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Medicaid Maximization and Diversion: Illusory State Practices that Convert Federal Aid into General State Revenue

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Medicaid Maximization and Diversion: Illusory State Practices that Convert Federal Aid into General State Revenue

*Daniel L. Hatcher**

CONTENTS

I. MEDICAID PROGRAM STRUCTURE AND REVENUE MAXIMIZATION	
CONSULTANTS	1227
II. MEDICAID REVENUE STRATEGIES	1229
<i>A. Intergovernmental Transfers: State “Spending” Sleight of Hand</i>	1229
<i>B. Upper Payment Limits: Federal Effort to Reduce Medicaid Schemes Turned into Mechanism for Expanded Medicaid Schemes</i>	1231
<i>C. “Quality Assessment Fees,” a.k.a. “Bed Taxes”</i>	1235
<i>D. School-Based Medicaid Maximization Strategies</i>	1240
<i>E. Nursing Home Revenue Maximization Strategies.....</i>	1245
1. Nursing Homes Used in IGT, UPL, and Bed Tax Schemes	1245
2. Municipal Agency Purchasing Nursing Homes to Take Their Federal Aid.....	1250
<i>F. Audits Unable to Keep Up with the Schemes</i>	1255
III. CONFLICT WITH STATUTORY PURPOSE	1257
CONCLUSION: RESTORING PURPOSE TO THE MEDICAID PROGRAM ...	1258

For years, states have been using illusory schemes to maximize federal aid intended for Medicaid services—and then often diverting some or all of the resulting funds to other use.¹ And states have help. Private revenue maximization consultants are hired by states to increase

* Professor of Law, University of Baltimore; J.D. 1996, University of Virginia School of Law. I would like to thank the organizers of the Seattle University School of Law’s 2016 Poverty Law Conference on Academic Activism for the opportunity to present an earlier draft of this Article, where I benefitted from excellent comments and discussion.

1. See DANIEL L. HATCHER, *THE POVERTY INDUSTRY: THE EXPLOITATION OF AMERICA’S MOST VULNERABLE CITIZENS* ch. 5 (2016) [hereinafter HATCHER, *THE POVERTY INDUSTRY*].

Medicaid claims, often for a contingency fee. We do not know the exact amount of federal Medicaid funds that has been diverted to state revenue and private profit each year, but it is in the billions.²

The states' revenue strategies take advantage of the matching-grant structure of the Medicaid program. When state funds are spent on eligible health care services, the state can then claim federal Medicaid matching funds—intended to increase the amount of money available for the Medicaid services. For example, Maryland has a fifty percent match percentage for the Medicaid program.³ So when Maryland spends \$500 dollars on eligible services, the state can claim another \$500 from the federal government—for a total of \$1,000 intended for health care for the poor.

Unfortunately, the revenue strategies developed by states and their contractors often subvert the intended match structure by claiming federal Medicaid matching grant funds without any actual state spending. A state might use budget maneuvers such as providing funds to a hospital serving the poor while simultaneously requiring the hospital to give the money back.⁴ Although no state spending actually occurs, the state may still use the round-trip of state money to claim the federal matching funds. In addition to the illusory nature of the claims, much of the resulting federal aid funds are then often diverted into general state coffers rather than used for Medicaid purposes. The U.S. Government Accountability Office (GAO) explains: “[W]e designated Medicaid to be a program at high risk of *mismanagement, waste, and abuse*, in part due to concerns about states' use of inappropriate financing arrangements.”⁵

In a time when Democrats and Republicans are seemingly unable to agree on anything, states have reached bipartisan political consensus on the practice of taking aid funds from the poor. Because an anti-tax climate exists in both red states and blue states, the states have looked elsewhere for revenue and Medicaid maximization schemes have become increasingly common. A 2007 GAO report explains the scope:

GAO has reported for more than a decade on varied financing arrangements that inappropriately increase federal Medicaid matching payments. In reports issued from 1994 through 2005, GAO found that some states had received federal matching funds by paying cer-

2. See *infra* notes 182–189.

3. Federal Financial Participation in State Assistance Expenditures, 79 Fed. Reg. 71426 (Dec. 2, 2014).

4. See *infra* notes 20–27.

5. DR. MARJORIE KANOF, U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-255T, MEDICAID FINANCING: LONG-STANDING CONCERNS ABOUT INAPPROPRIATE STATE ARRANGEMENTS SUPPORT NEED FOR IMPROVED FEDERAL OVERSIGHT 7 (2007) (emphasis added), available at <http://www.gao.gov/assets/120/118488.pdf>.

tain government providers, such as county operated nursing homes, amounts that greatly exceeded established Medicaid rates. States would then bill [the Centers for Medicare and Medicaid Services] for the federal share of the payment. However, these large payments were often temporary, since some states required the providers to return most or all of the amount. States used the federal matching funds obtained in making these payments as they wished. Such financing arrangements had significant fiscal implications for the federal government and states. *The exact amount of additional federal Medicaid funds generated through these arrangements is unknown, but was in the billions of dollars.*⁶

Irony also exists in state practices regarding Medicaid funds. While using strategies to divert the federal aid from its intended purpose, states are also seeking to reduce Medicaid fraud at the state level. States have increased their efforts to prosecute doctors and other health care providers who use false and illusory claims for the Medicaid funds from the states. However, while trying to deter the fraudulent practices of health care providers seeking to misuse Medicaid funds from the states, the states continue to use their own illusory practices to divert Medicaid funds from the federal government.

Part I of this Article sets out the structure of the Medicaid program and describes states' use of revenue maximization contractors to assist in their Medicaid revenue strategies. Part II describes details of the numerous revenue strategies states have developed to claim increased federal Medicaid funds through illusory means and how the funds are then diverted to state revenue. In Part III, the Article describes how the revenue practices conflict with the statutory purpose of the Medicaid program. The Article concludes with suggestions to curb the illusory revenue strategies and to better ensure that Medicaid funds truly assist the vulnerable populations in need of such services.

I. MEDICAID PROGRAM STRUCTURE AND REVENUE MAXIMIZATION CONSULTANTS

Congress enacted the Medicaid program in 1965 “to make medical services for the needy more generally available.”⁷ Medicaid is the largest federal grant-in-aid program, accounting for forty percent of total federal funds provided to states.⁸ Medicaid is often described as an entitlement program and includes two forms of entitlements: individuals who meet

6. *Id.* at ii (emphasis added).

7. S. REP. NO. 89-404, at 66 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 2014.

8. Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 10–11 (2006).

the Medicaid eligibility requirements are entitled to coverage, and states are entitled to federal matching funds after spending state funds on eligible services for enrolled individuals.⁹ Individuals enrolled in the program do not directly receive any Medicaid payments to pay for their health care. Instead, when a health care provider provides an individual with Medicaid-eligible services, the provider will then bill the state Medicaid agency for the services.¹⁰ It is those state payments to the health care providers that then entitle the states to federal matching payments. States can seek matching funds for the medical services and can also seek federal Medicaid funds for various administrative costs.

Structured under the economic theory of fiscal federalism, state agencies run the Medicaid programs and the federal government provides funding assistance and regulatory oversight.¹¹ States that spend their own funds on Medicaid services can receive match payments from the federal government to increase their total health care spending for low-income residents.¹² The match percentage states receive from the federal government is based on a formula called the federal medical assistance percentage (FMAP). The FMAP varies based on the relative wealth of each state.¹³ For example, Massachusetts has a fifty percent FMAP and Mississippi has an FMAP of almost seventy-five percent (meaning, if Mississippi spends \$25 on eligible services, the state can claim \$75 in federal Medicaid matching funds).¹⁴

The federal matching funds are also described as federal financial participation (FFP) and are designed to encourage states to spend more state funds on eligible services.¹⁵ If a state spends more of its own funds on covered services, the state can claim more federal matching funds at the state's associated FMAP.

Private revenue maximization consultants often help states with Medicaid claiming at every stage of the process—seeking to both increase the federal matching funds while also decrease payouts to health care providers. Some health care providers, such as hospital systems, will also hire their own revenue maximization consultants to help increase

9. ANDY SCHNEIDER ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE MEDICAID RESOURCE BOOK 87 (2002), available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/05/mrbintro.pdf>.

10. *Id.* at 100.

11. Daniel L. Hatcher, *Poverty Revenue: The Subversion of Fiscal Federalism*, 52 ARIZ. L. REV. 675, 682–87 (2010) [hereinafter Hatcher, *Poverty Revenue*].

12. SCHNEIDER ET AL., *supra* note 9, at 86.

13. *Id.* at 94.

14. Federal Financial Participation in State Assistance Expenditures, 79 Fed. Reg. 71426 (Dec. 2, 2014).

15. SCHNEIDER ET AL., *supra* note 9, at 86.

Medicaid payments from the states.¹⁶ Then, the states often hire private contractors to audit the claims from health care providers—seeking to reduce incorrect or fraudulent payouts.¹⁷ As the states hire contractors to reduce Medicaid payments to providers, the states often simultaneously hire contractors to maximize their claims for Medicaid matching funds from the federal government.¹⁸ While the states use contractors to claim federal Medicaid funds, the federal government in turn often hires private contractors to audit Medicaid claims—and additional contractors are often available to help respond to audits.¹⁹

II. MEDICAID REVENUE STRATEGIES

Often encouraged by their revenue maximization consultants, states have concocted numerous strategies to increase claims for federal Medicaid matching funds. The schemes vary in detail but include a common illusory theme: money is moved around to create the appearance of state spending in order to claim matching funds from the federal government, but no state spending actually occurs. And once the federal Medicaid dollars are claimed, the states often reroute the federal aid from Medicaid purposes to general state coffers. These revenue strategies create harm because they divert funds from those in need and undermine the intended partnership between the federal government and states in funding the Medicaid program. This Part describes several of the states' revenue maximization schemes: intergovernmental transfers, upper payment limits, quality assessment fees (or "bed taxes"), school-based Medicaid maximization, and nursing home revenue strategies. Further, this Part explains how federal government audit attempts have failed to keep up with these revenue strategies.

