



Testimony

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Policy, Health Care and Entitlements,
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Completed and Preliminary
Work Indicate that
Transparency around State
Financing Methods and
Payments to Providers Is
Still Needed for Oversight

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GAO Highlights

Highlights of [GAO-14-817T](#), a testimony before the Subcommittee on Energy Policy, Health Care and Entitlements, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

Medicaid is a joint federal and state program for which the federal government matches state Medicaid expenditures. Total program costs were about \$432 billion in federal fiscal year 2012. States use various sources of funds to finance the nonfederal share, such as state funds and funds from health care providers and local governments. Medicaid has been on GAO's list of high-risk programs since 2003, in part, because of concerns about federal oversight of complex state Medicaid financing arrangements where states seek funds from the providers for the nonfederal share of the payments, and oversight of large supplemental payments that states often make to government providers. States may have incentives to overpay providers that help finance the nonfederal share to maximize federal matching funds.

This statement highlights (1) findings from GAO's report being issued today on how states' reliance on health care providers and local governments to finance Medicaid changed from state fiscal years 2008 through 2012, and implications of these changes; and (2) preliminary results from GAO's ongoing work on what is known about data to oversee state Medicaid payments to government and private providers. For this work, GAO surveyed states, interviewed CMS and state officials, and reviewed information in three states selected, in part, on the basis of size, Medicaid payments, and geographic diversity. GAO shared information on its preliminary observations with CMS and incorporated comments as appropriate.

View [GAO-14-817T](#). For more information, contact Katherine M. Iritani at (202) 512-7114 or iritanik@gao.gov.

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Completed and Preliminary Work Indicate that Transparency around State Financing Methods and Payments to Providers Is Still Needed for Oversight

What GAO Found

In its report being issued today ([GAO-14-627](#)), GAO found that states' reliance on funds from health care providers and local governments to finance Medicaid has increased in recent years, with implications for federal costs. In state fiscal year 2012, while most of the nonfederal share was from state general funds, states used funds from health care providers and local governments to finance 26 percent, or over \$46 billion, of the total nonfederal share of Medicaid payments. States' reliance on funds from health care providers and local governments to finance the nonfederal share increased by over 21 percent from state fiscal years 2008 through 2012. States' increasing use of funds generated from health care provider taxes was one main contributing factor to this increase. States' increasing reliance on providers and local governments to finance Medicaid can effectively shift costs from the state to the federal government, as illustrated by GAO's work in three selected states. For example, in one state, a \$220 million payment increase for private nursing facilities funded by a tax on private nursing facilities resulted in an estimated \$110 million increase in federal matching funds and no increase in state general funds, and a net payment increase to the facilities, after paying the taxes, of \$105 million.

GAO's preliminary results from ongoing work related to state Medicaid payments to government providers shows that data needed for overseeing Medicaid payments are lacking. Federal payment data do not capture on a provider-specific basis certain large supplemental payments states often make and generally lack information on provider ownership. At the state level, preliminary results in three selected states suggest that payment data primarily maintained by states are not always reliable and can be challenging to obtain and assess. GAO's preliminary analysis of Medicaid payments to government hospitals in one state suggests the need for and value of better data for oversight. GAO estimates that on an average per day basis, the state's 2011 inpatient hospital payments were higher for local government hospitals than for private hospitals. For local government hospitals, the higher average payment was largely due to supplemental Medicaid payments the state made to two local government hospitals. State officials said these hospitals served patients with greater needs. However, the state's own estimate of what Medicare would have paid these hospitals for similar services was \$100 million, much less than the \$416 million in supplemental Medicaid payments and \$70 million in regular payments that the hospitals received. Documentation from the Centers for Medicare & Medicaid Services' (CMS) payment review process did not identify the actual supplemental payments these hospitals received. GAO plans to issue its final report later this year.

In GAO's past reports and the report being released today ([GAO-14-627](#)), GAO has made recommendations to CMS to improve Medicaid payment oversight and develop a data collection strategy to improve the transparency of state financing methods. CMS has taken steps to improve the transparency and oversight of Medicaid financing and payments but has not implemented all of GAO's prior recommendations, and has generally disagreed with GAO's new recommendation. CMS believes that additional action is not needed. As discussed in the statement, GAO continues to believe that provider-specific information on state Medicaid financing and payments is needed.

