kaiser commission on medicaid and the uninsured

MEDICAID'S FEDERAL-STATE PARTNERSHIP:

ALTERNATIVES FOR IMPROVING FINANCIAL INTEGRITY

Prepared by
Penny Thompson

February 2004

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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Medicaid's Federal-State Partnership:
Alternatives for Improving Financial Integrity

The Medicaid program was established as a federal-state program in 1965 to provide health and long-term care coverage for low-income families, seniors, and people with disabilities. Medicaid provides health care coverage for low-income children and their parents, long-term care services, including home and community based care, used largely by seniors and people with disabilities, and fills in gaps in Medicare coverage for 6 million low-income seniors who qualify for both Medicare and Medicaid. The Medicaid program, which will serve an estimated 50 million people in 2003, will cost states and the federal government more than $275 billion in federal fiscal year 2002.[1]

Medicaid is financed through a combination of state and federal funds. The federal government matches all state spending on Medicaid services at a set rate, which varies by state. This matching system has provided substantial state and federal support for health and long-term care services through Medicaid, and has helped cushion states from the impact of unpredictable changes in program costs as a result of changes such as economic conditions, health care costs, and demographics. The matching system also ensures that both the federal government and the states have a stake in program management and outcomes.

Questions have been raised at a number of points in the program's history about the program's financial management, especially in regard to whether federal matching funds are being spent appropriately. These concerns have been raised by many states' use of "Medicaid maximization" strategies to leverage excess federal Medicaid funds without making comparable increases in state funds. The Bush Administration last year proposed to move from the existing federal/state matching structure to one in which the federal government provides states that elect to receive them set allotments of federal funds. According to Administration officials, one of the reasons for this proposed approach was to reduce concerns over federal financial exposure raised by use of Medicaid maximization strategies.[2] More recently, in its budget plan for fiscal year 2005, the Administration reiterated its support for the allotment approach and also proposed new program integrity initiatives that are estimated to save the federal government $23.5 billion over the next ten years.[3]

However, Medicaid's financial management vulnerabilities could be addressed directly, and without jeopardizing the benefits of its existing federal/state

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[1] Congressional Budget Office, Medicaid Fact Sheet, March 2003, www.cbo.gov..
[2] "HHS Secretary Tommy Thompson Announces Medicaid Reform Plan," January 31, 2003, transcript at www.kaisernetwork.org.
[3] U.S. Office of Management and Budget, Budget of the United States Government, Fiscal Year 2005, U.S. Government Printing Office, Washington, D.C. 2004. http://www.whitehouse.gov/omb/budget/fy2005/budget.html, pages 149 and 372.

matching structure, through improvements to the program's financial management. This paper identifies a number of alternative approaches the federal government could take to strengthen financial management of Medicaid. Using models from both the private sector and government, this paper suggests financial management improvements that could significantly reduce the program's exposure to questionable practices, improve the program's responsiveness to emerging financial management issues, and control federal costs while maintaining the federal matching payments that have helped the program provide health and long-term care services to low-income Americans.

Introduction

In the almost 40 years since its inception, the Medicaid program has formed an increasingly large and important component of the country's health care system, accounting for 17 percent of the overall $1.1 trillion in total personal health spending in the U.S. in 2000.[4] Medicaid, which provides both health and long-term care services, is now larger than Medicare, the federal health insurance program for Americans age 65 and older. Medicaid represents the second largest category of state spending (next to education) and is by far the largest source of federal grant funds to the states, dwarfing transportation, education, public assistance, and corrections.[5]

Medicaid plays a huge role insuring the nation's 38 million low-income children and some of their parents, and covers one in every five children in the United States. At the same time, Medicaid plays a significant role for low-income seniors and people with disabilities, providing coverage for long term care services, and helping the disabled achieve choice and freedom in home and community based settings. For the six million individuals who are enrolled in both Medicare and Medicaid, Medicaid has filled in the gaps in Medicare's benefits package, including for long-term care and prescription drugs.

At the federal level, Medicaid is administered by the Centers for Medicare and Medicaid Services (CMS)[6], part of the U.S. Department of Health and Human Services (HHS). States operate the program under federal guidelines and rules. States have considerable flexibility in designing their programs, including whether to extend coverage for optional services and groups of people. Each state has its own state plan which outlines its program; amendments to the plan (like the underlying plan itself) are subject to approval by the federal government, in order

[4] Centers for Medicare and Medicaid Services, "Program Information on Medicare, Medicaid, SCHIP and other programs of the Centers for Medicare and Medicaid Services," June 2002 edition, Table 3.23. Original source: Office of the Actuary, National Health Statistics Group.
[5] Centers for Medicare and Medicaid Services, "Program Information," Table 3.28. Original source: National Association of State Budget Officers, 2000 State Expenditure Report.
[6] Formerly the Health Care Financing Administration (HCFA).

to ensure federal requirements are met. States can also receive waivers of federal rules from CMS.

The program is funded with both federal and state dollars. State expenditures are matched by the federal government according to a formula that varies inversely with the state's per capita income. The federal share is referred to as a state's "matching rate," or federal medical assistance percentage (FMAP). Under this formula, the federal share of Medicaid program expenditures ranges from 50 to 77 percent of total spending (although different match rates apply to administrative, technology, or special expense categories). In a state with a 50 percent matching rate, Medicaid spending is borne equally between the states and the federal government. Every dollar invested by the state earns another dollar for the program from the federal government. Overall, the states were reported to have contributed 43 percent of program costs in 2002, with the federal government providing the remaining 57 percent.

This matching system achieves a number of goals. From the perspective of providing health coverage, the program helps support state efforts, during both weak and strong economic times, to provide health care coverage to low-income populations. The matching system ensures that when state spending increases as a result of an economic downturn, increased cost or use of services, or demographic changes like the aging of the population, federal matching payments increase as well. From a program management perspective, federal matching payments, much like employer matching in individual 401(k) plans, encourage state investment in the program. The federal-state matching system is also designed to make sure that states have a stake in program management and outcomes. In deciding how much to budget for the program, states are establishing priorities. By investing in the program, they are accountable for the way funds are spent and managed.

For all its benefits, however, these matching arrangements are prone to some vulnerabilities. Medicaid spending is largely driven by state decisions, such as who to cover, what services to offer, and how much to pay providers, and states have incentives to maximize the amount of spending that classifies as Medicaid spending to obtain federal matching funds for that spending. At times, these incentives have had a positive effect on health coverage and support for state public health infrastructure, as states have sought to ensure that services that Medicaid covers to individuals who qualify for the program generate federal matching funds. However, these incentives have also led to a number of state strategies that have had the effect of inflating the federal share of Medicaid spending, diverting federal funds from uses related to health care, and undermining public confidence in the program's financial accountability. These strategies have turned on the ability of states to trigger a federal match without actually incurring a state cost.

