United States Government Accountability Office

GAO

Report to the Ranking Member, Committee on Finance, U.S. Senate

May 2008

MEDICAID

CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments

GAO-08-614

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Highlights

Highlights of GAO-08-614, a report to the Ranking Member, Committee on Finance, U.S. Senate

Why GAO Did This Study

The financing of the $299 billion Medicaid program is shared between the federal government and states. States pay qualified providers for covered Medicaid services and receive federal matching funds from the Department of Health & Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) for expenditures authorized in their state Medicaid plans. In addition to these standard Medicaid payments, most states make supplemental payments to certain providers, which are also matched by federal funds. GAO was asked for information about Medicaid supplemental payments. GAO examined (1) what information states report about supplemental payments on Medicaid expenditure reports and (2) in selected states, how much was distributed as supplemental payments, to what types of providers, and for what purposes. GAO analyzed CMS's Medicaid expenditure reports and surveyed five states that make large supplemental payments.

What GAO Recommends

GAO recommends that the Administrator of CMS (1) expedite issuance of the final rule implementing additional DSH reporting requirements and (2) develop a strategy to identify all of the supplemental payment programs established in states' Medicaid plans and review those programs that have not been subject to review under CMS's 2003 initiative. CMS generally agreed with these recommendations.

To view the full product, including the scope and methodology, click on GAO-08-614. For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

CMS Medicaid expenditure reports show that states made at least $23 billion in supplemental payments in fiscal year 2006, with the federal share of these payments totaling over $13 billion. States made $17.1 billion in payments through Disproportionate Share Hospital (DSH) programs, which under federal law provide additional reimbursement, up to a cap, to hospitals that serve large numbers of low-income individuals. In addition, states made at least $6.3 billion in non-DSH supplemental payments, including payments through Upper Payment Limit (UPL) programs, under which states make payments to providers up to the upper limit for obtaining federal matching funds. However, information on non-DSH supplemental payments was incomplete. The exact amount and distribution of fiscal year 2006 non-DSH payments to states are unknown because states did not report all their payments to CMS. CMS officials said that they were updating reporting requirements to collect better information on supplemental payments, including finalizing a rule proposed in 2005 responding to federal law that required states to report more detailed information on DSH payments and seeking improved UPL payment information. As of April 2008, specific implementation dates for these actions were not known. CMS's plans did not include a requirement that states report all UPL payments on a facility-specific basis, as GAO recommended in 2004 (See *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO-04-228). GAO believes this 2004 recommendation remains valid.

The five states GAO surveyed—California, Massachusetts, Michigan, New York, and Texas—reported making $12.3 billion in Medicaid supplemental payments in federal fiscal year 2006 through programs with broadly stated purposes, with half of these payments made to local government hospitals. Collectively, the five states reported making payments through 48 supplemental payment programs, with each state operating from 3 to 15 different programs that paid hospitals, nursing facilities, or other providers. The five states reported purposes for their programs that often focused on various categories of eligible providers serving individuals on Medicaid, with low incomes, or without insurance. The state Medicaid plan sections establishing the states' supplemental payments did not always clearly identify how the payments would be calculated. CMS officials said that as part of an oversight initiative started in 2003, CMS ensures that state plans demonstrate a link between the distribution of supplemental payments and Medicaid purposes. However, not all state supplemental payment programs have been reviewed under CMS's initiative. In each of the five states, supplemental payments were concentrated on a small proportion of providers: the 5 percent of providers receiving the largest amount of supplemental payments in individual states received from 53 percent to 71 percent of all supplemental payments. Some providers received substantial payments from more than one supplemental payment program.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
DSH	Disproportionate Share Hospital
FMR	Financial Management Report
HCFA	Health Care Financing Administration
HHS	U.S. Department of Health & Human Services
UPL	Upper Payment Limit

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United States Government Accountability Office
Washington, DC 20548

May 30, 2008

The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate

Dear Senator Grassley:

Since 2003, Medicaid—the federal and state program that finances health care for certain low-income individuals—has been on GAO's list of high-risk programs because of concerns about the program's size, growth, diversity, and fiscal management.[1] One management challenge stems from the joint federal-state financing of the $299 billion program.[2] As pressures on state and federal budgets have increased, states have sought to maximize the federal funds they receive through their Medicaid programs, while at the same time the federal government has sought to control inappropriate Medicaid spending. Under federal Medicaid law, the federal government reimburses states for its share of allowable expenditures.[3] States pay qualified health care providers for covered services, then seek reimbursement for the federal share of the payments.[4] In addition to the standard payments they make for Medicaid services, most state Medicaid programs make supplemental payments—payments separate from and in addition to those made at a state's standard Medicaid payment rates—to certain providers. For years, we and others have raised concerns regarding states' inappropriate use of supplemental payment arrangements to leverage billions of dollars in federal Medicaid matching funds without a commensurate increase in state Medicaid expenditures. These inappropriate arrangements involved large supplemental payments to

[1]GAO, *High-Risk Series: An Update*, GAO-07-310 (Washington, D.C.: January 2007).

[2]This figure represents combined federal and state Medicaid expenditures for provider services in fiscal year 2006, the latest year for which data were available. For the purpose of this report, expenditures for administration are not included.

[3]Under a statutory formula, the federal government may reimburse from 50 to 83 percent of a state's Medicaid expenditures for services. States with lower per capita incomes receive higher federal matching rates. 42 U.S.C. §§ 1396b(a), 1396d(b).

[4]Medicaid programs are administered by the 50 states, the District of Columbia, Puerto Rico, and 4 U.S. territories.

government providers such as state- or county-owned hospitals or nursing homes. We have made numerous recommendations since 1994 to improve oversight of these Medicaid payments, including recommending improved monitoring and reporting of them.[5] A variety of legislative, regulatory, and federal oversight actions have helped to curb these inappropriate Medicaid supplemental payment arrangements, including a federal oversight initiative begun in 2003 that closely reviewed states' supplemental payments.[6] There is continued congressional interest in understanding state supplemental payment programs, including the amount of payments made and the characteristics of the Medicaid providers receiving the payments.[7]

States have established a variety of programs to administer supplemental payments; for the purpose of this report, we classify these programs into two types.[8] Under federal law, states are required to make Disproportionate Share Hospital (DSH) payments to hospitals that treat large numbers of low-income and Medicaid patients.[9] States' DSH

[5]For example, in a 2004 report, we found that states were continuing to claim excessive federal matching funds through supplemental payment arrangements. Among other recommendations, we recommended that Congress consider a recommendation that remained unimplemented from a 1994 report that would prohibit Medicaid payments to government facilities that exceeded their costs. See GAO, *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*, GAO/HEHS-94-133 (Washington, D.C.: Aug. 1, 1994). We also recommended that CMS improve its oversight of states' Medicaid supplemental payments by improving state reporting on upper payment limit arrangements, including requiring reporting on facility-specific payments. See *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO-04-228 (Washington, D.C.: Feb. 13, 2004).

[6]This federal initiative was launched in August 2003 by the Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees states' Medicaid programs, to review and evaluate the appropriateness of states' Medicaid payments by assessing whether states had inappropriate financing arrangements that required providers to return payments to the states. In a 2007 report, we reviewed this initiative and found that more transparency was needed regarding the way in which CMS was implementing its initiative and the review standards it was using to end certain arrangements. See *Medicaid Financing: Federal Oversight Initiative is Consistent with Medicaid Payment Principles but Needs Greater Transparency*, GAO-07-214 (Washington, D.C.: Mar. 30, 2007).

[7]In May 2007, CMS issued a final rule that, if implemented, would impose additional limits and requirements for states when seeking federal reimbursement for supplemental payments made to providers. Congress placed a moratorium on this rule until May 25, 2008.

[8]In this report, we use the term *program* to refer to an individual supplemental payment arrangement to make payments to certain providers.

[9]See 42 U.S.C. §§ 1396a(13)(A), 1396r-4.

programs are subject to annual caps on the amount of DSH payments a state may make as well as on the DSH payments individual hospitals may receive. States also make non-DSH supplemental payments. For example, over the years, many states have used the flexibility under Medicaid's Upper Payment Limit (UPL) provisions—which define the upper limit on payments for which states can receive federal matching funds—to make supplemental payments.[10] States establish Medicaid provider payment rates, and in practice, states' standard Medicaid payments are often less than the UPL. Because of this gap, states have established programs to make supplemental payments to certain providers above standard Medicaid payment rates but within the UPL. Unlike DSH payments, UPL payments are not specifically required to be established under federal law. UPL payments interact with DSH payments in that any Medicaid payments made to a hospital count toward the hospital's DSH cap, reducing the total DSH payments the hospital may receive. In recent years, some states have also been allowed to make supplemental payments under Medicaid demonstrations authorized under section 1115 of the Social Security Act.[11] In this report, we use the term non-DSH payments[12] to include both UPL payments and supplemental payments made under Medicaid demonstrations.

The federal Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health & Human Services (HHS), oversees state Medicaid programs, including supplemental payment programs, by approving covered populations, services, and payment methods in each

[10]Federal regulations applicable during the course of our review defined UPLs for services provided by hospitals, nursing facilities, intermediate care facilities for the mentally retarded, and clinics. These UPLs are based on an estimate of the amount that Medicare, the federal health program that covers seniors aged 65 and older and some disabled persons, pays for comparable services. See 42 C.F.R. §§ 447.272, 447.321 (2006).

[11]Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive compliance with certain federal Medicaid requirements, as well as to authorize Medicaid expenditures that would not otherwise be allowable, for demonstration projects that are likely to promote Medicaid objectives. See 42 U.S.C. § 1315. Throughout this report, we refer to section 1115 demonstrations as Medicaid demonstrations.

[12]In this report, we use the terms non-DSH payments and non-DSH supplemental payments interchangeably.

state's Medicaid plan.[13] States receive federal reimbursement for Medicaid expenditures by submitting quarterly expenditure reports. In response to your request for information about the amount of states' Medicaid supplemental payments and the types of providers receiving supplemental payments, this report addresses the following questions:

1. What information do CMS Medicaid expenditure reports provide regarding Medicaid supplemental payments?

2. In selected states, how much was distributed as Medicaid supplemental payments, to what types of providers, and for what purposes?

To determine what information CMS Medicaid expenditure reports provide regarding the amount and distribution of Medicaid supplemental payments, we analyzed Medicaid expenditure data reported to CMS by states on a standardized form, the CMS-64, for the most recent year available, fiscal year 2006.[14] We compiled the amount of DSH and non-DSH payments reported by individual states and analyzed their distribution by category of service (such as inpatient hospital, mental health facility, or nursing facility) and provider category (that states report as either state government, local government, or private[15]), where those data were available. To understand CMS expenditure reports, Medicaid reporting requirements, and DSH and non-DSH supplemental payments, we conducted interviews with CMS officials and reviewed relevant federal laws, regulations, and guidance. To assess the reliability of states' CMS-64

[13]Specifically, 42 C.F.R. § 447.201 requires that state Medicaid plans describe the policy and the methods to be used in setting payment rates for each type of service included in the state's Medicaid program. Supplemental payments administered under Medicaid demonstrations generally are governed by the terms and conditions approved by CMS for each demonstration, which are not part of the state plan.

[14]Throughout this report, the term fiscal year refers to the federal fiscal year. States can make adjustments to their CMS-64 submissions for up to 2 years. Our analysis of CMS fiscal year 2006 expenditure data incorporated adjustments to expenditures that had been submitted by states through the end of fiscal year 2006 for DSH payments, and as of October 5, 2007, for non-DSH supplemental payments (see app. I).

[15]Federal regulations applicable during the time of our review apply UPLs for certain services on an aggregate basis to three categories of facilities: state-government-owned or -operated facilities, nonstate-government-owned or -operated facilities, and privately owned and operated facilities. See 42 C.F.R. §§ 447.272, 447.321 (2006). CMS requires states to report on expenditure reports non-DSH supplemental payments made under the UPL separately by these three categories. In this report, we use the term local government to describe the nonstate government category.

submissions, we reviewed the steps CMS takes to ensure the accuracy of expenditure data submitted by states. We determined that the data were reliable for use in this report, and include any limitations identified. A discussion of our methodology and data reliability assessment can be found in appendix I. Finally, we discussed planned changes to CMS's Medicaid supplemental payment reporting requirements with CMS officials.

To examine how Medicaid supplemental payments are distributed to providers and for what purposes, we surveyed a nongeneralizable sample of five states: California, Massachusetts, Michigan, New York, and Texas. We selected these states on the basis of the significance of their supplemental payments: specifically, we reviewed DSH payment information reported to CMS and the most complete information available on non-DSH supplemental payments, which was reported by states to the Urban Institute, a nonpartisan economic and social policy research organization, for fiscal year 2005.[16] Based on these sources, the five states we selected spent the largest amount on Medicaid supplemental payments in 2005, with each state making estimated payments of more than $1.6 billion that year. Two of the five states, California and Massachusetts, operated Medicaid demonstrations during fiscal year 2006 that changed certain characteristics of their supplemental payment programs. We obtained detailed information from each of the five states on the supplemental payment programs they had in place in fiscal year 2006. The data we collected included the amount of each payment to a provider, the name of the provider that received the payment, the provider's type (such as hospital, psychiatric hospital, or nursing facility), and the provider's ownership category.[17] We analyzed the state-reported data to identify how DSH and non-DSH supplemental payments were distributed among different types of programs, across provider ownership categories, and across provider types. To determine the purpose for payments, we asked states to provide a description of each supplemental payment program they operated and reviewed the state Medicaid plan provisions that described the methods and standards used to calculate payments made

[16]T.A. Coughlin, S. Zuckerman, and J. McFeeters, "Restoring Fiscal Integrity to Medicaid Financing? Some progress has been made in reforming Medicaid financing, yet problems persist," *Health Affairs*, vol. 26, no. 5 (2007).

[17]For each provider, our survey asked states to list its type of ownership: state government, nonstate government, or private. We have reported the provider ownership category as reported by the states in response to our survey.

from these programs.[18] To assess the reliability of states' reported payment amounts, we compared states' reported payment information to CMS's expenditure reports, and where we found major differences, we reported them. We determined that the data were reliable for the purposes of this report. A discussion of our methodology and data reliability assessment can be found in appendix I. The findings from the five reviewed states cannot be used to make inferences about supplemental payments in other states. We conducted our work from October 2007 through May 2008 in accordance with generally accepted government auditing standards.

Results in Brief

CMS reports show that at least $23 billion was spent on Medicaid supplemental payments in fiscal year 2006, with the federal share of these payments totaling over $13 billion, but information on payments was incomplete. For DSH payments, CMS's expenditure reports show states and the federal government spent $17.1 billion that year, and individual states' total DSH payments ranged from less than $1 million to over $3 billion and represented from less than 1 percent to over 16 percent of state Medicaid payments. For non-DSH payments, the total amount and distribution of payments made in fiscal year 2006 is unknown, because states did not separately report all their payments to CMS. Since 2001, CMS has required states to report certain supplemental payments on a separate informational section of their expenditure reports, but states do not receive federal reimbursement based on this section of the expenditure reports. CMS officials said that they were updating reporting requirements to obtain better information on supplemental payments. The agency's plans include requiring separate reporting of UPL payments by category of service as a condition of receiving federal matching funds for them and finalizing a rule proposed in 2005 responding to a federal law requiring states to provide more detailed information on DSH payments. As of April 2008, specific implementation dates for these actions had not been established. CMS officials indicated that their planned actions did not include requiring states to report UPL payments on a facility-specific basis, as we had recommended to CMS in 2004. Facility-specific reporting, we found in 2004, was important to CMS's ability to monitor payment arrangements. CMS agreed with the 2004 recommendation, but had not implemented it as of May 2008.

[18]We did not include programs authorized under a Medicaid demonstration in this analysis since they are administered under the terms and conditions of Medicaid demonstrations, rather than under states' Medicaid plans.

The five states we surveyed—California, Massachusetts, Michigan, New York, and Texas—reported making $12.3 billion in Medicaid supplemental payments in fiscal year 2006 through programs with broadly stated purposes, with half of these payments made to local government hospitals. Collectively, the five states reported making payments through 15 DSH and 33 non-DSH programs, with each state operating from 3 to 15 different programs. The five states reported purposes for their programs that often focused on various categories of eligible providers serving individuals on Medicaid, with low incomes, or without insurance. For example, one state had three DSH programs, including two for public hospitals serving a disproportionate number of Medicaid, indigent, and uninsured patients, and nine non-DSH programs for purposes such as uncompensated hospital and clinic costs associated with health care for the uninsured, nursing facility services for Medicaid individuals, and construction renovation reimbursement for local government hospitals serving Medicaid individuals. The state Medicaid plan sections establishing the states' supplemental payments did not always clearly identify how the payments would be calculated. CMS officials said that as part of the agency's oversight initiative started in 2003, CMS ensures that state plans demonstrate a link between the distribution of supplemental payments and Medicaid purposes. However, not all state supplemental payment programs have been reviewed under CMS's 2003 initiative. In each of the five states, supplemental payments were concentrated on a small proportion of providers: the 5 percent of providers receiving the largest amount of supplemental payments in individual states received between 53 percent and 71 percent of all state Medicaid supplemental payments. Some providers received substantial payments from more than one supplemental payment program.

