

**Memorandum**

SEP 11 2001

Date *Michael Mangano*  
From Michael F. Mangano  
Principal Deputy Inspector General

Subject Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers (A-03-00-00216)

To Thomas Scully  
Administrator  
Centers for Medicare and Medicaid Services

Attached are two copies of a final report that consolidates the results of seven Office of Inspector General audits, conducted in six States, of Medicaid enhanced payments to local public providers and the use of intergovernmental transfers (IGT). It also presents data on current or expected enhanced payment programs in 22 other States.

The objectives of our review were to analyze the States' use of IGTs to finance enhanced payments to county or local government-owned nursing facilities and hospitals as part of their compliance with Medicaid upper payment limit regulations and to evaluate the financial impact of these transfers on the Medicaid program. An IGT represents a transfer of funds from one level of government to another. Under Medicaid upper payment limit rules, States are permitted to establish payment methodologies that allow for enhanced payments to non-State-owned government providers, such as county-owned nursing facilities and hospitals. The enhanced payments, which trigger a Federal matching payment, are in addition to the basic payment rates for Medicaid providers.

In Federal Fiscal Year 2000, 28 States made or planned to make at least \$10.3 billion in Medicaid enhanced payments which included \$5.8 billion in Federal matching funds. Prior to 1999, only 12 States had enhanced payment programs. If not brought under control, the rapid growth of these enhanced payment programs threaten the financial stability of the Medicaid program.

Our audits of seven enhanced payment programs in six States found that the enhanced payments to local government-owned providers were not based on the actual cost of providing services to Medicaid beneficiaries, nor did we find a direct relationship in the use of these funds to increase the quality of care provided by these public facilities. We also found that a large portion of the enhanced payments were not retained by the nursing facilities to provide services to resident Medicaid beneficiaries. Instead, some or most of the funds were transferred back to the States for other uses. Some of the funds transferred back to the State governments were earmarked for use in health care related service areas but not necessarily for Medicaid covered services approved in the State plans.

In contrast to the nursing facilities, hospital providers kept a large portion of the enhanced payments. However, the hospitals either did not receive Medicaid disproportionate share hospital (DSH) payments from their State, or returned the majority of the Medicaid DSH payments to their State through IGTs. It appears, for these providers, that States have used enhanced payments in place of DSH payments, although Medicaid DSH payments are intended to help hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients.

For the portion of the enhanced payments that was returned to the States, it appears that the States did not incur a health care expenditure for which Federal matching funds were claimed. This condition draws into question whether the amounts returned to the State agencies constitute a refund required to be reported as other collections, and consequently offset against expenditures reported to the Centers for Medicare and Medicaid Services (CMS).<sup>1</sup> As is, State agencies have developed mechanisms to obtain Federal Medicaid funds without committing the States' share of required matching funds.

Our review concluded that the States' use of the IGT as part of the enhanced payment program was a financing mechanism designed to maximize Federal Medicaid reimbursements, thus effectively avoiding the Federal/State matching requirements. The States were clear winners because they were able to reduce their share of Medicaid costs and cause the Federal Government to pay significantly more than it should for the same volume and level of Medicaid services.

In two early alert memorandums and seven draft reports detailing the results of our individual reviews of enhanced payment programs in six States, we recommended that CMS move as quickly as possible to issue regulatory changes to the upper payment limit rules. In an effort to curb the abuses resulting from enhanced payment programs and ensure that State Medicaid payment systems promote economy and efficiency, CMS issued a proposed rule in October 2000 with a final rule on January 12, 2001 that modified upper payment limit regulations in accordance with the Benefits Improvement and Protection Act of 2000. The regulatory action, which included a gradual transition policy, created three separate aggregate upper payment limits--one each for private, State, and non-State government operated facilities. During the transition, the financial impact of the new regulations will be gradually phased in and become fully effective on October 1, 2008. The CMS also increased the enhanced payments States may pay public hospitals from 100 percent to 150 percent of the amount that would be paid under Medicare payment principles. Nursing facilities and intermediate care facilities for the mentally retarded would continue to be limited to 100 percent of the amounts paid under Medicare payment principles.

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<sup>1</sup> Formerly known as the Health Care Financing Administration.

We commend CMS for taking action to change the upper payment limit regulations. The CMS projected these revisions to save \$55 billion in Federal Medicaid funds over the next 10 years. However, when fully implemented, these changes will only limit, not eliminate, the amount of financial manipulation of the Medicaid program the States can perform because the regulation did not require that the enhanced funds be retained by the targeted facilities to provide medical services to Medicaid beneficiaries. We also believe that the transition periods included in the final regulation are longer than needed for States to adjust their financial operations in response to these upper payment limit controls. And, we do not believe the higher payment limit for non-State-owned government hospitals has been adequately supported through an analysis of these hospitals' financial operations. Returning the upper payment limit cap to 100 percent would result in a savings of about \$497 million in Federal Medicaid funds during the transition in the three States we reviewed with hospital enhanced payment programs. Therefore, we recommended that CMS:

1. Annually audit the accuracy of the States' upper payment limit calculation and enhanced payments to ensure that the expected savings of \$55 billion are realized.
2. Provide States with definitive guidance on calculating the upper payment limit so that there is a uniform standard applicable to all States. We believe this should include using facility-specific upper payment limits that are based on actual cost report data.
3. Require that, for States to seek Federal financial participation (FFP) to match State enhanced payments, they must demonstrate that the enhanced payments were actually made available to the facilities and the facilities used the funds to furnish Medicaid approved services to Medicaid eligible beneficiaries.
4. Require that the return of Medicaid payments by a county or local government to the State be declared a refund of those payments and thus be used to offset the FFP generated by the original payment.
5. Reconsider capping the aggregate upper payment limit at 100 percent for all facilities rather than the 150 percent allowance for non-State-owned government hospitals.
6. Seek authority to eliminate or reduce the transition periods included in the new upper payment limit regulations.

In response to our draft report, CMS officials believed that the information presented in the report will be very valuable to them as they continue to work with the States to shape

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Federal payment policy. Overall, CMS responded positively to the majority of our recommendations. The CMS' comments are included in their entirety as an appendix to the report.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at 410-786-7104.

To facilitate identification, please refer to Common Identification Number A-03-00-00216 in all correspondence relating to this report.

Attachments

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICAID ENHANCED  
PAYMENTS TO LOCAL PUBLIC  
PROVIDERS AND THE USE OF  
INTERGOVERNMENTAL TRANSFERS**



**September 2001  
A-03-00-00216**

# EXECUTIVE SUMMARY

## BACKGROUND

This final report consolidates the results of seven Office of Inspector General audits, conducted in six States, of Medicaid enhanced payments to local public providers and the use of intergovernmental transfers (IGT).<sup>1</sup> It also presents data on current or expected enhanced payment programs in 22 other States. Under Medicaid upper payment limit rules, States are permitted to establish payment methodologies that allow for enhanced payments to non-State-owned government providers, such as county nursing facilities and hospitals. The enhanced payments, which trigger a Federal matching payment, are in addition to the basic payment rates for Medicaid providers. The basic Medicaid payments were not included as part of our review.

## OBJECTIVES

The objectives of our review were to analyze the States' use of IGTs to finance enhanced payments to county or local government-owned nursing facilities and hospitals as part of their compliance with Medicaid upper payment limit regulations and to evaluate the financial impact of these transfers on the Medicaid program.

## SUMMARY OF FINDINGS

In Fiscal Year 2000, 28 States made or planned to make at least \$10.3 billion in Medicaid enhanced payments which included \$5.8 billion in Federal matching funds. Prior to 1999, only 12 States had enhanced payment programs. If not brought under control, the rapid growth of these enhanced payment programs threaten the financial stability of the Medicaid program.

