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HCFA Reversed Its Position and Approved Additional State Financing Schemes



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<p>Abstract</p> <p>States have been searching for ways to help finance the \$196 billion Medicaid program, a jointly funded federal-state program providing health care services to certain low-income, elderly, and disabled people. Over the years, some states have taken advantage of the flexibility that the Congress has built into the Medicaid program by devising financing schemes that inappropriately boost the federal share of program expenditures. Last year, we testified about a regulatory loophole some states were exploiting to increase federal Medicaid payments under existing upper payment limit provisions. 1 These provisions represent upper bounds on what the federal government is willing to pay as its share of the costs of different classes of covered services. States were inappropriately increasing federal Medicaid payments by paying nursing homes and hospitals owned by local governments more than they would normally receive and then having them return the bulk of the extra money to the state. The states then sought federal matching funds based on the full amount they paid to providers which they were free to use as they wished. These schemes were adding billions of dollars a year to federal Medicaid costs without the states paying their statutorily specified share of program costs and with some of the federal funds being spent for non-Medicaid purposes. The Congressional Budget Office concluded in January 2001 that such schemes were the most notable factor behind recent increases in federal Medicaid spending, which is growing at a rate nine times that of the Medicaid population. 2</p>		
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Abbreviations

BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CMS	Centers for Medicare and Medicaid Services
DSH	disproportionate share hospital
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OIG	Office of Inspector General
UPL	upper payment limit



G A O

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United States General Accounting Office
Washington, DC 20548

October 30, 2001

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Don Nickles
United States Senate

States have been searching for ways to help finance the \$196 billion Medicaid program, a jointly funded federal-state program providing health care services to certain low-income, elderly, and disabled people. Over the years, some states have taken advantage of the flexibility that the Congress has built into the Medicaid program by devising financing schemes that inappropriately boost the federal share of program expenditures. Last year, we testified about a regulatory loophole some states were exploiting to increase federal Medicaid payments under existing “upper payment limit” provisions.¹ These provisions represent upper bounds on what the federal government is willing to pay as its share of the costs of different classes of covered services. States were inappropriately increasing federal Medicaid payments by paying nursing homes and hospitals owned by local governments more than they would normally receive and then having them return the bulk of the extra money to the state. The states then sought federal matching funds—based on the full amount they paid to providers—which they were free to use as they wished. These schemes were adding billions of dollars a year to federal Medicaid costs without the states paying their statutorily specified share of program costs and with some of the federal funds being spent for non-Medicaid purposes. The Congressional Budget Office concluded in January 2001 that such schemes were the most notable factor behind recent increases in federal Medicaid spending, which is growing at a rate nine times that of the Medicaid population.²

¹*Medicaid: State Financing Schemes Again Drive Up Federal Payments* (GAO/T-HEHS-00-193, Sept. 6, 2000).

²*The Budget and Economic Outlook: Fiscal Years 2002-2011* (Washington, D.C.: Congressional Budget Office, Jan. 2001).

After hearing about this latest financing scheme, the Congress acted promptly to stop it, as it has done in the past when similar schemes have come to light. In response to the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA),³ the Health Care Financing Administration (HCFA)⁴ issued regulations in January 2001 designed to curtail financing schemes involving excessive payments to local government providers, for which a separate upper payment limit did not exist. However, in April 2001, less than 1 month after the revised upper payment limit regulation became effective, HCFA decided to amend the regulation to shorten the amount of time some states were allowed to comply with the new regulation. This latest revision to the upper payment limit regulation was published on September 5, 2001.

This report addresses (1) how HCFA's actions to implement the January 2001 upper payment limit regulation permitted additional states to establish the same type of financing schemes that it was attempting to curtail and (2) the estimated additional costs to the federal government of the largest two of these newly established schemes. In preparing this report, we reviewed HCFA's notices of proposed rule-making and final regulations and documentation related to the four states affected by the September 2001 regulation: Florida, Michigan, Virginia, and Wisconsin. We focused our work on Virginia and Wisconsin because they represented 96 percent of the excessive federal payments the agency identified as subject to its latest regulation. We also drew upon our earlier work.⁵ We conducted our work between August and September 2001 in accordance with generally accepted government auditing standards.

Results in Brief

HCFA reversed its stated position that it would deny approval of any pending state plan amendments that would not comply with the new upper payment limit regulation. The position reversal resulted in its approval of new financing schemes for several states—including Virginia and Wisconsin—that had pending proposals mimicking the schemes identified last year. These schemes include funneling excessive Medicaid payments

³P.L. 106-554, Appendix F, Sec. 705, 114 Stat. 2763, 2763A-575.

⁴In June 2001, HCFA was renamed the Centers for Medicare and Medicaid Services (CMS). We continue to refer to HCFA where agency actions were taken under its former name.

⁵See list of related GAO products at the end of this report.

through local governments on behalf of nursing homes to secure federal matching funds.

HCFA's approval of Virginia's and Wisconsin's new financing schemes enables these two states to generate an estimated \$722 million in excessive federal payments. The agency's September regulation, which limited the length of time states can operate their newly approved excessive funding schemes, reduced these estimated excessive federal payments by about \$483 million from an earlier estimate of \$1.2 billion. HCFA's January regulation had established transition periods to allow states time to reduce their reliance on federal funds that state schemes had generated. The transition periods were of varying lengths, depending on how long a state had been receiving excessive federal payments from one of these schemes. Believing that states just starting to receive excessive federal payments—such as Virginia and Wisconsin—did not need the 2-year transition period established in the January regulation, HCFA decided to shorten the transition period in order to limit federal liability. While this September regulation will reduce the drain on federal Medicaid funds, we question HCFA's decision to approve additional financing schemes, given the explicit effort to curtail such schemes.

In commenting on a draft of this report, the Administrator of the Centers for Medicare and Medicaid Services (CMS) and the Virginia and Wisconsin state Medicaid directors disagreed with our conclusion that HCFA's decision in January 2001 to approve additional state financing schemes was unjustified. We continue to believe that HCFA had the authority, the discretion, and the responsibility to deny any proposed state plan amendments that were inconsistent with protecting the fiscal integrity of the Medicaid program.