A. Intergovernmental Transfers: State "Spending" Sleight of Hand

States and their contractors have frequently used a category of Medicaid financing strategies termed "intergovernmental transfers" or IGTs. The IGT mechanism provides for a round-trip of state funds. For example, a state could provide a large payment to a health care provider—such as a Disproportionate Share Hospital (DSH), which serves a larger share of the poor than other hospitals. Such payment allows the state to claim federal Medicaid matching funds that are intended to be combined with the state spending on Medicaid services. However, once the federal match is claimed, the state might require the health care pro-

16. Hatcher, *Poverty Revenue*, *supra* note 11, at 687.

17. HATCHER, *THE POVERTY INDUSTRY*, *supra* note 1, at 34–35.

18. *Id.*

19. *Id.*

vider to immediately return the initial state payment through an IGT. Thus, no state spending actually occurs, but the state retains the federal matching funds that result from this sleight of hand. The GAO describes the strategy as follows:

In particular, these arrangements create the illusion that a state has made a large Medicaid payment . . . which enables the state to obtain a federal matching payment. In reality, the large payment is temporary, since the funds essentially make a round-trip from the state to the Medicaid providers and back to the state. As a result of such round-trip arrangements, states obtain excessive federal Medicaid matching funds while their own state expenditures remain unchanged or even decrease.²⁰

States have been using this IGT scheme for over twenty years. For example, in 1993, Michigan made payments of \$122 million to county health facilities.²¹ Such payments triggered the claiming of \$155 million in federal Medicaid matching funds, for a total of \$277 million intended for Medicaid services by the health facilities.²² But on the very same day of the state payments to the health care facilities, the facilities transferred \$271 million back to the state.²³ Thus, the health care facilities only retained \$6 million—rather than the intended \$277 million—and the state gained \$149 million in general revenue by the illusory practice (\$271 million less \$122 million initial state payment).²⁴

Some states have even forced counties to carry out the IGT strategy using bank loans. The counties took out bank loans, wired the money to the states, and the states would provide the money right back to the counties—but this time as “Medicaid payments.”²⁵ Once receiving the payments, the counties repaid the bank loans, and the states claimed and retained all the federal Medicaid matching funds.²⁶

These financing schemes have not gone unnoticed by the federal government, but states and their revenue maximization consultants have stayed one step ahead of any federal effort to clamp down on the practices. The GAO explains, “As various schemes involving IGTs have come

20. KATHRYN G. ALLEN, U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-04-574T, MEDICAID: INTERGOVERNMENTAL TRANSFERS HAVE FACILITATED STATE FINANCING SCHEMES 5 (2004), available at <http://www.gao.gov/new.items/d04574t.pdf>.

21. *Id.*

22. *Id.*

23. *Id.* at 6.

24. *Id.*

25. *Id.*

26. *Id.*

to light, Congress and CMS have taken actions to curtail them, but as one approach has been restricted, others have often emerged.”²⁷

B. Upper Payment Limits: Federal Effort to Reduce Medicaid Schemes Turned into Mechanism for Expanded Medicaid Schemes

As the federal government attempted to reduce the illusory financing schemes, states just created new strategies—even finding ways to exploit federal efforts to limit Medicaid claims. For example, the federal government started setting limits, called Upper Payment Limits (UPLs), on how much it will pay to match state Medicaid spending on eligible health care facilities. The UPLs are an attempt by the federal government to reduce states’ excessive and illusory claiming of federal Medicaid funds.²⁸ But states and their contractors have turned the UPLs on their heads, using the mechanisms intended to reduce inappropriate Medicaid claims as a significant part of expanded illusory practices.²⁹

A hypothetical nursing home payment structure can help shed light on how states use the UPLs in their revenue strategies. The federal government might set a \$150 UPL on a day of nursing home care. In response, the state may significantly undercut the limitation—setting its payment rate for nursing homes to only \$100 per day, as the cost for the actual services provided to a nursing home resident who is eligible for Medicaid. Then, the state can exploit the \$50 gap between the UPL and actual state payments.

To exploit the gap and carry out the UPL revenue scheme, the state could provide a supplemental (or enhanced) payment that is greater than the actual cost of medical services provided to a Medicaid beneficiary (which is the state’s normal Medicaid payment rate). The supplemental payment can be the amount between its normal payment and the UPL (so a \$50 supplemental payment based on the example above). The state then claims federal Medicaid matching funds for the supplemental payment, forces the nursing home to return the supplemental payment to the state in the form of an IGT (since the supplemental payment is not for the actual cost of medical services), and the state keeps the federal matching funds.³⁰

27. KATHRYN G. ALLEN, U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-05-836T, MEDICAID: STATES’ EFFORTS TO MAXIMIZE FEDERAL REIMBURSEMENTS HIGHLIGHT NEED FOR IMPROVED FEDERAL OVERSIGHT 7 (2005), available at <http://www.gao.gov/assets/120/111839.pdf>.

28. KATHRYN G. ALLEN, U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-04-228, MEDICAID: IMPROVED FEDERAL OVERSIGHT OF STATE FINANCING SCHEMES IS NEEDED 7–10 (2004), available at <http://www.gao.gov/assets/250/241469.pdf>.

29. *Id.*

30. Teresa A. Coughlin et al., *States’ Use of Medicaid UPL and DSH Financing Mechanisms*, 23 HEALTH AFF. 245, 246–47 (2004).

As with the traditional IGT strategies, the UPL scheme has allowed states to claim federal Medicaid matching funds without any actual state spending. Medicaid funds are supposed to be used for Medicaid purposes, not for other state needs such as paying for a state's education system, but states often use federal funds for other purposes. Oregon, New York, and Texas provide examples. Oregon's Legislative Fiscal Office explains its UPL strategy in detail:

The federal Medicaid Upper Payment Limit (MUPL) program allows states to pay publicly affiliated nursing facilities a rate equal to the maximum Medicare rate for all Medicaid nursing facility clients in the state when the Medicare rate exceeds the rate the state would otherwise pay for Medicaid clients. This lets Oregon claim additional federal revenue at no added General Fund cost. The Department of Human Services (DHS) implements the plan by making payments of General Fund and Federal Medicaid Funds to nine public health districts that operate nursing facilities. The health districts immediately give all or most of the payment to the state through an intergovernmental transfer. After the health districts transfer the payment back to DHS, DHS deposits the Federal Funds portion of the original payment into a special MUPL account as Other Funds. These funds can be used to finance legislatively approved programs.³¹

In summary, Oregon uses general fund money to make supplemental payments beyond the actual costs of medical care to nursing facilities in order to trigger the additional federal matching funds. The nursing facilities "immediately give all or most of the payment [back] to the state through an intergovernmental transfer."³² Then the state pockets the additional federal funds.

When Oregon first established this revenue strategy, it funneled all federal Medicaid funds into the state's general revenue. In 2001, the state established targeted purposes for the MUPL account, but the bulk of the money was to be used for the state's education system.³³ A state document explains that for the biennial budget beginning in 2001, the financing strategy would result in approximately \$227.3 million in new federal Medicaid funds, and approximately ninety percent was to be rerouted away from Medicaid services to the state's education system.³⁴ Thus, Oregon's maximization and diversion of federal Medicaid funds could

31. PEGGY ARCHER, OR. LEGISLATIVE FISCAL OFFICE, BUDGET INFORMATION BRIEF/2001-4: MEDICAID UPPER PAYMENT LIMIT (2001), available at https://www.oregonlegislature.gov/lfo/Documents/bb2001_4.pdf.

32. *Id.*

33. *Id.*

34. *Id.*

allow the state to free up state dollars that would have otherwise been required for education spending.³⁵

While some states like Oregon use the Medicaid funds resulting from such strategies for targeted non-Medicaid purposes, other states are even more aggressive in their deceit—using federal aid resulting from illusory schemes to claim even more federal aid using illusory schemes. By recycling the federal funds to claim more federal funds, these states have essentially developed a Ponzi scheme like that infamously used by Bernie Madoff. In fact, while New York prosecuted Madoff, the state had already employed a Madoff-like UPL strategy: “Funds generated by the state’s UPL arrangement were deposited into its Medical Assistance Account. Proceeds from this account were used to pay for the state share of the cost of Medicaid payments, effectively recycling federal funds to generate additional federal Medicaid matching funds.”³⁶

Hypocritical actions such as those in New York can be found elsewhere, including Texas. It is not uncommon for politicians in Texas to express their dislike for federal aid programs, and former Governor Rick Perry is no exception. However, from 2008 to 2013, Perry used illusory IGT and UPL strategies like those described above to divert over \$1.7 billion in federal Medicaid matching funds to his general coffers.³⁷ The intent of Medicaid’s matching structure is for states and the federal government to share in the cost of Medicaid services. But through Perry’s schemes, “Texas contributes no money and instead forces the state hospitals to provide the state’s contribution, then takes the federal contribution for the general fund.”³⁸

35. *Id.*

36. DR. MARJORIE KANOF, U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-08-255T, MEDICAID FINANCING: LONG-STANDING CONCERNS ABOUT INAPPROPRIATE STATE ARRANGEMENTS SUPPORT NEED FOR IMPROVED FEDERAL OVERSIGHT 9 (2007), available at <http://www.gao.gov/assets/120/118488.pdf>.

37. SUSAN COMBS, TEX. COMPTROLLER OF PUB. ACCOUNTS, THE 2008-09 CERTIFICATION REVENUE ESTIMATE, available at http://www.texastransparency.org/State_Finance/Budget_Finance/Reports/Certification_Revenue_Estimate/cre0809/cre08.pdf (estimating 439.3 million in general fund revenue from the disproportionate share hospital program); TEX. COMPTROLLER OF PUB. ACCOUNTS, THE 2010-11 CERTIFICATION REVENUE ESTIMATE, available at http://www.texastransparency.org/State_Finance/Budget_Finance/Reports/Certification_Revenue_Estimate/cre1011/text.php (estimating 595 million in general fund revenue from the disproportionate share hospital program and upper payment limit program); TEX. COMPTROLLER OF PUB. ACCOUNTS, THE 2012-13 CERTIFICATION REVENUE ESTIMATE, available at http://www.texastransparency.org/State_Finance/Budget_Finance/Reports/Certification_Revenue_Estimate/cre1213/text.php (estimating 669 million in general fund revenue from the disproportionate share hospital program and upper payment limit program).

38. Harvey Rice, *State Takes Charity Care Money from UTMB*, HOUS. CHRON. (Mar. 31, 2013, 10:53 PM), <http://www.houstonchronicle.com/news/houston-texas/houston/article/State-takes-charity-care-money-from-UTMB-4398633.php>.

Texas's diversion of federal Medicaid funds from the intended Medicaid services harmed the intended beneficiaries of the funds: "The practice discourages state hospitals from treating the poorest Texans."³⁹ The funds were intended for hospitals serving the poor, but Texas took the money for its general coffers. With less aid funds, the state hospitals like the University of Texas Medical Branch had no choice but to reduce health care for the poor; the hospital "dramatically reduced the number of uninsured patients it cared for . . . dropping from 3,182 in 2008 to 233 in 2011."⁴⁰

The GAO, the federal government watchdog organization, explains the illusory nature of the revenue schemes such as those used in Texas. The GAO states the simple fact that Medicaid funds should be used for Medicaid purposes: "The U.S. Government Accountability Office, however, believes the money should be used for its intended purpose. 'Our position is that Medicaid payments should be made for Medicaid services made to Medicaid patients,' said Katherine Iritani, GAO director for health care issues."⁴¹

Concern regarding UPL revenue strategies is not new. The federal government has attempted for well over twenty years to clamp down on the illusory state schemes. But the practices continue to grow—and the numbers are not small. In 2011 alone, states reported making at least \$43 billion in supplemental payments (with \$26 billion from UPL payments)—which represented over a thirty-four percent increase from \$32 billion in 2010.⁴² And such supplemental payments are the type used in the UPL schemes.