Our reviews of seven Medicaid enhanced payment programs in six States found that:

- < Enhanced payments to local government-owned providers were not based on the actual cost of providing services to Medicaid beneficiaries, or directly related to increasing the quality of care provided by the public facilities that received the enhanced payments.
- < Enhanced payments to nursing facilities were not retained by the nursing facilities to provide services to Medicaid beneficiaries. Instead, the majority of the funds were returned by the providers to the States through IGTs resulting in millions of dollars available to States for other uses.

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<sup>1</sup>Intergovernmental transfers are exchanges of funds among or between different levels of government.

- < The hospital providers kept a larger portion of the enhanced payments, in contrast to what nursing home providers retained. In addition, while the hospital providers served a large number of Medicaid beneficiaries and uninsured patients, the hospitals either did not receive Medicaid disproportionate share hospital (DSH) payments from the State, or returned the majority of the Medicaid DSH payments to the State through IGTs. It appears, for these providers, that States have used enhanced payments in place of DSH payments, although Medicaid DSH payments are intended to help hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients.
- < Some of the funds transferred back to the State governments were earmarked for use in health care related service areas but not necessarily for Medicaid-covered services approved in the State plans. But even if the funds were used for other Medicaid-related activities, this practice resulted in Federal funds being used as the State match to generate additional Federal funds.
- < Because millions of dollars in enhanced payments were returned to the States, it appeared that the States did not incur health care expenditures for which Federal matching funds were claimed. This condition raises a question as to whether the amounts returned to the States constitute refunds required to be reported as other collections and, consequently, offset against expenditures reported to the Centers for Medicare and Medicaid Services (CMS).<sup>2</sup> As is, the States developed mechanisms to obtain Federal Medicaid funds without committing their share of the required matching funds.

On October 10, 2000, CMS proposed regulations to close the upper payment limit loophole that cost Federal taxpayers billions of dollars without commensurate increases in Medicaid coverage or improvements in the care provided to Medicaid beneficiaries. In addition to the regulations proposed by CMS, in December 2000, Congress passed legislation that the President signed into law, the Benefits Improvement and Protection Act of 2000 (BIPA), instructing CMS to implement a transition period for States with plan amendments approved or in effect before October 1, 1992. On January 12, 2001, CMS issued a final rule that modified the upper limit regulations, and included the transition period passed by Congress.

The new regulations amended 42 CFR 447.272 and 447.321 to provide for three separate aggregate upper limits--one each for private, State, and non-State government operated facilities. The CMS also changed the regulations to allow for a higher upper limit for payments to non-State-owned government hospitals (150 percent of what Medicare would pay, rather than 100 percent) to recognize the perceived higher cost of inpatient and outpatient services in public hospitals.

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<sup>2</sup> Formerly known as the Health Care Financing Administration.

To ensure the ability of States to adjust to the revised regulations, the final rule included several transition periods for States with approved rate enhancement State plan amendments (SPA). States with SPAs effective before October 1, 1992, have an 8-year transition period to come into compliance with the new upper limits. States with SPAs effective after October 1, 1992 and before October 1, 1999 have a 5-year transition period. States with plans effective after October 1, 1999 have a 2-year transition ending September 30, 2002.

These modifications will help close the loophole in the Medicaid regulations. However, we believe the transition periods included in the final rule are longer than needed for States to adjust their financial operations in response to these upper payment limit controls. And, we do not believe the higher payment limit of 150 percent for non-State-owned government hospitals has been adequately supported through an analysis of these hospitals' financial operations. Returning the upper payment limit cap to 100 percent would result in a savings of about \$497 million in Federal Medicaid funds during the transition in the three States we reviewed with hospital enhanced payment programs. In addition, the final rule does not require that the enhanced Medicaid payments be retained by the targeted facilities to provide Medicaid services to Medicaid residents. Therefore, under the revised regulations, the financial mechanisms used by the States would continue, albeit on a smaller scale.

## CONCLUSION AND RECOMMENDATIONS

The States' use of the IGT as part of the enhanced payment program is a

financing mechanism designed to maximize Federal Medicaid reimbursements, thus effectively avoiding the Federal/State matching requirements. The combination of enhanced payments and IGTs has become a financial windfall for States.

In early alert memorandums and draft reports detailing the results of our individual reviews of enhanced payment programs in six States, we recommended that CMS move quickly to issue regulatory changes to the upper payment limit rules. In an effort to curb the abuses resulting from enhanced payment programs and ensure that State Medicaid payment systems promote economy and efficiency, CMS issued a proposed rule in October 2000 with a final rule on January 12, 2001 to modify upper payment limit regulations in accordance with BIPA. We commend CMS for taking action to revise the Medicaid upper payment limit regulations. The revisions are projected to save \$55 billion in Federal Medicaid funds over the next 10 years. However, we believe that CMS' regulatory changes do not go far enough in protecting the financial integrity of the Medicaid program. Therefore, we recommended that CMS:

1. Annually audit the accuracy of the States' upper payment limit calculation and enhanced payments to ensure that the expected savings of \$55 billion are realized.
2. Provide States with definitive guidance on calculating the upper payment limit so that there is a uniform standard applicable to all States. We believe this should

include using facility-specific upper payment limits that are based on actual cost report data.

3. Require that, for States to seek Federal financial participation (FFP) to match State enhanced payments, they must demonstrate that the enhanced payments were actually made available to the facilities and the facilities used the funds to furnish Medicaid approved services to Medicaid eligible beneficiaries.
4. Require that the return of Medicaid payments by a county or local government to the State be declared a refund of those payments and thus be used to offset the FFP generated by the original payment.
5. Reconsider capping the aggregate upper payment limit at 100 percent for all facilities rather than the 150 percent allowance for non-State-owned government hospitals.
6. Seek authority to eliminate or reduce the transition periods included in the new upper payment limit regulations.

In response to our draft report, CMS officials believed that the information presented in the report will be very valuable to them as they continue to work with the States to shape Federal payment policy. Overall, CMS responded positively to the majority of our recommendations. The CMS' comments are included as **APPENDIX C** to this report.

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# INTRODUCTION

## Background

### **The Medicaid Program**

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

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

### **Upper Payment Limit**

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

The upper payment limit rules in effect during our audit period contained a loophole that permitted States to establish payment methodologies that allow for enhanced payments to non-State-owned (public) government providers, such as county-owned nursing facilities and hospitals. The enhanced payments are in addition to the basic Medicaid payments made to those providers. States are not required to justify to the Centers for Medicare and Medicaid Services (CMS)<sup>1</sup> the details of why these enhanced payments are needed.

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<sup>1</sup> Formerly known as the Health Care Financing Administration.

On October 10, 2000, CMS proposed regulations to close the loophole that cost Federal taxpayers billions of dollars without commensurate increases in Medicaid coverage or improvements in the care provided to Medicaid beneficiaries. In addition to the regulations proposed by CMS, in December 2000, Congress passed legislation that the President signed into law, the Benefits Improvement and Protection Act of 2000 (BIPA), instructing CMS to implement a transition period for States with State plan amendments (SPA) approved or in effect before October 1, 1992. On January 12, 2001, CMS issued a final rule that modified the upper payment limit regulations, and included the transition period passed by Congress.

The new regulations amended 42 CFR 447.272 and 447.321 to provide for three separate aggregate limits--one each for private, State, and non-State government operated facilities. The CMS also changed the regulations to allow for a higher upper limit for payments to non-State-owned government hospitals (150 percent of what Medicare would pay, rather than 100 percent) to recognize the perceived higher cost of inpatient and outpatient services in public hospitals.

