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POLICY BRIEF

State Abuse of the Medicaid Program

How state officials manipulate Medicaid and increase costs to taxpayers

by
Dr. Roger Stark, Policy Analyst
Colin Swanson, Research Assistant

February 2010

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for health care

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Key Findings

- Medicaid is a health care entitlement program with funding split between the states and the federal government. Poorer states receive a higher percent of federal funds than richer states.
- Medicaid is the single fastest growing part of the budget in most states, including Washington, and threatens to undermine funding for other state programs.
- Officials in some states, including Washington, manipulate the rules of Medicaid to leverage more money from the federal government, shifting the cost of their states' programs on to federal taxpayers.
- State officials arrange for hospitals and nursing homes to receive higher Medicaid payments, which in turn funnel this money into state treasuries. Washington state's proposed nursing home bed tax is an example of this type of arrangement.

Recommendations

1. Repeal the Medicaid Safety Net Act.
2. Place heavy limits and restrictions on Disproportionate Share Hospital payments and Upper Payment Limits.
3. Increase oversight and transparency on Intergovernmental Transfers and provider taxes.
4. Freeze funding at 2007 or even 2005 levels.
5. Tighten eligibility requirements.
6. Avoid supplementing provider taxes such as a nursing homes bed tax.

Introduction

The Medicaid program to provide health coverage for low-income people began in 1965 with the passage of Title XIX of the Social Security Act. It has always been an entitlement, with no defined limit on the number of beneficiaries or the cost of the program. As long as a person meets the legal criteria for participation in the program, that person receives Medicaid benefits, regardless of total cost to taxpayers.

From the beginning, a link was established between Medicaid eligibility and the welfare program, Aid to Families with Dependant Children (AFDC).[1] Medicaid is now the largest health insurance system in the United States and is the largest means-tested health care program in the world.

The cost of Medicaid is shared between federal and state governments. Each state receives federal money on a sliding scale based on average personal income, with poorer states getting a higher percentage of federal funds. For example, Alabama and Arkansas receive 69% and 73% federal funding respectively, whereas a number of wealthier states receive the minimum of 50% of federal money for their Medicaid match. At present, the average match for Medicaid spending is 57% in federal money and 43% in state funds.[2]

Medicaid spending is now the fastest growing line item in almost every state budget. In 2006, Medicaid spending accounted for fully 23% of the average state budget.[3]

When enacted in the mid-1960s, Congress estimated Medicaid would cost around $500 million the first year. The actual cost was double that, $1 billion. By 1970 the cost of the program had grown five-fold, to $5 billion. In the years following the cost of Medicaid ballooned, reaching a total of $336 billion a year by 2007.

Total spending on Medicaid in Washington state was $4.13 billion in fiscal 2008. Not counting added spending from the 2009 federal stimulus package, this number is projected to increase by 4.7% to $4.32 billion for fiscal 2009. The contribution from Washington state taxpayers for both years is 48% of the total, which is significantly higher than the nationwide state matching average of 43%.

[1] "Medicaid Legislative History, 1965-2000," The Kaiser Commission on Medicaid and the Uninsured, Appendix 1, page 175, 2000.
[2] "Brief Summaries of Medicare and Medicaid," by Earl Dirk Hoffman, Jr., et al., Centers for Medicare and Medicaid Services, Department of Health and Human Services, November 1, 2008.
[3] "2005 State Expenditure Report," National Association of State Budget Officers, November 2006, pages 2 and 3.

According to the National Association of State Budget Officers, Medicaid costs will grow much faster than state revenue growth for the foreseeable future, meaning the program will consume an ever-larger share of state budgets. For 2007, Medicaid expenses for federal and state governments combined totaled $336 billion. This number is projected to reach $523 billion by 2013, a 56% increase in just six years.[4]

Unless rates of spending increase slow down, Medicaid spending will double by 2017.[5] At an average growth rate of 8% a year, Medicaid is the fastest growing federal entitlement program.[6] The non-partisan Congressional Budget Office estimates that without changes in current policies the Medicaid program alone will account for almost 6% of the nation's Gross Domestic Product by 2017.[7]

This paper discusses state-federal Medicaid financing since the 1980s and how state officials have manipulated the federal program to receive extra matching money. Washington state's proposed provider tax and the proposed "bed tax" on nursing homes are examples of how state officials adopt policies in an effort to leverage more federal funding from the Medicaid program. Since Medicaid is an entitlement with no statutory limit on spending, there is no limit to how much state officials can try to gain from the program.

