integrity issues in particular, has ebbed and flowed throughout the years (see chart below). In the past, DSMD letters have been used as a means for CMS to issue guidance to the states. The number issued since 2000 has been far below that of the previous five-year period. Only 90 have been issued from 2001 to 2005, compared to 218 from 1996-2000.

Dear State Medicaid Director Letters (DSMDs) [17]

| Year | Total Number of DSMDs Per Year | Total Number Addressing Reimbursement/State Financing Issues |
|---|---|---|
| 2005 | 6 | 0 |
| 2004 | 10 | 2 |
| 2003 | 12 | 4 |
| 2002 | 24 | 3 |
| 2001 | 38 | 11 |
| 2000 | 73 | 10 |
| 1999 | 44 | 8 |
| 1998 | 57 | 57 |
| 1997 | 41 | 41 |
| 1996 | 3 | 0 |
| 1995 | 3 | 0 |
| 1994 | 1 | 0 |

There was consensus that participants would like to have a process in place for states to have input into these rules, clarify gray areas that emerge after regulations are issued, and communicate this policy decision to all states. In addition, several participants mentioned that there may be a need to adopt a formal process for CMS to respond to states' questions. One participant mentioned that, in addition to fixed rules, CMS needs to be "nimble" and able to react to issues that arise.

[17] Information obtained from CMS website (http://cms.hhs.gov/states/letters/) 11/29/05.

Some participants suggested looking to the IRS as a model for the process of interpreting policy on state-federal issues. The IRS publishes the *IRS Bulletin*, which is a cumulative bulletin of its revenue rulings.[18] These rulings are legal opinions that apply across the board to all taxpayers who fit the circumstances. In the case of CMS, rulings could consist of agency opinion about fiscal integrity issues that would apply across the board to all the states that fit the circumstances. CMS could create a similar type of bulletin that would be available on its web site to states and other stakeholders.

### Other means – state plan amendments and waivers

Many participants share a concern that CMS has used unusual means – divorced from the typical administrative process – to handle fiscal integrity issues.

For example, in 2003 CMS began requiring "Five Funding Questions" (see Appendix II) to be answered before State Plan Amendments are approved. Although this document does not fit within the Administrative Procedures Act process, it may actually be one of the most comprehensive efforts to date to improve fiscal integrity. According to one meeting participant, the Five Funding Questions have been an effective means to change state behavior: at the time of our meeting, at least 25 states had agreed to sunset financing arrangements that do not satisfy the federal criteria.

As mentioned previously, many participants were also concerned that CMS has negotiated fiscal integrity issues on a state-by-state basis, rather than relying on consistent regulations or guidance. It is not clear how CMS's "Five Funding Questions" have been interpreted state-to-state. Although there is little information that is publicly available, states have at times reported their impression that CMS interpretation varies. There was a strong consensus among participants that the process of resolving fiscal integrity disputes should be separate and apart from waiver negotiations and approval of state plan amendments.

## Federal Monitoring to Ensure Compliance with the Rules

The work group proposed different types of information that could be used to demonstrate state compliance and suggested improvements to the current reporting/auditing system as well as tools that CMS could provide to help states supply the necessary information.

### Data reporting

It appears that current reporting mechanisms do not collect information that is sufficient to establish fiscal integrity. Currently, the only financial information that CMS regularly collects from all states in a standardized manner is projected and actual expenditures, submitted on CMS-37 and CMS-64 forms. This information is required by law, and the

[18] Conversation with Stanley Oshinsky, Esq., Supervisory Attorney, Office of Director of Practice, IRS, November 21, 2005.

data are used by CMS to determine and reconcile federal matching payment to the states. However, as noted earlier, CMS has broad authority to get the information it wants or needs.[19]

| Current Process for Submitting CMS-37 and CMS-64 Forms[20] | |
|---|---|
| At least 45 days prior to start of quarter | • State submits CMS-37 at least 45 days prior to the start of the quarter (November 15, February 15, May 15, August 15) through MBES/CBES.<br>• Appropriate CMS Regional Office (RO) reviews submission and CMS Central Office (CO) provides obligation and authority of federal funding through the Payment Management System (PMS). |
| First day of quarter | • Federal funding obligation/authority available through PMS. |
| During quarter | • State has opportunity to re-certify for the quarter and submit a revised CMS-37 if it appears that they have underestimated and Federal funding is insufficient. |
| By 30 days after end of quarter | • State submits CMS-64 reconciling actual expenditures with estimates on CMS-37. CMS RO conducts financial review. If necessary, CMS RO issues disallowances for blatantly objectionable items or calls CMS CO attention to questionable items for further review. |

**Current Data Reporting Practices**

Currently, states must submit two financial reports per quarter to CMS: the Medicaid Program Budget Report (CMS-37); and the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64). These reports are submitted electronically through the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) by the executive officer of the state's Medicaid agency or a designee authorized by the state. They are public information.