Concerns first surfaced in the mid to late 1980s, when states used provider taxes and donations as revenue sources. States began to collect funds from providers (either by taxing them or encouraging "donations") who participated in the Medicaid program. CMS developed rules to allow states to use these tactics, including a 1985 regulation allowing donations to be used as the state match, and a manual instruction allowing certain taxes. At the time, CMS thought that the use of these revenue sources would assist states in fulfilling their obligations to providers and beneficiaries under the program. States used those revenues to make Medicaid payments to the parties making the donations, effectively resulting in a "wash" for providers and states. The payments generated a federal match which could then support a variety of state needs in Medicaid, health care, or other areas. These programs became increasingly popular in early 1990s: by 1992, most states had them.[7] The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 restricted states' ability to use this mechanism, prohibiting the use of provider donations as the state share and establishing requirements for "permissible" provider taxes that could be used as the state share and prohibited the use of provider donations as the state share.

During this same period, states used the disproportionate share hospital (DSH) program to increase the level of payments it made to providers. When combined with provider taxes and donations, it meant that unlimited revenue could be used to make unlimited payments, generating unprecedented federal matching, without costing the providers or states any real money. Under the DSH program, states make supplemental payments to hospitals which care for a larger than normal number of Medicaid and uninsured patients. States used the program to make large payments. The hospitals would then transfer much or all of the money back to the state. Federal and state DSH expenditures increased from less than $2 billion in 1990 to over $17 billion in 1992, an 850 percent increase.[8] To address this startling increase, caps on overall DSH spending were included in The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991. State and hospital specific limits and requirements were included in the Omnibus Budget Reconciliation Act of 1993. The Balanced Budget Act of 1997 pushed down the state limits for DSH funding, promising to raise them later.[9]

More recently, states made use of Medicaid's "upper payment limit" policy as they did the DSH program. The upper payment limit is contained in a longstanding Medicaid rule which requires that state payments to a particular group of providers (such as publicly-owned nursing homes) may not, in the aggregate, exceed the amount that Medicare would have paid to this group. States made use of "room" between their actual payment levels and the ceiling

[7] Teresa Coughlin and Stephen Zuckerman, "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences," Urban Institute, June 1, 2002, p. 6.
[8] Ibid.
[9] Karen Matherlee, "The Federal-State Medicaid Match: An Ongoing Tug-of-War over Practice and Policy," George Washington University National Health Policy Forum, p. 6-7.

represented by the upper payment limit to allow municipally owned hospitals and nursing homes make supplemental payments to the state up to the limit imposed by the UPL. Those payments generated the federal match, and the states then transferred much or all the money back to the providers through intergovernmental transfers. The HHS Office of the Inspector General (OIG) issued a series of reports beginning in 1999 detailing how states were using UPL strategies. The OIG conducted detailed reviews in six states and found that the number of states using UPL strategies increased from 12 before 1999 to 28 in fiscal year 2000.[10] In March 2001, CMS responded to the growth in the use of these strategies by issuing a regulation that significantly curtailed the use of these strategies by effectively pushing down the room the UPL provides to states. The regulation also provided various transition periods for phase out of UPL programs in place.[11]

Although the federal government has ultimately responded when different creative financing strategies have emerged, it has frequently been slow to do so, failing to act until the amount of federal financial liability and consequent public attention are substantial. Frequently, the federal government has been either unable or unwilling to use administrative means to reject claims for federal matching for these transactions; at times, it has tacitly encouraged or allowed the practice to "bail out" states facing significant budget shortfalls. Meanwhile, the practices spread quickly through the states once it become apparent the federal government was going to allow the practice.

The use of these creative financing strategies has led to strong concern by some federal officials about the program's financial integrity. The U.S. General Accounting Office has questioned whether the program has gone too far in granting state flexibility in program design and operation[12] and not far enough in preventing states from exploiting financial loopholes that have threatened the program's stability and the health of the federal-state partnership. In 2002, GAO added Medicaid to its list of "high risk" programs, citing lack of financial controls over states' claims for federal matching.[13]

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[10] U.S. Department of Health and Human Services, "Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers," A-03-00-00216, September 2000.

[11] In addition to these issues, the Medicaid program has also faced recent challenges with regard to the manner in which states are charging the federal government for school-based administrative claiming. Moreover, like other health insurers, including Medicare, Medicaid is subject to potential provider fraud. See A. Schneider, "Reducing Medicaid Fraud: The Potential of the False Claims Act," Taxpayers Against Fraud Education Fund, June 2003.

[12] See U.S. General Accounting Office, "Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns," GAO-02-817, July 2002; and "Long Term Care: Federal Oversight of Growing Medicaid Home and Community Based Waivers Should be Strengthened," GAO-03-576, June 2003.

[13] U.S. General Accounting Office, "Major Management Challenges and Program Risks: Department of Health and Human Services," GAO-03-101, p. 27-29.

Concern over the program's financial management have led some to call for major structural changes to the program's financing structure. The Chairman of the Committee on Energy and Commerce has recommended that the federal government cap the federal contribution for optional program benefits and covered groups in order to "significantly reduce the incentives for states to maintain or prospectively implement [inappropriate] financing schemes." In testimony before the Committee on Energy and Commerce's Subcommittee on Health, the Administrator of the Centers for Medicare and Medicaid Services (the agency within the U.S. Department of Health and Human Services responsible for administering the program) stated that Medicaid "needs fundamental structural reforms that will return the program to a federal and state partnership" and argued that providing states a "global financing option," such as the Administration's 2003 allotment proposal, would help mitigate "financial gamesmanship."

However, as an answer to concerns about financial integrity and the overall health of the federal-state partnership, the current call for allotments or similar approach has only one advantage and several significant drawbacks. The primary advantage of such an approach is that it reduces the overall level of federal financial exposure, thereby limiting the extent of losses that the federal government can incur due to new manipulations and schemes. (As a corollary, it also reduces the "gains" for states that engage in such manipulations.) However, by themselves, allotments do not ensure that federal dollars are being used appropriately; only that there is an overall limit to the amount of dollars that could be used inappropriately. At the same time, moving to a capped federal payment system would create significant unintended consequences for the ways in which the program provides health coverage to the low-income population, since federal matching payments have contributed substantially to the program's success as a health and long-term care insurer.[14]

As an alternative to radical restructuring of the program, federal policymakers could consider ways to improve the financial management of the Medicaid program as it is presently configured. This paper identifies administrative and legislative reforms the federal government could undertake to improve the financial management of the Medicaid program. A concerted effort to strengthen Medicaid financial management and controls with targeted reforms could effectively address the program's present vulnerabilities. Using existing models from both the private sector and other government programs, including Medicaid's sister program, Medicare, this paper identifies a range of measures the government could take to reduce or mitigate the federal exposure to wasteful, unnecessary or fraudulent spending.

