



Testimony

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Committee on Energy and Commerce,
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MEDICAID

Improving Transparency and Accountability of Supplemental Payments and State Financing Methods

Statement of Katherine M. Iritani
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GAO Highlights

Highlights of [GAO-16-195T](#), a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Medicaid is an over \$500 billion dollar jointly financed program for which the federal government matches state Medicaid expenditures. Within certain limits, states can make supplemental payments to providers in addition to their regular claims-based payments and receive federal matching funds. These payments have grown in the past decade. To finance the nonfederal share of Medicaid payments, states can use funds from local governments and providers, within federal parameters. CMS is responsible for overseeing state programs and ensuring that state payments are consistent with Medicaid payment principles—including that they are economical and efficient, and appropriately financed.

States may have incentives to make excessive supplemental payments to certain providers who finance the nonfederal share of the payment. GAO has a body of work from 2004 to 2015 raising concerns with Medicaid supplemental payments and financing methods. Congress and CMS have taken actions to improve accountability for these payments, and GAO has made further suggestions for Congress and CMS.

This statement highlights key issues and opportunities for improving transparency and oversight from GAO's work related to (1) certain supplemental payments states make to providers, and (2) states' financing of the non-federal share of Medicaid. This testimony is based on GAO reports from 2004 to 2015 on state Medicaid financing and supplemental payments, and selected updates from CMS on the status of prior recommendations.

View [GAO-16-195T](#). For more information, contact Katherine M. Iritani at (202) 512-7114 or iritanik@gao.gov.

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What GAO Found

GAO has found that complete and reliable data are lacking on the tens of billions in Medicaid supplemental payments states often make, hindering transparency and oversight. In a November 2012 report, GAO found that Congress and the Centers for Medicare & Medicaid Services (CMS) have acted to improve transparency and accountability for one type of Medicaid supplemental payment known as disproportionate share hospital (DSH) payments, made for uncompensated care costs experienced by hospitals serving low-income and Medicaid patients. Since 2010, DSH payments are required to be reported to CMS and are subject to independent audits that assess their appropriateness. States also make other supplemental payments—referred to here as non-DSH payments—to hospitals and other providers that, for example, serve high-cost Medicaid beneficiaries. Gaps in oversight remained for non-DSH supplemental payments, which as of 2011 exceeded DSH in amounts paid. For example, GAO reported that 39 states made non-DSH supplemental payments to 505 hospitals that, along with regular Medicaid payments, exceeded those hospitals' total costs of providing Medicaid care by about \$2.7 billion. Medicaid payments are not limited to a provider's costs for services, but GAO concluded in an April 2015 report that payments that greatly exceed costs raise questions about whether they are economical and efficient as required by law, and the extent to which they are ultimately used for Medicaid services. CMS lacks data on supplemental payments made to individual providers. Per federal internal control standards, agencies should have reliable information for decision making and reporting, and reasonable assurance that agency objectives, such as compliance with laws, are being met. In 2012, CMS officials said legislation was needed to implement non-DSH reporting and auditing requirements, and GAO suggested that Congress consider requiring CMS to provide guidance on permissible methods for calculating non-DSH payments and require state reports and audits.

GAO found in a July 2014 report that states are increasingly relying on providers and local governments to finance Medicaid and data needed for oversight are lacking. About \$46 billion or 26 percent of the nonfederal share was financed with funds from providers and local governments in 2012—an increase from 21 percent in 2008. GAO found that states' financing arrangements can effectively shift costs from states to the federal government. In one state, a \$220 million payment increase for nursing facilities funded by a \$115 million tax on nursing facilities yielded a net payment increase to the facilities of \$105 million. The state obtained \$110 million in federal matching funds for the payments. GAO found that CMS generally does not require or otherwise collect data from states on sources of funds to finance Medicaid, nor ensure that the data it does collect are accurate and complete. GAO identified, for example, incomplete reporting of provider taxes. As a result, CMS cannot fully assess the appropriateness of states' financing or the extent to which the increased reliance on providers and local governments serves to provide fiscal relief to states or improve access. Per federal internal control standards, agencies should collect accurate and complete data for monitoring. GAO recommended in 2014 that CMS improve the data states report on Medicaid financing. The agency disagreed, stating its efforts were adequate. GAO maintains its recommendation is valid.

