

**GAO**

Testimony

Before the Committee on Oversight and  
Government Reform, House of  
Representatives

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## MEDICAID FINANCING

# Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight

Statement of Dr. Marjorie Kanof, Managing Director  
Health Care





Highlights of [GAO-08-255T](#), a testimony before the Committee on Oversight and Government Reform, House of Representatives

## Why GAO Did This Study

Medicaid, a joint federal-state program, financed the health care for about 60 million low-income people in fiscal year 2005. States have considerable flexibility in deciding what medical services and individuals to cover and the amount to pay providers, and the federal government reimburses a proportion of states' expenditures according to a formula established by law. The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for overseeing Medicaid.

Growing pressures on federal and state budgets have increased tensions between the federal government and states regarding this program, including concerns about whether states were appropriately financing their share of the program. GAO's testimony describes findings from prior work conducted from 1994 through March 2007 on (1) certain inappropriate state Medicaid financing arrangements and their implications for Medicaid's fiscal integrity, and (2) outcomes and transparency of a CMS oversight initiative begun in 2003 to end such inappropriate arrangements.

To view the full product, including the scope and methodology, click on [GAO-08-255T](#). For more information, contact Marjorie Kanof at (202) 512-7114 or [kanofm@gao.gov](mailto:kanofm@gao.gov).

## MEDICAID FINANCING

### Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight

#### What GAO Found

GAO has reported for more than a decade on varied financing arrangements that inappropriately increase federal Medicaid matching payments. In reports issued from 1994 through 2005, GAO found that some states had received federal matching funds by paying certain government providers, such as county operated nursing homes, amounts that greatly exceeded established Medicaid rates. States would then bill CMS for the federal share of the payment. However, these large payments were often temporary, since some states required the providers to return most or all of the amount. States used the federal matching funds obtained in making these payments as they wished. Such financing arrangements had significant fiscal implications for the federal government and states. The exact amount of additional federal Medicaid funds generated through these arrangements is unknown, but was in the billions of dollars. Because such financing arrangements effectively increase the federal Medicaid share above what is established by law, they threaten the fiscal integrity of Medicaid's federal and state partnership. They shift costs inappropriately from the states to the federal government, and take funding intended for covered Medicaid costs from providers, who do not under these arrangements retain the full payments.

In 2003, CMS began an oversight initiative that by August 2006 resulted in 29 states ending inappropriate financing arrangements. Under the initiative, CMS sought satisfactory assurances that a state was ending financing arrangements that the agency found to be inappropriate. According to CMS, the arrangements had to be ended because the providers did not retain all payments made to them but returned all or a portion to the states. GAO reported in 2007 that, although CMS's initiative was consistent with Medicaid payment principles, it was not transparent in implementation. CMS had not used any of the means by which it normally provides states with information about Medicaid program requirements, such as the published state Medicaid manual, standard letters issued to all state Medicaid directors, or technical guidance manuals. Such guidance could be helpful to inform states about the specific standards it used for reviewing and approving states' financing arrangements. In May 2007, CMS issued a final rule that would limit Medicaid payments to government providers' costs. GAO has not reported on CMS's rule.

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Mr. Chairman and Members of the Committee:

I am pleased to be here today as you explore recent regulatory actions of the administration related to the Medicaid program and the potential effects of these actions on patients, providers, and states. Medicaid, a joint federal and state program that covered about 60 million people in fiscal year 2005, fulfills a crucial role in providing health coverage for a variety of vulnerable populations, including certain low-income children, families, and individuals who are aged or disabled. Ensuring the program's long-term sustainability is therefore very important.