To ensure the ability of States to adjust to the revised regulations, the final rule included several transition periods for States with approved rate enhancement plan amendments. States with SPAs effective before October 1, 1992, have an 8-year transition period to come into compliance with the new upper limits. States with SPAs effective after October 1, 1992 and before October 1, 1999 have a 5-year transition period. States with plans effective after October 1, 1999 have a 2-year transition ending September 30, 2002.

## **Objectives, Scope, and Methodology**

Our reviews were performed in accordance with generally accepted government auditing standards. This report consolidates the results of seven Office of Inspector General (OIG) audits in six States. It also presents data on current or expected Medicaid enhanced payments in 22 other States. The objectives of our reviews were to analyze the States' use of intergovernmental transfers (IGT) to finance enhanced payments to county or local government-owned nursing facilities and hospitals as part of their compliance with Medicaid upper payment limit regulations and to evaluate the financial impact of these transfers on the Medicaid program.

We reviewed Medicaid enhanced payments to nursing facility providers in Alabama, Nebraska, Pennsylvania, and Washington. We reviewed Medicaid enhanced payments to hospital providers in Alabama, Illinois, and North Carolina. For each State selected, we reviewed the SPA and other applicable criteria on the computation and use of IGTs. We met with CMS regional office staff to discuss their role and review their records pertaining to the State's Medicaid program. We interviewed key personnel with the State and reviewed applicable State records supporting the funding pool calculations, enhanced payments, and IGTs. We also attempted to track and determine the use of the dollars that were transferred between State and local governments. Where applicable, we selected several locally-owned providers that received enhanced payments to determine how the enhanced payments were used. Finally, we had our regional offices contact

CMS regional offices and State Medicaid officials in 22 other States that had approved enhanced payment plans as of October 2000, to obtain the States' latest financial information on their enhanced payment programs. Our reviews began in May 2000 and were completed in December 2000.

## FINDINGS

Our reviews in Alabama, Illinois, Nebraska, North Carolina, Pennsylvania, and Washington identified \$3.3 billion in annual Medicaid enhanced payments to non-State-owned government providers for nursing or hospital services. These payments generated \$1.9 billion in Federal matching funds. The CMS approved these enhanced payment programs through amendments to each State's Medicaid plan. Additionally, we identified 22 other States, as of October 2000, making annual Medicaid enhanced payments of \$7 billion to local providers that generated an additional \$3.9 billion in FFP. In total, 28 States made or planned to make at least \$10.3 billion in annual Medicaid enhanced payments which included \$5.8 billion in Federal matching funds (**APPENDIX B**).

What is especially alarming is the rapid proliferation of these programs. Prior to 1999, only 12 States had enhanced payment programs. Beginning in 1999, however, 16 additional States implemented enhanced payment programs. The rapid growth of these programs threaten the financial stability of the Medicaid program.

### **Summary of OIG Reviews of Seven Enhanced Payment Programs**

Our audits of seven enhanced payment programs concluded that the States' use of the IGT as part of the enhanced payment program is a financing mechanism

designed to maximize Federal Medicaid reimbursements, thus effectively avoiding the Federal/State matching requirements. The States used IGTs and the flexibility inherent in the upper payment limit rule to finance enhanced Medicaid payments to local-owned nursing facilities or hospitals. Each State created a funding pool to provide Medicaid enhanced payments to local government-owned providers. In general, the funding pools were calculated by determining the difference between the upper payment limit (based on Medicare payment principles) and the allowable Medicaid payments for each facility in the State. The combined total of the differences for all facilities in the State represented the funding pool. The total pool was distributed to the local providers (as an enhanced payment) based on the proportionate number of Medicaid beneficiary days at each facility. Except for hospitals in North Carolina, once each provider received the enhanced payment (Federal and State share), a portion of the funds was transferred back to the State for other uses or returned to its original source.

Although the specifics of the enhanced payment programs and associated financing mechanisms differed somewhat in the six States we reviewed, they shared some common characteristics.

- < Enhanced payments to local government-owned providers were not based on the actual cost of providing services to Medicaid beneficiaries, or directly related to increasing the quality of care provided by the public facilities that received the enhanced payments.
- < Enhanced payments to nursing facilities were not retained by the facilities to provide services to Medicaid beneficiaries. Instead, the majority of the enhanced payments were returned by providers to the States through IGTs resulting in millions of dollars available to States for other uses.
- < The hospital providers kept a large portion of the enhanced payments in contrast to the nursing home providers. In addition, while the hospital providers served a large number of Medicaid beneficiaries and uninsured patients, the hospitals either did not receive Medicaid disproportionate share hospital (DSH) payments from the State, or returned the majority of the Medicaid DSH payments to the State through IGTs. It appears, for these providers, that States used enhanced payments in place of DSH payments, although Medicaid DSH payments were intended to help hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients.
- < Some of the funds transferred back to the State governments were earmarked for use in health care related service areas but not necessarily for Medicaid-covered services approved in the State plans. But even if the funds were used for other Medicaid-related activities, this practice resulted in Federal funds being used as the State match to generate additional Federal funds.
- < Because millions of dollars in enhanced payments were returned to the States, it appeared that the States did not incur health care expenditures for which Federal matching funds were claimed. This condition raised a question as to whether the amounts returned to the States constituted refunds required to be reported as other collections and, consequently, offset against expenditures reported to CMS. As is, the States developed mechanisms to obtain Federal Medicaid funds without committing their share of the required matching funds.

The States were clear winners in that they were able to reduce their share of Medicaid costs and cause the Federal Government to pay significantly more than it should for the same volume and level of Medicaid services. We present below some of the details we noted in our seven reviews to provide some insights into the financial transactions which occurred between the State and local governments. Also, **APPENDIX A** provides a summary schedule of our audit results. We have previously issued reports to CMS on each of these audits.

## Alabama

This State had SPAs that allowed for enhanced payments to both public hospital and nursing facility providers. We performed reviews of both of Alabama's enhanced payment programs.

### Public Hospitals

Alabama received an approved SPA from CMS in 1994 allowing for enhanced payments to local government-owned hospitals. For State Fiscal Years (SFY) 1994 through 1997, only publicly-owned hospitals were included in the calculation of the allowable funding pool. Starting in SFY 1998, the State included privately-owned hospitals in the calculation of the funding pool.

The State share of Medicaid expenditures was approximately 30 percent. For SFYs 1994 through 1997, prior to the inclusion of private facilities in the funding pool calculation, the State required the facilities to provide 35 percent of the funding pool (the State share plus 5 percent). The State then claimed the Federal share of 70 percent and paid 100 percent of the funding pool to the providers. In effect, the net gain to the hospitals was 65 percent (100 percent of the funding pool less the 35 percent originally provided to the State) and the net gain to the State was the remaining 5 percent.

After the State began including private hospitals in the funding pool calculation, the State no longer required the facilities to provide 35 percent of the payments. Instead, it required the public hospitals that were included in the distribution of the funding pool to put up only the State share of 30 percent. However, upon receiving the enhancement payments, the public hospitals were required to return to the State 100 percent of the Federal share of the enhanced payment relating to the private facilities being included in the funding pool calculation. Thus, by changing funding pool methodologies to include private facilities, the State created a financial windfall for itself without having to commit any of its own funds.

We were unable to determine the use of the enhanced payments by both the State and the providers. At the providers, the payments were deposited into general funds used to pay hospital expenses. Because the enhanced payments were not accounted for separately, we were unable to determine specifically how the funds were used and whether or not they were used for Medicaid beneficiaries. At the State agency, the returned Federal matching funds were deposited into a special revenue account used by the State to pay Medicaid expenses. Therefore, Federal funds were used as the State match to generate additional Federal funds.