Background

The Congress has structured Medicaid as a federal-state partnership that provides federal matching funds for covered state expenditures and, within broad federal guidelines, gives states considerable flexibility in deciding what medical services to cover and how much to reimburse medical providers. At the federal level, the program is administered by CMS, within the Department of Health and Human Services (HHS). Each state operates its program under a plan that CMS must approve for compliance with current law and regulations. CMS must also approve any amendments to the plan. On average, the federal government pays 57

percent of Medicaid costs, which totaled an estimated \$196 billion in fiscal year 2000.⁶

To ensure the reasonableness of payments to providers, HCFA established a set of upper payment limits on the total amounts it would agree to pay for a variety of services.⁷ The upper limits are based on what Medicare (the federal health care program for elderly and some disabled individuals) would pay for comparable services. The upper payment limit is not a price to be paid for each service provided or a limit on the amount paid to individual facilities, but rather a ceiling on Medicaid payments for a category of providers above which the federal government will not share. Because state Medicaid payment rates are generally less than Medicare rates, states often have large gaps between their actual Medicaid payments and what they would pay using Medicare payment rates. States' upper payment limit schemes are designed to exploit this gap so the state can obtain federal matching funds without paying its statutorily determined share.

Previous State Financing Schemes—and Efforts to Curtail Them—Go Back More Than a Decade

Despite limits on federal payments, the flexibility that states have to set Medicaid's payment rates has provided the opportunity for some to develop various financing schemes in the past that inappropriately increased federal Medicaid payments. Over more than a decade, states have used a variety of schemes to boost federal Medicaid funding without contributing their specified share. As these schemes came to light, they were subsequently restricted by law or regulation (see table 1). For example, after HCFA became aware of schemes involving excessive federal payments to state-owned hospitals and nursing homes, it promulgated regulations to restrict excessive payments to these providers. Such restrictions, however, did not extend to certain government health care providers, such as local- and county-level providers.

⁶The federal matching rate varies for each state, ranging from 50 to 83 percent. States with lower per capita income receive a higher federal matching rate.

⁷Separate upper payment limits exist for several different classes of services. These include inpatient hospital services, outpatient hospital services, nursing facility services, and intermediate care services for the mentally retarded.

Table 1: Previous Medicaid Financing Schemes for Generating Excessive Federal Funds Without Committing a Corresponding State Contribution

Financing scheme	Summary	How subsequently restricted
Excessive payments to state facilities	Excessive payments were made to state-owned facilities, increasing federal payments.	HCFA promulgated regulations in 1987 that established payment limits for state-operated inpatient and institutional facilities.
Provider taxes and contributions	Revenues from provider-specific taxes or donations were used to increase state Medicaid spending. The taxes and contributions were matched with federal funds and paid to the providers. These providers could then return most of the federal moneys to the state.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 barred certain provider donations, placed restrictions on provider taxes, and set other restrictions for state contributions.
Excessive disproportionate share hospital (DSH) payments	DSH payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the state and federal funds to the state.	The Omnibus Budget Reconciliation Act of 1993 limited which hospitals could receive DSH payments, capped the amount of DSH payments individual hospitals could receive, and capped states' total DSH payments. The Balanced Budget Act of 1997 further reduced state-specific DSH allotments for fiscal years 1998 through 2002.
Excessive DSH payments to state mental hospitals	A large proportion of state DSH payments were directly returned to the state treasury or were paid to state-operated psychiatric hospitals to indirectly cover the cost of services provided to patients that Medicaid cannot directly pay for.	The Balanced Budget Act of 1997 limited the proportion of a state's DSH payment that can be paid to state psychiatric hospitals.

Source: GAO/T-HEHS-00-193, Sept. 6, 2000.

Latest Financing Scheme Involved Local Government Providers

The financing scheme we identified last year was the latest variant being used by some states. In this scheme, excessive payments were made to health facilities owned by local governments. Such providers included county-owned nursing homes and hospitals and local hospital districts. States determined the amount of the excessive payments by computing the difference between the upper payment limit (that is, the maximum payment eligible for a federal match) and the total amount the state would normally have paid to Medicaid providers. The state then made payments equaling all or part of the difference to certain local government-operated

facilities. These excessive payments were separate and in addition to what the state would normally pay for services these facilities provided. The facilities would agree in advance to return most or all of the extra money. Once the money was returned, the state then had additional money that it could use to pay its share of future Medicaid payments—thus generating even more federal matching funds—or to spend however else it decided. A variation of this scheme involved local providers advancing funds to the state, which it would then simply return to the local providers in the guise of a payment for valid covered services. The state would then claim federal matching funds on the excessive payment without having spent any state funds.

Such funding arrangements violate the integrity of the Medicaid program for several reasons. First, they effectively increase the federal matching rates—which are set by law—because they generate additional federal Medicaid expenditures, while total state contributions remain unchanged. For example, as we testified last year, New Jersey’s financing arrangement with local nursing homes would effectively increase the federal matching rate from 50 percent to 62 percent if the state retained all \$500 million of the excessive federal funds it generated. Second, the schemes funnel federal Medicaid dollars to the state that can be used at its discretion, with no assurance that the money is used for valid Medicaid services. The state can actually use these funds to supplant part of its share of Medicaid expenditures, thereby essentially bringing in still more federal Medicaid dollars. Third, these funding arrangements are inconsistent with statutory requirements that the states ensure that Medicaid payments are economical and efficient, because the chosen methods result in grossly excessive payments, well beyond the cost of services provided.⁸

By fiscal year 2000, the number of states taking advantage of these types of schemes and making excessive payments to local government providers had grown to 28, according to the HHS Inspector General, costing Medicaid an estimated \$5.8 billion that year alone. Last September, the HHS Office of Inspector General (OIG) testified before the Senate Finance Committee that in some cases it was clear the federal funds were not reimbursing valid Medicaid costs. For example, the OIG found that between 1997 and 1999, Pennsylvania generated about \$1.9 billion in excessive federal Medicaid payments, of which \$407 million was known to have been spent on non-Medicaid services; another \$558 million was

⁸42 U.S.C. sec. 1396(a)(30)(A).

unbudgeted and available to the state for non-Medicaid uses. Similarly, we found that Iowa's excessive payment arrangement with county nursing homes resulted in average federal spending of about \$969 daily per Medicaid bed—an 18-fold increase from the prior federal spending level of \$54 per bed per day.

