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Report to Congressional Requesters

April 2015

MEDICAID

CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy

GAO-15-322

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GAO Highlights

Highlights of GAO-15-322, a report to congressional requesters

Why GAO Did This Study

Under Medicaid, a joint federal-state program, states pay health care providers and receive federal matching funds for their payments. States may have incentives to make excessive Medicaid payments to certain institutional providers such as hospitals operated by local governments. Medicaid payments are not limited to providers' costs, but federal law requires they be economical and efficient. Large payments that exceed costs raise questions as to whether the payments are for Medicaid purposes.

GAO was asked to review state Medicaid payments to government providers compared to private, that is, for-profit and non-profit providers. GAO examined (1) in selected states, how state Medicaid payments to government hospitals compare to those made to private hospitals, and, for selected hospitals, to their Medicaid costs and total hospital operating costs; and (2) CMS oversight. GAO assessed hospital payments by ownership for three states selected in part based on size and geographic diversity, reviewed laws, regulations, guidance, and other documents, and interviewed CMS and state officials.

What GAO Recommends

GAO recommends that CMS take steps to ensure states report provider-specific payment data, establish criteria for assessing payments to individual providers, develop a process to identify and review payments to individual providers, and expedite its review of the appropriateness of New York's hospital payments. HHS concurred with the recommendations.

View GAO-15-322. For more information, contact Katherine M. Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

GAO's assessment of Medicaid payments to government and private hospitals in three selected states was hampered by inaccurate and incomplete data on payments. States must capture but are not required to report all payments they make to individual institutional providers, nor are states required to report ownership information. For example, large supplemental payments states often make to hospitals are not reported by hospital. GAO assessed data for hospitals in two of three selected states, Illinois and New York; the third state, California, did not have accurate or complete payment data that would allow an assessment of total payments made to individual hospitals. In the two states, GAO's estimates of average daily payments—total payments adjusted for differences in patient health, divided by patient days—made to government and private hospitals showed inconclusive trends, but also identified that a small number of government hospitals were receiving high payments that warrant oversight.

- In Illinois, average daily payments for inpatient services were comparable for government and private hospitals, but these averages masked wide variations in daily payments for both types of hospitals. Daily payments ranged from less than $600 to almost $10,000 for local government hospitals and from $750 to over $11,000 for private hospitals. For seven hospitals with high daily payments, GAO examined how payments compared to each hospital's costs of providing Medicaid services as reported by the hospital in cost reports and found that six of the seven hospitals' Medicaid payments exceeded their Medicaid costs.
- In New York, average daily payments were higher for government hospitals than private hospitals, but as with Illinois these averages masked wide variations, with daily payments ranging from about $200 to over $9,000 for local government hospitals and from less than $200 to $3,400 for private hospitals. Four of nine selected government and private hospitals with high daily payments had Medicaid payments that exceeded Medicaid costs: two were local government hospitals that, all together, received payments exceeding their costs by nearly $400 million.

One selected hospital in Illinois and two in New York had Medicaid payments that exceeded the local government hospitals' total operating costs, including costs associated with all services provided to all patients they served.

Oversight of Medicaid payments to individual hospitals and other institutional providers, which is the responsibility of the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS), is limited in part by insufficient information on payments and also by the lack of a policy and process for assessing payments to individual providers. CMS does not collect provider-specific payment and ownership information. CMS also lacks a policy and standard process for determining whether Medicaid payments to individual providers are economical and efficient. Excessive state payments to individual providers may not be identified or examined by CMS. For example, CMS's oversight mechanisms did not identify large overpayments to two New York hospitals until they were identified by GAO. CMS began reviewing the appropriateness of these payments during the course of GAO's review.

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Abbreviations

BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CHIP	The State Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DSH	Disproportionate Share Hospital
FMAP	federal medical assistance percentage
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
ICF/DD	intermediate care facilities for the developmentally disabled
MACPAC	Medicaid and CHIP Payment and Access Commission
MSIS	Medicaid Statistical Information System
NPI	National Provider Identifier
SMDL	State Medicaid Director Letter
T-MSIS	Transformed Medicaid Statistical Information System
UPL	upper payment limit

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Congressional Requesters

Medicaid, a joint federal and state health care program, involves significant and growing expenditures for the federal government and the states. In 2014, Medicaid was projected to provide health care coverage for 65 million enrolled individuals at a cost of $508 billion.[1] The federal government matches each state's Medicaid expenditures for services according to the state's federal medical assistance percentage (FMAP).[2] Within broad federal requirements, states administer their individual Medicaid programs under the oversight of the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS). For example, states determine which providers are eligible to receive payments and which services to cover, set payment rates that different providers will receive for various covered services, and pay providers for claims submitted for services rendered. Providers of these services, particularly institutional providers such as hospitals and nursing facilities, may be owned and operated by private entities—including both for-profit and not-for-profit entities—or by state or local governments.[3] Under federal law, in order to receive federal matching funds, payments generally (1) must be made for covered Medicaid items and services; (2) must be consistent with economy, efficiency, and quality of care; and (3) must not exceed the Medicaid upper payment limit (UPL), which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. In addition to regular, claims-based Medicaid payments, states

[1]See Department of Health and Human Services, *2013 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2013).

