



## **RSC Policy Brief: Medicaid and the States**

*April 2, 2008*

**In light of potential regulatory and legislative actions designed to make adjustments to Medicaid's joint state-federal financing mechanism, the RSC has prepared the following policy brief analyzing several elements of the various policy proposals.**

**Executive Summary:** The Centers for Medicare and Medicaid Services (CMS) has issued several proposed regulations concerning various issues relating to federal reimbursement of certain Medicaid services. Although the proposed regulations address state financing arrangements that government reports have questioned for decades, the Democratic Congress passed moratoria prohibiting CMS from issuing final regulations. Many conservatives may be wary of any further legislative efforts to override the proposed regulations—or to provide a temporary increase in the federal Medicaid match in an economic “stimulus” bill—as encouraging states to engage in questionable funding schemes and poor financial planning, resulting in significantly higher outlays for the federal government.

**Background:** The Medicaid program, enacted in 1965, serves as a federal-state partnership providing entitlement health care coverage to certain low-income and disabled populations. Federal funding for the program is provided on a matching basis, according to a Federal Medical Assistance Percentage (FMAP) formula established in statute.

Because of the nature of the federal match, states have for some time created mechanisms designed to maximize the federal share of spending on Medicaid services. In 1991, Congress passed legislation (P.L. 102-234) designed to restrict Medicaid provider taxes, as states were collecting funds from providers, then rebating those funds back to the providers once the states had utilized the taxes collected to capture additional federal matching funds. The 1991 provisions were designed to avoid provider-specific taxes, and included “hold harmless” mechanisms guaranteeing that providers would receive all their money back after it was used by the state to recoup additional federal funds; however, broad-based provider taxes remained permissible, and states soon developed other ways to maximize federal Medicaid spending.

**Proposed Regulations:** During the past year, the Centers for Medicare and Medicaid Services (CMS) has attempted to move forward on several proposed regulations addressing specific issues and service areas within the Medicaid program. Specifically, the various proposed rules would:

- Limit reimbursement for publicly-owned health providers to costs incurred, narrow the definition of unit of government, and require providers to retain all Medicaid payments, in order to restrain intergovernmental transfers designed primarily to maximize states' federal Medicaid payments;
- Eliminate Medicaid reimbursement for graduate medical education;
- Restrict the scope of rehabilitation services subject to the federal Medicaid match and eliminate coverage of day habilitation services for individuals with developmental disabilities;
- Prohibit federal Medicaid payments for administrative activities performed by schools and transportation of children to and from school;
- Restrict the scope of Medicaid outpatient hospital services and clarify the upper payment classification for outpatient services; and
- Restrict the scope of targeted case management services, and specify that Medicaid will not reimburse states for services where another third party is liable for payment.

The proposed regulations were issued at various times between May and December 2007, and are collectively projected to result in at least \$12.1 billion in savings to the federal government over the next five fiscal years.<sup>1</sup> By point of comparison, these savings would constitute approximately 1% of total federal spending on Medicaid, which over the next five years is estimated to total \$1.2 trillion.<sup>2</sup>

In addition, in February 2008, CMS issued proposed regulations altering current regulations on provider taxes; this rule, proposed as a result of legislative changes enacted in the Tax Relief and Health Care Act of 2006 (P.L. 109-432) and the Deficit Reduction Act of 2005 (P.L. 109-173), would reduce the maximum provider tax under the federal "safe harbor" from 6% to 5.5% and make other related changes, saving an estimated \$400-600 million over five years.<sup>3</sup>

**Recent Legislative Developments:** In response to several of the Medicaid payment rules proposed last year, Congress has taken action to block CMS from issuing final regulations. Section 7002(a)(1) of the 2007 wartime supplemental appropriations bill (P.L. 110-28) prohibited promulgation of regulations related to cost limits for providers and graduate medical education (GME) for one year—until May 25, 2008. In addition, Medicare physician payment legislation passed last December (P.L. 110-173) included prohibitions on promulgation of

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<sup>1</sup> Kaiser Commission on Medicaid and the Uninsured, "Medicaid: Overview and Impact of New Regulations," (Washington, DC, Report 7739, January 2008), available online at <http://kff.org/medicaid/upload/7739.pdf> (accessed March 31, 2008), p. 2.

<sup>2</sup> Office of Management and Budget, *Analytical Perspectives: Budget of the United States Government, Fiscal Year 2009*, available online at <http://www.whitehouse.gov/omb/budget/fy2009/pdf/spec.pdf> (accessed April 1, 2008), p. 383.

<sup>3</sup> Jean Hearne, "Medicaid Provider Taxes," CRS Report RS22843, March 21, 2008, pp. 4-6.

regulations addressing rehabilitation and school-based transportation services until June 30, 2008.