The federal government does not sufficiently monitor the states regarding how they use these revenue maximization mechanisms or how they use the federal matching funds intended for Medicaid services. The GAO explained in 2012 that "[w]e and others have raised concerns about the need for improved transparency regarding the size of the payments and who receives them, as well as the need for improved accountability regarding how the funds are related to Medicaid services."⁴³

Further, states are reacting to an incentive built into the UPL Medicaid maximization efforts—and their reaction is not good. If states reduce the amount of their regular payments to health care providers—and therefore reduce the quality of care—they can increase their exploitation

39. *Id.*

40. *Id.*

41. *Id.*

42. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-13-48, MEDICAID: MORE TRANSPARENCY OF AND ACCOUNTABILITY FOR SUPPLEMENTAL PAYMENTS ARE NEEDED 2 (2012), available at <http://www.gao.gov/assets/660/650322.pdf>.

43. *Id.*

of the UPL strategies to divert more federal funds. Because states exploit UPLs by making supplemental payments between the gap of the UPL set by the federal government and the state payment amounts normally given to health care providers, if the states reduce their regular payment amounts, the gap will increase. The bigger the gap, the larger the supplemental payments and the greater the amount of federal Medicaid matching funds claimed (and often diverted). Evidence unfortunately indicates that such a result is occurring. The GAO has reported that states are greatly increasing the amounts of these UPL payment strategies in recent years, and “[a]t the same time, we have reported that many states have reduced regular Medicaid payment rates in response to budgetary pressures.”⁴⁴

C. “Quality Assessment Fees,” a.k.a. “Bed Taxes”

States use another form of revenue strategies to maximize federal Medicaid funds: tax schemes commonly called “bed taxes.” The strategies are often labeled with more positive sounding terms such as “provider assessments,” “federal reimbursement allowances,” “Medicaid enhancement,” and “quality assessment fees.”

The bed taxes are similar to IGT strategies, but the initial funding comes from the health care providers. With IGTs, states provide payments to the providers and then the providers send the money right back to the states—and the illusory payments are used to claim federal Medicaid matching funds. With bed taxes, the health care providers are taxed to raise the state money for the illusory spending.⁴⁵ For example, a state could initiate a new tax on a health care facility, such as a nursing home (called a bed tax because the tax is based on the number of beds used for patients by the health care facility). The state places the tax dollars in a state trust fund for uncompensated care and claims the money as state Medicaid spending, triggering federal matching funds. Then, the state may pay the nursing home back for some, or all, of the cost of the bed tax through either direct payments or increased state Medicaid payment rates (so the taxes can often be temporary).

Some states use the increased federal Medicaid funds from such bed tax strategies for health care purposes—including increasing payments to health care providers. But other states use much of the federal aid as general state revenue—such as Wisconsin, which diverted \$13.8

44. *Id.* at 5 n.19.

45. See HATCHER, *supra* note 1, at 119–20.

million annually in bed tax scheme revenue from nursing homes into general revenue.⁴⁶

Mitt Romney used an identical scheme when he was governor of Massachusetts. Romney denounced federal aid in his past campaign for the presidency, including his “47 percent” comments about people on government assistance.⁴⁷ But when he was governor, Romney pursued such federal government assistance and then took the money for his general coffers.⁴⁸

Although Romney asserted in his 2004 budget that he was balancing the state budget without increasing taxes and “without the use of fiscal gimmicks,”⁴⁹ the “outside sections” of his budget details included fiscal gimmicks in the form of bed tax schemes.⁵⁰

His gimmicks included taxing public hospitals and shifting money in and out of an uncompensated care trust fund, back to hospitals as adjustment payments, and diverting resulting federal Medicaid funds into his general coffers. Below is one example:

[T]he division of medical assistance . . . shall take any appropriate action to obtain the maximum amount of federal financial participation available for amounts paid to hospitals, determined by the division to be disproportionate share hospitals Such appropriate action may include, but shall not be limited to, the assessment on hospitals for their liability to the uncompensated care pool Such appropriate action shall include the establishment or renewal of an interdepartmental services agreement between the division and the division of health care finance and policy which may authorize the division to make deposits into and payments from an account established for the purposes of this section within the Uncompensated Care Trust Fund, . . . or authorize the division of health care finance and policy to transfer uncompensated care fee revenue collected

46. WIS. HEALTH CARE ASS'N & WIS. CTR. FOR ASSISTED LIVING, BACKGROUND PAPER: FUNDING SOURCES TO SUPPORT NURSING HOME RESIDENT CARE (2007), available at <http://archives.whcawical.org/whca-docs/032007wn-a.pdf>.

47. See Brad Plumer, *Mitt Romney Verses the 47 Percent*, WASH. POST (Sept. 17, 2012), <https://www.washingtonpost.com/blogs/ezra-klein/wp/2012/09/17/romney-my-job-is-not-to-worry-about-those-people/> (“There are 47 percent of the people who will vote for the president no matter what. All right, there are 47 percent who are with him, who are dependent upon government, who believe that they are victims, who believe the government has a responsibility to care for them, who believe that they are entitled to health care, to food, to housing, to you-name-it.”).

48. Daniel L. Hatcher, *Romney's Medicaid Shell Game*, BOS. GLOBE (Oct. 12, 2012), <https://www.bostonglobe.com/opinion/2012/10/12/podium-medicare/X5KHn9vVJjFRPgDAtxku3M/story.html> [hereinafter Hatcher, *Romney's Medicaid Shell Game*].

49. COMMONWEALTH OF MASS., THE GOVERNOR'S BUDGET RECOMMENDATION HOUSE 1 FISCAL YEAR 2004: EXECUTIVE SUMMARY HIGHLIGHTS, available at <http://www.mass.gov/bb/fy2004h1/downloads/execsummary.pdf>.

50. See *infra* notes 53–54.

*from hospitals . . . to the division for the purposes of making disproportionate share adjustment payments to hospitals qualifying for such payments In no event shall the amount of money assessed upon each hospital exceed the hospital's gross liability to the uncompensated care trust fund Any federal funds obtained as a result of said actions shall be deposited in the General Fund.*⁵¹

In another section, he proposed the following:

[T]he department of mental health, the department of public health, the division of medical assistance and the division of health care finance and policy *shall take any appropriate action to obtain the maximum amount of federal financial participation available for amounts paid for low-income care costs at those mental health and public health facilities determined to be disproportionate share hospitals* Such appropriate action may include, but shall not be limited to, the establishment of a separate account within the Uncompensated Care Trust Fund, . . . for the purpose of making disproportionate share payment adjustments to such qualifying mental health and public health facilities *Any federal funds obtained as a result of actions taken pursuant to this section shall be deposited in the General Fund.*⁵²

In addition to the above examples, Romney also proposed maximizing federal funds using mental health facilities, nursing homes, and pharmacies. Again, he suggested diverting the resulting tax revenue and federal Medicaid funds into his general state revenue.⁵³ To help effectuate these strategies, Romney used revenue maximization contractors such as the Public Consulting Group (PCG).⁵⁴

In 2005, the GAO investigated the practices by Romney, and other states with such schemes, including the use of contingency-fee revenue maximization consultants, and concluded the revenue strategies were

51. COMMONWEALTH OF MASS., THE GOVERNOR'S BUDGET RECOMMENDATION HOUSE 1 FISCAL YEAR 2004: FFP FOR THE UNCOMPENSATED CARE TRUST FUND (2003) (emphasis added), available at <http://www.mass.gov/bb/fy2004h1/outsec/h280.htm>.

52. COMMONWEALTH OF MASS., THE GOVERNOR'S BUDGET RECOMMENDATION HOUSE 1 FISCAL YEAR 2004: FFP FOR DISPROPORTIONATE SHARE HOSPITAL PAYMENTS TO DMH/DPH FACILITIES (2003) (emphasis added), available at <http://www.mass.gov/bb/fy2004h1/outsec/h281.htm>.

53. COMMONWEALTH OF MASS., THE GOVERNOR'S BUDGET RECOMMENDATION HOUSE 1 FISCAL YEAR 2004: NURSING HOME ASSESSMENT TO THE GENERAL FUND (2003), available at <http://www.mass.gov/bb/fy2004h1/outsec/h144.htm>; COMMONWEALTH OF MASS., THE GOVERNOR'S BUDGET RECOMMENDATION HOUSE 1 FISCAL YEAR 2004: PHARMACY ASSESSMENT TO THE GENERAL FUND (2003), available at <http://www.mass.gov/bb/fy2004h1/outsec/h147.htm>.

54. And when Romney's CFO and Budget Director for the Massachusetts Medicaid program left his administration, the individual later joined PCG as a senior consultant. See Jim Waldinger: *Health Care Reform Subject Matter Expert*, PUB. CONSULTING GRP., <http://www.publicconsultinggroup.com/health/sme/JimWaldinger.html> (last visited Mar. 30, 2016).

inappropriate.⁵⁵ The Romney administration defended the revenue schemes using such consultants, but the GAO explained “our concern was that hospitals should benefit from increased federal reimbursements and Massachusetts’s arrangement appeared to result in lower payments to hospitals, despite increased claims for federal reimbursement.”⁵⁶

As another example of a state bed tax scheme, Missouri’s former Governor John Ashcroft (Attorney General under George W. Bush) initiated a bed tax strategy he labeled the “Hospital Federal Reimbursement Allowance” (FRA) program.⁵⁷ Ashcroft’s illusory scheme used Medicaid funds as a revenue source—larger than Missouri’s inheritance/estate tax, corporate income tax, and county foreign income tax combined.⁵⁸

In legislation that Ashcroft signed into law in 1992, the statutory language explains how money taxed from hospitals can be used to claim federal Medicaid matching funds, and how the money can then be placed into a fund with the payments made by hospitals, and tagged for payments back to the hospitals:

The director of the department of social services shall make a determination as to the amount of federal reimbursement allowance due from the various hospitals . . .

. . . .

The federal reimbursement allowance owed or, if an offset has been requested, the balance, if any, after such offset, shall be remitted by the hospital to the department of social services. The remittance shall be made payable to the director of the department of revenue. The amount remitted shall be deposited in the state treasury to the credit of the “Federal Reimbursement Allowance Fund,” which is hereby created for the purpose of providing payments to hospitals.⁵⁹

Further, the legislation describes how the purpose of the legislation is to claim more federal Medicaid matching funds: “The requirements . . .

55. U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-05-748, MEDICAID FINANCING: STATES’ USE OF CONTINGENCY-FEE CONSULTANTS TO MAXIMIZE FEDERAL REIMBURSEMENTS HIGHLIGHTS NEED FOR IMPROVED FEDERAL OVERSIGHT 90 (2005) (emphasis added), available at <http://www.gao.gov/assets/250/246870.pdf>.

56. *Id.*

57. MO. HOSP. ASSOC., THE HOSPITAL FEDERAL REIMBURSEMENT I (2010), available at <http://www.ded.mo.gov/Content/MO%20Hospital%20Assn%2c%20THE%20HOSPITAL%20FEDERAL%20REIMBURSEMENT%20ALLOWANCE.pdf>.