[2]The FMAP is based on a formula established by law under which the federal share of a state's Medicaid expenditures for services generally may range from 50 to 83 percent. States with a lower per capita income receive a higher FMAP for services. On average, the FMAP is 57 percent.

[3]For purposes of this report, we identify two types of government providers: (1) those owned or operated by a state and (2) those owned or operated by a local government. Health care facilities owned and operated by the federal government, such as hospitals and nursing homes operated by the Department of Veterans Affairs, are not in the scope of our study.

may also make supplemental payments, which are generally paid in lump sums, to institutional providers. States receive federal matching funds for regular and supplemental payments.

We have previously found that some states have made excessive Medicaid payments to certain institutional providers—such as local government hospitals—that resulted in an inappropriate shift in costs from states to the federal government.[4] Providers that receive supplemental payments offer important services as they often serve a large number of Medicaid patients and the uninsured—vulnerable populations who are generally sicker and have more complex needs than patients served at other hospitals. However, we found that supplemental payments to these providers can be excessive.[5] In addition, we found that these payments typically involved financing arrangements under which a small number of providers supplied funds to the state for the nonfederal share, generally through intergovernmental fund transfers or provider taxes, and in turn received large supplemental payments, enabling states to obtain billions of dollars in additional federal matching funds.[6] We testified in July 2014 that states' reliance on government and private providers for financing Medicaid has increased in recent years, further increasing the potential for cost-shifting from the states to the federal government.[7]

CMS plays an important role in ensuring the fiscal integrity of Medicaid. Its responsibilities include ensuring that federal Medicaid matching funds are provided for eligible expenditures, and that the federal government and states share in the financing of the Medicaid program, as established

[4]See GAO, *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes,* GAO-04-574T (Washington, D.C.: Mar. 18, 2004); and *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). A list of related GAO products appears at the end of this report.

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

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

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

by law. However, we and others have reported concerns about the agency's oversight, including a lack of data on large Medicaid payments often made to institutional providers.[8] In 2003, we designated Medicaid as a high-risk program, in part because of concerns about excessive supplemental payments states made to government institutional providers and the oversight of these payments, and we recommended closer federal scrutiny of Medicaid payments to government providers to ensure that payments are consistent with federal requirements.[9]

You asked us to study state Medicaid payments to government providers. This report examines (1) the information CMS Medicaid expenditure reports include about payments by type of provider ownership nationwide; (2) for selected states, how state Medicaid payments to government hospitals compare to state Medicaid payments to private hospitals and, for selected hospitals, how Medicaid payments compare to hospitals' Medicaid costs and total operating costs; and (3) the extent to which CMS oversees payments to government and private providers.

To determine the information CMS Medicaid expenditure reports include about payments by type of provider ownership nationwide[10], we analyzed Medicaid expenditures for federal fiscal year 2011—the most recent year for which complete data were available at the time of our analysis. These are data that states reported to CMS using a standardized form, the CMS-64, to claim federal matching funds. We determined that these data were sufficiently reliable for the purposes of our report, by discussing known data reliability issues with CMS, reviewing related documentation, and conducting logic tests.

To determine how, for selected states, state Medicaid payments to government hospitals compare to Medicaid payments to private hospitals and, for selected hospitals, how Medicaid payments compare to hospitals' Medicaid costs and total operating costs, we selected a nongeneralizable

[8]See Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (Washington, D.C.: March 2014). See GAO-14-627 and GAO, *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*, GAO-13-48 (Washington, D.C.: November 26, 2012).

[9]See GAO, *High-Risk Series: An Update*, GAO-09-271 (Washington, D.C.: Jan. 22, 2009).

[10]For purposes of this report, nationwide refers to the 50 states and the District of Columbia.

sample of three states—California, Illinois, and New York. These states were selected on the basis of having large Medicaid programs as determined by spending for Medicaid services; making large amounts of certain supplemental Medicaid payments to providers; and geographic diversity.[11] Findings from our analysis of payments and costs for selected hospitals in selected states are not generalizable.

- To compare payments for government hospitals to payments for private hospitals, we analyzed inpatient payments to hospitals, including general acute care, children's, and cancer hospitals. We excluded all psychiatric hospitals from our analysis due to the unique nature of the patients served and services provided at these hospitals. We compared average payments by type of hospital ownership—state government, local government, or private—for inpatient hospital services provided in state fiscal year 2011, the most recent year for which data were available. To do so, we combined hospital-specific claims-based payment data from CMS's national claims data system—the Medicaid Statistical Information System (MSIS)—with data provided to us by the three states on hospital ownership and hospital-specific supplemental payments not included in the Medicaid claims. We determined that the Illinois and New York data were sufficiently reliable for our purposes by contacting state Medicaid department officials and clarifying conflicting, unclear, or incomplete information. However, as we discuss in this report, we determined that the data we received from California were not useable for purposes of comparing payments by type of provider ownership. We also conducted interviews with Medicaid officials in these states.
- To compare hospitals' estimated Medicaid payments received to those hospitals' Medicaid costs and operating costs, we selected the three hospitals in each of the three ownership groups that had the highest daily payments, for a total of seven hospitals in Illinois (this state only had one state government hospital) and nine hospitals in New York. For these selected hospitals, we obtained information on each hospital's Medicaid inpatient hospital costs and days of inpatient services in state fiscal year 2011 from Medicaid cost reports that the