In a related matter, it appeared that Alabama used enhanced payments to partially replace Medicaid DSH payments. Medicaid DSH payments are intended to help hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients. In SFY 1994, the year prior to the first full year of enhanced payments, the hospitals returned 68 percent of their total DSH payments to the State. According to State officials, this percentage was increased to

86 percent by SFY 1996. During our audit period, the hospitals retained approximately \$70 million per year less in DSH payments.

During SFY 1997 through 2000, Alabama reported \$432 million<sup>2</sup> in enhanced payments generating \$302 million in Federal matching funds. Of the total \$432 million, the 30 percent State share of almost \$130 million provided by the hospitals through IGTs was always returned to the hospitals. Of the remaining \$302 million, the hospitals retained \$216 million and returned \$86 million to the State. The net gain of this financing mechanism to Alabama was \$86 million (\$302 million Federal share less \$216 million retained by the hospitals).

### **County Nursing Facilities**

Alabama's program was approved in September 1999 and began making enhanced payments to nine county-owned hospital based nursing facilities. Each year Alabama determined the available funding pool for enhanced payments by calculating the amount of funds available under the upper limit regulation. Next, the State transferred the enhanced payments, including the State and Federal share, to the eligible nursing facilities on a monthly basis. Within a few days of receiving the enhanced payments, the nursing facilities returned 96.5 percent to Alabama. The nursing facilities used the retained portion (3.5 percent) of the enhanced payments to pay for facility expenses. Alabama deposited the returned portion (96.5 percent) into a fund used to pay Medicaid expenses. Thus, Federal funds were used as the State match to generate additional Federal funds.

During SFYs 1999 and 2000, Alabama reported \$83.5 million in enhanced payments generating \$58.5 million in Federal matching funds. Subsequent to the initial payment by the State, approximately \$80.6 million was returned to the State and only about \$2.9 million was retained by the nursing facilities. The net gain of this financing mechanism to Alabama was \$55.6 million (\$58.5 million Federal share less \$2.9 million retained by the nursing facilities).

## **Illinois**

In Illinois, the Illinois Department of Public Aid (IDPA) administers the Medicaid program. In 1991, IDPA began an enhanced payment program to Cook County for inpatient and outpatient hospital services. Unlike other States that we reviewed, enhanced payments in Illinois included both regular payments for Medicaid services and a supplement, which was in addition to the normal payment level. Currently, the program benefits three hospitals and associated clinics.

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<sup>2</sup>In addition to the \$432 million, Alabama officials informed us at the exit conference that they made three retroactive payments totaling \$98 million (Federal share \$68.7 million) relating to SFYs 1997, 1998, and 1999. We did not review these additional payments.

Each year, IDPA estimated the upper limits (what Medicare would pay for services) using base year 1992 actual cost trended forward. These upper limits, in the aggregate for all hospitals in the State, were compared to the projected payments based on payment rates applied to the anticipated number of services. The difference yielded the amount available for enhanced payments. To fund the State share of the enhanced payments, Cook County was required to make IGTs to IDPA amounting to one-half the sum of the total enhanced payments. Cook County wire transferred the IGT to IDPA. The IDPA then wire transferred the IGT along with the Federal share back to Cook County. Upon receipt, Cook County retained an amount equal to the original IGT and an agreed upon portion of the Federal share and wire transferred the remaining funds back to the State's General Revenue Fund.

Since inception, IDPA reported \$5.9 billion in enhanced payments generating about \$2.9 billion in Federal matching funds. Of the \$5.9 billion, about \$3 billion represented a payback of funds that were initially transferred as IGTs from Cook County to IDPA to use as the State share to draw about \$2.9 billion in FFP. Subsequent to the initial payment by IDPA, approximately \$866.6 million was returned to the State and about \$2 billion was retained by Cook County. The funds retained by Cook County were deposited into an account used solely for the operations of 3 county hospitals and about 30 outpatient clinics. The funds returned to IDPA were deposited into the General Revenue Fund and traceability of these funds was lost. The net gain of this financing mechanism to Illinois since inception of the program was about \$866.6 million (\$2.9 billion Federal share less about \$2 billion retained by the County).

## **Nebraska**

In 1992, Nebraska began an enhanced payment program to city and county-owned nursing facilities. In 1998, CMS approved a SPA which greatly expanded the State's enhanced payment program. Each year, Nebraska determined the available funding pool for enhanced payments by multiplying the difference between the Medicare payment rate and the Medicaid rate applicable to each facility by the facility's total Medicaid resident days. The combined total of the differences for all facilities in the State represented the funding pool for enhanced payments. The State then transferred the enhanced payments, including the State and Federal share, to the eligible nursing facilities. Immediately upon receipt, the nursing facilities transferred the enhanced payments less a \$10,000 per facility participation fee back to the State. Of the funds returned, Nebraska deposited an amount equal to the State share of the enhanced payments to the State's General Revenue Fund. The remaining funds were deposited in the Nebraska Health Care Trust Fund and from there disbursed into three additional Health Care Trust Funds.

During SFYs 1998 through 2000, Nebraska reported \$227 million in enhanced payments generating \$139 million in Federal matching funds. Subsequent to the initial payment by the State, approximately \$225.5 million was returned to the State and only about \$1.5 million in participation fees was retained by the nursing facilities. Of the returned funds, \$88 million was deposited in the State's General Revenue Fund and \$137.5 million was transferred to the Nebraska Health Care Trust Fund. As of April 30, 2000, the four Health Care Trust Funds had

available balances totaling almost \$137 million. The net gain of this financing mechanism to Nebraska for the past 3 years was \$137.5 million (\$139 million Federal share less \$1.5 million in participation fees retained by the nursing facilities).

## **North Carolina**

In 1995, North Carolina implemented two enhanced payment programs. Enhanced payments were made to public and private hospitals that had Medicaid deficits and met certain other criteria. The State calculated its enhanced payment pool based on estimated Medicaid inpatient and outpatient cost deficits excluding Medicaid DSH payments. The public hospitals actually only received approximately 67 percent (63 percent Federal and 4 percent State funds) of the total enhanced payment because the remaining 33 percent consisted of certified public expenditures (CPE) of the hospitals. The CPEs were used as a portion of the State match. Private hospitals' enhanced payments were approximately 67 percent of their costs deficits, consisting of 63 percent Federal and 37 percent State funds. The entire enhanced payment made by the State was retained by the hospitals.

During SFYs 1996 through 1999, North Carolina reported \$647 million in enhanced payments generating \$412 million in Federal matching funds. The net gain of this financing mechanism to North Carolina hospital providers was \$529 million (\$647 million total enhanced payments less \$118 million in CPEs that were used as a portion of the State match). The net gain to North Carolina was \$0 because the public and private hospitals kept all of the Federal matching funds included in the enhanced payments. However, the State's portion of the enhanced payments came from a trust fund that was funded by the 90 percent of Medicaid DSH payments that public hospitals were required to return to the State. The return of DSH payments by public hospitals to the State raised the question as to whether the enhanced payments would be needed if the total DSH payments were retained by the hospitals. Therefore, by returning DSH payments to the State, the State developed a mechanism to receive additional Federal Medicaid funds without committing its share of required matching funds.

## Pennsylvania

In Pennsylvania, the Department of Public Welfare (DPW) administers the Medicaid program. The DPW's enhanced payment program began in 1991. Under its CMS approved State plan, DPW made enhanced payments to 20 counties which owned 23 nursing facilities. These enhanced payments, which were in addition to the regular Medicaid payments to these facilities, were called supplementation payments.