The CMS-37 is a statement of Medicaid funding requirements for a certified quarter, and contains estimates and underlying assumptions for two fiscal years (FYs) – the current FY and the budget FY. After reviewing the form, CMS issues the state a grant award for federal funding for that quarter. States detail the estimated federal and state shares, and total costs of providing benefits and administering the Medicaid program. Costs are specified by benefit, service, and administrative activity. Also, states provide estimates of the numbers of people eligible for Medicaid by eligibility category.

States certify that state and local funds are, or will be, available for the certified quarter in order to receive federal matching funds. If it appears that the state's original request for federal funding is insufficient, states may also request more by re-certifying for the quarter and submitting a revised CMS-37 report. Information from the CMS-37 is also used in formulating the federal Medicaid budget.

The CMS-64 is an accounting statement of Medicaid grant funds for the reported quarter and prior fiscal years. States must report only actual expenditures using source documents such as invoices, cost reports, and eligibility records; estimates are not permissible. The CMS-64 is used

[19] 42 U.S.C. S. 1396(a)(6).

[20] Provided by the Centers for Medicare & Medicaid Services, CMSO, FSBG, DFM (Betsy Hanczaryk – Fiscal Management Specialist).

to reconcile the use of federal Medicaid funds that were advanced to states based on the CMS-37 filed for the reported quarter. States detail the actual expenditures of federal funds as well as the calculated total computable costs. Similar to the cost reporting on the CMS-37, expenditures are also specified.

One participant voiced concern that the data currently reported through the quarterly CMS-37 and CMS-64 reports only track what states spend money on, not where the money comes from. They also lack the detail necessary to identify sources of state funds and track the flow of funds and transactions between states and providers.

Participants also recommended that CMS provide tools to facilitate state reporting of the requested information, including simplified reporting templates for the states and a system to track the flow of funds between states and providers. States generally have concerns about increased federal data collection because it is burdensome and not often used by the federal government.

### Certification statements and auditing

A new system that fosters fiscal integrity needs to contain strong certification statements, clear penalties for misreporting, and an independent auditing body to establish additional oversight.

One participant suggested that CMS audit provider claims to examine whether provider payments are consistent with the payment methodology. Although some auditing mechanisms may be in place due to requirements of the Single Audit Act of 1984,[21] a 2002 GAO report found that the follow-up on audit findings has been inadequate.

Another participant suggested that CMS collect data and approach reporting like a "Sarbanes-Oxley for States," requiring state submission of financial statements audited by an independent body, and certification of these statements, with penalty of perjury, by the State Medicaid Director or governor.[22]

### Transparency

It might also be easier to monitor state activities if state Medicaid agencies made their policies and practices, and underlying documentation, more transparent. One state participant suggested that states should be given time to create web-based "annotated state plans." For example, each plan would have three columns: in the left-hand column there would be a reference to federal law or regulation; in the middle column there would

[21] The Single Audit Act requires audits of state and local government entities that expend at least $300,000 in federal awards annually. Some states use state auditors while other states hire independent public accounting firms.

[22] Currently, states must certify that claimed expenditures are consistent with federal regulations and the state's approved Medicaid plan. GAO, "Medicaid Financing: States Use of Contingency Fee Consultants to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight," June 2005, p.2. GAO-05-748. However, an independent audit is not required.

be the state plan provision; and on the right, there would be live hyperlinks to state regulations, state manuals, or state contracts that implement those provisions. This way, how states comply with federal law becomes transparent, and can be updated in real-time, like a bulletin board that provides information to the federal government and the public. This method would also help states stay organized. As they changed a link (a state regulation, manual provision, or contract) they would have to consider how to revise the state plan to conform. A web-based system would also help auditors trace state activities.

**Recent Actions by CMS**

In response to concerns about inadequate oversight, CMS has recently taken steps to beef-up oversight of financial management. One hundred new auditors have been hired to monitor state activities, enforce compliance with CMS financial management procedures, and conduct focused financial management reviews to target improper revenue maximization strategies. (See also text box about Deficit Reduction Act Requirement for Medicaid Integrity Program.) It is unclear how well this model works. One participant had already met with auditors in his state and thought that auditors would be able to do their jobs better if they had sufficient information, perhaps by having states put together web-based "annotated state plans" as described above.

In a notice published in the Federal Register on January 7, 2004, CMS proposed modifications to the CMS-37 report by requiring states to submit up-front documentation to support the budget and expenditure information. CMS' intent was to "identify and resolve any potential funding and/or expenditure issues with the States prior to the budget actually being formulated and/or implemented and the expenditures actually paid and claimed by the states."[23] The notice generated controversy because the standard sixty-day comment period was limited to one day. CMS conceded that the comment period was insufficient and announced its intention to re-publish the notice after consultation with state partners. At the time of the writing of this paper, this still has not occurred.

## Accountability Mechanisms

Even if rules were clear and uniformly applied, a process was established for resolving remaining questions, and there was appropriate reporting and monitoring of data, some participants felt there could still be lack of compliance. There was a consensus that incentives and consequences, or "sticks and carrots," would need to be built into this new fiscal integrity system in order to ensure that states and the federal government all play by the rules. In addition, participants thought that a certain amount of transparency, or independent review, might need to take place.