In December 2000, the Congress mandated that HCFA's pending regulation be finalized to revise the upper payment limit.⁹ This regulation restricts the ability of states to inappropriately generate federal funds through these financing schemes with local government providers. In doing so, however, the Congress and HCFA recognized that some states had used these schemes long enough to develop considerable reliance on the excessive federal payments as part of their overall state budgets. Thus, the regulation provided for three transition periods, ranging from about 2 years to 8 years, before states had to fully comply. In effect, this provision gave the states a period of time during which they could continue to receive excessive federal payments. The length of a state's transition period depended on how long it had been using the scheme. For those in effect since before October 1992, states could continue to receive some excessive payments until October 2008. By contrast, states with approved state plan amendments that did not comply with the revised regulation and took effect after October 1999 would have their payments phased out by October 2002. HCFA justified the shorter transition period for these latter states because it had notified all states on July 26, 2000, that it intended to change the rules to close this loophole and that the states should therefore not develop a reliance on these funds. The regulation was published on January 12, 2001, and became effective on March 13, 2001.

⁹In response to BIPA, HCFA established several new upper payment limits for different provider classes in addition to those that already existed for state-owned or -operated facilities (42 C.F.R. 447). These included an aggregate upper payment limit for inpatient hospitals, nursing facilities, and intermediate care facilities for the mentally retarded furnished by all other government-owned or -operated facilities (that is, local government facilities). An aggregate upper payment limit was also established for outpatient hospital and clinic services provided by state government facilities and a separate aggregate upper payment limit was established for outpatient hospital and clinic services provided by all other government facilities. The regulation also provided for an increased upper payment limit—up to 150 percent of what would be paid for comparable services under Medicare payment principles—for services provided by nonstate public hospitals.

HCFA's Position Reversal Opened the Door for More Excessive Payments

HCFA decided in April 2001 to change its stated position on the January upper payment regulation to allow approval of pending state plan amendments under the old rule. This change allowed even more states to exploit the upper payment limit loophole. While HCFA was developing the January regulation, a number of state plan amendments with upper payment limit provisions had been submitted but not approved. HCFA's position about how to handle pending plan amendments—submitted before the March 13, 2001, effective date of the regulation but unapproved—changed over time, as follows:

1. In responding to public comments as part of its January 2001 published regulation, HCFA's stated position was that pending state plan amendments would be reviewed under the new regulation. HCFA indicated that, once the final regulations were issued, it would rely on them to review state plan amendments and would disapprove amendments that did not comply with them. This meant that these states would not qualify for a transition period to bring their plans into compliance with the new regulation's requirements.¹⁰ In publishing the January regulation, HCFA stated:

“We have given all states ample notice of our position that these programs are abusive and of our intent to publish this regulation to curtail such programs. To affirmatively approve pending applications would be counterproductive to our purposes of preserving the fiscal integrity of the Medicaid program.”¹¹

2. This stated position notwithstanding, the January 2001 regulation was silent as to whether plan amendments currently under consideration would be reviewed using the new regulation or the old one. On April 3, 2001, HCFA indicated in a new proposed rule that it had decided to review pending plan amendments under the old regulation, essentially

¹⁰This statement of policy was expressed in the October 10, 2000, proposed regulation and in the agency's response to comments published with the final regulation on January 12, 2001. The language of the proposed regulation explicitly states that plan amendments not in compliance with the new regulation would receive a transition period only if they were approved before the effective date of the new regulation.

¹¹If CMS neither approves nor denies an amendment within 90 days, the amendment is deemed approved. In some cases, the process may extend up to 180 days if additional information is requested from the state. Some earlier state financing schemes were in effect as a result of this deemed approval status because HCFA had decided not to affirmatively approve them.

reversing its earlier position.¹² Reviewing plan amendments under the old regulation, without modification, gave states the opportunity to receive excessive federal payments through September 30, 2002.

3. On September 5, 2001, CMS issued a rule shortening the transition period from September 30, 2002, for those upper payment limit financing schemes in plan amendments that were pending when the January regulation was issued, that were subsequently approved, and that did not comply with the January regulation.¹³ CMS stated that the full transition period for these recent plan amendments was not appropriate. The final rule limited the transition period to 1 year after the effective date of the plan amendment or November 5, 2001, whichever is later.

These changes affected the amount of time given to states before they had to comply with the upper payment limit regulation that went into effect on March 13, 2001, and the period during which they could still collect excessive federal matching payments. (See app. I for a chronology of events related to HCFA's change of position on pending state plan amendments.)

HCFA's Position Reversal Had Substantial Financial Effect

HCFA's reversal of its position on approving abusive financing schemes involved a number of states, with substantial financial effect. In April 2001, HCFA reported that 11 states with pending plan amendments might be affected by its proposed rule to shorten the transition period. However, by the time CMS issued the rule in September 2001, the number of states had narrowed to four: Florida, Michigan, Virginia, and Wisconsin.¹⁴ HCFA approved Virginia's and Wisconsin's state plan amendments—which contain the same kinds of inappropriate schemes we reported last year in other states—on June 4, 2001, and May 8, 2001, respectively. Under the January 2001 rule, CMS data show that these states would have generated over \$1.2 billion in excessive federal matching payments. The September

¹²Because the wording in the January rule was not explicit, the agency had the discretion to interpret the regulation differently, change its position, and still comply with the new regulation, according to HHS legal and program officials.