The federal government and the states share responsibilities for financing and administering Medicaid. Within broad federal requirements, states have considerable flexibility in deciding what medical services and individuals to cover and the amount to pay providers, and the federal government reimburses a proportion of states' expenditures according to a formula established by law.<sup>1</sup> The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for overseeing states' Medicaid programs and ensuring the propriety of expenditures for which states seek federal reimbursement. Total Medicaid expenditures are significant and growing, totaling an estimated \$317 billion in fiscal year 2005, and are expected to continue to grow.<sup>2</sup>

Growing pressures on federal and state budgets have increased tensions between the federal government and the states regarding Medicaid. In recent years, tensions have arisen regarding CMS's actions in overseeing the appropriateness of provider payments for which states have sought federal reimbursement, including whether states were appropriately financing their share, that is, the nonfederal share of these payments. Starting in the early 1990's and as recently as 2005, we and others have reviewed aspects of inappropriate Medicaid financing arrangements in some states, often involving supplemental payments made to government providers that were above and beyond states' typical Medicaid payment rates. We have also reviewed CMS's oversight of such arrangements, most recently reporting in March 2007 on an initiative started in 2003 to end inappropriate arrangements. In May 2007 CMS issued a final rule that

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<sup>1</sup>States and the federal government share in Medicaid expenditures. The federal share can range from 50 to 83 percent.

<sup>2</sup>This figure represents estimated federal and state Medicaid program expenditures for provider services and administration in fiscal year 2005.

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would affect state Medicaid financing arrangements. In my testimony today I will summarize and describe our findings (1) on past inappropriate state Medicaid financing arrangements, including their implications for the fiscal integrity of the Medicaid program; and (2) on the outcomes and transparency of CMS's 2003 initiative, which provides context for considering the effect of the May rule on various stakeholders. My testimony is based on our previous work assessing various Medicaid financing arrangements and federal oversight of these arrangements. We conducted this body of work from June 1993 through March 2007. We have not reported on CMS's May 2007 rule. We conducted our work in accordance with generally accepted government auditing standards.

In summary, we have reported for more than a decade on varied financing arrangements that inappropriately increase federal Medicaid matching payments. In reports issued from 1994 through 2005, we reported on various arrangements whereby states received federal matching funds by paying certain government providers, such as county owned or operated nursing homes, amounts that greatly exceeded established Medicaid rates.<sup>3</sup> The large payments were often temporary since some states required the government providers to return all or most of the money to the states. States used the federal matching funds received for these payments—which essentially made a round-trip from the states to providers and back to the states—at their own discretion. Such financing arrangements had significant fiscal implications for the federal government and states. The exact amount of additional federal Medicaid funds generated through these arrangements is not known, but was in the billions of dollars. Despite congressional and CMS action taken during those years to limit such arrangements, we found in recent years that improved federal oversight of such arrangements was needed. Because such financing arrangements effectively increase the federal Medicaid share above what is established by law, they threaten the fiscal integrity of Medicaid's federal and state partnership. They shift costs inappropriately from the states to the federal government, and take funding intended for Medicaid providers, who do not under these arrangements retain the full payments.

CMS's oversight initiative, started in 2003 to end inappropriate state financing arrangements, by August 2006 had resulted in 29 states ending financing arrangements in which providers did not retain the supplemental payments they received. Although we found that CMS's initiative was

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<sup>3</sup>See related GAO products at the end of this statement.

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consistent with Medicaid payment principles, we also 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 financing arrangements. For example, to inform states about the specific standards it used for reviewing and approving states' financing arrangements under its new initiative, CMS had not used any of the means by which it typically provides information to states about the Medicaid program, such as its published state Medicaid manual, standard letters issued to all state Medicaid directors, or technical guidance manuals. Consequently, states were concerned about standards that were applied in CMS's review of their arrangements and the consistency with which states were treated. These observations provide some context for the controversy surrounding CMS's May 2007 rule. We have not reported on CMS's May 2007 rule or other rules related to Medicaid financing issued this year. The extent to which the rule will address concerns about the transparency of CMS's initiative and review standards will depend on how CMS implements it.