- **Sticks for states** -- One suggested mechanism would be for the federal government to penalize states by creating a disallowance for inappropriate claims

[23] 69 Fed. Reg., 922(January 7, 2004).

or unapproved funding mechanisms *and* requiring states to replace withdrawn federal money with state money, so that funds remain in the same and program functions are not hurt. For example, in the Temporary Assistance for Needy Families (TANF) Program, when a state fails to meet the terms required to receive federal funds, its grant in the subsequent year is reduced by the disallowed amount, and the state must provide additional state funds to make up for the federal reductions.[24]

- **Carrots for states –** Some participants felt that the federal government could also reward states that follow the fiscal integrity rules by providing additional funding. Participants had different ideas about how to calculate the reward. Some participants thought the award should be based on a state's compliance record on fiscal integrity, as measured by an independent auditor. Other participants thought that the bonus should be based on health outcomes, similar to programmatic goals in TANF, in which the federal government awards states bonuses based on employment, job retention, and other outcome measures.[25]

- **Sticks for the federal government –** One way that participants suggested to hold the federal government accountable would be to require CMS to annually report to Congress on fiscal integrity efforts and its record of rulemaking and oversight for the year. In addition, the HHS Inspector General or another independent agency could provide an annual review to ensure that CMS had not disallowed a state's practices unless it violated federal law or regulations. Last, the federal government could be required to reimburse states for any inappropriate disallowances, with interest, or could even pay a penalty to the state. This could help ensure that CMS treats all states equally, according to clear rules.

- **Carrots for the federal government –** Participants suggested that there are some inherent benefits to the federal government in creating and adhering to fiscal integrity policy . As fiscal integrity improves, the federal government will ultimately save time and money. As states have more confidence in the Medicaid program, state legislators may begin to more realistically budget funds for Medicaid, and rely less on bringing in more federal funds. Also, the federal government will save time and energy currently spent trying to solve fiscal integrity problems on a state-by-state basis.

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[24] Note, meeting participants felt that CMS rarely uses the tools it has available to it already (i.e. disallowances) to provide disincentives to states.

[25] While such a bonus would not directly reward fiscal integrity, it would reward states that are using their Medicaid budgets effectively to promote health.

# HOW TO EVALUATE THE IMPACT AND SUCCESS OF FISCAL INTEGRITY MECHANISMS

## Financial

A key measure of whether fiscal integrity efforts have worked is financial. Participants discussed how to evaluate the financial success or failure of fiscal integrity efforts. One participant suggested that a reduction in anomalies in spending trends over time might result from improved fiscal integrity. Another participant thought that if nominal and net payments for individual providers—rather than a class of providers—were the same, it would show improved fiscal integrity. Also, in a world without fiscal integrity problems, retrospective denials of funding would diminish or cease to exist. Last, a participant suggested that if states and the federal government were to spend the right amount for the medical services they bought—neither too much nor too little—then we would have achieved fiscal integrity.

## Cost of Compliance

Many participants were sensitive to the potential cost of compliance with fiscal integrity efforts. Concerns ranged from disruption of Medicaid operations due to loss of funding to states spending increased time and administrative costs on new efforts to negative effects on program outcomes such as more uninsured residents. However, other participants felt strongly that although it takes effort to be accountable, just as it does to pay our taxes, it is the price of admission to a well-functioning public program.

### Disruption to Medicaid operations

Most participants fear that changes to fiscal integrity rules may cause states to lose federal funding that they currently rely on to enroll needy beneficiaries and pay providers for services. One participant felt that, in order to ensure the continuity of financing and health coverage, changes could be made on a prospective basis, with existing arrangements grandfathered-in or slowly phased out, to limit the destabilizing effect on states. Providing adequate transition time, grace periods, and additional short-term enhanced funding would help states adjust to these changes and plan for any financial repercussions to their programs.

### Increased time and administrative costs

Participants also expressed concern about additional time and administrative costs associated with complying with new fiscal integrity requirements. Attempts to minimize the amount of time and administrative costs in complying with data and reporting requirements by making systems simple and coordinated or built on systems already in place would greatly help states.

## Negative effects on program features and outcomes

Perhaps the gravest concern among participants was that changes to fiscal integrity rules might reduce the availability of federal funds that states have come to rely on and that this in turn could generate negative effects on states' program features and outcomes. These effects could include: provider rate reductions that reduce participation; cuts in eligibility that increase the number of uninsured residents; and cuts in benefits that lead to vulnerable patients going without needed care. Many participants expressed the enormous need to simultaneously change macro-level funding issues to resolve some of these problems.

## Design and operation of the program

Much of the dialogue among workgroup participants centered on the need to address the legitimate reasons why states engage in aggressive financing practices. States have used creative financing mechanisms to generate the revenue necessary to expand coverage to needy populations. Some states expanded their Medicaid programs during stronger economic times when they had more fiscal capacity to pay their share of program expenditures. As the economic cycle took a turn for the worse—and state general funds ran low while demand for Medicaid increased—states struggled to generate the revenues to run their programs under current rules. Of course, some states have been aggressive in obtaining federal financing simply because they wish to minimize the state-borne cost of their programs.

