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Health, Education and Human Services Division
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The Honorable John R. Kasich
Chairman, Committee on the Budget
House of Representatives

Dear Mr. Chairman:

We detailed how certain financial arrangements enabled Michigan, Tennessee, and Texas to obtain about $800 million in federal Medicaid funds without effectively committing their share of state matching funds in a 1994 report.[1] While federal legislation has restricted certain state financing arrangements, some provisions did not take effect until after we finished field work in the three states for that report.

Your Committee's recent hearings[2] on Medicaid spending growth again raised concerns about these state spending practices. As a result, you requested that we update certain information from our 1994 report to determine what financing arrangements states were using in fiscal year 1995 to obtain federal Medicaid funds. Because Michigan used several approaches to obtain federal matching funds and was part of our prior review, we agreed with your staff to focus our information update on Michigan's 1995 financing arrangements.

To identify Michigan's current financing arrangements, we obtained documentation and met with Michigan Department of Management and Budget, state Medicaid, and regional Health Care Financing Administration (HCFA) officials. Michigan's financing arrangements are not unique because other studies have shown that many states also have special financing arrangements to obtain federal matching funds.

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

[2]At these April 4, 1995, hearings, we testified on Medicaid spending pressures. See Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/T-HEHS-95-129, Apr. 4, 1995).

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Michigan officials reviewed a draft of this letter and said that it accurately reflects the state's financing arrangements.

BACKGROUND

In 1965, Medicaid was established as a jointly funded federal/state program providing medical assistance to qualified low-income people. 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 particular services. In 1993, Medicaid cost federal and state governments $131 billion, almost $100 billion more than it cost a decade ago.

Each state operates its Medicaid program under a state plan that HCFA must approve for compliance with current law and regulations. In addition to reimbursing medical providers for services rendered, states must make Medicaid payments to hospitals serving large numbers of Medicaid and other low-income patients under the disproportionate share hospital (DSH) program.

The federal and state governments share Medicaid costs--including DSH payments--with the federal government, paying at least 50 percent and no more than 83 percent of a state's costs as determined by a formula. This formula, which compares a state's average per capita income with the national per capita income, is intended to reduce differences among the states in medical care coverage to the poor and fairly distribute the financing of program benefits among the states. The formula determines the ratio of federal and state expenditures. The amount of state expenditures triggers federal matching funds--the larger the state expenditure, the larger the federal matching funds.

For many years, states have used special financing arrangements, such as provider taxes and donations, intergovernmental transfers, and DSH payments, to increase the portion of the state Medicaid programs funded by the federal government. States have benefited from these arrangements because federal funds paid to providers are given to providers only to be returned to the state. Thus, states can reduce their share of Medicaid costs or not incur any state expenditures while generating additional federal funds. This has resulted in greatly increased federal Medicaid payments. For example, DSH expenditures,

including state funds, increased dramatically from slightly less than $1 billion in 1990 to about $16.7 billion in 1993.

The dramatic increase in federal Medicaid payments to states raised concerns that the federal government was paying an inappropriately large share of Medicaid program costs. As a result, the Congress passed legislation in 1991 and 1993[3] that limited the sources of state matching funds, placed a cap on DSH payments, and set limits on the amount of DSH payments that could be made to providers. Nonetheless, states continue to find innovative ways to generate state matching funds that are used to obtain additional federal monies.

SUMMARY OF MICHIGAN'S FINANCING ARRANGEMENTS

According to its fiscal year 1996 executive budget, Michigan has been among the most successful states in obtaining additional federal Medicaid funds. Since fiscal year 1991, Michigan's costs have been reduced by $1.8 billion through a variety of financing partnerships with medical providers and local units of government. Michigan benefited from these partnerships because most federal matching funds paid to providers were returned to the state, thereby reducing state appropriations. Michigan officials emphasized that all the programs are consistent with federal laws and regulations and that the funds obtained are only used to finance the Medicaid program. These officials added that if such funds are lost, it is likely that Michigan will be forced to sharply reduce Medicaid health care services.

Even though federal legislation has curtailed certain financing practices, Michigan continues to find new ways to obtain federal matching funds. From 1991 through 1993, Michigan used provider donations to maximize federal DSH funds and reduce state costs. Because the 1991 amendments severely restricted provider donations, the state relied on a DSH payment to the state-owned University of Michigan Hospital and additional payments to nursing homes, rather

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[3]The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) (1991 amendments) and the Omnibus Budget Reconciliation Act of 1993 (P.L. 101-239) (OBRA 1993) placed restrictions on state's financing arrangements.

than provider donations, to obtain over $433 million in federal matching funds in fiscal year 1994.