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee:

I am pleased to be here today as you explore federal oversight of state financing of Medicaid and state Medicaid payments to government providers. The size, growth, and diversity of the Medicaid program create significant challenges for administration and oversight. Medicaid is administered by states, overseen by the Centers for Medicare & Medicaid Services (CMS),¹ and financed jointly by the federal government and states based on a statutory formula. Medicaid is the nation's largest health program as measured by enrollment and the second largest health program, after Medicare, by expenditures. A significant pressure on federal and state budgets, Medicaid outlays in federal fiscal year 2012 were \$432 billion, up from \$352 billion in 2008.

Medicaid has been on GAO's list of high-risk programs since 2003, in part, because of these challenges and also due to concerns about gaps in federal oversight.² These concerns included CMS's oversight of states' complex Medicaid financing arrangements and large supplemental payments that states often make—particularly to state or local government providers such as state or county hospitals—in addition to the regular, claims-based payments. States generally finance their share of Medicaid—often called the nonfederal or state share—by using state general funds appropriated by state legislatures. However, states can, within certain federal parameters, use other sources of funds to finance Medicaid.³ For example, they may seek contributions from local governments or impose taxes on health care providers. One concern with some of these financing arrangements is that they may create incentives for states to overpay providers in order to reduce states' financial obligations. For example, we have found that states have established complex financing arrangements to make excessive payments—often

¹See Appendix I for a list of abbreviations used in this statement.

²See GAO, *High Risk Series: An Update*, [GAO-13-283](#) (Washington, D.C.: February 2013).

³For example, under federal law, state funds must be used for at least 40 percent of the nonfederal share, allowing up to 60 percent to come from local government revenues. For purposes of this statement, sources of funds are the means (e.g., taxes) by which funds are supplied by entities (e.g., providers) to the state to be used to finance the nonfederal share of Medicaid; we do not use the term sources to refer to the entities themselves.

large Medicaid supplemental payments—to government providers in order to leverage federal funds for the payments.⁴ In the case of state government providers, excessive Medicaid payments can reduce the state’s obligation to supply funds to the provider for non-Medicaid services. In the case of local government providers, when they or local governments supply the nonfederal share of Medicaid payments, states may have an incentive to make excessive Medicaid payments to local government providers because the state has a reduced obligation to supply funds to finance the nonfederal share. Private providers that serve Medicaid beneficiaries can be taxed in order to provide funds for the state share of Medicaid payments. Generally, these taxes are levied on large providers, particularly hospitals or nursing facilities, and they are acceptable to providers because the tax revenues they supply allow the state to increase the payments they receive. As the agency overseeing Medicaid at the federal level, CMS is responsible for ensuring that state Medicaid payments made under such financing arrangements are consistent with Medicaid payment principles, including requirements that Medicaid payments be economical and efficient and ensure access to care for Medicaid beneficiaries, and that the federal government and states share in the financing of the Medicaid program as established by law. We 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.⁵

You asked us to testify today on our work related to states’ financing of the nonfederal share of the Medicaid program, Medicaid payments states make to government providers, and CMS oversight. My remarks will focus on our recent findings related to the following two areas of the Medicaid program,

1. the extent to which states’ reliance on health care providers and local governments to finance Medicaid has changed in recent years and the implications of these changes; and

⁴See GAO, *Medicaid Financing: Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight*, [GAO-08-650T](#) (Washington, D.C., April 3, 2008).

⁵See GAO, *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*, [GAO-13-48](#) (Washington, D.C.: Nov. 26, 2012).

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2. what is known about data to oversee state Medicaid payments to government providers compared to private providers.

My testimony draws from a report we are issuing today that examines how states are financing the nonfederal share of the Medicaid program, and preliminary observations from ongoing work for this Subcommittee and the Committee on Oversight and Government Reform, House of Representatives, examining payments that selected states make to government providers.

