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Health, Education and Human Services Division

B-270874

January 23, 1996

The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

Dear Mr. Dingell:

Because of increasing health care costs over the past decade, states have been searching for new ways to help finance the $140 billion Medicaid program, a jointly funded federal and state entitlement program that provides medical assistance to low-income people. Under the program, the federal government pays states a Medicaid health care expenditures they report to the Department of Health and Human Services' Health Care Financing Administration (HCFA). The federal government's share, which is determined by a statutory formula, is at least 50 percent and no more than 83 percent of a state's cost. In fiscal year 1994, federal Medicaid payments accounted for 57 percent of all Medicaid medical expenditures.

Beginning in the mid-1980s, states began to use so-called creative financing mechanisms such as provider-specific taxes and voluntary contributions, which were subsequently returned to the providers in the form of increased Medicaid reimbursements. These mechanisms allowed states to increase federal Medicaid contributions they received without effectively increasing their own matching funds. Such actions contributed significantly to Medicaid's annual spending growth of over 25 percent in 1991 and 1992. To restrict the use of these practices, the Congress passed legislation in 1991 that limited the sources of state matching funds. In 1993, the Congress added limits on payments that could be made under the disproportionate

share hospital (DSH) program[1] to further restrict state financing mechanisms.[2]

However, the Congress' November 1995 budget reconciliation bill, vetoed by the President on December 6, 1995, would have eliminated the restrictions placed on certain financing arrangements and states would have been allowed to once again use provider-specific taxes and donations to reduce their contribution of matching funds. Because of concerns over the potential impact of this most recent congressional action, you requested that we summarize our previous work on this issue, including work on state financing arrangements in Michigan, Tennessee, and Texas.[3]

In summary, before the legislation that limited states' use of provider taxes and donations, the amounts raised by such mechanisms ranged from as little as $50,000 in Kansas to as much as $1.2 billion in Pennsylvania. Among the 32 states with these programs, the revenues represented on average 23.5 percent of states' nonfederal expenditures on Medicaid. In some cases, these financing mechanisms helped to raise nearly half of a state's total Medicaid budget.[4]

Our work showed that Michigan, Texas, and Tennessee used several creative financing approaches. Michigan, for example, used various financing mechanisms that effectively increased the federal share of its Medicaid expenditures from 56 percent to 68 percent in 1993. Since fiscal year 1991, Michigan has reduced its share of Medicaid costs by

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[1]This program provides supplemental payments to hospitals that serve large numbers of Medicaid and other low-income patients.

[2]The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) and the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) (OBRA 1993) placed restrictions on states' financing arrangements.

[3]See Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994), and Michigan Financing Arrangements (GAO/HEHS-95-146R, May 5, 1995). See enclosure for additional GAO reports on the Medicaid program.

[4]The Question Behind the Medicaid Provider Tax Debate: What Constitutes a State Dollar, National Health Policy Forum, Issue Brief No. 625 (Washington, D.C.; July 12, 1993), p. 4.

almost $1.8 billion through financing partnerships with medical providers and local units of government. Our analysis of Michigan's transactions last year showed that even though legislation curtailed certain creative financing practices, the state was able to reduce its share of Medicaid costs at the expense of the federal government by $428 million through other mechanisms.

BACKGROUND

Within a broad legal framework, each state designs and administers its own Medicaid program. States decide whether to cover optional services and how much to reimburse providers for a particular service. Besides payments to reimburse medical providers for services rendered, states are required to make additional Medicaid payments to hospitals that serve large numbers of Medicaid and other low-income patients. Within federal guidelines, states determine if a hospital qualifies for additional Medicaid DSH payments and the amount of such payments. There are no federal restrictions on how hospitals may use the DSH payments.

Creative financing mechanisms that states began to use in recent years to maximize federal Medicaid contributions without effectively committing their own share of matching funds took various forms. Using a hypothetical example, hospitals might pay $50 million in taxes or provider donations to the state. The state, in turn, makes $60 million in payments to hospitals. The state receives federal matching funds based on the Medicaid expenditure of $60 million. If the state has a 50-percent matching rate, it receives $30 million of federal funds. Because the state received $80 million in revenue ($50 million from hospitals and $30 million from the federal government) and made $60 million in payments, it had a net gain of $20 million. The state's actions also resulted in the hospitals receiving a net increase in revenues of $10 million, entirely from federal dollars.