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee:

I am pleased to be here today as you discuss legislative proposals related to Medicaid financing and certain payments states often make, known as supplemental payments. The size, growth, and diversity of Medicaid create significant challenges for administration and oversight. Medicaid is the nation's largest health program as measured by enrollment and the second largest health program, after Medicare, as measured by expenditures. Medicaid is administered by states, overseen by the Centers for Medicare & Medicaid Services (CMS), and financed jointly by the federal government and states based on a statutory formula. It is a significant component of federal and state budgets, with estimated outlays of \$529 billion in fiscal year 2015, of which \$320 billion was expected to be financed by the federal government and \$209 billion by the states.¹ By 2020, Medicaid expenditures are projected to total \$725 billion, with federal expenditures alone totaling \$436 billion.

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, such as taxes on health care providers and funds from local government providers or local governments on behalf of providers.² States' financing of the nonfederal share is subject to federal limits and requirements. For example, states must use state funds to finance at least 40 percent of the nonfederal share of total Medicaid expenditures each year. This limit is applied in the aggregate; that is, across each state's entire Medicaid program, and not for individual 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 setting payment rates for providers. Many states make supplemental payments—payments above regular claims-based payments for Medicaid services—to certain providers, mainly

¹Centers for Medicare & Medicaid Services, Office of the Actuary, *2014 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2015).

²For 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.

hospitals. The federal government shares in the costs of these payments. Supplemental payments are a significant component of Medicaid spending, totaling at least \$43 billion in fiscal year 2011, up from \$32 billion in fiscal year 2010 and at least \$23 billion in fiscal year 2006. These amounts were likely understated because reporting of supplemental payments was incomplete.³

As the agency overseeing Medicaid at the federal level, CMS is responsible for providing guidance to states on federal Medicaid requirements and for overseeing state programs, including ensuring that state Medicaid payments are appropriately financed and consistent with Medicaid payment principles. For example, Medicaid payments generally must be for Medicaid covered items and services, and consistent with efficiency, economy, and quality of care.

We have reported over many years on a number of challenges facing Medicaid and have a significant body of work on states' supplemental payments to providers and financing of the non-federal share. Both Congress and CMS have taken significant steps to improve transparency and accountability in these areas. We believe there are opportunities for additional improvements that are important in view of both the significant spending for supplemental payments and the integrity of the program. My testimony today will cover our work related to the supplemental payments states often make to certain institutional providers, and to states' financing of the nonfederal share of the Medicaid program. My remarks focus on key issues related to:

1. certain supplemental payments states make to providers, and opportunities for improved oversight and transparency, and
2. states' financing of the non-federal share of Medicaid, and opportunities for improved oversight and transparency.

My remarks are based on multiple reports and testimonies we have produced on these topics since 2004, including our recent report on key issues facing the Medicaid program; our reports on opportunities to reduce fragmentation, duplication and overlap in federal programs; and

³See GAO, *Medicaid: States Reported Billions More in Supplemental Payments in Recent Years*, [GAO-12-694](#) (Washington, D.C.: July 20, 2012), and *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*, [GAO-13-48](#) (Washington, D.C.: Nov. 26, 2012).

our most recent high-risk update.⁴ My remarks on supplemental payments states make to providers are based in large part on findings from our November 2012 report, which examined how information from newly required reporting facilitated CMS's oversight of certain types of supplemental payments, and the extent to which similar information existed to facilitate CMS's oversight of other types of supplemental payments.⁵ For that report, we reviewed audits and reports, analyzed data on supplemental payments, and interviewed CMS officials. My remarks on states' financing of the non-federal share of Medicaid are based in large part on findings from our July 2014 report, which examined the extent to which states have relied on funds from health care providers and local governments to finance the nonfederal share of Medicaid; the extent to which states have changed their reliance on health care providers and local governments to help finance the nonfederal share of Medicaid in recent years and the implications, if any, of these changes; and the extent to which CMS collects data to oversee states' use of various sources of funds.⁶ For that report, we administered a questionnaire to all state Medicaid agencies, examined effects of financing changes in a nongeneralizable sample of three states selected in part based on Medicaid spending and geographic diversity, and interviewed CMS officials. The reports cited provide further details on our scope and methodology. My remarks also draw on information we obtained from CMS between March 2015 and June 2015 about the status of our prior recommendations in these areas, as well as current CMS efforts related to Medicaid.⁷

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards

⁴See GAO, *Medicaid: Key Issues Facing the Program*, [GAO-15-677](#) (Washington, D.C.: July 30, 2015), *2015 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits*, [GAO-15-404SP](#) (Washington, D.C.: April 14, 2015), and *High-Risk Series: An Update*, [GAO-15-290](#) (Washington, D.C.: February 11, 2015). See Related GAO Products at the end of this statement for additional reports on these topics.

⁵See [GAO-13-48](#).

⁶See 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).