¹³This new regulation applies to state plan amendments effective after September 30, 1999, submitted to HCFA before March 13, 2001, and approved by HCFA after January 21, 2001.

¹⁴CMS indicated that the remaining seven states would comply with the January 2001 regulation and therefore would not be affected by the September regulation.

rule will reduce this estimate to about \$722 million. In our view, approving these state plan amendments and granting any transition period is inconsistent with CMS' stated position about its intent to curtail such schemes and continues to undermine the integrity of the financing partnership.

Most Recent Plan Amendments Continue Abusive Funding Schemes

As with the abusive schemes we have reported previously, Virginia and Wisconsin were given approval to employ financing schemes that make excessive Medicaid payments—well beyond the cost of the services provided—to a few local governments on behalf of nursing homes. The excessive payments are made to obtain federal matching funds, with the local providers keeping little, if any, of the funds. The states, which contribute little or none of their own funds, can ultimately retain the excessive federal payments to use for any purpose they choose.

Virginia's and Wisconsin's approved plan amendments both rely on same-day wire transfers involving banks, local governments that own or operate nursing homes, and the state. These transfers create the illusion of legitimate Medicaid payments, which are then used to bring in hundreds of millions in matching federal Medicaid dollars. In both states, this mechanism involves relatively few local-government-owned or -operated nursing homes—six homes in Virginia and five in Wisconsin. There are essentially six steps to the process, as shown in table 2. These steps include having the local government take out a bank loan and wire the proceeds to the state, which then immediately transfers the money back to the local government. This round-trip transfer of funds can be completed in a matter of minutes.

Table 2: Overview of Process for Exploiting Upper Payment Limit

Step	Activity
1	State calculates difference in upper payment limit amount (what Medicare would have paid for comparable services) and what the state actually pays nursing homes for Medicaid services.
2	County government takes out a bank loan that is based on calculation in step 1. The loan covers the full amount, both the state and the federal share, of the excessive Medicaid payment.
3	County wires the loaned money from its bank account directly to the state.
4	State creates an official "Medicaid payment" by immediately wiring the loaned funds back to the county bank account.
5	County uses money returned by the state to pay off the loan.
6	State can then claim the federal share of the payment that it made to the county.

A substantial amount of money is anticipated to be processed in these two states through these same-day wire transactions and through the federal matching funds generated by the transactions. As illustrated in table 3, the amount of excessive federal matching funds that would have been generated under the January rule exceeds \$1.2 billion.

Table 3: Federal Share of Excessive Payments in Virginia and Wisconsin Under HCFA’s January 2001 Regulation

Dollars in millions				
State	Fiscal year 2000	Fiscal year 2001	Fiscal year 2002	Total
Virginia		\$146 ^a	\$218	\$364
Wisconsin	\$93 ^b	374	374	841
Total	\$93	\$520	\$592	\$1,205

^aVirginia can claim excessive payments for 8 months in fiscal year 2001.

^bWisconsin made excessive payments in 3 months of fiscal year 2000. These earlier payments are allowed because the Wisconsin amendment was effective July 1, 2000.

Source: Calculations are based on CMS estimates, updated to reflect the latest available state-specific data.

The payments permissible under Virginia’s and Wisconsin’s approved financing schemes grossly exceed what the states typically pay for comparable services. Moreover, the states are free to use the federal proceeds as they wish. For example, Virginia would provide six local government nursing homes, on average, an additional \$617 in federal funds per Medicaid nursing home resident per day over the \$53 per day in federal funds, on average, that these homes normally receive per Medicaid nursing home resident. Wisconsin indicated, in documents submitted to HCFA, that the \$748 million in federal matching funds that it would draw down over fiscal years 2001 and 2002 will be deposited in a newly created and interest-earning Medicaid Trust Fund. According to state information, the federal funds will be used in future fiscal years to finance payment increases for a variety of Medicaid providers, beyond nursing homes in three counties. If it does so, the state would essentially be recycling federal funds to draw down additional federal funds to be used for other purposes.

September Rule Will Reduce Magnitude of Expected Excessive Payments

By shortening the allowed transition period to comply with the new upper payment limits, the September rule will reduce the magnitude of excessive federal payments for these two states by about \$483 million—from over \$1.2 billion to about \$722 million (see table 4).

Table 4: Impact of September 5, 2001, Rule on Excessive Federal Payments to Virginia and Wisconsin

Dollars in millions			
State	Excessive federal payments under January 2001 rule	Reduction (savings) under September 2001 rule	Estimated excessive federal payments
Virginia	\$364	\$146	\$218
Wisconsin	841	337	504
Total	\$1,205	\$483	\$722

Source: GAO analysis of state plan amendment documentation.