These alternatives have several potential benefits. First, and most clearly, they could control costs, reduce the program's exposure to abuse, and improve the

[14] See Victoria Wachino, et al., Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds, Kaiser Commission on Medicaid and the Uninsured, January 2004.

federal government's responsiveness to financial management problems that emerge over time. Second, they could help the federal government maintain the basic federal matching approach, which has benefited states and beneficiaries. Finally, these alternatives could also have substantial appeal to states. Under this approach, states would continue to receive federal support for their programs in proportion to their own investments. While additional and stronger financial controls would prevent manipulations that create temporary winners, states would be protected from a "financial arms race" in which they feel pressured to adopt questionable accounting strategies to generate federal funds because other states are doing so to their advantage. States would also be protected from the inequities and uncertainties that accompany these arrangements and from the dislocations to state finances when new rules are imposed to eliminate loopholes. In short, states would gain a more reliable, consistent and transparent federal partner with whom to work.

Methodology

To examine the Center for Medicare and Medicaid Services' existing Medicaid financial controls, and to identify opportunities for strengthening the federal government's approach to managing Medicaid finances, this paper examined five key dimensions of financial management:

1. ***Organizational commitment***, the assignment of resources and responsible personnel to Medicaid financial management;
1. ***standards and requirements,*** the rules by which CMS processes demands for payments;
2. ***risk management***, the process of continually assessing the environment and its challenges;
3. ***reporting and disclosures*** of financial matters; and
4. ***monitoring and enforcement***, the extent to which infractions can be identified and consequences applied.

These features represent a complete cycle of financial controls, beginning with organizational desire to have an effective program, then developing sound rules by which to judge financial transactions, modulating the focus of these efforts depending on exposure, ensuring that the agency possesses and provides reliable data, and holding entities and individuals accountable for their actions.

To assess present financial management conditions and possibilities for reform, this analysis identified several critical questions that correspond to each of the five key dimensions of financial management. Exhibit 1 displays some of these.

Exhibit 1. Dimensions and Sample Questions to Assess Financial Controls

Dimension	Sample Questions
Commitment	• Does executive leadership emphasize the importance of financial management and integrity to staff? • Is financial management and integrity part of the organization's mission statement? • Is there a strategic or tactical plan to guide the organization and provide focus to staff? • Are there appropriate separation of duties to ensure checks and balances? • Does the organization make good on its commitment by devoting adequate resources to financial management?
Standards and Requirements	• Are standards clear for what payments will be made, and under what circumstances? • Are they subject to a wide range of interpretation? • Do the standards relate back to the purposes of the program? • Do they contain enough specificity to prevent abuse? • Are they applied consistently?
Risk Assessment and Management	• Is there a formal process for assessment of risks? • Are there mitigation plans? • Are risk areas subject to special scrutiny and controls?
Reporting and Disclosures	• Is information collected that is sufficient and reliable to determine if standards are met? • Is information collected that is sufficient and reliable to determine the impact of payment decisions? • Is the information certified as to its reliability? • Is information disclosed to the public in sufficient detail to allow stakeholders to understand payment decisions?
Enforcement	• Do penalties exist for errors or misrepresentations? • Are the penalties sufficient to deter conduct that otherwise provides substantial benefits? • Are they applied frequently enough to represent a deterrent to fraud and abuse?

Results of Analysis

ORGANIZATIONAL COMMITMENT

Current Conditions

The President's 2004 budget called for more attention to Medicaid financial management. It notes that the Administration plans to include "reestablishing and elevating the importance of financial management oversight at CMS"[15] as a priority for Medicaid.

[15] Executive Office of the President of the United States, Office of Management and Budget, Budget of the United States Government, Fiscal Year 2004, p. 130.

The resources devoted to Medicaid financial management and oversight reflect the low priority that has been placed on this activity in the last decade. In 1992, 95 regional analysts were dedicated to financial management for Medicaid; in 2002, the number was 65.[16] The reductions took place as Medicaid outlays increased by 74 percent and a major new program (the State Children's Health Insurance Program) was added to the analysts' responsibilities.[17] The reductions also took place over a period of time in which analysts were directed to focus on providing technical assistance to states rather than reviewing expenditure data or conducting focused financial reviews in areas of concern or significant exposure. In fact, CMS regional offices were not required to perform any focused financial reviews between 1994 and 2001; those requirements were reinstituted in 2002. Thus, in addition to total resources declining, the resources that remained focused on nondiscretionary items, such as processing states' budget and expenditure reports, rather than providing proactive oversight in areas of federal concern.

The low level of resources devoted to financial management for Medicaid has had a direct impact on activities and results. Fewer reviews of state expenditures have taken place, with a corresponding reduction in disallowances (rejected claims).[18] Since the level of disallowances has decreased substantially at the same time scrutiny has been minimized, it is more likely that the results are due to degradation of federal oversight rather than increased compliance by states.

The President's budget highlights a further problem: the lack of a predictable, consistent, adequate source of funding for Medicaid financial management. The Administration has indicated its intention to secure $20 million in funding from the Health Care Fraud and Abuse Control Account (HCFAC) to support its new initiatives in the area of Medicaid financial management. In 2002, CMS received $2.675 million from the HCFAC account for a single initiative to improve Medicaid financial management.[19] It received $6.5 million for that initiative in 2003 from HCFAC funds. While $20 million represents nearly a tenfold increase from 2002, even that level of supplemental funding falls considerably short of what is appropriate for the largest governmental health program in the U.S., and hardly provides sufficient funding for the myriad of activities in which CMS needs to engage in order to improve its financial management of this program.

As a model for Medicaid, however, mandatory, dedicated accounts like HCFAC are useful points of comparison. The HCFAC account was established in 1996

[16] U.S. General Accounting Office, "Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed," GAO-02-300, February 2002, p. 14.
[17] Ibid.," p. 22.
[18] Ibid., p. 23.
[19] U.S. Department of Health and Human Services and the U.S. Department of Justice, "Health Care Fraud and Abuse Control Program: Annual Report for FY 2002," September 2003, p. 14. The funds are being used to support Payment Accuracy Measurement projects in the states, an effort to document payment error rates for Medicaid.

as part of the Health Insurance Portability and Accountability Act. It is funded by the Medicare trust fund. The Secretary of HHS and the Attorney General jointly certify the amount of funds necessary to combat health care fraud and abuse, up to a maximum amount specified in the statute. The fund dedicates the majority of resources to the HHS OIG. The OIG has benefited mightily from the infusion of dollars, as well as the ability to plan for the future with a guaranteed funding stream. HIPAA also included provisions for mandatory supplemental funding of the Federal Bureau of Investigation; and established the Medicare Integrity Program, with its own funding, which CMS administers. HIPAA provided that the amounts specified in the statute are available without further appropriation; meaning that they reside on the "mandatory", not the "discretionary" side of the federal budget. The results have been predictable: billions recovered for the Medicare trust fund.[20]

While Medicaid program officials can request funds from the HCFAC account, the amount available to program agencies other than HHS OIG and DOJ is limited, and the Center for Medicaid and State Operations must compete with other HHS programs (such as the Administration on Aging, Assistant Secretary for Budget, Technology and Finance, and Office of General Counsel) for allocations from this portion of the account. Thus, while HIPAA provided mandatory funding of between $150 and $160 million for the OIG, over $100 million for the FBI, and over $700 million for the Medicare Integrity Program in 2003, Medicaid fights with other HHS agencies to obtain $20 million. As of January 2004, negotiations were still continuing between HHS and DOJ on the 2004 agency requests. Among other things, CMS hopes to use this funding to obtain 100 staff to carry out financial management duties for Medicaid.