On March 13, 2008, House Energy and Commerce Committee Chairman John Dingell (D-MI) and Rep. Tim Murphy (R-PA) introduced H.R. 5613, Protecting the Medicaid Safety Net Act. The legislation would extend until April 1, 2009, the existing moratoria on CMS' issuance of the Medicaid regulations discussed above, and would further impose moratoria on issuance of proposed rules addressing case management, re-defining hospital outpatient services, and allowable provider taxes. An Energy and Commerce hearing on the legislation is scheduled for April 3, 2007, and further legislative action is possible, either as a stand-alone measure or as part of Medicare physician reimbursement legislation.

In addition, House Energy and Commerce Health Subcommittee Chairman Frank Pallone (D-NJ) has introduced H.R. 5268, which would provide a temporary increase in federal Medicaid matching funds to states under the FMAP formula for five fiscal quarters, through October 2009. Similar proposals were circulated early this year as part of the debate surrounding the "stimulus" bill; while the National Governors Association and state Medicaid directors expressed strong support for these provisions, they were not included in the final legislation. However, it is possible but not certain that such measures regarding FMAP could be attached to either the wartime supplemental appropriations legislation or a possible second "stimulus" package being discussed by the Democratic leadership.

**GAO Analysis:** Since 1994, the Government Accountability Office (GAO) has compiled more than a dozen reports highlighting problems with Medicaid financing, and specifically the ways in which state governments attempt to "game" Medicaid reimbursement policies in order to maximize the amount of federal revenue funding state health care programs. The persistent shortcomings in federal oversight of these state funding schemes prompted GAO to add the Medicaid program to its list of federal entities at high risk of mismanagement, waste, and abuse in 2003.

Several of the GAO reports discuss state reimbursement efforts for several of the services CMS proposes to change in its new regulations. For instance, testimony in June 2005 analyzed the ways in which 34 states—up from 10 in 2002—employed contingency-fee consultants to maximize federal Medicaid payments. The report found that from 2000-2004, Georgia obtained \$1.5 billion in additional reimbursements, and Massachusetts \$570 million.<sup>4</sup> The report concluded that the states' claims for targeted case management "appear to be inconsistent with current CMS policy" and claims for rehabilitation services "were inconsistent with federal law."<sup>5</sup> In other areas, GAO found potentially inappropriate behavior—higher reimbursements for school-based health and administrative services that were not fully passed on to the relevant school districts, and questionable administrative costs, such as a 100% claim on a Massachusetts

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<sup>4</sup> Government Accountability Office, "Medicaid Financing: States' Use of Contingency Fee Consultants to Maximize Federal Reimbursements Highlights Need for Increased Federal Oversight," (Washington, Report GAO-05-748, June 2005) available online at <http://www.gao.gov/new.items/d05748.pdf> (accessed March 31, 2008), p. 4.

<sup>5</sup> Ibid., p. 19.

state official's salary as a Medicaid administrative cost, even though the official worked on unrelated projects for other states designed to increase their own Medicaid reimbursements.<sup>6</sup>

The GAO reports also demonstrate states' use of intergovernmental transfers to maximize federal Medicaid reimbursements. In these schemes, local-government health facilities transfer funds to the state Medicaid agency. The Medicaid agency in turn transfers funds back to the local-government facility—but not before filing a claim with CMS to obtain federal reimbursement. Although permissible under current law in many cases, GAO found that these schemes “are inconsistent with Medicaid's federal-state partnership and fiscal integrity.”<sup>7</sup>

Many of the GAO reports over the past decade—whose titles are listed at the bottom of this brief—have included calls for additional federal oversight around various state Medicaid reimbursement initiatives, particularly the need for clear and consistently applied guidance from CMS about the permissiveness of various financing arrangements.<sup>8</sup> Several of CMS' proposed regulations attempt to remedy this problem, and restore clarity and fiscal integrity to the Medicaid program.

**Reports of Medicaid Waste and Fraud:** Although much of the debate surrounding the proposed CMS regulations has centered on the proper scope and limits of covered services within the Medicaid program, it is also worth noting the considerable amount of waste and criminal fraud present within some state Medicaid programs. An extensive investigation published by *The New York Times* in July 2005 revealed several examples of highly questionable activity within the New York Medicaid program:

- A Brooklyn dentist who billed Medicaid for performing 991 procedures in a single day;
- One physician who wrote 12% of all the prescriptions purchased by New York Medicaid for an AIDS-related drug to treat wasting syndrome—allegedly so the steroid could be re-sold on the black market to bodybuilders;
- Over \$300 million—far more than any other state Medicaid program—in spending on transportation services, some of which involved rides for seniors mobile enough to rely on public transportation and other services which investigators believe may not have been performed at all; and
- A school administrator in Buffalo who in a single day recommended that 4,434 students receive speech therapy funded by Medicaid—part of \$1.2 billion in improper spending by the state on speech services, according to a federal audit.

A former state investigator of Medicaid abuse estimated that fraudulent claims totaled approximately 40% of all Medicaid spending in New York—nearly \$18 billion per year, which may help explain why New York's Medicaid expenditures greatly exceed California's, despite a smaller overall population and fewer Medicaid beneficiaries.<sup>9</sup>

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<sup>6</sup> Ibid., pp. 27-29.