⁷See appendix I for related GAO recommendations and matters for congressional consideration.

require that we plan and perform the audit to obtain 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).⁸ Some states design their Medicaid programs to have local governments 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. Under federal law, provider taxes must be broad-based, must be uniformly imposed, and must not hold providers harmless; that is, they must not provide a direct or indirect guarantee that providers will receive all or a portion of tax payments back. Taxes that are at or below 6 percent of the individual provider's net patient service revenues are considered not to have provided an indirect guarantee that providers will receive their tax payments back.

In addition to flexibility in determining sources of funds they use to finance their nonfederal share, states have flexibility, within broad federal requirements, in designing and operating their Medicaid programs, including determining which 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). The UPL is based on what Medicare would pay for the same services. States often make two general types of Medicaid supplemental payments:

⁸The 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.

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- First, under federal Medicaid law, states are required to make disproportionate share hospital (DSH) payments to certain hospitals. These payments are designed to help offset these hospitals' uncompensated care costs for serving Medicaid and uninsured low-income patients. States' Medicaid payment rates are not required to cover the full costs of providing care to Medicaid beneficiaries, and many providers also provide care to low-income patients without any insurance or ability to pay. Under federal law, DSH payments are capped at a facility-specific level and state level.
 - Second, many states also make another type of Medicaid supplemental payment, referred to here as non-DSH supplemental payments, to hospitals and other providers who, for example, serve high-cost Medicaid beneficiaries. Unlike DSH payments, non-DSH supplemental payments are not required under federal law, do not have a specified statutory or regulatory purpose, and are not subject to firm dollar limits at the facility or state level. Unlike regular Medicaid payments, which are paid on the basis of covered Medicaid services provided to Medicaid beneficiaries through an automated claims process, non-DSH supplemental payments are not necessarily made on the basis of claims for specific services to particular patients and can amount to tens or hundreds of millions of dollars to a single provider, annually. States can generally make non-DSH payments up to the UPL. Typically, state Medicaid payment rates are lower than what the Medicare program would pay, and so many states make supplemental payments under the UPL. Non-DSH supplemental payments, like regular Medicaid payments, must be consistent with Medicaid payment principles. Under federal law, to receive federal matching funds, payments generally must (1) be made for covered Medicaid items and services, (2) be consistent with economy, efficiency, and quality of care, and (3) not exceed the UPL. Supplemental payments may also be made under Medicaid

demonstrations, but may not be subject to these requirements, depending on the terms of the demonstration.⁹

Historically, DSH payments exceeded Medicaid non-DSH payments. In recent years the opposite has occurred, and non-DSH payments have exceeded DSH payments. In fiscal year 2011, Medicaid non-DSH payments totaled nearly \$26 billion compared to over \$17 billion for DSH payments.

Complete and Reliable Data on Non-DSH Supplemental Payments are Lacking, Hindering Transparency and Oversight

For about two decades, we have raised concerns about supplemental payments and the adequacy of federal oversight. We have designated Medicaid a high-risk program due in part to these concerns. For example, in a February 2004 report, we found that over the years some states had made relatively large non-DSH supplemental payments to relatively small numbers of government-owned providers, and that these providers were then sometimes required to return these payments to the states, resulting in an inappropriate increase in federal matching funds. We also found that some states had used widely varying and inaccurate methods for estimating their non-DSH payment amounts, which may inflate the amount of non-DSH supplemental payments.¹⁰ CMS is responsible for ensuring that state Medicaid payments are consistent with federal requirements, including that payments are consistent with economy and efficiency and are for Medicaid-covered services. To do so, it is important

⁹Under section 1115 of the Social Security Act, states may apply to and receive approval from CMS for a demonstration that allows states to deviate from their traditional Medicaid program. Spending authorities under the demonstrations provide states with the ability to claim federal Medicaid funds for new types of expenditures, including the costs of making additional payments to providers. These supplemental payments are governed by the terms and conditions of the individual demonstrations. Our work prior to 2013 did not generally refer to demonstration supplemental payments as non-DSH payments. Our work in 2014 and 2015 refers to demonstration supplemental payments as a type of non-DSH supplemental payment. CMS, when reporting states' non-DSH supplemental payment expenditures, includes both supplemental payments made under a state Medicaid plan and demonstration supplemental payments.

¹⁰See GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, [GAO-04-228](#) (Washington, D.C.: February 13, 2004). In this report, we recommended CMS issue guidance on permissible methods for estimating non-DSH payment amounts. CMS concurred with our recommendation, and has taken some steps to improve oversight of these payments, but has not specified uniform methods for calculating non-DSH supplemental payment amounts.

for CMS to have relevant, reliable, and timely information for management decision making and external reporting purposes.¹¹

In recent years, our work examining these payments has identified several instances of payments that further raise concerns about whether Medicaid payments that greatly exceeded costs are economical and efficient. For example, as reported in November 2012, we found that 39 states had made non-DSH 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.¹² In some cases, payments greatly exceeded costs; for example, one hospital received almost \$320 million in non-DSH payments and \$331 million in regular Medicaid payments, which exceeded the \$410 million in costs reported for the hospital for providing Medicaid services by about \$241 million.