This paper then reviews how past government efforts have failed to curtail manipulation of Medicaid and how more government intervention will only lead to more gaming of the system. The study concludes with a discussion of policy recommendations that would effectively control Medicaid costs, reform Medicaid financing, limit manipulation of the rules by state officials, and help make the program financially sustainable into the future.

The Original Medicaid Program

As enacted in 1965, the Medicaid program was added as Title XIX of the Social Security Act. As an entitlement, the new law committed federal taxpayers to paying for health services, regardless of cost, for all U.S. residents who meet the eligibility requirements.[8] Eligibility was initially defined as:

1. All children in families with incomes of less than 133% of the federal poverty level (FPL)
2. All adult caretakers of eligible children
3. Elderly people not receiving supplemental social security benefits
4. The legally blind
5. The disabled

Medicaid was set up as a joint federal and state program, with Washington D.C. providing broad national guidelines and the individual states deciding the type, duration and amount of health services to be provided, as well as the eligibility criteria.

The original thinking in Congress was that a joint program would protect taxpayers because state legislators would not be as willing to spend their state

[4] "Brief Summaries of Medicare and Medicaid," by Earl Dirk Hoffman, Jr., et al., Centers for Medicare and Medicaid Services, Department of Health and Human Services, November 1, 2008.
[5] "Federal Medicaid Payments," CBO March 2008 Baseline: Medicaid, Congressional Budget Office, March 2008, at www.cbo.gov/budget/factsheets/2008b/medicaidBaseline.pdf.
[6] "The Budget and Economic Outlook, 2007 – 2017, An Update," Congressional Budget Office, August 2007, page 9, at www.cbo.gov/ftpdocs/85xx/doc8565/08-23-Update07.pdf.
[7] Ibid, page 3.
[8] "Medicaid Milestones, 1965 - 2000," History, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, at www.cms.hhs.gov/History/Downloads/Medicaid-Milestones.pdf.

dollars on an entitlement plan. The rapid expansion in the eligibility and cost of the program since then, however, has shown this supposition to be false. The opposite has occurred. State lawmakers have greatly expanded the program in their pursuit of federal matching dollars.

States that wanted to participate in Medicaid were required to submit a comprehensive plan to the Medicaid office in Washington, D.C. Officials in all 50 states did so. Although the federal guidelines were intended by Congress merely to set broad parameters, the original regulations ran to 220 pages of single-spaced type and included specific mandatory eligibility and benefit criteria.

Originally, not all poor people qualified for Medicaid. Eligibility requirements based on income have been a moving target for state officials through the years, and have led to a variety of added state-only programs for the poor and for uninsured people who are not covered by the federal Medicaid program.

How Medicaid is Financed

As mentioned, the cost of Medicaid is shared between federal and state governments. Each state receives federal money on a sliding scale based on average personal income, with poorer states getting a higher percentage of federal funds. This sliding scale is based on a calculation called the Federal Medical Assistance Program (FMAP).[9] According to the Social Security Act, the Secretary of Health and Human Services (HHS) is required to publish the Federal Medical Assistance Percentages each year. The Secretary calculates the percentages from Department of Commerce statistics of average income per person in each state and for the nation as a whole.[10]

Expansion of Federal Medicaid Payments to the States

The General Accounting Office (GAO) has reported over a decade of financial arrangements that inappropriately increase federal Medicaid matching payments. Between 1994 and 2005, the GAO claimed that some states received federal funds by paying amounts greatly exceeding Medicaid rates to particular government entities and providers.[11] States then charged the national Centers for Medicare and Medicaid Services (CMS) for the federal share of the payment, shifting the cost inappropriately from the state to the federal government. Although not specifically illegal, these actions clearly violated the spirit of the Medicaid program.

Excess Payments in the 1980s

Instead of holding down Medicaid costs, states have historically sought ways to increase spending in an effort to secure more federal matching funds. For example, in the Omnibus Reconciliation Act of 1980, Congress enhanced the flexibility of states to provide payments for nursing facilities.[12] This act established that states were allowed to set nursing home rates in accordance to their perceived "needs."