58. *Id.*

59. H.B. 1744, 1992 Leg., Reg. Sess. (Mo. 1992) (codified at MO. REV. STAT. §§ 208.459, 208.465 (2016)).

shall apply only as long as the revenues generated under section 208.405, RSMo, are eligible for federal financial participation”⁶⁰

By 2009, the bed tax strategy resulted in \$1.522 billion in federal Medicaid funds claimed by Missouri.⁶¹ The funds claimed through the illusory practice (no actual state spending) were not limited to spending on Medicaid services as intended, but much of the money was apparently directed towards health care related issues. Instead, the idea was to replace otherwise required state spending with federal spending:

Throughout the highs and lows of the state’s financial condition, the program has evolved to maximize federal matching dollars and reduce the burden of [the state Medicaid program] on state general revenue [T]he FRA is a major source of revenue to the state, surpassing all but the two largest sources of general revenue This releases traditional general revenue to be used for other state priorities.⁶²

Missouri’s scheme has greatly increased its match rate. Missouri’s normal match rate is about thirty-seven percent to receive a sixty-three percent federal match. However, the Missouri bed tax strategy undermines the intended matching structure of the Medicaid program: “[b]ecause Missouri has pursued provider taxes aggressively to fund its program costs, nearly half of the state’s share of the cost of the Medicaid program comes from these provider taxes.”⁶³ Since Missouri does not actually spend any state money in such tax strategies, “[o]nly 21 percent of the cost of the Medicaid program comes from general revenue funds.”⁶⁴ Thus, the Missouri strategy leads the federal government to pay almost eighty percent of the state’s Medicaid program rather than the intended sixty-three percent. As a result, “vast amounts of general revenue have been made available over the years to be spent on other state priorities.”⁶⁵ And other states have surpassed Missouri’s example. For example, Alabama’s use of illusory Medicaid maximization schemes turned the state’s intended 2:1 match into a 9:1 match (\$9 in federal Medicaid funds for every \$1 of state spending).⁶⁶

60. *Id.* (citing bill § 208.400).

61. MO. HOSP. ASSOC., *supra* note 57.

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.*

66. ALA. MEDICAID PHARM. STUDY COMM’N, MEDICAID: A TIME FOR CHANGE 4 (2012), available at http://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.2_Boards_Committees/2.2.1_Med_Adv_Commission/2.2.1_Advisory_Commission_Presentation_11-1-12.pdf.

D. School-Based Medicaid Maximization Strategies

In addition to using health care facilities, states have used disabled school children in schools in similar Medicaid maximization and diversion strategies. States can claim federal Medicaid matching funds on behalf of school children, for both certain health services and school administrative costs. Eligible services include health services related to needs in special education, rehabilitative services, physical and speech therapy, and under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.⁶⁷ Eligible administrative costs can include costs for Medicaid outreach and education, enrollment assistance, health care referrals, and other coordination of services.

Again, states often employ revenue maximization consultants to help with their strategies to increase school-based federal Medicaid funds. Like with the other strategies, states often divert some of the federal aid away from the school children to general state revenue. According to the 2000 report by the GAO, at least eighteen states were diverting a portion of the Medicaid funds intended for disabled school children into state general revenue.⁶⁸ Ten of those states diverted between forty to eighty-five percent of the federal aid, and many of the states used revenue maximization contractors to increase claims for the funds.⁶⁹ Further, some states have expanded their school-based Medicaid maximization strategies by digging backwards for retroactive claims. As one example, in addition to the eighteen states identified by the GAO, Maine retroactively claimed \$8.8 million in school-based federal Medicaid funds and then rerouted all of those funds into to the state's general coffers to help balance the state budget.⁷⁰ The Inspector General's Office for the U.S. Department of Health and Human Services concluded:

Federal regulations stipulate that (1) it is the State's responsibility to make payments to providers that furnish Medicaid services

The State agency did not follow Federal regulations when it processed the retroactive claims for Medicaid school-based health services. The State did not incur any expenditures because it did not remit the Federal share received for those claims to the provider

67. 42 C.F.R. § 440.345 (2015).

68. KATHRYN G. ALLEN & ROBERT H. HAST, U.S. GENERAL ACCOUNTING OFFICE, GAO/T-HEHS/OSI-00-87, MEDICAID: POOR OVERSIGHT AND IMPROPER PAYMENTS COMPROMISE POTENTIAL BENEFIT 15 (2000), available at <http://www.gao.gov/assets/110/108362.pdf>.

69. *Id.*

70. OFFICE OF INSPECTOR GENERAL, U.S. DEP'T. OF HEALTH AND HUMAN SERVICES, A-01-04-00004, REVIEW OF MAINE'S MEDICAID RETROACTIVE CLAIMS FOR SCHOOL-BASED HEALTH SERVICES—JANUARY 2001 THROUGH JUNE 2003, at i (2005), available at <https://oig.hhs.gov/oas/reports/region1/10400004.pdf>.

school districts. Rather, the State deposited the Federal share in the State's general fund.⁷¹

The following examples provide some additional insight of how states use impoverished, disabled school children in revenue strategies.

In Michigan, the state's use of a contractor to help with efforts to maximize school-based Medicaid funds led to pay-for-play concerns. Michigan shifted over \$100 million of the federal Medicaid funds to its general revenue, and nonetheless required school districts to pay for the services of the revenue contractor.⁷² The contractor received twenty percent of the federal aid as payment for its services and the school districts only received about \$4 out of every \$10 in federal aid intended to help the schools provide needed Medicaid related services to children.⁷³ As such, Michigan was diverting much of the federal aid resulting from the revenue maximization contract.

Along with diverting federal aid away from educational institutions, the state also faced scrutiny regarding improper gifts. According to the GAO, while Michigan contracted with Deloitte to maximize claims for the school-based Medicaid, Deloitte was providing gratuities and gifts to government officials responsible for the contracts:

In our April 2000 report, we discussed the circumstances surrounding the process used by a consortium of eight Michigan intermediate school districts to contract with Deloitte Consulting LLC for consulting and billing services.

....

We conducted an investigation and determined that Deloitte had provided gratuities, including meals and tickets to professional sporting and theater events, to the school district officials responsible for awarding the contract for consulting services. Records provided to us by Deloitte show that it spent over \$170,000 for the gratuities from 1997 through 1999. Officials receiving the gratuities included members of the school district consortium's Medicaid Program Steering Committee and Contract Negotiation Committee.⁷⁴

71. *Id.*

72. WILLIAM J. SCANLON, U.S. GENERAL ACCOUNTING OFFICE, GAO/T-HEHS-99-148, MEDICAID: QUESTIONABLE PRACTICES BOOST FEDERAL PAYMENTS FOR SCHOOL-BASED SERVICES 8 (1999), available at <http://www.gao.gov/assets/110/107966.pdf>.

73. *Id.* at 2.

74. Letter from Robert H. Hast, Assistant Comptroller General for Special Investigations, U.S. General Accounting Office, to William V. Roth, Jr., Chairman, and Daniel Patrick Moynihan, Ranking Minority Member, Committee on Finance, U.S. Senate (Sept. 8, 2000) (footnotes omitted), available at <http://www.gao.gov/assets/100/90080.pdf>.

Because such gifts or gratuities can be prohibited if made to influence business transactions with government agencies, the GAO referred the matter to the U.S. Attorney's Office.⁷⁵

Like other states, New York has diverted about half of school-based Medicaid funds to general state revenue—over \$170 million annually.⁷⁶ New Jersey is probably the leader in the illusory practice. However, New Jersey schools have retained as little as \$7.50 for every \$100 in Medicaid funds intended for school children.⁷⁷ The GAO explains how the scheme works:

[S]chool districts' funds often are used to supply the state's share of Medicaid funding for school-based claims. In these cases, the maximum additional funding that a school district can receive is what the federal government contributes. This is substantially less than what a private sector Medicaid provider would receive for delivering similar services. For example, a physician who submits a claim with an allowable amount of \$100 will receive \$100: \$50 in state funds and \$50 in federal funds in those states with equal matching between federal and state sources. Given the source of the states' share of funding, states' policies to retain portions of the federal reimbursement, and schools' contingency fee arrangements with private firms, the net amount of federal funds returned to a school district varies considerably . . . [and may be] as little as \$7.50 in New Jersey in federal Medicaid reimbursement for every \$100 spent to pay for services and activities performed in support of Medicaid-eligible children.⁷⁸

Governor Chris Christie hired a revenue maximization contractor to help continue the practice. The Public Consulting Group helps to run the "Special Education Medicaid Initiative" or SEMI.⁷⁹ The SEMI program requires local New Jersey school districts to determine the maximum number of school children eligible for federal Medicaid funds. State documents illustrate the SEMI target revenue projections for the 2013–2014

75. *Id.*

76. KATHRYN G. ALLEN & ROBERT H. HAST, U.S. GENERAL ACCOUNTING OFFICE, GAO/T-HEHS/OSI-00-87, MEDICAID: POOR OVERSIGHT AND IMPROPER PAYMENTS COMPROMISE POTENTIAL BENEFIT 15 (2000), available at <http://www.gao.gov/assets/110/108362.pdf>.

77. *Id.* at 15–16.

78. *Id.*

79. PUB. CONSULTING GRP., STATE OF NEW JERSEY: SCHOOL BASED MEDICAID REIMBURSEMENT PROGRAMS PROVIDER HANDBOOK 5 (2014), available at <http://www.nj.gov/treasury/administration/pdf/semi-handbook.pdf>.

school year.⁸⁰ The Public Consulting Group determines the number of eligible children and plugs the children into a target revenue maximization goal of at least eighteen services eligible for federal Medicaid funds.⁸¹ Below is the equation using the school children:

$$\text{Claimable Student Population} \times \text{Annual Revenue per Student} = \text{District SEMI Revenue Projection}^{82}$$

If schools do not meet the target goals for using school children to maximize federal Medicaid funds, they are punished by a reduction in school funding.⁸³ Further, schools are required to obtain at least a ninety percent return rate seeking parents to consent to using their children in the process.⁸⁴ The revenue contractor explains best practices for maximizing parental consent, including that “[w]hen it comes to obtaining Parental Consent, districts sometimes need to be creative in their methods.”⁸⁵

In his FY 2013–2014 budget, Governor Christie explains how 82.5 percent of the school-based Medicaid funds resulting from the SEMI program is routed away from special education services to his general coffers.⁸⁶ The school districts only receive 17.5 percent of the federal aid intended to help them serve disabled children.⁸⁷ Further, the revenue contractor helps New Jersey with a Medicaid Administrative Claiming (MAC) initiative to increase claims for federal aid for school administrative costs related to Medicaid services.⁸⁸ Again, Christie diverts 82.5 percent of the Medicaid funds to his general state revenue:

40. Notwithstanding the provisions of any law or regulation to the contrary, each local school district that participates in the Medicaid Administrative Claiming (MAC) initiative shall receive a percentage of the federal revenue realized for current year claims. The percentage share shall be 17.5% of claims approved by the State by June 30.⁸⁹

80. Letter from Christopher D. Cerf, Commissioner, State of N.J. Dep’t of Educ., to Chief School Administrators, Charter School Lead Person, School Business Administrators & Directors of Special Education (Jan. 29, 2013) [hereinafter Cerf Letter], available at <http://www.state.nj.us/treasury/administration/pdf/SpecialEducationMedicaidInitiative.pdf>.