As we reported in April 2015, our more recent analysis of average daily payment amounts—which reflect both regular payments and non-DSH supplemental payments—identified hospitals for which Medicaid payments received exceeded their Medicaid costs, and we also found a few cases where states made payments to local government hospitals that exceeded the hospitals' total operating costs.¹³ CMS's oversight mechanisms had not identified large overpayments to two hospitals in one state that resulted from non-DSH supplemental payments until we identified them. CMS began reviewing the appropriateness of the two hospitals' payments during the course of our review. As we concluded in our 2012 and 2015 reports, 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, including whether they are consistent with economy and efficiency, whether they

¹¹According to federal internal control standards, agencies are responsible for determining through monitoring that relevant, reliable, and timely information is available for management decision making and external reporting purposes. In addition, agencies are responsible for continually examining and improving internal controls to provide reasonable assurance that the objectives of the agency, such as compliance with applicable laws and regulations, are being achieved. See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

¹²See [GAO-13-48](#).

¹³See GAO, *Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy*, [GAO-15-322](#) (Washington, D.C.: April 10, 2015).

contribute to beneficiaries' access to quality care, and the extent to which they are ultimately used for Medicaid purposes. However, CMS lacks data at the federal level on non-DSH supplemental payments, and the payments are not subject to audit.¹⁴

Based on our findings, we have identified opportunities to improve the oversight, transparency, and accountability of non-DSH supplemental payments to providers, in particular through improved reporting, auditing, and guidance. Since 2010, states have been required by federal law to submit annual facility-specific reports and annual independent certified audits on DSH payments.¹⁵ In connection with the independent audit requirement, standard methods were established for calculating DSH payment amounts.¹⁶ However, similar requirements for reporting, annual independent audits, and guidance on acceptable methods for calculating non-DSH supplemental payments are not in place for non-DSH payments. As we reported in November 2012, we found that the newly implemented annual reporting and audits for DSH payments improved CMS oversight—and we concluded that better reporting and audits of non-DSH supplemental payments could improve CMS's oversight of these payments as well.

As our work has shown, states' non-DSH supplemental payments can be complex and challenging to assess. Hospital-specific information can be helpful to CMS and others for understanding, at the provider level, the relationship of supplemental payments to both regular Medicaid payments and Medicaid costs. For example, reporting of non-DSH payments that states make to individual hospitals and other providers relative to the providers' Medicaid costs could improve the transparency of these payments. In addition, audits could improve accountability by providing information on how these payments are calculated and the extent to which payments to individual providers are consistent with the Medicaid payment principles of economy and efficiency.¹⁷ Absent complete and

¹⁴See GAO-15-322 and GAO-13-48.

¹⁵These requirements were mandated by statute. In 2008, CMS issued a final rule to implement the 2003 DSH audit and report requirements. The first sets of DSH audits and reports, covering payments made in 2005 through 2007, were submitted to CMS in December 2010. See [GAO-13-48](#).

¹⁶See [GAO-12-694](#) and [GAO-13-48](#).

¹⁷See [GAO-13-48](#).

reliable provider-specific data on the non-DSH supplemental payments individual providers receive, CMS may not identify potentially excessive payments to providers, and the federal government could be paying states hundreds of millions—or billions—of dollars more than what is appropriate.¹⁸

CMS has taken some steps to improve oversight of these payments, but has not established facility-specific reporting requirements, required annual independent audits of states' non-DSH payments, or specified uniform methods for calculating non-DSH supplemental payment amounts. Steps CMS has taken include issuing a state Medicaid Director letter in 2013 to obtain more information on non-DSH supplemental payments and awarding a contract in May 2014 to review Medicaid supplemental payment information, the outcomes of which were not yet known as of July 2015.¹⁹ CMS said in 2012 that legislation was necessary for them to implement reporting and auditing requirements for DSH payments, and that legislation would be needed for the agency to implement similar requirements for non-DSH supplemental payments. Consequently, we have suggested that Congress consider requiring CMS to take steps to improve the transparency and accountability of non-DSH supplemental payments, including requirements similar to those in place for DSH.