To determine the extent to which states' reliance on health care providers and local governments to finance Medicaid has changed in recent years and the implications of these changes for the report we are releasing today, we sent a questionnaire to all states and the District of Columbia.⁶ The questionnaire collected information on each state's use of funds from health care providers and local governments, state general funds, and other sources to finance the nonfederal share of Medicaid from 2008 through 2012. In addition, we obtained more in-depth information on any implications of changes in reliance on funds from health care providers and local governments from a nongeneralizable sample of three states, selected on the basis of having large Medicaid programs, as determined by spending for Medicaid services; making large amounts of certain supplemental payments to providers; having made changes in sources of funds to finance the nonfederal share, and in Medicaid payment rates from 2008 through 2011; and geographic diversity.⁷ We also conducted interviews with Medicaid department officials in these states and CMS officials, including representatives from regional offices, regarding states' use of various sources of funds to finance the nonfederal share of Medicaid and CMS oversight. The findings from our in-depth analysis of the three states cannot be generalized to other states. To assess the reliability of data provided by the states, we reviewed each state's questionnaire data and in-depth information on funds from health care providers and local governments to address discrepancies and omissions, and interviewed state officials. On the basis of our review, we

⁶We fielded the questionnaire from July 2013 through November 2013, and received responses from all states. For purposes of this statement, "states" refers to the 50 states and the District of Columbia.

⁷In total, the three states' Medicaid payments were over \$100 billion in 2010, or about 28 percent of total Medicaid payments that year; and the state supplemental payments totaled almost \$5 billion.

determined these data were sufficiently reliable for our purposes. Assessing states compliance with federal requirements related to sources of funds for the nonfederal share was not within the scope of our review.

For our ongoing work related to what is known about data to oversee state Medicaid payments to government providers compared to private providers, we have interviewed CMS officials, including representatives from the CMS regional offices, about the oversight of Medicaid payments to government providers and the data they use. In addition, to determine how state Medicaid payment amounts to government providers compare to state Medicaid payment amounts to private providers, we are reviewing payments in the three states selected for our report on state Medicaid financing sources.⁸ To date, we have reviewed one state's data for hospital inpatient services and determined that it was sufficiently reliable for our purposes. To assess these data's reliability, we discussed them with state Medicaid officials; we also clarified conflicting, unclear, or incomplete information. Our preliminary observations regarding this state's payments for inpatient hospital services are not generalizable to other types of payments made by this state or Medicaid payments made by other states. We expect to complete our work examining what is known at the federal level about payments to government providers and in selected states later this year.⁹ We also obtained and reviewed documentation of CMS's review and approval of this state's Medicaid payments to government providers in 2011. Assessing whether state Medicaid payments comply with federal requirements is not within the scope of our ongoing work. We shared our preliminary observations from this ongoing work with CMS officials to obtain their views. CMS officials provided us with technical comments, which we incorporated as appropriate.

We conducted the work upon which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

⁸We selected these states because the issues related to government provider payments share the same risk factors as issues related to state Medicaid financing, including having large Medicaid programs, as determined by spending for Medicaid services, and making large amounts of certain supplemental Medicaid payments to providers.

⁹Our ongoing work is also examining, in selected states, payments for inpatient hospital, outpatient hospital, nursing facility and intermediate care facilities for the developmentally disabled (ICF/DD) by provider ownership.

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicaid is an open-ended entitlement: states are generally obligated to pay for covered services provided to eligible individuals, and the federal government is obligated to pay its share of a state's expenditures under a federally approved state Medicaid plan. The federal share of each state's Medicaid expenditures is based on a statutory formula known as the Federal Medical Assistance Percentage (FMAP).¹⁰ On average, the federal share of Medicaid service expenditures is about 57 percent. Some states design their Medicaid programs to require local governments to contribute to the programs' costs, for example, through intergovernmental transfers of funds from government-owned or -operated providers to the state Medicaid program. States may, subject to certain requirements, also receive funds to finance Medicaid payments from health care providers, for example, through provider taxes—taxes levied on providers such as hospitals or nursing facilities. For example, federal law allows up to 60 percent of the nonfederal share to be financed by local governments. This requirement is applied on the basis of total annual Medicaid program spending and not on individual payments or types of payments.

In addition to flexibility in determining sources of funds to use to finance their nonfederal share, states have flexibility, within broad federal requirements, in designing and operating their Medicaid programs, including determining services to cover and setting payment rates for providers. In general, federal law provides for federal matching funds for state Medicaid payments for covered services provided to eligible beneficiaries up to a ceiling or limit, often called the upper payment limit (UPL).¹¹ The UPL is based on what Medicare would pay for the same

¹⁰The FMAP is based on a formula established by law under which the federal share of a state's Medicaid expenditures for services generally may range from 50 to 83 percent. States with lower per capita income receive a higher FMAP for services.