Medicaid pursues such funding without the additional standing and credibility of a dedicated Chief Financial Officer (CFO). Within CMS, the Center for Medicaid and State Operations (CMSO) is responsible for managing the Medicaid program, including financial and programmatic decisions. CMS has a CFO, but he does not currently exercise authority over substantive financial matters affecting Medicaid; instead, those authorities reside in the director of CMSO. The CFO undertakes budget formulation and execution for the agency and exercises considerable financial control over Medicare, providing balance to the beneficiary and provider focus in other CMS offices. In contrast, virtually all the key financial decisions made regarding Medicaid are made within CMSO, the same organization charged with achieving programmatic objectives and an effective working relationship with states. CMSO "develops, interprets and applies specific laws, regulations and policies that directly govern the financial operation and management of the Medicaid program and the related interactions

[20] See, for example, Jack A. Meyer, "Fighting Medicare Fraud: More Bang for the Federal Buck," Taxpayers Against Fraud Education Fund, June 2003.

with the states and regional offices."[21] Thus, the Medicare program benefits from the focus and accountability of a CFO, but the Medicaid program does not. Similarly, within CMSO, there is no CFO, controlling financial management resources and acting as an institutional force for accountability and fiscal discipline.

The Chief Financial Officers' Act of 1990 recognized the importance of this function and required designated federal departments to have a CFO, and to establish deputy CFO positions in their agencies. As a result of the way federal departments are organized, this means that the U.S. Department of Health and Human Services is required to have a CFO, as is CMS; but one is not required for any individual program, no matter how large. Because the CMS CFO concentrates on Medicare, Medicaid-- representing a quarter of a trillion dollars in federal and state expenditures--has been left without a dedicated, executive financial officer in control of financial resources and day to day financial operations. CFOs are required in the Department of Education, Department of Transportation, Department of Justice, Department of Housing and Urban Development, and Department of Homeland Security —but their combined 2003 spending, as reported in the President's 2004 Budget, is less than federal Medicaid spending in that year.[22]

Finally, the Medicaid program lacks a published, comprehensive financial management plan. In his testimony before the Energy and Committee Subcommittee on Health, the CMS Administrator indicated his intention to create such a plan in the near future. The Medicare program developed a comprehensive plan for program integrity in 1999 in response to appeals from Congress to demonstrate its commitment to ongoing improvements to protect the program from losses to fraud, waste and abuse. The Medicare comprehensive plan for program integrity included initiatives that focused on how Medicare could better manage the program to improve integrity (including significant changes in contracting and provider enrollment) and identified a series of high risk program areas on which it would focus its attention. The plan provided internal focus and public accountability to Medicare's program integrity efforts at a time when Congress, providers and beneficiaries doubted the program's resolve to making substantial improvements. Later, the Medicare program also published a comprehensive plan for financial management, a broader document outlining problems and plans to address weaknesses in the program's internal controls, oversight, and financial systems.

[21] Federal Register, "Department of Health and Human Services, Health Care Financing Administration, Statement of Organization, Functions and Delegations of Authority," Volume 62, Number 85, Notices, Page 24120-24126.

[22] The figures are: $59.5 billion for Education; $38 billion for HUD; $52.3 billion for Transportation;,22.7 for Justice; $28 for Homeland Security. All figures are from the President's 2004 budget document.

Possibilities for Reform

Require HHS to create a CFO for Medicaid: Vesting financial oversight and authority in executive officers whose sole function is to create and enforce financial controls and accountability is also an aid to altering culture to increase accountability. Such officers should have sufficient scope of authority to affect substantive decisions on program finances, with sufficient resources at their disposal to provide adequate coverage of dollars at risk. (Possibilities for reform are summarized in Exhibit 2).

Create a Medicaid Financial Oversight Board: In publicly funded organizations, audit committees play a role in ensuring that financial controls are developed and implemented within the organization; such committees are currently being strengthened and their importance emphasized following the accounting failures of a number of large companies in recent years. CMS could also adopt this model to create accountability outside of the Medicaid office, using Departmental and non-Medicaid agency staff as committee members. This board could be similar to those currently in place in CMS for management of Medicare contractors and State survey agencies. It could be expanded even further to include nongovernmental members and its proceedings made public as an even greater impetus to transparency and accountability.

Create a Medicaid Integrity Fund: Resources for financial management in Medicaid have dropped as the challenges and dollars at risk have increased. To respond to financial threats and eroding investment and confidence in other arenas, Congress has created protected funds to support oversight activities. As discussed earlier, or example, HIPAA created dedicated funding of hundreds of millions of dollars specifically for payment safeguards functions undertaken to protect Medicare from fraud, waste and abuse. The Sarbanes-Oxley Act set aside $98 million in 2003 for an additional 200 employees at the Securities and Exchange Commission dedicated to oversight. A similar approach could be implemented for Medicaid, funding staff at CMS central and regional offices (and possibly in the states), and private contractors solely focused on financial oversight.

***Set Mandatory Spending Levels for Medicaid Financial Oversight*:** Shortchanging Medicaid financial management efforts will cost the federal government much more in the long term than the investment in capacity costs today. As a result, Congress could also make its investment in financial oversight part of the mandatory, as opposed to discretionary, federal budget, as they did with HCFAC.

Create a Medicaid Comprehensive Plan for Financial Integrity: CMS should complete and issue formally, and publicly, its comprehensive plan for Medicaid financial integrity. As with the Medicare comprehensive plan for program integrity, CMS should seek input and comment from the GAO and the OIG on the

document before it is finalized. The plan could build on the areas discussed in this paper.

