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**United States Senate**

**Hearing on**  
***Medicaid Waste, Fraud, and Abuse:***  
***Threatening the Health Care Safety Net***

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## Introduction

Chairman Grassley, Ranking Member Baucus, and distinguished members of the committee, thank you for inviting me to appear before you today to discuss state Medicaid financing arrangements, such as intergovernmental transfer (IGT) and upper payment limit (UPL) financing arrangements that involve public hospitals and nursing facilities, as well as Medicaid school-based reimbursement.

My name is Charles Milligan and I am the executive director of the Center for Health Program Development and Management (Center) at the University of Maryland, Baltimore County (UMBC). The Center is a 55-person multi-disciplinary research and policy entity that works with public agencies and nonprofit community-based agencies in Maryland and elsewhere to improve the health and social outcomes of vulnerable populations through research, analysis, and evaluation. Since its inception in 1994, the Center has maintained a successful, nationally recognized partnership with the Maryland Department of Health and Mental Hygiene (Maryland's Medicaid agency) to analyze state health policies and help to develop solutions for the Maryland Medicaid program. Before taking my current position, for four years I was vice president at The Lewin Group, where I provided services to approximately twenty state Medicaid programs, working for both the legislative and executive branches of state government. Before that, I was the appointed Medicaid and S-CHIP director for the State of New Mexico, serving under Governor Gary Johnson.

As members of this committee, you are aware of the enormous toll Medicaid spending is exerting on the states. Between 2000 and 2003, growth in Medicaid spending (federal and state) averaged 10.2 percent annually, resulting in an increase in program expenditures by one-third in just three years. Medicaid spending increases were largely driven by enrollment growth, stemming in part from the economic downturn during that period. At the state level, annual Medicaid spending grew by an average of 11.3 percent, leading many states to implement cuts in Medicaid benefits, payment rates, and eligibility. In 2003, state Medicaid spending typically accounted for 21 percent of a state's expenditures, surpassing for the first time state expenditures for primary and secondary education.

In recent years, Medicaid enrollment has grown rapidly, now surpassing 50 million beneficiaries nationally. This growth in Medicaid enrollment occurred during a period marked by two other important factors—a rising rate in the uninsured, and federal support for safety net providers through programs like disproportionate share hospital (DSH) payments that was not indexed to the rising rate of Medicaid eligibles and the uninsured and therefore failed to keep up with the growing financial burdens faced by safety net providers such as public hospitals.

State use of special Medicaid financing techniques—such as reliance on IGTs to provide the state matching funds to pay public providers up to the Medicare UPL—clearly has increased. In my opinion, it is quite appropriate for Congress and the Bush Administration to look into these state practices, which in unusual cases may be the source of fraud and abuse. In doing so, however, it is important not to lose sight of the fact that states have pursued permissible IGT and



UPL practices in part as a response to the rapidly increasing demand for safety net services driven by growth in Medicaid enrollment and the uninsured.

Inextricably related to these special financing issues, the rapid increase in Medicaid costs has led to a major shift in the public discussion of Medicaid. In recent months, a consensus appears to be emerging among federal and state policymakers that Medicaid cannot be sustained in its current form. The basic Medicaid entitlement—that all beneficiaries must receive the same benefits and be subject to the same set of rules—is being questioned by state and federal policy makers, in a bi-partisan way. Now more than any time in recent history, reform may emerge in a dialogue that is and must be connected to the underlying fiscal discussion. Medicaid reform, if properly developed, may protect the mission of Medicaid and yet allow for meaningful change to Medicaid in a way that will preserve its long-term crucial role for the poor, people with disabilities, seniors, and others who depend on the Medicaid program. It is my sincere hope that Congress and the Bush Administration approach the Medicaid budget discussion and the Medicaid reform discussion as a single topic, rather than as two unrelated topics.