States also benefit when they use their own funds to initiate payments to public providers. Under this financing mechanism, states generate federal matching funds by increasing payment rates for a particular group of public providers, such as nursing homes, public hospitals, or community mental health boards. However, these

providers, through the use of intergovernmental transfers,[5] return all or the majority of federal and state funds to state treasuries.

The 1991 and 1993 federal legislation essentially banned provider donations, required that provider taxes be broad-based, limited provider taxes to 25 percent of a state's share of Medicaid expenditures, and prevented states from repaying provider taxes in the form of increased rates. Also, the legislation placed a cap on a state's total DSH payments and limited such payments to 100 percent of a hospital's unrecovered costs of serving Medicaid and uninsured patients. However, the legislation imposed few restrictions on states' use of intergovernmental transfers.

PROVIDER TAXES AND DONATIONS

Until 1986, states made little use of provider donations to finance their Medicaid program. Before that time, public and private donations could only be used as matching funds for the cost of training state administrative staff. However, in 1985, HCFA issued new rules that allowed such donations to be used as a state's share of financial participation for the entire Medicaid program.[6] Based on a state's federal matching rate, each $1 of provider donations could generate about $1 to $4 in federal matching funds.

We found that in fiscal years 1991 to 1993, Michigan used hospital donations to help raise about $684 million for its Medicaid program. In fiscal year 1993, for example, hospital donations of $202 million generated additional federal matching funds of $256 million. This allowed Michigan to make DSH payments of $458 million, including $256 million in federal matching funds to 53 hospitals;

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[5]A transfer of funds from one government agency or level to the state. This usually involves transfers from a county, city, or hospital district to a state Medicaid agency.

[6]Tennessee and West Virginia were the first states to take advantage of the changed rules by having hospitals make donations to their state Medicaid agencies to obtain federal matching funds. In West Virginia, the federal matching funds were used to clear up a backlog of outstanding claims. Although HCFA challenged the propriety of West Virginia's hospital donations, a federal district court found for the state.

however, the hospitals returned all but $6 million of the federal funds to the state. As a result, the state received a $250 million net benefit from the federal share of the DSH payments which the state could use to fund $566 million in additional Medicaid payments.

In 1993, our work showed that Tennessee required certain medical providers to pay a $2,600 tax on their nursing home beds and a 6.75-percent tax on services, including hospital services. The nursing home bed tax was initiated in 1992. The hospital services tax replaced a tax on hospitals that was based on Medicaid utilization and, according to HCFA, did not meet the conditions of the 1991 amendments.[7]

State revenue from the taxes on nursing homes ($93 million) and hospitals ($365 million) in fiscal year 1993 was $458 million, which generated an additional $954 million in federal matching funds. These funds, totaling $1.4 billion, accounted for 52 percent of the total $2.7 billion that the state spent on Medicaid in 1993. Among the expenditures made from the $2.7 billion was a $550 million payment to reimburse nursing homes and hospitals for taxes paid on Medicaid patients and for DSH payments.

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[7]Even though the nursing home bed and the hospital services tax were initially approved, HCFA is reviewing these taxes to ensure that they are in compliance with the 1991 amendments. The focus of HCFA's review of the nursing home bed tax is Tennessee's granny grant program, which provides payments to indigent nursing home patients. These payments are slightly less than the tax that the nursing homes pay. According to HCFA, the combination of nursing homes being able to pass on the tax to patients receiving granny grants and the reimbursement of the tax on behalf of Medicaid patients means the nursing homes are virtually guaranteed a return of a major portion of the tax. Regarding the hospital service tax, HCFA is concerned that the tax may not treat health and nonhealth entities the same and, thus, may not qualify as a nonhealth-care-related tax. HCFA advised Tennessee that because the tax is viewed as a health-care-related tax, the state needed to request a waiver from the broad-based requirements and to show that providers were not reimbursed for the taxes they paid. Tennessee officials maintain that the tax is not a health-care-related tax and, therefore, not subject to such requirements. Tennessee discontinued the hospital services tax on January 1, 1994, when it began a Medicaid demonstration program called TennCare.