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## Background

Title XIX of the Social Security Act establishes Medicaid as a joint federal-state program to finance health care for certain low-income children, families, and individuals who are aged or disabled.<sup>4</sup> 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 each state's federally approved Medicaid plan. 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.<sup>5</sup>

CMS has an important role in ensuring that states comply with statutory Medicaid payment principles when claiming federal reimbursements for payments made to institutional and other providers who serve Medicaid beneficiaries. For example, Medicaid payments must be "consistent with efficiency, economy, and quality of care,"<sup>6</sup> and states must share in

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<sup>4</sup>42 U.S.C. §§ 1396 et seq. (2000).

<sup>5</sup>Throughout this statement, we refer to funds used by state Medicaid programs to pay providers for rendering Medicaid services as "payments." We refer to federal funds received by states from CMS for the federal share of states' Medicaid payments as "reimbursements."

<sup>6</sup>See 42 U.S.C. § 1396a(a)(30)(A) (2000).

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Medicaid costs in proportions established according to a statutory formula.<sup>7</sup>

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 physicians' services, nursing home care, and inpatient hospital care), and the rates of and methods for calculating payments to providers. State Medicaid plans generally do not detail the specific arrangements a state uses to finance the nonfederal share of program spending. Title XIX of the Social Security Act allows states to derive up to 60 percent of the nonfederal share from local sources, as long as the state itself contributes at least 40 percent.<sup>8</sup>

Over the last several years, CMS has taken a number of steps to help ensure the fiscal integrity of the Medicaid program. These include making internal organizational changes that centralize the review of states' Medicaid financing arrangements and hiring additional staff to review each state's Medicaid financing. The agency also published in May 2007 a final rule related to Medicaid payment and financing.<sup>9</sup> This rule would, among other things, limit payments to government providers to their cost of providing Medicaid services. The Secretary is prohibited by law from implementing the rule until May 25, 2008.<sup>10</sup>

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<sup>7</sup>Under the formula, the federal government may pay from 50 to 83 percent of a state's Medicaid expenditures. States with lower per capita incomes receive higher federal matching rates. 42 U.S.C. § 1396d(b) (2000).

<sup>8</sup>See 42 U.S.C. § 1396a(a)(2) (2000). Local governments and local government providers can contribute to the nonfederal share of Medicaid payments through mechanisms known as intergovernmental transfers, or IGTs. IGTs are a legitimate feature in state finance that enable state and local governments to carry out their shared governmental functions, for example through the transfer of revenues between governmental entities.

<sup>9</sup>See 72 Fed. Reg. 29,748 (May 29, 2007).

<sup>10</sup>See Pub. L. No. 110-28, § 7002, 121 Stat. 112, 187 (2007).

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**Concerns about  
Certain Medicaid  
Financing  
Arrangements that  
Undermine Medicaid's  
Fiscal Integrity Are  
Long-Standing**

From 1994 to 2005, we have reported numerous times on a number of financing arrangements that create the illusion of a valid state Medicaid expenditure to a health care provider. Payments under these arrangements have enabled states to claim federal matching funds regardless of whether the program services paid for had actually been provided. As various schemes have come to light, Congress and CMS took several actions from 1987 through 2002, through law and regulation, to curtail them (see table 1).

**Table 1: Medicaid Financing Schemes Used to Inappropriately Generate Federal Payments and Federal Actions to Address Them, 1987–2002**

Financing 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 (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 could then return most of the federal payment to the states.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 essentially barred certain provider donations, placed a series of restrictions on provider taxes, and set other restrictions for state contributions.
Excessive disproportionate share hospital (DSH) payments	DSH payments are meant to compensate those 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 both the amount of DSH payments states could make and the amount 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 state psychiatric hospitals.
Upper payment limit (UPL) for local government health facilities	In an effort to ensure that Medicaid payments are reasonable, federal regulations prohibit Medicaid from paying more than a reasonable estimate of the amount that would be paid under Medicare payment principles for comparable services. This UPL applies to payments aggregated across a class of facilities and not for individual facilities. As a result of the aggregate upper limit, states were able to make large supplemental payments to a few local public health facilities, such as hospitals and nursing homes. The local government health 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 to issue a final regulation that established a separate payment limit for each of several classes of local government health facilities. In 2002, CMS issued a regulation that further lowered the payment limit for local public hospitals.