[9] "Medicaid Financing," National Health Policy Forum, January 19, 2009, at http://www.nhpf.org/library/the-basics/Basics_MedicaidFinancing_01-15-09.pdf, page 1.
[10] "Federal Medical Assistance Percentages," Department of Health and Human Services November 26, 2008, at http://aspe.hhs.gov/health/fmap10.htm.
[11] "Medicaid Financing," United States Government Accountability Office, April 2009, at http://www.gao.gov/new.items/d08650t.pdf, page 3.
[12] "DAB No. 129," Departmental Appeals Board, Washington State Department of Social Health and Services, March 22, 1989, at http://www.hhs.gov/dab/decisions/dab1029.htm.

These payment rates were based on an estimated limit set by state officials before actual costs were known. State officials would deliberately set the estimate of their costs far above the amount actually needed by the nursing providers. Then the nursing providers would return the excess Medicaid payments they received to the states' treasuries in the form of state nursing home taxes. The arrangement allowed state officials to receive increased federal money in the form of "kickbacks" from nursing home providers.

In 1987, the federal government imposed restrictions on these excess payments. However, unaware of the unintended consequence, officials issuing these rules created a loophole which opened a path for exploiting four technical payment mechanisms:

1. Intergovernmental Transfers (IGTs)
2. Upper Payment Limits (UPLs)
3. Disproportionate Share Hospital (DSH) payments
4. Provider taxes

1. Intergovernmental Transfers

Intergovernmental transfers (IGTs) are shifts of public funds among different levels of governments (for example from counties to states) or government entities (for example from public hospitals to state agencies). According to the Social Security Act, "the Secretary may not restrict states' use of funds where such funds are derived from state or local taxes…regardless of whether the unit of government is also a health care provider."[13]

In other words, the federal government does not have control of a state's funding that is transferred within the state. IGTs are a legal way for a state to pay for its share of Medicaid. Since 2001, twenty states, including Washington, have adopted this practice. However, the policy can be financially abusive when used in association with Upper Payment Limits, Disproportionate Share Hospital payments and provider taxes.

2. Upper Payment Limits

According to the CMS, Upper Payment Limits (UPLs) set a ceiling on how much the federal government will pay as its share of a state's Medicaid costs. The UPL was originally created as a regulation tool to control federal spending. As stated, states obtained federal funding far exceeding the amounts needed during the early 1980s.

In 1987, the Health Care Financing Administration (HCFA) issued regulations to limit total payments to state-operated hospitals and nursing faculties.[14] Despite the good intention to control expenditures, Medicaid providers, such as hospitals, found a loophole to avoid these restrictions. They banded their UPLs together to increase the overall supplemental compensation they received.

These combined UPLs created a gap between the upper payment limit and the regular reimbursement rate, which providers then used to receive additional payments above the reimbursement rate. Consequently, states ended up paying some Medicaid providers (especially hospitals owned by local governments) money far surpassing the established payment rate.

[13] "Medicaid Financing Issues: Intergovernmental Transfers and Fiscal Integrity," Kaiser Commission on Medicaid and the Uninsured, February 2005, at http://www.kff.org/medicaid/upload/Medicaid-Financing-Issues-Intergovernmental-Transfers-and-Fiscal-Integrity-Fact-Sheet.pdf.
[14] "An Overview of IGTs, UPLs and DSH," by David Rousseau, Current Issues in Medicaid Financing, Kaiser commission on Medicaid and the Uninsured, April 2004, page 11.

Through intergovernmental transfers (IGTs), a state government then required the providers to return the excess payments to the state. The state treasury pocketed the excess cash, which state lawmakers spent on other programs. A number of states allowed county-owned hospitals to keep a small percentage of the federal funds.[15]

The GAO estimates that in 2001, Wisconsin effectively increased the federal matching share of its total Medicaid expenditures from 59% to 68%, resulting in higher costs to federal taxpayers and a large windfall to the state treasury.[16] Here is an example of how it worked:

> **Step 1**. The state Medicaid agency made a $41 million supplemental payment to a local public hospital. The payment consisted of $30.5 million from federal taxpayers and $10.5 million from the state.
>
> **Step 2**. The local public hospital then sent $39 million to the state treasury as an Intergovernmental Transfer.
>
> **Step 3**. The result was federal taxpayers paid $30.5 million, hospital officials kept $2 million, and the state treasury netted $29.5 million.

