Medicaid Money Laundering Harms Long-Term Care

Stephen Moses

New research shows that Medicaid money laundering schemes negatively impact nursing home patients and may particularly harm people with Alzheimer's and dementia.

The Medicaid program is massive and growing rapidly. It consumed 2.9 percent of gross domestic product (GDP) in 2019 before it exploded during the COVID public health emergency. The Congressional Budget Office projects that Medicaid will reach 5 percent of GDP by 2035 and 7 percent by 2080.

While states administer and help pay for Medicaid, the federal government shoulders most of the cost. But the program's size and political pressure prevent the federal government from conducting meaningful oversight. For most enrollees, the federal-state distribution of Medicaid costs is determined by a formula, with a statutory floor. Depending on the state's per capita income, the federal government pays between 50 percent and 83 percent of Medicaid's total cost. In other words, the federal government provides states with funding for the amount it spends from its own tax base. For a state receiving an average 60 percent federal Medicaid match rate, every $1 in state Medicaid spending generates $1.50 in federal Medicaid funds. This financing structure creates a strong incentive for states to *appear* to be devoting state resources to Medicaid in order to receive as much federal funding as possible.

Every state except one (Alaska) taxes health care providers to generate extra revenues they use to boost their federal Medicaid match without drawing on their own general funds. Likewise, many states use intergovernmental transfers (IGTs), whereby local or state government entities transfer funds to the state's Medicaid agency to inflate federal matching funds. (For more background on IGTs, see Paragon's recently published policy brief.) Paragon calls these and similar schemes "legalized money laundering," because they are used to maximize federal expenditures at minimal state cost, often diverting them to unauthorized purposes. The largest laundered sums involve hospitals and insurers, but states also tax nursing homes and other long-term care (LTC) providers (though less so) for the same purpose.

New NBER Research Reveals How Money Laundering Harms Patients

A recent paper published by the National Bureau of Economic Research (NBER) documents how Medicaid's fiscal structure leads to a misallocation of resources and harms patients. The research, led by Martin Hackmann, an associate professor at UCLA, focuses on Medicaid spending in the nursing home industry.

Combining audit reports with survey data, the authors found that between 2000 and 2002, 16 states used creative financing schemes to divert at least $17 billion in Medicaid funds away from nursing homes. They estimate that states inflated nominal reimbursement rates by 30 percent over the effective rate, growing the Federal Medicaid Assistance Percentage—which determines the level of federal Medicaid funding—by 16 percentage points. Congress directed the Department of Health and Human Services (HHS) to limit these schemes but inadvertently created a new method for states to maximize federal funds with minimal state expenditures.

The Indiana Case Study

The NBER study provides a case study showing how Indiana's nursing home residents were harmed due to perverse state incentives and lax federal oversight. Here is how Indiana's scheme worked.

Prior to 2003, states could divert funds accrued from public and private nursing homes to county-owned nursing homes and, subsequently, redirect them to state coffers. The majority of states operated such IGT schemes in the early 2000s. Pennsylvania represents a particularly egregious example. The state paid $300 million to 23 county-owned nursing homes, which triggered $400 million in federal matching funds. However, of the total $700 million, providers kept only $1.5 million (0.2 percent). The rest was transferred to the Pennsylvania government through an IGT.

In 2003, in response to these abuses, HHS introduced new restrictions, banning states from redirecting money from *private* nursing homes. But states soon developed strategies to bypass these restrictions as well.

Because the 2003 reform allowed IGT schemes involving *public* nursing homes to continue, Indiana simply induced county-owned hospitals to "acquire and municipalize" private nursing homes. Consequently, the share of public nursing homes grew from 5 percent in 2000 to 95 percent by 2017, allowing the IGT money laundering scam to explode. The ploy was highly effective at maximizing federal Medicaid revenue: In 2020, Indiana received nearly $1 billion in Medicaid supplemental payments for nursing facilities—exceeding much larger states such as California and New York. The Indianapolis Star reported that, of the $4.3 billion in

additional Medicaid funding flowing to nursing homes, up to 70 percent has been diverted away from Medicaid patients in favor of other state projects. Indiana's scheme still operates today, funneling billions of federal taxpayer dollars away from Medicaid. In essence, these schemes permit states to obtain a massive infusion of federal dollars to use for any purposes. Congress should end this abuse.