If CMS obtained better information on states' Medicaid supplemental payments it would be in a better position to review payments and ensure that they are appropriately spent for Medicaid purposes. Because CMS needs improved state reporting on the amount and distribution of Medicaid supplemental payments to adequately oversee and monitor states' payments, we believe our 2004 recommendation to improve reporting on UPL payments, including obtaining facility-specific payment information, remains valid. In addition, we are recommending that the Administrator of CMS expedite issuance of a final rule implementing additional DSH reporting requirements and develop a strategy to identify all of the supplemental payment programs established in states' Medicaid plans and to review those that have not been subject to review under CMS's August 2003 initiative.

In commenting on a draft of this report, HHS stated that CMS generally agreed with our recommendations and identified a means by which it could implement our 2004 recommendation to request facility-specific information on UPL payments. HHS also commented that a 2007 GAO report (GAO-07-214) had officially validated that a May 2007 final rule would address concerns related to the supplemental payment programs in this report. Certain elements of the May 2007 rule relate to concerns our past work has raised. However, we have not assessed or reported on this final rule, and the extent to which the rule would address our past concerns related to supplemental payment programs will depend on how it is implemented. In addition to HHS's comments, we obtained technical comments from the five states we surveyed, which we incorporated as appropriate.

Background

Medicaid—a federal-state partnership that finances health care for low-income individuals, including children, families, the aged, and the disabled—provided health coverage for over 60 million individuals in 2007. Title XIX of the Social Security Act established Medicaid as a joint federal-state program.[19] States operate their Medicaid programs by paying qualified health care providers for a range of covered services provided to eligible beneficiaries and then seeking reimbursement for the federal share of those payments. Within broad federal requirements, each state administers and operates its Medicaid program in accordance with a state Medicaid plan, which must be approved by CMS. A state Medicaid plan details the populations a state's program serves, the services the program covers (such as physician services, nursing facility care, and inpatient hospital care) and the methods for calculating payments to providers. The state Medicaid plan also describes the supplemental payment programs administered by the state.[20]

Medicaid is an open-ended entitlement program, under which the federal government is obligated to pay its share of expenditures for covered services provided to eligible individuals under a state's federally approved Medicaid plan.[21] A state may collect up to 60 percent of its Medicaid share

[19]42 U.S.C. §§ 1396a, et seq.

[20]In addition, states may also receive approval from CMS for a Medicaid demonstration. Under these demonstrations, states may cover populations, cover services, or establish payment methodologies differently from the state Medicaid plan.

[21]42 U.S.C. §§ 1396b(a), 1396d(b).

from local governments as long as the state government itself contributes at least 40 percent.[22] Local governments and local government providers can contribute to the state share[23] of Medicaid payments in certain ways, for example, through intergovernmental fund transfers.[24]

DSH payments supplement standard Medicaid payment rates to help offset certain hospitals' unreimbursed costs. Under federal Medicaid law, each state receives an annual DSH allotment. DSH allotments are the maximum amounts of federal matching funds each state is permitted to claim for DSH payments. States' DSH allotments were first established in 1991 based on each state's historical DSH spending.[25] States are required to make DSH payments to hospitals that treat a disproportionate share of low-income and Medicaid patients. Federal Medicaid law caps the amount of DSH funding a state may pay to an individual hospital each fiscal year: DSH payments cannot exceed the unreimbursed cost of furnishing hospital services to Medicaid beneficiaries and the uninsured.[26] In determining a hospital's unreimbursed costs, states must offset costs with all Medicaid payments received by the hospital, including any UPL payments. In other words, UPL payments count against a hospital's DSH cap. A state may establish one or more DSH programs to make DSH payments, subject to these limits, and each program must be documented by the state and approved by CMS in the state's Medicaid plan. As with other Medicaid program changes, to change or initiate a new DSH

[22]See 42 U.S.C. § 1396a(a)(2).

[23]In this report, we use the term state share to refer to the nonfederal share of Medicaid payments.

[24]Local governments and local government providers can contribute to the state share of Medicaid payments through mechanisms known as intergovernmental transfers and certified public expenditures. Intergovernmental transfers are a mechanism in state finance that enables state and local governments to carry out their shared functions, for example, through the transfer of revenues between government entities. When certified public expenditures are used to fund the state share, a government provider certifies to the state its Medicaid expenditures. The state then claims federal reimbursement for the federal share of that amount. See 42 U.S.C. § 1396b(w)(6).

[25]See Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. No. 102-234, § 3, 105 Stat. 1793, 1799-1804 (1991) (codified, as amended, at 42 U.S.C. § 1396r-4(f)). Congress has amended requirements for calculating these DSH allotments since their establishment. Currently, CMS calculates each state's fiscal year DSH allotment using a statutorily defined formula.

[26]See 42 U.S.C. § 1396r-4(g).

program, a state must submit a state plan amendment to CMS for review and approval prior to implementation.

In contrast to DSH payments, states are not required to establish non-DSH supplemental payments for providers. Federal Medicaid regulations establish the UPL as an upper limit on federal reimbursement for Medicaid payments.[27] UPL payments are a product of the gap between standard Medicaid payment rates and the UPL: in practice, states' standard Medicaid payments are often less than the UPL, so states have established supplemental payment programs to make supplemental payments above standard Medicaid rates but within the UPL. UPL payments are approved by CMS in states' Medicaid plans. For example, a state might establish a UPL program to provide additional payments to certain nursing facilities that serve low-income populations to fill the gap between what standard Medicaid rates pay toward the cost of services and higher payments permitted through the UPL. Some states, including California and Massachusetts, have also in recent years been allowed to make supplemental payments under Medicaid demonstrations.[28]

To obtain the federal matching funds for Medicaid payments made to providers, each state files a quarterly expenditure report to CMS. This expenditure report, known as Form CMS-64, compiles state payments in over 20 categories of medical services, such as inpatient hospital services, outpatient hospital services, mental health services, nursing facility services, and physician services. The CMS-64 expenditure report captures some information on supplemental payments. For example, states are required to report their total DSH payments to hospitals and mental health facilities separately from other Medicaid payments in order to receive federal reimbursement for them. States are not, however, required to report disaggregated information on DSH payments made to individual

[27]Federal regulations applicable during the course of our review define certain UPLs based on a reasonable estimate of what Medicare—the federal heath care program for seniors aged 65 and older and some disabled individuals—pays for comparable services. Separate UPLs exist for inpatient services provided by hospitals, nursing facilities, and intermediate care facilities for the mentally retarded, and outpatient services provided by hospitals and clinics. These UPLs are applied on an aggregate basis to three categories of providers: local (nonstate) government-owned or -operated facilities, state-government-owned or -operated facilities, and privately owned and operated facilities. See 42 C.F.R. §§ 447.272, 447.321 (2006).

[28]Supplemental payments administered under Medicaid demonstrations generally are governed by terms and conditions approved by CMS for each demonstration, which are not part of the state plan.

providers in order to obtain federal matching funds. Instead, states are required to maintain supporting documentation for DSH programs, including the amount of DSH payments made to each hospital, and to make this information available to CMS upon request. UPL payments are not reported separately from other payments for the purpose of obtaining federal matching funds. Reporting of supplemental payments under Medicaid demonstrations can vary by demonstration.

Much attention has been focused on Medicaid supplemental payments, in part because of concerns that we and others have raised about inappropriate Medicaid supplemental payment arrangements between states and certain providers. From 1994 through 2007, we issued reports on various arrangements whereby states received federal matching funds by making large supplemental payments to certain government providers, such as county-owned nursing facilities, in amounts that greatly exceeded standard Medicaid rates.[29] The payments were often temporary, since some states required government providers to return all or most of the money to the state government. States used the federal matching funds received for these payments at their own discretion, in some cases to finance or pay for the state's share of the Medicaid program. Since the late 1980s, a variety of regulatory or legislative actions have been taken at the federal level to curb inappropriate Medicaid financing arrangements involving excessive supplemental payments. (See table 1.)

[29]A list of related GAO products can be found at the end of this report.

Table 1: Medicaid Arrangements Using Supplemental Payments to Inappropriately Generate Federal Payments and Federal Actions to Address Them, 1987 through 2002

Payment arrangement	Description	Action taken
Excessive payments to state health facilities	States made excessive Medicaid payments to state-owned health facilities, which subsequently returned these funds to the state treasuries.	In 1987, the Health Care Financing Administration[a] (HCFA) issued regulations that established payment limits specifically for inpatient and institutional facilities operated by states.
Provider taxes and donations	Revenues from provider-specific taxes on hospitals and other providers and from provider "donations" were matched with federal funds and paid to the providers. These providers would then return most of the federal payment to the states.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 imposed restrictions on provider donations and provider taxes.
Excessive disproportionate share hospital (DSH) payments	DSH payments are meant to compensate hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the state and federal funds to the state.	The Omnibus Budget Reconciliation Act of 1993 placed limits on which hospitals could receive DSH payments and capped the amount of DSH payments individual hospitals could receive.
Excessive DSH payments to state mental hospitals	A large share of DSH payments were paid to state-operated psychiatric hospitals, where they were used to pay for services not covered by Medicaid or were returned to the state treasuries.	The Balanced Budget Act of 1997 limited the proportion of a state's DSH payments that can be paid to institutions of mental disease and other mental health facilities.
Excessive upper payment limit (UPL) payments to certain local government health facilities	The UPL is a ceiling on federal matching of Medicaid expenditures based on what Medicare would pay for comparable services. The UPL applied to payments aggregated across classes of facilities. As a result of this aggregate upper limit, states were able to make large supplemental payments to a few individual government health facilities, such as county hospitals and nursing facilities. The facilities then returned the bulk of the state and federal payments to the states.	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required HCFA[a] to issue a final regulation that established a separate aggregate payment limit for each of several types of services provided by local government health facilities. HCFA[a] issued its final regulation on January 12, 2001. In 2002, CMS issued a regulation that further lowered the payment limit for local public hospitals.

Source: GAO.

Note: See GAO, *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes*, GAO-04-574T (Washington, D.C.: Mar. 18, 2004).

[a]Before June 2001, CMS was known as the Health Care Financing Administration (HCFA).

In addition to the regulatory and legislative actions referenced in table 1, CMS has taken additional steps to improve Medicaid's financial management and its oversight of states' supplemental payment programs. These include making internal organizational changes that centralize the review of state plan amendments, hiring additional staff to analyze each state's Medicaid program, and increasing the scrutiny of states' Medicaid supplemental payment programs and the programs' financing methods. In August 2003, CMS launched an oversight initiative to review and evaluate

the appropriateness of states' Medicaid payments as part of its efforts to strengthen financial oversight and the fiscal integrity of the Medicaid program. Under the initiative, a state's submission of a proposal to change provider payments in its state plan triggers CMS scrutiny of the appropriateness of any related payment arrangement. Through this initiative CMS had identified, as of August 2006, 55 supplemental payment programs in 29 states using financing arrangements in which government providers did not retain all the supplemental payments made to them and had taken actions to end these arrangements.[30]

In May 2007, CMS published a final rule in part to address concerns related to states' inappropriate financing arrangements involving supplemental payments.[31] Among other things, the rule, if implemented, would limit Medicaid reimbursement to certain providers operated by units of government to an amount that does not exceed the provider's costs of providing Medicaid-covered services.[32,33] Concerns were raised that the rule

[30]See GAO-07-214.

[31]72 Fed. Reg. 29,748 (May 29, 2007).

[32]We have recommended that Congress prohibit Medicaid payments to government providers that exceed their costs. See GAO, *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*, GAO/HEHS-94-133 (Washington, D.C.: Aug. 1, 1994).

[33]Medicaid DSH payments would not be included under this regulatory limit. DSH payments, however, are already subject to defined limits under federal Medicaid law. The final rule, if implemented, also would, among other things, (1) provide criteria that states must apply in determining whether a provider or other entity is a unit of government for the purposes of financing the state share of Medicaid payments, (2) require states to allow providers to retain all of the Medicaid payments made to them, and (3) require governmental providers to submit cost reports to states when claims for federal reimbursement are based on certified public expenditures.

would harm certain providers. Congress placed a moratorium on this rule until May 25, 2008.[34]

CMS Reports Show $23 Billion Spent on Medicaid DSH and Non-DSH Supplemental Payments in Fiscal Year 2006, but This Amount Is Likely Understated as Information on Non-DSH Payments Is Incomplete

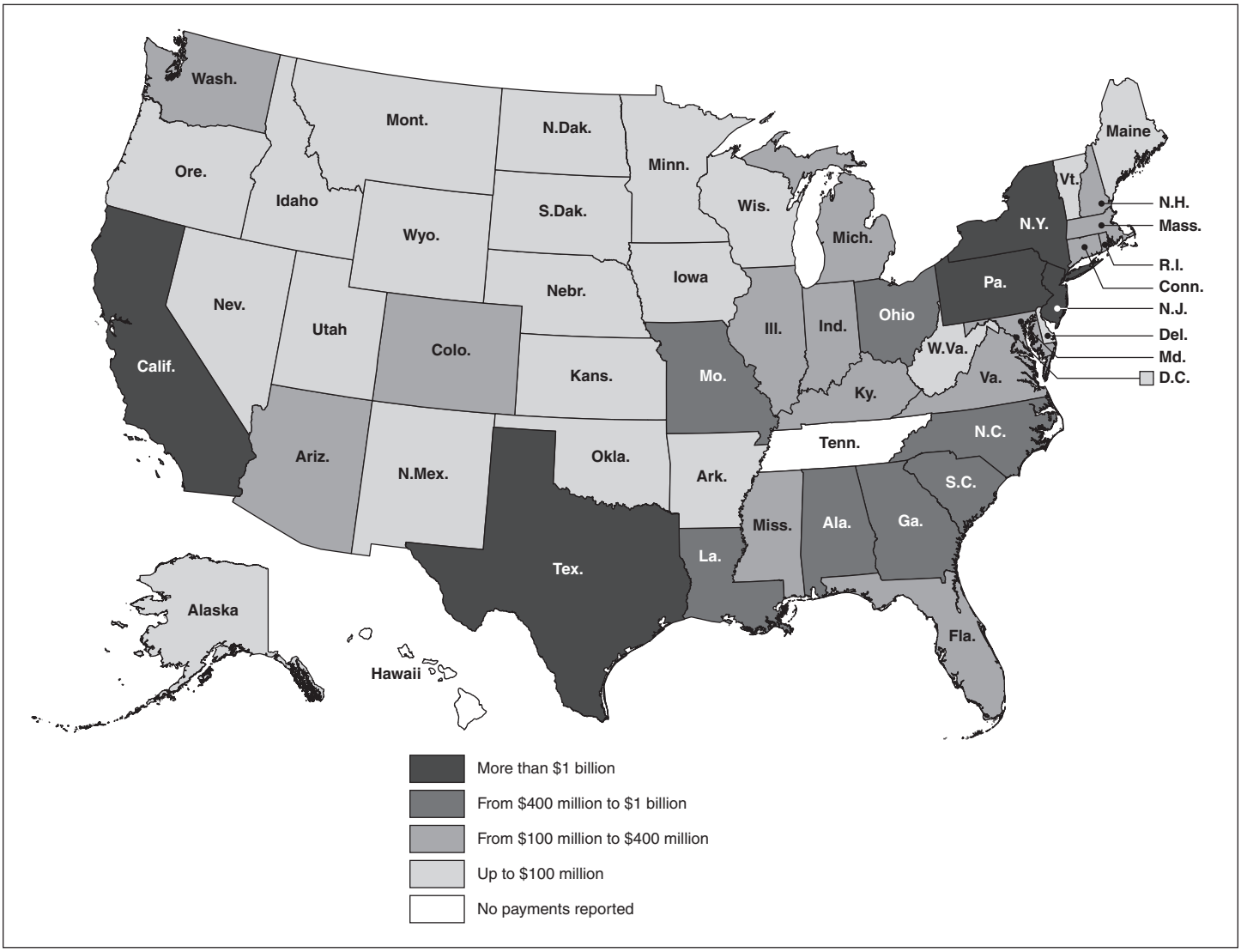
CMS expenditure reports show that states and the federal government spent at least $23.48 billion on DSH and non-DSH supplemental payments in fiscal year 2006, with the federal share of these payments totaling at least $13.37 billion, but states did not provide complete information on non-DSH payments. States reported more than $17 billion in DSH payments and $6 billion in non-DSH supplemental payments in fiscal year 2006, but the non-DSH payment information was not complete as states did not report all of their payments. Since 2001, CMS has required states to report certain supplemental payments on a separate informational section of their expenditure reports, but states do not receive federal reimbursement based on this section of the expenditure reports. CMS officials said that they were updating reporting requirements to obtain better information on states' supplemental payments. As of April 2008, specific implementation dates for these actions had not been established. CMS's planned changes did not include requiring states to report facility-specific UPL payments, a gap we had identified in 2004 and recommended that CMS address.

[34]U.S. Troop Readiness, Veterans Care, Katrina Recovery, and Iraq Accountability Appropriations Act, Pub. L. No. 110-28, § 7002, 121 Stat. 112, 187 (2007). In addition, on March 11, 2008, a suit was filed against HHS and CMS, under which plaintiffs are requesting that a court prohibit the federal government from implementing this final rule. Plaintiffs allege that HHS and CMS exceeded their authority under federal law in publishing this final rule with respect to the following: (i) requiring states to impose certain criteria when determining the governmental status of entities eligible to finance the state share of Medicaid expenditures, (ii) limiting Medicaid reimbursement for certain governmental providers to the cost of Medicaid services and (iii) publishing a final rule despite a Congressional moratorium prohibiting such action. On May 23, 2008, the Court determined that HHS and CMS violated the congressional moratorium and ordered that the rule be vacated and returned to CMS. Thus, the rule did not go into effect on May 25, 2008. See *Alameda County Medical Center, et al. v. Leavitt, et al.*, no. 1:08-00422 (D.D.C. filed Mar. 11, 2008).