In fiscal year 1995, additional payments to nursing homes and DSH payments are still being used as the primary sources for obtaining over $478 million in federal funds. The 1994 University of Michigan Hospital DSH payment was reduced significantly, however, by provisions in OBRA 1993 that limit the amount of DSH payments to providers. To make up for the reduced payment to the University of Michigan Hospital, the state is making DSH payments to 23 public hospitals and retroactively adjusting payment rates for community mental health boards.[4]

Our review of Michigan fiscal year 1995 financing partnerships found that state costs will be reduced by $428 million, as shown in table 1 and discussed in greater detail in the rest of this letter. The state can reduce its costs at the expense of the federal government because the vast majority of federal funds are, as in prior years, being returned to the state through intergovernmental transfers.

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[4]Community mental health boards are responsible for managing the resources and directing the provision of care to the state's mentally ill and developmentally disabled population.

Table 1: Michigan Financing Programs, Fiscal Year 1995

(Dollars in Millions)

Program description	Federal Medicaid funds	Federal funds kept by providers	Net benefit to the state
Regular DSH[a]	$25.6	$25.6	0
Special DSH	187.7	1.5	$186.2
Increased payments for mental health services	63.4	9.9	53.5
Increased payments for nursing home services	148.9	6.0	142.9
Increased payments for outpatient services	53.0	7.6	45.4
Totals	$478.6	$50.6	$428.0

[a]The regular DSH program consists of additional payments made almost entirely to private hospitals and not returned to the state. Under the special DSH program, additional payments are made to public hospitals but returned to the state.

In fiscal year 1996, Michigan expects to carry out similar transactions. However, federal legislation will again reduce the funds generated from these transactions, forcing the state to devise new programs to make up for the decreased revenues. Using the above transactions and other financing programs, Michigan expects to obtain over $414 million in federal matching funds. As in prior years, these funds will be returned to the state, reducing its Medicaid appropriation.

STATE REALIZES BENEFIT OF ABOUT $200 MILLION BY ADJUSTING PAYMENTS FOR NURSING HOME AND MENTAL HEALTH MEDICAID SERVICES

Michigan, by adjusting payment rates for certain county nursing homes, community mental health boards, and state mental health hospitals obtained $212.3 million in federal matching funds in fiscal year 1995. With state funds of $161.2 million, the state will pay $373.5 million to these providers in fiscal year 1995. However, the providers will retain only $15.9 million--about 4 percent of the payments--and return the rest to the state. As a result, the state will realize a net benefit of $196.4 million from the federal matching funds.

For the past several years, Michigan has obtained additional federal Medicaid funds by adjusting the daily Medicaid payment rates (by about 200 percent) for 41 county nursing homes and four other local government long-term care facilities. In fiscal year 1993, these Michigan nursing homes received additional Medicaid payments of $277 million, including about $155 million in federal Medicaid funds but returned $271 million to the state. In fiscal year 1995, payments of $262 million have been made, including $148.9 million in federal funds. The nursing facilities returned all but $6 million to the state. Michigan expects to carry out similar transactions in fiscal year 1996.

In originally seeking HCFA's approval for increased rates, Michigan did not have to justify that the county nursing facilities needed increased reimbursements. The state did, however, have to show that the increase would not violate the Medicare upper limit test for nursing home payments.[5] Although the average daily Medicaid payment for the affected nursing facilities in Michigan increased from $90 to $269, the average rate of all nursing homes in the state remained below the Medicare upper limit of $99. This was the case because reimbursements to all other nursing

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[5]While states set Medicaid reimbursement rates, they must ensure HCFA that such rates are reasonable and adequate and do not exceed what Medicare would pay for the service. The Medicare upper limit test requires that the average Medicaid rate does not exceed the average Medicare rate. Medicare is a federal health insurance program for people 65 years of age or older, certain disabled persons, and most persons with end-stage renal disease.

facilities--accounting for 86 percent of all Medicaid inpatient days--remained the same.[6]

Michigan is also increasing the fees paid to community mental health boards and certain public hospitals that provide mental health Medicaid services. Such payment rates had not been revised for several years, according to state officials. After revising the state's outdated fee schedule, Michigan officials decided that, in fiscal year 1995, the boards and hospitals would receive retroactive increases for mental health services that had been paid at the old rates in 1993 and 1994. The increases would equal the difference between the old rates and the revised rates to the extent that provider charges exceeded the old rate.