In my remarks that follow, I will describe how IGT and UPL financing arrangements work, demonstrate the enforcement challenges that would exist if the federal government sought to alter these arrangements, outline the benefits that accrue to safety-net institutions, and offer recommendations to redress the underlying risk for fraud and abuse in an alternative way. This will be followed by a discussion of similar considerations in the area of school-based reimbursement in Medicaid.

### **Intergovernmental Transfers and the Upper Payment Limit**

No one disagrees that Medicaid provides an important safety net for the country's most vulnerable populations and the health care providers that serve them. Medicaid is an important source of financing for the nation's public hospitals, federally-qualified health centers, Indian Health Services, maternal and child health clinics, and others. Medicaid can account for as much as half of net patient care revenues for these providers. Similarly, many state- and county-owned nursing facilities have large Medicaid resident populations and are dependent on Medicaid revenue.

Moreover, it is crucial to not lose sight of the fact that Medicaid beneficiaries rely on these providers for their care. Ultimately, the financing arrangements developed by state and local governments that involve these public providers almost without exception are motivated by a desire to ensure access to care for Medicaid enrollees, and to some extent the uninsured.

It is the nation's public hospitals and state- and county-run nursing homes that are the primary beneficiaries of IGT and UPL financing arrangements. These financing arrangements have become more commonplace as states have endeavored to maximize federal matching dollars in response to caps in Medicaid DSH, at a time of rising rates of Medicaid enrollees and the uninsured.

In brief, an intergovernmental transfer, or IGT, is the movement of state or local tax revenues from one public agency to the Medicaid agency. The IGT could originate at a county government, which transfers funds to the state Medicaid agency. It could originate at a state health department, which would pass the funds to Medicaid. Other examples also exist. The IGT, then, is the source of the state or local matching funds, which are utilized by the Medicaid agency to draw down federal financial participation (FFP) at the given state's matching rate.

The Medicaid agency then uses these matched funds to increase the payment rate to a public provider affiliated with the governmental entity that supplied the IGT in the first place. This increase is in the form of a higher payment for an actual health care service provided to an actual Medicaid beneficiary. For example, the payment for a delivered service may increase from \$100 to \$150. The ceiling on Medicaid's payment to this public provider, roughly speaking, is what Medicare instead would have paid for the same service, had it been a Medicare claim for a Medicare beneficiary. Thus, the federal government, through the Medicare rates, sets the ceiling, or upper payment limit (UPL), on Medicaid's payments to hospitals and nursing facilities.

As described more fully below, the IGT (from a county government, for example) is the source of the state match, which, when matched with FFP, is used to increase the payment rates to a public provider (a county hospital, for example), which is related to the entity that provided the original IGT. UPL arrangements were estimated to total more than \$11 billion in 2001.

In its budget proposal to Congress, the Bush Administration stated its concern that using IGT and UPL arrangements undermine the federal-state Medicaid partnership in two important ways: 1) in some financing arrangements, the federal matching rate appears to be effectively increased; and 2) payments to providers can exceed costs.