Source: GAO, *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes*, [GAO-04-547T](#) (Washington, D.C.; Mar. 18, 2004).

Note: Before June 2001, CMS was known as the Health Care Financing Administration (HCFA).

Many of these arrangements involve payment arrangements between the state and government-owned or government-operated providers, such as local-government-operated nursing homes. They also involved supplemental payments—payments states made to these providers separate from and in addition to those made at a state’s standard Medicaid



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payment rate. The supplemental payments connected with these arrangements were illusory, however, because states required these government providers to return part or all of the payments to the states.<sup>11</sup> Because government entities were involved, all or a portion of the supplemental payments could be returned to the state through an intergovernmental transfer, or IGT. Financing arrangements involving illusory payments to Medicaid providers have significant fiscal implications for the federal government and states. The exact amount of additional federal Medicaid funds generated through these arrangements is not known, but was in the billions of dollars. For example, a 2001 regulation to curtail misuse of the UPL regulation was estimated to have saved the federal government approximately \$17 billion from fiscal year 2002 through fiscal year 2006. In 2003, we designated Medicaid to be a program at high risk of mismanagement, waste, and abuse, in part due to concerns about states' use of inappropriate financing arrangements.<sup>12</sup>

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### Inappropriate Medicaid Financing Arrangements Undermine Medicaid's Fiscal Integrity

States' use of these creative financing mechanisms undermined the federal-state Medicaid partnership as well as the program's fiscal integrity in three ways. First, inappropriate state financing arrangements effectively increased the federal matching rate established under federal law by increasing federal expenditures while state contributions remained unchanged or even decreased. Figure 1 illustrates a state's arrangement in place in 2004 in which the state increased federal expenditures without a commensurate increase in state spending. In this case, the state made a \$41 million supplemental payment to a local-government hospital. Under its Medicaid matching formula, the state paid \$10.5 million and CMS paid \$30.5 million as the federal share of the supplemental payment. After