As part of the supplementation payment process, each year DPW determined the available funding pool by calculating the amount of Medicaid funds available under the Medicare upper limit regulations. It then entered into an agreement with the County Commissioners Association of Pennsylvania (CCAP) whereby the counties borrowed funds from a single bank (referred to as the transaction bank) using tax and revenue anticipation notes. The county funds maintained at the transaction bank were then transferred to a DPW bank account, also at the transaction bank, as the initial source to fund the pool. Within 24 hours of receipt, DPW transferred the amount received from the counties, plus a \$1.5 million program implementation fee, back to the county bank accounts maintained at the transaction bank as Medicaid supplementation payments for nursing facility services. The counties used the supplementation payments to pay the bank notes. The counties then forwarded the unused portion of the program implementation fee to CCAP. The DPW reported the supplementation payments to CMS as county nursing facility supplementation payments and claimed FFP. As demonstrated, the reported supplementation payments allegedly intended for the county-owned nursing facilities were not really payments at all. They were merely transfers of funds between county bank accounts and the account maintained by DPW. The transactions were generally completed within one banking day, and except for a \$1.5 million program implementation fee, the funds never left the bank that maintained the accounts for DPW and the counties.

During SFY 1997 to SFY 1999, DPW reported \$3.4 billion in supplementation payments, none of which was ever paid directly to participating county-owned nursing facilities. These reported supplementation payments generated \$1.9 billion in Federal matching funds without any corresponding increase in services to the Medicaid residents of the participating county nursing facilities. The net effect of DPW's IGT financing mechanism was that the Federal Government paid significantly more for the same level of Medicaid services, while the DPW paid significantly less. Further, \$406.9 million, or about 21 percent of the Federal match generated by the IGT transactions, was not even budgeted for Medicaid purposes, and another \$557.5 million, or 29 percent, remained unbudgeted and available to Pennsylvania for non-Medicaid related use. The remaining \$968.6 million, or 50 percent, of the Federal match, was budgeted for Medicaid expenditures. Therefore, Federal funds were recycled to generate additional Federal funds.

Because it only contributed a \$1.5 million transaction fee towards each enhanced payment, the net gain to Pennsylvania during our audit period was over \$1.89 billion (\$1.9 billion Federal share less \$7.5 million in transaction fees).

## Washington

During SFY 2000, Washington made enhanced payments to 14 public hospital district (PHD) nursing facilities based on their proportion of Medicaid care days. These payments totaled \$147 million including \$76.2 million in Federal matching funds. The funding pool for the enhanced payments was the difference between Medicaid costs and Medicaid payments for all nursing facilities in the State. The costs were derived from Medicaid cost reports. The Medicare upper payment limit was not used to determine the funding pool, except as a ceiling for Medicaid nursing facility costs.

The 14 PHD nursing facilities retained \$9.8 million of the \$147 million in enhanced payments. Three health-related organizations shared \$10.2 million while the remaining \$127 million was transferred back to the State. It appeared that the returned funds were either designated or used for State health care needs, regardless of a person's Medicaid eligibility.

The net gain of this financing mechanism to Washington during SFY 2000 was \$56.2 million (\$76.2 million Federal share less \$9.8 million retained by the providers and \$10.2 million provided to several health care organizations).

### **CMS' Corrective Measures Need to be Expanded**

In two early alert memorandums and seven draft reports detailing the results of our individual reviews of enhanced payment programs in six States, we recommended that CMS move as quickly as possible to issue regulatory changes to the upper payment limit rules. In an effort to curb the abuses resulting from enhanced payment programs and ensure that State Medicaid payment systems promote economy and efficiency, CMS issued a proposed rule in October 2000 with a final rule on January 12, 2001 that modified upper payment limit regulations (66 Federal Register 3148) in accordance with BIPA.<sup>3</sup> According to CMS' press release at the time, the final rule closed a loophole in Medicaid regulations costing Federal taxpayers billions of dollars without commensurate increases in coverage or improvements in the care provided to Medicaid beneficiaries. The final rule was projected to save \$55 billion over the next 10 years by ending certain accounting techniques used to inappropriately obtain extra Federal Medicaid matching funds that are not necessarily spent on health-care services for Medicaid beneficiaries.

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<sup>3</sup>In addition to the regulations proposed by CMS, in December 2000, as a finalization of their October 2000 draft rule, Congress passed legislation that the President signed into law (BIPA of 2000) instructing CMS to implement a transition period for States with plan amendments approved or in effect before October 1, 1992. On January 12, 2001, CMS issued a final rule that modified the upper payment limit regulations, and included the transition period passed by Congress.

The new regulations amended 42 CFR 447.272 and 447.321 to provide for three separate aggregate upper limits--one each for private, State, and non-State government operated facilities. The CMS also changed the regulations to allow for a higher upper limit for payments to non-State-owned government hospitals (150 percent of what Medicare would pay, rather than 100 percent) to recognize the perceived higher cost of inpatient and outpatient services in public hospitals.

To ensure the ability of States to adjust to the revised regulations, the final rule included several transition periods for States with approved rate enhancement plan amendments. States with SPAs effective before October 1, 1992, have an 8-year transition period to come into compliance with the new upper payment limits. States with SPAs effective after October 1, 1992 and before October 1, 1999 have a 5-year transition period. States with plans effective after October 1, 1999 have a 2-year transition ending September 30, 2002. The final rule does not reduce Federal Medicaid enhanced payment funds for any State during its 2001 budget year.

While we disagree with the need for the 5- and 8-year transition periods for States to adjust their financial operations in response to these upper payment limit controls, we estimate savings to the Federal Government of \$3.7 billion during the required transition periods for the seven enhanced payment programs we reviewed. This \$3.7 billion effect was calculated using the details of the SFY 2000 enhanced payment plans that had been approved by CMS. No adjustments for future inflation impacts were made in calculating this effect. In addition, once the transition period is over, we estimate savings to the Federal Government of \$6.1 billion over the subsequent 5 years in the six States we reviewed...raising the total savings to \$9.8 billion.

<b>EFFECT OF UPPER PAYMENT LIMIT REGULATIONS DURING TRANSITION PERIOD (\$ in millions)</b>					
<b>State</b>	<b>Facility Type</b>	<b>Transition Period Years</b>	<b>FFP Without Change in Regulations</b>	<b>FFP With Change in Regulations</b>	<b>FFP Savings</b>
Alabama	Nursing	5	\$155	\$110	\$45
Alabama	Hospital	5	\$555	\$625	(\$70)
Illinois	Hospital	8	\$5,130	\$3,850	\$1,280
Nebraska	Nursing	8	\$495	\$353	\$142
North Carolina	Hospital	5	\$726	\$924	(\$198)
Pennsylvania	Nursing	8	\$7,722	\$5,365	\$2,357
Washington	Nursing	5	\$380	\$271	\$109
<b>Total Savings During Transition Period</b>					<b>\$3,665</b>

Despite these significant savings, the regulations limit but do not end the States' manipulation of the Medicaid program. The regulations do not require that the enhanced payments be based on financial need and paid directly to the targeted nursing facilities or hospitals for direct health care services for their Medicaid residents.

As the table above illustrates, the transition rules have only a limited effect on current income levels. For example, from July 2000 through June 2009, Pennsylvania would receive \$7.7 billion in Federal matching funds if its current level of enhanced payments remained unchanged.

Under CMS' new regulations, we estimate that Pennsylvania would still receive \$5.4 billion for this same time period for providing no additional services to the targeted nursing facilities. After the phase-out period, Pennsylvania would still receive at least \$127 million per year in Federal funds for providing no additional services for Medicaid patients in the county nursing facilities.