Exhibit 2
Summary of Issues, Approaches, and Alternatives for Reform

Dimension of Financial Management	Questions to Assess Current Financial Controls	Alternative Approaches to Improve Financial Controls
Organizational Commitment	➢ Does executive leadership emphasize the importance of financial management and integrity to staff? ➢ Is financial management and integrity part of the organization's mission statement? ➢ Is there a strategic or tactical plan to guide the organization and provide focus to staff? ➢ Is there appropriate separation of duties to ensure checks and balances? ➢ Does the organization make good on its commitment by devoting adequate resources to financial management?	➢ Create a CFO for Medicaid ➢ Create a Medicaid Financial Oversight Board ➢ Create a Medicaid Integrity Fund ➢ Set Mandatory Spending Levels for Medicaid Financial Oversight ➢ Complete a Medicaid Comprehensive Financial Management Plan
Standards and Requirements	➢ Are standards clear for what payments will be made, and under what circumstances? ➢ Are they subject to a wide range of interpretation? ➢ Do the standards relate back to the purposes of the program? ➢ Do they contain enough specificity to prevent abuse? ➢ Are they applied consistently?	➢ Pay no more than costs to government-owned facilities ➢ Further define "economic and efficient." ➢ Establish facility-specific limits ➢ Establish general principles for reimbursement ➢ Establish "anti-churning rule" ➢ Further specify matching sources ➢ Publish UPL methodology
Risk Assessment and Management	➢ Is there a formal process for assessment of risks? ➢ Are there mitigation plans? ➢ Are risk areas subject to special scrutiny and controls?	➢ Focus on "related party" transactions ➢ Audit all supplemental payments ➢ Dedicate staff to reviewing high-risk transactions ➢ Reduce staff and emphasis on low-risk transactions ➢ Emphasize "Do It Right"

Exhibit 2 (continued)
Summary of Issues, Approaches, and Alternatives for Reform

Dimension of Financial Management	Questions to Assess Current Financial Controls	Alternative Approaches to Improve Financial Controls
Reporting and Disclosures	➢ Is information collected that is sufficient and reliable to determine whether standards are met? ➢ Is information collected that is sufficient and reliable to determine the impact of payment decisions? ➢ Is the information certified as to its reliability? ➢ Is information disclosed to the public in sufficient detail to allow stakeholders to understand payment decisions?	➢ Collect key financial data from states ➢ Report on effective matching rates ➢ Complete effort to collect financial data on amendments
Enforcement	➢ Do penalties exist for errors or misrepresentations? ➢ Are the penalties sufficient to deter conduct that otherwise provides substantial benefits? ➢ Are they applied frequently enough to represent a deterrent to fraud and abuse?	➢ Institute other remedies ➢ Increase executive-level accountability ➢ Expand accountability ➢ Increase levels of scrutiny or approvals for states with track records of questionable claiming

STANDARDS AND REQUIREMENTS

Current Conditions

Standards to Prevent Excessive Payments: In 1967, due to concern over rising costs, the Social Security Act was amended to include requirements about payment to providers, specifying that states should specify their payment methodologies in their state plans submitted for approval by the federal government and that those methods should ensure that payments are consistent with efficiency, economy and quality of care. The upper payment limit (UPL) was devised as a way to implement these provisions for economy and efficiency, using Medicare rates as a standard. Originally drafted as a requirement to take

Medicare rates "into consideration," it was ultimately strengthened to provide that the payment could not "exceed" what Medicare would pay.[23]

Because the UPL was viewed as an overall control on spending, the Medicaid program began to rely on it exclusively as a means to measure and manage state payment rates. In effect, the agency's practice was to focus on this regulation to the exclusion of other standards which might have been used to preclude or deny excessive claims. HHS rules on grants administration specify that matching contributions must be "necessary and reasonable for proper and efficient accomplishment of project or program objectives"[24]. Circular A-87, issued by the Office of Management and Budget, sets out general principles for determining allowable costs incurred by states, localities and tribes under grants and agreements with the federal government. The circular states, among other things, that in order for costs to be allowable under federal awards, they must be net of any applicable credits, and be reasonable. The circular defines a reasonable cost as one which "in its nature and amount…does not exceed that which would be incurred by a prudent person…" It also goes on to refer to other factors which should be taken into consideration in order to determine if costs are reasonable: generally recognized as ordinary and necessary; restrained by sound business practices and arms length bargaining; comparable to market prices; consistent with prudence; or not deviating from established practices which might unjustifiably increase the federal government's cost.[25]

The UPL acts more like a budget cap or a "fail-safe" than a tool for encouraging efficiency or ensuring reasonableness, since the payments allowed to any given facility are unrelated to the costs of providing services or to any "fair market value" of the services provided to Medicaid beneficiaries. Nonetheless, over the years, the agency increasingly relied on the UPL as its primary cost containment tool to ensure that states were not "overpaying" providers, particularly public or government owned facilities.

CMS has refined the upper payment limit in response to abuses in which states "paid" government owned facilities amounts up to the UPL, and then had those dollars transferred back to the state. However, it has not established facility specific limits, or established any additional requirements for payments to individual facilities. It has not established a specific methodology for calculating the UPL. Nor has it clarified that the UPL is one method of ascertaining whether costs are acceptable, rather than the sole method.

[23] U.S. General Accounting Office, "Problems in Providing Guidance to States in Establishing Rates of Payment for Nursing Home Care Under the Medicaid Program," Reference Number 096594, April 19, 1972.
[24] 45 Code of Federal Regulations Part 74, Subpart C, section 74.23.
[25] Office of Management and Budget, Circular A-87, "General Principles for Determining Allowable Costs," p. 6.

Determining What Is a Qualified Expenditure: CMS defines expenditures as payments. Payments qualify for match by simply residing in a provider's account for a single moment of time. Despite the State Medicaid Manual's assertion that "federal financial participation is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers," federal officials match both expenditures which reimburse a provider for the cost of providing a service to a Medicaid beneficiary, and ones made only for the sole purpose of generating a federal match and returning immediately to the state. Recognizing this vulnerability, federal officials drafted a regulation more than ten years ago defining an expenditure; as contemplated by federal staff at the time, an expenditure would be calculated as "net of" any intergovernmental transfers made as part of the transaction. Drafted at the same time as the rule limiting provider taxes and donations, it was shelved as representing too much for states to absorb at once.

Determining What Sources Can be Used for the State Share: Medicaid law does contain some limits on revenue sources for states. For example, there are now strict rules which set out how taxes and donations can be structured. In addition, there is an overall limit on the amount of intergovernmental transfers that can be used to fund the state's share of the program, but because of the legitimate role of IGTs in state budgeting and funding it is set at a very high level. There is no specific limit or prohibition on the use of intergovernmental transfers from institutions participating in the Medicaid program.

Consistent Application of Standards: In 2002, CMS created a National Institutional Reimbursement Team (NIRT) to consolidate expertise and ensure timely and consistent response to state plan amendments (SPAs) on institutional reimbursement. The NIRT effectively replaces the prior system of review and approval of such SPAs by individual regional offices, which had created gaps in consistency and communication on these matters. Composed of both central and regional office staff who have experience and expertise in reviewing institutional SPAs, the NIRT is to "assure consistent application of Medicaid institutional reimbursement policy nationally, (and) identify and timely address emerging Medicaid institutional reimbursement issues." After review by the NIRT, the CMSO director communicates with the states on their amendments. This centralization of activity is intended to improve the agency's ability to make timely and consistent decisions on these payment issues.[26] CMSO has also created a similar group for noninstitutional reimbursement.