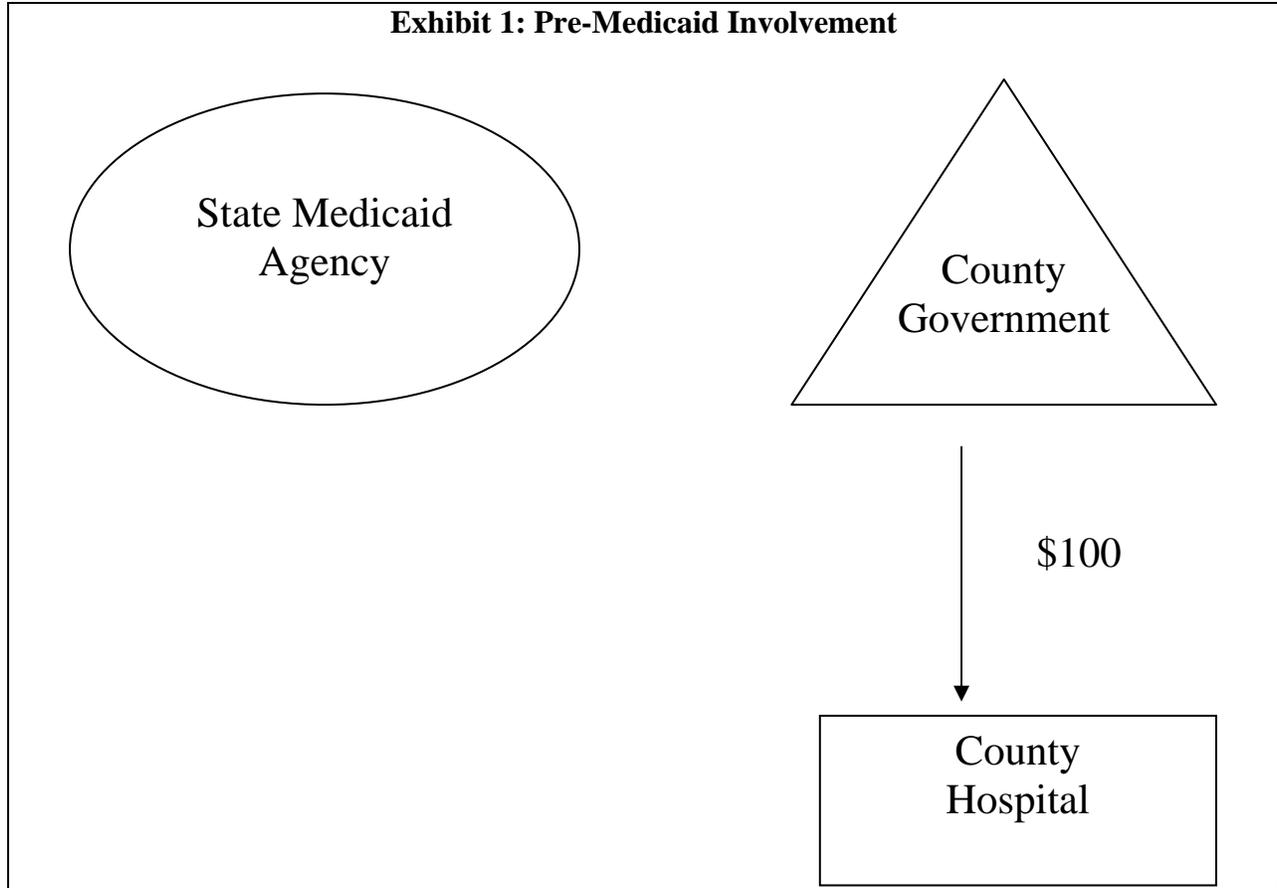
A 2002 survey of states reported in the March/April 2004 issue of the journal *Health Affairs* found that, in the 34 states responding, 56 percent of total federal and state UPL payments went to nursing facilities, primarily publicly-owned homes; 27 percent went to private or local hospitals; and 2 percent went to state or university hospitals. States received 80 percent of the UPL gains made available through nursing homes; most placed these gains in the Medicaid general fund. Clearly, IGT and UPL arrangements have proliferated, and have been used by states to finance the burden of rapidly rising Medicaid costs and costs related to indigent care.

In the discussion that follows, I describe how IGT and UPL arrangements work, step by step.

### **Starting Point: Pre-Medicaid Involvement**

All examples use a case study of a county government and a county hospital. The same general approach applies to other intergovernmental arrangements. Exhibit 1 illustrates how a county government provides financing to a county hospital assuming no involvement with Medicaid. Funding for services provided (in this case, \$100) is simply transferred directly from the county government to the county hospital with no involvement of the state Medicaid agency.