81. *Id.*

82. *Id.*

83. N.J. ADMIN. CODE § 6A:23A-5.3 (2015).

84. Cerf Letter, *supra* note 80.

85. *SEMI Parental Consent Best Practices*, STATE OF N.J. DEP’T OF THE TREASURY, <http://www.state.nj.us/treasury/administration/pdf/semi-parental-consent-best-pretices.pdf> (last visited Oct. 24, 2014).

86. DEP’T OF THE TREASURY, STATE OF N.J., APPROPRIATIONS HANDBOOK: FISCAL YEAR 2013–2014, at E-4 (2013), available at <http://www.state.nj.us/treasury/omb/publications/14approp/pdf/genprov.pdf>.

87. *Id.*

88. APPROPRIATIONS HANDBOOK, *supra* note 86.

89. *Id.*

According to multiple federal audits, Christie's use of revenue maximization contractors for school-based Medicaid funds has resulted in inappropriate claims. In a 2010 audit by the federal Office of Inspector General, considering school-based Medicaid funds that were claimed while using MAXIMUS as the revenue consultant, over half of the claims sampled were determined as "noncompliant."⁹⁰ New Jersey was asked to refund over \$8 million in inappropriately claimed federal aid, but the Christie administration refused.⁹¹ In an audit of New Jersey's school-based Medicaid claims when the Public Consulting Group was its revenue maximization contractor, thirty-six percent of the claims were noncompliant.⁹² Again, the Christie administration refused a request by the Office of Inspector General to return over \$5.6 million in inappropriately claimed federal aid.⁹³

As New Jersey diverts millions in school-based Medicaid funds away from schools, some school districts are so underfunded that they have resorted to selling the sides of school buses for advertisements.⁹⁴ The public affairs officer for the New Jersey School Boards Association explained that schools would rather not use such advertising, but they were desperately underfunded:

In a perfect world, schools would be fully funded and school boards wouldn't even have to think about programs like this But, these are difficult times for many school districts and sometimes a community expects their school board to look at all different options."⁹⁵

While the states' practices of funneling school-based Medicaid funds away from schools is troubling, fault also lies with the federal government. Needed oversight has been lacking and federal guidance is often vague at best. As the GAO explains, "[t]hese weak controls permit an environment for opportunism in which inappropriate claims could gener-

90. OFFICE OF INSPECTOR GENERAL, DEP'T OF HEALTH & HUMAN SERVICES, A-02-07-01051, REVIEW OF NEW JERSEY'S MEDICAID SCHOOL-BASED HEALTH CLAIMS SUBMITTED BY MAXIMUS, INC. 5 (2010), available at <https://oig.hhs.gov/oas/reports/region2/20701051.pdf>.

91. *Id.* at 9.

92. OFFICE OF INSPECTOR GENERAL, DEP'T OF HEALTH & HUMAN SERVICES, A-02-07-01052, REVIEW OF NEW JERSEY'S MEDICAID SCHOOL-BASED HEALTH CLAIMS SUBMITTED BY PUBLIC CONSULTING GROUP, INC. 5 (2010), available at <https://oig.hhs.gov/oas/reports/region2/20701052.pdf>.

93. *Id.* at 9.

94. School children have further been affected by efforts to raise revenue when their buses were used for Comcast advertising. See Tony Gicas, *Extra Revenue for Schools*, NORTHJERSEY.COM (Nov. 30, 2012), http://www.northjersey.com/news/181487561_Extra_revenue_for_schools.html.

95. *Id.*

ate excessive Medicaid payments.”⁹⁶ Also, the use of revenue maximization contractors “places these firms ‘in the driver’s seat,’ where they design the methods to claim administrative costs, train school personnel to apply these methods, and submit administrative claims to the state Medicaid agencies to obtain the federal reimbursement that provides the basis for their fees.”⁹⁷ The financial incentive can encourage inappropriate claims: “By being able to capture a share of the school district’s federal payments, states and private firms are motivated to experiment with ‘creative’ billing practices.”⁹⁸

E. Nursing Home Revenue Maximization Strategies

The Medicaid revenue strategies used by states and their contractors extend beyond the schemes using school children and impoverished individuals needing health care. Nursing home residents are also used as a means of leveraging more federal funds. This subpart describes how nursing homes are used in strategies similar to those discussed above, including IGTs, UPLs and bed taxes. Specific examples are examined in New York, Indiana and Maryland. Also, a strategy explaining how a municipal agency purchased for-profit nursing homes to route Medicaid funds, intended for the nursing homes, to other purposes, is discussed in detail.

1. Nursing Homes Used in IGT, UPL, and Bed Tax Schemes

States have been using nursing homes in IGT, UPL, and bed tax schemes for years, but these schemes are largely unknown or misunderstood by the public. As a result of the strategies, when states divert needed Medicaid funds away from nursing homes to private profit and state revenue, the elderly poor often languish with inadequate care.

As the U.S. Department of Health and Human Services’ Office of Inspector General (OIG) explained in congressional testimony, some of the initial fiscal concerns with Medicaid revenue maximization strategies:

This is the most common method we have noted by which States divert funds from an intended purpose after drawing down the Federal share of the benefit.

96. WILLIAM J. SCANLON, U.S. GENERAL ACCOUNTING OFFICE, GAO/T-HEHS-99-148, MEDICAID: QUESTIONABLE PRACTICES BOOST FEDERAL PAYMENTS FOR SCHOOL-BASED SERVICES 2 (1999), available at <http://www.gao.gov/assets/110/107966.pdf>.

97. *Id.* at 12.

98. *Id.* at 13.

States' use of IGTs to divert funds has the following consequences: a State's share of its Medicaid program inappropriately declines; Federal taxpayers pay more than their statutory share; and the increased Federal Medicaid funding derived from those financing mechanisms becomes comingled in general revenue accounts, where it can be used for purposes unrelated to Medicaid, including as the State's match to draw down more Federal dollars for Medicaid and other federally matched grant programs.⁹⁹

The OIG also explained how nursing homes lost needed (and intended) funding as a result of the revenue schemes: "Some of our recent audits have explored States' use of IGTs in which some or all of the Medicaid funds that were directed to local public nursing facilities as enhanced payments made under UPL rules were returned to the States instead of being retained at the facilities for the care of patients."¹⁰⁰ Harm resulted from the diversion of funds:

In every case, we found that the gross Medicaid per diem and enhanced payments were sufficient to cover operating costs, but the net payments were not. The nursing facilities were required to return substantial portions of their enhanced payments to the States to be used for other purposes. As a result, the facilities were underfunded. We believe this under funding had a negative impact on quality of care.¹⁰¹

Therefore, as the OIG explained, the diversion of Medicaid funds results in insufficient funding for the nursing homes and poor quality of care. Multiple state examples are helpful to understand the practices and the impact.

Beginning with New York, a 2013 national review of nursing home quality gave the state an overall "F" letter grade.¹⁰² New York is ranked 45th in the country in terms of overall nursing home quality of care, and received multiple "F" grades regarding staffing levels: "Professional nursing services were almost nonexistent in New York's nursing homes"¹⁰³

99. *Hearing Before S. Comm. on Fin.*, 109th Cong. 1–2 (June 28, 2005) (statement of George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, Office of Inspector General, U.S. Dep't of Health and Human Services) [hereinafter Reeb Testimony], available at <https://oig.hhs.gov/testimony/docs/2005/50628-reeb-fin.pdf>.

100. *Id.* at 3.

101. *Id.*

102. *New York*, FAMILIES FOR BETTER CARE, <http://nursinghomereportcards.com/state/ny/> (last visited Oct. 22, 2014).

103. *NY's Nursing Homes Earn Failing Grade*, FAMILIES FOR BETTER CARE (Sept. 16, 2013), <http://nursinghomereportcards.com/2013/09/16/nys-nursing-homes-earn-failing-grade/>.

Despite the need for more nursing home funding to improve quality of care, New York has been using its nursing homes in revenue schemes and diverting the funds. After setting its regular Medicaid payments much lower than what the nursing homes need, New York used the UPL strategy to make enhanced supplemental payments in order to trigger more federal funds, but forced the nursing homes to return up to ninety percent of the UPL funds.¹⁰⁴ Two county nursing homes in New York illustrate the impact.

The OIG reported how New York State and Albany County collaborated to use the Albany County Nursing Home to leverage and divert over \$82 million in Medicaid dollars intended to serve the nursing home residents to the county and state general revenue funds.¹⁰⁵ Following the details of the budgetary sleight of hand scheme, New York used \$45.5 million in county funds to make supplemental UPL payments—triggering \$45.5 million federal Medicaid matching payments.¹⁰⁶ After initially paying the combined \$91 million to the county nursing home operating bank account, the county transferred the \$91 million out of the nursing home account to the county general fund.¹⁰⁷ Then, the state took \$36 million of the \$91 million in Medicaid funds for state general revenue—without spending a dime in state money.¹⁰⁸ The county took back a little more than its original investment, leaving only \$9.1 million for the nursing home system.¹⁰⁹

Because the Albany County nursing home system was forced to return ninety percent of the Medicaid payments that were intended for nursing home care, the nursing facility faced an operating budget shortfall of about \$22 million.¹¹⁰ The diversion of federal aid funds from the nursing home occurred despite the facility receiving an “immediate jeopardy” rating by the state Department of Health.¹¹¹ Due to the lack of funding, the nursing facility was not able to fill 90 needed nursing positions—contributing to the poor care.¹¹²

In another New York example, the A. Holly Paterson Extended Care Facility was used in a similar scheme that caused the nursing facility to operate at a \$25 million deficit.¹¹³ In a similar shifting of funds, the

104. Reeb Testimony, *supra* note 99, at 4.

105. *Id.* at 3–5.

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.*

112. *Id.*

113. *Id.* at 6.

state made \$101.4 million in supplemental UPL nursing home Medicaid payments—using all county funds, and resulting in \$101.4 million federal Medicaid matching payments.¹¹⁴ New York again paid the combined \$202.8 million to the county nursing home operating bank account.¹¹⁵ The county shifted \$182.5 million out of the nursing home account to the county general fund, the state took \$81.1 million from the county general fund, and the nursing home was left with only ten percent of the Medicaid funds intended to help nursing home residents.¹¹⁶

As with Albany County, harm resulted—one patient even died. New York was able to make greater UPL payments by keeping its regular daily state Medicaid payments to nursing homes at a low rate, in order to increase claims for federal Medicaid matching funds. Most of that federal aid was then diverted away from the nursing facility to state and county general revenue, while the A. Holly Patterson nursing facility received an “immediate jeopardy” rating by the state Department of Health.¹¹⁷ Further, due to deficiencies from the lack of funds, residents faced harm—including the death of a resident.¹¹⁸ The nursing facility faced insufficient funds and was unable to fill almost 100 needed nursing positions.¹¹⁹

Like New York, unfortunately, Indiana also received an “F” grade for its nursing homes.¹²⁰ In the 2013 report, Indiana was ranked 49th in overall quality of nursing home care, and almost ninety-four percent of the state’s nursing homes had deficiencies.¹²¹ Further, the GAO concluded in 2009 that Indiana had the “most poorly performing” nursing homes of any state in the country.¹²² A 2010 investigation by the Indianapolis Star determined that “the most critical caregivers are more scarce in Indiana nursing homes than anywhere else.”¹²³ According to the report,

114. OFFICE OF INSPECTOR GENERAL, U.S. DEP’T OF HEALTH AND HUMAN SERVICES, A-02-03-01004, ADEQUACY OF NEW YORK STATE’S MEDICAID PAYMENTS TO A. HOLLY PATTERSON EXTENDED CARE FACILITY app. B (2005), available at <http://oig.hhs.gov/oas/reports/region2/20301004.pdf>.