[11]In federal fiscal year 2011, these three states' total Medicaid payments represented 29 percent of total national Medicaid payments.

hospitals submit to the states.[12] To estimate a total Medicaid cost amount for each hospital that was based on the same days of service reported in each state's Medicaid claims, we first divided Medicaid costs by Medicaid days to determine a daily Medicaid cost amount, and then multiplied this daily cost amount by the days of service reported in the hospital's Medicaid claims. To compare the selected Illinois and New York hospitals' total operating costs for all services and all patients to Medicaid payments and other supplemental payments, we identified the total operating cost amount on the hospitals' Medicaid cost reports. We determined that the state cost report data were sufficiently reliable for our purposes based on interviews with state Medicaid officials and comparing data to other reliable sources. (See appendix I for more details on our methodology.)

To determine the extent to which CMS oversees Medicaid payments to government and private providers, we interviewed CMS officials, including representatives from the CMS regional offices, about the information they collect on Medicaid payments by type of provider ownership and their processes for overseeing state Medicaid payments. We obtained and reviewed documentation of CMS review and approval of state Medicaid payments. We also reviewed relevant federal laws, regulations, and guidance, and assessed the information against standards for internal control in the federal government.[13]

We conducted this performance audit from March 2013 through February 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[12]For purposes of our report, we used Medicaid payments and costs for services provided between June 1, 2010, and July 31, 2011, for Illinois, and between April 1, 2010, and March 31, 2011, for New York, to correspond with each state's respective fiscal year.

[13]See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

Background

Within broad federal requirements under Title XIX of the Social Security Act, 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 (1) describes the groups of individuals to be covered and the methods for calculating payments to providers; (2) establishes criteria and requirements for providers to be eligible to receive payments; (3) describes the categories of services covered, such as inpatient hospital services, nursing facility services, and physician services; and (4) must be approved by CMS in order for the state to receive matching funds for the federal share of Medicaid payments it makes. Any changes a state wishes to make in its Medicaid plan, such as establishing new Medicaid payments to providers or changing methodologies for determining provider payment rates, must be submitted to CMS for review and approval as a state plan amendment.

Federal matching funds are available to states for different types of payments that states make. For regular, claims-based payments made directly to providers that have submitted bills for services rendered, states pay the providers based on established payment rates for the services provided.[14] For supplemental payments, states generally make monthly, quarterly, or annual lump sum payments or may include the payments as adjustments to regular, claims-based payments. Supplemental payments include Disproportionate Share Hospital (DSH) payments, which states are required by federal law to make to certain hospitals. These payments are designed to help offset these hospitals' uncompensated care costs for serving large numbers of Medicaid and uninsured low-income individuals.[15] Many states also make other supplemental payments that are not required under federal law. These payments include Medicaid UPL supplemental payments, which are Medicaid payments that are above the regular Medicaid payments but within the UPL, defined as the

[14]States make payments directly to providers under a fee-for-service delivery system. States also make capitation payments to managed care organizations that contract with the state to provide or arrange for medical services for Medicaid beneficiaries enrolled with the managed care organization. The managed care organizations pay the providers. Most states use both fee-for-service and managed care delivery systems, with some beneficiaries receiving services through fee-for-service and others receiving services through managed care.

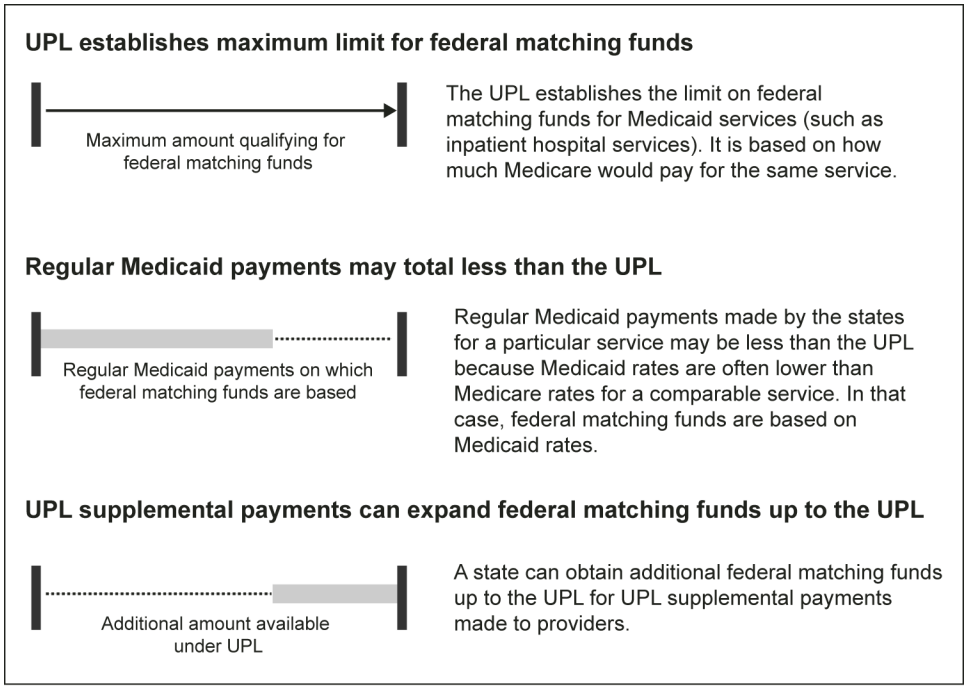
[15]See 42 U.S.C. §§ 1396a(13)(A), 1396r-4. Uncompensated care costs are the costs incurred in providing services during the year to Medicaid and uninsured patients minus any payments made to the hospital for Medicaid and uninsured patients for those services.