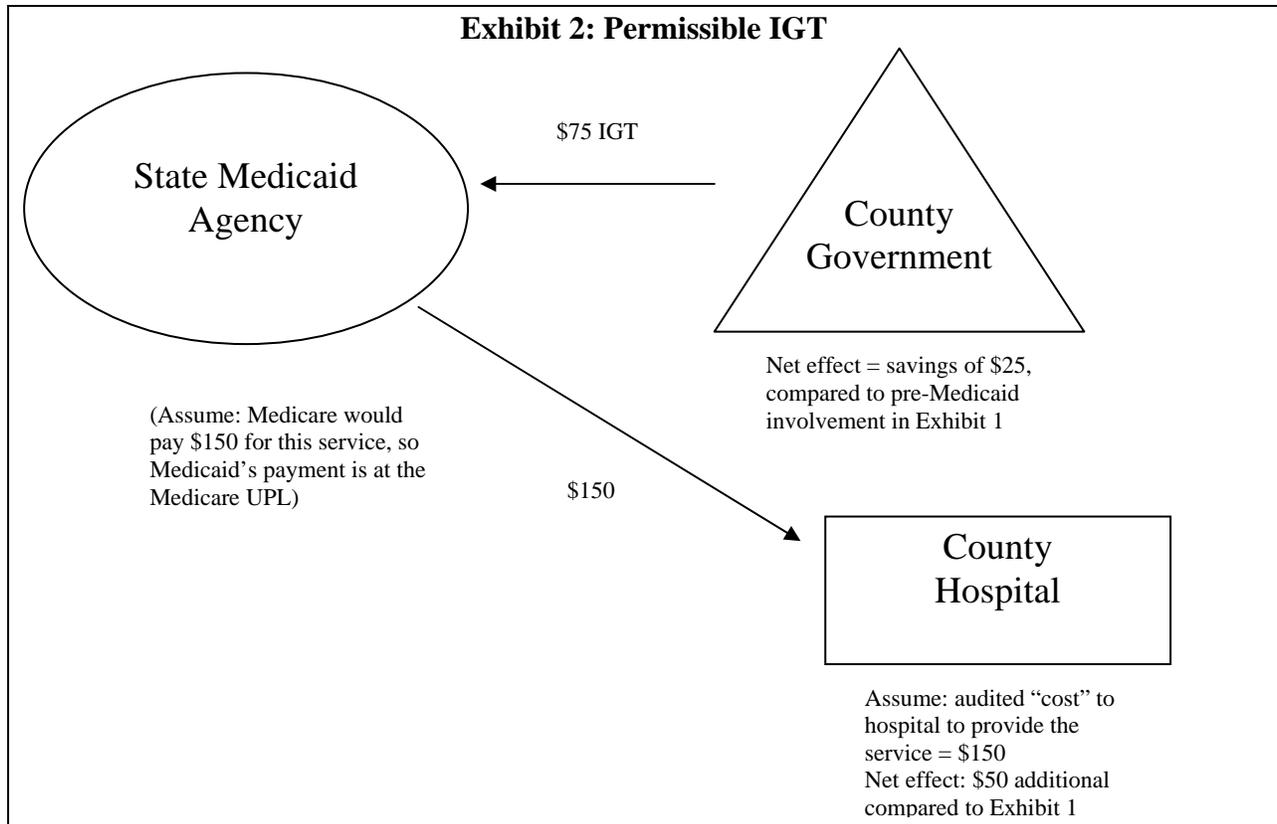
**Exhibit 1: Pre-Medicaid Involvement**



**Permissible IGT**

Exhibit 2 illustrates an arrangement that would be considered permissible under new rules proposed by the Bush Administration. Assume that the county hospital provides a service with a Medicare UPL of \$150. The county government transfers \$75 to the state Medicaid agency, the county's funds are matched 50/50 by the federal government, and the county hospital receives \$150 for an actual service provided to a Medicaid beneficiary. This also assumes that the audited cost to the hospital to provide the service is at least \$150. The outcome of this arrangement is that the hospital realizes a \$50 net gain ( $\$150 - \$100$ ) over the amount it would receive with no Medicaid involvement (Exhibit 1), and the county's financial burden has been eased by \$25 compared to the original model. The total benefits of \$75 (\$50 to the county hospital, and \$25 to the county government) are due to the infusion of \$75 in federal Medicaid funds.