115. *Id.*

116. *Id.*

117. *Id.* at ii.

118. *Id.* at 2.

119. *Id.*

120. *Indiana*, FAMILIES FOR BETTER CARE, <http://nursinghomereportcards.com/state/in/> (last visited Oct. 22, 2014).

121. *Id.*

122. U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-09-689, NURSING HOMES: CMS’S SPECIAL FOCUS FACILITY METHODOLOGY SHOULD BETTER TARGET THE MOST POORLY PERFORMING HOMES, WHICH TENDED TO BE CHAIN AFFILIATED AND FOR-PROFIT 15 (2009), available at <http://www.gao.gov/assets/300/294408.pdf>.

123. *Report: Many Indiana Nursing Homes Understaffed*, WIBC (Mar. 7, 2010), <http://www.wibc.com/blogs/report-many-indiana-nursing-homes-understaffed>.

“Indiana ranks 51st—lower than every other state and the District of Columbia—in the amount of time certified nursing assistants spend with residents.”¹²⁴

But an unfortunate trend continues. Despite deep concerns regarding quality of care, Indiana has used revenue schemes to divert millions in federal Medicaid funds annually from nursing home care to its general funds. While its nursing homes struggle, Indiana and its revenue contractor have used the facilities to further its bed tax revenue strategies. Myers and Stauffer, L.C., contracted to help set the state’s Medicaid payment rates (including for nursing homes) and also to help with the state’s bed tax strategy.¹²⁵ Under the bed tax, ironically called the “quality assessment fee” or QAF, Indiana has diverted much of the resulting federal Medicaid funds into its general funds.¹²⁶ The state used the strategy to divert \$59.2 million in Medicaid funds from nursing homes to state general funds in 2013,¹²⁷ \$36.6 million in 2012,¹²⁸ \$39.6 million in 2011,¹²⁹ and tens of millions annually for many years prior.

Finally, although Maryland is one of the richest states in the country, the state received a “D” grade for nursing home quality of care—virtually tied with Mississippi, the poorest state in the country.¹³⁰ Maryland has been called “the worst nursing home state in the Mid-Atlantic Region.”¹³¹ Over ninety-five percent of the state’s nursing homes have deficiencies, and Maryland also received “D” grades in direct staffing hours and RN hours.¹³²

Yet again, despite the need to improve the funding and quality of care at Maryland’s nursing homes, the state has used its nursing facilities to divert a significant part of federal Medicaid funds to other state use.

124. *Id.*

125. *Indiana Nursing Home Medicaid Reimbursement Update*, H.O.P.E. NEWSBRIEFS, Sept. 2011, at 2, available at <http://www.hoosierownersandproviders.org/files/2015-09/1109.pdf>.

126. *Id.*

127. CHRISTOPHER D. ATKINS, IND. STATE BUDGET AGENCY, LIST OF APPROPRIATIONS MADE BY THE REGULAR SESSION OF THE 2013 INDIANA GENERAL ASSEMBLY FOR THE BIENNIUM JULY 1, 2013 TO JUNE 30, 2015, at 11 (2013), available at http://www.in.gov/sba/files/AP_2013_0_0_2_Budget_Report.pdf.

128. ADAM M. HORST, IND. STATE BUDGET AGENCY, LIST OF APPROPRIATIONS MADE BY THE REGULAR SESSION OF THE 2013 INDIANA GENERAL ASSEMBLY FOR THE BIENNIUM JULY 1, 2011 TO JUNE 30, 2013, at 11 (2011), available at http://www.in.gov/sba/files/ap_2011_all.pdf.

129. IND. STATE BUDGET AGENCY, GENERAL FUND AND RAINY DAY FUND SUMMARIES FISCAL YEAR ENDING JUNE 30, 2011, at 11 (2011), available at http://www.in.gov/sba/files/FY_2011_Close-Out_Surplus_Statement.pdf.

130. *Maryland*, FAMILIES FOR BETTER CARE, <http://nursinghomereportcards.com/state/md/> (last visited Oct. 22, 2014).

131. J. Anthony Burke, *U.S. Nursing Homes Get Failing Grades in Caring for Their Residents*, EXAMINER (Feb. 18, 2014), <http://www.examiner.com/article/u-s-nursing-homes-get-failing-grades-caring-for-their-residents>.

132. *Maryland*, *supra* note 130.

Like other states, Maryland also uses nursing homes in a bed tax revenue strategy.¹³³ The O'Malley administration doubled the bed tax from two percent to four percent in 2010, and changed the law to route up to thirty-five percent of the Medicaid funds to state general funds.¹³⁴ The administration then increased the tax again in 2011 to 5.5 percent, and up to six percent in 2012.¹³⁵

Prior to 2010, Maryland law provided that Medicaid funds claimed for nursing homes could only be used for nursing homes. The increased federal Medicaid funds could not be used to decrease state appropriations for nursing home care.¹³⁶ The law required that federal aid from the bed tax strategy be used "only to fund reimbursements to nursing facilities under the Medicaid program" and that "the funds allocated by the Department as reimbursements to nursing facilities under this section shall be in addition to and may not supplant funds already appropriated for this purpose."¹³⁷ However, 2010 legislation changed the requirement, allowing for a significant amount of the aid to be diverted. The legislation explained that only "[a]t least 65% of the funds allocated by the Department as reimbursements to nursing facilities under this section shall be in addition to and may not supplant funds already appropriated for this purpose."¹³⁸ Therefore, up to thirty-five percent of the federal aid intended for nursing home care was freed up for other state use.¹³⁹

2. Municipal Agency Purchasing Nursing Homes to Take Their Federal Aid

The private sector has taken notice of the profit potential from privately run nursing homes—even lucrative investment firms such as the Carlyle Group. In 2007, the Carlyle Group acquired HCR Manor Care, one of the largest private operators of nursing homes in the United States, for \$6.3 billion.¹⁴⁰

133. Kevin Spradlin, *Nursing Home Administrators Say Tax Would Penalize Elderly*, CUMBERLAND TIMES-NEWS (Feb. 24, 2010), http://www.times-news.com/news/local_news/nursing-home-administrators-say-tax-would-penalize-elderly/article_3408dba9-311a-5a4c-b186-9cf49c6fa20a.html.

134. *Id.*

135. MD. CODE ANN., HEALTH-GEN. § 19-310.1, amended by Acts 2012, 1st Sp. Sess., c. 1, § 1, eff. June 1, 2012.

136. MD. CODE ANN., HEALTH-GEN. § 19-310.1, amended by Acts 2010, c. 484, § 3, eff. June 1, 2010.

137. *Id.*

138. *Id.* (emphasis added).

139. *Id.*

140. Press Release, HCR Manor Care, Carlyle Closing (Dec. 21, 2007), <http://www.hcr-manorcare.com/about-hcr-manorcare/corporate-matters/stock-bond-holders/carlyle-closing/>.

According to the Kaiser Commission on Medicaid and the Uninsured, “[r]esearch indicates that for-profit, or proprietary, facilities may have poorer performance on quality measures or lower staffing levels than non-profit or government facilities.”¹⁴¹ Further studies indicate that for-profit nursing homes more often prescribe antipsychotic drugs to nursing home residents, often to reduce staffing needs.¹⁴²

In Indiana, a municipal hospital agency also noticed the revenue potential from for-profit nursing homes. As explained above, Indiana nursing homes have received some of the worst quality ratings in the country.¹⁴³ But when the hospital agency developed a scheme to buy up private nursing homes all across the state, the goal was diverting federal aid intended for the nursing homes to other uses, rather than improving quality of care.

The agency involved in the nursing-home purchasing scheme is the Health and Hospital Corporation (HHC), a municipal agency that operates the Marion County Health Department and hospital system (which includes Indianapolis).¹⁴⁴ HHC was operating at a \$30 million annual deficit in the early 2000s.¹⁴⁵ State legislators urged the agency to look for ways to help maximize federal funds to offset state and local government costs, and HHC accordingly worked with the state human services agency on revenue strategies.¹⁴⁶ And HHC found a target revenue source: low-income, elderly residents in for-profit nursing homes across Indiana.

To implement its revenue strategy, the agency started buying for-profit nursing homes, not just near Indianapolis where the agency is located, but all across the state. The agency worked with state officials to turn poor-performing nursing homes into a revenue opportunity, taking advantage of federal Medicaid funding policies.¹⁴⁷ After the federal government determines maximum payment amounts for federal Medicaid matching payments, states can decide what nursing home facilities should receive the maximum payments.¹⁴⁸ Using that discretion, Indiana

141. KAISER COMM’N ON MEDICAID & THE UNINSURED, OVERVIEW OF NURSING FACILITY CAPACITY, FINANCING, AND OWNERSHIP IN THE UNITED STATES IN 2011, at 4 (2013), available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/06/8456-overview-of-nursing-facility-capacity.pdf>.

142. *Non-Profit vs. For-Profit Nursing Homes: Is There a Difference in Care?*, CTR. FOR MEDICARE ADVOCACY, <http://www.medicareadvocacy.org/non-profit-vs-for-profit-nursing-homes-is-there-a-difference-in-care/> (last visited Nov. 3, 2014).

143. See *supra* note 120 and accompanying text.

144. Heather Gillers, Tim Evans, Mark Nichols & Mark Alesia, *Cash Flowed In, Care Lagged*, INDIANAPOLIS STAR, May 9, 2010, at A1.

145. *Id.*

146. *Id.*

147. *Id.*

148. *Id.*

enacted legislation determining that the state's government-owned nursing homes would receive higher Medicaid payments.¹⁴⁹ The bill allowed "the Office of Medicaid Policy and Planning (OMPP) to increase Medicaid reimbursement rates for government-owned and operated nursing facilities to the extent allowed by federal statutes and regulations."¹⁵⁰

Analysis of the legislation explains the intent was to maximize federal Medicaid funds:

In addition, the bill requires that each governmental transfer or other nursing home payment mechanism that OMPP implements must maximize the amount of federal financial participation that the state can obtain. This provision can be interpreted as requiring the state to investigate and implement alternative means of leveraging federal dollars through the Medicaid program potentially increasing federal reimbursement with little or no additional state funding.¹⁵¹

The goal was clear. Purchase nursing homes so they are government-owned, which would lead to an increase in federal Medicaid funds. Then, route the money to other uses, rather than to nursing home care.