Possibilities for Reform

Pay No More than Costs to Government Owned Facilities: When states make excessive payments, they are creating "profits" which are available for transfer back to the state for other uses. If the payments made to hospitals or

[26] Centers for Medicare and Medicaid Services, Letter from Dennis Smith to State Medicaid Directors, May 29, 2002.

nursing homes were economical and efficient, and needed by the institutions to recoup their operating costs, no additional margin would be available for transfer. Thus, limiting excessive payments is a key step in strengthening financial standards.

Both the U.S. General Accounting Office and the HHS Office of Inspector General have recommended that payments to government owned facilities be tied to costs. GAO has recommended that Medicaid allow states to reimburse government facilities no more than costs; OIG has recommended that facility specific limits be established based on costs.

Further define economic and efficient: Medicaid can further define the requirement that payments be consistent with economy and efficiency. Similar standards apply when the federal government contracts with private organizations to perform specific functions. Federal contracting generally follows Federal Acquisition Regulations (FAR) and cost accounting standards. The FAR requires that before a contractor can claim a cost, it must be allowable, allocable, and reasonable. A cost is reasonable if "in its nature and amount, it does not exceed that which would be incurred by a prudent person in the conduct of competitive business." [27]

The principles in A-87 could be reasserted to apply generally to any expenditure made by a state Medicaid program and submitted as part of its claim to the federal government. CMS currently applies the provisions of A-87 to administrative claims for Medicaid, and to costs claimed by state survey agencies.

Establish Facility Specific Limits: Because the UPL regulation establishes an aggregate limit, it still allows states to overpay specific facilities, in ways that are unrelated to true needs or costs. The OIG has recommended facility specific limits to address this problem (such as those created to address DSH issues).

Establish General Principles for Reimbursement: Regulatory language could be developed to guide state plan and expenditure review, establishing overarching principles for determining whether expenditures can be matched. One of those principles could be that, notwithstanding any other provision, only expenditures which support program purposes--the provision of covered services by participating providers to eligible beneficiaries--can be matched. (As noted above, similar language currently resides in the State Medicaid Manual.) The OIG has made this recommendation to CMS. To further clarify this requirement, CMS could identify expenditures that have no direct relationship to a provider, service or premium, and eligible beneficiary, which are eligible for match because they support program purposes or are otherwise required by statute (such as DSH, administration, technology).

[27] Federal Acquisition Regulations, 31.201-3.

Another intergovernmental program, the Community Development Block Grant Program, operated by the Housing and Urban Development, uses this approach to ensure that grant funds are distributed appropriately. It has published a series of criteria that it uses to determine which activities to assist. One of its most important criteria, "arguably most important," is to determine if the activity meets one of the program's national objectives.[28]

Currently, leaders of the accounting profession are considering how to implement more general principles in their rules for representing and disclosing accounting transactions. Experts fear that the specificity of rules for accounting in the United States has led to an "ultra-legalistic attitude"[29] and suggest that that one remedy would be an overarching requirement to "place economic substance over form."[30] Medicaid could assert a similar principle as one of its criteria in determining if state expenditures are eligible for federal matching.

Establish Medicaid "Anti-Churning" Rule: As an alternative or an adjunct to focusing on the level of payments made, Medicaid could focus on whether a payment was made at all. If the state knew that the dollars it was directing towards a facility had to remain there in order to generate a federal match, it would be less likely to provide a level of payment in excess of what the facility needed.

To accomplish this, Medicaid would have to better define an expenditure to mean an actual payment rather than an accounting transaction**.** In order to distinguish between a true expenditure and an accounting transaction, the OIG has suggested that CMS treat IGTs as refunds or credits that must be offset against payments. The OIG argued that the UPL regulation should have set the requirement that the facilities receiving enhanced funds retain those funds to support the provision of services to Medicaid beneficiaries, in order to eliminate, and not just limit, program vulnerabilities. CMS could also define that any payment made with a promise to repay represents a pass through rather than expenditure.

Such protections against sham transactions are present in other programs. The Internal Revenue Service, for example, has "anti-churning" rules which are intended to prevent sham transactions from getting favorable tax treatments. Anti-churning rules preclude transferring property to related parties (family members and co-owners, for example) and then reacquiring it in order to obtain certain advantages under the tax code. The IRS states that if the transaction did not result in a significant change of ownership or use, it does not qualify for the tax benefit.[31]

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[28] U.S. Department of Housing and Urban Development, "Guidebook to the Community Development Block Grant Entitlement Program," p. 1-1.
[29] D.R. Myddelton, "Accounting Standards in Crisis? (Part 1)," Credit Control, p. 19.
[30] Robert H. Colson, "FASB Charts a New Course," CPA Journal, February 2003, p. 23.
[31] Internal Revenue Service, "Publication 535: Business Expenses," p. 4.

Further Specify Matching Sources: Coughlin and Zuckerman have suggested that Medicaid specify which sources of revenues it will accept or not accept, expanding the approach which has been largely successful in limiting tax and donation schemes. [32] This approach focuses on ensuring that states invest a "real dollar" into the program in order to get a matching federal dollar. If states are investing real dollars into the program, the overall balance of state and federal interest is restored, and states become reinvested in making best use of the funds.

Publish a UPL methodology: Rather than leaving the decision about how to calculate the UPL up to the states, the OIG has recommended that CMS publish a UPL methodology that must be used by states.

RISK MANAGEMENT

Current Conditions

***Risk Assessment*:** An effective financial management system includes an approach to assessing and managing risks. CMS has made some important improvements in its risk assessment and management approach in the last two years. In 2001, CMS undertook a risk assessment program in which regional and central office financial management staff worked together to identify and rate risk areas. CMS used a number of indicators, including dollars at risk, policy confusion, and prior audit findings to determine which areas represented the greatest risks for the program. The assessment took in areas in which improper payments might be made to providers by states, and to states from the federal government.

Not surprisingly, CMS concluded that one of the greatest risks facing the program involved areas in which states pay their own publicly owned or operated facilities. In most other areas of the program, states and the federal government share the same level of interest in being prudent purchasers and setting rates and payment methodologies with sound fiscal management techniques. In the case of state or locally owned health care providers, schools, prisons, and other government agencies, state and federal interests can diverge.

Risk Mitigation: A second step after risk assessment is risk mitigation. Risk mitigation is a process to develop strategies and approaches to minimize, monitor or accept risks which have been identified, based on the likelihood of occurrence and the impact on the program if failures occur. To address risks that it identified, CMS has embarked on a strategy that includes reinstituting requirements for focused financial reviews carried out by the regions, and contracting with the Office of Inspector General to conduct approximately 15

[32] Coughlin and Zuckerman, "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences," p. 12.

audits this year (most focused on the interaction of DSH and UPL in a number of states). However, in the time CMS has undertaken this risk assessment and management strategy, it has not added any new financial management staff, which significantly impedes the total number, the range and scope, and the timeliness of reviews. The agency was able to secure funding from the Health Care Fraud and Abuse Control account in order to support its contract with the OIG, but this funding source cannot be used to hire federal staff.