¹⁸As we reported in April 2015, we found that CMS oversight of provider supplemental payments is limited because the agency does not require states to report provider-specific data on these payments, nor does it have a policy and standard process for determining whether Medicaid payments to individual providers are economical and efficient. We recommended that CMS improve its oversight by taking steps to ensure that states report accurate, provider-specific payment data, and by developing a policy and process for reviewing payments to individual providers to determine whether they are economical and efficient, and HHS concurred with our recommendations.

¹⁹The contract will develop options for improving oversight of payments to support CMS's Medicaid program integrity and oversight efforts. As of July 2015, the contract study was ongoing. According to CMS officials, CMS plans to develop an appropriate action plan as necessary when the results of the contract study are available.

States are Increasingly Relying on Providers and Local Governments to Finance Medicaid, and Data Needed for Oversight is Lacking

Our work has found that states are increasingly relying on providers and local governments to finance Medicaid, and has also pointed to the need for better data and improved oversight to ensure that Medicaid payments are financed consistent with federal requirements, to understand financing trends, and to ensure federal matching funds are used efficiently. Further, our work has shown that state flexibility to seek contributions from local governments or impose taxes on health care providers to finance Medicaid may create incentives for states to overpay providers in order to reduce states' financial obligations. Such financing arrangements can have the effect of shifting costs of Medicaid from states to the federal government. Benefits to providers, which may be financing a large share of any new payments, and to the beneficiaries whom they may serve, may be less apparent. CMS is responsible for ensuring that state Medicaid payments made under financing arrangements are consistent with Medicaid payment principles, including that they are economical and efficient, and that the federal government and states share in the financing of the Medicaid program as established by law. To oversee the Medicaid program, it is important for CMS to have accurate and complete information on the amount of funds supplied by health care providers and local governments to states to finance the nonfederal share of Medicaid.²⁰

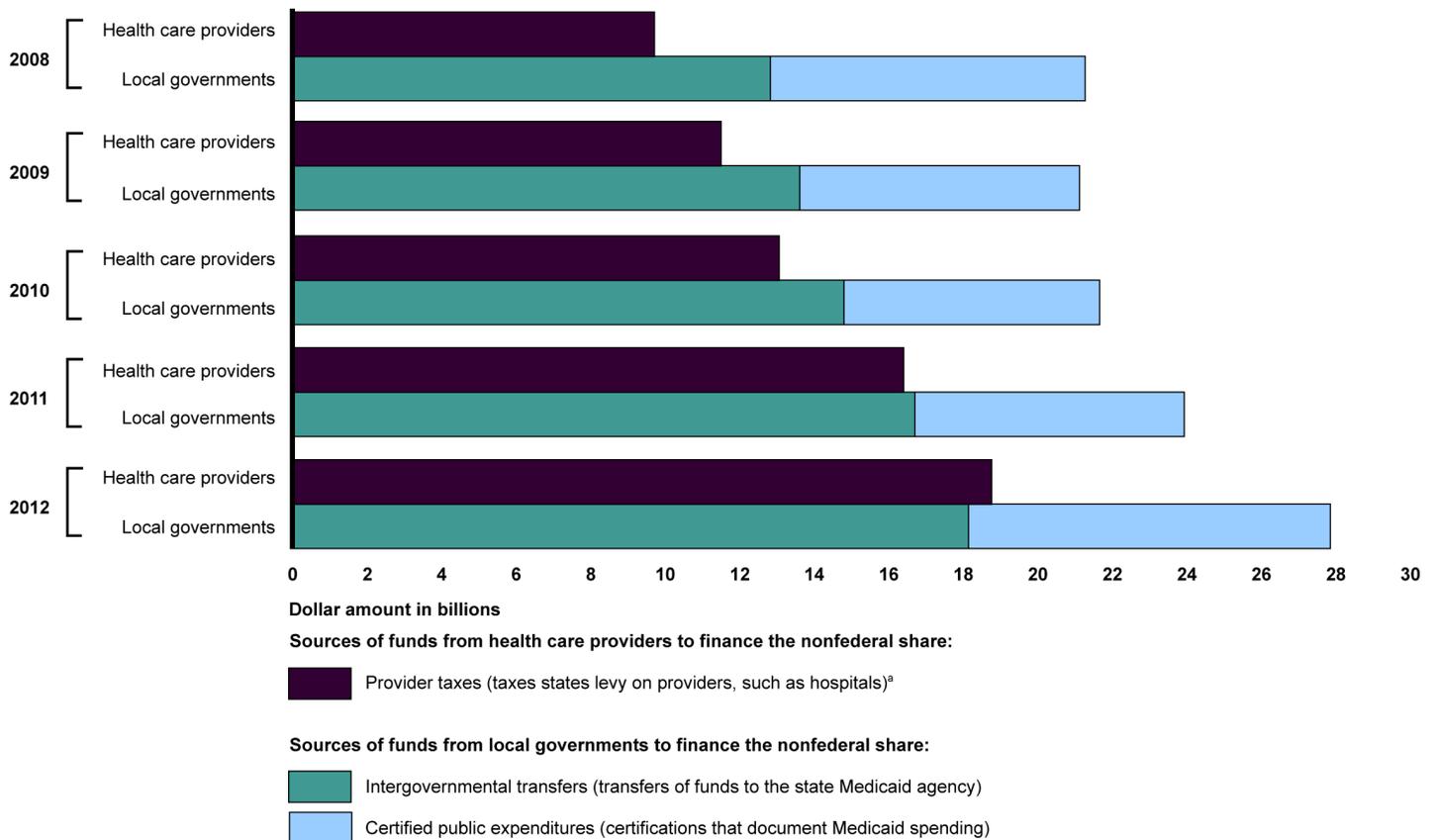
As we reported in July 2014, our survey of all state Medicaid programs found that states are increasingly relying on providers and local governments to help fund Medicaid. For example, in state fiscal year 2012, funds from providers and local governments accounted for 26 percent (or over \$46 billion) of the approximately \$180 billion in the total nonfederal share of Medicaid payments that year—an increase from 21 percent (\$31 billion) in state fiscal year 2008.²¹ (See fig. 1.) These sources were used to fund Medicaid supplemental payments—both DSH and non-DSH—to a greater extent than other types of payments, and we found this reliance was growing. For Medicaid DSH and non-DSH