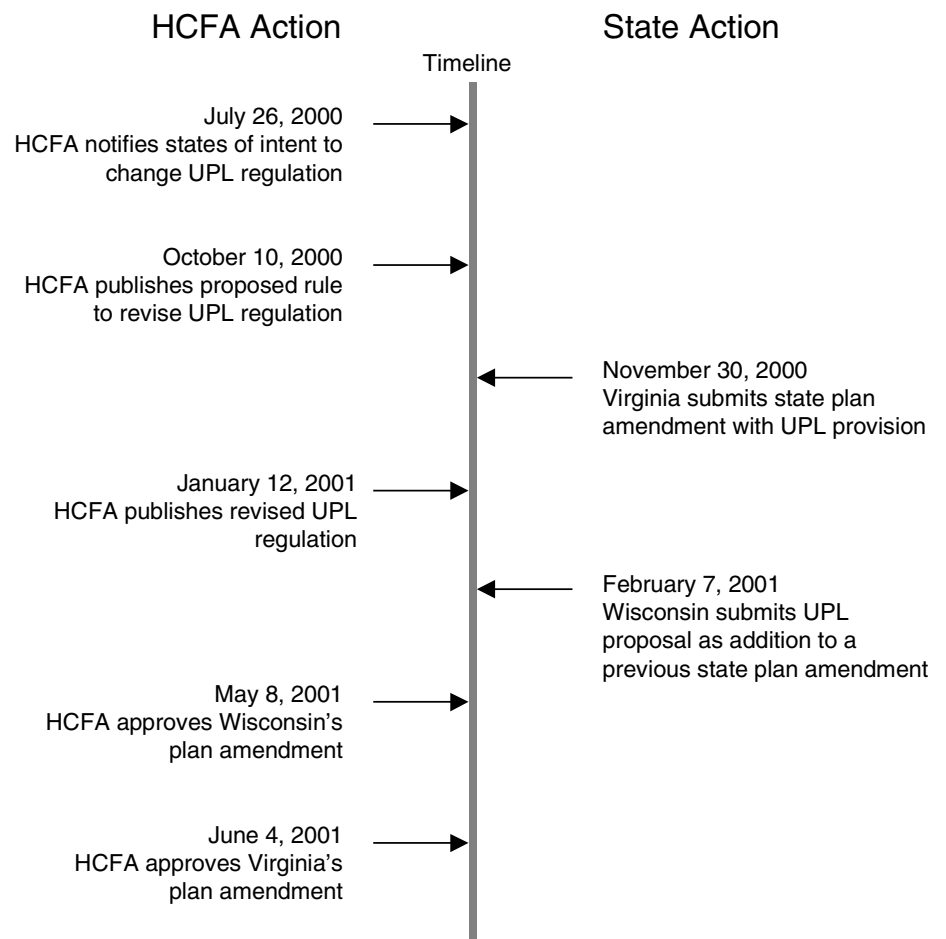
If both states had been limited to a 1-year transition period as specified in the latest proposed rule, the estimated savings would have been higher. However, the time associated with finalizing the rule and establishing its effective date as November 5, 2001, essentially cost another \$130 million in excessive federal payments. Wisconsin will effectively have a period of over 16 months during which it can claim excessive federal payments. Because of the July 2000 effective date of Wisconsin's plan amendment, the state is able to operate its financing scheme for 127 days beyond its 1-year transition period. We estimate that for every day the state exceeds its 1-year transition period, about \$1 million can be generated in excessive matching funds. In total, Wisconsin will be able to claim about \$130 million in additional excessive federal payments from July 1, 2001, to November 5, 2001.

No Apparent Justification for Transition Period for Newest Plan Amendments

Our review of the facts surrounding the Virginia and Wisconsin plan amendments does not support the need for any transition period to comply with the January 2001 regulation intended to curtail abusive upper payment limit schemes. The fact that Virginia's and Wisconsin's plan amendments are recent argues against the need for a transition period. Transition periods established in HCFA's January 2001 rule to allow states time to achieve compliance with the new upper payment limit regulations were aimed at states that had developed a budgetary reliance on excessive payment schemes. Virginia and Wisconsin do not meet that criterion. As illustrated in figure 1, Virginia's and Wisconsin's plan amendments were

submitted and approved after HCFA began to take regulatory action to stop these excessive payment schemes.

Figure 1: Key Dates in Revising the Upper Payment Limit (UPL) Regulation and Approving Pending Plan Amendments in Virginia and Wisconsin



Virginia did not propose its excessive payment scheme until after HCFA publicly released the draft of its regulation to curb such schemes. Wisconsin first introduced its \$374 million annual upper payment limit provision to HCFA in February 2001, after the January rule was published, as part of a response to HCFA questions on unrelated issues in a broader state plan amendment submitted on September 21, 2000.

CMS' response to public comments in its September 5, 2001, rule-making appears to question the appropriateness of approving any new financing schemes, especially Wisconsin's. For example, CMS stated:

"We...believe that any State that submitted an amendment after the January 12, 2001 publication date of the final rule arguably had no basis to expect the amendment would be approved or had any history of reliance on such spending."

Nevertheless, the agency did not apply this criterion to Wisconsin's plan. It concluded that the excessive payment provisions submitted February 7, 2001, did not constitute a new plan amendment but were rather a change to an earlier plan amendment submitted in September 2000. According to agency officials, there was no clear guidance on how to consider a revised state proposal such as Wisconsin's.¹⁵

Conclusions

HCFA's actions in implementing its revised upper payment limit regulations are troubling. At the same time that HCFA was attempting to close a glaring loophole, it allowed additional states to engage in the very schemes it was trying to shut down, at a substantial additional cost to the federal government. The January 2001 regulation was designed to provide a balance between protecting the integrity of the Medicaid program and providing a reasonable transition for those states that had developed some budgetary reliance on excessive Medicaid payments. Given HCFA's stated position since July 2000 that it viewed these state financing schemes as abusive, we believe that its approval of additional schemes was unjustified.

Experience tells us that even as the Congress and HCFA have in the past identified and acted to close down various state financing schemes that exploit the federal share of the Medicaid program, other schemes invariably emerge. Consequently, continued vigilance is needed to identify and respond to the next scheme before it reaches the financial magnitude that makes it both a staple of state financing and a potential threat to the integrity of the funding partnership. Furthermore, it is imperative that federal and state partners work together to protect the financial integrity of the Medicaid program and to ensure that scarce resources are

¹⁵To prevent similar last-minute changes, HCFA stated in its April 3, 2001, proposed rule that any material changes submitted after March 13, 2001, to a pending plan amendment would be treated as a new plan amendment.

appropriately used to meet the health needs of Medicaid-eligible beneficiaries.

Agency and State Comments and Our Evaluation

We obtained comments on a draft of this report from the Administrator of CMS and the Virginia and Wisconsin state Medicaid directors (see apps. II, III, and IV). They disagreed with our conclusion that HCFA's decision to approve additional state financing schemes was unjustified. However, the Administrator pointed out the agency's strong opposition to financing schemes and its intent to ensure the protection of federal funds by ensuring that states receive a federal match only for appropriate expenditures that are also appropriately matched with state funds.