We also believe CMS' higher aggregate payment limit for non-State-owned government hospitals has not been adequately supported through an analysis of these hospitals' financial operations. As shown in the preceding table, Alabama and North Carolina would actually receive **more** FFP for its Medicaid payments to public hospitals under the new regulations. These two States illustrate the excessive nature of CMS' 150 percent allowance for public hospitals. Our reviews of hospital enhanced payment programs in Alabama, Illinois, and North Carolina found that participating hospitals retained 50 percent, 34 percent, and 100 percent, respectively, of the total enhanced payments made during our audit period. Also, Alabama required hospitals to return

86 percent of its DSH payments while North Carolina required its public hospitals to return 90 percent of DSH payments. We believe the public hospitals would receive adequate reimbursement to provide services to Medicaid beneficiaries and uninsured patients by (1) retaining 100 percent of the State and Federal shares of the enhanced Medicaid payments up to the aggregate limit payable under Medicare payment principles, and (2) receiving and retaining 100 percent of the State and Federal shares of the allowable DSH payments.

Of the 28 States with Medicaid enhanced payment programs in FY 2000, 15 had enhanced payment programs that targeted hospitals. These 15 States made about \$4.5 billion in Medicaid enhanced hospital payments including \$2.5 billion representing Federal matching funds. For the three States included in our review, we estimate that if CMS limited payments to public hospitals to 100 percent of what Medicare would pay rather than 150 percent as changed by the regulation, an additional \$497 million in Federal matching funds would be saved during the transition period.

Also, if the cap was returned to 100 percent after the transition period ended for the three States we reviewed (regardless of whether the cap remained at 150 percent during the transition period), we estimated a savings of \$665 million in Federal funds could be realized in the subsequent 5-year budget period. Although we did not perform reviews in the other 12 States with hospital enhanced payment programs (in place at the time of our review), we believe that similar significant savings would result if payments were limited to 100 percent of what Medicare would pay.

Finally, CMS did not provide States with clear guidance on how to calculate the upper payment limits. Our reviews showed no uniformity among the six States. Alabama, Illinois, North Carolina, and Washington applied various methods to use cost data to compute the Medicare upper limit. In Nebraska during SFYs 1998 and 1999, the Medicare skilled nursing rate was used as the routine cost limit or a prospective payment rate applicable to the Nebraska facilities. In SFY 2000, Nebraska changed again and implemented a case-mix methodology to calculate their funding pools. Conversely, Pennsylvania's Medicare upper limit was established using different versions of the Resource Utilization Groups (RUG)<sup>4</sup>, and/or resident assessments information applicable to nursing home residents.

Allowing States the flexibility in complying with Medicare payment principles allowed the calculation of the funding pools to have significant differences. For example, had Alabama used higher RUG rates in its SFY 2000 nursing facility calculations, its upper payment limit would have increased to between \$129 million and \$341 million from a pool of \$44 million. Washington's pool in SFY 2000 could have been increased to \$195 million from \$147 million.

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<sup>4</sup>As part of the Medicare prospective payment system for skilled nursing facilities (SNF), RUGs are used to determine the payment for SNF services. The RUGs may be used by States to calculate the upper payment limit.

# CONCLUSION AND RECOMMENDATIONS

Based on our audits of seven enhanced payment programs, we believe that widespread manipulation by States of the upper payment limit requirements as described in this report could undermine the stability of the Medicaid program. Our concern is heightened by the fact that CMS estimates that Federal Medicaid spending for FY 2000 increased by \$3.4 billion over earlier projections, with a large portion of this due to the funding mechanisms involving IGTs and enhanced payments. The combination of enhanced payments and related IGT programs must be brought under control to safeguard the Federal/State financial partnership in the Medicaid program and to maintain its financial stability.

In early alert memorandums and draft reports detailing the results of our individual reviews of enhanced payment programs in six States, we recommended that CMS move quickly to issue regulatory changes to the upper payment limit rules. In an effort to curb the abuses resulting from enhanced payment programs and ensure that State Medicaid payment systems promote economy and efficiency, CMS issued a proposed rule in October 2000 with a final rule on January 12, 2001 to modify upper payment limit regulations in accordance with BIPA. The CMS' regulatory action establishes three separate aggregate upper payment limits--one each for private, State, and non-State government operated facilities. However, CMS did not provide States with clear guidance on how to calculate the upper payment limit. The CMS also increased the enhanced payments States may pay public hospital providers from 100 percent to 150 percent of the amount that would be paid under Medicare payment principles. Nursing facilities and intermediate care facilities for the mentally retarded continued to be limited to 100 percent of the amounts paid under Medicare payment principles.

We commend CMS for taking action to revise the Medicaid upper payment limit regulations. The CMS projects these revisions to save \$55 billion in Federal Medicaid funds over the next 10 years. However, when fully implemented, these changes will only limit, not eliminate, the amount of financial manipulation of the Medicaid program the States can perform. In addition, we believe the transition periods included in CMS' regulation are longer than needed for States to adjust their financial operations in response to these upper payment limit controls. And, we do not believe the higher aggregate payment limit for non-State-owned government hospitals has been adequately supported through an analysis of these hospitals' financial operations. Returning the upper payment limit cap to 100 percent would result in a savings of about \$497 million in Federal Medicaid funds during the transition in the three States we reviewed with hospital enhanced payment programs. Therefore, we recommended that CMS:

1. Annually audit the accuracy of the States' upper payment limit calculation and enhanced payments to ensure that the expected savings of \$55 billion are realized.
2. Provide States with definitive guidance on calculating the upper payment limit so that there is a uniform standard applicable to all States. We believe this should

include using facility-specific upper payment limits that are based on actual cost report data.

3. Require that, for States to seek FFP to match State enhanced payments, they must demonstrate that the enhanced payments were actually made available to the facilities and the facilities used the funds to furnish Medicaid approved services to Medicaid eligible beneficiaries.
4. Require that the return of Medicaid payments by a county or local government to the State be declared a refund of those payments and thus be used to offset the FFP generated by the original payment.
5. Reconsider capping the aggregate upper payment limit at 100 percent for all facilities rather than the 150 percent allowance for non-State-owned government hospitals.
6. Seek authority to eliminate or reduce the transition periods included in the new upper payment limit regulations.

### **CMS' Comments**

The CMS officials believe that the information presented in the report will be very valuable to them as they continue to work with the States to shape Federal payment policy. Of the seven recommendations contained in our draft report, CMS concurred with two, partially concurred with two, is further reviewing one, and non-concurred with the remaining two.

The CMS concurred with our recommendation (Number 1) to annually audit the accuracy of the States' upper payment limit calculations and enhanced payments to ensure that the expected savings from the revised upper payment limit regulations are realized. The CMS also concurred with our recommendation (Number 5) that it reconsider capping the aggregate upper payment limit at 100 percent for all facilities rather than the 150 percent allowance for non-State-owned government facilities.

The CMS concurred in part with our recommendation (Number 2) to provide definitive guidance on calculating the upper payment limit giving preference to using facility-specific limits based on actual cost report data. While it agreed that it should provide more guidance to States, CMS is currently deciding whether "safe harbor" guidelines or policy, setting out limited choices to States, is the best approach. Regarding facility-specific cost-based limits, CMS stated that it considered these when developing the upper payment limit final rule, but adopted restructured aggregate limits to allow States some flexibility to better respond to their unique challenges of maintaining access to services. If, under the new rule, States continue to use public health care facilities as a transfer agent to leverage Federal Medicaid funding, CMS will look to further reforms, which may include facility-specific limits. The CMS also partially concurred with our recommendation (Number 3) to require that for States to seek FFP to match State enhanced

payments, they must demonstrate that the enhanced payments were actually made available to the facilities and that the facilities used the funds to furnish Medicaid approved services to Medicaid beneficiaries. The CMS agreed with the first part of the recommendation, but said that the second part requires further review since it would require notice and comment rulemaking to implement, as it has the effect of a facility-specific cost-based limit. The CMS will revisit facility-specific limits if States continue to use public health care facilities to leverage Federal funding.