Some legislators in Indiana tried to protect the funds for nursing homes. The state's house and senate passed a different bill requiring that federal aid from the revenue strategies using nursing homes must be used for the nursing homes: "All money used to generate additional federal financial participation under this chapter through an intergovernmental transfer or other payment mechanism and any additional payments that are received by the state through an intergovernmental transfer or other payment mechanism under this chapter shall be distributed to Medicaid nursing facilities."¹⁵² Unfortunately, then-Governor Frank O'Bannon vetoed the legislative effort,¹⁵³ and Governors Joe Kernan, Mitch Daniels, and Mike Pence allowed the strategy to continue, buying up nursing homes to leverage and divert federal aid.

Once legislation was enacted, HHC started searching for for-profit nursing homes to use in its strategy and purchased its first twelve in 2003.¹⁵⁴ Operating in the Indianapolis hospital system, the agency should

149. Engrossed S.B. 309, 112th Gen. Assemb., 1st Reg. Sess. (Ind. 2001), available at <http://www.in.gov/legislative/bills/2001/ES/ES0309.1.html>.

150. IND. STATE LEGISLATIVE SERVS. AGENCY, OFFICE OF FISCAL & MGMT. ANALYSIS, FISCAL IMPACT STATEMENT 1 (2001), available at <http://www.in.gov/legislative/bills/2001/PDF/FISCAL/SB0309.003.pdf>.

151. *Id.*

152. Engrossed H.B. 1866, 112th Gen. Assemb., 1st Reg. Sess. (Ind. 2001) (Conf. Rep.), available at <http://www.in.gov/legislative/bills/2001/HCCP/CC186604.001.html>.

153. Press Release, Frank O'Bannon, Governor of Ind., Governor Vetoes HEA 1866 (May 11, 2001), available at <http://www.in.gov/apps/utills/calendar/presscal?PF=gov&Clist=4&Elist=34726>.

154. Gillers et al., *supra* note 144.

have been focused on improving quality of care of its health facilities, but according to reports, HHC was primarily focused on increasing cash flow. When the agency started purchasing the nursing facilities, it did not actually take over operations. Rather, HHC simply bought the nursing home licenses, leased the properties from the private companies that owned the rights, and then hired a private company to operate the nursing homes.¹⁵⁵ American Senior Communities was the company running the private nursing homes prior to the initial HHC purchases in 2003, and after the purchases HHC hired the same company to keep operating them.¹⁵⁶

Although HHC is located solely in Indianapolis, the agency purchased nursing home licenses across the state in twenty-two counties.¹⁵⁷ As of 2013, HHC has purchased fifty-nine for-profit nursing homes as part of its strategy.¹⁵⁸ And after the purchases, an investigation showed that HHC did not improve the quality of care in the facilities. The contract HHC initiated with the private nursing home operators included no requirements regarding staffing levels, and no standards or incentives regarding quality of care.¹⁵⁹ The Indianapolis Star reported that as of 2010, “[t]en of the 17 homes HHC purchased in 2003 have worse state report card scores.”¹⁶⁰ Further, in “recent nationwide federal five-star rankings, 16 of the 27 HHC homes purchased through 2008—those HHC has owned the longest—received the lowest rating possible.”¹⁶¹ The investigation also determined that the “amount of time residents in HHC nursing homes receive from nursing aides is lower than the statewide average, [a]nd Indiana is 51st in the U.S., after all 50 states and the District of Columbia, in staffing levels for the aides.”¹⁶² But despite concerns, the president and executive director of HHC contended that more nursing staff would not necessarily improve care—an argument that defies common sense as well as expert opinions that one of the key measures of nursing home quality of care is nursing staff ratios.¹⁶³

HHC claimed ownership in order to trigger higher federal Medicaid payments for government-owned nursing facilities, despite the fact that the agency did not actually operate the nursing homes. But regardless of

155. *Id.*

156. *Id.*

157. *Id.*

158. J.K. Wall, *Feds Scrutinize Nursing Home Buying Spree*, INDIANAPOLIS BUS. J. (Apr. 27, 2013), <http://www.ibj.com/feds-scrutinize-nursing-home-buying-spree/PARAMS/article/41005>.

159. Gillers et al., *supra* note 144.

160. *Id.*

161. *Id.*

162. *Id.*

163. *Id.*

the illusory nature of the strategy, HHC purports to have a mission to serve the public health and the interests of its beneficiaries: “to promote and protect the health of everyone in the community and provide health care to those who are underserved.”¹⁶⁴ Adhering to that mission, the agency should have used any federal aid claimed on behalf of nursing homes, especially nursing homes providing poor quality care, to improve the services for the nursing home residents. But unfortunately, improving nursing home care has not been HHC’s motive.

When HHC buys a for-profit nursing home, the purchase can immediately lead to an additional \$55 in federal Medicaid payments per day per nursing home resident.¹⁶⁵ The agency then has diverted most of the extra money away from the nursing homes, using the funds for other purposes such as a new \$750 million dollar hospital complex.¹⁶⁶ Indiana and HHC have viewed the strategy as successful, providing for additional federal funds that were routed to build a new hospital system without the otherwise required increase in property taxes or state and local spending.¹⁶⁷ But for the residents of the nursing homes, the strategy has not been successful. As HHC bought up the nursing homes, the agency left the residents in poor care while their federal aid was diverted.¹⁶⁸ When asked about the practices, a professor of bioethics explained the immorality of HHC actions: “As a general moral principal when dealing with vulnerable persons, your first duty is to make sure they have adequate protection and services that meet their needs”¹⁶⁹

HHC used the federal aid funds it routed from the nursing home residents to build a new \$750 million dollar hospital complex.¹⁷⁰ HHC named the complex Eskenazi Health in recognition of a real estate developer’s \$40 million donation.¹⁷¹ But much more of the money came from HHC taking aid from nursing home residents. By 2010, HHC obtained \$218 million through its revenue strategy, and the cash flow increased to \$104 million annually by 2012.¹⁷² The HHC scheme of buying up nursing homes to divert their federal aid resulted in quite the hospital system:

Indiana has never seen a hospital quite like this.

164. HEALTH & HOSP. CORP., <http://www.hhcorp.org/hhc/> (last visited Mar. 23, 2016).

165. Gillers et al., *supra* note 144.

166. *Id.*

167. *Id.*

168. *Id.*

169. *Id.*

170. *Wishard to Get \$40M Donation, New Name*, INDY CHANNEL (June 22, 2011), <http://www.theindychannel.com/news/wishard-to-get-40m-donation-new-name>.

171. *Id.*

172. Wall, *supra* note 158.

From the spiraling wooden sculpture suspended from the ceiling in the main concourse to the vegetable garden on the roof, the brand-new Eskenazi Hospital keeps you wondering what you will see around the next corner.

....

Up on the rooftop, a 5,000-square-foot “Sky Farm” features a produce and flower garden laid out in neat rows. A nearby shed is filled with gardening tools. Patients and employees will be able to plant and pick fruits, vegetables and flowers, or just sit on a bench and gaze at the horizon.¹⁷³

Resulting from their \$40 million donation, HHC put a sculpture of Mr. Eskenazi and his wife in the hospital’s main concourse.¹⁷⁴ The president of HHC explained that in making the hospital system “beautiful and unique,” “we didn’t want to forget our history,” and “[w]e want to look forward while honoring where we came from.”¹⁷⁵ But providing a different view of where the hospital system came from, the long-term-care policy director for United Senior Action explained, “They are funding this hospital literally on the backs of these [nursing home] residents.”¹⁷⁶ Through the practice, HHC built a new hospital complex, and companies running the nursing homes were able to profit.¹⁷⁷ The strategy also resulted in arguable benefit to many taxpayers by avoiding the property taxes that would have otherwise been required to fund the project.¹⁷⁸ But while ownership of the nursing homes and federal aid was shifted around, and everyone else seemed to benefit, the nursing home residents were still trapped in poor care.

F. Audits Unable to Keep Up with the Schemes

The strategies discussed in this Article are not new, and the federal government is often aware of them. At times, federal agencies and the executive branch have tried to clamp down on the illusory practices. However, as soon as the federal government tries to restrict one type of practice, the states and their contractors seem to invent another to constantly stay one step ahead. Federal regulatory attempts have occurred multiple times, including a federal regulation requiring improved transparency and accountability requirements for DSH payments that are of-

173. John Russell, *Eskenazi Hospital Prepares to Open*, INDYSTAR (Nov. 16, 2013), <http://www.indystar.com/story/news/2013/11/16/eskenazi-hospital-prepares-to-open/3609921/>.

174. *Id.*

175. *Id.*

176. Gillers et al., *supra* note 144.

177. *Id.*

178. *Id.*

ten used in the revenue strategies.¹⁷⁹ In addition to the regulations, the Patient Protection and Affordable Care Act includes cuts to federal DSH payments, because the payments should be less necessary as more of the previously uninsured have access to health insurance.¹⁸⁰

However, the federal government's attempts have not addressed another category of "non-DSH supplemental payments."¹⁸¹ As traditional DSH payments may become less available, states have increased their targeting of the non-DSH supplemental payments as another source of revenue strategies. According to the GAO, the federal Medicaid matching non-DSH supplemental Medicaid payments grew by over \$8 billion from 2006 to 2010.¹⁸² Of those payments, \$2.3 billion was claimed by only one state—Texas.¹⁸³

Despite the attempts by the federal government to reduce other forms of Medicaid revenue strategies, the revenue maximization schemes and diversion of federal aid have continued. For example, the budget estimates for Indiana show \$58 million from the state's disproportionate share hospital program going into the general fund each year for FY 2012 and FY 2013.¹⁸⁴ In North Carolina, the general fund budget documents for FY 2012 and FY 2013 include \$115 million in funds generated from the disproportionate share program each year.¹⁸⁵ In Texas, federal aid from the disproportionate share program is considered by the state as non-tax revenue that is "available for general purpose spending."¹⁸⁶ The Texas budget estimate explains: "With respect to federal payments, General Revenue-related revenues from the Disproportionate Share Program, which helps pay for indigent care at state and local hospitals and the closely related Upper Payment Limit Program . . . are expected to total

179. Disproportionate Share Hospital Payments, 73 Fed. Reg. 77904 (Dec. 19, 2008) (codified at 42 C.F.R. pts. 447, 455).

180. Robin Rudowitz, *How Do Medicaid Disproportionate Share Hospital (DSH) Payments Change Under the ACA?*, KAISER FAMILY FOUNDATION (Nov. 13, 2013), <http://kff.org/medicaid/issue-brief/how-do-medicare-disproportionate-share-hospital-dsh-payments-change-under-the-aca/>.

181. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO 12-694, MEDICAID: STATES REPORTED BILLIONS MORE IN SUPPLEMENTAL PAYMENTS IN RECENT YEARS 18 (2012), available at <http://www.gao.gov/assets/600/592785.pdf> (accessed Nov. 30, 2014).