¹¹The UPL is not applied to payments to individual providers and instead applies to payments to all providers rendering specific services within an ownership class, such as state government-owned or -operated hospital's payments for inpatient services. UPL's exist for inpatient hospital services provided by hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities, and for outpatient services provided by hospitals' and clinics.

services. Typically, state Medicaid payment rates are lower than what the Medicare program would pay, and so many states make supplemental payments under the UPL. Unlike regular Medicaid payments, which are generally based on claims submitted by providers for services rendered, supplemental payments often consist of large, lump sum payments made on a monthly, quarterly, or yearly basis and can be targeted to small groups of providers, such as local government hospitals. Supplemental payments totaled at least \$43 billion in federal fiscal year 2011, including \$26 billion made under the UPL, but reporting was incomplete. Supplemental payments have been growing in size, as they totaled at least \$23 billion in federal fiscal year 2006.

Our prior work has raised concerns about gaps in the oversight of supplemental payments made under the UPL.¹² As part of its oversight responsibilities, CMS is responsible for ensuring that state Medicaid payments are consistent with federal requirements, including that Medicaid payments are economical and efficient. In recent years, we have found several instances of payments that raise concerns about compliance with these requirements. For example, in November 2012, we reported that 39 states had made supplemental payments to 505 hospitals that, along with their regular Medicaid payments, exceeded those hospitals' total costs of providing Medicaid care by \$2.7 billion. Although Medicaid payments are not required to be limited to a provider's costs of delivering Medicaid services, payments that greatly exceed these costs raise questions; for example, as to whether payments are being used for allowable Medicaid expenditures.¹³ We have previously made recommendations to CMS—including recommendations to require states to report the amounts of UPL supplemental payments that they make to individual providers—to review all state supplemental payment programs, and enhance the oversight of payments made to government providers.¹⁴ CMS has not implemented all of these recommendations. We have also

¹²See the list of Related Products at the end of this statement.

¹³See [GAO-13-48](#).

¹⁴See GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, [GAO-04-228](#) (Washington, D.C.: Feb. 13, 2004), *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, [GAO-05-748](#) (Washington, D.C.: June 28, 2005) and *Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, [GAO-08-614](#) (Washington, D.C.: May 30, 2008).

suggested that the Congress consider requiring CMS to require states to submit annual independent audits of supplemental payments made under the UPL, which are not currently subject to audit.¹⁵

CMS uses a range of tools to oversee state Medicaid payments, including review and approval of states' Medicaid plans and amendments. State plans describe, among other things, who and how much states will pay for particular services. For any new payment or payment change, a state must submit a state plan amendment, for which CMS asks the state to provide

- information and data showing that state Medicaid provider payments (regular and supplemental payments combined) do not exceed the UPL for the category of service and type of provider ownership; and
- a written response to a set of standard questions intended to gauge the appropriateness of state payments and financing. For example, CMS asks states during this process if the payment change will result in any government provider receiving payments that exceed the provider's reasonable costs of providing Medicaid services.

CMS also tracks and reviews states' total Medicaid expenditures on a quarterly basis. States seek federal matching funds by submitting aggregated spending amounts for broad categories of services on a standard form known as the CMS-64.

¹⁵See [GAO-13-48](#).

States' Reliance on Funds from Providers and Local Governments to Finance Medicaid Has Increased in Recent Years, with Implications for Federal Costs

States Used Funds from Providers and Local Governments to Finance over \$46 Billion, or 26 Percent, of the Nonfederal Share of Payments in 2012, an Increase from 2008

In the report that is being released today, we found that states used funds from health care providers and local governments to finance 26 percent, or over \$46 billion, of the \$180 billion in the total nonfederal share of Medicaid payments—both regular and supplemental—in state fiscal year 2012.¹⁶ Of the total amount of funds from health care providers and local governments, taxes on providers were the largest single source of funds, followed by transfers of funds from local governments. Of the over \$46 billion, states received \$18.8 billion from health care provider taxes and \$18.1 billion from transfers of funds from local governments.¹⁷

States' reliance on funds from health care providers and local governments to finance the nonfederal share of Medicaid payments increased by over 21 percent from state fiscal years 2008 through 2012, in large part due to increases in revenues from health care provider taxes. Specifically, the percentage of funds from health care providers and local

¹⁶See GAO, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, [GAO-14-627](#) (Washington, D.C.: July 29, 2014).