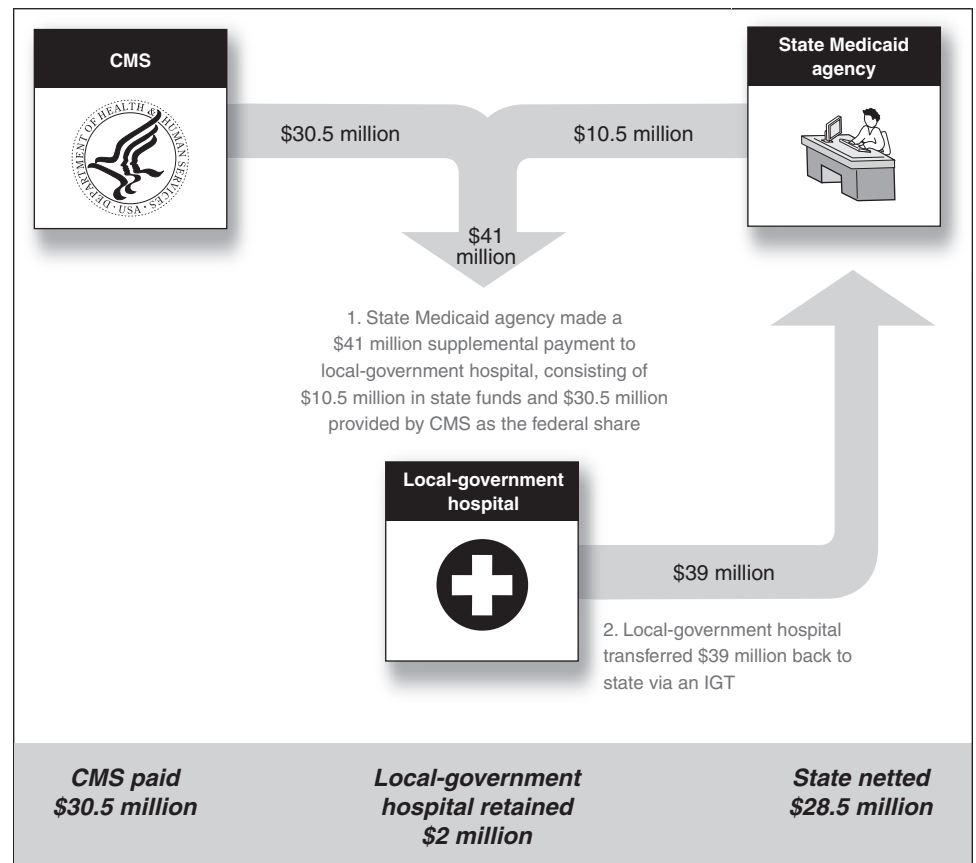
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<sup>11</sup>The two most common supplemental payments that involved illusory payments to government providers are upper payment limit, or UPL, payments and disproportionate share hospital, or DSH, payments. Illusory UPL payments are based on the misuse of Medicaid UPL provisions. UPLs are the federal government's way of placing a ceiling on the federal share of a state Medicaid program; they are the upper bound on the amounts the federal government will pay a state for the federal share of state spending on certain services. Some states made supplemental payments up to the UPL but then required the providers to return all or a portion of the payment. Under Medicaid law, states are required to make special hospital payments to supplement standard Medicaid payment rates and help offset costs for hospitals that serve a disproportionate share of low-income or uninsured patients; these payments came to be known as disproportionate share hospital, or DSH, payments.

<sup>12</sup>GAO, *Major Management Challenges and Program Risks: Department of Health and Human Services*, [GAO-03-101](#) (Washington, D.C.: January 2003).

receiving the supplemental payment, however, the hospital transferred back to the state approximately \$39 million of the \$41 million payment, retaining just \$2 million. Creating the illusion of a \$41 million hospital payment when only \$2 million was actually retained by the provider enabled the state to obtain additional federal reimbursements without effectively contributing a nonfederal share—in this case, the state actually netted \$28.5 million as a result of the arrangement.

**Figure 1: Example of How One State Increased Federal Medicaid Matching Funds without Increasing State Spending**



Source: GAO analysis of one state's financing arrangement for state fiscal year 2004.

Second, CMS had no assurance that these increased federal matching payments were retained by the providers and used to pay for Medicaid services. Federal Medicaid matching funds are intended for Medicaid-covered services for the Medicaid-eligible individuals on whose behalf payments are made. Under these arrangements, however, payments for

such Medicaid-covered services were returned to the states which could then use the returned funds at their own discretion. In 2004, we examined how six states with large supplemental payment financing arrangements involving nursing homes used the federal funds they generated. As in the past, some states deposited excessive funds from financing arrangements into their general funds, which may or may not be used for Medicaid purposes. Table 2 provides further information on how states used their funds from supplemental payment arrangements, as reported by the six states we reviewed in 2004.