CMS Expenditure Reports Show More Than $17 Billion in DSH Payments Made in Fiscal Year 2006

CMS expenditure reports show that states made $17.15 billion in DSH payments in fiscal year 2006, with the federal government reimbursing states $9.65 billion for its share of these payments. As illustrated in figure 1, 48 states and the District of Columbia reported making DSH payments, with total payments ranging from less than $1 million in Wyoming to over $3 billion in New York. The 10 states with the largest total DSH payments in fiscal year 2006 accounted for over 72 percent of the $17.15 billion nationwide total, and the five states with the largest total DSH payments—California, New Jersey, New York, Pennsylvania, and Texas—accounted for more than half of the nationwide total.

Figure 1: State DSH Supplemental Payments in Fiscal Year 2006



Source: GAO analysis of CMS-64 expenditure data, Map Resources (map).

Notes: Puerto Rico and the U.S. territories that operate Medicaid programs are not included on this map because they did not make DSH payments in fiscal year 2006.

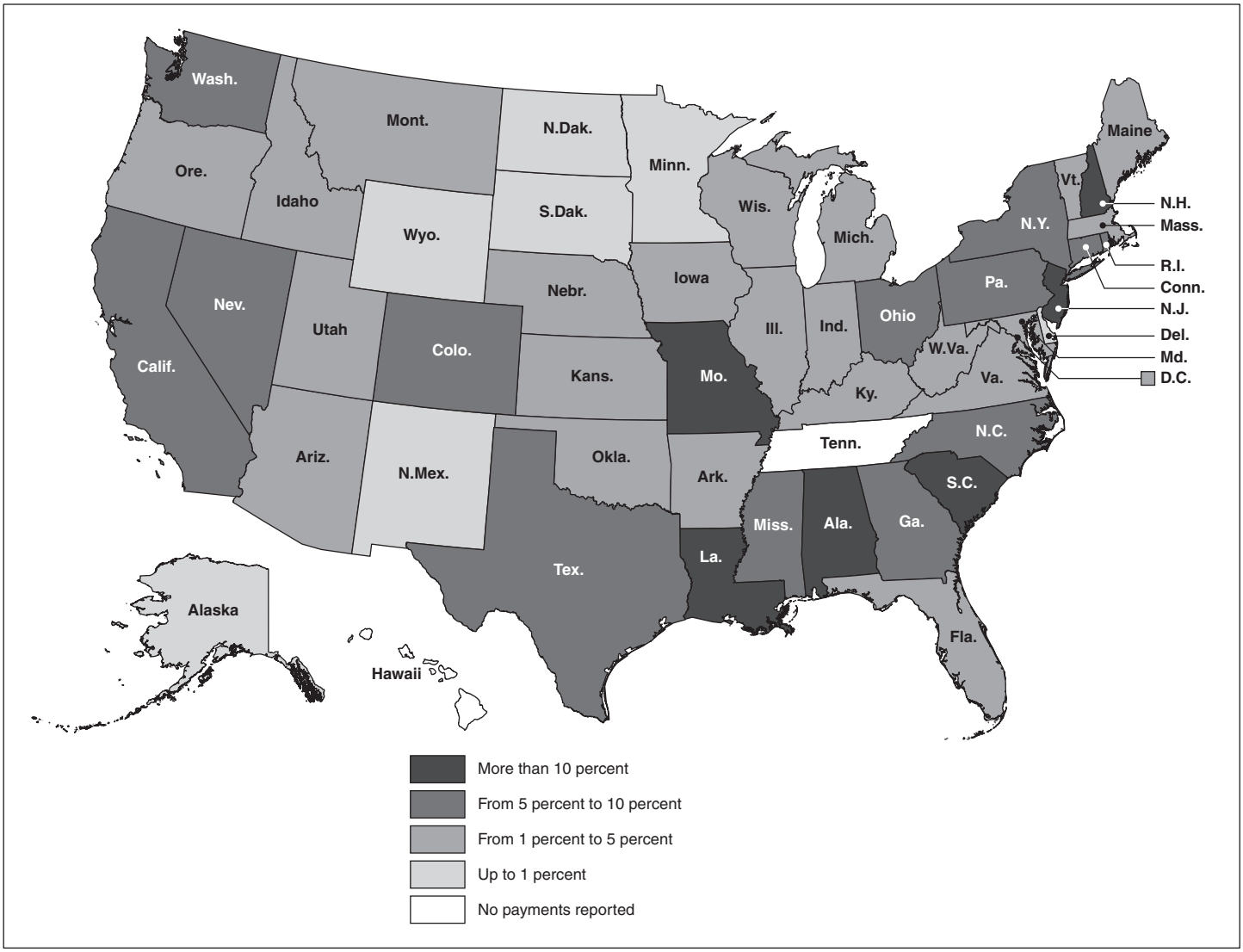
Tennessee and Hawaii did not make DSH payments directly to hospitals in fiscal year 2006; both states operated Medicaid demonstrations under which DSH funding is incorporated into payments made to managed care organizations that provide health coverage to Medicaid beneficiaries. However, the Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 404, 120 Stat. 2922, 2995-6 (2006) (codified, as amended, at 42 U.S.C. § 1396r-4(f)(6)), established DSH allotments for both states and allowed the states to submit changes to their state plan, which, if approved, would authorize both states to make DSH payments and to receive federal reimbursement for these payments in fiscal year 2007. The Medicare, Medicaid, SCHIP Extension Act of 2007, Pub. L. No. 110-173, § 204, 121 Stat. 2492, 2513-2514 (2007) (codified, as amended, at 42 U.S.C. § 1396r-4(f)(6)) extended the states' authority to make DSH payments through June 2008.

Massachusetts officials noted that the $346 million Massachusetts reported as DSH payments on its 2006 expenditure report were actually non-DSH payments made under a Medicaid demonstration.

CMS expenditure reports also showed that DSH payments as a percentage of states' Medicaid payments varied.[35] As illustrated in figure 2, DSH payments ranged from less than 1 percent to over 16 percent of state Medicaid payments.

[35]Here, the term Medicaid payments refers to a state's medical assistance payments, which are the total Medicaid payments made by a state for services, including supplemental payments but not including administrative costs.

Figure 2: State DSH Supplemental Payments as a Percentage of States' Medicaid Payments in Fiscal Year 2006



Source: GAO analysis of CMS-64 expenditure data, Map Resources (map).

Notes: Here, the term Medicaid payments refers to a state's medical assistance payments, which are the total Medicaid payments made by a state for services, including supplemental payments but not including administrative costs.

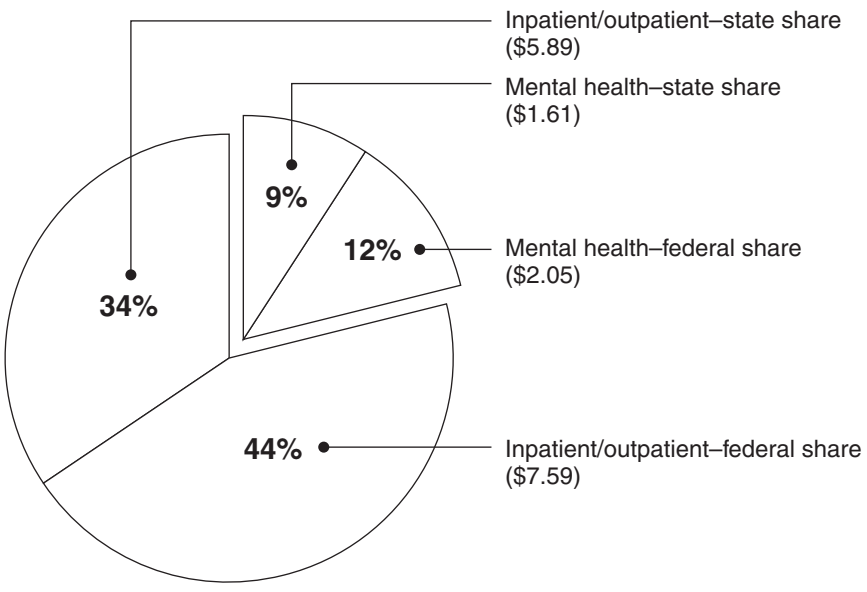
Puerto Rico and the U.S. territories that operate Medicaid programs are not included on this map because they did not make DSH payments in fiscal year 2006.

Tennessee and Hawaii did not make separate DSH payments directly to hospitals in fiscal year 2006; both states operated Medicaid demonstrations under which DSH funding is incorporated into payments made to managed care organizations that provide health coverage to Medicaid beneficiaries. However, the Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 404, 120 Stat. 2922, 2995-6 (2006) (codified, as amended, at 42 U.S.C. § 1396r-4(f)(6)), established DSH allotments for both states and allowed the states to submit changes to their state plan, which, if approved, would authorize both states to make DSH payments and to receive federal reimbursement for these payments in fiscal year 2007. The Medicare, Medicaid, SCHIP Extension Act of 2007, Pub. L. No. 110-173, § 204, 121 Stat. 2492, 2513-2514 (2007) (codified, as amended, at 42 U.S.C. § 1396r-4(f)(6)) extended the states' authority to make DSH payments through June 2008.

Appendix II lists each state's total DSH payments in fiscal year 2006 and each state's total as a proportion of the state's Medicaid payments and of total nationwide DSH payments.

CMS expenditure reports divide DSH payments into two categories of service: traditional inpatient and outpatient services, and inpatient and outpatient mental health services. The 2006 CMS expenditure reports indicate that states made about 80 percent of the total nationwide DSH payments ($13.48 billion) to hospitals for traditional inpatient and outpatient services, and about 20 percent of the payments ($3.66 billion) to hospitals for mental health services. (See fig. 3.)

Figure 3: Proportion of Total DSH Payments Made by States, by Category of Service



Source: GAO analysis of CMS-64 expenditure data.

Note: Percentages do not sum to 100 percent because of rounding.

CMS Expenditure Reports Show More Than $6 Billion in Non-DSH Payments Made in Fiscal Year 2006, but States Did Not Provide Complete Information on Non-DSH Payments

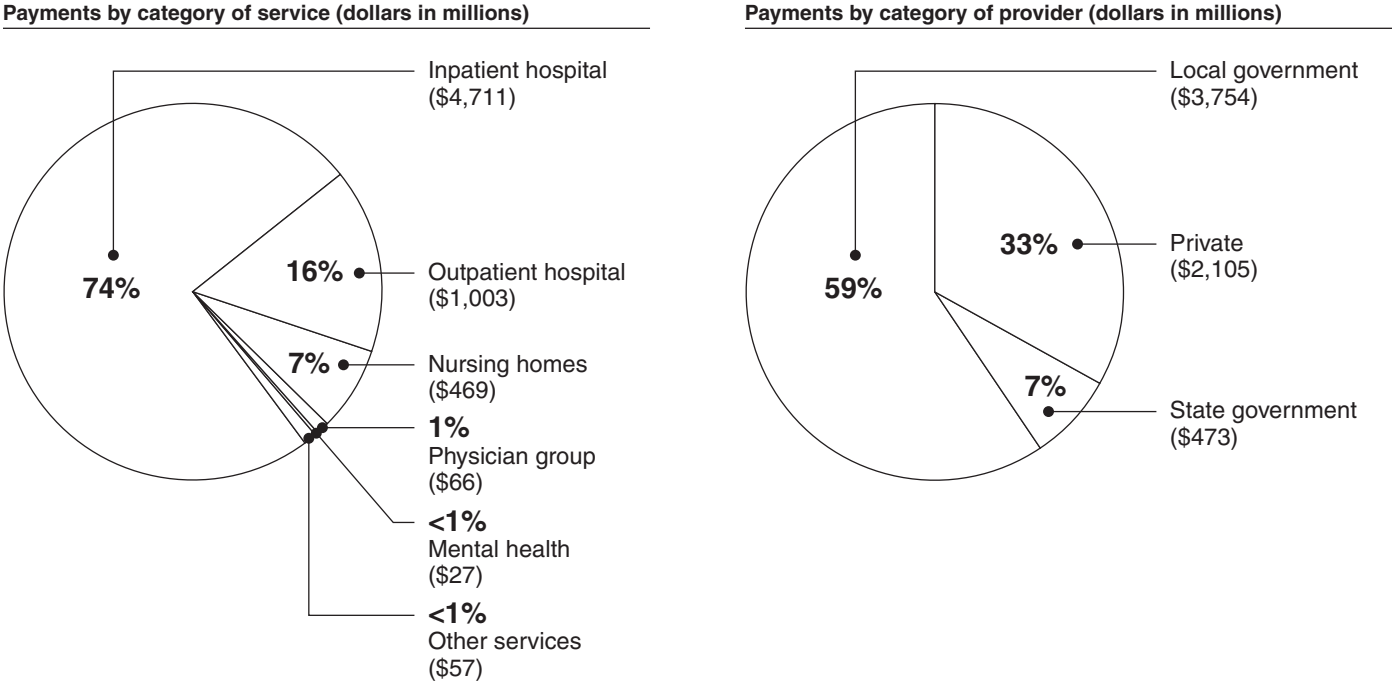
On 2006 CMS expenditure reports, states reported making $6.33 billion in non-DSH payments, mainly to hospitals and nursing facilities. The federal share of these payments was $3.73 billion. States are required to separately report expenditure data on non-DSH payments made under the UPL to CMS on an informational section of the CMS-64 expenditure report called the CMS 64.9I form, but not as a condition of receiving federal matching funds.[36]

On CMS expenditure reports, 28 states reported making non-DSH payments in fiscal year 2006 with total payments ranging from less than $10 million in Washington to over $1 billion in California. On the CMS 64.9I form, states report payments by category of service for state government, local government, or private providers.[37] As illustrated in figure 4, the payments states made in fiscal year 2006 covered a range of medical services. Payments made for inpatient hospital services accounted for 74 percent of the non-DSH payments made by the states, with payments totaling $4.71 billion (including a federal share of $2.74 billion). Local government providers received the largest amount of the non-DSH payments, accounting for 59 percent of total payments.

[36]For the purpose of receiving federal matching funds, states include non-DSH payments on other sections of the CMS expenditure report.

[37]For non-DSH payments made under the UPL, the CMS 64.9I forms do separately identify payments to these categories of providers. These categories correlate with UPLs for certain services, which are applied to three separate categories as defined under federal regulations applicable during the time of our review: state-government-owned or -operated facilities, local-government-owned or -operated facilities, and privately owned and operated facilities. See 42 C.F.R. §§ 447.272, 447.321(2006). CMS expenditure reports currently do not separately identify DSH payments made to state government, local government, and private providers.

Figure 4: Distribution of Non-DSH Payments Reported by 28 States on CMS Expenditure Reports in Fiscal Year 2006, by Category of Service and by Category of Provider



Source: GAO analysis of CMS-64.9I forms.

Notes: GAO analyzed data from CMS 64.9I forms from 28 states' expenditure reports to develop this figure. Percentages do not sum to 100 percent because of rounding.

See appendix II for more information on the non-DSH supplemental payments states reported to CMS.

CMS expenditure reports do not capture all of the non-DSH payments made by states. The Urban Institute, a nonpartisan economic and social policy research organization, administered a survey of states' 2005 supplemental payments.[38] Of the 35 states responding to the survey, 29 reported that they had made non-DSH supplemental payments that year. Five states responding to the Urban Institute reported making non-DSH payments totaling over $1.5 billion in 2005, but did not report any non-DSH payments on their 2005 CMS 64.9I forms. Twenty-three states reported to both the Urban Institute and CMS that they made non-DSH payments, but

[38]Coughlin, Zuckerman, and McFeeters, "Restoring Fiscal Integrity To Medicaid Financing? Some progress has been made in reforming Medicaid financing, yet problems persist."

the amounts reported were different. For example, 4 states reported non-DSH payments to the Urban Institute that were at least $100 million more than those they reported to CMS; in one case, the amount reported to Urban Institute was almost $879 million more than the amount reported to CMS. In addition, in our surveys of 5 states about their supplemental payments, the states reported more to us in non-DSH payments than they reported on their CMS 64.9I forms, including more than $2 billion in supplemental payments made under Medicaid demonstrations.[39] Although some differences could be attributed to differences in how states interpreted the reporting requirements in each case,[40] including whether they included supplemental payments made under Medicaid demonstrations, these discrepancies illustrate that the CMS 64.9I forms did not fully capture non-DSH supplemental payments made by states in fiscal years 2005 and 2006. Although states have been required to complete the CMS 64.9I form since 2001, states do not receive federal reimbursement based on this reported information.[41]

[39]California reported about $530 million more in non-DSH payments to us than they reported to CMS, and Massachusetts reported over $1.6 billion in non-DSH payments to us, but did not report these payments to CMS. Officials from these two states attributed the differences to supplemental payments made under Medicaid demonstrations that the states did not report on their CMS 64.9I forms, a section of the CMS expenditure report for reporting non-DSH supplemental payments made under the UPL. The instructions for completing the CMS 64.9I form do not specify whether supplemental payments under Medicaid demonstrations should be included. In addition, Michigan reported about $753 million more to us in non-DSH payments than the state reported to CMS on its CMS 64.9I form.

[40]The Urban Institute defined Medicaid supplemental payments as enhanced payments made to providers over and above regular Medicaid payment. CMS's 64.9I form defines supplemental payments as additional payments to providers to supplement or enhance the regular Medicaid payment. Neither the Urban Institute survey instructions nor the instructions for the CMS 64.9I form specified whether states should report supplemental payments under Medicaid demonstrations. We did not reconcile the differences we identified.