¹⁷State general funds supplied \$113.2 billion of the nonfederal share of Medicaid in state fiscal year 2012, and intra-agency funds supplied \$11.9 billion. Intra-agency funds include contributions from other state agencies, such as state departments of mental health, that pay Medicaid providers, for example, through an intra-agency agreement; a transfer of funds to the state Medicaid agency from a state government entity that has been appropriated state general funds; or a certification of expenditures for Medicaid-covered services provided to a Medicaid beneficiary from a state government entity that has been appropriated state general funds.

governments that states used to finance the nonfederal share increased from 21 percent to 26 percent during this 5-year period, for an increase of 5 percentage points, or 21 percent. While the total amount of funds from all sources, including state funds,¹⁸ increased during this period, funds from providers and local governments increased as a percentage of the nonfederal share, while the percentage of state funds decreased. Health care provider taxes represented the source of funds from health care providers and local governments with the largest increase, \$9 billion, during the 5-year time period. We found that a total of 85 new provider taxes were implemented in 32 states during this time period.

Our analysis shows that for supplemental payments alone, the percentage of the nonfederal share that states financed with funds from health care providers and local governments was relatively high, and increasing. In particular, the percentage of the nonfederal share of supplemental payments that was financed with funds from providers and local governments increased from 57 percent in 2008 to 70 percent in 2012. In other words, almost three-quarters of the nonfederal share of supplemental payments was financed by providers, and not state funds. These large payments that states can target to small groups of providers without linking them to services provided were, to a much greater extent than regular Medicaid payments, financed by the providers.¹⁹

In the report we are releasing today, we also found that CMS does not collect complete and accurate data on state Medicaid financing methods. States are required, under federal law, to report the amounts of funds from provider taxes and donations used to finance the nonfederal share, but CMS has not ensured that this data is complete and accurate. Reporting of funds from local government providers and local governments that are used by states to finance the nonfederal share of Medicaid is not required under federal law. CMS may seek on a case-

¹⁸For purposes of this statement state funds refer to state general funds and intra-agency funds.

¹⁹The percentages for supplemental payments were significantly higher than the percentages for regular payments in each year from state fiscal year 2008 through 2012. For example, in 2012 providers supplied 74 percent (or \$9.2 billion) of the nonfederal share of the largest type of supplemental payments, compared to 23 percent (or \$25.8 billion) of regular payments. Federal law requires that no more than 60 percent of the nonfederal share is financed by local governments. However, this requirement is applied on the basis of total annual Medicaid program spending and not on individual payments or types of payments.

specific basis information on financing arrangements when reviewing individual state plan amendments; however, the information provided varies by state, and CMS officials reported that states are not required to identify the amount of funds provided by or on behalf of any specific providers or the amount of payments made to providers. Without accurate and complete information on state sources of funds, we concluded that CMS is unable to adequately understand and oversee Medicaid financing and payments, including net payments, to individual providers. In the report we are releasing today, we recommend that CMS take steps to ensure states report accurate and complete information on all sources of funds used to finance the nonfederal share. CMS did not agree with our recommendation and stated that the agency's current data collection processes are sufficient, and at this time more detailed reporting is not needed.

Changes in Financing Arrangements in Selected States Illustrate How the Arrangements Can Shift Medicaid Costs to the Federal Government

In the report being released today, we present information on recent changes in financing arrangements involving funds from providers and local governments in three selected states that illustrates how such changes can shift Medicaid costs from the state to the federal government. In effect, states seeking to raise payment rates to providers can finance those increased rates by asking providers to provide the funds to finance the state share of the payment, and then seek federal matching on the larger amount. By increasing providers' Medicaid payments, and at the same time imposing requirements on providers receiving the payments to supply all or most of the nonfederal share for the payments, states could obtain additional federal matching funds for those facilities' payments without a commensurate increase in state general funds. The use of funds from providers and local governments is, as previously described, allowable under federal rules, but it can also have implications for federal costs. And from the providers' perspective, the use of funds from providers to finance an increase in Medicaid payments results in a net payment to the provider that is less than the amount used for purposes of claiming federal funds.