estimated amount that Medicare would pay for comparable services. UPL supplemental payments, like regular claims-based payments, must be made for allowable Medicaid expenditures and must comply with applicable federal requirements. Regular and UPL supplemental payments are not limited to providers' costs of delivering Medicaid services; however, as Medicaid payments, they are intended to pay for Medicaid-covered services provided to Medicaid beneficiaries and must by law be economical and efficient. States may also make other supplemental payments to hospitals, nursing facilities, and other providers authorized under Medicaid demonstrations.[16] (See app. II for information on our past concerns about Medicaid supplemental payments.)

The Medicaid UPL is a ceiling on the amount of federal matching funds a state may receive for Medicaid payments; it is based on the amount that Medicare would pay for similar services. Because states' regular payments are often lower than what Medicare would pay for comparable services, states are able to make UPL supplemental payments, which are separate from and in addition to regular payments, and the federal government will share in those payments up to the maximum amount allowed under the UPL. (See fig. 1.)

[16]Under section 1115 of the Social Security Act, states may apply to and receive approval from CMS for a demonstration that allows states to deviate from their traditional Medicaid program. Spending authorities under the demonstrations provide states with the ability to claim federal Medicaid funds for new types of expenditures, including the costs of making additional payments to providers from funding pools authorized under such demonstrations. These supplemental payments are governed by the terms and conditions of the individual demonstration.

Figure 1: Overview of How States Make Upper Payment Limit (UPL) Supplemental Payments in Addition to Regular Medicaid Payments under Medicaid's UPL



Source: GAO. | GAO-15-322

Note: The UPL applies to regular Medicaid payments and UPL supplemental payments and does not include Disproportionate Share Hospitals (DSH) supplemental payments. DSH supplemental payments are made to cover the hospitals' uncompensated care costs for inpatient and outpatient hospital services provided to Medicaid and uninsured patients and have separate payment limits.

The UPL is not a provider-specific limit but instead is applied on an aggregate basis for certain provider ownership types and categories of services. Specifically, the UPL is applied on an aggregate basis to the three ownership types—local government, state government, and private. Separate UPLs exist for providers of inpatient hospital services, outpatient hospital services, nursing facility services, and physician and other practitioner services, and for services provided in intermediate care facilities for the developmentally disabled (ICF/DD).[17]

[17]See , e.g., 42 C.F.R. §§ 447.272, 447.321 (2014). Although federal regulations do not specify an upper payment limit for physician and other practitioner services, CMS has imposed limits on supplemental payments to these providers.

To obtain federal funding for both regular and supplemental payments, states submit their estimated aggregate expenditures by type of service to CMS each quarter for an upcoming quarter. After CMS has approved the estimate, it makes federal funds available to the state for the purpose of making Medicaid payments during the upcoming quarter. States typically make Medicaid payments to providers with a combination of nonfederal funds and federal funds. Within 30 days of the end of each quarter, states are required to submit their actual expenditures for the quarter on the standardized form CMS-64.[18] CMS uses the CMS-64 data, which aggregates states' expenditures, to reconcile actual expenditures with states' estimates.

[18]42 C.F.R. § 430.30. CMS reconciles the amount of federal funds advanced to the state at the beginning of the quarter with the amount of federal funds claimed for payments made during the quarter to finalize the federal funding provided to the state. This results in a reconciliation adjustment to finalize the federal reimbursement to the state for the quarter.