In FY 2002, CMS carried out 59 financial management reviews, resulting in over $260 million in questioned FFP. Over half of the questioned amount was refunded to the federal government by December 2002. Eight DSH reviews were conducted to determine if states were complying with the hospital specific limits contained the 1993 legislation. Seven UPL reviews were conducted to determine if states were computing UPL appropriately and complying with new regulations. The value of such reviews lies not just in identifying disallowances (in fact, few disallowances were taken in these areas) but also in providing feedback on policy issues and programmatic vulnerabilities, and in elevating the attention of both states and federal staff.

Possibilities for Reform

Focus on "Related Party" Transactions: CMS could focus on developing controls and higher standards for high risk transactions, such as those involving government owned facilities. Auditing standards emphasize the importance of examining related party transactions, defined as transactions between parties with family or business ties.[33] Negotiations and transactions between disinterested and unrelated parties are assumed to be carried out with each party acting strictly in her or his best interest, at "arm's length" from each other. The self-interest of each party acts as a control on the transaction. Because this may not be true in the case of related parties, such transactions receive stricter scrutiny.

As CMS has already determined during its 2001 risk assessment, states and publicly funded providers share interests in ways similar to those shared by related parties. Thus, CMS could decide to build on its work in 2002 and further increase reviews and audits in this area. It could also establish a stricter definition of "economy and efficiency" for those specific kinds of transactions, in light of the higher risks of excessive payment.

Audit all supplemental payments: Supplemental payments, such as those made under the DSH and UPL programs, are high risk transactions. CMS could review all such payments to ensure that limits are being applied correctly, or (in light of resource constraints) require detailed, provider based reporting on these

[33] U.S. General Accounting Office/President's Council on Integrity and Efficiency, "Financial Audit Manual: Exposure Draft," Volume 2, GAO-01-281G, p. 1006-1.

transactions. The OIG has recommended to CMS that it conduct reviews of how the states have calculated the UPL.

Dedicate staff to reviewing high risk transactions: Because the number of financial management staff is so low, and so many of their duties are driven by state submissions, it is difficult to carve out protected space for careful and proactive reviews of high risk areas. States submit quarterly expenditure reports and plan amendments that must be addressed by CMS staff within specified timeframes. In 2002, the federal Medicaid director determined that he would require regional offices to devote resources to proactive financial management reviews at one review per full-time equivalent in the regional office's Medicaid financial management section. CMS could build on this important effort by actually assigning dedicated staff (similar to the NIRT) devoted to carrying out these kinds of reviews.

Reduce staff and emphasis on low risk transactions: One of the important points about the assignment of staff to high risk areas is the corollary that low risk, low return areas receive proportionately less attention and review. CMS should ensure that it resists the temptation to assign staff to these areas, accepting the result that small leakage will inevitably occur in those areas. CMS' decision over the past several years to deemphasize quality monitoring of eligibility decisions is an example of how an agency can appropriately avoid investment in low risk, low impact areas, when resources are needed to address much higher risk, higher impact areas.

Emphasize the "Do It Right" philosophy: When Medicare launched an aggressive program integrity effort in the late 1990s, it emphasized the message of "Pay it Right" in order to assure health care providers that it wanted to make accurate payments, not just reduce those errors that cost the federal government money. A similar approach is important here, to emphasize the federal government's interest and intention in matching all appropriate claims from states.

INFORMATION AND MONITORING

Current Conditions

State Plan Data: Information from states on their payment approaches varies in detail and usefulness to federal officials, and there has been little direction from the federal government on which data to supply in order to receive plan amendment approvals. For many years, states have only needed to provide the most general information on their payment methodologies and assure the federal government that they adhere to the UPL in order to receive approval on their state plans. Further, key information from state plan amendments are not entered into financial management or general management information systems, in a way that allows the data to be easily accessed, reviewed and analyzed.

(State plan amendments are published on the web in narrative form; key data for tracking purposes are entered into a management information system, but the data are not detailed.) States have not been required to describe the disposition of payments, although a number do.

CMS now requires states to provide certain financial data when submitting amendments for approval, so that information is captured consistently about financial transactions and impact for every amendment under review. This is a welcome development in ensuring that full and complete information is provided to the federal government as part of states' submissions. Managed carefully so as not to impose the unnecessary burden of providing repetitive information, or of overloading CMS with irrelevant information, this process could represent a useful step toward improving federal understanding and oversight of state finances.

Expenditure Reports and Claims Data: CMS collects a significant amount of data from states on their expenditures, through the CMS-64 and later through claims level data submitted to the program. Revenue sources are not reported (other than provider taxes and donations), and the infrastructure does not currently support easy access and analysis of claims level data. CMS, for example, is concerned that double payments may be being made between the DSH and UPL programs (and as indicated above, has sought out the assistance of the OIG in understanding this issue), but the expenditure data is not refined enough to allow provider-based analysis of various payment streams and transfers. Although the current systems have worked well for getting money to states, and expenditure and claim data back, they are not accounting systems able to provide detailed understanding of state level transactions. In addition, while states have 30 days after the end of the quarter to submit their expenditure reports, they have up to two years afterwards to make corrections or additions. Certified Public Expenditures (CPEs) that represent resource uses in public facilities like schools may particularly lag in reporting. Finally, CMS has encountered problems in getting claims and then making it available to users in a timely manner, due to a series of problems at the state and federal level.

CMS hopes to use a portion of HCFAC funding in 2004 to begin work on a financial systems redesign project. The importance of beginning this effort immediately cannot be overstated. A redesigned system would eliminate extraneous data collection, thereby easing burdens on states, better focus on actual financial data CMS can use to oversee the program, and provide public accountability.

Possibilities for Reform

Redesign CMS' Medicaid information systems to collect key financial data from states: As indicated above, CMS is currently considering how to strengthen its Medicaid financial management systems and has plans to begin a

systems redesign effort. As part of this process, it should focus on both the timeliness of data and the ability of the system to provide key real-time or near-time financial performance data on state income sources, payments to public providers, supplemental payments, CPEs, and beneficiaries served.

Report on Effective Matching Rates: CMS could also assess how such data could be made available to the public and serve a wider audience for greater accountability. CMS issues a number of reports on Medicaid, including reports on state expenditures; but as referenced above, it does not collect the necessary data for the agency to report consistently, accurately and timely on intergovernmental transfers and revenue sources in general. Such data is critical to understanding the true extent of state investment in the Medicaid program.

In 2002, Coughlin and Zuckerman estimated effective matching rates for 23 states by subtracting an amount they estimated did not "represent real health care spending." They used data from OIG reports and an Urban survey of states to do their calculations. Using these data, Coughlin and Zuckerman estimated that these states effectively increased their federal match from an average of 56 percent to 59 percent.[34] With more detailed and targeted data, CMS could assess the true level of health care spending for Medicaid in states and the impact on federal matching. The calculations could form the basis for annual publication of effective matching rates.