The CMS commented that it continues to review our recommendation (Number 4) to require that the return of Medicaid payments be declared a refund and be used to offset the FFP generated by the original payment. In previous instances, proposed CMS disallowances when States did not offset funds have been overturned at the Departmental Appeals Board on the basis that CMS must give States clear notice of applicable credit policies before taking disallowance actions. The CMS is reviewing alternatives for achieving this policy goal.

The CMS did not concur with our recommendation (Number 6) to seek authority to eliminate or reduce the transition periods included in the new upper payment limit regulations. According to CMS, the transition periods were established pursuant to either notice and comment rulemaking, or to legislation. To offer new proposals at this time would undermine the consensus reached through those processes. The CMS added, however, that in an area where the final regulation was ambiguous (i.e., pending amendments), it had proposed a rule specifying a shorter transition period than would otherwise be permissible under the January final rule.

Finally, the CMS did not concur with a draft recommendation to seek authority to impose a civil penalty against the States for using Medicaid funds for other than Medicaid approved services. The CMS agreed that Medicaid funds should only be used to support allowable Medicaid activities, but stated that the imposition of civil penalties is unnecessary and would undermine its relationships with States. It believed that through the issuance of clearer policies and guidance, it will be able to achieve the intent of this recommendation.

### **OIG's Response**

We are pleased that CMS responded positively to the majority of our recommendations. Our recommendations are intended to help restore financial integrity to the Medicaid program. We urge CMS to complete its review of our recommendations and to take the necessary actions to implement them or equivalent alternatives. Also, we continue to believe that the transition periods included in the CMS' regulation are longer than necessary and that CMS should pursue authority to shorten them. Finally, we agree with CMS' comments with respect to our draft recommendation regarding civil penalties and have deleted it from this final report. However, we have several other Medicaid reviews underway involving State financing mechanisms. Upon completion of these reviews, we may reintroduce this recommendation.

In addition, we plan to conduct future audits involving State upper payment limit calculations. We would be pleased to work with CMS in developing the scope of these audits. We look forward to our continued cooperative efforts to ensure that Federal Medicaid funds available under the upper payment limit regulations are used appropriately.

**MEDICAID ENHANCED PAYMENT PROGRAMS**  
**SUMMARY OF AUDIT FINDINGS**

	Alabama	Alabama	Illinois	Nebraska	North Carolina	Pennsylvania	Washington
OIG Audit Report Number	A-04-00-02169	A-04-00-02165	A-05-00-00056	A-07-00-02076	A-04-00-00140	A-03-00-00203	A-10-00-00011
Audit Period	1996 - 2000	1999 - 2000	1991 - 2000	1998 - 2000	1996 - 1999	1997 - 1999	1999 - 2000
Year Program Implemented	1994	1999	1991	1992	1995	1991	1999
Eligible Government Entities	Public Hospitals	Rural Hospital Based Nursing Facilities	County-Owned Hospitals	City and County Nursing Facilities	Private and Public Hospitals	County Nursing Facilities	Public Hospital District Nursing Facilities
Initial Source of the State Share of Enhanced Payments During Audit Period	Public Hospitals	State Funds	County Governments	State Funds	CPEs/ DSH Funds	County Governments	State Funds
Total Enhanced Payments During Audit Period	\$432 million	\$83.5 million	\$5.9 billion	\$227 million	\$647 million	\$3.4 billion	\$147 million
Federal Share of Enhanced Payments During Audit Period	\$302 million	\$58.5 million	\$2.9 billion	\$139 million	\$412 million	\$1.9 billion	\$76.2 million
Net Gain to Providers During Audit Period	\$216 million	\$2.9 million	\$2 billion	\$1.5 million	\$529 million	\$0	\$9.8 million
Percentage of Enhanced Payments Providers Retained During Audit Period	50 %	4 %	34 %	1 %	100% <sup>1</sup>	0 %	7 %
Net Gain to State During Audit Period	\$86 million	\$55.6 million	\$866.6 million	\$137.5 million	\$0	\$1.89 billion	\$56.2 million <sup>2</sup>
DSH Payments Returned to State	\$335 million per year <sup>3</sup>	N/A	N/A <sup>4</sup>	N/A	\$145 million in FY 1999 <sup>5</sup>	N/A	N/A

<sup>1</sup>Although North Carolina hospital providers retained all of the enhanced payments made by the State, \$118 million (or 18 percent) of the \$647 million in enhanced payments was funded by the CPEs of the hospitals.

<sup>2</sup>In addition, \$10.2 million was shared by three health related organizations.

<sup>3</sup>During our audit period, DSH payments averaged about \$389 million per year. The percent of DSH payments returned to the State increased from 68 percent (\$265 million) prior to the first full year of enhanced payments to 86 percent (\$335 million) in FY 1996.

<sup>4</sup>The public hospitals that received enhanced payments were all located in Cook County; Cook County hospitals were not included in the pool of Illinois hospitals eligible to receive DSH payments even though their patient census characteristics were similar to other Illinois hospitals that received DSH payments.

<sup>5</sup>Public hospitals in North Carolina were required to return 90 percent of Medicaid DSH payments to the State.

<b>ANNUAL MEDICAID ENHANCED PAYMENTS (\$ in millions)</b>				
<b>State</b>	<b>Type of Facility</b>	<b>Initial State Plan Effective Date</b>	<b>Annual Enhanced Payments</b>	<b>Annual FFP</b>
Alabama	Nursing	September 1999	\$44.2	\$30.7
Alabama	Hospital	October 1995	\$158.4	\$110.9
Alaska	Hospital	April 2000	\$20.0	\$12.0
Arkansas	Hospital	May 2000	\$55.9	\$40.7
California <sup>1</sup>	Hospital	July 1989	\$1,459.8	\$754.3
Georgia	Hospital	December 1999	\$672.2	\$402.5
Illinois	Hospital	July 1991	\$1,138.9	\$569.5
Indiana <sup>2</sup>	Hospital	March 1994	\$213.9	\$132.7
Indiana	Community Mental Health Center	April 1998	\$6.0	\$3.7
Iowa	Nursing	October 1999	\$202.1	\$127.5
Kansas	Nursing	January 2000	\$129.6	\$77.8
Louisiana	Nursing	October 2000	\$685.0	\$483.0
Michigan	Nursing	June 1993	\$281.0	\$148.1
Michigan	Hospital	June 1993	\$300.0	\$158.1
Minnesota	Nursing	June 1994	\$9.3	\$4.8

<sup>1</sup> California has three section 1915b waivers: 1) inpatient services at county and private hospitals and university medical centers (effective July 1989); 2) debt service for DSH (effective July 1989), and 3) graduate medical education (GME) for hospitals receiving GME (effective July 1997).

<sup>2</sup> Indiana has three SPAs: 1) inpatient services at municipal hospitals (effective April 1998); 2) outpatient services at local government hospitals (effective March 1994); and 3) outpatient services at local government hospitals (effective April 1998).