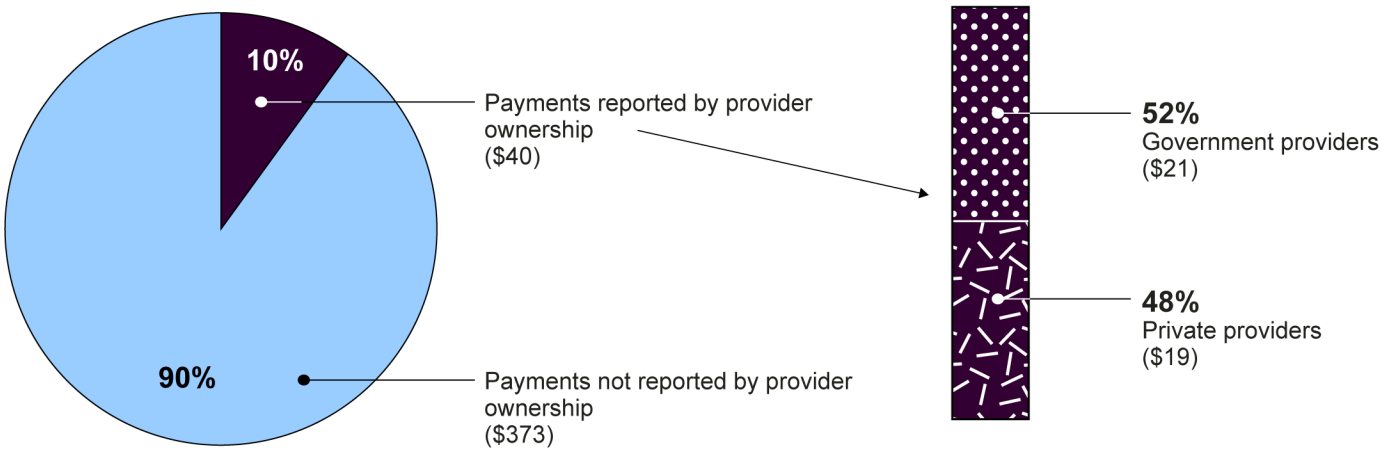
CMS Medicaid Expenditure Reports Include Data on Provider Ownership for 10 Percent of Payments Made in 2011

CMS-64 expenditure reports on Medicaid payments show provider ownership for 10 percent of total Medicaid payments made in federal fiscal year 2011. Each quarter, states submit their total Medicaid payments on the CMS-64 expenditure reports by more than 70 categories of service. The expenditure reports capture aggregate state expenditures and are not intended to collect provider-specific payment information. Provider ownership information is reported for 6 categories of service for UPL supplemental payments and 2 categories of service for regular payments,[19] accounting for $40 billion, or 10 percent, of the $414 billion in Medicaid payments in federal fiscal year 2011.[20] Of the $40 billion in CMS-64 expenditure data that is reported by provider ownership, payments to government providers accounted for $21 billion, or 52 percent, and payments to private providers accounted for the remaining $19 billion, or 48 percent. (See fig. 2.) Because states report their CMS-64 expenditure data at an aggregate state level and not by provider or by claim, we could not determine the extent to which the difference in payments to government providers versus private providers was due to a higher volume of services provided or a larger number of providers in the ownership group.

[19]The six categories of service for UPL supplemental payments are (1) inpatient hospital services, (2) outpatient hospital services, (3) nursing facility services, (4) physician and surgical services, (5) other practitioner services, and (6) intermediate care facilities for the developmentally disabled (ICF/DD) services. The two categories of service for regular payments are (1) school-based services and (2) ICF/DD services. According to CMS officials, school-based services are made to public schools, and for purposes of this report, we categorized all of these payments as being made to government providers.

[20]Total Medicaid payments in the federal fiscal year were determined by using CMS-64 expenditure report data. Our calculation may differ from other published calculations using this same data source because we made adjustments to capture only payments made for federal fiscal year 2011. Specifically, we removed expenditures reported by states in federal fiscal year 2011 that were for services provided in an earlier year, and included CMS-64 expenditures reported in federal fiscal years 2012 and 2013 that were for services provided in federal fiscal year 2011.

Figure 2: Medicaid Payments Reported by Provider Ownership and Percentage of Those Payments Made to Government or Private Providers, Federal Fiscal Year 2011



Source: GAO analysis of CMS data. | GAO-15-322

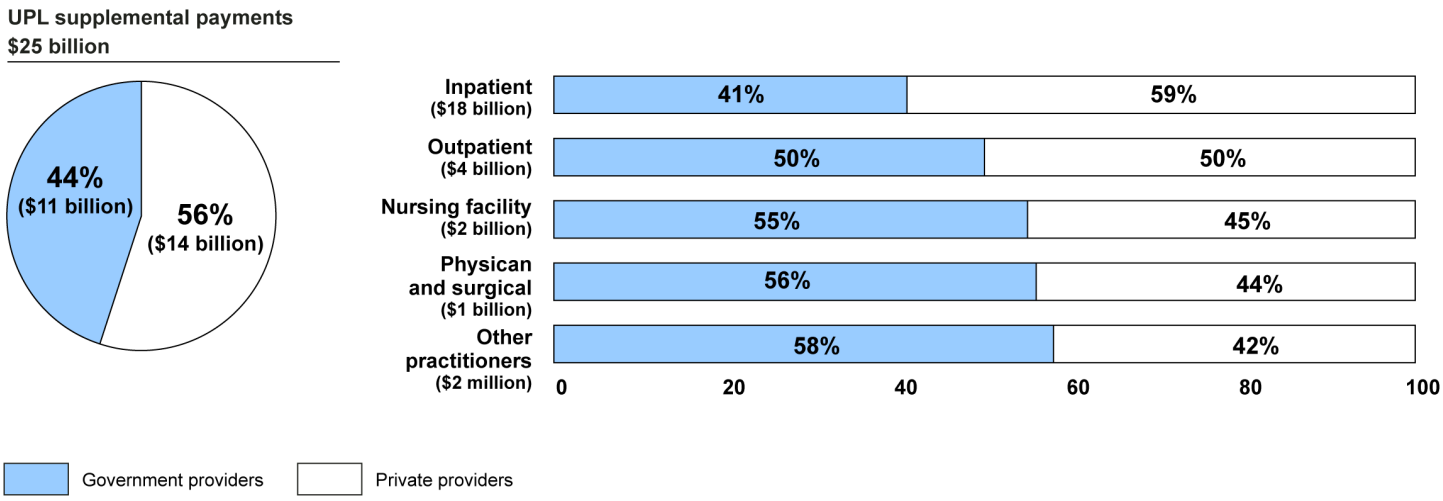
Note: The CMS-64 expenditure data used in this analysis included regular payments, Disproportionate Share Hospital (DSH) supplemental payments, and upper payment limit (UPL) supplemental payments, including UPL supplemental payments made under the authority of Medicaid Section 1115 waiver demonstration programs.