Similarly, Virginia provided six local government nursing homes an additional $617 in federal funds per Medicaid nursing home resident per day.[17] Iowa officials increased their Medicaid spending 18 fold – from a starting cost of $54 per resident per day to $969 per resident per day by 1999.[18]

As of 2004, Washington's estimated total UPL payments were almost $500 million.[19]

UPLs are not effective at controlling federal expenditures because the upper limit is not set on the price paid for each service provided. Rather it is imposed as an overall ceiling on Medicaid expenses above which the federal government would pay.[20]

State officials easily evade the upper limit by transferring money, as described, from local government hospitals and nursing homes to the state treasury.

3. Disproportionate Share Hospitals

Hospitals that treat a significant portion of Medicaid and special needs patients qualify for special supplemental funding through the Disproportionate Share Hospitals (DSH) program. The purpose of DSH payments are to encourage hospitals to serve more Medicaid and low-income uninsured patients than other

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[15] "Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight," United States Government Accountability Office, April 2008, at http://www.gao.gov/new.items/d08650t.pdf, page 8.
[16] "Intergovernmental Transfers Have Facilitated State Financing Schemes," United States Government Accountability Office, March 2004, at http://www.gao.gov/new.items/d04574t.pdf, page 1.
[17] "Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes," United States Government Accountability Office, October 2001, at http://www.gao.gov/new.items/d02147.pdf, page 11.
[18] Ibid, page 7.
[19] "An Overview of IGTs, UPLs and DSH," by David Rousseau, Current Issues in Medicaid Financing, Kaiser commission on Medicaid and the Uninsured, April 2004, at http://www.cliftoncpa.com/Assets/pdf/CG-DSH-18.pdf, page 8.
[20] "Medicaid: State Financing Schemes Again Drive Up Federal Payments," U.S. General Accountability Office, September 2000, page 3, at www.wa.gov/archive/2000/he00193t.pdf.

medical facilities. According to Section 1902 of the Social Security Act, states are required to set the public process for determining DSH payments.[21]

This public process describes two ways of obtaining DSH payments. The primary method is a complex statutory formula that determines the DSH patient percentage for a given hospital. The second method applies to large urban hospitals that can show that more than 30% of their total net inpatient care revenues come from state and local governments for indigent care (other than Medicare or Medicaid).[22]

Similar to UPLs, states can make excess payments to government-owned hospitals which then use Intergovernmental Transfer payments to return the excess state payments back to the state's treasury, while keeping the federal matching funds that came with the original state payments. In 2007, DSH payments totaled $15.8 billion in combined federal and state funds,[23] an 18% increase over the level in 2004.[24]

As an example of how this manipulation of Medicaid works, in one year Michigan officials made DSH payments of $458 million, which included $256 million in federal Medicaid matching funds, to 53 public hospitals. These hospitals used only $208 million to pay for medical services for Medicaid patients and then sent the balance of $250 million to the state treasury.[25] By manipulating the Medicaid program, Michigan lawmakers gained control of $250 million in public money to which they would not otherwise have had access.

The amount the Michigan hospitals sent to the state treasury almost exactly equaled the amount the hospitals had received in Medicaid matching funds. Put another way, Michigan lawmakers used the public hospitals as a financial device for funneling federal Medicaid dollars into the state treasury. Michigan lawmakers then used these federal dollars to fund general state programs.

4. Provider Taxes

Since the 1990s, states have collected revenue from the taxation of providers such as hospitals, nursing facilities, and managed care organizations. These taxes count as Medicaid expenditures through DSH or UPL payments. The state taxes providers pay qualify for federal matching payments and are paid to the providers.[26] The providers then return most of the federal payments to the states. Between 1991 and 1992, these state taxes accounted for 25% of Medicaid's annual spending growth.[27]

In 1991, Congress enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments to restrict federal payment generated by state