In three selected states, we reviewed a financing arrangement that involved financing the nonfederal share of new Medicaid payments with funds from provider taxes or transfers of funds from local governments put in place in recent years. For these arrangements, we estimated the effect on the federal and state shares of new payments the state was making. In each case, we determined that the result was a net increase in payments to the providers—after accounting for both the payment increase they received, as well as the increased funds they or a local

government provided to the state to finance the nonfederal share of the payments—and increases in costs to the federal government. The state contribution to the new Medicaid payments, in each case, did not increase compared to what it would have been had the new financing arrangement not taken place. For example, one state increased regular Medicaid payments for nursing facilities in May 2011, and financed these payments with a provider tax on nursing facilities. According to our estimates, the increased regular Medicaid payment and new provider tax had the effect of increasing federal matching payments by \$110 million. The overall net increase in provider payments—that is, the increase in total Medicaid payments (\$220 million) minus the total cost of the new provider tax (\$115 million)—was \$105 million. The state supplied \$5 million less in state general funds than it would have paid had the increased payment and new provider tax not gone into effect.²⁰

²⁰As part of our analysis, we estimated the amount of regular Medicaid payments to providers, provider taxes collected, and the state and federal share of Medicaid payments had the increases in provider taxes and Medicaid payments not taken place.

Preliminary Results Suggest That Data Needed to Oversee Medicaid Payments to Government and Private Providers Are Lacking

Our ongoing work has identified two major gaps in federal data necessary for overseeing Medicaid payments. First, neither of the two major sets of data that CMS has available for oversight captures the ownership status—government or private—of individual providers.²¹ Second, federal data on state Medicaid payments generally capture regular payments for services rendered by individual providers, but generally do not capture states' lump sum supplemental payments to individual providers.²² We have previously reported that data on the providers receiving supplemental payments, and the amounts paid to particular providers, are maintained by the state making the payments.²³ States generally do not submit these payments to CMS for inclusion in its automated claim data system, which captures regular payments made to individual providers. Without provider-specific payment data that includes supplemental payments, CMS does not have a complete picture of how the \$43 billion in supplemental payments mentioned above in this statement was allocated among the individual government or private providers. As a result of these two gaps in the federal data on state Medicaid payments, CMS is not able to assess payments to government providers compared to private providers, and cannot detect any outlier provider payments, such as providers receiving significantly larger amounts in Medicaid payments than other providers providing similar services. This lack of data also limits CMS's ability to ensure that payments to individual providers are economical and efficient.

²¹CMS has two data sets available for overseeing Medicaid payments, but each data set has a different purpose and neither one provides the data needed for effective oversight. Neither of these data sets provides CMS with the data needed to effectively monitor states' Medicaid payments to government providers. The Medicaid Statistical Information System (MSIS) is a national eligibility and claims data set and is the federal source of Medicaid expenditure data that can be linked to a specific enrollee and provider. The CMS-64 data set aggregates states' Medicaid expenditures by broad expenditure categories, and is used by CMS to reimburse the states for the federal share of Medicaid expenditures. States are required to provide CMS with MSIS and CMS-64 expenditure data quarterly. 42 C.F.R. § 430.30(b), (c).

²²Once states receive approval to make a particular supplemental payment under their state plan, they are allowed to make these payments outside of CMS's automated claims system.

²³See GAO, *High-Risk Series: An Update*, [GAO-13-283](#) (Washington, D.C.: February 2013), *Medicaid: Data Sets Provide Inconsistent Picture of Expenditures*, [GAO-13-47](#) (Washington, D.C.: Oct. 29, 2012).

At the state level, our ongoing work has found that the state payment data needed to understand provider-specific payments can be challenging to obtain and assess, and are not always reliable. We have sought to obtain payment data on supplemental payments, by ownership, from three selected states to combine with federal data on regular Medicaid payments so that we could assess how total Medicaid payments to government providers compare to payments to private providers. Doing this work, however, has proved to be difficult, illustrating the challenge in overseeing Medicaid payments and ensuring that payments to individual providers are economical and efficient. In each of the three states, we encountered obstacles in capturing complete information on payments and provider ownership. For example, states may

- use multiple provider identification numbers for the same provider;
- use a different provider identification number for supplemental payments versus regular payments, complicating the process of combining data sets to understand full payments to individual providers;²⁴ and
- be unable to report provider ownership by state government, local government, and private.