The amounts and percentages of Medicaid payments made to government providers varied nationwide by the type of payment—UPL supplemental and regular—and the categories of service within those types of payments for the payments reported by provider ownership in federal fiscal year 2011. Of the $40 billion in Medicaid payments reported by provider ownership, $25 billion was for UPL supplemental payments and, of that, $11 billion, or 44 percent, was paid to government providers. Of the $16 billion in regular payments, $10 billion, or 66 percent, was paid to government providers. Among the six categories of service for which UPL supplemental payments were reported, payments to government providers ranged from $1 million for other practitioner services to

$7 billion for inpatient hospital services.[21] As illustrated in figure 3, the percentages of payments to government providers ranged from 41 percent for inpatient services to 58 percent for other practitioner services. (See fig. 3. See app. III for information on each state's Medicaid payments reported by ownership for the six categories of service for UPL supplemental payments and the two categories of service for regular payments in federal fiscal year 2011.)

[21]UPL supplemental payments for one of the six categories—ICF/DD, were negative and, therefore, were not included in the range for payments to government providers or the percentages of payments to government providers. For federal fiscal year 2011, two states—North Dakota and Wisconsin—reported UPL supplemental payments for ICF/DD. North Dakota reported a negative UPL supplemental ICF/DD adjustment—a recoupment by CMS in 2011 for disallowed payments from a prior year—that resulted in a total negative UPL supplemental ICF/DD payment amount for North Dakota. This negative total payment was greater than the payments reported by Wisconsin, resulting in a total negative payment amount nationally for this category of service.

Figure 3: The Amount and Percentage of Upper Payment Limit (UPL) Supplemental Medicaid Payments Reported by Provider Ownership That Were Paid in Federal Fiscal Year 2011



Source: GAO analysis of CMS data. | GAO-15-322

Notes: The CMS-64 expenditure data used in this analysis included upper payment limit (UPL) supplemental payments made to hospitals, nursing facilities, and other providers, and other supplemental payments made under the authority of Medicaid Section 1115 waiver demonstration programs.

UPL supplemental payments for one of the six categories—intermediate care facilities for the developmentally disabled (ICF/DD), were negative and, therefore, were not included in the range for payments to government providers or the percentages of payments to government providers. For federal fiscal year 2011, two states—North Dakota and Wisconsin—reported UPL supplemental payments for ICF/DD. North Dakota reported a negative UPL supplemental ICF/DD adjustment—a recoupment by CMS in 2011 for disallowed payments from a prior year—that resulted in a total negative UPL supplemental ICF/DD payment amount. North Dakota's total negative UPL supplemental ICF/DD payment amount was greater than the payments reported by Wisconsin, resulting in a total negative payment amount nationally for this category of service. As such, we were unable to calculate what percentage of the payments was paid to government versus private providers.

For the two categories of service for regular payments that were reported by provider ownership, payments to government providers were higher for ICF/DD services, at $8 billion, or 61 percent, of the $14 billion in total payments for ICF/DD services. Payments to government providers were lower for school-based services, at $2 billion, but represented 100 percent of these payments.

In Three Selected States, Insufficient Data Precluded a Comprehensive Assessment of Medicaid Payments, and Focused Comparisons Possible In Two States Were Inconclusive

Assessing Medicaid payments to individual hospitals was hampered by insufficient data. In two states with reliable data, Illinois and New York, our estimates of average daily payments made to government and private hospitals showed inconclusive trends, but also identified that a small number of government hospitals were receiving high payments that warrant oversight. For example, some selected hospitals in each of these states received Medicaid payments in excess of total operating costs.

A Comprehensive Assessment of Medicaid Payments to Individual Hospitals in Selected States Was Precluded by Inaccurate and Incomplete Data

Our assessment of Medicaid payments to individual hospitals in three selected states—California, Illinois, and New York—was hampered by inaccurate and incomplete state data on Medicaid payments and CMS claims data on Medicaid payments and days of service. States must capture and report payment data to CMS, but the data needed to compare payments by individual provider and provider ownership are not specifically required. Despite extensive work we conducted in California to obtain and analyze Medicaid claims and UPL supplemental payment data, we were unable to compare individual hospitals' daily payments by hospital ownership for inpatient hospital services. This was because California lacked reliable data to enable an assessment of Medicaid payments made to individual hospitals. The data California provided on its Medicaid supplemental payments and hospital ownership, neither of which are reported in MSIS, were not usable due to inconsistent hospital identification numbers—including state identification numbers and National Provider Identifiers (NPI)[22]—payment amounts that changed in different versions of the data, and missing hospital ownership information.