DSH PAYMENTS

In exchange for provider donations and taxes, states often made supplemental DSH payments to providers. Such payments were used because they were not tied to actual health care costs and, until the 1993 legislation, there were no limitations on the amount paid to providers. The limits in the 1993 legislation restricted DSH payments to no more than 200 percent of a state hospital's unrecovered costs in 1995 and 100 percent of such costs in 1996. These restrictions have caused states to modify their DSH programs. DSH payments had exploded from slightly less than $1 billion in 1990 to over $17 billion in 1992. After the 1993 legislation, DSH payments fell slightly, to about $16.7 billion in 1993. In fiscal year 1994, DSH payments of about $17 billion were made by states.

We found that Michigan has adjusted its DSH program because of federal legislation. As noted above, the program initially relied on provider donations to generate federal matching funds. Because of legislative limitations placed on provider donations, Michigan's 1994 DSH program included a single $489 million payment to the University of Michigan Hospital rather than individual payments to 53 hospitals as in prior years. This single payment included $276 million in federal matching funds and $213 million in state funds. On the same day that it received the payment, the hospital returned the entire amount to the state through an intergovernmental transfer. As a result, the state realized a net benefit of $276 million from the federal share of the DSH payment that the state could use to fund $633 million in additional Medicaid payments.

In 1995, OBRA 93 restricted the DSH payment that could be made to the University of Michigan Hospital to no more than 200 percent of the hospital's unrecovered costs for Medicaid and uninsured patients. As a result, we found that the state reduced the hospital's DSH payment to $53.2 million (including $30.2 million in federal funds) or about $436 million less than the previous year. To make up for part of the funds lost, the state made DSH payments of about $270 million, including federal funds of about $153.5 million, to 8 state psychiatric and 15 public hospitals. The state realized a net benefit of about $182 million from the federal share of these DSH payments because providers returned all but $1.5 million to the state. The $182 million was available to fund $422 million in additional Medicaid payments.

We found that in 1993, under the Texas Disproportionate Share Program for State-Owned Teaching Hospitals, three state-owned university hospitals transferred $149 million (representing their charity care charges) to the Texas Department of Human Services. These funds and another $271 million in federal matching dollars were used to make monthly DSH payments to the three hospitals. The hospitals kept $194 million of the DSH payments, which included $45 million more than their actual charity care charges.[8] However, as required by the state legislature, the hospitals returned $226 million to the state through intergovernmental transfers. These funds were available to fund additional Medicaid expenditures of $636 million. Texas cannot use this financing mechanism in the future due to OBRA-93 restrictions on DSH payments in excess of a hospital's unreimbursed cost of providing care to Medicaid and uninsured patients.

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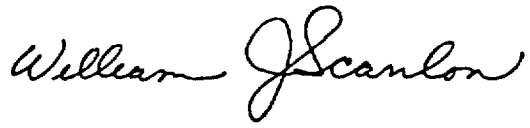
We trust that this information will be useful as the Congress continues to debate Medicaid issues. Copies of this letter will be made available to other interested parties upon request. Please contact Kathryn Allen on (202) 512-7059 or Alfred Schnupp on (202) 512-7159 if you have questions about this letter.

Sincerely yours,



William J. Scanlon
Director, Health Systems Issues

Enclosure

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[8]Texas legislation authorized the hospitals to keep the $45 million plus their actual charity care charges.

RELATED GAO PRODUCTS

Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs (GAO/HEHS-96-44, Nov. 8, 1995).

Medicaid: State Flexibility in Implementing Managed Care Programs Requires Appropriate Oversight (GAO/T-HEHS-95-206, July 12, 1995).

Medicaid: Statewide Section 1115 Demonstrations' Impact on Eligibility, Service Delivery, and Program Cost (GAO/T-HEHS-95-182, June 21, 1995).

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

Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, Apr. 4, 1995).

Medicaid: Restructuring Approaches Leave Many Questions (GAO/HEHS-95-103, Apr. 4, 1995).

Medicaid: Experience With State Waivers to Promote Cost Control and Access to Care (GAO/T-HEHS-95-115, Mar. 23, 1995).

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

Medicaid: The Texas Disproportionate Share Program Favors Public Hospitals (GAO/HRD-93-86, Mar. 30, 1993).

Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46, Mar. 17, 1993).

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