A central issue raised in these comments related to proposed state plan amendments that were pending at the time of HCFA's issuance of the January 12, 2001, rule with its March 13 effective date. The CMS Administrator commented that the treatment of pending amendments was not clearly addressed in the January 12 rule and that our draft report did not cite any clear statement on this issue. The Virginia Medicaid director asserted that HCFA's approval of Virginia's plan amendment, which was pending at the time the rule was finalized on January 12, was not only permissible but also consistent with past practice and necessary to avoid the retroactive application of the final rule. He further asserted that HCFA had no choice but to approve Virginia's plan.

We agree that the January 12 rule was not clear on how to address pending state plan amendments; we have revised the report to clarify that the rule was silent on this point and added appendix I to provide a more complete chronology of HCFA's changing position on approving state plan amendments. We concluded that a careful analysis of the public record of proposed and final rules demonstrated a fundamental shift in HCFA's position in how to deal with a pending state plan amendment—from an initial stated intent to deny any pending proposals that would not comply with the revised upper payment limits to a subsequent decision to approve them.

We disagree, however, with Virginia's position that HCFA had no choice but to approve its proposal. Under Medicaid, federal funding is authorized for amounts spent for covered medical and other services. As our report points out, the funding schemes that these pending amendments proposed do not relate to amounts that would actually be spent for covered services but to arrangements between states, counties, and local providers to obtain excessive federal payments. The Administrator has the statutory

authority to disapprove any proposed state plan amendment that is inconsistent with the Medicaid statute. Given the long-standing and clearly stated congressional and HCFA intent to eliminate abusive state financing schemes and given the evidence that HCFA had in hand that Virginia's and Wisconsin's proposals would continue such practices with no assurance that excessive federal payments were being spent for valid Medicaid services and beneficiaries, we continue to believe that HCFA had the statutory authority, the discretion, and the responsibility to deny any such proposed state plan amendments regardless of the extent to which similar abusive practices existed in the past.

The CMS Administrator also commented that, once the Virginia and Wisconsin state plan amendments were approved (June 4 and May 8, 2001, respectively), he did not have the authority to retroactively deny payments under the September 5 final rule that shortened transition periods for states with newly approved amendments. Our analysis and report did not address issues dealing with retroactive denial of payments. We concluded that HCFA's approvals of these two states' state plan amendments were unjustified, given clearly stated congressional and HCFA intent to eliminate such abusive state financing practices. Having affirmatively approved these two states' plan amendments, however, we support the agency's efforts to phase out federal matching payments as quickly as possible.

The CMS Administrator and Virginia Medicaid director raised issues pertaining to the scope of our work and the sense that we were singling out certain states or individuals for criticism. We clearly pointed out in our report that our scope was restricted to those four states that were affected by the September 2001 regulation, and we further limited our work to Virginia and Wisconsin because these two states accounted for 96 percent of the excessive federal payments that the CMS actuary identified as resulting from the regulation. In the course of our work, we did not investigate the role that individual federal officials did or did not play, or whether any officials recused themselves from the decision-making process. As specified in the report, we based our analysis and conclusions on the public record of HCFA's proposed and final rules, public comments submitted as part of the formal rule-making process, and supporting documentation that HCFA had available on proposed state plan amendments.

Finally, the CMS Administrator commented that he has been especially vocal about stopping financing schemes that simply recycle state dollars for federal dollars with no real expenditure being made—a common

practice across the country—and that he intends to end these practices in order to ensure the fiscal integrity of the Medicaid program. We fully support CMS efforts in this regard and believe that it should exert its full authority and discretion to do so.

The Virginia Medicaid director also stated that HCFA has made clear on numerous occasions that it permits states to engage in intergovernmental transfers in connection with provider payments that do not exceed upper payment limits and that such transfers are not inconsistent with governing law. In this report, we did not take issue with intergovernmental transfers as a legitimate tool or mechanism that state and local governments use in jointly financing activities of government. We do take issue, however, with the fact that this mechanism is often inappropriately used as a subterfuge to create the illusion that a state has made payments for valid Medicaid services for eligible Medicaid beneficiaries in order to claim matching federal payments.

The Wisconsin Medicaid director commented that the state has had an approved intergovernmental transfer funding mechanism in place since 1985, and therefore our conclusion that it had no budgetary reliance on this funding, which was the basis for HCFA's granting states varying transition periods to wean themselves from the excessive federal funding, was incorrect. We disagree with this point of view. The \$374 million annual upper payment limit provision that Wisconsin submitted to HCFA on February 7, 2001, was separate from, and in addition to, its previously approved arrangements costing about \$23 million annually. Wisconsin therefore had no established historical budgetary reliance on its February 7 proposed financing scheme, which HCFA approved in May 2001.

As arranged with your offices, unless you release its contents earlier, we plan no further distribution of this report until 30 days after its issuance date. At that time, we will send copies of this report to the Secretary of Health and Human Services, the Administrator of CMS, and other interested parties. We will make copies available to others upon request.

If you or your staffs have any questions regarding this report, please contact me on (202) 512-7118 or Frank Pasquier on (206) 287-4861. Other major contributors included Tim Bushfield, Terry Saiki, Stan Stenersen, and Stefanie Weldon.