[41]States receive federal matching funds for non-DSH payments based on the information they provide on other sections of the CMS-64 report. Reimbursement for UPL payments is based on the CMS 64.9 base form, where UPL payments are combined and reported with other standard Medicaid payments. Reimbursement for supplemental payments made under Medicaid demonstrations is based on CMS 64.9 waiver forms, and reporting requirements can vary by demonstration.

CMS Plans to Address Many, but Not All, Gaps in State Reporting of Supplemental Payment Information

In February 2008, CMS officials told us the agency had planned two actions to improve reporting on Medicaid supplemental payments. As of April 2008, specific implementation dates for these actions had not been established.

- First, officials said that they were redesigning CMS expenditure reports, in part to improve reporting of supplemental payments, and were expecting to implement the new report format in summer 2009. CMS officials told us that in the redesigned report, states would be required to separately report UPL payments; that is, UPL payments would no longer be combined with standard Medicaid payments on the section of the expenditure report that states complete to receive federal reimbursement. CMS officials said that the redesigned report would provide a more accurate and complete source of information on states' Medicaid supplemental payments. According to CMS officials, tentative plans for the redesigned report included requirements for states to report information on the distribution of supplemental payments by category of service.

- Second, officials said that a final rule implementing certain congressional mandates to establish new DSH reporting requirements is expected to be issued in 2008. Currently, states must apply a cap on DSH payments to individual hospitals under federal law, but states' expenditure reports do not enumerate payments to individual DSH hospitals. In 2003, however, a law was enacted requiring states to report additional and more detailed information for each hospital receiving a DSH payment.[42] In response, CMS issued a proposed rule in 2005. The proposed rule, if finalized, would require states to separately report detailed information on payment and costs—including standard Medicaid payments, DSH payments, UPL payments, and uncompensated care costs—for each hospital receiving a

[42]Congress mandated improvements to DSH reporting in 1997 and 2003, including requiring states to report provider-level information on each DSH program they administer. The Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4721(c), 11 Stat. 251, 514 (1997) (codified, as amended, at 42 U.S.C. § 1396r-4(a)(2)) required states to provide an annual report to the Secretary of Health and Human Services describing DSH payments made to each hospital. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101(d), 117 Stat. 2066, 2430-2431 (2003) (codified, as amended, at 42 U.S.C. § 1396r-4(j)) mandated that beginning in fiscal year 2004, HHS require states to submit to HHS an annual report identifying DSH payments and the hospitals receiving these payments and to submit an annual independently certified audit that verifies states' compliance with certain federal requirements for DSH payments.

DSH payment.[43] These reports would be separate from and in addition to states' expenditure reports.

CMS's planned actions to improve reporting on supplemental payments will not address all gaps in state reporting of supplemental payments. The proposed rule, if finalized, would require states to report facility-specific UPL payments to DSH hospitals. However, states would not be required to report facility-specific payments made to hospitals that do not receive DSH payments or payments made to other types of providers. Further, while CMS officials told us they plan to redesign the expenditure report to require states to report information on UPL payments, they were not planning to require facility-specific reporting. CMS officials expressed concerns that this level of information could be burdensome to collect and unnecessary and said that CMS can request this level of reporting detail from states when they submit state plan amendments to CMS for review. In a 2004 report, we identified concerns with CMS's lack of comprehensive information on states' UPL payments—information that we believed was necessary to adequately oversee the payments, including monitoring for dramatic changes in payments, conducting timely reviews of states' payments, and taking timely oversight actions. We recommended in that report that CMS improve state reporting by requiring all states to report UPL payments made to all providers and to report these payments on a facility-specific basis.[44] CMS agreed with this recommendation but had not acted on it as of May 2008.

[43]The proposed DSH reporting rule, if finalized, would also require that states report other information about each DSH hospital, including whether the hospital is state government, local government, or private, the unduplicated number of Medicaid-eligible and uninsured individuals who received hospital services, and the amount of funds transferred by the hospital to a state or local government as a condition of receiving Medicaid payments, if any. States would also be required to submit an annual independently certified audit that verifies states' compliance with federal requirements for DSH payments. See 70 Fed. Reg. 50,262 (Aug. 26, 2005).

[44]As part of our review we assessed the sufficiency of CMS's oversight of state UPL payment arrangements to ensure that claims submitted by states are calculated appropriately and are eligible for federal Medicaid reimbursement. We found that CMS had taken a number of steps to strengthen its oversight, but also found that the agency did not have a process to identify supplemental payments made to specific facilities. To further strengthen CMS oversight, we recommended that the agency require states to report UPL payments made to individual providers. (See GAO-04-228.)

Five Surveyed States Reported Distributing $12.3 Billion in Supplemental Payments in Fiscal Year 2006 for Broadly Stated Purposes, Often to Local Government Hospitals

The five states we surveyed—California, Massachusetts, Michigan, New York, and Texas—reported making supplemental payments totaling $12.3 billion in fiscal year 2006 through 15 DSH and 33 non-DSH programs, with about half of these payments made to hospitals classified as local government by the states. The five states reported broadly stated purposes for their programs that often focused on various categories of eligible providers serving individuals on Medicaid, with low incomes, or without insurance. About $7.4 billion in DSH payments and $4.9 billion in non-DSH supplemental payments were made to more than 1,500 providers, mainly to hospitals. In each state, supplemental payments were concentrated on a small proportion of providers, and some providers received payments through multiple programs.

Information from Five Surveyed States Shows Medicaid Supplemental Payments Were Distributed through Multiple Programs for Broadly Stated Purposes

The five surveyed states reported making payments to 1,531 providers through a total of 48 supplemental programs in fiscal year 2006, including 15 DSH programs and 33 non-DSH programs.[45] Four of the five states administered both DSH and non-DSH programs; one state, Massachusetts, reported having no DSH programs (see table 2). About $7.4 billion in DSH payments were made to 695 hospitals, or 50 percent of all hospitals in the four states, and $4.3 billion of the $4.9 billion in non-DSH payments were made to 1,069 nursing facilities and hospitals, or 13 percent of the nursing facilities and 39 percent of the hospitals in the five states.

[45]The five states reported administering a total of 52 supplemental payment programs in fiscal year 2006, but reported making no payments from 4 programs.

Table 2: Number of Medicaid DSH and Non-DSH Supplemental Payment Programs, Number of Providers Receiving Payments, and Total Payment Amounts Made in Fiscal Year 2006, as Reported by the Five Surveyed States in January 2008

Dollars in millions

State	Type of program	Number of programs[a]	Number of providers receiving payments[b]	Total payments[c]
California	DSH	3	159	**$2,347**
	Non-DSH[d]	9	261	**1,554**
	Total	**12**	**272**	**3,900**
Massachusetts	DSH	0	0	**0**
	Non-DSH[e]	15	82	**1,634**
	Total	**15**	**82**	**1,634**
Michigan	DSH	6	127	**427**
	Non-DSH	5	647	**766**
	Total	**11**	**660**	**1,193**
New York	DSH	5	222	**3,028**
	Non-DSH	2	48	**421**
	Total	**7**	**270**	**3,449**
Texas	DSH	1	187	**1,549**
	Non-DSH	2	122	**530**
	Total	**3**	**247**	**2,079**
All five states	DSH	15	695	**7,351**
	Non-DSH	33	1,160	**4,905**
	Grand total	**48**	**1,531**	**$12,255**

Source: GAO analysis of data from a GAO survey of five states.

[a]The number of programs listed is the number of programs from which the states made supplemental payments in 2006.

[b]Some providers received payments from multiple programs; totals represent numbers of unique providers that received payments.

[c]Payment amounts may not sum to totals because of rounding.

[d]Includes payments that California reported of $912 million made under three supplemental payment programs authorized by Medicaid demonstrations.

[e]Includes payments that Massachusetts reported of $1,187 million under 10 supplemental payment programs authorized by Medicaid demonstrations.

The five states' supplemental programs were configured in various ways. One state, Texas, reported making all of its supplemental payments through three programs—one DSH program and two non-DSH programs, one directed toward large urban public hospitals and another for rural hospitals. California made supplemental payments through three DSH programs and nine non-DSH programs, often targeted to specific provider types (see table 3).[46] Massachusetts reported that it did not administer a DSH program, but the state administered 15 non-DSH programs, which were also often targeted to specific provider types, such as one program titled "Safety Net Care Payments for Pediatric Specialty Hospitals and Hospitals with Pediatric Specialty Units."[47] See appendix III for a list of all supplemental payment programs through which the five states made payments in fiscal year 2006.

[46]On August 24, 2005, CMS approved a Medicaid demonstration in California, the California MediCal Hospital Uninsured Care Demonstration. This demonstration was in effect during fiscal year 2006. The demonstration created a non-DSH program, the Safety Net Care Pool, for designated governmental providers. Through this program, the state can use funds from the pool to stabilize the government hospital system and expand healthcare coverage to the uninsured. Safety Net Care Pool funds may be accessed only by the state, counties, or cities and designated providers for uncompensated costs of medical services provided to uninsured individuals, as agreed upon by CMS and the state.

[47]On January 26, 2005, CMS approved a 3-year extension to the Medicaid demonstration in Massachusetts, the MassHealth Medicaid demonstration. The demonstration, which was in effect during fiscal year 2006, created a Safety Net Care Pool, which represents the combined total of what Massachusetts had previously spent on DSH programs and non-DSH payments to Medicaid managed care organizations. In fiscal year 2006, the state funded 10 non-DSH programs through the Safety Net Care Pool, some of which had been DSH programs prior to their inclusion in the demonstration.

Table 3: California's Supplemental Payment Programs and Numbers of Providers Receiving Payments in Fiscal Year 2006, as Reported by the State in January 2008

Dollars in millions

Type of program	Program name	Number of providers receiving payments in FY 2006	Payment amount[a]
DSH	DSH Program for Designated Public Hospitals	23	$2,051
	DSH Program for Non-Designated Public Hospitals	30	11
	DSH Payments Made Under Former Methodology	155	285
	DSH total	**159[b]**	**2,347**
Non-DSH	Safety Net Care Pool[c]	22	801
	DSH Replacement Payments for Private Hospitals[d]	99	363
	Public Hospital Outpatient Supplemental Reimbursement Program	70	209
	Construction Renovation Reimbursement Program[c]	15	87
	Enhanced Payments to Private Trauma Hospitals	11	39
	Distressed Hospital Fund[c]	11	24
	Distinct Part/Nursing Facility Supplemental Payment Program	19	12
	Outpatient DSH Payment Program[d]	111	10
	Small and Rural Hospital Payment Program	71	8
	Non-DSH total	**261[b]**	**1,554**
	DSH and non-DSH total	**272[b]**	**$3,900**

Source: GAO analysis of survey responses from California.

[a]Payment amounts may not sum to totals because of rounding.

[b]Some providers received payments from multiple programs; totals represent numbers of unique providers that received payments.

[c]Program was authorized under a Medicaid demonstration.

[d]Although the name of this program contains the term DSH, we considered it to be a non-DSH program because payments were not counted against the state's DSH allotment.

The five states broadly described each program's purpose in our survey. The purpose of DSH payments is well established under federal law and regulation: DSH payments provide compensation to hospitals for uncompensated care provided to Medicaid and uninsured individuals.[48] States' descriptions of their programs provided some details on the categories of hospitals that would receive DSH payments from each

[48]The scope of this report did not include an assessment of whether states' DSH or non-DSH programs were consistent with federal requirements.

program. The purposes for DSH programs, as reported by the five states, included the following:

- providing supplemental reimbursement to public hospitals that serve a disproportionate number of Medicaid, indigent, and uninsured patients;
- providing health care services to low-income patients with special needs who are not covered under other public or private health care programs;
- providing additional DSH funding for hospitals and hospital systems that received less than a specified amount from one of the state's other DSH pools; and
- ensuring access to services for indigent persons with serious mental illness requiring inpatient treatment.

In contrast to DSH payments, non-DSH supplemental payments do not have a specific statutory or regulatory purpose. In some cases, the states' reported purposes for their non-DSH programs were similar to those of the DSH programs in that they provided supplemental payments to hospitals serving Medicaid, indigent, or uninsured individuals, or a combination of these groups. The purposes of the non-DSH programs for hospitals and other providers, as reported by the five states, included the following:

- providing supplemental payments to most of the largest Medicaid hospital providers in the state;
- supplementing Medicaid payments to certain types of hospitals, such as rural hospitals, pediatric specialty hospitals, and hospitals operated by the state Department of Mental Health;
- ensuring access by Medicaid beneficiaries to high-quality hospital or nursing home care;
- reimbursing public health clinics for their cost of providing services to Medicaid beneficiaries;
- providing enhanced Medicaid payments for outpatient hospital trauma and emergency services to private hospitals meeting certain criteria;
- reimbursing public dental clinics for their cost of providing services to Medicaid beneficiaries;

- providing partial reimbursement of the debt service incurred on revenue bonds for the construction, renovation, replacement, or retrofitting of eligible hospitals; and

- encouraging providers to make available to Medicaid recipients the most advanced forms of medical diagnostic and treatment services available through university-based medical service systems.

According to CMS officials, state Medicaid plans should specify the method by which payment amounts are calculated and how they are correlated with services provided to Medicaid beneficiaries or, in the case of DSH programs, to Medicaid beneficiaries or uninsured individuals. In some cases, we found that the state Medicaid plan sections establishing the states' supplemental payments did not clearly identify how the payments would be calculated. CMS officials said that as part of its oversight initiative started in August 2003, CMS ensures during its state plan amendment review process that states demonstrate a link between the distribution of supplemental payments and Medicaid purposes, which would include uncompensated care in the case of DSH payments. Such vetting only occurs, however, as states establish new supplemental payment programs or make changes to established programs. Thus, not all state supplemental payment programs have been reviewed under CMS's 2003 initiative. In the case of the 35 supplemental payment programs operated by the five states we surveyed that were approved under the states' Medicaid plans,[49] 6 programs (17 percent) had not been reviewed and approved by CMS through the state plan amendment process since the beginning of the oversight initiative that started in August 2003.[50] State officials told us that these 6 programs had not been changed since CMS's 2003 initiative or subject to review under the initiative. We were unable to determine from states' documentation when 5 additional supplemental payment programs were most recently reviewed and approved by CMS.

[49]Thirteen supplemental payment programs that made payments in fiscal year 2006 operated under Medicaid demonstrations rather than state Medicaid plans. We did not include these programs in this analysis since they were administered under the terms and conditions of a Medicaid demonstration.

[50]Of the six programs approved prior to CMS's 2003 initiative, three are DSH programs and three are non-DSH programs. The three DSH programs had fiscal year 2006 payments totaling $1.2 billion (16 percent of the total DSH payments made under the five states' Medicaid plans). The three non-DSH programs had fiscal year 2006 payments totaling $30 million (1 percent of the total non-DSH payments made under the five states' Medicaid plans).

Surveyed States Reported Paying the Largest Portion of Medicaid Supplemental Payments to Local Government Hospitals

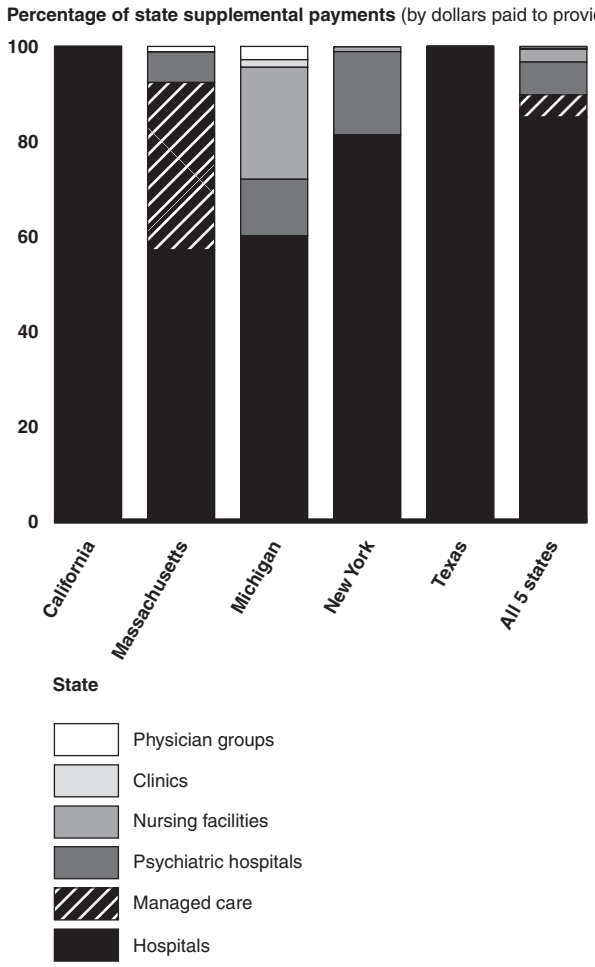
Of the $12.3 billion in total supplemental payments reported by the five states, $11.3 billion, or 92 percent, was made to hospitals and the remainder went to other types of providers, specifically nursing facilities, clinics, physician groups, and, in one state, managed care organizations.[51] The states reported that local government providers received the majority (57 percent) of supplemental payments. Local government hospitals, in particular, received 51 percent of supplemental payments reported by the five states.

Distribution of Supplemental Payments by Provider Type

In each of the five states, hospitals received a majority of the state's total supplemental payments. (See fig. 5.) The five states reported making $7.4 billion in DSH payments and $3.9 billion in non-DSH payments (80 percent of all non-DSH payments) to hospitals, including psychiatric hospitals, in fiscal year 2006.