[21] "State Plans for Medical Assistance," Social Security Act, Section 1902(a)(13), at www.ssa.gov/OP_Home/ssact/title19/1902.htm.
[22] "Disproportionate Share Hospital," Center for Medicare & Medicaid Services, at http://www.cms.hhs.gov/acuteinpatientpps/05_dsh.asp.
[23] "Medicaid Financing," National Health Policy Forum, January 19, 2009, at www.nhpf.org/library/the-basics/Basics_MedicaidFinancing_01-15-09.pdf, page 4.
[24] "An Overview of IGTs, UPLs and DSH," by David Rousseau, Current Issues in Medicaid Financing, Kaiser commission on Medicaid and the Uninsured, April 2004, .http://www.cliftoncpa.com/Assets/pdf/CG-DSH-18.pdf, page 9.
[25] "Michigan Financing Arrangements," United States Government Accountability Office, May 1995, at http://archive.gao.gov/paprpdf1/154203.pdf, page 8.
[26] "Medicaid Financing," Kaiser Commission on Medicaid and the Uninsured, April 2004, at http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14261, page 108.
[27] "State Medicaid Financing Practices," United States Government Accountability Office, January 1996, at http://archive.gao.gov/paprpdf1/156091.pdf, page 1.

provider taxes. States were still allowed to collect these taxes, however the revenue had to meet strict requirements:[28]

- Must cover at least all non-federal, non public providers in a class
- The tax is imposed uniformly upon every provider
- Does not provide a payment that holds the provider "harmless" of the cost
- Prohibits taxes that exceed 25% of the state's share of Medicaid expenditures

Since this amendment was passed, the states and the CMS have been in constant dispute over which provider taxes are allowed. Even so, these new requirements have been generally successful in limiting the worst exploitation of the federal program by state officials.

However, many states still rely heavily on these taxes to fund their Medicaid budgets (some states generated almost 20% of their Medicaid budgets through provider taxes).[29] State officials have not given in easily to the new requirements. The federal government has loosened the requirements in response to states' demand to continue collecting provider taxes. New administrative rules exempt taxes from federal restrictions if the revenues generated by the new tax account for less than 6% of the revenue received by the taxpayers (known as "safe harbor").[30]

Government Reform to Reduce Exploited Funding

Federal officials are aware of how state officials manipulate the Medicaid program in order to maximize the amount of federal money states receive and have initiated various Medicaid reforms over the past thirty years. Following is a list of the major federal reform efforts.

Timeline of Federal Action on DSH Payments, IGTs, Provider Taxes, and UPLs

1981 – Congress requires states to make additional payments to DSH hospitals for inpatient services (Omnibus Budget Reconciliation Act of 1981).

1987 – Congress establishes a minimum federal standard for qualifying as a DSH hospital (Omnibus Budget Reconciliation Act of 1987).

1991 – Congress

1) establishes detailed rules for provider taxes used to generate revenues as state share of Medicaid spending,

2) prohibits CMS from restricting IGTs of state or local tax revenues, and

3) limits DSH spending in each state to 12% of total Medicaid spending (Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991).

[28] "Medicaid Provider Tax," by Jean Heame, Congressional Research Service report to Congress, April 2008, at http://aging.senate.gov/crs/medicaid9.pdf, 2.
[29] "Medicaid Financing," Kaiser Commission on Medicaid and the Uninsured, April 2004, at http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14261, page 110.
[30] "Medicaid Provider Tax," by Jean Hearme, Congressional Research Service report to Congress, April 2008, at http://aging.senate.gov/crs/medicaid9.pdf, page 4.

1993 – Congress imposes facility-specific ceilings on the amount of DSH payments states may make to DSH hospitals (Omnibus Budget Reconciliation Act of 1993).

1997 – Congress specifies and phases down over FY 1997 through FY 2002 allotments of federal DSH funds for each state (Balance Budget Act of 1997).

2000 – Congress

1) increases state-specific allotments of federal DSH funds for FY 2001 and FY 2002, and

2) requires CMS to issue final regulations applying UPLs to providers owned or operated by local governments allowing for a transition period of up to eight years (Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000).

2001 – CMS issues final regulation establishing UPLs for local public providers and transition periods (66 Federal Register at 3154, 3173, January 12, 2001.

2003 – Congress increases state-specific allotments of federal DSH funds for FY 2004 by 18% (Medicare Prescription Drug, Improvement and Modernization Act of 2003).