The key problem, as the paper shows, is the federal government's open-ended and high matching grant structure. This feature of Medicaid's design gives states strong incentives to artificially inflate their Medicaid spending to receive additional federal funds to be used for non-Medicaid purposes. By encouraging state policymakers to focus on increasing the *quantity* of Medicaid services, the federal funding formula leads to a decline in the *quality* of care patients receive.

More Nursing Home Deaths, Lower Quality Facilities for Alzheimer's/Dementia Patients

The negative effects of such schemes extend beyond waste and abuse of federal taxpayer money. Using data on nursing home quality, the NBER paper shows that the diversion of money away from nursing homes to other state uses harms patients. After Indiana developed its post-2003 financing plan, the state experienced an increase in Medicaid nursing home occupancy, with the growth especially concentrated in lower-quality nursing homes. The paper estimates that these reallocations to low-quality facilities resulted in the deaths of about 50 patients per year.

To reach these conclusions, the NBER paper created a theoretical model, using administrative, audit, and survey data—exemplified by the Indiana case study—to show how states boost their federal matching funds by increasing care volume but end up causing quality to decline, especially for their most vulnerable recipients. The model shows how, because the federal government cannot adequately track state spending, states increase the *nominal* rate they pay nursing homes and other LTC providers (thus increasing the federal matching funds they receive), but then they actually pay the providers a lower *effective* rate, resulting in both higher care quantity and lower quality. States divert the resulting "public markup" toward other, often non-Medicaid purposes.

After the conversion from private to public nursing homes, Indiana's volume of Medicaid-financed care increased by 5 percent. For Alzheimer's disease-related dementias, the increase was even larger—12 percent—and included an expansion of Alzheimer's special care units. These patients are a special case, having relatively long nursing home stays and comprising 35

percent of patient days, thus presenting a high potential for federal funds diversion. While there was no statistically significant change in care quality overall after the conversion, there were large differences in quality among nursing homes. Medicaid volume increased across the entire quality distribution of nursing homes, but the largest increase occurred among the 20 percent of nursing homes with the worst safety and quality ratings.

According to the paper, "shifting patients from the lowest to the highest-quality quintile could boost their survival rate by 31 percentage points" and "reallocating Medicaid funds to enhance care quality, or usage at higher-quality facilities, could cut costs on dementia care by up to 1.7 [percent] without compromising quality-adjusted quantity of care." Based on Indiana's $1.8 billion annual Medicaid spending on dementia stays, this amounts to $310 million of wasteful spending over a decade. Thus, Indiana's creative financing schemes skewed the quality-quantity balance by promoting the expansion of lower-quality nursing home care.

The NBER analysis concludes that creative Medicaid financing in the nursing home sector for the purpose of maximizing federal matching funds can lead to two kinds of distortions. First, lower quality providers that can expand care at lower costs are incentivized to expand Medicaid volume. Second, the fiscal incentives favor institutional care over home- and community-based alternatives. In the pursuit of this creative financing scheme, Indiana succeeded in vastly increasing federal Medicaid funds but at the cost of lowering nursing home care quality, especially for the program's most vulnerable long-stay Alzheimer's patients.

The NBER Paper Shows the Folly of Creative Medicaid Financing Schemes

Defenders of Medicaid "money laundering" often claim that these schemes are necessary to give states the resources to adequately fund health services for the poor. This argument fails to appreciate how creative financing schemes distort state incentives, contribute to low provider payments, and encourage policymakers to expand nominal access to care without genuinely addressing health system capacity. As Indiana's nursing home experience shows, patients often pay the price for these misguided policies.

To help prevent such resource diversion, Congress has rightly sought to curb some of states' Medicaid money laundering schemes. As the NBER's research shows, further encouraging state fiscal discipline may even save patients' lives. Congress and HHS should crack down on abusive Medicaid IGT schemes that lead to windfalls for states, raise federal deficits, and harm the neediest patients.