Our ongoing effort to compile reliable and accurate provider-specific ownership and supplemental payment data has been, and continues to be, a time consuming and labor intensive effort as a result of data obstacles. We have encountered issues with data in all three states. For one of the three states, we have determined that data issues are of such difficulty that they preclude completing an assessment. The state was not able to provide us with data that were sufficiently reliable to allow us to identify Medicaid payments by provider ownership.²⁵

²⁴Providers are assigned a unique identification number so that they can be separately identified from other providers; however, this does not necessarily result in each provider only having one unique identification number. State Medicaid programs have multiple divisions and programs that interact with providers, and each of these may have a different data processing system for tracking provider information and use a different provider identification number.

²⁵Our ongoing work is examining payments for four categories of Medicaid services: Inpatient Hospital Services, Outpatient Hospital Services, Nursing Facility Services, and Intermediate Care Facilities for the developmentally disabled in two states. For these services we are comparing payments for three types of ownership: state government, local government, and private.

In one state for which we have determined that data were sufficiently reliable to report today, our preliminary analysis of the state's payments for inpatient hospitals in state fiscal year 2011 suggests the need for and value of having complete data to analyze Medicaid payments by provider ownership.²⁶ For this state, we were able to combine the state-provided supplemental payments made under the UPL and provider ownership data with the federal claims data on regular payments and Medicaid patient days.²⁷ Although our work analyzing this state's data to examine payments for different types of services to different types of providers is ongoing, we have completed the preliminary analysis for one type of service: inpatient hospital payments. With these data, we have determined each hospital's daily payment amount by dividing total Medicaid payments for each hospital by the hospital's total Medicaid patient days. We then calculated the average daily payment amounts for three categories of provider ownership: state government, local government, and private. Where possible, our preliminary analysis adjusted regular payments for differences in the conditions of the patients treated by the hospitals, commonly referred to as "case mix" adjustments.²⁸ Our preliminary analysis shows that

- For the regular payments, state government hospitals had the highest average daily payment amount, at about \$1,140, which was 19 percent higher than the average for local government hospitals (\$940) and 29 percent higher than the average for private hospitals (\$860).
- When the state's supplemental payments were factored in, local government hospitals replaced state government hospitals as receiving the highest average, and the gap between the local government hospitals' and private hospitals' averages increased further. Local government hospitals' average daily payment amount

²⁶For purposes of this analysis, we excluded state government mental health hospitals.

²⁷For purposes of this analysis, we did not include disproportionate share hospital (DSH) supplemental payments—Medicaid supplemental payments that states are required by federal law to make to hospitals that serve large numbers of Medicaid and low-income individuals.

²⁸We case mix adjusted regular payments for all hospitals for which case mix information was provided—about 84 percent of the state's hospitals. These hospitals' regular payments are based on a prospective payment system—a predetermined payment amount—under which each hospital's payment amount is adjusted to reflect the differences in the conditions of the patients treated by the hospital.

was about \$1,470, which was 25 percent higher than the average for state government hospitals (\$1,140) and 44 percent higher than for private hospitals (\$930).

Our preliminary analysis also shows that, because the state was targeting its UPL supplemental payments to only two local government hospitals, the higher payments to these hospitals accounted for much of the differences in average daily payment amounts when UPL supplemental payments were included in the average. Together these hospitals received nearly \$416 million in UPL supplemental payments, compared to \$70 million in regular Medicaid payments. Our preliminary analysis of the average daily payment amounts for regular and UPL supplemental payments for these two hospitals suggests that the average amount at one hospital was as high as about \$8,800 per day, significantly higher than the approximately \$1,470 average amount for all local government hospitals.²⁹ The other hospital had a lower average, although it was still higher than the average for private hospitals. According to the state's Medicaid officials, these hospitals served higher needs patients.

Our preliminary examination of key documentation around CMS's review of the provisions authorizing the state's supplemental payments to these two local government hospitals shows that CMS's documentation did not identify the large supplemental payments the two hospitals received. We reviewed the state plan amendment authorizing the supplemental payment, the funding questions that CMS asked when the state submitted a proposed change to the payment, and the annual report the state submitted to CMS in 2011 regarding the state's estimated UPL for local government hospitals. Our preliminary observations when reviewing this documentation were that

- The state plan amendment approved by CMS in June 2011 authorized the state to make over \$400 million in supplemental payments proportionally to all local government hospitals eligible for a