Despite these intensive efforts by federal officials to stop state manipulation of Medicaid, by 2000 the Health and Human Services Office of Inspector General found that officials in nearly 30 states were exploiting Medicaid rules to secure federal funds beyond what they would otherwise receive.[31] The exact amount state officials collected in this way is unknown, but federal auditors estimate the number to be in the billions of dollars.

These regulations against Medicaid manipulation were ineffective because after the federal government implemented a new rule, CMS would shorten the time it allowed states to comply with the new regulations. Because of these time constraints, CMS would then reverse its position and approve federal matching funds under the old regulations, which led to the continued manipulation of the Medicaid program by state officials.

Recent Federal Actions

Since these regulations were ineffective, the GAO decided greater transparency was needed. The GAO and CMS worked together to introduced an oversight proposal in 2003 that resulted in a majority of the offending states ending at least one inappropriate financial arrangement. With this initiative, a state submits a proposal to change provider payments under its Medicaid plan.

CMS approves this plan in accordance with how each state operates its own Medicaid program and then investigates all financial arrangements. CMS withholds supplemental appropriations until it is confident the manipulative financial arrangements within the states have ended.[32]

The result of this proposal are mixed. From August 2003 to August 2006, twenty-nine states ended 55 financing arrangements that CMS determined to be

[31] "Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes," U. S. Government Accountability Office, October 2001, at http://www.gao.gov/new.items/d02147.pdf, page 6.

[32] "Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency," U. S. Government Accountability Office, March 2007 http://www.gao.gov/new.items/d07214.pdf, page 2.

manipulative.[33] Even though this was a major accomplishment for CMS, it did not end state officials' manipulation of the Medicaid program. Nearly two-thirds of the involved states continue to seek supplemental payments using financial arrangements which they were supposed to have ended.[34]

There are two reasons for this lack of success. First, even though there was a proposed regulation published in the Federal Register on January 18, 2007, detailed approval standards for these financial arrangements lacked written guidance. Only eight of the 29 states received written guidance on how to end their manipulative financial arrangements.[35]

Second, the states were never provided with a clear, written explanation of why they must restrict these financial deals. In fact, 30 of the 55 financial arrangements established as exploitative by the GAO involved no evidence that CMS had told the states their arrangements were inconsistent with the Medicaid payment principles.[36]

Due to the lack of transparency, the CMS published a proposed rule in 2007 clarifying allowable arrangements for financing the non-federal share of Medicaid payments. The regulation also limited Medicaid provider payments to the legal reimbursement schedule.[37]

However the GAO did not have enough time to fully analyze this new rule. On April 23, 2008, the House of Representatives passed the Medicaid Safety Net Act (MSNA) which placed a moratorium until March of 2009 on this proposed regulation.[38] This moratorium threatened to stifle regulations against states attempting to maximize their federal funding for Medicaid – compromising all the effort implemented to date to curtail these financial schemes. Although the MSNA passed the House with an overwhelming majority, the Senate did take up the legislation and it did not become law.

Washington State's Bed Tax on Nursing Homes

Despite the partial success of federal restrictions in reducing the manipulation of the Medicaid program by state officials, by 2004 thirty-four states had imposed a Nursing Home Provider Tax, including Washington.[39] As of February 2010, Washington's deficit has ballooned to over $2.8 billion.[40] The state is analyzing all possibilities to narrow the deficit. The State Health Care Association suggested reintroducing a bed tax on nursing home providers as a way of increasing the federal Medicaid matching funds paid to the state.

This proposal is not a new idea. In 2003, Washington lawmakers imposed a bed tax on nursing facilities of $6.50 per patient per day.[41] The tax was projected to increase funds by over $70 million, which would be matched with federal funds to allow the legislature to increase nursing home payments by a total of

[33] Ibid., page 5.
[34] Ibid., page 6.
[35] Ibid., page 28.
[36] Ibid., page 30.
[37] Ibid., page 29.
[38] "Medicaid Financing: Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight," U. S. Government Accountability Office, March 2007 http://www.gao.gov/new.items/d08650t.pdf, page 11.
[39] " Nursing Home Provider Taxes," by Robin Cohen, Connecticut General Assembly, May 2004, at http://www.cga.ct.gov/2004/rpt/2004-R-0386.htm.
[40] " Changing the Budget Status Quo," by Jason Mercier, Washington Policy Center, December 2008, at www.washingtonpolicy.org/Center/government/policynotes/ChangingbudgetStatusQuo.pdf
[41] "Nursing Home Reimbursement," House Republican Committee, June 2008, at http://hrc.leg.wa.gov/issues/Issues101/Budget/NursingHomeReimbursement.pdf.