Unlike DSH, which may be a direct subsidy to a public hospital not linked to a health care claim or encounter, the IGT and UPL arrangement is premised on a Medicaid beneficiary receiving a service for which the county hospital submits a claim to Medicaid, and is paid at the rate of \$150.



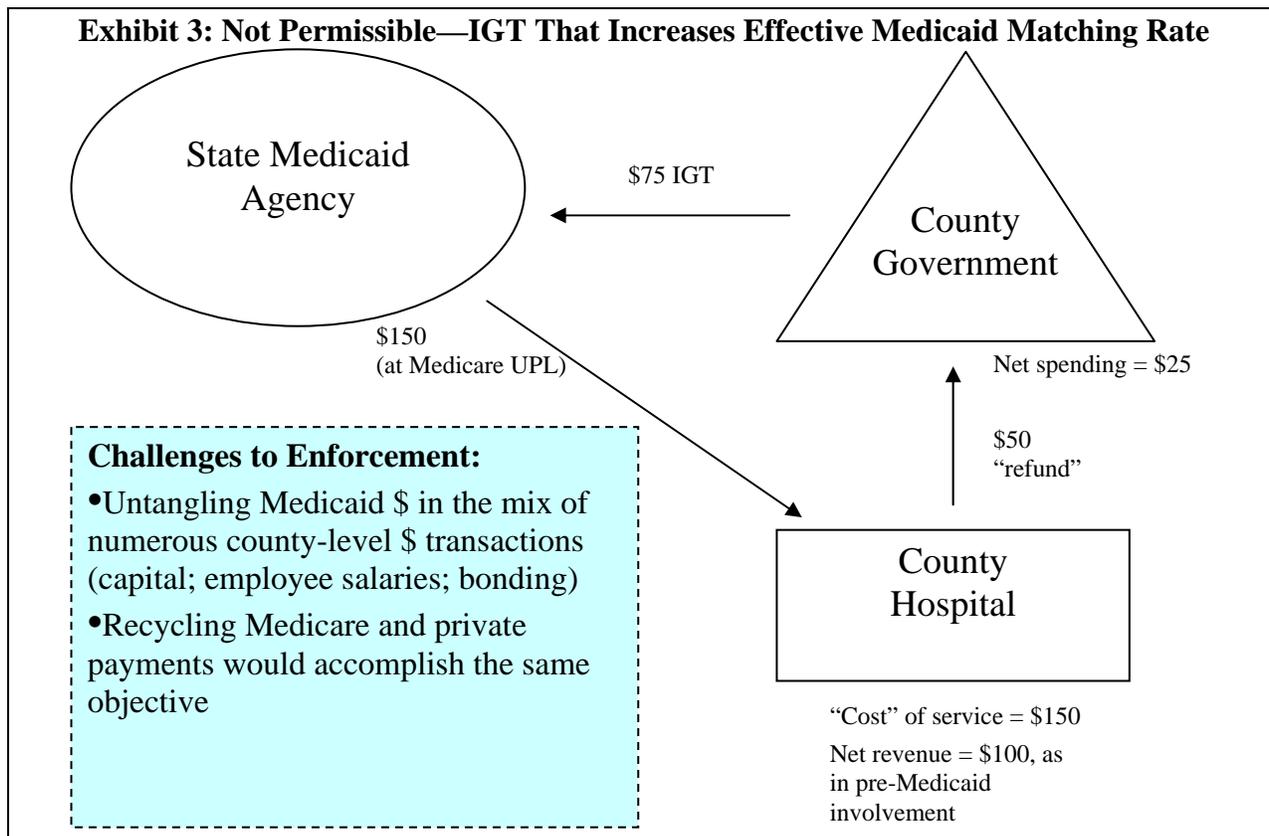
**Not Permissible—Violation of IGT Rule by Increasing Effective Federal Matching Rate**

Exhibit 3 shows an IGT arrangement that would be defined by the Bush Administration as effectively raising the federal-state matching rate to 75/25, which would not be permissible under the IGT provision of the Bush Administration’s proposal. Again the county government transfers \$75 to the state Medicaid agency, the county’s funds are matched 50/50, and the county hospital receives \$150 for the service. Then, \$50 is “recycled” back to the county government. The county government’s net spending therefore is \$25 (\$75 - \$50). Thus, the recycling results in an effective match rate of 75/25 (the net county contribution of \$25 generates \$75 in FFP).