Kathryn G. Allen

Kathryn G. Allen
Director, Health Care—Medicaid and
Private Health Insurance Issues

Appendix I: Chronology of HCFA's Changing Position on Pending State Plan Amendments

Date	Event	Impact of event on states with pending amendments
July 26, 2000	HCFA sends letter to all state Medicaid directors	Letter announces HCFA's intent to (1) phase out upper payment limit financing mechanisms and (2) pursue steps that put an immediate end to paying states that file plan amendments in the intervening period before any regulation takes effect.
October 10, 2000	HCFA issues proposed rule	The proposed rule says that states with pending plan amendments not in compliance with the new regulation would qualify for a transition period only if they were approved before the effective date of the final regulation.
December 21, 2000	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000	The act directs the Secretary of Health and Human Services to issue a final regulation based on the October 2000 proposed rule.
January 12, 2001	HCFA responds to public comments	HCFA again says that noncompliant pending plan amendments would be reviewed under the new regulation. Plan amendments not in compliance with the new regulations would not qualify for transition periods.
	HCFA issues final rule	The final rule is silent as to whether plan amendments currently under consideration would be reviewed using the new regulation or the old one. According to HCFA officials, the language change from the proposed rule resulted from an inadvertent editing revision.
April 3, 2001	HCFA issues proposed rule	HCFA indicated that it had decided to review pending plan amendments under the old regulation, essentially reversing its earlier position. This change in position gave states with such plan amendments the opportunity to receive excess federal payments through September 30, 2002. The rule proposes reducing the transition period to 1 year for such pending plan amendments.
September 5, 2001	CMS issues final rule	The final rule adopts shorter transition periods for plan amendments that were pending when the January regulation was issued, that were subsequently approved, and that did not comply with the January regulation. The final rule limits the transition period to 1 year after the effective date of the plan amendment or November 5, 2001, whichever is later.

Appendix II: Comments From the Centers for Medicare and Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

OCT 19 2001

The Administrator
Washington, D.C. 20201

Kathryn G. Allen
Director, Health Care—Medicaid and
Private Health Insurance Issues
General Accounting Office
Washington, D.C. 20548

Dear Ms. Allen:

I have reviewed the above GAO draft report. I believe this report unfairly and inappropriately portrays the actions and decision of the Centers for Medicare and Medicaid Services (CMS). There are several points that I want to make very clear.

First, I want to point out that we are strongly opposed to financing schemes. Prior to congressional action of any kind, CMS recognized this abuse and proposed new regulations to curtail it. We have been very clear that we will ensure the protection of Federal funds by ensuring that states receive a Federal match only for appropriate expenditures that are also appropriately matched with state funds. Furthermore, I personally have a twelve-year track record of fighting Medicaid Disproportionate Share Hospital (DSH) payments, intergovernmental transfers, and Upper Payment Limit (UPL) financing as inappropriate funding mechanisms. I also doubt that there is anyone in the nation who has more bruises from trying to expose these funding abuses.

Second, I want to make it very clear that Secretary Tommy Thompson, Deputy Secretary Claude Allen, and Dennis Smith, the Director of the Center for Medicaid and State Operations were completely recused from making any decision regarding Wisconsin and Virginia. Michael McMullen, Acting Deputy Administrator approved the proposed rule issued on April 3, 2001 to address pending applications. After I was confirmed on May 23, 2001, I had the authority to make these decisions—and I alone have made each and every decision since. I approved the final rule issued on September 5, 2001.

Third, it is important to understand the history of the decision-making process. The regulation published during the last administration on January 12, 2001, specified a transition period for plans that had already received Federal approval. The treatment of pending amendments was not clearly addressed in the January 12 final rule (and the draft audit report does not cite any clear statement on this issue).

CMS reviews state plan amendments under the law on the effective date of the plan amendment. For pending amendments, the proposed effective date is generally the first day of the calendar quarter of submission, which for the amendments in question was prior to the change in the UPL rule. In April, we published the proposed rule, which clarified the policy of how pending applications would be treated. At the time this decision was made, we identified 11 states that had pending plans that were potentially affected by this regulation. After we had time to more thoroughly review the state plan amendments, and after the publication of the proposed rule, CMS found that only four

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.

**Appendix II: Comments From the Centers for
Medicare and Medicaid Services**

states had filed for UPL amendments that were potentially impacted by the new UPL regulations -- Michigan, Florida, Virginia, and Wisconsin.

As I indicated, I arrived on May 23, 2001. At that time, I had every intention of not allowing retroactive payments to these four states. The Health and Human Services General Counsel opined that I was prohibited from denying these payments under Bowen vs. Georgetown; the Administrative Procedures Act precludes rules such as the UPL regulation from being given retroactive effect. Therefore, I could not apply the September 5 UPL final rule to these four state plan amendments.

I have been especially vocal about this agency stopping financing schemes that simply recycle state dollars for Federal dollars with no real expenditure being made. This has been a common practice across the country. My intention is to end these practices through a national transition process. My actions will ensure the fiscal integrity of the Medicaid program, and I deeply resent the clear implications of this irresponsible report. If you wish to see where UPL decisions are made in the future, look no further than me. If you have trouble, my phone number is (202) 690-6726.

Sincerely,



Tom Scully
Administrator

Cc: Senator Charles Grassley
The Honorable David M. Walker

Appendix III: Comments From the Commonwealth of Virginia



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

ERIC S. BELL
DIRECTOR

October 17, 2001

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/225-4512 (Fax)
800/343-0634 (TDD)

Ms. Kathryn G. Allen
Director, Health Care – Medicaid and
Private Health Insurance Issues
United States General Accounting Office
Washington, D.C. 20548

Dear Kathryn:

Virginia's Department of Medical Assistance Services (DMAS) is in receipt of your agency's draft report entitled Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes (GAO-02-147). Please consider this letter as a formal response to your letter dated October 10, 2001. DMAS greatly appreciates the opportunity to respond to several issues in the report and hopes these comments will be incorporated into the report's final version.

HCFA (predecessor to CMS)¹ has made clear on numerous occasions, that it permits States to engage in intergovernmental transfers in connection with provider payments that do not exceed upper payment limits, and that such transfers are not inconsistent with governing law. In October 2000, HCFA published proposed changes in the Medicaid upper payment limits that would restrict, but not eliminate, States' ability to benefit from these intergovernmental transfers. Virginia submitted its proposed State plan amendment on November 30, 2000, at which time the proposed changes were pending but not final. Virginia cannot be singled-out for criticism for seeking to do what many States had already done, and which was still permissible under law when Virginia submitted its amendment. As a matter of law, HCFA's regulations as finally adopted did not take effect until March 13, 2001. Therefore, we believe that CMS had no choice but to approve Virginia's plan.