$91.7 million. Since Washington's federal matching ratio was around 50% at this time, state officials were able to obtain over $30 million more from the federal government. This additional funding was stored in a reserve account to ease the budget deficit that year, and then spent on general state programs.

With the implemented regulation on provider taxes, the state faced heavy federal scrutiny on its new bed tax. Initially the federal government denied the request, but reluctantly approved the tax. Out of all the nursing homes in Washington, a total of 34 were excluded (because they did not accept public money), but the remaining 266 nursing homes were taxed.

As mentioned, certain revenues generated by a provider tax were exempt from the federal limits imposed in 1991.[42] This opened the door for Washington state officials to recycle their Medicaid dollars and increase federal expenditures. They could use these supplemental expenditures to reduce their budget deficit.

The bill, however, faced strong opposition. First, the new revenue was not appropriated for nursing homes payment, a move heavily criticized by the nursing home industry ($25 million of the raised revenue was used instead to offset tax credits for the aerospace industry).[43] At the same time, CMS imposed strict oversight to make sure the state did not exploit the tax to receive larger federal Medicaid payments. Soon state legislators decided to rescind the tax. First the state government passed a bill in 2005 that would have phased out the tax until its repeal in 2011. Due to the unpopularity of the tax, the 2006 legislature voted to repeal the tax entirely by 2007.[44]

Wisconsin Fraud and Abuse of its Nursing Home Bed Tax

Even though Washington was unable to exploit Medicaid expenditures, Wisconsin found a way to bypass federal requirements and show the provider's tax can still be financially abusive. Wisconsin officials established a nursing home bed tax in 1991. The tax started out at $32 a month per occupied nursing home bed and by 2005 lawmakers raised it to $75 per bed. Currently under the Governor's 2007-2009 budget, the tax increased to $101.10 in 2007-08 and to $125.33 in 2008-09. The governor's intention was to increase Medicaid nursing reimbursement rates by 2% each year.[45]

There is more that meets the eye with this bed tax. State officials will always attempt to maximize their federal funding to help pay for other state programs. Of each additional federal dollar that is spent on nursing homes, only 41 cents would be used to pay nursing home expenses. The remaining 59 cents would be devoted to other state spending.[46]

Even though Washington lawmakers failed to exploit federal Medicaid expenditures with their bed tax, Wisconsin officials have been able to receive added federal funds – proving that the federal efforts to end the abuse of provider taxes have not been entirely effective.

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[42] "Medicaid Provider Tax," by Jean Hearme, Congressional Research Service report to Congress, April 2008, at http://aging.senate.gov/crs/medicaid9.pdf, 2.
[43] "State Responses to Budget Crisis in 2004: An Overview of Ten States - Case Study of Washington" Kaiser Commission on Medicaid and the Uninsured, January 2004, at http://www.kff.org/medicaid/upload/State-Case-Study-Medicaid-and-the-2003-05-Budget-Crisis-A-Look-At-How-Washington-Responded-Report.pdf, page 4.
[44] "Senate 6368: Nursing Facility Bed Tax" Washington Legislature, February 2006, http://apps.leg.wa.gov/documents/billdocs/200506/Pdf/Bills/Session%20Law%202006/6368.SL.pdf.
[45] "Nursing Home Medicaid Rate Increase and Provider Bed Tax," Wisconsin Association of Homes and Services for the Aging, Inc., February 2007, at http://www.wahsa.org/07marates.pdf.
[46] "Don't Tax You; Don't Tax Me; Tax the Sick and Elderly," by Dale Schultz, 17th District of Wisconsin, at www.legis.wi.gov/senate/sen17/news/Press/2009/pr2009-038.asp.

Is Government Intervention the Solution to the Problem?

State officials will always try to maximize their federal funding while the federal government continues to impose restrictions on state manipulation of the program. However, are these tighter federal regulations really worthwhile?