[51]One state, Massachusetts, reported making supplemental payments to Medicaid managed care organizations under a Medicaid demonstration. This program ended on June 30, 2006. See app. III for additional details.

Figure 5: Distribution of Supplemental Payments Made in Fiscal Year 2006 across Different Types of Providers, as Reported by the Five Surveyed States in January 2008



Source: GAO analysis of data from a GAO survey of five states.

Four of the five states reported making non-DSH payments to types of providers other than hospitals, such as managed care organizations, nursing facilities, clinics, and physician groups. Payments to these other types of facilities and providers totaled nearly $1 billion, including the following:

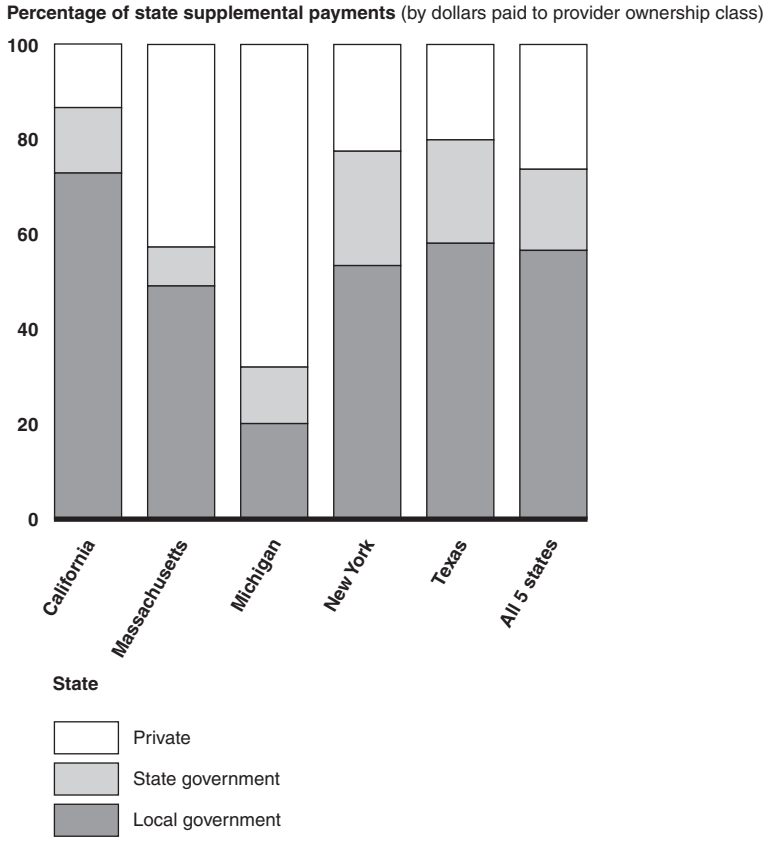
- $577 million paid to managed care organizations,
- $329 million paid to nursing facilities,
- $53 million paid to physician groups, and
- $19 million paid to clinics.

See appendix IV for details on the distribution of each state's DSH and non-DSH payments by provider type.

Distribution of Supplemental Payments by Ownership Category

All five states reported distributing supplemental payments to providers in each of three categories: state government, local government, and private providers. Overall, $6.9 billion, or 57 percent, of the total supplemental payments made by the five states in fiscal year 2006 were paid to local government providers. (See fig. 6.) At the individual state level, the distribution across categories varied. The proportion of payments made to local government providers, for example, ranged from a low of 20 percent in Michigan to a high of 73 percent in California. In California, Massachusetts, New York, and Texas, local government providers received the largest proportion of the state's supplemental payments. Michigan reported that private providers received the largest portion (68 percent) of the state's supplemental payments.

Figure 6: Distribution of Supplemental Payments Made in Fiscal Year 2006 by Provider Ownership Category, as Reported by the Five Surveyed States in January 2008



Source: GAO analysis of data from a GAO survey of five states.

See appendix IV for details on the distribution of each state's DSH and non-DSH payments by ownership category.

Distribution of Supplemental Payments by Provider Type and Ownership Category Combined

Of the total supplemental payments made by the five states in fiscal year 2006, states reported that $6.2 billion, or 51 percent, were made to local government hospitals, as illustrated in table 4. The distribution of payments by both provider type and ownership category differed from state to state. In three states—California, Texas, and New York—the majority of payments were made to local government hospitals. In Michigan, the largest portion of the state's total supplemental payments—

$572 million, or 48 percent of payments—was paid to private hospitals, and the second largest portion of the state's supplemental payments—$238 million, or 20 percent of payments—was paid to private nursing facilities. In Massachusetts, the largest portion of the state's supplemental payments—$679 million, or 42 percent of payments—was paid to private hospitals, and the second largest portion—$577 million, or 35 percent of payments—was paid to local government managed care organizations.[52]

Table 4: Supplemental Payments Made in Fiscal Year 2006, Grouped by Provider Type and Category of Ownership and Ranked by Total Payment Amount, as Reported by the Five Surveyed States in January 2008

Dollars in millions

Total reported payments: $12.3 billion

Rank	Provider type	Category of ownership[a]	Number of states making payments	Payment amount	Payments as percentage of total supplemental payments[b]
1	Hospital	Local government	5	$6,212	51%
2	Hospital	Private	5	2,965	24
3	Hospital	State government	4	1,248	10
4	Psychiatric hospital	State government	3	852	7
5	Managed care organization	Local government	1	577	5
6	Nursing facility	Private	1	238	2
7	Nursing facility	Local government	3	91	1
8	Physicians group	Local government	1	34	0
9	Clinic	Local government	1	19	0
10	Physicians group	Private	1	19	0
Total				**$12,255**	**100%**

Source: GAO analysis of data from a GAO survey of five states.

[a]Category of ownership is as reported by states. State-reported ownership category was not always the same as the type of the organization that operated the facility as recorded in a database of providers maintained by CMS. See app. IV for more information.

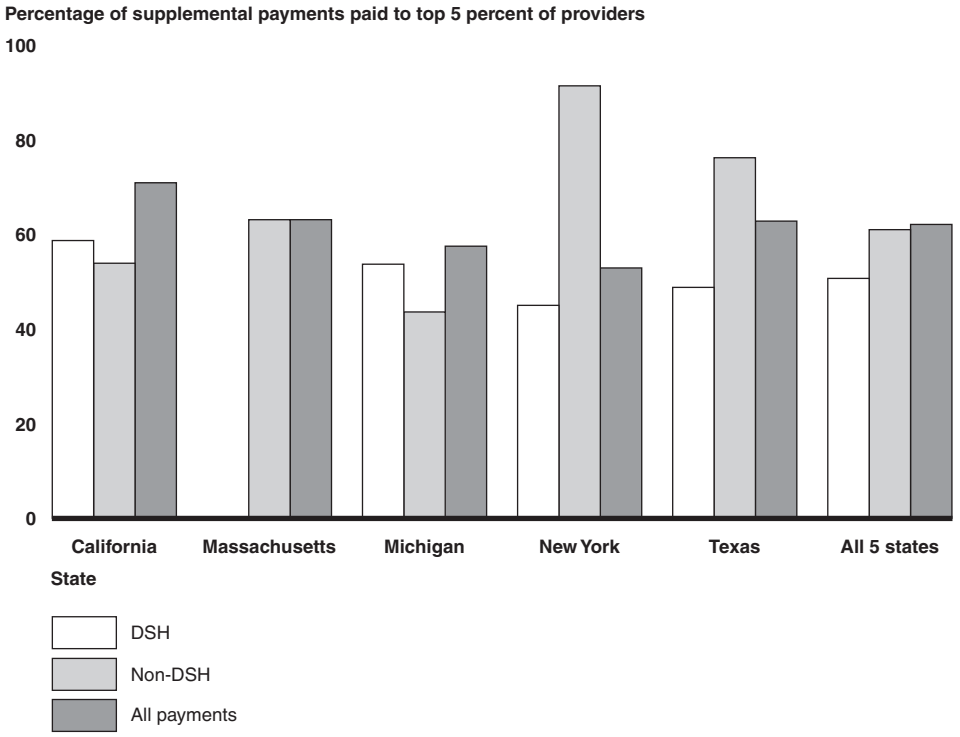
[b]Percentages less than 0.5 percent were rounded to zero.

[52]The state's supplemental payments to managed care organizations ended on June 30, 2006.

A Small Proportion of Providers Received Over Half of the Supplemental Payments, and Some Providers Received Payments from Multiple Programs

Information from the five states shows that a small proportion of providers received a large proportion of each state's supplemental payments. Specifically, the 5 percent of providers receiving the largest supplemental payments in individual states received between 53 percent and 71 percent of all Medicaid supplemental payments. (See fig. 7.) In two states, non-DSH supplemental payments were particularly concentrated: in New York, the top 5 percent of providers receiving non-DSH payments accounted for 91 percent of the total non-DSH payments, and in Texas, the top 5 percent of providers accounted for 76 percent of the total non-DSH payments.

Figure 7: Proportion of Fiscal Year 2006 Supplemental Payments Made to Top 5 Percent of Providers, by Payment Type, in Each of the Five Surveyed States, as Reported by States in January 2008



Source: GAO analysis of data from a GAO survey of five states.

Note: For each state, we identified the percentage of payments made to the 5 percent of providers receiving the largest amount of DSH payments, the 5 percent of providers receiving the largest amount of non-DSH payments, and the 5 percent of providers receiving the largest combined amount of DSH and non-DSH payments. For all five states combined, we calculated the percentages by adding the payments made to the 5 percent of providers receiving the largest amount of payments in each state and dividing this number by the total payments made by all five states.

See appendix V for additional information on the concentration of supplemental payments reported by the five states.

In the five surveyed states, 30 percent of the 1,531 providers receiving supplemental payments received payments from multiple programs, accounting for 69 percent of their supplemental payments.[53] The percentage of providers receiving payments from multiple programs in each state ranged from a low of 17 percent in Massachusetts to a high of 65 percent in California. Some providers received substantial payments from more than one supplemental payment program. For example, in one state one hospital received $420 million in DSH payments and $154 million in non-DSH supplemental payments in fiscal year 2006. In another state one hospital received $173 million in DSH payments and $73 million in non-DSH supplemental payments that year.

Appendix V provides additional information on the extent to which providers in five states received supplemental payments from multiple programs.

Conclusions

Pressures on federal and state budgets have focused attention both on the importance of the Medicaid program and on its high costs. As a source of health care for the nation's most vulnerable populations, Medicaid's long-term sustainability is critical to millions of people. However, sustaining the $299 billion program will require ensuring that expenditures are appropriately limited to Medicaid purposes. Supplemental payment programs have historically been susceptible to abuse, particularly programs involving large payments to government providers that allowed states to inappropriately leverage federal Medicaid matching funds. Legislative, regulatory, and other agency actions have addressed some of these concerns.

States made supplemental payments totaling at least $23 billion in fiscal year 2006, and the federal government spent over $13 billion in matching funds for these payments. Despite the significance of supplemental payments, CMS lacks complete information on states' payments and has not reviewed all supplemental payment programs under its 2003 initiative.

[53]In general, providers receiving larger payments also received payments from more programs: the 5 percent of providers receiving the largest total payments received payments, on average, from about 3.1 programs each, while the remaining 95 percent of providers received payments, on average, from about 1.4 programs each.

To provide effective oversight, federal officials need reliable and complete information, including information on all programs administered by states as well as information on the providers that receive payments from these programs. Complete information about the distribution of Medicaid supplemental payments, however, is still lacking at the federal level. For example, complete data on non-DSH payments and data on DSH and non-DSH supplemental payments made to individual providers are not available from CMS expenditure reports. Congress has long sought better information on DSH payments, including information on payments to individual providers, and we have expressed similar concerns over the lack of information related to non-DSH payments. CMS is planning to take action in 2008 to finalize a rule proposed in 2005 that would implement detailed DSH reporting in response to federal statutory requirements and also plans to make improvements to its expenditure reports to collect data on some non-DSH payments. These planned actions address many of the gaps in state reporting of supplemental payments and should be put into effect as soon as possible. Even when they are implemented, however, states will not be required to report all of the supplemental payments that they make to individual providers.

We believe that a recommendation from our prior work that CMS improve state reporting of UPL payments, including collecting information on payments by facility, remains valid. Such an improvement could be achieved by establishing reporting requirements for non-DSH supplemental payments, such as collecting payment information on a facility-specific basis, comparable to those proposed for DSH payments. In 2004, CMS agreed with the recommendation that it improve its UPL reporting requirements and collect facility-specific payment information, but as of May 2008, had not implemented it. Furthermore, not all supplemental payment programs have been subject to CMS review through the oversight initiative that CMS began in 2003 to assess and ensure the appropriateness of state supplemental payments. Until reliable and complete information on states' supplemental payments is available, federal officials overseeing the program and others will lack information they need to review payments and ensure that they are appropriately spent for Medicaid purposes.

Recommendations for Executive Action

To improve the oversight of states' Medicaid supplemental payments, we recommend that the Administrator of CMS take the following two actions:

- expedite issuance of the final rule implementing additional DSH reporting requirements, and

- develop a strategy to identify all of the supplemental payment programs established in states' Medicaid plans and to review those programs that have not been subject to review under CMS's August 2003 initiative.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment. In its response, HHS stated that CMS generally agreed with our recommendations to expedite issuance of the final DSH rule and to develop a strategy to review all state supplemental payment programs to ensure they are consistent with Medicaid requirements. HHS also identified a means by which it could implement our 2004 recommendation to request facility-specific information on UPL payments.

HHS provided additional comments that it believed were critically important to the final report. HHS stated that the final rule implementing DSH payment reporting requirements will only collect facility-specific supplemental payment information for hospitals that qualify for DSH payments, and that hospitals that do not receive DSH payments and non-hospital Medicaid providers are not subject to the rule. We note that our draft report contained this information. Further, because of these and other data reporting limitations, we determined our 2004 recommendation that CMS improve its requirements for states for reporting UPL payments, such as requiring states to report payments on a facility-specific basis, was still valid. HHS said the volume of information that would be collected under this recommendation could not feasibly be transmitted through the Medicaid Budget and Expenditure System, a system states use to submit Medicaid expenditure data to CMS. We note that we have not specified the system by which improved UPL information should be collected. HHS also provided an example of one means it could use to obtain facility-specific information through its review of states' Medicaid expenditure reports. In our view, the billions of dollars paid annually in non-DSH supplemental payments warrants improved reporting of information on payments comparable to planned DSH reporting requirements, including reporting of facility-specific payment information.

HHS also noted that states are entitled each year to expend their entire allotment and that therefore, the $17 billion DSH spending referenced in the draft report will largely remain unchanged after issuance of the final DSH rule. Although improved reporting may not result in DSH savings, we maintain that having improved and audited data on DSH and other supplemental payments at the facility level is important to ensuring that facility-specific DSH limits are not exceeded and that payments are appropriate.

In its general comments, HHS asserted that GAO had officially validated that a May 2007 final rule would address concerns related to the supplemental payment programs in this report. Some aspects of the May 2007 rule relate to concerns about supplemental payment programs raised in our past work. However, we have not assessed or reported on this final rule, and the extent to which the rule would address our past concerns will depend on how it is implemented.

We also obtained technical comments from California, Massachusetts, Michigan, New York, and Texas, which we considered and incorporated as appropriate.

As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days after its issuance date. At that time, we will send copies of this report to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff members have any questions, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix VII.

Sincerely yours,

James C. Cosgrove
Director, Health Care Issues

Appendix I: Scope and Methodology

This appendix describes in detail how we did our work for our review of states' Medicaid supplemental payments to hospitals through states' Disproportionate Share Hospital (DSH) programs and to providers through states' other supplemental payment programs, permitted under Medicaid's Upper Payment Limit (UPL) provisions or under Medicaid demonstration authority, which in this report we refer to as non-DSH programs.[1] We reviewed states' supplemental payments nationwide by examining Medicaid expenditures reported by states to the Centers for Medicare & Medicaid Services (CMS) on Form CMS-64. We also selected a nongeneralizable sample of five states and collected information about the supplemental payments made to providers from each of their supplemental payment programs.

Analysis of CMS Expenditure Reports

To determine what CMS Medicaid expenditure reports show regarding the amount and distribution of DSH and non-DSH payments, we examined the standardized expenditure reports states submit to CMS on a quarterly basis, Form CMS-64. States submit CMS-64 expenditure data electronically to the Medicaid Budget and Expenditure System and must certify that the data are correct to the best of their knowledge. We reviewed expenditure data provided to CMS from all states for fiscal year 2006, the most recent year for which complete data were available.[2] We obtained fiscal year 2006 DSH payments from CMS's Financial Management Report (FMR). The FMR summarizes each state's quarterly expenditures reports as a fiscal year total. The FMR incorporates payment adjustments reported by the states. For non-DSH supplemental payments, we extracted expenditure data reported on the CMS 64.9I form, a section of the CMS expenditure report on which states are required to report non-DSH supplemental payments made under the UPL for informational purposes. CMS allows states to make adjustments to their prior CMS-64 submissions for up to 2 years. For DSH payments, the FMR for 2006 incorporated payment

[1]Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive compliance with certain federal Medicaid requirements as well as to authorize Medicaid expenditures that would not otherwise be allowable for demonstration projects that are likely to promote Medicaid objectives. See 42 U.S.C. § 1315. Throughout this report, we refer to section 1115 demonstrations as Medicaid demonstrations. Supplemental payments administered under Medicaid demonstrations are generally governed by terms and conditions approved by CMS established for each demonstration. In this report, we use the terms non-DSH payments and non-DSH supplemental payments interchangeably to include both UPL payments and supplemental payments made under Medicaid demonstrations.