These reasons point to the possibility that other policy changes could reduce the fiscal gaming that occurs. A federal matching formula that more quickly responds to economic downturns would reduce the financing pressure on the program. Federal action to meet the needs of the growing number of people without health insurance would reduce the burden on Medicaid programs to fill in this gap. While changes such as these would not eliminate the incentives for states to maximize federal funding, they would reduce those incentives and eliminate some of the excuses states give when they push the limits of the rules.

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## NEXT STEPS

State participants in the meeting agreed that finding a consensus on fiscal integrity is a very important goal. However, making it happen means that many interest groups would have to make fiscal integrity a priority. Stakeholders talk about this problem on and off, but the systemic issues remain unaddressed, and the administrative steps taken by CMS (waiver negotiations, plan amendments, etc.) are not sufficient or appropriate to deal with a problem that has such a significant impact on states and program beneficiaries.

Organizations such as the National Governors Association, the National Conference of State Legislatures, the National Association of State Medicaid Directors, and the National Association of State Budget Officers, along with advocates and other interest groups, would first need to begin discussions among themselves, create a fiscal integrity agenda, and begin to come to consensus. These ideas would then need to be brought to Congress and the Administration, debated and discussed though hearings and other public processes, and developed into legislation or proposed regulations. One participant suggested that the organizations mentioned above develop model regulations. The new 5-year comprehensive plan in the DRA for a Medicaid Integrity Program might be a venue for these discussions. Or, alternatively, HHS could establish a commission under the Federal Advisory Committee Act with public meetings that could explore these issues and present specific recommendations for action.

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## CONCLUSION

The Medicaid program carries a heavy load as the primary source of health care coverage for the poorest and most vulnerable Americans. Its administration is necessarily complex, due to its size and scope, and it is made more complex by its joint federal/state oversight and administration. Involving these two levels of government provides a source of creativity and variability, but it inevitably also creates tension. While much of the tension is programmatic, since Medicaid accounts for 43 percent of all federal grants to states, the tension is fiscal as well.

Over the years, states have learned various legal mechanisms for maximizing the share of the program costs borne by the federal government. States' adoption of these practices is quite varied: some states pursue every vehicle aggressively while others have not adopted them. The federal response has also been varied. Despite the fierce rhetoric condemning states for playing "fiscal games," many of these mechanisms have been tacitly encouraged or permitted to grow and operate long after the federal government became aware of them. The reasons for federal complicity are similarly varied, ranging from a desire to support state efforts funded by these mechanisms, to a willingness to cut deals with particular states, to a realization by members of Congress that halting these actions would hurt their own states.

The result has been the creation of an environment of mistrust. Federal regulators are on watch for new financing schemes they consider inappropriate. State administrators are fearful that a change in the federal perspective will translate into the unraveling of programs they established with the federal government's permission and support. States feel that they do not know what will or will not be approved by federal administrators, while federal administrators feel that they do not have the information they need to determine if states are financing and operating their programs appropriately. Congress, state legislatures, and governors echo these concerns and wonder whether the large Medicaid budgets are justified.

While concerns regarding Medicaid's fiscal integrity are warranted, they also need to be kept in perspective. The program is large and costly primarily because it serves more than 55 million people, many of whom have substantial health care needs. Skirmishes over the balance between state and federal financing distract us from the greater challenge of operating the program in an efficient manner, identifying sufficient funding for the program, and considering options for reducing the number of Americans without health insurance.

While the meeting NASHP held regarding fiscal integrity was not designed to develop consensus, the clear sense of the meeting attendees was that the Medicaid program could do better. Many options exist for improving the intergovernmental financial relationship that underlies the program. The key features of a program with fiscal integrity are a clear set of rules, established through a public process, administered fairly and openly for all to see. A variety of possible mechanisms for setting those rules exists, but what is most important is that they be developed and followed.

Fundamentally, improving Medicaid's fiscal integrity is at least as much of a political challenge as it is a substantive challenge. Not only is it a challenge worth taking on – most simply because taxpayers deserve the best from the programs they fund – but also because political and administrative energy should be focused where it is needed most, which is on operating this complex and important program.