<sup>7</sup> Ibid., p. 24.

<sup>8</sup> See *ibid.*, p. 30.

<sup>9</sup> Clifford Levy and Michael Luo, “Medicaid Fraud May Reach into Billions,” *The New York Times* 18 July 2005, available online at

Likewise, reports from the Department of Health and Human Services' Inspector General reflect Medicaid reimbursement submissions by states that either lack appropriate documentation for the claims or represent inappropriate use of Medicaid resources. For example, one May 2003 claim for Medicaid targeted case management reimbursement included the following notation from the case manager explaining her contact with the beneficiary:

Phone call with mother. Discussed the outstanding warrant for [name redacted]. She does not know where he is. She will call police when he shows up.

While it may represent good public policy for this type of contact—which attempted to locate a juvenile for whom an outstanding arrest warrant existed—some conservatives would argue that such actions lie outside the scope of the Medicaid program's intent and represent a far-from-ideal expenditure of federal matching dollars.

**Conservative Concerns:** Given the many GAO reports highlighting problems with state Medicaid financing schemes, and the disturbing reports of fraud and graft within many Medicaid programs, some conservatives may be troubled by potential legislative action to override CMS' modest attempts at limiting questionable behavior by state Medicaid agencies. Likewise, a potential increase in the Medicaid FMAP formula might be viewed by some conservatives as a “bailout” for states which over-extended entitlement promises over the last few years—and which have failed to implement strong anti-fraud programs to ensure that Medicaid funds are spent wisely. Some conservatives may argue that states wishing to reverse CMS' proposed rules, or to seek an “emergency” FMAP increase from the federal government, should first ensure that their own fiscal houses are in order with respect to Medicaid waste, fraud, and abuse.

Although many state governors and Medicaid directors have pointed to the recent economic slowdown as putting a particular squeeze on their budgets, a recent study by researchers at the Urban Institute found that revenue loss generates a measurably larger impact on state budgets than enrollment increases in Medicaid and related public health programs.<sup>10</sup> Because potential state deficits during economic downturns therefore stem largely from failed revenue models rather than greater public reliance on Medicaid and related programs, some conservatives may question whether the tactic of relying upon the federal government for backstop assistance will have the twin negative effects of increasing federal spending and debt while encouraging “moral hazard” among states with flawed budgetary models.

However, the discussion of Medicaid funding levels does provide conservatives with an opportunity to raise the important issue of entitlement reform. One possible solution would see Medicaid converted into a block grant program, allowing for predictable payments to states, ending state distortionary schemes designed to win additional federal dollars, and enabling

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[http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html?\\_r=1&pagewanted=print&oref=slogin](http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html?_r=1&pagewanted=print&oref=slogin) (accessed March 29, 2008).

<sup>10</sup> John Holahan, Stan Dorn, *et al.*, “Medicaid, SCHIP, and Economic Downturn: Policy Challenges and Policy Responses,” (Washington, DC, Alliance for Health Reform briefing on Health Care and the Economic Slowdown, February 15, 2008), available online at

[http://www.allhealth.org/briefingmaterials/MedicaidSCHIPeconomicdownturn\\_2-14-2008-1079.ppt](http://www.allhealth.org/briefingmaterials/MedicaidSCHIPeconomicdownturn_2-14-2008-1079.ppt) (accessed March 29, 2008).

Congress to engage in a more rational attempt to control health care costs while setting clear national fiscal priorities. At a minimum, some conservatives may support efforts to convert those portions of Medicaid not directly related to essential medical services into a discretionary spending program, which would re-focus Medicaid on its original mission of providing health care for low-income individuals, while allowing services tangential to that mission to compete with other federal programs for scarce funding dollars.

For further information on this issue see:

- [RSC Policy Brief: Medicaid Funding Issues](#)
- [New York Times Article: New York Medicaid Fraud May Reach into Billions](#)
- [November 2007 GAO Testimony: Medicaid Financing: Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight](#)
- [March 2007 GAO Report: Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency](#)
- [June 2006 GAO Report: Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts](#)
- [June 2005 GAO Testimony: Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight](#)
- [June 2005 GAO Testimony: Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight](#)
- [March 2004 GAO Testimony: Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes](#)
- [February 2004 GAO Report: Medicaid: Improved Federal Oversight of State Financing Schemes Needed](#)
- [October 2001 GAO Report: Medicaid: HCFA Reversed its Position and Approved Additional State Financing Schemes](#)
- [September 2000 GAO Testimony: Medicaid: State Financing Schemes Again Drive Up Federal Payments](#)
- [April 2000 GAO Report: Medicaid in Schools: Improper Payments Demand Improvement in HCFA Oversight](#)
- [June 1999 GAO Testimony: Medicaid: Questionable Practices Boost Federal Payments for School-Based Services](#)
- [August 1994 GAO Report: Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government](#)

**RSC Staff Contact:** Chris Jacobs, [christopher.jacobs@mail.house.gov](mailto:christopher.jacobs@mail.house.gov), (202) 226-8585

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