[2]Throughout this report, the term fiscal year refers to the federal fiscal year.

adjustments that had been reported through the end of fiscal year 2006. For non-DSH payments we incorporated payment adjustments to the CMS 64.9I forms submitted by the states through October 5, 2007.

We compiled the amount of DSH and non-DSH payments reported by individual states and analyzed their distribution by category of service (such as inpatient hospital, mental health facility, or nursing facility) and by provider category (that states report as either state government, local government, or private[3]), where those data were available.

To assess the reliability of states' CMS-64 submissions, we reviewed the steps CMS takes to ensure the accuracy of expenditure data submitted to the Medicaid Budget and Expenditure System. We also compared these expenditure data to data the five selected states submitted to us and compared the non-DSH expenditure data to similar data published by the Urban Institute. To understand CMS expenditure reports, Medicaid reporting requirements, and DSH and non-DSH supplemental payments, we conducted interviews with CMS officials and reviewed relevant laws, regulations, and guidance. We concluded that states' reported DSH payments in fiscal year 2006 were sufficiently reliable for use in this report because CMS reimburses states based on these data and because CMS also reports these data publicly on its Web site. However, we determined that states' reported data on non-DSH payments in fiscal year 2006 were less reliable than data on DSH payments. States are required to submit non-DSH payment information separately from, and in addition to, their base expenditures. CMS does not reimburse states on the basis of these data.[4] We did not examine reporting requirements under specific states' Medicaid demonstrations.[5] We concluded that states' reported fiscal year

[3]Federal regulations applicable during the time of our review apply UPLs for certain services on an aggregate basis to three categories of facilities: state-government-owned or -operated facilities, non-state-government-owned or -operated facilities, and privately owned and operated facilities. See 42 C.F.R. §§ 447.272, 447.321 (2006). The CMS-64 requires states to separate non-DSH payment information by these categories.

[4]States receive federal matching funds for non-DSH payments based on the information they provide on other sections of the CMS-64 report. Reimbursement for UPL payments is based on the CMS 64.9 base form, where UPL payments are combined and reported with other standard Medicaid payments. Reimbursement for supplemental payments made under Medicaid demonstrations is based on CMS 64.9 waiver forms, and reporting requirements can vary by demonstration.

[5]Reporting of supplemental payments under Medicaid demonstrations can vary by demonstration. The instructions for completing the CMS 64.9I form do not specify whether supplemental payments under Medicaid demonstrations should be included.

2006 non-DSH payments were suitable for limited, descriptive purposes, and we noted the limitations of these expenditure data in the report. We also compared information on Medicaid supplemental payments provided to us by the five selected states (based on the selection criteria described below) with the information the states reported on CMS expenditure reports. Where we found major discrepancies, we noted them in the report and included state officials' explanations for some of the differences.

See appendix II for results of our analysis of CMS expenditure reports.

Analysis of the Distribution of Supplemental Payments in Five Selected States

To examine how Medicaid supplemental payments are distributed to providers and for what purposes, we surveyed a nongeneralizable sample of five states—California, Massachusetts, Michigan, New York, and Texas. We selected these states because they reported spending the largest amount on Medicaid supplemental payments in fiscal year 2005 based on the combined total of their DSH payments (as reported to CMS) and estimated non-DSH payments (imputed from data published by the Urban Institute).[6] The five states each reported making more than $1.6 billion in estimated Medicaid supplemental payments in 2005. The estimated combined total of these states' Medicaid supplemental payments accounted for more than 40 percent of the estimated fiscal year 2005 Medicaid supplemental payments for all states. Two of the five states,

[6]In a 2007 report, the Urban Institute reported for 35 states fiscal year 2005 UPL payments as a percentage of these states' total Medicaid spending (see T.A. Coughlin, S. Zuckerman, and J. McFeeters, "Restoring Fiscal Integrity to Medicaid Financing? Some progress has been made in reforming Medicaid financing, yet problems persist," *Health Affairs*, vol. 26, no. 5 (2007)). We imputed the dollar amount of these states' UPL payments by multiplying the percentages reported by the Urban Institute by each state's fiscal year 2005 total Medicaid spending, as reported to CMS.

California and Massachusetts, operated Medicaid demonstrations that changed certain characteristics of their supplemental payment programs.[7]

In January 2008, we obtained information from each state about fiscal year 2006 DSH and non-DSH payments, including the amount of each payment, the name of the provider that received the payment, the provider's type (such as hospital, nursing facility, or clinic), and the provider's ownership category (state government, local government, or private).[8] We also interviewed state officials about their Medicaid supplemental payments. To determine the purpose for programs, we asked states to provide a description of each supplemental payment program they operated, and assessed the state Medicaid plan provisions that describe the methods and standards used to calculate payments made from these programs.[9] To assess the reliability of states' reported payment amounts, we compared states' reported payment information to CMS's expenditure reports, and where we found major differences, we reported them. For other provider data reported by states, specifically, information on provider ownership category, we compared states' data with provider data in CMS's On-Line Survey, Certification, and Reporting system that contains information on

[7]On August 24, 2005, CMS approved a Medicaid demonstration in California, the California MediCal Hospital Uninsured Care Demonstration. The demonstration created a supplemental payment program, the Safety Net Care Pool, for designated governmental providers. Through this program, the state can use funds from the pool to stabilize the government hospital system and expand health care coverage to the uninsured. Safety Net Care Pool funds may be accessed only by the state, counties, or cities and designated providers for uncompensated costs of medical services provided to uninsured individuals, as agreed upon by CMS and the state. On January 26, 2005, CMS approved a 3-year extension to the Medicaid demonstration in Massachusetts, the MassHealth Medicaid demonstration. The demonstration, which was in effect during fiscal year 2006, created a Safety Net Care Pool of $1.34 billion per year, which represents the combined total of what Massachusetts had previously spent on DSH programs and supplemental payments to Medicaid managed care organizations. The state funded 10 non-DSH supplemental payment programs through the Safety Net Care Pool, some of which had been DSH programs prior to their inclusion in the demonstration.

[8]For each provider, our survey asked states to list its type of ownership: state government, nonstate government, or private. We have reported provider ownership category as reported by the states in response to our survey.

[9]We did not include programs authorized under a Medicaid demonstration in this analysis since they are administered under the terms and conditions of the demonstrations, rather than under the states' Medicaid plans.

the type of organization that operates the facilities.[10] We provide examples of differences we found in states' information as compared to CMS's. Although the scope of this review did not include identifying the reasons for them, differences in payment amounts may be due to payment adjustments made after we extracted CMS data and states not reporting supplemental payments made under Medicaid demonstrations on the CMS 64.9I form. We have reported the information as reported to us by states. The findings from our nongeneralizable sample of five states cannot be used to make inferences about supplemental payment programs in other states. See appendixes III through V for the results of our analysis of the state-reported data.

We conducted our work from October 2007 through May 2008 in accordance with generally accepted government auditing standards.

[10]CMS maintains a database called the On-Line Survey, Certification, and Reporting system that contains information on all health care providers participating in Medicare and Medicaid. This system is used to monitor health care facilities' compliance with federal health and safety standards. The On-Line Survey, Certification, and Reporting system contains provider-reported information on the type of organization that operates each facility, for example, whether the facility is state government, local government, nonprofit, or proprietary.

Appendix II: Information on Medicaid Supplemental Payments in the States and the District of Columbia, as Reported by States

This appendix provides payment information, by state, compiled from fiscal year 2006 CMS-64 expenditure reports. Table 5 provides the amount of DSH payments by state and also identifies for each state (1) the proportion of the state's total Medicaid payments accounted for by DSH payments and (2) the proportion of nationwide DSH payments accounted for by the state's DSH payments. Table 6 provides similar information, by state, for the non-DSH payments that 28 states reported to CMS for informational purposes on the CMS 64.9I form.

Table 5: State DSH Payments Made in Fiscal Year 2006 as a Percentage of Total State Medicaid Payments and Total National DSH Payments, by State

Dollars in millions

		State DSH payments			
State	Total state Medicaid payments[a]	Total	Federal share	Total state DSH payments as percentage of total state Medicaid payments	Total state DSH payments as percentage of total national DSH payments
Alabama	$3,860	$417	$290	10.80%	2.43%
Alaska	945	7	4	0.74	0.04
Arizona	6,189	138	93	2.24	0.81
Arkansas	2,854	39	29	1.37	0.23
California	33,840	2,339	1,169	6.91	13.64
Colorado	2,850	174	87	6.11	1.02
Connecticut	4,068	269	134	6.61	1.57
Delaware	946	4	2	0.44	0.02
District of Columbia	1,285	45	31	3.48	0.26
Florida	12,621	320	188	2.53	1.86
Georgia	6,480	425	257	6.55	2.48
Hawaii[b]	1,091	0	0	0.00	0.00
Idaho	1,027	16	12	1.60	0.10
Illinois	9,967	209	105	2.10	1.22
Indiana	5,637	161	101	2.86	0.94
Iowa	2,539	27	17	1.07	0.16
Kansas	2,057	58	35	2.82	0.34
Kentucky	4,329	197	137	4.56	1.15
Louisiana	4,688	740	516	15.78	4.31
Maine	1,897	48	30	2.51	0.28
Maryland	4,916	122	61	2.47	0.71
Massachusetts	9,561	346[c]	173	3.62	2.02

Dollars in millions

State	Total state Medicaid payments[a]	State DSH payments		Total state DSH payments as percentage of total state Medicaid payments	Total state DSH payments as percentage of total national DSH payments
		Total	Federal share		
Michigan	8,237	384	217	4.66	2.24
Minnesota	5,367	38	19	0.71	0.22
Mississippi	3,240	171	130	5.28	1.00
Missouri	6,382	740	458	11.59	4.31
Montana	720	11	8	1.56	0.07
Nebraska	1,499	23	14	1.54	0.13
Nevada	1,175	80	44	6.77	0.46
New Hampshire	1,086	182	91	16.71	1.06
New Jersey	9,109	1,288	644	14.14	7.51
New Mexico	2,444	19	13	0.77	0.11
New York	43,554	3,068	1,534	7.04	17.89
North Carolina	8,720	461	293	5.29	2.69
North Dakota	499	2	<2	0.46	0.01
Ohio	11,768	735	439	6.24	4.28
Oklahoma	2,871	39	27	1.37	0.23
Oregon	2,900	44	27	1.52	0.26
Pennsylvania	15,402	1,019	560	6.61	5.94
Rhode Island	1,674	112	61	6.72	0.66
South Carolina	3,934	445	308	11.31	2.59
South Dakota	602	1	<1	0.18	0.01
Tennessee[b]	6,014	0	0	0.00	0.00
Texas	17,684	1,543	936	8.72	9.00
Utah	1,450	19	14	1.34	0.11
Vermont	947	24	14	2.59	0.14
Virginia	4,608	157	78	3.40	0.91
Washington	5,524	304	152	5.51	1.77
West Virginia	2,076	74	54	3.58	0.43
Wisconsin	4,583	63	36	1.37	0.37
Wyoming	418	<1	<1	0.12	<0.01
Total	**$299,022**[d]	**$17,149**[e]	**$9,646**[e]	**5.74%**	

Source: GAO analysis of CMS-64 data as of the end of fiscal year 2006.

Note: Total DSH payments represent payments made in fiscal year 2006 and may include payments that apply to prior fiscal years.

[a]Total state Medicaid payments represents both the state and federal share and includes all payments made by the states to providers, including DSH and non-DSH payments. It does not include expenditures for program administration.

[b]Hawaii and Tennessee did not have any DSH allotments in fiscal year 2006. Both states operated Medicaid demonstrations under which DSH funding is incorporated into payments made to managed care organizations that provide health coverage to Medicaid individuals. However, the Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 404, 120 Stat. 2922, 2995-6 (2006) (codified, as amended, at 42 U.S.C. § 1396r-4(f)(6)), established DSH allotments for both states and allowed the states to submit changes to their state plans, which, if approved, would authorize both states to make DSH payments and to receive federal reimbursement for these payments in fiscal year 2007. The Medicare, Medicaid, SCHIP Extension Act of 2007, Pub. L. No. 110-173, § 204, 121 Stat. 2492, 2513-2514 (2007) (codified, as amended, at 42 U.S.C. § 1396r-4(f)(6)) extended the states' authority to make DSH payments through June 2008.

[c]According to state officials, the $346 million Massachusetts reported as DSH payments on its 2006 expenditure report were actually non-DSH payments made under a Medicaid demonstration. Massachusetts officials stated that these non-DSH payments were reported as DSH payments because a form for reporting these payments had not been created at the time the state was seeking reimbursement for them.

[d]This total includes $889 million in Medicaid payments made by Puerto Rico and four U.S. territories. Puerto Rico and the four U.S. territories did not make any DSH payments in 2006.

[e]Payment amounts may not add to total because of rounding.

Table 6: State Non-DSH Payments Made in Fiscal Year 2006 as a Percentage of Total State Medicaid Payments, Ranked Alphabetically by State

Dollars in millions

State	Total state Medicaid payments[a]	State non-DSH supplemental payments		Total state non-DSH payments as percentage of total state Medicaid payments
		Total	Federal share	
Alabama	$3,860	$275	$191	7.12%
Alaska	945	30	18	3.22
Arizona	6,189	—	—	—
Arkansas	2,854	63	47	2.22
California	33,840	1,024	512	3.02
Colorado	2,850	140	70	4.90
Connecticut	4,068	—	—	—
Delaware	946	—	—	—
District of Columbia	1,285	—	—	—
Florida	12,621	681	401	5.39
Georgia	6,480	332	201	5.13
Hawaii	1,091	18	11	1.69
Idaho	1,027	—	—	—
Illinois	9,967	631	317	6.33
Indiana	5,637	—	—	—
Iowa	2,539	—	—	—
Kansas	2,057	—	—	—
Kentucky	4,329	—	—	—
Louisiana	4,688	31	22	0.67
Maine	1,897	—	—	—
Maryland	4,916	—	—	—
Massachusetts	9,561	—	—	—
Michigan	8,237	13	7	0.16
Minnesota	5,367	—	—	—
Mississippi	3,240	175	133	5.39
Missouri	6,382	116	72	1.83
Montana	720	33	24	4.65
Nebraska	1,499	48	29	3.20

Dollars in millions

State	Total state Medicaid payments[a]	State non-DSH supplemental payments: Total	State non-DSH supplemental payments: Federal share	Total state non-DSH payments as percentage of total state Medicaid payments
Nevada	1,175	—	—	—
New Hampshire	1,086	19	10	1.76
New Jersey	9,109	—	—	—
New Mexico	2,444	49	35	2.01
New York	43,554	385	192	0.88
North Carolina	8,720	825	524	9.46
North Dakota	499	—	—	—
Ohio	11,768	46	27	0.39
Oklahoma	2,871	28	19	0.99
Oregon	2,900	15	9	0.51
Pennsylvania	15,402	—	—	—
Rhode Island	1,674	—	—	—
South Carolina	3,934	335	232	8.51
South Dakota	602	—	—	—
Tennessee	6,014	127	81	2.10
Texas	17,684	818	496	4.63
Utah	1,450	—	—	—
Vermont	947	—	—	—
Virginia	4,608	—	—	—
Washington	5,524	9	5	0.17
West Virginia	2,076	36	26	1.72
Wisconsin	4,583	29	16	0.62
Wyoming	418	—	—	—
Total	**$299,022**[b]	**$6,332**[c]	**$3,725**[c]	**2.12%**

Source: GAO analysis of CMS 64.9I forms.

Notes: This table includes data from CMS 64.9I forms as adjusted as of October 5, 2007.

A dash in a cell indicates that we were unable to distinguish whether the state did not submit information on the CMS 64.9I form, which is part of the CMS-64 expenditure report, or did submit the CMS 64.9I form but reported that the state made no non-DSH payments in 2006.

We found evidence that CMS 64.9I forms do not fully capture the non-DSH payments made by states. The CMS 64.9I form is an informational form and is not used for reimbursement purposes.

[a]Total state Medicaid payments represents both the state and federal share and includes all payments made by the states to providers, including DSH and non-DSH payments. It does not include expenditures for program administration.

[b]This total includes $889 million in Medicaid payments made by Puerto Rico and four U.S. territories.

[c]Payment amounts may not add to total because of rounding.

Appendix III: Summary of Medicaid Supplemental Payment Programs in Five Surveyed States

We obtained information from each of the five states we surveyed on the supplemental payment programs they had in place in fiscal year 2006. We asked the states to provide information about each supplemental payment program they operated, including

- the program's purpose;
- the providers that received payments and the amount of payment they received; and
- whether payments were made as lump-sum payments (for example, as a quarterly or annual payment made to a provider) or as an enhanced payment rate (an additional amount that is added to the individual payments made to providers for specific services).

The five states reported making all payments in fiscal year 2006 as periodic lump sums. The purpose, number of providers receiving payments, and total payments made for each program are summarized in tables 7 through 11.

California's Fiscal Year 2006 Supplemental Payment Programs

California officials reported that in fiscal year 2006 the state paid nearly $4 billion in Medicaid supplemental payments through three DSH and nine non-DSH supplemental payment programs. Supplemental payments were made to hospitals and nursing facilities. Total payments through the programs ranged from $11 million to over $2 billion for DSH programs and from $8 million to over $1 billion for non-DSH programs. See table 7 for a description of each supplemental payment program administered by California.