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# APPENDIX I: POLICY ACTIONS AND STEPS ON DSH, PROVIDER TAXES, UPLS, AND IGTS

## DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

| YEAR | ORIGINAL | ACTION | CITE |
|---|---|---|---|
| **1981** | *Congress requires states to make additional payments to DSH hospitals for inpatient services* | **Additional payments required for hospitals with large numbers of Medicaid and uninsured patients.** Congress gives states the flexibility to pay for inpatient hospital services using "reasonable and adequate" rates, instead of the cost-based reimbursement system that Medicare had in effect. Recognizing that states would likely reduce Medicaid payment rates for inpatient hospital services and such a reduction would severely impact hospitals treating large numbers of Medicaid and uninsured patients, Congress also requires states to make additional payments to such hospitals in the form of DSH payments. | Omnibus Reconciliation Act of 1981 (P.L. 97-35) |
| **1987** | *Congress establishes a minimum federal standard for qualifying as a DSH hospital* | **Minimum federal standard for qualifying as a disproportionate share hospital established.** With fewer than half of all states establishing the mandated DSH program, Congress passes a provision that requires states to submit a Medicaid state plan amendment describing their DSH policy. Congress also establishes a minimum federal standard for qualifying as a disproportionate share hospital and broad parameters for DSH payment adjustments, giving states wide discretion. | Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) |
| **1991** | *Congress limits DSH spending in each state to 12 percent of total Medicaid spending, with exceptions for "high-DSH" states as of FY92* | **State-level cap on DSH established.** DSH payments rapidly increase from under $1 billion in FY 1990 to over $17.4 billion in FY 1992. Congress limits DSH spending in each state to 12 percent of total Medicaid spending, with exceptions for states with FY 1992 DSH payments exceeding 12% of their FY 1992 Medicaid costs ("high-DSH" states). Payments for high-DSH states are maintained at FY 1992 amounts until these allotments | Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 101-234) |

| YEAR | ORIGINAL | ACTION | CITE |
|---|---|---|---|
| | | equal 12% of the state's Medicaid costs for its current fiscal year. | |
| **1992** | *HCFA issues regulations implementing the 1991 limits.* | **Regulation on DSH limits issued.** HCFA issues regulations implementing the 1991 limits. | 42 CFR 447.296-447.299 |
| **1993** | *Congress imposes facility-specific ceiling on the amount of DSH payments states may make to individual DSH hospitals;*<br>*1-year transition for private DSH hospitals;*<br>*1-year transition for high-DSH public hospitals (200%)* | **Facility-level cap on DSH established.** Congress imposes a facility-specific ceiling on the DSH payments states may make to individual DSH hospitals, limiting these payments to 100% of the uncompensated costs of care for Medicaid and uninsured patients. Private DSH and high-DSH public hospitals are provided a one year phase-in period. | Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) |
| **1997** | *Congress specifies declining allotments of federal DSH funds for each state FY 1998 to FY 2002; limits DSH payments to IMDs (7-year transition); establishes temporary 175% facility-specific ceiling for public hospitals in California* | **State-specific allotments reduced.** Congress specifies declining allotments of federal DSH funds for each state from FY 1998 to FY 2002, reducing total allotments by 8.6% over the time period.<br><br>**DSH payments to IMDs capped.** Due to the exclusion of Medicaid coverage for services delivered to patients between the ages of 21 and 64 in institutions for mental diseases (IMDs), many states substituted Medicaid DSH funding for state IMD funding. To mitigate this practice, Congress limits DSH payments to IMDs to 33% of a state's total DSH payments. (7-year transition period)<br><br>**Facility-level cap temporarily increased for CA public hospitals.** Congress establishes a temporary, facility-cap for CA public hospitals at 175% of uncompensated costs. | Balanced Budget Act of 1997 (P.L. 105-33) |
| **1999** | *Congress makes 175% facility-specific ceiling in California permanent;*<br>*Increases state-specific DSH allotments for DC, NM, MN, WY* | **Facility-level cap permanently increased for CA public hospitals**. Congress makes the 175% facility-specific ceiling in California permanent and increases state-specific DSH allotments for DC, NM, MN, WY for FY 2000 through FY 2002. | |

| YEAR | ORIGINAL | ACTION | CITE |
|---|---|---|---|
| **2000** | *Congress increases state-specific DSH allotments for FY 01 and FY 02;*<br>*extends 175% facility-specific ceiling to all States for SFY 03 and SFY 04;*<br>*provides FFP for payment adjustment to Cook County Hospital* | **Pending reductions in DSH allotments repealed.** Congress eliminates the BBA DSH cuts for FY 2001 and FY 2002, but leaves the FY 2003 reduction of 11.6% intact. State-specific DSH allotments for FY 2001 and FY 2002 are increased based on the consumer price index.<br><br>**Facility-level cap temporarily increased for all states.** Congress also extends 175% facility-specific ceiling to all States for SFY 03 and SFY 04. .<br><br>**Matching payment adjusted for Cook County Hospital.** Congress provides FFP for payment adjustment to Cook County Hospital | Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554) |
| **2003** | *Congress increases all state-specific allotments for FY 2004 by 16%, low-DSH states allotments grow by 16% annually through FY 2008; requires annual reports, independent certified audit of facility-specific limits*<br><br>*CMS begins requests for information about state funding sources in connection with all SPA proposals (Five Funding Questions)* | **State-specific allotments increased for all states, with further increases for low-DSH states.** Congress increases all state-specific allotments for FY 2004 by 16%; low-DSH states allotments grow by 16% annually through FY 2008.<br><br>**State reporting requirements enacted.** Congress requires state reporting of DSH payments made to individual hospitals, and requires annual reports, and independent certified audits of facility-specific limits.<br><br>**Information about state financing sources for Medicaid is requested by CMS.** CMS begins to request information about financing sources of the state share of Medicaid through the State Plan Amendment (SPA) review process. Question 1 asks whether providers retain all Medicaid payments, including DSH, or any portion is returned to the state, local government, or any other intermediary. SPAs will not be approved until states have provided a full explanation and agreed to terminate any improper financing arrangements. | Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173)<br><br>For Five Funding Questions, See Appendix II |

