



Medicaid Topics

Financing: Intergovernmental Transfers and Other Special Financing Mechanisms

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Because of competing demands for public services, especially with recent budget shortfalls, many states exceed their fiscal capability that gives their Medicaid programs the incentive to substitute federal funds for state funds. The Medicaid program's federal-state matching payment structure for covered services provides the mechanism for this substitution. In general, this process of "Medicaid maximization" allows states to cover services that have traditionally been state or local responsibilities and to receive federal matching funds for the costs of furnishing these services to Medicaid beneficiaries. The higher the state's matching rate or FMAP (Federal Medical Assistance Percentage), the greater the replacement potential.

The major Medicaid maximization strategies most applicable for states to employ in this way include:

- 1) intergovernmental transfers (IGTs)
- 2) taxes on health care providers
- 3) disproportionate share hospital (DSH) payments.

In general, these strategies have come under greater scrutiny and criticism by federal officials concerned with the use of tactics by states that maximize receipt of federal Medicaid funds.

Intergovernmental Transfers

Many states have turned to IGTs as the best strategy to raise their state Medicaid shares. IGTs are exchanges of public funds between different levels of government and are a common feature in state finance. In the early 1990s, many states began to use IGTs as a way to leverage federal Medicaid dollars to continue or expand coverage of services or to pay higher reimbursement rates to providers. The transfer of funds may take place from one level of government to another (i.e., counties to states) or within the same level of government (i.e., from a state university hospital to the state Medicaid agency). Thus, states can use county or state expenditures to generate a federal match to support Medicaid services. As of 2001, there were at least 16 states with some form of local financing matching requirement.¹

While IGTs are legal and a useful financing source for states, they may become problematic if they

- Raise the federal share of total Medicaid funding far above their nominal statutory federal matching rate;
- Make federal matching funds available for purposes other than purchasing covered services for Medicaid beneficiaries;
- Inflate the overall Medicaid spending growth rates without a commensurate increase in spending for services for Medicaid enrollees;
- Create incentives for states to reduce their own funding for public hospitals and nursing homes and replace their funds with federal dollars.

In some cases, through IGTs, states have required local government providers (e.g., county-run nursing homes or municipal hospitals) to transfer back to the state some or all of the federal Medicaid funds originally paid to those providers that exceed the usual Medicaid payment rate. States may use these transferred funds for Medicaid or for other purposes such as to fill state budget shortfalls for other programs or to draw down additional federal Medicaid dollars.

¹ States include Arizona, California, Colorado, Florida, Iowa, Kansas, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Washington, Wisconsin.

Consequently, when states reduce state Medicaid spending, they lose federal revenue.

Proposed Federal Changes

- Provide federal matching funds to states only for those benefit payments that Medicaid providers keep (restricting IGTs). That is, for payments in excess of the usual Medicaid payment rate, the federal government proposes to stop matching any portion that providers are required to return to the state.
- Require states to comply with new rules about Medicaid's UPL. Change the permissible upper payment limit for services delivered by local government providers (e.g., county-run nursing homes or municipal providers) from the Medicare payment rate to no more than the cost of providing services.

Federal savings over 10 years: *\$15.2 billion*

Otherwise, CMS is attempting to limit IGTs by more careful review of state plan amendments and through renegotiation of the terms of section 1115 waivers.

Provider Taxes

Although use of health care provider tax and donation programs became a common practice among states to raise the state share (and thus increase federal matching payments) for making Medicaid payments (especially DSH payments) by the early 1990s, Congress in 1991 banned states' use of provider donations and imposed restrictions on provider taxes. Under federal law and regulations, a state's ability to use provider-specific taxes to fund their state share of Medicaid expenditures is limited. Those taxes cannot generally exceed 25% of the state (or non-federal) share of Medicaid expenditures, and the state cannot provide a guarantee to the providers that the taxes will be returned to them.

Despite these changes, several states are now using or considering use of provider taxes to supplement stagnant or declining provider reimbursement rates. This is in part because of a safe harbor—if the taxes returned to a provider are less than 6% of the provider's revenues, the prohibition on guaranteeing the return of tax funds is not violated. As a result, a state could impose a provider tax of 6% of revenues, return those revenues right back to those providers in the form of a Medicaid 'payment' and receive a federal match for those amounts.

Proposed Federal Changes

- Phase-down the current safe-harbor tax on providers from 6% to no more than 3%.

Disproportionate Share Hospital (DSH) Payments

Federal Medicaid DSH payments, authorized by Congress in the 1980s and directed to hospitals that serve a large number of Medicaid and low-income patients with special needs, are allocated among states in amounts set forth as ceilings in federal statutes. Although states may claim federal matching funds for DSH payments made to qualifying hospitals up to these ceilings, changes by Congress in the late 1990s set fixed ceilings on DSH payments to each state. The Medicare Modernization Act of 2003 raised ceilings by \$1.2 billion in 2004 and by smaller amounts in later years.

Some states have used their DSH programs to make unusually large payments to government-owned hospitals, which then use IGTs to return the bulk of the funds to the state treasury. Such transactions, involving both UPL and DSH, were estimated in 2001 to have raised the average federal matching rate by three percentage points.

Proposed Federal Changes

- Convert Medicaid DSH payments into a block grant to the states. In exchange for less funding, states would be given greater flexibility to use these funds of their low-income and uninsured populations in more cost-effective ways (e.g., using funds to support non-hospital outpatient clinics and primary care providers).

Importance to Family Physicians

- Although IGTs and provider taxes more directly involve institutional providers (i.e., hospitals, nursing homes), both hospital and non-hospital based clinic services in local health care institutions often utilize family physicians as an important provider of primary and preventive care services to low-income and Medicaid beneficiaries.
- If Medicaid DSH payments to states are funneled through a proposed block grant, and states are given flexibility to use these funds to provide care to Medicaid beneficiaries in non-hospital settings, family physicians (as important providers of primary care to Medicaid patients) may have the opportunity to receive such funds to enhance their care to low-income and Medicaid beneficiaries.
- Medicaid support of residency training (for family physicians in particular who care for significant numbers of Medicaid beneficiaries as part of the graduate medical education) in many states could be expanded by using IGTs and state appropriations for medical school and family medicine training as match.