Table 7: California Supplemental Payment Programs from Which Payments Were Made in Fiscal Year 2006, as Reported to GAO by the State in January 2008

Dollars in millions

Program type	Program name	Program purpose as reported by the state	Number of providers receiving payments in FY 2006	Payment amount[a]
DSH	DSH Program for Designated Public Hospitals	Provides supplemental reimbursement to Designated Public Hospitals that serve a disproportionate number of MediCal (Medicaid), indigent, and uninsured patients. The primary goal of the supplemental payments is to maintain access to health care for this population.	23	$2,051
	DSH Program for Non-Designated Public Hospitals	Provides supplemental reimbursement to Non-Designated Public Hospitals that serve a disproportionate number of MediCal, indigent, and uninsured patients. The primary goal of the supplemental payments is to maintain access to health care for this population.	30	11
	DSH Payments Made Under Former Methodology	This program provides supplemental reimbursement to Public and Private hospitals that serve a disproportionate number of MediCal, indigent and uninsured patients. Primary goal of the supplemental payments is to maintain access to health care for this population.	155	285
	Total DSH		**159[b]**	**2,347**
Non-DSH	Safety Net Care Pool[c]	Provides supplemental reimbursement to Designated Public Hospitals for uncompensated hospital and clinic costs associated with health care services provided to the uninsured.	22	801
	DSH Replacement Payments for Private Hospitals[d]	Provides supplemental reimbursement to private hospitals that serve a disproportionate number of MediCal, indigent, and uninsured patients. Primary goal of the supplemental payments is to maintain access to health care for this population.	99	363

Dollars in millions

Program type	Program name	Program purpose as reported by the state	Number of providers receiving payments in FY 2006	Payment amount[a]
	Public Hospital Outpatient Supplemental Reimbursement Program	Provides supplemental reimbursement for an outpatient department of a general acute care hospital that is owned by a city, county, city and county, the University of California, or health care district that meets specified requirements and provides hospital services to MediCal beneficiaries.	70	209
	Construction Renovation Reimbursement Program[c]	Provides partial reimbursement of the debt service incurred on revenue bonds for the construction, renovation, replacement, or retrofitting of eligible hospitals and/or their ancillary or fixed equipment used to provide services to MediCal beneficiaries.	15	87
	Enhanced Payments to Private Trauma Hospitals	Provides enhanced MediCal payments for outpatient hospital trauma and emergency services to private hospitals within Los Angeles County and Alameda County that have demonstrated a need for assistance in ensuring the availability of essential trauma services for MediCal beneficiaries.	11	39
	Distressed Hospital Fund[c]	Provides supplemental payments to hospitals participating in the Selective Provider Contracting Program. Contract hospitals that meet the requirements as determined by California Medical Assistance Commission are invited annually to submit proposals for disbursements from the Distressed Hospital Fund per Welfare and Institutions Code, Section 14166, et seq.	11	24
	Distinct Part/Nursing Facility Supplemental Payment Program	Provides supplemental reimbursement for a Distinct Part/Nursing Facility of a general acute care hospital that is owned or operated by a city, county, city and county, or health care district; to provide services to MediCal (Medicaid) beneficiaries	19	12

Dollars in millions

Program type	Program name	Program purpose as reported by the state	Number of providers receiving payments in FY 2006	Payment amount[a]
	Outpatient DSH Payment Program[d]	Provides enhanced reimbursement to eligible acute care hospitals for outpatient services that serve a disproportionate number of MediCal (Medicaid), indigent, and uninsured patients. The primary goal of the supplemental payments is to maintain outpatient access to health care for this population.	111	10
	Small and Rural Hospital Payment Program	Provides an increase to the reimbursements for outpatient services rendered to a disproportionate number of MediCal (Medicaid), indigent, and uninsured patients by small and rural hospitals.	71	8
	Total non-DSH		**261[b]**	**1,554**
	Total supplemental		**272[b]**	**$3,900**

Source: GAO analysis of survey responses from California.

[a]Payment amounts may not sum to totals because of rounding.

[b]Some providers received payments from multiple programs; totals represent numbers of unique providers that received payments.

[c]Program was authorized under a Medicaid demonstration.

[d]Although the name of this program contains the term DSH, we considered it to be a non-DSH program because payments were not counted against the state's DSH allotment.

Massachusetts's Fiscal Year 2006 Supplemental Payment Programs

Massachusetts officials reported that in fiscal year 2006 the state paid over $1.6 billion in Medicaid supplemental payments through 15 non-DSH supplemental payment programs. Supplemental payments were made to hospitals, including psychiatric hospitals; managed care organizations; and a physician group. Four programs were in operation for only part of 2006: two of these programs were terminated at the end of the third quarter of fiscal year 2006 and two began at the start of the fourth quarter. On January 26, 2005, CMS approved a 3-year extension to the Medicaid demonstration in Massachusetts, the MassHealth demonstration. The demonstration, which was in effect during fiscal year 2006, created a Safety Net Care Pool, which represents the combined total of what Massachusetts had previously spent on DSH programs and supplemental payments to Medicaid managed care organizations. The state funded 10

non-DSH supplemental payment programs through the Safety Net Care Pool, some of which had been DSH programs prior to their inclusion in the demonstration. In addition to supplemental payments, Massachusetts funded its Commonwealth Care Health Insurance Program through the Pool. Under Commonwealth Care, the state provides premium assistance subsidies to private managed care organizations for providing sliding scale health insurance to previously uninsured people with low incomes and is part of the state's transition from supplemental payments to providers to expanding coverage of individuals. See table 8 for a description of each supplemental payment program administered by Massachusetts.

Table 8: Massachusetts Supplemental Payment Programs from Which Payments Were Made in Fiscal Year 2006, as Reported to GAO by the State in January 2008

Dollars in millions

Program type	Program name	Program purpose as reported by the state	Number of providers receiving payments in FY 2006	Payment amount[a]
DSH	None reported	NA		
	Total DSH		**0**	**$0**
Non-DSH	Supplemental Payments for Managed Care Organizations (ended on June 30, 2006)[b]	To support the transition of safety net health systems from providing unmanaged services to the uninsured to providing managed care services to individuals newly eligible for Medicaid as a result of an expansion of Massachusetts's Medicaid program under the authority of a Medicaid demonstration.	2	$577
	Uncompensated Care Safety Net Care Payment[b]	For acute hospitals that incur uncompensated costs for services to low-income patients.	57	225
	Essential MassHealth Hospital rate payment	For hospitals that are deemed to be essential to the MassHealth program in that they are legislatively mandated to have a public mission.	6	209
	Public Service Hospital Safety Net Care Payment[b]	For safety net acute hospitals that have significant free care charges and a disproportionately public payer mix.	2	177
	Public Service Hospital rate payment	For safety net acute hospitals that have significant free care charges and a disproportionately public payer mix.	1	124
	Safety Net Care Payments for State-Owned Non-Acute Hospitals Operated by the Department of Mental Health[b]	For unreimbursed nonacute hospital services provided by hospitals operated by the Massachusetts Department of Mental Health.	8	105
	Acute Hospitals with High Medicaid Discharges	For acute hospitals that serve a substantial share of the Medicaid population.	9	88
	Section 122 of Chapter 58 Safety Net Health System payments (began on July 1, 2006)[b]	For unreimbursed free care and Medicaid services, including Medicaid managed care services and Commonwealth Care, and the operation of the safety net health systems at the two publicly operated or public-service state-defined disproportionate share hospitals with the highest relative volume of uncompensated care costs in hospital fiscal year 2007.	2	50

Dollars in millions

Program type	Program name	Program purpose as reported by the state	Number of providers receiving payments in FY 2006	Payment amount[a]
	Safety Net Care Payments for Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health[b]	For unreimbursed nonacute hospital services provided by hospitals operated by the Massachusetts Department of Public Health.	4	30
	Physician Supplemental Payment	For the physician group that exists to support the mission of the teaching hospital affiliated with the Commonwealth-owned medical school.	1	19
	Safety Net Care Payments for Pediatric Specialty Hospitals and Hospitals with Pediatric Specialty Units[b]	Recognizes the unique population and/or the acute severity of illness within the case mix seen by pediatric specialty hospitals and hospitals with pediatric specialty units.	4	12
	High Public Payer Hospital Safety Net Care Payment[b]	For acute hospitals that have the highest percentages of revenue from Medicare, Medicaid, other government payers, and free care, relative to total revenue.	6	12
	Supplemental Medicaid Rate for Pediatric Specialty Hospitals	For the unique population and the acute severity of illness within the case mix seen by pediatric specialty hospitals.	1	6
	Safety Net Care Payments for Pediatric Non-Acute Hospitals (began on July 1, 2006)[b]	For the unique population and the acute severity of illness within the case mix seen by pediatric nonacute hospitals.	1	1
	Basic Safety Net Care Payment (ended on June 30, 2006)[b]	For acute hospitals that have a disproportionate amount of inpatient Medicaid days or low-income utilization.	6	0
	Total non-DSH		**82[c]**	**1,634**
	Total supplemental		**82**	**$1,634**

Source: GAO analysis of survey responses from Massachusetts.

Note: NA = not applicable.

[a]Payment amounts may not sum to totals because of rounding; dollar amounts less than $500,000 were rounded to zero.

[b]Program was authorized under a Medicaid demonstration.

[c]Some providers received payments from multiple programs; totals represent numbers of unique providers that received payments.

Michigan's Fiscal Year 2006 Supplemental Payment Programs

Michigan officials reported that in fiscal year 2006 the state paid over $1 billion in Medicaid supplemental payments through six DSH and five non-DSH supplemental payment programs. The state made supplemental payments to hospitals, including psychiatric hospitals; nursing facilities; clinics; and physician groups. See table 9 for a description of each supplemental payment program administered by Michigan.

Table 9: Michigan Supplemental Payment Programs from Which Payments Were Made in Fiscal Year 2006, as Reported to GAO by the State in January 2008

Dollars in millions

Program type	Program name	Program purpose as reported by the state	Number of providers receiving payments in FY 2006	Payment amount[a]
DSH	Indigent Care Agreements DSH Pool	To provide health care services to low-income patients with special needs who are not covered under other public or private health care programs.	51	$158
	Institute for Mental Disease DSH Pool	To ensure access to services for indigent persons with serious mental illness requiring inpatient treatment.	5	142
	Government Provider DSH Pool	To ensure funding for costs incurred by public facilities providing inpatient hospital services that serve a disproportionate number of low-income patients with special needs.	18	74
	$45 Million DSH Pool	To provide health care services to low-income patients with special needs who are not covered under other public or private health care programs. Payments are distributed to hospitals with a high proportion of indigent care based on their percentage of inpatient indigent charges to their total inpatient charges.	57	45
	$5 Million Small Hospital DSH Pool	To ensure DSH funding for hospitals and hospital systems that received less than $900,000 in state fiscal year 2004 from the $45 million DSH pool.	106	5

Dollars in millions

Program type	Program name	Program purpose as reported by the state	Number of providers receiving payments in FY 2006	Payment amount[a]
	University with College of Allopathic and Osteopathic Medicine DSH Pool	To ensure continued access to medical care for indigents and to increase the efficiency and effectiveness of medical practitioners providing services to Medicaid beneficiaries under managed care.	1	3
	Total DSH		**127**[b]	**427**
Non-DSH	Hospital UPL	To ensure continued access by Medicaid beneficiaries to high-quality hospital care.	145	432
	Nursing Home UPL	To ensure continued access by Medicaid beneficiaries to high-quality nursing home care.	415	281
	Public Physician UPL	To encourage providers to make available to Medicaid recipients the most advanced forms of medical diagnostic and treatment services that are uniquely available through the technological and research capabilities of university-based medical service systems.	49	34
	Public Health Clinic Reimbursement	To reimburse public health clinics for their cost of providing services to Medicaid beneficiaries.	40	14
	Public Dental Clinic Reimbursement	To reimburse public dental clinics for their cost of providing services to Medicaid beneficiaries.	4	5
	Total non-DSH		**647**[b]	**766**
	Total supplemental		**660**[b]	**$1,193**

Source: GAO analysis of survey responses from Michigan.

[a]Payment amounts may not sum to totals because of rounding.

[b]Some providers received payments from multiple programs; totals represent numbers of unique providers that received payments.

New York's Fiscal Year 2006 Supplemental Payment Programs

New York officials reported that in fiscal year 2006 the state paid over $3 billion in Medicaid supplemental payments through five DSH and two non-DSH supplemental payment programs. Supplemental payments were made to hospitals, including psychiatric hospitals, and nursing facilities. See table 10 for a description of each supplemental payment program administered by New York.

Table 10: New York Supplemental Payment Programs from Which Payments Were Made in Fiscal Year 2006, as Reported to GAO by the State in January 2008

Dollars in millions

Program type	Program name	Program purpose as reported by the state	Number of providers receiving payments in FY 2006	Payment amount[a]
DSH	DSH Public Hospital DSH Cap Subsidy	Payments provide subsidies to hospitals for indigent care costs.	18	$1,026
	DSH Indigent Care High Need Pool	Payments provide subsidies to hospitals for indigent care costs.	194	848
	DSH Office of Mental Health Subsidy	Payments provide subsidies to hospitals for indigent care costs.	25	605
	DSH Indigent Care Adjustment	Payments provide subsidies to hospitals for indigent care costs.	15	489
	DSH Office of Mental Health/Office of Alcoholism and Substance Abuse Services Subsidies	Payments provide subsidies to hospitals for indigent care costs.	61	61
	Total DSH		**222[b]**	**3,028**
Non-DSH	Inpatient Hospital UPL	Payments provide additional revenue to critical safety net hospitals.	2	385
	Nursing Home UPL	Payments provide additional revenue to critical safety net nursing facilities.	46	36
	Total non-DSH		**48**	**421**
	Total supplemental		**270**	**$3,449**

Source: GAO analysis of survey responses from New York.

[a]Payment amounts may not sum to totals because of rounding.

[b]Some providers received payments from multiple programs; totals represent numbers of unique providers that received payments.

Texas's Fiscal Year 2006 Supplemental Payment Programs

Texas officials reported that in fiscal year 2006 the state paid over $2 billion in Medicaid supplemental payments through one DSH and two non-DSH supplemental payment programs. Supplemental payments were made only to hospitals. See table 11 for a description of each supplemental payment program administered by Texas.

Table 11: Texas Supplemental Payment Programs from Which Payments were Made in Fiscal Year 2006, as Reported to GAO by the State in January 2008.

Dollars in millions

Program type	Program name	Program purpose as reported by the state	Number of providers receiving payments in FY 2006	Total payments[a]
DSH	Disproportionate Share Hospital	Reimburses hospitals that provide a disproportionate amount of inpatient care to indigent patients.	187	$1,549
	Total DSH		**187**	**1,549**
Non-DSH	Large Urban Public Hospital	To make supplemental payments to most of the largest Medicaid hospital providers in Texas.	11	474
	Rural Hospital	To make supplemental Medicaid payments to rural hospitals in Texas.	111	56
	Total non-DSH		122	530
	Total supplemental		247[b]	$2,079

Source: GAO analysis of survey responses from Texas.

[a]Payment amounts may not sum to totals because of rounding.

[b]Some providers receive payments from multiple programs; totals represent numbers of unique providers receiving payments.

Appendix IV: Distribution of Medicaid Supplemental Payments, by Provider Type and Ownership, in Five Surveyed States

Officials from the five surveyed states reported making DSH and non-DSH supplemental payments in fiscal year 2006 to a variety of provider types (such as hospitals, nursing facilities, or physician groups) and provider ownership categories (state government, local government, or private). In fiscal year 2006, in total, the five states reported making $10.4 billion in payments to hospitals (85 percent of total payments), $852 million to psychiatric hospitals (7 percent), $577 million to managed care organizations (5 percent), $329 million to nursing facilities (3 percent), $53 million to physician groups (less than 1 percent), and $19 million to clinics (less than 1 percent). The five states made most payments (57 percent) to local government providers; payments to providers they categorized as owned by state governments accounted for 17 percent of the total supplemental payments made by the five states, and payments to private providers accounted for 26 percent of payments. Tables 12 and 13 show the distribution of each state's fiscal year 2006 supplemental payments, by provider type and provider ownership category, respectively.

