Feds say hospitals that redistribute Medicaid money violate law

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The Biden administration wants to crack down on private arrangements among some hospitals to reimburse themselves for taxes that help fund coverage for low-income people. It contends the practice violates federal

law.

Federal regulators say these arrangements "appear designed to" redirect Medicaid dollars away from facilities that treat the poorest patients to those that "provide fewer, or even no, Medicaid-covered services," according to a proposed enforcement plan released May 3 by the Centers for Medicare & Medicaid Services.

The practice is typically orchestrated by the lobbying groups that represent hospitals in state capitals—and is often kept secret. Not even federal regulators know how widespread it is, although programs operate in at least a few states, including California and Missouri. It's also the subject of a Texas lawsuit that could block the federal government's proposal.

"It does seem like these associations are finding a way to distribute the money in a really weird way," said Joshua Gordon, the director of health policy for the Committee for a Responsible Federal Budget in Washington, D.C. "But without the transparency, we don't exactly know what's going on."

Previous efforts to block these payback arrangements have gone nowhere in the face of opposition from the powerful health care industry and state health officials who fear that clamping down could result in less money for Medicaid, the joint state-federal health insurance program for low-income people. Several Medicaid experts predicted the latest proposal could meet the same fate, or face immediate court challenges if adopted.

The federal government's sweeping and contentious proposal would require states to police hospitals, nursing homes, and other health care providers to ensure they made no private agreements to redistribute Medicaid dollars.

Public and private hospitals argue CMS has no jurisdiction to regulate private transactions and has overstepped its legal authority. Together with state health officials from around the country, they warn the move could strip billions of federal dollars from Medicaid and threaten safety-net coverage for 94 million low-income people. Texas alone could lose $6 billion a year, according to Texas Health and Human Services.

KFF Health News attempted to interview state health leaders and hospital association officials around the country, but they declined to comment or did not respond to repeated calls and emails.

The federal government's proposal is part of a broader Medicaid financing package, and it resurrects a long-standing effort by administrations of both parties over the years to rein in Medicaid spending—which ballooned to $734 billion in 2021.

In this case, regulators are targeting what are known as provider taxes, which states are increasingly imposing on hospitals, nursing homes, and other health care providers to help states pay for their share of the Medicaid program. The more provider taxes states levy, the more money they can also get in federal funding.

These taxes are a critical source of revenue that all states except Alaska rely on for their Medicaid programs—and to get federal matching Medicaid dollars. They account for 17% of state Medicaid funding in 2018, according to a 2020 report by the Government Accountability Office, which called for more transparency in how the money is collected and spent.

In California, hospitals have redistributed provider tax funds since 2009. Here's how it works: Hospitals with a significant share of low-income patients get more Medicaid funding back than they pay in the tax, so they donate a small portion of their Medicaid funding to a charity run by

the leadership of the California Hospital Association, a statewide lobbying organization. The charity awards grants to the hospitals that treat a smaller share of low-income patients and don't receive as much funding back as they paid in taxes.

For instance, Cedars-Sinai in Los Angeles, one of the country's richest hospitals, paid nearly $172 million in provider taxes in 2022, eclipsing the $151 million it got back in Medicaid dollars. Then, it received nearly $28 million from the hospital association's charity—earning about $6.9 million from the program, the hospital's audited financial statements show.

Meanwhile, faith-based Adventist Health, which serves a larger share of poor people and operates roughly two dozen hospitals in California, Oregon, and Hawaii, paid $148 million in taxes in 2022 and reaped $401 million in Medicaid dollars through the program, according to its independently audited financial statements. It then contributed $3 million of that Medicaid money to the charity.

Federal law sets stringent rules for provider taxes: They must be broad-based and apply to all providers within a certain category, like hospitals; providers within a state must be taxed at the same rate; and taxes can't be returned directly or indirectly to providers as part of a "hold harmless" agreement.

It's that last clause that has spurred the feds to act.

Regulators say some health care providers, to gain the needed support within their ranks for the tax, are moving the tax money—and the federal revenue it draws to states—among themselves.

"We believe providers with relatively higher Medicaid volume agree to redistribute some of their Medicaid payments to ensure broad support

for the tax program," they wrote in their proposal.

These agreements "undermine the fiscal integrity" of the Medicaid program, they wrote.

It's unclear how widespread such agreements are because hospitals don't make them public. CMS said it has identified "instances" of Medicaid redistribution payments, but spokesperson Greg Myers declined to elaborate.

Jonathan Williams, vice president of government affairs at Sutter Health, which operates about 20 hospitals across Northern California, argued in a June 30 letter to the federal agency that these arrangements help hospitals expand "care networks and afford necessary incentives to ensure that providers can continue caring for Medicaid beneficiaries with unique and specific care needs."

Missouri's hospital association also runs a "pooling arrangement," in which hospitals that get more Medicaid money than they paid in taxes can donate funds to the hospitals that didn't.

"Missouri providers have had various private agreements to redistribute funds among themselves for decades, with the full knowledge and approval of CMS," according to an unsigned and undated letter to the agency from the MO HealthNet Division, which runs the state's Medicaid program.

In 2002, Missouri got federal approval for its redistribution program by pledging to use the funds for Medicaid services, whereas California has not received approval.

The federal government's plan would require states to get health care providers to attest that they don't participate in any arrangement that

violates federal law. State officials described the proposal as an impractical administrative burden that could dissuade hospitals, nursing homes, and other providers from participating in Medicaid altogether. "Imposing additional requirements on providers that participate in Medicaid managed care networks would only serve to further dissuade network participation, which will have a negative impact on member access to care," Mike Levine, the assistant secretary for MassHealth, Massachusetts' Medicaid program, wrote to CMS on July 3.

Texas, which has long tangled with the federal agency over how it funds its Medicaid program, sued in federal court earlier this year after the agency declared in a separate letter to states that these types of arrangements aren't allowed and must be reported. The letter was sent in February, before the agency issued its formal proposal.

In June, a federal judge handed Texas and its health care industry a victory, temporarily delaying the reporting requirement that regulators had outlined in their February letter. The judge agreed with Texas that the agency had exceeded its legal authority and couldn't regulate private agreements.

State health officials and hospital leaders are pointing to the Texas court case as evidence that the agency's May proposal to crack down on the redistribution of Medicaid funds is a "widely controversial interpretation" of the law, as the Tennessee Hospital Association put it in a July 3 letter to CMS.

Federal regulators have not said if or when they will implement their plan. The last time the agency issued a sweeping Medicaid financing proposal, it withdrew it almost a year later.

Mark McClellan, who served as head of the Centers for Medicare & Medicaid Services for two years during the George W. Bush

administration, predicted states and Congress would push back hard if the new proposal moved forward.

"Medicaid is a huge component of state spending and keeps getting bigger," McClellan said. "So, sudden CMS changes or clamping down is going to be disruptive for state coverage."