In the 1980s, states obtained excessive federal payments. The federal government responded by cracking down with new regulations in an attempt to stop payments, unaware these new regulations merely created new loopholes for state officials to exploit.

Recognizing this problem, federal officials imposed more regulations during the 1990s. State officials were still able to avoid federal oversight, however. Finally when the CMS got serious in 2003 and attempted to stop unorthodox Medicaid financing arrangements, the oversight lacked transparency – states were still able to continue to use these creative financial schemes to leverage ever-larger federal matching funds.

Even when the federal government imposed relatively successful restrictions on provider taxes, some state officials, in Wisconsin for example, still managed to receive excess payments. Washington officials were ultimately unsuccessful, because of federal objections, in their attempt to exploit federal funding with a nursing home bed tax. This year, however, they are trying again with a new bed tax.

The Obama administration and Congress are already laying the groundwork for a massive additional government intervention into health care. The Medicaid Safety Net Act confirms the federal government's priority is to expand Medicaid programs rather than promoting transparency and oversight between the federal and state governments. Massive government intervention will open opportunities for state legislators, including those in Washington, to off-load their Medicaid costs onto federal taxpayers.

Recommendations

Massive government intervention will open opportunities for state legislators, including those in Washington state, to shift their Medicaid costs on to federal taxpayers. Instead of imposing futile regulations, federal and state government officials should take the following actions.

First, they should repeal the Medicaid Safety Net Act. This would reintroduce the restrictions and oversight on exploiting financing schemes established earlier by the GAO. In order for these restrictions to actually limit mistreatment of federal funding, Congress should freeze funding at fiscal 2007, or even fiscal 2005, levels.

Second, Congress should restore entitlement eligibility requirements to the original 1965 level. This step would dramatically reduce excessive federal funding and help control costs. Returning to the original intent of Medicaid would target state and federal health care funding to people who need it most: low-income families that lack access to affordable health coverage. Restoring Medicaid's original purpose would place the program on a firmer and more sustainable basis going forward, forestalling the day when Medicaid goes bankrupt, or when program growth consumes the majority of annual state budgets.

Third, state officials should refrain from implementing new provider taxes, such as a nursing bed tax, in an effort to use federal Medicaid matching funds to pay for general state programs. If state officials face budget problems, they should

reduce expenditures rather than adding a state tax that is designed to game federal dollars.

Summary of Recommendations

1. Repeal the Medicaid Safety Net Act
2. Place heavy limits and restrictions on Disproportionate Share Hospital payments and Upper Payment Limits
3. Increase oversight and transparency on Intergovernmental Transfers and provider taxes
4. Freeze funding at 2007 or even 2005 levels
5. Tighten eligibility requirements
6. Avoid supplementing provider taxes such as a nursing homes bed tax

Conclusion

The economic recession lowdown has already caused an increase in unemployment and a slowing in the yearly growth of the tax base. As unemployment rises, the growth of Medicaid is predicted to increase; yet there will be less tax revenue to support increased enrollment in this entitlement program.

The vast majority of states, including Washington, face substantial budget deficits in the next fiscal year. Logic would say that state policymakers should slow down the expansion of their Medicaid programs. Instead, the reverse seems to be happening – state officials are aggressively seeking ways to balance their budgets without decreasing long-term expenditures.

State officials have been gaming with federal dollars since the 1980s. Instead of freezing their funding levels and tightening eligibility requirements, state governments have used the following financial schemes to not only help pay for their Medicaid program but to pay for other state programs too – Intergovernmental Transfers (IGTs), Upper Payment Levels (UPLs), Disproportionate Share Hospitals (DSHs) and Provider Taxes.

Imposing yet more government regulations, or enacting sweeping government control of American health care, will not solve the issue at hand. Experience verifies that even as the federal government intervened to stop this exploitation, other schemes perpetually materialize. The advancement of transparency and oversight to protect the financial integrity of the Medicaid program will allocate scarce resources efficiently.

Limited public safety net programs will always be needed to provide health care for the poorest and most vulnerable people in our society. However, state officials' use of financial schemes to exploit an important federal program to pay for general state spending, demonstrates one reason the cost of Medicaid is the fastest growing line item in every state budget. Only thorough financial reform will ensure that Medicaid is placed on a sound long-term basis, so it remains reliably available to provide vital health services for low-income families in the future.

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