²⁰According to federal internal control standards, federal agencies should collect accurate and complete data to monitor programs they oversee. See [GAO/AIMD-00-21.3.1](#).

²¹We found that the percentage and amount of funds from health care providers and local governments that states used to finance the nonfederal share of Medicaid payments varied significantly among states in state fiscal year 2012. For example, in the 48 states that reported using funds from health care providers and local governments, the percentage of funds from providers and local governments ranged from less than 1 percent in South Dakota and Virginia to 53 percent in Missouri. See [GAO-14-627](#).

supplemental payments, the percentage of the nonfederal share financed with funds from providers and local governments increased from 57 percent (or \$8.1 billion) in state fiscal year 2008 to 70 percent (or \$13.6 billion) in state fiscal year 2012. Several states relied on health care providers and local governments for the entire nonfederal share of supplemental payments in 2012.

Figure 1: Amount of the Nonfederal Share of Medicaid Payments from Health Care Providers and Local Governments, State Fiscal Years 2008 through 2012



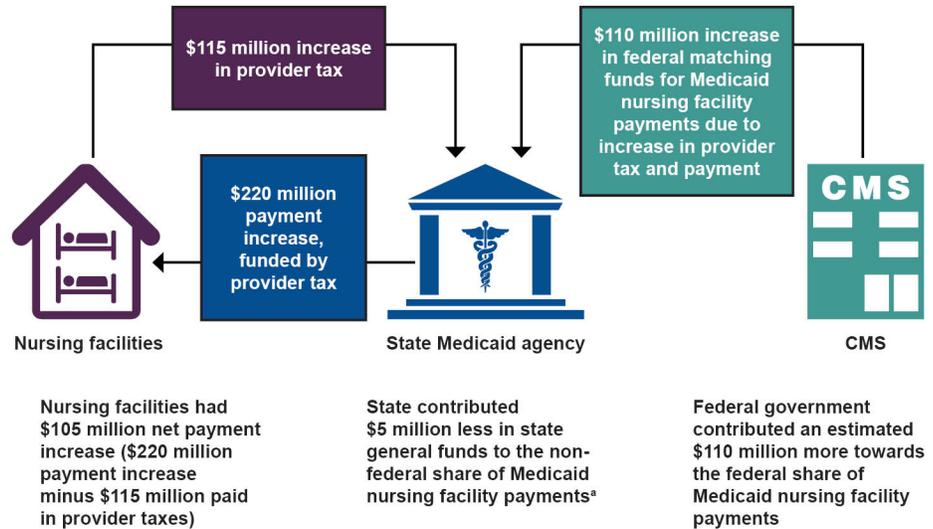
Source: GAO. | GAO-16-195T

^aFor this graphic, we use the term provider tax to refer to health care provider taxes, fees, or assessments. The amounts of provider taxes reported include provider donations. Provider donations totaled \$17 million in 2008, \$16 million in 2009, \$78 million in 2010, \$69 million in 2011, and \$72 million in 2012.