Even if recycling is rampant, a proposition for which there is not yet concrete evidence, it will be extremely difficult for the Bush Administration to enforce a ban on the “recycling” of funds. The financial relationships between the county government and the hospital are so replete (new bonds for capital to build a new wing; county funds for employees’ wages and benefits; hospital purchasing of county-level administrative services; joint purchasing of utilities; etc.) that it would be extremely difficult to isolate Medicaid funds in the overall traffic of money moving between the county government and hospital. But assume the Administration was able to ban the recycling of Medicaid funds successfully. Presumably, the hospital still could send other funds to the county government (for services provided to privately insured patients that led to funds from private insurance companies, for example) that would accomplish the same overall objective.

Last, it must be noted that every state’s overall tax structure is unique—some states have no state income tax and instead rely on property or sales taxes. In some states, the tax burden is borne at

the local level, because local government traditionally has held the main strong service role for health care delivery. In other states, the tax burden and primary role for health and social services is borne at the state level. If the federal government were to bar local funds from inclusion in Medicaid financing by banning IGTs in a state where local taxation and a strong local government role is traditional, it would run the risk that the federal government would be endorsing one form of state tax structure (central collection at the state level) over others, which might be perceived as an inappropriate federal intrusion into state tax policy.

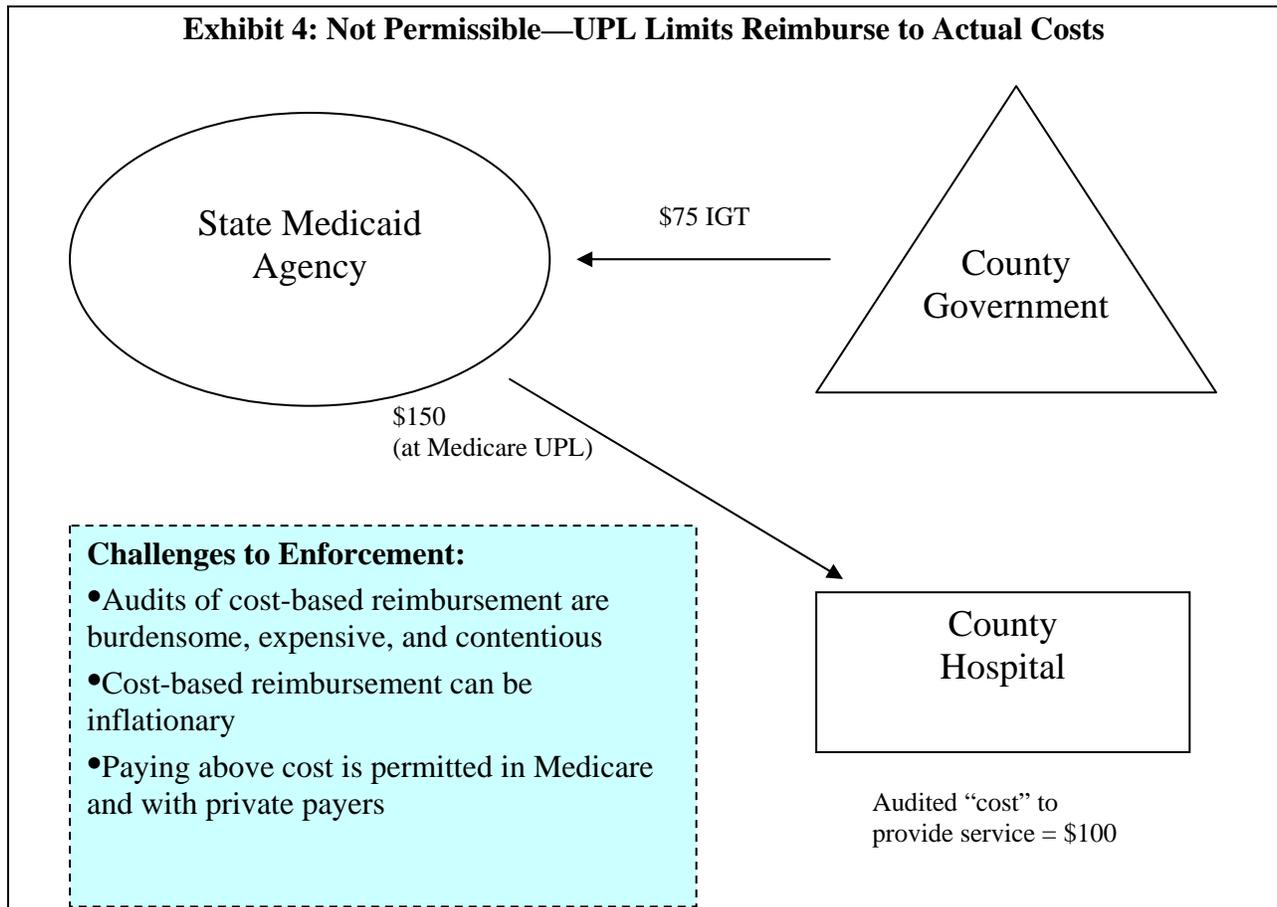