Complete effort to collect key financial data on amendments: CMS should continue its efforts to require states to provide accurate answers to key financial questions for each amendment submitted. CMS could also make inclusion of those answers part of the requirements for public disclosure of rate setting methodologies by states. After the first six months of experience with this process, CMS should review whether less, additional or different data is required to support informed federal decisionmaking.

ENFORCEMENT

Current Conditions

Remedies: Enforcement is a very difficult issue in intergovernmental programs. Typical enforcement strategies that may work for nongovernmental entities do not apply. The whistleblower provisions of the Federal False Claims Act, which provide mechanisms for fighting fraud against the federal government and which have been so instrumental in fighting fraud in federal defense and health programs, do not apply to states. There are no intermediate sanctions available, such as civil money penalties (CMPs). States cannot be excluded or debarred. Virtually the only risk that states run in developing such arrangements is that they

[34] Coughlin and Zuckerman, "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences," p. 9 and appendix A.

will eventually have to pay back the money they should never have received in the first place.

Rewards: On the other hand, these modest risks are offset by substantial rewards that await the states that engage in these practices. The politics of power and interest work to the advantage of these states. Rather than fearing penalties, states are often confident that they will prevail in protecting their arrangements, particularly if a large number of them are engaged in the practice. Even after steps are taken to limit arrangements, states often have reason to hope for stays. In 2002, as they developed their budgets, some states assumed additional federal funds would flow to them as a result of increased matching rates or an easing of UPL reforms.[35]

Levels of accountability: Certifications of claims and data provided are important to an effective financial management strategy for personal accountability. Certifications of claims and information increase confidence in their accuracy. If ultimately determined to be false, such assurances provide an avenue of enforcement against the certifying individual or institution. The CMS-64 is a certified form, and contains statements that the information is accurate and complies with applicable rules. The state has some discretion on who will sign it (the executive officer or designee). There are no certifications made by federal employees when they approve plan amendments or expenditure reports, which is a typical arrangement.

Possibilities for Reform

In general, the ability of the federal government to institute effective enforcement strategies against states is limited. Other than taking disallowances, few tools are likely to be made available to the federal government. For this reason, prevention and monitoring to protect against losses, and quick action before states become overly dependent on questionable revenue streams, is absolutely essential.

Institute other remedies: In a draft report to CMS, the HHS OIG recommended that the agency pursue authority for CMPs to impose on states. CMS disagreed with the recommendation, saying that it would harm the federal-state working relationship, and the OIG withdrew it.[36] Nonetheless, the concept may continue to merit discussion, given the small number of tools available to CMS to address abuse and the limited exposure of states who engage in such practices. In order to be most credible, the CMP authority could reside in the HHS OIG, which has experience in applying sanctions. CMPs could represent an alternative or

[35] John Holahan et al., "The State Fiscal Crisis and Medicaid: Will Health Programs be Major Budget Targets?", Kaiser Commission on Medicaid and the Uninsured, January 2003, p. 11.
[36] U.S. Department of Health and Human Services, Office of Inspector General, "Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers," p. 16.

adjunct to negotiating settlements on large disallowances. They could also represent a remedy in cases where states are denying claims or applications inappropriately (demonstrating the federal government's commitment to "do it right").

Increase executive level accountability: The certification of accounts by Chief Executive Officers was one of the first reforms implemented in the wake of the Enron and WorldCom accounting scandals. The Securities and Exchange Commission required CEOs to certify that their accounts were accurate by August 2002. To increase executive accountability over financial data submitted to the program, and financial decisions within the agency, Medicaid could require that Governors, State Medicaid Directors and CMS Administrators certify financial data and decisions, increasing the level of personal accountability they have in the program's operations.

Increase the accountability of other actors: States sometimes contract with consultants to help them maximize their federal claiming. These consultants presently face few, if any, risks, if their recommendations to states result in practices that jeopardize the financial integrity of the Medicaid program. Steps could be taken to hold these actors accountable for their participation in questionable activities, such as using a CMP authority to sanction them for their contribution to inappropriate claiming. The federal government could also reduce the incentives for consultants or advisors to provide overly aggressive advice to states by prohibiting contingency-based fee arrangements, in which consultants are paid a percentage of the claims submitted to and paid by the federal government. Recently controversy has arisen over such an arrangement in Georgia, resulting in a substantial windfall for the contractor.[37]

Increase levels of approval and scrutiny for states with history of questionable claiming: CMS can also increase the required signoffs, level of detail, and scrutiny applied to prospective state plan amendments, waivers, and other action items submitted by states with high levels of disallowances or questionable claiming.

CONCLUSION

The long term financial health of Medicaid and the integrity of the federal-state partnership demand attention to financial management and controls. States' use of the upper limit payment to generate federal matching without actual state expenditures, in addition to earlier, similar problems with states' use of taxes and donations and the DSH program, point to shortcomings in the programs' financial management.

[37]Andy Miller, "State's funds pursuit costly," The Atlanta Journal Constitution, September 29, 2003.

Piecemeal, issue-specific, reactive fixes are not sufficient to provide confidence in the future. At the same time, it is not necessary to abandon the matching formula altogether.

The program can be significantly strengthened with targeted reforms to improve cultural commitment, standards and requirements, risk assessment and management, reporting and disclosures, and enforcement. These steps have the real potential to place Medicaid on par with other public and private programs, without undermining the financing structure that provides important benefits and protections to states and beneficiaries.

The current pressures on the federal and state budgets might suggest to some that this is not the right moment to institute strict financial controls that might reduce the flow of federal dollars to some states. The counterargument to that view is that, when resources are scarce at both the federal and state levels, the need to ensure that federal contributions are made for legitimate expenditures and purposes is greatest. Further, states facing fiscal strains will find it difficult to resist loopholes. States may feel compelled to follow the example of one Virginia city, which had previously refused to participate in a UPL program because it considered the mechanism unethical, but finally relented last year, saying it needed the money too badly to stand on principle.[38]

Though this paper has attempted to lay out a long list of options and approaches for program managers to consider, not all the steps discussed above are equally viable, important or necessary. Medicaid officials should discuss these ideas, identify the most promising, and generate other thoughts, through a dialogue with the states and responsible HHS, OIG, GAO officials. It is most important that Medicaid commit to the actions all parties agree will have the most beneficial effect in each of dimensions critical to effective financial management.

This paper was prepared for the Kaiser Commission on Medicaid and the Uninsured by Penny Thompson, an independent consultant who has served as the Deputy Director of the Center for Medicaid and State Operations for Centers on Medicare and Medicaid Services and CMS' Director of Program Integrity, and has also worked on Medicaid and Medicare program integrity issues in the Office of Inspector General of the Department of Health and Human Services. For further information, please contact the Kaiser Commission on Medicaid and the Uninsured at (202) 347-5270.

[38] Meredith Kruse, "Norfolk agrees to use U.S. Medicaid loophole," Virginian-Pilot, April 3, 2003, p. B-9.

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