[22]The NPI is a national, unique 10-digit identification number assigned to health care providers that must be used in specified administrative and financial transactions, under the Health Insurance Portability and Accountability Act (HIPAA). Pub. L. No. 104-191, § 262(a), 110 Stat. 1936, 2021 (amending 42 U.S.C. § 1320d-2(b)) (Aug. 21, 1996); 45 C.F.R. § 162.406.

For example, the California Medicaid officials provided their supplemental payments in over 20 different spreadsheets, each of which represented a different type of payment and included, by hospital, a hospital identification number and the payment amount. However, the spreadsheets used different types of hospital identification numbers among different spreadsheets, and the California officials were unable to provide a crosswalk of the different identification numbers. As a result, hospital payments listed on multiple spreadsheets could not be matched to determine how much in supplemental payments the state was paying the individual hospitals, and could not be matched with the MSIS claims data by hospital.

Although data provided by Illinois and New York were sufficiently reliable for assessing certain Medicaid payments to individual providers for inpatient hospital services, both states had Medicaid payment gaps that precluded assessment of all Medicaid payments the states made. In Illinois, 3 of the 21 local government hospitals in the state received large supplemental Medicaid payments that are based on criteria outlined in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)—referred to as BIPA payments.[23] These payments, which Illinois makes annually, are significant—totaling nearly $750 million annually. Because these BIPA payments are not for specified Medicaid services or related to the cost of providing Medicaid services, we did not include them when determining daily payments. Similarly, states are not required to report DSH supplemental payments by the uncompensated care costs related to Medicaid patients versus uninsured patients. Therefore, we did not include them when determining daily payments. Illinois, in state fiscal year 2011, paid $335 million in DSH supplemental payments, of which $304 million was paid to 3 local government hospitals, $27 million was paid to the state's 1 state government hospital, and $4 million was paid to 38 private hospitals. New York, in state fiscal year 2011, paid over $2 billion in these payments, of which over $1 billion was paid to 20 local government hospitals, $250 million was paid to 5

[23]Hospitals eligible to receive these payments are those that, as of October 1, 2000, (1) are state- or local-owned or -operated, (2) are not receiving Medicaid DSH supplemental payments, and (3) have a low income utilization rate in excess of 65 percent. Pub. L. No. 106-554, § 701(d), 114 Stat. 2763, 2763A-571 (Dec. 1, 2000). According to CMS officials, while eligibility for BIPA supplemental payments includes the requirement that a hospital must not have been receiving DSH supplemental payments on October 1, 2000, hospitals could subsequently receive DSH supplemental payments and remain eligible for BIPA supplemental payments.

state government hospitals, and $670 million was paid to 158 private hospitals.[24] Because it was unclear what portion of these payments was related to the cost of providing uncompensated care related to Medicaid patients versus uninsured patients, we did not include them when determining Medicaid payments by hospital ownership.

In addition, claims data for both Illinois and New York could not be used for analyzing payments to individual providers for outpatient hospital, nursing facility, and ICF/DD services. For outpatient hospital services, available claims data did not provide sufficient information to determine the number of outpatient visits. Some of the outpatient claims were for bundled services—that is, services that were provided over a series of visits—and, therefore, we could not calculate outpatient payments on a per visit basis. For both nursing facility and ICF/DD services, available claims data were not reliable for determining the number of days of service provided. Adjustment claims for these services only reported adjustments to the payments and did not indicate the days of service that were similarly affected. As a result, we could not determine an accurate number of days of service for each provider and, therefore, could not calculate daily payments.

[24]For both Illinois and New York, the total number of hospitals receiving DSH supplemental payments and the total DSH supplemental payment amounts do not include the DSH supplemental payments made to hospitals that were excluded from our analysis, including, for example, out-of-state hospitals and psychiatric hospitals.

Illinois Government and Private Hospitals' Average Daily Inpatient Medicaid Payments Were Comparable in 2011, but Individual Hospitals' Daily Payments Varied Widely, and One Government Hospital Received Payments That Exceeded Its Total Operating Costs

For inpatient services provided by 193 hospitals in Illinois in state fiscal year 2011, government hospitals' and private hospitals' average daily payments were comparable.[25] In comparing these regular and UPL supplemental payments by hospital ownership, we adjusted the regular payments for differences in the conditions of the patients treated by the hospitals, commonly referred to as "case-mix" adjustment.[26] The average daily payment was highest for the state government hospital at $2,666, compared to $2,639 for the local government hospitals, and $2,620 for private hospitals.