Virginia's plan amendment was pending at the time the final regulation was adopted and had been submitted well in advance of the publication of the final rule. Thus, the decision by the agency to rule on the proposal based on the law existing when it was filed with the agency, was not only permissible, but also consistent with past practice and necessary to avoid the retroactive application of the final rule.

¹ Because most of the actions in question occurred before HCFA's name was changed to CMS we refer to the federal agency throughout this letter as HCFA.

Ms. Kathryn G. Allen
October 17, 2001
Page 2

A State plan amendment typically takes effect either on the first day of the quarter in which it is submitted to the agency for approval, or on the day after the State gives public notice of the proposed change in its plan, whichever is later. Notwithstanding the fact that federal approval frequently is not granted until a later time, once approval is granted, the approval relates back to the effective date. Upon receiving approval of a plan amendment, therefore, a State may seek reimbursement from the federal government consistent with the plan amendment based on its effective date and governed by regulations that existed at that time. There is nothing in HCFA's proposed or final rule revising the Medicaid upper payment limits stating any intention to change this longstanding policy.

The GAO draft report refers to the prior Administration's "stated position" that it would deny approval of any pending State proposals that had not already gone into effect by January 12, 2001, when the final rule was published. Later there was uncertainty as to whether this "cut-off" date was predicated on the publication date of the final rule or its effective date of March 13, 2001. Neither position would have been consistent with HCFA's prior and consistent practice of approving State plan amendments based on the law in effect as of the effective date of the amendment. The contrary result would amount to retroactive application of law or policy changes, which is highly disfavored.

The new Administration appears to have properly reached the conclusion that it would have been wrong to retroactively disapprove plan amendments. We believe this position is consistent with prior practice and with the efficient administration of Medicaid's cooperative program of shared federal and state responsibilities.

After properly approving Virginia's State plan amendment, HCFA amended its regulations to limit Virginia's transition period in a manner that is inconsistent with its final rule published January 12, 2001. Because Virginia's plan was approved with an effective date of January 27, 2001, well before the final regulation's effective date of March 13, 2001, Virginia was entitled under HCFA's final rule to take advantage of the previous version of the upper payment limit regulation through the end of fiscal year 2002. This transition period was specifically commanded in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, through which Congress instructed the agency to adopt as a final rule its proposed rule as it appeared, with the exception that Congress provided for a *longer* transition period for one category of States. Nevertheless, there is no basis for the GAO's assertion that Virginia should not have been allowed to utilize at all the Medicaid upper payment limit regulation in effect before March 13, 2001.

We would point out further that as a result of the various actions of HCFA, Virginia has been afforded much less of an opportunity than other States to take advantage of the legal funding opportunity utilized by a majority of the States in the union. We believe that, rather than criticizing Virginia for doing something it is legally entitled to do, the GAO should criticize the arbitrary restrictions placed on Virginia in a manner inconsistent with the opportunities afforded other States.

**Appendix III: Comments From the
Commonwealth of Virginia**

Ms. Kathryn G. Allen
October 17, 2001
Page 3

Lastly, we would like to express our objections to the use of the word "scheme" in the title and body of your report. According to the *American Heritage Dictionary*, scheme is defined as "an underhand or secret plan; plot; intrigue." In fact, the state plan amendment in question was openly presented and described in every detail. It is unprofessional of GAO to use such language normally reserved for the political arena. If you are looking for a pejorative word, we suggest the word "loophole" as more apt description.

Virginia openly and properly submitted a state plan amendment in accordance with the Upper Payment Limit provisions in effect at that time on November 30, 2000. The federal government had no choice but to approve an acceptable change in a Medicaid State Plan.


Yours truly,



Eric Bell
Director

EB/bws

Appendix IV: Comments From the State of Wisconsin

<p>Scott McCallum Governor</p>		<p>DIVISION OF HEALTH CARE FINANCING</p>
<p>Phyllis J. Dubé Secretary</p>	<p>State of Wisconsin Department of Health and Family Services</p>	<p>1 WEST WILSON STREET P O BOX 309 MADISON WI 53701-0309</p>
		<p>Telephone: 608-266-6922 FAX: 608-266-1095 TTY: 608-261-7798 www.dhfs.state.wi.us</p>

October 22, 2001

Kathryn G. Allen
Director, Health Care – Medicaid and
Private Health Insurance Issues
United States General Accounting Office
Washington, DC 20548

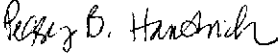
Dear Ms. Allen:

Thank you for the opportunity to review your draft report Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes (GAO-02-147).

We do not agree with your conclusion that the Health Care Financing Administration (HCFA) acted improperly in approving Wisconsin's state fiscal year 2001 nursing home state plan which included an expansion of Wisconsin's previously existing Intergovernmental Transfer (IGT) program. We believe that both Wisconsin and HCFA acted well within the authorities granted in the 2000 Benefits Improvement and Protection Act language. In addition, Wisconsin has had an IGT program in place, subject to annual HCFA approvals, since 1985. Therefore, GAO's assertion that Wisconsin had no reliance on IGT funding mechanisms is incorrect.

Thank you, again, for the opportunity to comment.

Sincerely,



Peggy B. Handrich
Administrator

PBH:my
PA10066.MB
J-11-1-01

Wisconsin.gov

Related GAO Products

Medicaid: State Financing Schemes Again Drive Up Federal Payments ([GAO/T-HEHS-00-193](#), Sept. 6, 2000).

Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit ([GAO/T-HEHS/OSI-00-87](#), Apr. 5, 2000).

Medicaid in Schools: Improper Payments Demand Improvement in HCFA Oversight ([GAO/HEHS/OSI-00-69](#), Apr. 5, 2000).

Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals ([GAO/HEHS-98-52](#), Jan. 23, 1998).

State Medicaid Financing Practices ([GAO/HEHS-96-76R](#), Jan. 23, 1996).

Michigan Financing Arrangements ([GAO/HEHS-95-146R](#), May 5, 1995).

Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government ([GAO/HEHS-94-133](#), Aug. 1, 1994).

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