Michigan estimates that it will pay retroactive increased payments of $111.5 million to the boards and hospitals. This includes $63.4 million in federal Medicaid matching funds and $48.1 million in state funds. In fiscal year 1995, the state paid $59.9 million to 55 boards and $7.9 million to 11 hospitals for 1993-94 services paid under the old fee schedule. As part of the arrangement, the mental health boards retained 10 percent of the payments (about $6 million) and returned the remainder to the state, while the hospitals returned all of their payments.

In November 1995, the state will pay the remaining $43.7 million to the boards and hospitals for 1995 mental health services. Again, all of the funds, minus the 10 percent allowance for the boards, will be returned to the state, which expects to realize a net benefit from these transactions of $53.5 million. The program will be continued in fiscal year 1996 and is expected to generate another $26.2 million for the state.

MOST MICHIGAN 1995 DSH PAYMENTS AGAIN RETURNED TO STATE

While legislation has prohibited certain financing arrangements, Michigan has adjusted its DSH program to meet new legislative requirements by reducing its payment to the University of Michigan Hospital and making payments to public and state hospitals. Its 1995 DSH program is still

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[6]The arrangement with the county nursing homes would not be allowed were these state-owned facilities. Federal regulations do not allow reimbursements to state facilities to be averaged with reimbursements for nonstate-owned facilities.

expected to generate an estimated $187.7 million in federal funds for the state. Combined with state funds of $142.7 million, DSH payments of $330.4 will be made to several public and state psychiatric hospitals.[7] Providers will keep $1.5 million and, as in prior years, return the funds to the state through intergovernmental transfers.

In fiscal year 1993, Michigan used hospital donations to help raise funds for its Medicaid program. Michigan made DSH payments of $458 million--including federal matching funds of $256 million--to 53 hospitals. All but $6 million of these payments were returned to the state. As a result, the state received a $250 million net benefit from the federal share of the DSH payment. Michigan stopped this practice because the 1991 amendments, which took effect in Michigan on January 1, 1993, severely limited provider donations. In response to these limitations, Michigan's 1994 DSH program included a $489 million payment to the University of Michigan Hospital. This 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 payment 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.

In 1995, OBRA 93 severely restricts the University of Michigan Hospital DSH payment. It limits DSH payments for fiscal year 1995 to 200 percent of a hospital's unrecovered costs for Medicaid and uninsured patients.[8] As a result, the hospital received a $53.2 million DSH payment (and returned $51.7 million to the state) or about $436 million less than last year.

To make up for part of the funds lost from the restrictions on the payments to the hospital, the state has made or will make DSH payments of about $277 million, including federal

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[7]In fiscal year 1995, Michigan made regular DSH payments of $45 million to 63 private and 7 public hospitals that will retain the funds.

[8]In subsequent years, OBRA-93 limits DSH payments to 100 percent of a hospital's uncovered costs. Michigan officials note that this restriction is the primary reason that state costs will increase by $103 million in fiscal year 1996.

funds of $158 million, to state psychiatric and other public hospitals. These payments include

-- a $25 million payment to Hurley Hospital, a public hospital located in Flint, Michigan;

-- $237.2 million in payments, ranging from about $4.6 million to $67 million, to 8 state psychiatric hospitals; and

-- $15 million in payments to 14 public hospitals.

The state will realize a net benefit $186.2 million from the federal share of these DSH payments because providers will return all but $1.5 million to the state. Michigan's fiscal year 1996 budget projects DSH payments of $279 million that will be returned to the state, realizing a net benefit of $158.1 million for the state.

MOST INCREASED PAYMENTS FOR MEDICAID OUTPATIENT SERVICES RETURNED TO THE STATE

In late 1994, Michigan officials determined that the state could make additional hospital outpatient payments of $40 million, including $22.7 million in federal funds, without exceeding what Medicare would pay for such services. All of these payments were made to Hurley Hospital, which retained only $7.6 million and returned the remainder, $32.4 million, to the state. The net benefit to the state was $15.1 million--the federal payment of $22.7 million minus the $7.6 million retained by the hospital.

In fiscal year 1995, Hurley Hospital will receive outpatient payments of $53.3 million. The hospital will return all of these funds to the state, which will realize a net benefit of $30.3 million. In fiscal year 1996, Hurley Hospital will receive and return to the state $40 million, resulting in $22.7 million state benefit.

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Copies of this letter are being sent to Michigan and HCFA officials. We will make copies available to other

interested parties upon request. Please contact Daniel S. Meyer at (312) 220-7683 or Alfred R. Schnupp at (202) 512-7159 if you have any questions about this letter.

Sincerely yours,

Sarah F. Jaggar,
Director, Health Financing
and Policy Issues

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