Our reports have illustrated how this increased reliance on non-state sources of funds can shift costs from states to the federal government, changing the nature of the federal-state partnership. For example, in our July 2014 report, our analysis of arrangements involving financing of the nonfederal share of Medicaid payments with funds from provider taxes or local governments in three selected states illustrated how Medicaid costs can be shifted from the state to the federal government and, to a lesser extent, to health care providers and local governments.²² 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. By increasing providers' Medicaid payments, and requiring providers receiving the payments to supply all or most of the nonfederal share, we found that states claimed an increase in federal matching funds without a commensurate increase in state general funds. For example, in our 2014 report, we found that in one state a \$220 million payment increase for nursing facilities in 2012 (which was funded by a tax on nursing facilities) resulted in an estimated \$110 million increase in federal matching funds; no increase in state general funds; and a net payment increase to the facilities, after paying the taxes, of \$105 million. (See fig. 2.)

²²See [GAO-14-627](#).

Figure 2: Example of How One State’s Use of Non-State Sources to Fund Medicaid Payments to Nursing Facilities Shifted Medicaid Costs to the Federal Government in State Fiscal Year 2012



Source: GAO. | GAO-16-195T

Note: This figure illustrates the estimated effect of a new provider tax and increased Medicaid payments on the state and federal share of total regular Medicaid payments to nursing facilities and on net Medicaid payments to nursing facilities in one state in state fiscal year 2012. For the analysis, we compared actual payments in that year to what payments would have been without the provider tax and increased Medicaid payments to nursing facilities.

^aThe state used state general funds to finance most of the nonfederal share of Medicaid, but we estimated that the provider tax resulted in the state needing to use \$5 million less in state general funds to finance its share of Medicaid.

As we found in our 2014 report, due to data limitations, CMS is not well-positioned to either identify states’ Medicaid financing sources or assess their impact. Apart from data on provider taxes, CMS generally does not require (or otherwise collect) information from states on the funds they use to finance Medicaid, nor ensure that the data that it does collect are accurate and complete.²³ The lack of transparency in states’ sources of funds and financing arrangements hinders CMS’s and federal policymakers’ efforts to oversee Medicaid. Further, it is difficult to

²³We reported in July 2014, for example, that when we compared the provider tax data reported to CMS in 2012 with state responses to our questionnaire, we found evidence of incomplete reporting. Specifically, 6 of the 47 states that reported in the questionnaire that they had at least one health care provider tax or provider donation in effect that year did not report a tax or donation to CMS in 2012.

determine whether a state's increased reliance on funds from providers and local governments primarily serves to (1) provide fiscal relief to the state by increasing federal funding, or (2) increase payments to providers that in turn help improve beneficiary access.

CMS has recognized the need for better data from states on how they finance their share of Medicaid and has taken steps to collect some data, but additional steps are needed. We recommended in July 2014 that CMS take steps to ensure that states report accurate and complete information on all sources of funds used to finance the nonfederal share of Medicaid, and offered suggestions for doing so. The Department of Health and Human Services (HHS) did not concur with our recommendation, stating that its current efforts were adequate; however, HHS acknowledged that additional data were needed to ensure that states comply with federal requirements regarding how much local governments may contribute to the nonfederal share, and stated that it would examine efforts to improve data collection for oversight.²⁴ As of June 2015, HHS reported that its position continued to be that no further action is needed. Given states' increased reliance on non-state sources to fund the nonfederal share of Medicaid, which can result in costs shifting to the federal government, we continue to believe that improved data are needed to improve transparency and oversight, such as to understand how increased federal costs may affect beneficiaries and the providers who serve them.

In conclusion, the flexibility states have in how they pay providers and finance the nonfederal share has enabled states to make excessive payments to certain providers and allowed states to shift costs to the federal government. While Congress and CMS have taken important

²⁴In commenting on a draft of our July 2014 report, HHS acknowledged that it does not have adequate data on state financing methods for overseeing compliance with a certain federal requirement related to the nonfederal share—the 60 percent limit on contributions from local governments to finance the nonfederal share—and stated that it will examine efforts to improve data collection toward this end. HHS also stated that it is working to identify needs for improvement in current payment and financing review processes. However, HHS did not concur with two options we suggested in our recommendation for short- and long-term ways of improving agency data collection. Specifically, HHS disagreed with suggestions that facility-specific data are needed for oversight, and that an enhanced Medicaid claims data system the agency is developing—called the Transformed Medicaid Statistical Information System (T-MSIS)—may be an appropriate means for collecting financing data. HHS stated that it believed that its current financing reviews are sufficiently reviewing provider-level data. See [GAO-14-627](#).

steps to improve the integrity of the Medicaid program through improved oversight of some Medicaid supplemental payments and financing arrangements, Congress and CMS need better information and more tools to understand who receives non-DSH supplemental payments and in what amounts, to ensure they are economical and efficient as required by law, and to determine the extent to which they are ultimately used for Medicaid purposes.