**Table 2: Selected States' Use of Funds Generated through UPL Arrangements, as of January 2004**

State	Use
Michigan	Funds generated by the state's UPL arrangement were deposited in the state's general fund but were tracked separately as a local fund source. These local funds were earmarked for future Medicaid expenses and used as the state match, effectively recycling federal UPL matching funds to generate additional federal Medicaid matching funds.
New York	Funds generated by the state's UPL arrangement were deposited into its Medical Assistance Account. Proceeds from this account were used to pay for the state share of the cost of Medicaid payments, effectively recycling federal funds to generate additional federal Medicaid matching funds.
Oregon	Funds generated by the state's UPL arrangement were used to finance education programs and other non-Medicaid health programs. UPL matching funds recouped from providers were deposited into a special UPL fund. Facing a large budget deficit, a February 2002 special session of the Oregon legislature allocated the fund balance, about \$131 million, to finance kindergarten to 12th grade education programs. According to state budget documents, the UPL funds were used to replace financing from the state's general fund.
Pennsylvania	Funds generated by the state's UPL arrangement were used for a number of Medicaid and non-Medicaid purposes, including long-term care and behavioral health services. In state fiscal years 2001–2003 the state generated \$2.4 billion in excess federal matching funds, of which 43 percent was used for Medicaid expenses (recycled to generate additional federal matching funds), 6 percent was used for non-Medicaid purposes, and 52 percent was unspent and available for non-Medicaid uses (does not total 100 percent because of rounding).
Washington	Funds generated by the state's UPL arrangement were commingled with a number of other revenue sources in a state fund. The fund was used for various state health programs, including a state-funded basic health plan, public health programs, and health benefits for home care workers. A portion of the fund was also transferred to the state's general fund. The fund was also used for selected Medicaid services and the State Children's Health Insurance Program (SCHIP), which effectively recycled the federal funds to generate additional federal Medicaid matching funds.
Wisconsin	Funds generated by the state's UPL arrangement were deposited in a state fund, which was used to pay for Medicaid-covered services in both public and private nursing homes. Because the state used these payments as the state share, the federal funds were effectively recycled to generate additional federal Medicaid matching funds.

Source: CMS and states.

Note: Information is based on work ending in January 2004. See GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, [GAO-04-228](#) (Washington, D.C.: Feb. 13, 2004).

Third, these state financing arrangements undermined the fiscal integrity of the Medicaid program because they enabled states to make payments to government providers that significantly exceeded their costs. In our view,

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this practice was inconsistent with the statutory requirement that states adopt methods to ensure that Medicaid payments are consistent with economy and efficiency.

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## CMS Oversight Initiative to End State Financing Arrangements Lacked Transparency

Our March 2007 report<sup>13</sup> on a recent CMS oversight initiative to end certain financing arrangements where providers did not retain the payments provides context for CMS's May rule. Responding to concerns about states' continuing use of creative financing arrangements to shift costs to the federal government, CMS has taken steps starting in August 2003 to end inappropriate state financing arrangements by closely reviewing state plan amendments on a state-by-state basis. As a result of CMS initiative, from August 2003 through August 2006, 29 states ended one or more arrangements for financing supplemental payments, because providers were not retaining the Medicaid payments for which states had received federal matching funds.

We found CMS's actions under its oversight initiative to be consistent with Medicaid payment principles—for example, that payment for services be consistent with efficiency and economy. We also found, however, that CMS's initiative to end inappropriate financing arrangements lacked transparency, in that CMS had not issued written guidance about the specific approval standards for state financing arrangements. CMS's initiative was a departure from the agency's past oversight approach, which did not focus on whether individual providers were retaining the supplemental payments they received. In contacting the 29 states that ended a financing arrangement from August 2003 through August 2006 under the initiative, only 8 states reported they had received any written guidance or clarification from CMS regarding appropriate and inappropriate financing arrangements. CMS had not used any of the means by which it typically provides information to states about the Medicaid program, such as its published state Medicaid manual, standard letters issued to all state Medicaid directors, or technical guidance manuals, to inform states about the specific standards it used for reviewing and approving states' financing arrangements. State officials told us it was not always clear what financing arrangements CMS would allow and why arrangements approved in the past would no longer be approved. Twenty-four of 29 states reported that CMS had changed its policy regarding

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<sup>13</sup>GAO, *Medicaid Financing: Federal Oversight Initiative is Consistent with Medicaid with Medicaid Payment Principles but Needs Greater Transparency*, [GAO-07-214](#) (Washington, D.C.: Mar. 30, 2007).