| YEAR | ORIGINAL | ACTION | CITE |
|---|---|---|---|
| **2005** | *CMS issues proposed rule implementing reporting and audit requirements* | **Proposed regulation on reporting and auditing requirements issued.** CMS issues proposed rule implementing reporting and audit requirements. | Medicaid Program; Disproportionate Share Hospital Payments<br><br>69 Fed. Reg. 28195-28817 (May 18, 2004) |

## PROVIDER DONATIONS AND TAXES

| YEAR | ORIGINAL | ACTION | CITE |
|---|---|---|---|
| **1985** | *HCFA issues regulations authorizing use of provider donations* | **Provider donations are permitted to finance any costs of state Medicaid spending.** To allow states flexibility in raising the state share of Medicaid funds, HCFA issues regulations authorizing the use of provider donations to finance any costs of state Medicaid spending. Prior to this, Medicaid rules permitted using provider donations only to fund training. | 42 CFR 433.45(b) |
| **1991** | *Congress effectively prohibits use of provider donations as state share; imposes detailed requirements for provider tax arrangements* | **Provider donations restricted from use to finance state share of Medicaid. Statutory definition and requirements for provider taxes are established.** Using provider tax and donation arrangements to draw down federal funding becomes an increasingly common practice. Congress effectively prohibits the use of provider donations as state share. Additionally, Congress imposes a statutory definition of a provider tax and detailed requirements for provider tax arrangements to clarify the rules under which states can collect revenue from provider taxes for a state's share of Medicaid funding. A provider tax must apply to all non-federal, non-public providers in a class ("broad-based") and equally to every provider in the class ("uniformity"), and the state or locality may not provide a payment or offset to the provider for any portion of the tax (no "hold harmless"). | Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 101-234) |
| **1992** | *HCFA issues regulations implementing 1991 limits on provider donations and taxes* | **Regulations on provider donations and taxes released.** HCFA issues regulations implementing 1991 limits on provider donations and taxes. | 42 CFR 433.55-433.74 |
| **1997** | *Congress waives imposition of 1991 provider tax limits on New York for amounts collected prior to 6/1/97* | **Provider tax limits waived for New York.** In 1994, HHS notifies New York that 15 of its provider taxes do not conform to the 1991 provider tax limits and the state must either return Federal funds in the amount of $955 million | Balanced Budget Act of 1997 (P.L. 105-33) |

| YEAR | ORIGINAL | ACTION | CITE |
|---|---|---|---|
| | | or apply for a waiver to operate these provider tax programs. New York submits waiver requests for allowance of its provider tax programs. HHS takes no formal action and thus New York turns to Congress for relief. Congress waives the imposition of 1991 provider tax limits on New York for amounts collected prior to 6/1/97 and deems these taxes compliant with the 1991 limits. (This provision is line item vetoed by President Clinton but then re-instated after the Supreme Court finds the line item veto power unconstitutional.) | |
| **2002** | *CMS settles $2.2 billion disallowance with MO with "Medicaid Partnership Plan" agreement for annual prospective CMS review of state funding sources* | **CMS enforces provider tax and donations rules.** CMS settles $2.2 billion disallowance with Missouri with the "Medicaid Partnership Plan," an agreement for annual prospective CMS review of state funding sources. | Unpublished. |
| **2003** | *CMS begins requests for information about state funding sources in connection with all SPA proposals (Five Funding Questions)* | **Information about state financing sources for Medicaid is requested by CMS.** CMS begins to request information about financing sources of the state share of Medicaid through the State Plan Amendment (SPA) review process. Question 2 asks states to describe whether the state share of each type of Medicaid payment is funded via provider taxes. SPAs will not be approved until states have provided a full explanation and agreed to terminate any improper financing arrangements. | For Five Funding Questions, See Appendix II |
| **2005** | *Congress considers prohibition on taxing Medicaid MCOs (3-year transition)* | **Congress closes managed care provider tax loopholes.** Congress includes provisions in the Deficit Reduction Act to close provider tax loopholes that permit | Deficit Reduction Act of 2005, S. 6051 (P. L. 109-171) |

| YEAR | ORIGINAL | ACTION | CITE |
|---|---|---|---|
| | *CMS approves 1115 waivers in CA and IA on condition that State does not impose certain provider taxes during the term of the waiver* | taxation of only the Medicaid business lines of managed care organizations. States with laws in effect as of December 8, 2005 have until October 1, 2009 to come into compliance.<br><br>**1115 waivers in CA and IA approved by CMS include restrictions on provider taxes.** CMS approves 1115 waivers in CA and IA on condition that state does not impose certain provider taxes during the term of the waiver. | CA and IA Waivers available on CMS Website[26] |

[26] The waiver database on the CMS website is available at: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp (viewed April 21, 2006). See also, Andy Schneider and Peter Harbage, "Medi-Cal Hospital Waiver Implementation," (August 23, 2005) and Peter Harbage and Andy Schneider, "Medicaid Hospital Waivers: Comparing California, Florida and Massachussetts," California HealthCare Foundation (April 2006).