²⁹For purposes of comparing this hospital's average daily payment to the average daily payment amounts for the three ownership types, we adjusted this hospital's regular Medicaid payments using the state's highest hospital case mix adjustment factor. We did this because case mix information was not available for this hospital, and by using the state's highest case mix adjustment it provides for the maximum possible adjustment. If we did not case mix adjust the hospital's regular payment amount, we estimated that with regular and UPL supplemental payments the hospital's average daily payment amount was about \$9,180.

payment under the state plan amendment. The state plan amendment, however, did not specify the number or names of hospitals that were eligible based on somewhat ambiguous eligibility criteria including that they be located in a city of a certain size and having received a certain amount of medical assistance payments.³⁰

- When the state proposed to increase the supplemental payment amount through a state plan amendment, CMS followed its process for requesting new information on the payments—in particular, whether any payments to governmental providers would exceed the providers’ reasonable costs of providing services. However, the state’s written response did not indicate whether any providers would be paid above their costs and instead stated that it was “unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.”
- Information provided by the state under CMS’s requirement that states submit information showing that state payments would not exceed the UPL did not contain information on the actual payments individual hospitals received.³¹ As requested by CMS, the state submitted information on the methodology for estimating each hospital’s UPL, but did not submit actual UPL payment information that would have shown that the state was making all of the supplemental payments to only two hospitals. The state’s estimate of what Medicare would have paid the hospitals for the Medicaid services provided was about \$100 million, compared to the \$416 million those two facilities received.³² Since the UPL is applied across a class of facilities, in this case local government hospitals,

³⁰The following state plan provision identifies the eligibility criteria for hospitals to receive supplemental payments: payments “...are authorized to government general hospitals, other than those operated...” by the state or the state university hospital “...receiving reimbursement for all inpatient services under Title XIX of the federal Social Security Act (Medicaid) pursuant to this Attachment of this State Plan and located in a city with a population of over one million, of up to \$286 million annually, as medical assistance payments.” Further, the state plan provisions for determining which providers receive payments and how much they will receive, states that payments “...shall be based on each such hospital’s proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year.”

³¹In June 2013, CMS began requiring states to submit information and data annually to demonstrate that hospital payments do not exceed the UPL, an action that was previously required only when a state proposed a change in payments.

³²The \$100 million is the state’s estimated UPL for the two hospitals.

and not for individual facilities or hospitals, the state was able to direct all supplemental payments available for all 21 local government hospitals under the UPL to the two local government hospitals.

In reviewing information on the state's payments to the two hospitals, our preliminary analysis found that the state did not contribute any state general funds to finance the nonfederal share of the two hospitals' supplemental payments, as the nonfederal share of the payments was financed by a local government that operated the two hospitals. This illustrates prior concerns we have raised about the incentives to overpay certain government providers, including those for which the state is not providing funds to finance the nonfederal share.³³

In discussing the circumstances around these two hospitals payments and payment amounts, CMS officials reported that they review the total amount of UPL supplemental payments for local government hospitals as a group, and not payments to individual hospitals. We will continue to complete our ongoing work and will issue a final report later this year including any suggested actions needed by CMS, as appropriate.

In conclusion, our report that is being released today on how states are financing the nonfederal share of Medicaid, and our ongoing work on Medicaid payments to government providers, demonstrate the importance and need for effective federal oversight. CMS has taken important steps over the years to enhance its oversight, including requiring annual demonstrations of state UPL estimates. We believe even more can be done to improve the transparency of Medicaid financing and payments, including previous recommendations that have not been implemented, such as facility specific reporting of supplemental payments and review of all state supplemental payment programs, and the recommendation from the report we are issuing today that CMS take steps to ensure states report accurate and complete data on all sources of funds to finance the nonfederal share.

³³See GAO, *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, [GAO-05-748](#) (Washington, D.C.: June 28, 2005).

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions you may have.

GAO Contacts and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact me at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Tim Bushfield, Assistant Director; Elizabeth Conklin; Julianne Flowers; Sandra George; Peter Mangano; and Roseanne Price were key contributors to this statement.

Appendix I: Abbreviations

CMS	Centers for Medicare & Medicaid Services
FMAP	Federal Medical Assistance Percentage
HCFA	Health Care Financing Administration
ICF/DD	intermediate care facilities for the developmentally disabled
MSIS	Medicaid Statistical Information System
UPL	upper payment limit

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Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed. [GAO-13-48](#). Washington, D.C.: November 26, 2012.

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