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financing arrangements, and 1 state challenged CMS's disapproval of its state plan amendment, in part on the grounds that CMS changed its policy regarding payment arrangements without rule making.<sup>14</sup> The lack of transparency in CMS's review standards raised questions about the consistency with which states had been treated in ending their financing arrangements. We consequently recommended that CMS issue guidance to clarify allowable financing arrangements.

Our recommendation for CMS to issue guidance for allowable financing arrangements paralleled a recommendation we had made in earlier work reviewing states' use of consultants on a contingency-fee basis to maximize federal Medicaid revenues.<sup>15</sup> Our work found problematic projects where claims for federal matching funds appeared to be inconsistent with CMS's policy or with federal law, or that—as with inappropriate supplemental payment arrangements—undermined Medicaid's fiscal integrity. Several factors contributed to the risk of state projects. Many were in areas where federal requirements had been inconsistently applied, evolving, or not specific. We recommended that CMS establish or clarify and communicate its policies in these areas, including supplemental payment arrangements.<sup>16</sup> CMS responded that clarifying guidance was under development for targeted case management, rehabilitation services, and supplemental payment arrangements.

We have recently initiated work to examine CMS's current oversight of certain types of state financing arrangements. We have not reported on CMS's May 2007 rule or other rules related to Medicaid financing issued this year. The extent to which the rule will address concerns about the

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<sup>14</sup>This state formally requested that the CMS Administrator reconsider the disapproval of the state plan amendment. The Administrator upheld the disapproval, finding the state's argument that CMS was required to use notice-and-comment rule making unsupported. The United States Court of Appeals for the Eighth Circuit denied the state's appeal of this decision. *Minnesota v. Ctrs. for Medicare and Medicaid Servs.*, 495 F.3d 991 (8th Cir. 2007).

<sup>15</sup>See GAO, *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, [GAO-05-748](#) (Washington, D.C.: June 28, 2005).

<sup>16</sup>Other areas where we found federal law and policies had been inconsistently applied, evolving, or not specific included targeted case management services, rehabilitation services, and Medicaid administrative costs. We found that states' claims in some of these categories had grown substantially in dollar amounts. For example, during fiscal years 1999 through 2003, combined state and federal spending for targeted case management services increased by 76 percent, from \$1.7 billion to \$3.0 billion, across all states.

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transparency of CMS's initiative and review standards will depend on how CMS implements it.

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## Concluding Observations

As the nation's health care safety net, the Medicaid program is of critical importance to beneficiaries and the providers that serve them. The federal government and states have a responsibility to administer the program in a manner that assures expenditures benefit those low-income people for whom benefits were intended. With annual expenditures totaling more than \$300 billion per year and growing, accountability for the significant program expenditures is critical to providing those assurances. The program's long-term fiscal sustainability is important for beneficiaries, providers, states, and the federal government.

For more than a decade, we have reported on various methods that states have used to inappropriately maximize federal Medicaid reimbursement, and we have made recommendations to end these inappropriate financing arrangements. Supplemental payments involving government providers have resulted in billions of excess federal dollars for states, yet accountability for these payments—assurances that they are retained by providers of Medicaid services to Medicaid beneficiaries—has been lacking. CMS has taken important steps in recent years to improve its financial management of Medicaid. Yet more can be done to enhance the transparency of CMS oversight. Consequently, we believe our recommendations regarding the clarification and communication of allowable financing arrangements remain valid.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Committee may have.

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## Contact and Acknowledgments

For future contacts regarding this testimony, please contact Marjorie Kanof at (202) 512-7114 or [Kanofm@gao.gov](mailto:Kanofm@gao.gov). Katherine Iritani, Assistant Director; Ted Burik; Tim Bushfield; Tom Moscovitch; and Terry Saiki made key contributions to this statement.

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# Related GAO Products

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

*Medicaid 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.

*High-Risk Series: An Update.* [GAO-05-207](#). Washington, D.C.: January 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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