## UPPER PAYMENT LIMITS

| YEAR | ORIGINAL | ACTION | CITE |
|---|---|---|---|
| **1987** | *HCFA issues regulations imposing aggregate upper payment limits (UPLs) on hospitals, nursing facilities, and ICFs/MR; on state-owned hospitals, nursing facilities, and ICFs/MR; and on outpatient hospital and clinic services.* | **Upper payment limits (UPLs) are established for certain facilities.** HCFA issues regulations limiting aggregate payments to providers. These UPLs are imposed on aggregate payments to all hospitals (state, county, and private) as a group; all nursing facilities as a group; and on outpatient hospital and clinic services.<br><br>Additionally, an UPL is imposed on aggregate payments to state-operated hospitals for inpatient services and another UPL is imposed on aggregate payments to state-operated nursing homes. Separate UPLs are not imposed on aggregate payments to county-operated hospitals or county-owned nursing homes. UPLs are based on Medicare payment principles and restricted to 100% of the Medicare payment. | 42 CFR 447.271-447.272 (1987) |
| **2000** | *Congress requires CMS to issue final regulations applying separate UPLs to hospitals, nursing facilities, and ICFs/MR operated by local governments (up to 8-year transition)* | **Separate UPLs are established for county facilities with a phase-in period.** Congress requires CMS to issue final regulations applying separate UPLs to hospitals, nursing facilities, and ICFs/MR operated by local governments. Recognizing that these intergovernmental transfers utilizing payments to county facilities are operating under federal approval and serve as a vital health care financing source for the states, the separate UPLs are phased-in over a one- to eight- year period, varying by provider type and state. | Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) |
| **2001** | *CMS issues final regulations establishing separate UPLs for hospitals, nursing facilities, and ICFs/MR operated by local governments (set at 150% of Medicare amount for hospital services)* | **Separate UPLs are established.** CMS issues final regulations establishing separate UPLs for hospitals, nursing facilities, and ICFs/MR operated by local governments. The UPL for hospitals is set at 150% of the Medicare amount. | 66 Fed. Reg. 3154 (January 12, 2001)<br><br>42 CFR 447.272, 447.304, 447.321 (2001) |

| YEAR | ORIGINAL | ACTION | CITE |
|---|---|---|---|
| **2002** | *CMS issues regulations reducing the 150% UPLs for hospitals to 100% of Medicare amount*<br><br>*CMS issues regulation extending transition period for VA and WI.* | **UPLs for hospitals are further reduced.** CMS issues regulations reducing the UPLs for hospitals from 150% to 100% of the Medicare amount.<br><br>**Phase-in period is extended for two states.** CMS issues regulation extending transition period for VA and WI. | 67 Fed. Reg. 2602 (January 18, 2002)<br><br>42 CFR 447.272 (2002) |
| **2003** | *CMS begins requests for information about state funding sources in connection with all SPA proposals (Five Funding Questions )* | **Information about state financing sources for Medicaid is requested by CMS.** CMS begins to request information about financing sources of the state share of Medicaid through the State Plan Amendment (SPA) review process. Question 4 asks states to provide a detailed methodology to estimate the UPL for each class of providers. SPAs will not be approved until states have provided a full explanation and agreed to terminate any improper financing arrangements. | For Five Funding Questions, See Appendix II |

## INTERGOVERNMENTAL TRANSFERS AND CERTIFIED PUBLIC EXPENDITURES

| YEAR | ORIGINAL | ACTION | CITE |
|---|---|---|---|
| 1991 | *Congress prohibits HCFA from restricting States' use of funds when derived from state or local taxes transferred from or certified by "units of government within a state" as the non-Federal share* | **States permitted to use certain public funds to finance non-federal share of Medicaid.** In financing the non-federal share of Medicaid, Congress prohibits HCFA from restricting the use of state and local tax revenues and appropriated funds to state university teaching hospitals that are transferred from or certified by units of government with a state. | Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 101-234) |
| 1992 | *HCFA issues regulation describing public funds as a state's share* | **Regulation describing public funds permitted for use in financing state share of Medicaid is issued.** HCFA issues regulation describing states' share of public funds. Public funds are appropriated directly to the state or local Medicaid agency, or transferred from other public agencies to the state or local agency and under its administrative control ("intergovernmental transfer," or IGT), or certified by the contributing public agency as representing expenditures eligible for Federal Financial Participation (FFP) under this section ("certified public expenditure," or CPE). | 42 CFR 433.51 |