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you might have at this time.

GAO Contacts and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Katherine M. Iritani at (202) 512-7114. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony include Tim Bushfield, Assistant Director; Robin Burke; Sandra George; Jessica Morris; Laurie Pachter; Said Sariolghalam; and Emily Wilson.

Appendix I: GAO's Matters for Congressional Consideration and Agency Recommendations

The following table lists matters for congressional consideration regarding actions to improve the transparency of and accountability for the Medicaid non-disproportionate share hospital (DSH) supplemental payments states make to providers. It also includes recommendations we have made to the Department of Health and Human Services (HHS) regarding actions to improve data and oversight of the sources of funds states use to finance the nonfederal share of Medicaid.

Table 1: GAO's Related Matters for Congressional Consideration, Agency Recommendations, and Status

GAO Report	Matters for Congressional Consideration and Agency Recommendations	Status
<p>Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed. GAO-13-48, November 26, 2012</p>	<p>Congress should consider requiring the Centers for Medicare & Medicaid Services (CMS) to</p> <ol style="list-style-type: none"> 1. improve state reporting of non-disproportionate share hospital (DSH) supplemental payments, including requiring annual reporting of payments made to individual facilities and other information that the agency determines is necessary to oversee non-DSH supplemental payments; 2. clarify permissible methods for calculating non-DSH supplemental payments; and 3. require states to submit an annual independent certified audit verifying state compliance with permissible methods for calculating non-DSH supplemental payments. 	<p>As of October 2015, Congress had not implemented this matter for its consideration.</p>
<p>Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection. GAO-14-627, July 29, 2014</p>	<p>CMS should develop a data collection strategy that ensures that states report accurate and complete data on all sources of funds used to finance the nonfederal share of Medicaid payments. There are short- and long-term possibilities for pursuing the data collection strategy, including</p> <ol style="list-style-type: none"> 1. in the short-term, as part of its ongoing initiative to annually collect data on Medicaid payments made to hospitals, nursing facilities, and other institutional providers, CMS could collect accurate and complete facility-specific data on the sources of funds used to finance the nonfederal share of the Medicaid payments, and 2. in the long-term, as part of its ongoing initiative to develop an enhanced Medicaid claims data system (T-MSIS), CMS could ensure that T-MSIS will be capable of capturing information on all sources of funds used to finance the nonfederal share of Medicaid payments, and, once the system becomes operational, ensure that states report this information for supplemental Medicaid payments and other high-risk Medicaid payments 	<p>In commenting on a draft of our report, the Department of Health and Human Services (HHS) did not concur with our recommendation, stating that its current efforts were adequate. However, HHS acknowledged that additional data were needed to ensure that states comply with federal requirements regarding how much local governments may contribute to the nonfederal share, and stated that it would examine efforts to improve data collection for oversight. As of June 2015, HHS reported that no further action was needed.</p>

Source: GAO. | GAO-16-195T

Related GAO Products

Medicaid: Key Issues Facing the Program. [GAO-15-677](#). Washington, D.C.: July 30, 2015.

2015 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits.

[GAO-15-404SP](#). Washington, D.C.: April 14, 2015.

Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy. [GAO-15-322](#). Washington, D.C.: April 10, 2015.

Medicaid Financing: Questionnaire Data on States' Methods for Financing Medicaid Payments from 2008 through 2012. [GAO-15-227SP](#).

Washington, D.C.: March 13, 2015, an e-supplement to [GAO-14-627](#).

High-Risk Series: An Update. [GAO-15-290](#). Washington, D.C.: February 11, 2015.

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.

Medicaid: Completed and Preliminary Work Indicate that Transparency around State Financing Methods and Payments to Providers Is Still Needed for Oversight. [GAO-14-817T](#). Washington, D.C.: July 29, 2014.

2013 Annual Report: Actions Needed to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits. [GAO-13-279SP](#).

Washington, D.C.: April 9, 2013.

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

Medicaid: States Reported Billions More in Supplemental Payments in Recent Years. [GAO-12-694](#). Washington, D.C.: July 20, 2012.

Medicaid: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs is Warranted. [GAO-10-69](#).

Washington, D.C.: November 20, 2009.

Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments. [GAO-08-614](#). Washington, D.C.: May 30, 2008.

Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency. [GAO-07-214](#). Washington, D.C.: March 30, 2007.

Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed. [GAO-04-228](#). Washington, D.C.: February 13, 2004.

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