**Not Permissible—Violation of UPL by Reimbursing Above Actual Cost**

Exhibit 4 demonstrates an arrangement that would violate the Administration’s proposal that seeks to limit Medicaid reimbursement to the lower of Medicare or the actual cost of providing services. At present, the second half of this test, restricting payments to no more than cost, does not exist. In Exhibit 4, the county government is paid \$150 (what Medicare would have paid for the same service). However, assume the actual cost to provide the service is \$100. In the new UPL test, which would limit Medicaid payments to the lower of Medicare *or* actual cost, the \$150 payment is impermissible since it exceeds the cost to the county hospital by \$50.

Again, it may prove to be difficult for the Bush Administration to enforce this rule. To do so, it would be incumbent on the provider to create auditable cost reports to isolate the cost of serving its Medicaid beneficiaries, and Medicaid agencies then would have to audit these cost reports. This reimbursement model, similar to the rule under the Boren Amendment that was repealed by

Congress in the 1997 Balanced Budget Act, is administratively burdensome, expensive, and often contentious as states and providers argue over whether certain costs should be allowed. Moreover, cost-based reimbursement can exert inflationary pressures, as providers are penalized for efficiency. In addition, Medicaid alone would be singled out for this cost-based test—the hospital still could bill Medicare for the full \$150 and be paid at this full rate. It is unclear why Medicaid should not be allowed to pay what Medicare pays for the identical service.



### A Better Approach to Addressing the IGT and UPL Financing Arrangements

Without a doubt, there is a risk of fraud and abuse in IGT and UPL arrangements, and it is fully appropriate for Congress and the Bush Administration to view these arrangements with a measure of skepticism and a clear focus on their fiduciary duty to federal taxpayers. Yet the magnitude of the actual problem cannot be accurately quantified, and it is important to note that these tools are used by states and local governments to maximize federal matching payments as a strategy to redress the fiscal challenges related to DSH caps, which have not kept up with the growth in Medicaid enrollment and the uninsured.