<b>ANNUAL MEDICAID ENHANCED PAYMENTS (\$ in millions)</b>				
<b>State</b>	<b>Type of Facility</b>	<b>State Plan Effective Date</b>	<b>Annual Enhanced Payments</b>	<b>Annual FFP</b>
Missouri	Nursing	August 2000	\$100.0	\$60.0
Missouri	Hospital	September 2000	\$27.2	\$16.3
Montana	Hospital	June 2000	\$1.0	\$0.7
Nebraska	Nursing	September 1992	\$91.0	\$55.4
New Hampshire	Nursing	March 1994	\$28.4	\$14.2
New Jersey	Nursing	March 2000	\$896.0	\$448.0
New Mexico <sup>3</sup>	Hospital	July 1993	\$42.7	\$31.3
New York	Nursing	July 1995	\$991.5	\$495.8
North Carolina	Hospital	September 1999	\$239.3	\$149.6
North Dakota	Nursing	April 1999	\$36.8	\$25.9
Oregon	Nursing	June 1999	\$56.3	\$33.8
Oregon	Hospital	June 1999	\$26.6	\$14.9
Pennsylvania	Nursing	May 1991	\$1,521.0	\$858.1
South Carolina	Hospital	October 1999	\$69.4	\$48.6
South Dakota	Nursing	February 2000	\$29.8	\$20.5
Tennessee	Nursing	October 1999	\$390.7	\$248.3
Washington	Nursing	September 1999	\$147.0	\$76.2
Washington	Hospital	July 2000	\$30.1	\$15.3
Wisconsin	Nursing	June 1985	\$178.6	\$105.0
<b>Total</b>			<b>\$10,279.7</b>	<b>\$5,774.2</b>

<sup>3</sup>New Mexico has two State plan amendments: 1) inpatient hospital services at a sole community hospital (effective July 1993) and 2) inpatient hospital services at State teaching hospitals (effective September 2000).



DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator  
Washington, D.C. 20201

**DATE:** JUL 25 2001

**TO:** Michael F. Mangano  
Acting Inspector General

**FROM:** Ruben J. King-Shaw, Jr.  
Deputy Administrator and Chief Operating Officer  
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Report: *Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers* (A-03-00-00216)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above-referenced draft report, which consolidated the results of seven OIG audits conducted in six states. The purpose of the reviews was to analyze how states used intergovernmental transfers (IGTs) to finance enhanced payments to county or local government-owned nursing facilities and hospitals and to evaluate the financial impact of these transfers on the Medicaid program. Based upon the individual reviews of enhanced payment programs in the six states, OIG concluded that the states' use of IGTs as part of the enhanced payment program was a financing mechanism designed to maximize Federal Medicaid reimbursement, thus effectively avoiding the Federal/state matching requirements.

We appreciate the effort that went into this report and the opportunity to comment on the issues it raises. We believe the information presented in the report will be very valuable to us as we continue to work with the states to shape Federal payment policy. Our detailed comments on the OIG recommendations follow.

#### OIG Recommendation

CMS should annually audit the accuracy of the states' upper payment limit calculation and enhanced payments to ensure that the expected savings of \$55 billion are realized.

#### CMS Response

We concur. We plan to actively monitor state compliance with the new upper payment limits through two actions. We plan to conduct thorough reviews of future state plan amendment requests to ensure compliance with new regulations. We will also monitor state claiming of upper payment limit expenditures through the HCFA-64 quarterly claiming process to ensure state payments comply with applicable limits.

The Health Care Financing Administration (HCFA) was renamed to the Centers for Medicare & Medicaid Services (CMS).  
We are exercising fiscal restraint by exhausting our stock of stationery.

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OIG Recommendation

CMS should provide states with definitive guidance on calculating the upper payment limit so that there is a uniform standard applicable to all states. OIG believes this should include using facility-specific upper payment limits that are based on actual cost report data.

CMS Response

We concur in part. We agree that we should provide more guidance on calculating the upper payment limit. We are currently addressing whether “safe harbor” guidance or policy, setting out limited choices to states, is the best approach. With respect to facility-specific cost-based limits, we considered this proposal when we published the January 12 final upper payment limit rule, but adopted restructured aggregate limits to allow states some additional flexibility to better respond to the unique challenges of maintaining access to services. If, under the upper payment limit rules, we find that states are still able to use public health care facilities as a transfer agent to leverage Federal Medicaid funding, we will look to many further reforms, which may include facility-specific limits.

OIG Recommendation

CMS should require that, for states to seek Federal financial participation (FFP) to match state enhanced payments, they must demonstrate that the enhanced payments were actually made available to the facilities and that the facilities used the funds to furnish Medicaid-approved services to Medicaid-eligible beneficiaries.

CMS Response

We concur with the first part of this recommendation. It is current policy that states must make an expenditure in order for FFP to be available. Once a Medicaid payment is made to a medical provider, the funding is then available to that provider to use as the provider sees fit.

The second part of this recommendation requires further review. It would require notice and comment rulemaking to implement, as it has the effect of a facility-specific cost-based limit. We considered facility-specific limits in promulgating the January 12 final upper payment limit rule. We elected not to impose facility-specific limits, because we believe states may require more flexibility in order to adequately respond and maintain the fragile network of Medicaid-participating providers. We believe the current upper payment limit regulations strike an adequate balance between accountability of Federal funds and state flexibility. A further discussion of facility-specific limits may be found in the “Other Alternatives Considered” section of the January final upper payment limit rule. However, as previously mentioned, if states are able to use public health care facilities to leverage Federal funding, then we will revisit the implementation of facility-specific limits.

OIG Recommendation

CMS should require that the return of Medicaid payments by a county or local government to the state be declared a refund of those payments and thus be used to offset the FFP generated by the original payment.

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CMS Response

This recommendation requires further review. We have in previous instances proposed disallowances when states did not offset funds. CMS' policy of treating returned provider funds as applicable credits had limited success in states' appeals of disallowances on this issue at the Departmental Appeals Board (DAB). In a series of decisions on this issue, the DAB overturned CMS disallowances on the basis that CMS must give states clear notice of our applicable credit policies before taking disallowance actions. We are reviewing alternative avenues for achieving the policy goal.

OIG Recommendation

CMS should reconsider capping the aggregate upper payment limit at 100 percent for all facilities rather than the 150 percent allowance for non-state-owned government hospitals.

CMS Response

We concur. In addition, the President's budget builds on recent regulatory actions by including a proposal to prohibit new hospital loophole plans approved after December 31, 2000, from receiving the higher upper payment limit allowed in the final rule. While we are reconsidering the 150 percent upper payment limit, we still believe the upper payment limit regulation makes important strides in reducing excessive funding arrangements. Before proposing further reforms, we want to make sure that the new rule will not have any unintended consequences that would undermine access to quality health care services.

OIG Recommendation

CMS should seek authority to eliminate or reduce the transition periods included in the new upper payment limit regulations.

CMS Response

We do not concur. The three transition periods were established pursuant to either notice and comment rulemaking, or to legislation. Therefore, offering new proposals at this time to reduce or eliminate these transition periods would undermine the consensus reached through those processes. In the one area where the final regulation was ambiguous (i.e., pending amendments), we have issued a notice of proposed rulemaking that proposes a shorter transition period than would otherwise be permissible under the January final upper payment limit rule.

OIG Recommendation

CMS should seek authority to impose a civil penalty against the states for using Medicaid funds for other than Medicaid-approved services.

CMS Response

We do not concur. We believe the effective management of the Medicaid program depends on a strong partnership between the Federal and state governments. While we agree that Medicaid funds should only be used to support allowable Medicaid activities, we think the imposition of civil penalties as a deterrent is unnecessary and would undermine the cooperative working

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arrangements that exist between CMS and the states. We believe that through the issuance of clearer policies and guidance, we will be able to achieve the objective underlying this recommendation without creating any friction that may occur if civil penalties were imposed against the states.