182. *Id.*

183. *Id.*

184. IND. STATE BUDGET AGENCY, GENERAL FUND: COMBINED STATEMENT OF UNAPPROPRIATED RESERVE (2011), available at http://www.in.gov/sba/files/ap_2011_0_0_51_reserve.pdf.

185. STATE OF N.C. OFFICE OF STATE CONTROLLER, GENERAL FUND MONTHLY FINANCIAL REPORT: MAY 31, 2013 (2013), available at http://www.osc.nc.gov/pdfs/May_2013_General_Fund_Monthly_Report.pdf.

186. TEX. COMPTROLLER OF PUB. ACCOUNTS, THE 2012-13 CERTIFICATION REVENUE ESTIMATE, http://www.texastransparency.org/State_Finance/Budget_Finance/Reports/Certification_Revenue_Estimate/cre1213/text.php.

\$669 million in 2012-13.”¹⁸⁷ California will likely claim more than Indiana, North Carolina, and Texas combined, using just a bed tax on hospitals. Legislation enacted in 2013 extends the bed tax on hospitals for three years, and plans for the resulting federal Medicaid funds included shifting the money into state general revenue:

In 2013, the fee raised \$3 billion. The state received \$620 million, some \$40 million went to hospitals as grants and the remainder was used as leverage to attract an additional \$1.9 billion in federal funds

It is estimated that extending that fee for three more years beginning next year will generate \$3 billion for the state’s General Fund¹⁸⁸

Further, Florida has not backed off from using intergovernmental transfers (IGTs) to save state general revenue—including over \$880 million in just one year:

Over the years the amount of dollars that have been used for these activities has grown substantially. A significant portion of the funding in the Medicaid budget for hospitals for inpatient and outpatient services is funded by IGT’s in lieu of state general revenue funds. For FY 2009-2010, there was \$880,351,951 in IGTs in the Florida Medicaid budget.¹⁸⁹

III. CONFLICT WITH STATUTORY PURPOSE

The Medicaid revenue maximization strategies undermine the core statutory purpose of the Medicaid program. When Congress enacted the Medicaid program in 1965, the purpose was not to simply give the states money to replace their spending on health care services for the poor. Nor was the purpose to give states billions in federal funds that they could just route to their general funds for any state purpose. With the Medicaid program, Congress sought to create a partnership between the federal government and the states, including shared financing, “so as to make medical services for the needy more generally available.”¹⁹⁰

When first enacted, Congress included a maintenance of state effort provision to assure that the federal funds, “which are to accrue to the

187. *Id.*

188. Bob Norberg, *California Hospital Group Proposes Ballot Initiative for Medi-Cal Provider Free*, CALIFORNIA HEALTHLINE (Oct. 10, 2013), <http://www.californiahealthline.org/capitol-desk/2013/10/california-hospital-group-proposes-ballot-initiative-for-medi-cal-provider-fee>.

189. FLA. AGENCY FOR HEALTH CARE ADMIN., FLORIDA MEDICAID INTERGOVERNMENTAL TRANSFER TECHNICAL ADVISORY PANEL REPORT 59 (2011), available at http://ahca.myflorida.com/Medicaid/igt/docs/Final_IGT_TAP_Report_010611.pdf.

190. S. REP. NO. 89-404, at 66 (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 2014.

States under the operation of the formula described above, shall be used directly in the public assistance program and may not be withdrawn from the program by the States.”¹⁹¹ Even though the provision has not continued into the current statutory language, the provision’s inclusion at the Medicaid program’s beginning clearly shows the intended purpose federal Medicaid funds—to combine the federal spending with state spending to attain increased funding for medical services for the poor.

State use of the Medicaid funds must be consistent with states’ Medicaid plans.¹⁹² States receiving federal Medicaid payments must “provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . to assure that payments are consistent with efficiency, economy, and quality of care.”¹⁹³ And the Medicaid program is structured with the intent to incentivize states to provide more Medicaid services. The federal payments are provided as a match to state spending.¹⁹⁴ The more states spend on Medicaid services, the more federal matching payments the states can claim.

The federal matching payments are considered federal financial participation. This FFP structure assumes that both the federal government and states will pay a matching percentage of the total Medicaid spending. The federal payments are clearly intended to supplement, not replace, the state spending. Thus, in the revenue strategies explained through this Article, when federal Medicaid matching payments are instead claimed through illusory schemes where no state spending actually occurs, and if the federal payments are just used to bolster state general revenue rather than for Medicaid services, the statutory purpose and intended structure of the federal payments are undermined.

CONCLUSION: RESTORING PURPOSE TO THE MEDICAID PROGRAM

To be clear, the answer to state practices of diverting Medicaid funds is not to make cuts to the Medicaid program. The answer is to stop the misuse of aid funds so vulnerable populations receive the assistance they desperately need.

When states hire private contractors to help use illusory revenue strategies to maximize federal Medicaid matching funds with no corresponding state spending, and states divert the federal aid to general coffers, the intended collaboration between the federal government and states in running and financing the Medicaid program is destroyed. The

191. *Id.* at 78, 245–46, reprinted in 1965 U.S.C.C.A.N. at 2025, 2211–12.

192. 42 U.S.C. § 1396c (2012).

193. *Id.* § 1396a(a)(30)(A).

194. Hatcher, *Poverty Revenue*, *supra* note 11, at 682–87.

solution is not difficult to understand. The core statutory purpose and structure of the Medicaid program must be protected to restore integrity to the program, to reduce states' misuse of billions in taxpayer dollars, and to ensure vulnerable children and adults receive the Medicaid services they desperately need.

When states claim federal Medicaid matching payments intended to increase Medicaid services, the states must not be allowed to redirect the funds to bolster their general state funds. Maintenance of effort requirements,¹⁹⁵ or "supplement, not supplant"¹⁹⁶ limitations, should be imposed on states and monitored.

States must be held accountable when Medicaid funds are diverted contrary to statutory purpose. The Center for Medicare and Medicaid Services (CMS) can strengthen its efforts under existing statutory authority to ensure to protect the integrity of the Medicaid program, and such authority must be exercised. The federal statute requiring "efficiency, economy and quality of care" is interpreted as providing CMS with broad authority to restrict state practices that conflict with the statutory purpose.¹⁹⁷ CMS can deny proposed state Medicaid plans that are inconsistent with the statutory purposes. The agency should also use the authority to better monitor and restrict the state diversion of federal Medicaid payments. CMS could require states that misuse the federal aid—those who route the funds to general state coffers—to redirect the federal aid to assist the intended benefits. And if a revenue contractor knowingly encourages or carries out illusory revenue practices that conflict with the statutory framework, the companies should be investigated under False Claims Act provisions and possibly blocked from future contracts with the federal aid programs.¹⁹⁸

Further, in addition to improving the integrity of state actions in their claims for federal Medicaid dollars, the federal government should also improve the process for claiming the funds. The federal regulations can be further clarified, improving the process to ensure that the statutory purposes of the Medicaid program are carried out. For example, to address states' use of illusory UPL supplemental payment strategies, the federal government should not reduce the upper payment limits but ra-

195. For example, welfare assistance block grants to states in the Temporary Assistance to Needy Families program (TANF) include a maintenance of effort requirement. 42 U.S.C. § 609(a)(7) (2012).

196. Such a "supplement, not supplant" requirement already exists in federal aid programs to improve state education services. See Mariana Kihuen, *Leaving No Child Behind: A Civil Right*, 17 AM. U. J. GENDER SOC. POL'Y & L. 113, 130 n.108 (2009).

197. Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs., 424 F.3d 931, 939–40 (9th Cir. 2005).

198. See 31 U.S.C. § 3729 (2012).

ther further clarify (and enforce) that any federal Medicaid funds claimed as a result of supplemental payments must be used for the intended Medicaid purposes.

Increased federal audits may be necessary to better police the actions of states and their contractors. But the federal government should reduce its own reliance on private contractors in the auditing process. Currently, contractors are being hired by the federal government to monitor the actions of contractors hired by the state governments. Medicaid contractors are assisting states in maximizing claims for federal aid while simultaneously working for the federal government to reduce payout of the same federal dollars. Making money both coming and going is certainly profitable for the contractors, but is harmful to fiscal federalism's hopes for harmonious collaboration between the federal and state governments.

Continued debate should consider possible structural changes to further reduce the misuse of aid funds, ranging from improvements to the current matching grant structure to complete federalization. Proposals to convert the Medicaid program into part of the current Medicare program would certainly reduce the diversion of federal aid, as states would no longer operate the program and the federal matching grant structure would be replaced with direct federal financing.¹⁹⁹ At the other end of the spectrum, proposals to restructure Medicaid by giving all the money to states, and letting them figure out the best use, would likely worsen the problems. For example, in the "flex fund" proposal by Senator Marcus Rubio, he seeks to consolidate most federal aid funds and hand over all the money to states as flexible funds to use as they wish.²⁰⁰ Likewise, Congressman Paul Ryan's "opportunity grant" proposes to terminate the current safety net programs and just give all the money to the states.²⁰¹ The argument for such block grant proposals is that, because states are better able to understand the needs of their residents, the states should have complete access and control over the federal aid dollars. But the theory is glaringly flawed.

Despite layers of regulations and multiple federal audits in the Medicaid program, states and their revenue maximization consultants

199. For an example of one such proposal, see Timothy Noah, *New Republic: Time to Federalize Medicaid*, NPR (July 24, 2012, 8:39 AM), <http://www.npr.org/2012/07/24/157276966/new-republic-time-to-federalize-medicaid>.

200. Jackie Kucinich, *Rubio: War on Poverty Has Been Lost*, WASH. POST (Jan. 8, 2014), <http://www.washingtonpost.com/blogs/post-politics/wp/2014/01/08/rubio-war-on-poverty-has-been-lost/>.

201. Robert Greenstein, *Commentary: Ryan "Opportunity Grant" Proposal Would Likely Increase Poverty and Shrink Resources for Poverty Programs Over Time*, CTR. ON BUDGET & POL'Y PRIORITIES (July 24, 2014), <http://www.cbpp.org/cms/index.cfm?fa=view&id=4176>.

seek out loopholes and illusory schemes to maximize and divert the aid to other uses. Removing all federal oversight, and just giving the money to the states, would only ensure that less of the federal aid gets to those in need. Considering Romney's Medicaid maximization strategies discussed earlier in this Article, "It's not hard to imagine how a governor—one that employs complex shell games to find loopholes in federal rules in order to maximize and divert federal aid—would use the federal funds if handed to the state without any federal oversight."²⁰² When states misuse federal aid, the response should not be to give those states even more flexibility to use the money however they want. Rather, we must take further steps to improve the claiming process, clarify statutory and regulatory language, close loopholes, and increase federal monitoring to end the illusory revenue schemes—to begin ensuring that simple but crucially important goal that Medicaid funds are used as intended, for Medicaid services.

202. Hatcher, *Romney's Medicaid Shell Game*, *supra* note 48.