Table 12: Supplemental Payments Made in Fiscal Year 2006 by Provider Type in Five States, as Reported to GAO by the States in January 2008

Dollars in millions

	Payment amount (percentage of total[a])						
State	**Hospital**	**Psychiatric hospital**	**Nursing facility**	**Physician group**	**Clinic**	**Managed care organization**	**Total**
California							
DSH payments	$2,347 (100%)	—	—	—	—	—	**$2,347 (100%)**
Non-DSH payments	1,542 (99)	—	12 (1)	—	—	—	**1,554 (100)**
Total payments	**3,888 (100)**	—	**12 (0)**	—	—	—	**3,900 (100)**
Massachusetts							
DSH payments	—	—	—	—	—	—	—
Non-DSH payments	933 (57)	105 (6)	—	19 (1)	—	577 (35)	**1,634 (100)**
Total payments	**933 (57)**	**105 (6)**	—	**19 (1)**	—	**577 (35)**	**1,634 (100)**
Michigan							
DSH payments	285 (67)	142 (33)	—		—	—	**427 (100)**
Non-DSH payments	432 (56)	—	281 (37)	34 (4)	19 (3)	—	**767 (100)**
Total payments	**717 (60)**	**142 (12)**	**281 (24)**	**34 (3)**	**19 (2)**	—	**1,193 (100)**
New York							
DSH payments	2,423 (80)	605 (20)	—	—	—	—	**3,028 (100)**
Non-DSH payments	385 (91)	—	36 (9)	—	—	—	**421 (100)**
Total payments	**2,808 (81)**	**605 (18)**	**36 (1)**	—	—	—	**3,449 (100)**
Texas							
DSH payments	1,549 (100)	—	—	—	—	—	**1,549 (100)**
Non-DSH payments	530 (100)	—	—	—	—	—	**530 (100)**
Total payments	**2,079 (100)**	—	—	—	—	—	**2,079 (100)**
Total							
DSH payments	**6,604 (90)**	**747 (10)**	**—**	**—**	**—**	**—**	**7,351 (100)**
Non-DSH payments	**3,822 (78)**	**105 (2)**	**329 (7)**	**53 (1)**	**19 (0)**	**577 (12)**	**4,905 (100)**
Grand total payments	**$10,425 (85%)**	**$852 (7%)**	**$329 (3%)**	**$53 (0%)**	**$19 (0%)**	**$577 (5%)**	**$12,255 (100%)**

Source: GAO analysis of data from a GAO survey of five states.

[a]Percentages less than 0.5 percent were rounded to zero; percentages may not add to 100 because of rounding.

Table 13: Supplemental Payments Made in Fiscal Year 2006 by Provider Ownership Category in Five States as Reported to GAO by the States in January 2008

Dollars in millions

	Payment amount (percentage of total[a])			
State	**State government**	**Local government**	**Private**	**All ownership categories**
California				
DSH payments	$346 (15%)	$1,934 (82%)	$67 (3%)	**$2,347 (100%)**
Non-DSH payments	192 (12)	908 (58)	453 (29)	**1,554 (100)**
Total payments	**537 (14)**	**2,842 (73)**	**521 (13)**	**3,900 (100)**
Massachusetts				
DSH payments	—	—	—	—
Non-DSH payments	134 (8)	802 (49)	698 (43)	**1,634 (100)**
Total payments	**134 (8)**	**802 (49)**	**698 (43)**	**1,634 (100)**
Michigan				
DSH payments	142 (33)	82 (19)	203 (48)	**427 (100)**
Non-DSH payments	—	158 (21)	608 (79)	**766 (100)**
Total payments	**142 (12)**	**240 (20)**	**811 (68)**	**1,193 (100)**
New York				
DSH payments	833 (28)	1,420 (47)	775 (26)	**3,028 (100)**
Non-DSH payments	—	421 (100)	—	**421 (100)**
Total payments	**833 (24)**	**1,841 (53)**	**775 (23)**	**3,449 (100)**
Texas				
DSH payments	453 (29)	687 (44)	408 (26)	**1,549 (100)**
Non-DSH payments	—	520 (98)	10 (2)	**530 (100)**
Total payments	**453 (22)**	**1,208 (58)**	**418 (20)**	**2,079 (100)**
Total				
Total DSH payments	**1,774 (24)**	**4,123 (56)**	**1,454 (20)**	**7,351 (100)**
Total non-DSH payments	**326 (7)**	**2,810 (57)**	**1,769 (36)**	**4,905 (100)**
Grand total payments	**$2,099 (17%)**	**$6,933 (57%)**	**$3,223 (26%)**	**$12,255 (100%)**

Source: GAO analysis of data from in a GAO survey of five states.

Note: States reported ownership by the three broad ownership categories, however, we also compared the reported ownership category of hospitals and nursing facilities to a database of providers maintained by CMS that contains provider reported information on the type of organization that operates the facilities. For the hospitals and nursing facilities identified by the states that we were able to match in CMS's database (796 of 961 hospitals; 351 of 479 nursing facilities), our comparison identified discrepancies that may be due in part to how the terms are defined. Of the 205 hospitals we identified in CMS's database that states classified as local government, 15 percent were listed as non-profit and 3 percent were listed as proprietary. Of the 17 hospitals we identified in CMS's database that states classified as state government, 12 percent were listed as nonprofit. Similarly, of the 93 nursing facilities we identified in CMS's database that states classified as local government, 7 percent were listed as private, either nonprofit (4 percent) or proprietary (3 percent).

[a]Percentages less than 0.5 percent were rounded to zero; percentages may not add to 100 because of rounding.

Appendix V: Extent That Supplemental Payments Were Concentrated and Providers Received Multiple Payments

Data from the five surveyed states showed that the states concentrated a large proportion of their DSH and non-DSH payments on a small percentage of providers and that over one-quarter of providers received payments from more than one supplemental payment program. In fiscal year 2006, the states reported making total supplemental payments of nearly $8 billion (63 percent of all supplemental payments) to 77 providers, which represented 5 percent of the providers receiving supplemental payments in the five states. Officials also reported that 452 providers—representing 30 percent of all providers receiving a supplemental payment in the five states—received payments from multiple programs. Seventy-one providers received payments from at least four programs, with payments exceeding $2.7 billion or 22 percent of the total reported supplemental payments in the five surveyed states. Table 14 shows the amount of each state's fiscal year 2006 supplemental payments that were paid to the 5 percent of providers receiving the largest payments, and the remaining 95 percent of providers. Table 15 shows the number of providers that received payments from multiple supplemental payment programs and the amount of payment received.

Table 14: Concentration of Supplemental Payments to Top 5 and Remaining 95 Percent of Providers Receiving Payments in Fiscal Year 2006 in Five States, as Reported to GAO by the States in January 2008

Dollars in millions

State	Top 5 percent of providers[a]	Remaining 95 percent of providers	Total, all providers
California			
Number of providers receiving payment	14	258	**272**
Payment amount	$2,767	$1,133	**$3,900**
Percentage of total payments	71%	29%	**100%**
Massachusetts			
Number of providers receiving payment	4	78	**82**
Payment amount	$1,031	$603	**$1,634**
Percentage of total payments	63%	37%	**100%**
Michigan			
Number of providers receiving payment	33	627	**660**
Payment amount	$685	$507	**$1,193**
Percentage of total payments	57%	43%	**100%**
New York			
Number of providers receiving payment	14	256	**270**
Payment amount	$1,826	$1,624	**$3,449**
Percentage of total payments	53%	47%	**100%**
Texas			
Number of providers receiving payment	12	**235**	**247**
Payment amount	$1,306	**$773**	**$2,079**
Percentage of total payments	63%	**37%**	**100%**
Total			
Number of providers receiving payment	**77**	**1454**	**1531**
Payment amount	**$7,615**	**$4,640**	**$12,255**
Percentage of total payments	**62%**	**38%**	**100%**

Source: GAO analysis of data from a GAO survey of five states.

Note: For each state we identified the percentage of payments made to the 5 percent of providers receiving the largest amount of supplemental payments. For all five states combined, this percentage was calculated by adding the payments made to the 5 percent of providers receiving the largest amount of payments in each state and dividing this number by the total payments made by all five states.

[a]When calculating the number of providers representing 5 percent, we rounded to the nearest whole number.

Table 15: Number of Providers Receiving Payments from Multiple Supplemental Payment Programs in Five States for Fiscal Year 2006, as Reported to GAO by the States in January 2008

Dollars in millions									
State	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Total**
California									
Number of providers receiving payment	96	68	65	17	16	9	—	1	**272**
Payment amount	$81	$186	$1,647	$238	$436	$1,179	—	$133	**$3,900**
Percentage of total payments	2%	5%	42%	6%	11%	30%	—	3%	**100%**
Massachusetts									
Number of providers receiving payment	68	7	4	1	—	2	—	—	**82**
Payment amount	$1,044	$87	$32	$18	—	$453	—	—	**$1,634**
Percentage of total payments	64%	5%	2%	1%	—	28%	—	—	**100%**
Michigan									
Number of providers receiving payment	536	44	55	23	2	—	—	—	**660**
Payment amount	$481	$120	$350	$152	$89	—	—	—	**$1,193**
Percentage of total payments	40%	10%	29%	13%	8%	—	—	—	**100%**
New York									
Number of providers receiving payment	194	61	15	—	—	—	—	—	**270**
Payment amount	$1,268	$675	1,507	—	—	—	—	—	**$3,449**
Percentage of total payments	37%	20%	44%	—	—	—	—	—	**100%**
Texas									
Number of providers receiving payment	185	62	—	—	—	—	—	—	**247**
Payment amount	$867	$1,212	—	—	—	—	—	—	**$2,079**
Percentage of total payments	42%	58%	—	—	—	—	—	—	**100%**
Total									
Number of providers receiving payment	**1,079**	**242**	**139**	**41**	**18**	**11**	**—**	**1**	**1,531**
Payment amount	**$3,740**	**$2,280**	**$3,536**	**$408**	**$525**	**$1,632**	**—**	**$133**	**$12,255**
Percentage of total payments	**31%**	**19%**	**29%**	**3%**	**4%**	**13%**	**—**	**1%**	**100%**

Source: GAO analysis of data from a GAO survey of five states.

Appendix VI: Comments from the Department of Health & Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary for Legislation

Washington, D.C. 20201

MAY 15 2008

James Cosgrove
Director, Health Care
Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Cosgrove:

Enclosed are the Department's comments on the Government Accountability Office's (GAO) draft report, entitled: "MEDICAID: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments" (GAO-08-614).

The Department appreciates the opportunity to review and comment on this report before its publication.

Sincerely,

for Vincent Ventimiglia, Jr.
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICAID: CMS NEEDS MORE INFORMATION ON THE BILLIONS OF DOLLARS SPENT ON SUPPLEMENTAL PAYMENTS (GAO 08-614)

The draft report is in response to your review of the Medicaid supplemental payments reported by States to the Centers for Medicare & Medicaid Services (CMS) and your review of selected States to determine the amount of supplemental payments made by five States, the types of providers to whom such payments were made by the five States, and the purposes of such payments. The draft report highlights that a significant portion of the Medicaid payments subject to this review are made by States to local government providers and are often concentrated on a small proportion of providers. In addition, the draft report recognizes the inconsistent and incomplete reporting by States of Medicaid supplemental and upper payment limit (UPL) payments. The draft report concludes that CMS lacks complete information on States' Medicaid payments and that CMS has not reviewed all Medicaid supplemental payment programs under the CMS financing initiative, which began in August of 2003.

The draft report makes casual reference to the final rule published in May of 2007, which in part, would limit Medicaid reimbursements to certain providers operated by units of government to an amount that does not exceed the provider's cost of providing Medicaid covered services. However, in its 2007 Report, "MEDICAID FINANCING: Federal Oversight Initiative is Consistent With Medicaid Payment Principles but Needs Greater Transparency" (GAO-07-214), the GAO recommended that CMS issue guidance to clarify allowable financing arrangements, consistent with Medicaid payment principles and further stated in its report that **the recommendation would remain open until such time that the May 2007 rule was finalized**. Thus, the GAO has already officially validated that the May 2007 rule would have addressed the concerns related to a significant portion of the Medicaid supplemental payments referenced in this draft report. First, the draft report highlights that a large portion of the Medicaid supplemental and/or UPL payments are paid to government (State and local) providers, which under the May 2007 rule would no longer qualify for Medicaid supplemental and/or UPL payments in excess of the cost of providing services to Medicaid individuals. Second, the May 2007 rule codified Medicaid financing rules requiring that providers retain their Medicaid payments, which would have addressed financing concerns referenced in this report for those State Medicaid supplemental and/or UPL payments programs that CMS has not reviewed under its August 2003 financing initiative. The draft report accurately identifies a Congressional moratorium placed on this rule until May 25, 2008.

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICAID: CMS NEEDS MORE INFORMATION ON THE BILLIONS OF DOLLARS SPENT ON SUPPLEMENTAL PAYMENTS (GAO 08-614)

GAO Recommendations

1. Expedite issuance of the final rule implementing additional disproportionate share hospital (DSH) reporting requirements; and,

2. Develop a strategy to identify all of the supplemental payment programs established in States' Medicaid plans and to review those that have not been subject to review under CMS's August 2003 initiative.

HHS Response

The CMS is generally in agreement with the draft recommendations and it is consistent with ongoing efforts by the agency; however, we believe the following considerations are critically important to the GAO's development of the final report, as well as to ensure that the GAO and CMS are in agreement with regard to the steps necessary to fulfill any recommendations included in the final report:

Recommendation 1 - While CMS intends to issue the final rule on DSH auditing and reporting requirements, we are not clear why the issuance of that regulation would be a primary recommendation for a report that is more directly focused on State reporting of Medicaid supplemental and UPL payments. We agree that the hospital-specific auditing and reporting of DSH payments would necessarily include the reporting of all Medicaid revenues received by an eligible DSH hospital in order to ensure compliance with the hospital-specific DSH limits, including Medicaid supplemental and/or UPL revenue. These auditing and reporting requirements, however, are exclusive to only those hospitals that qualify for DSH payments.

States with eligible uncompensated care costs in excess of their DSH allotment often utilize Medicaid supplemental and/or UPL payments to help hospitals subsidize such uncompensated care costs. Thus, hospitals that receive Medicaid supplemental and/or UPL payments but that do not receive DSH payments are not subject to the final rule on DSH auditing and reporting requirements. Similarly, no information on Medicaid supplemental and/or UPL payments is required under the DSH auditing and reporting final rule for non-hospital providers receiving Medicaid supplemental and/or UPL payments, including nursing facilities and physicians. The law enacting the DSH auditing and reporting requirements provided no authority for CMS to request such information.

In sum, by itself, the final rule on DSH auditing and reporting requirements will not nearly capture the universe of health care providers receiving Medicaid supplemental and/or UPL payments. Moreover, the DSH program is a Congressionally instructed allotment program, to which States are entitled each year to expend their entire allotment.

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICAID: CMS NEEDS MORE INFORMATION ON THE BILLIONS OF DOLLARS SPENT ON SUPPLEMENTAL PAYMENTS (GAO 08-614)

Therefore, the $17 billion spending referenced in the draft report will largely remain unchanged after the issuance of the final DSH auditing and reporting rule. To the extent the auditing and reporting requirements identify DSH overpayments to particular hospitals; States may redistribute their DSH allotment spending in future years to other qualified DSH hospitals, up to their hospital-specific DSH limit.

Recommendation 2 - Medicaid "supplemental payments" and "UPL payments" are basically synonymous terms. In general, both of these are a type of payment program that enhances regular Medicaid payment rates for services provided to Medicaid beneficiaries. It is important to note that both Medicaid supplemental and UPL payments are limited by the UPL test and often States make payment up to the UPL, irrespective of whether they refer to such Medicaid payments as supplemental, UPL, or even enhanced payments.

Your report recognizes that local government providers are the recipients of a significant portion of the Medicaid supplemental and/or the UPL payments (and DSH). During the August 2003 financing initiative, CMS addressed numerous financing arrangements associated with Medicaid supplemental and/or UPL payments made by States to local government providers to ensure such financing was consistent with Federal requirements. As your report properly highlights, CMS took action to end at least 68 supplemental payment programs in 30 States that were inconsistent with the Federal requirements, many of which involved local government providers.

We are enhancing our financing initiative strategy through the modifications to the Medicaid expenditure reports in order to segregate types of service to which the Medicaid supplemental payment applies. This will allow CMS to better identify individual Medicaid payment programs and will allow CMS to continue to ensure proper State financing for any payment program that has yet to be reviewed under the CMS financing initiative that began in August 2003. As noted in the draft report, CMS anticipates the implementation of these changes to the Medicaid expenditure reports by fiscal year 2009.

Finally, we do not believe facility-specific reporting of Medicaid supplemental and/or UPL payments on the Medicaid expenditure reports is feasible due to the volume of information that would be necessary to transmit through the Medicaid Budget and Expenditure System. However, CMS could request facility-specific information as back-up documentation to support the line-item expenditures during our review of States' Medicaid expenditure reports. To the extent States do not provide this information, CMS could withhold Federal funding associated with the Medicaid supplemental and/or UPL payments for which CMS requested such back-up documentation.

We thank the GAO staff for their work in this important area of Medicaid supplemental payments reported by States to CMS.

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Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

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Acknowledgments

In addition to the contact named above, Katherine M. Iritani, Assistant Director; Susannah Bloch; Ted Burik; Tim Bushfield; Helen Desaulniers; Elizabeth T. Morrison; Tom Moscovitch; Perry Parsons; and Hemi Tewarson made key contributions to this report.

Related GAO Products

Medicaid Financing: Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight. GAO-08-650T. Washington D.C.: April 3, 2008.

Medicaid Financing: Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight. GAO-08-255T. Washington D.C.: November 1, 2007.

Medicaid Financing: Federal Oversight Initiative is Consistent with Medicaid Payment Principles but Needs Greater Transparency. GAO-07-214. Washington D.C.: March 30, 2007.

High-Risk Series: An Update. GAO-07-310. Washington, D.C.: January 2007.

Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts. GAO-06-705. Washington D.C.: June 22, 2006.

Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight. GAO-05-836T. Washington D.C.: June 28, 2005.

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.

Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes. GAO-04-574T. Washington D.C.: March 18, 2004.

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

Major Management Challenges and Program Risks: Department of Health and Human Services. GAO-03-101. Washington D.C.: January 2003.

Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes. GAO-02-147. Washington D.C.: October 30, 2001.

Medicaid: State Financing Schemes Again Drive Up Federal Payments. GAO/T-HEHS-00-193. Washington D.C.: September 6, 2000.

Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government. GAO/HEHS-94-133. Washington D.C.: August 1, 1994.

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