I would like to offer two alternative strategies for addressing IGT and UPL financing arrangements: first, the cleanest way for the federal government to exert control is to lower the size of the actual Medicaid payment for a given service to the county hospital (in my example

throughout this testimony). This avoids both the impossible task of tracing dollars after receipt by the provider, and it avoids the administrative expense and burden of audited cost reports. This is best accomplished by focusing on Medicare's payment to hospitals as the ceiling. If Medicare's payment is too high, and therefore sets a Medicaid ceiling in the UPL that is too high, the cleanest approach is to tackle Medicare's fees. Second, much of the incentive to engage in IGT and UPL arrangements would be dissipated if DSH payments were indexed to Medicaid enrollment and estimates of the number of people who are uninsured. Reviewing the role of DSH in this discussion could help alleviate this "gaming" by states, counties, and hospitals.

### **Medicaid School-Based Reimbursement**

The issue of Medicaid reimbursement for school-based services follows a similar pattern to the IGT/UPL discussion. Under the federal Individuals with Disabilities Education Act (IDEA), school districts are obligated to provide certain therapies and other services to children requiring special education. Absent Medicaid funding, the school districts would be furnishing these services entirely with local school funding, typically from property tax revenue. However, because many of these children are on Medicaid, and because therapies are covered Medicaid services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provision of Medicaid, states and school districts have sought to secure FFP when school districts deliver special education health care services to Medicaid-enrolled children.

The controversy arises in the methodology by which school districts are paid for these services. Because school districts are not primarily health care providers, they are not typically organized to bill insurers like Medicaid on a claim-by-claim basis for individually covered services. That is, although they presumably could bill *any* insurer for providing a covered health care service to a covered child, school districts are not set up to submit claims using CPT codes. Therefore, most Medicaid reimbursement arrangements for school-based services are developed using a fairly complex cost-based reimbursement model.

This model often uses a time-study to determine the allocation of staff time necessary to provide speech therapy, for example, to children in special education. This time study would capture not only the therapist's time, but perhaps a small piece of time by the school secretary to do scheduling, and small amounts of time from others in the school as well, whose work facilitates the therapy. Then these pieces of time from many individuals are converted to a cost by using their respective salaries, benefits, and other direct and indirect costs. All of these allocations then determine that a single speech therapy visit might "cost" \$75, for example.

To oversimplify a little, the Bush Administration is concerned that some school-based reimbursement methodologies overstate the overall costs and the time required by school staff members to support special education, because both the school and the Medicaid agency share an incentive to maximize federal Medicaid funds. This concern has been amplified by the presence of certain consultants, who might be paid a contingency percentage of the amount of federal Medicaid funds received in a successful Medicaid school-based financing arrangement.

This is another area where federal oversight and scrutiny certainly is warranted, in the interest of protecting federal taxpayers. At the same time, however, many of the concerns could be addressed by acknowledging that (a) schools are being asked to serve more and more children in special education without commensurate increases in federal funds, (b) Medicaid reimbursement for school-based services is allowable under EPSDT, so the real focus should be on establishing clear guidelines on what reimbursement methodologies are permissible, (c) most consultants are ethical, and are providing services not dissimilar from tax accountants who assist taxpayers in (legally) maximizing their funds; and (d) states generally have been operating in accordance with the methodologies contained in federally-approved Medicaid state plan amendments.

## **Conclusion**

The risk to the federal Medicaid treasury in IGT, UPL, school-based reimbursement, and other areas traditionally involves situations where state or local governmental entities act as Medicaid providers, and the source for state matching funds is a state or local unit of government with a close relationship to that governmental health care provider. It is appropriate for Congress and the Bush Administration to review these arrangements. Still, it is crucial to retain the perspective that states generally have been acting in accord with legal reimbursement standards, and states and local governmental entities have been motivated by a goal of serving the rapidly growing number of Medicaid eligibles.

In addition, as the Medicaid rolls swell and state and federal policymakers grapple with the effect of this expansion on the government, it is vitally important to link, rather than delink, the fiscal objectives with the overall Medicaid policy reform discussion that hopefully will be engaged.

Thank you for the opportunity to share my remarks with you. Please know that I stand ready to assist you in any way that I can as you consider proposals to reform the Medicaid program.