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|---|---|---|---|
| 2003 | *CMS begins requests for information about state funding sources in connection with all SPA requests (Five Funding Questions)* | **Information about state financing sources for Medicaid is requested by CMS.** CMS begins to request information about financing sources of the state share of Medicaid through the State Plan Amendment (SPA) review process. Question 2 asks states if any of the state's share is being provided through the use of local funds using IGTs or CPEs, to fully describe the matching arrangement. SPAs will not be approved until states have provided a full explanation and agreed terminate any improper financing arrangements. | For Five Funding Questions, See Appendix II |
| 2005 | *CMS approves 1115 waivers for MA and CA phasing out certain IGTs and replacing them with CPEs based on reported costs*<br><br>*CMS approves 1115 waiver to IA limiting total Medicaid payments to each government-operated hospital or nursing facility to actual costs* | **1115 waivers approved in MA, CA, FL, and IA include provisions targeting financing mechanisms.** CMS approves 1115 waivers for MA and CA, which phase out certain IGTs and replace them with CPEs based on reported costs and approves 1115 waiver to IA limiting total Medicaid payments to each government-operated hospital or nursing facility to actual costs. The FL waiver does not expressly reference IGTs, but the state is required to terminate its UPL program, which involves IGTs if it wants access to low-income pool funds. | Waivers available on CMS Website[27] |

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[27] The waiver database on the CMS website is available at: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp (viewed April 21, 2006). See also, Andy Schneider and Peter Harbage, "Medi-Cal Hospital Waiver Implementation," (August 23, 2005) and Peter Harbage and Andy Schneider, "Medicaid Hospital Waivers: Comparing California, Florida and Massachussetts," California HealthCare Foundation (April 2006).

## APPENDIX II: FIVE FUNDING QUESTIONS[28]

In 2003, CMS began requiring these "Five Funding Questions" to be answered before State Plan Amendments are approved. Although it is not clear how these questions have been interpreted state to state, at the time of our meeting at least 25 states had agreed to sunset financing arrangements that do not satisfy these criteria. As might be expected, states are not pleased with having to answer these questions in order to amend their Medicaid State Plans.

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Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved state plan.

1. Do providers retain all of the Medicaid payments including the federal and state share (includes normal per diem, DRG, DSH, supplemental, enhanced payments, other) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.) For DSH payments, please also indicate if you are making DSH payments in excess of 100% of costs and the percentage of payments in excess of 100% that are returned to the state, local governmental entity, or any other intermediary organization.

Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope, or quality of care and services available under the plan.

2. Please describe how the state share of each type of Medicaid payment (normal per diem, DRG, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditure and state share amounts for each type of Medicaid payment. If any of the state share is being provided through the use of local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for federal financial participation to states for expenditures for services under an approved state plan.

3. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

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[28] Provided as an attachment to the testimony of Dennis G. Smith, Director, Center for Medicaid and State Operations, CMS, The Committee on Energy and Commerce, "Inter-governmental Transfers: Violations of the Federal-State Medicaid Partnership or Legitimate State Budget Tool?" (April 1, 2004).

4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated).
5. Does any public provider receive payments that in the aggregate (normal per diem, DRG, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the federal share of the excess to CMS on the quarterly expenditure report?

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## APPENDIX III: GLOSSARY OF FISCAL INTEGRITY TERMS[29]

- **Certified public expenditure (CPE)** – Federal Medicaid law and regulation authorize the use of CPEs as the non-federal share of Medicaid spending.[30] CPEs are funds certified by counties, university or teaching hospitals, or other public entities within a state as having been spent on the provision of covered services to Medicaid beneficiaries.

- **Disproportionate share hospital (DSH) payment** – Payments made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients.

- **Federal Financial Participation (FFP)** – The technical term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs. States receive FFP for expenditures for services at different rates, depending on their per capita incomes. FFP for administrative expenditures also varies in its rate, depending on the type of administrative cost.

- **Intergovernmental transfer (IGT)** – State and local governments use IGTs to carry out their shared governmental functions, such as collecting and redistributing revenues to provide essential government services. But by using IGTs, states can also transfer funds to or from local-government entities, such as government-owned nursing homes, as part of complex financing schemes that inappropriately boost the share of Medicaid costs.[31]

- **Provider donation** – A sponsorship payment made to the state by a health care provider.

- **Provider tax** – A tax, fee, assessment, or other mandatory payment required of health care providers by a state.

- **Upper payment limits (UPL)** – Limits set forth in Centers for Medicare & Medicaid Services (CMS) regulations on the amount of Medicaid payments a state may make to hospitals, nursing facilities, and other classes of providers and plans.

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[29] Adapted from "The Medicaid Resource Book," Kaiser Family Foundation, July 2002 unless otherwise noted.
[30] Andy Schneider and Peter Harbage, "Medi-Cal Hospital Waiver Implementation," August 23, 2005. Section 1903(w)(6) of the Social Security Act, 42 USC 1903b(w)(6); 42 CFR 433.51(b).
[31] GAO, Testimony of Kathryn Allen Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives "Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes." March 18, 2004.

## APPENDIX IV: ATTENDEES LIST

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Tuesday, November 1, 2005

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