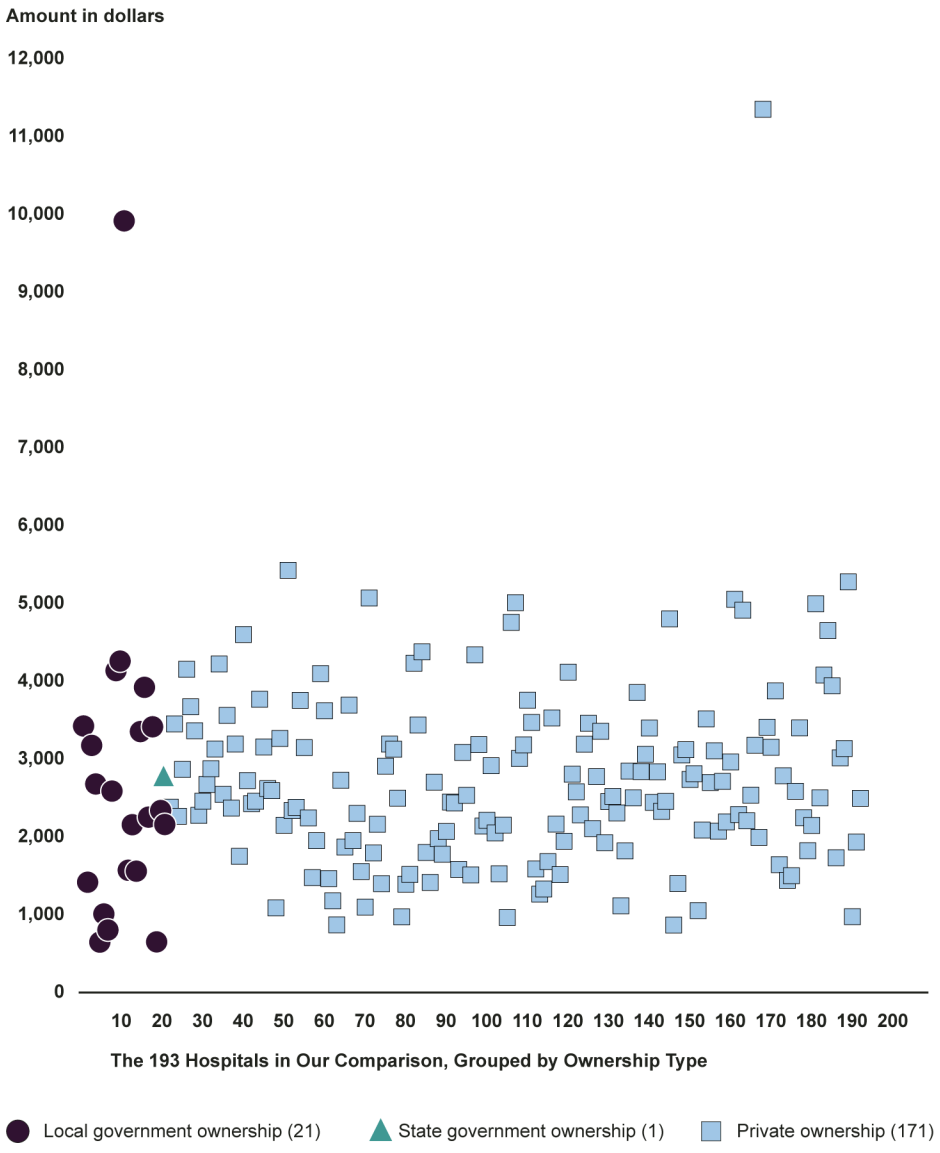
While government and private hospitals had comparable average daily payments for inpatient services, the daily payments for the individual hospitals within the ownership groups were wide ranging and varied. For example, the daily payments for local government hospitals ranged from $552 to $9,822, compared to $754 to $11,239 for private hospitals.[27] (See fig. 4.) These varying daily payments make it difficult to draw conclusions about payment differences by hospital ownership, but helped in the identification of individual hospitals with significantly higher daily payments compared to other hospitals. (See app. I for information on the methodology used for comparing average daily payments for inpatient hospital services in Illinois by hospital ownership, and app. IV for more detailed information on Illinois's Medicaid payments for inpatient hospital services by hospital ownership, including the average, median, and range of the daily payments.)

[25]To ensure that hospitals with very low inpatient days were not skewing the average daily payments, we excluded from this analysis the hospitals that had the lowest 5 percent of inpatient days in state fiscal year 2011 among all Illinois hospitals. As a result, we excluded 4 local government hospitals and 17 private hospitals.

[26]We case-mix-adjusted regular payments for all hospitals for which case mix information was provided—about 76 percent of Illinois's hospitals.

[27]The highest daily payments for both the local government and the private hospitals were due to large UPL supplemental payments that significantly increased the daily payments. Without supplemental payments the highest payments were $2,383 for local government hospitals and $1,329 for private hospitals.

Figure 4: Illinois Hospitals' Inpatient Daily Medicaid Payments by Provider Ownership, State Fiscal Year 2011



Source: GAO analysis of data from CMS (inpatient hospital claims) and Illinois (provider ownership and supplemental payments). | GAO-15-322

Notes: This analysis included regular payments that were adjusted to account for differences in the conditions of the patients treated at the hospitals, commonly referred to as "case-mix" adjustment, and upper payment limit (UPL) supplemental payments. Approximately 76 percent of hospitals had regular payments that were adjusted.

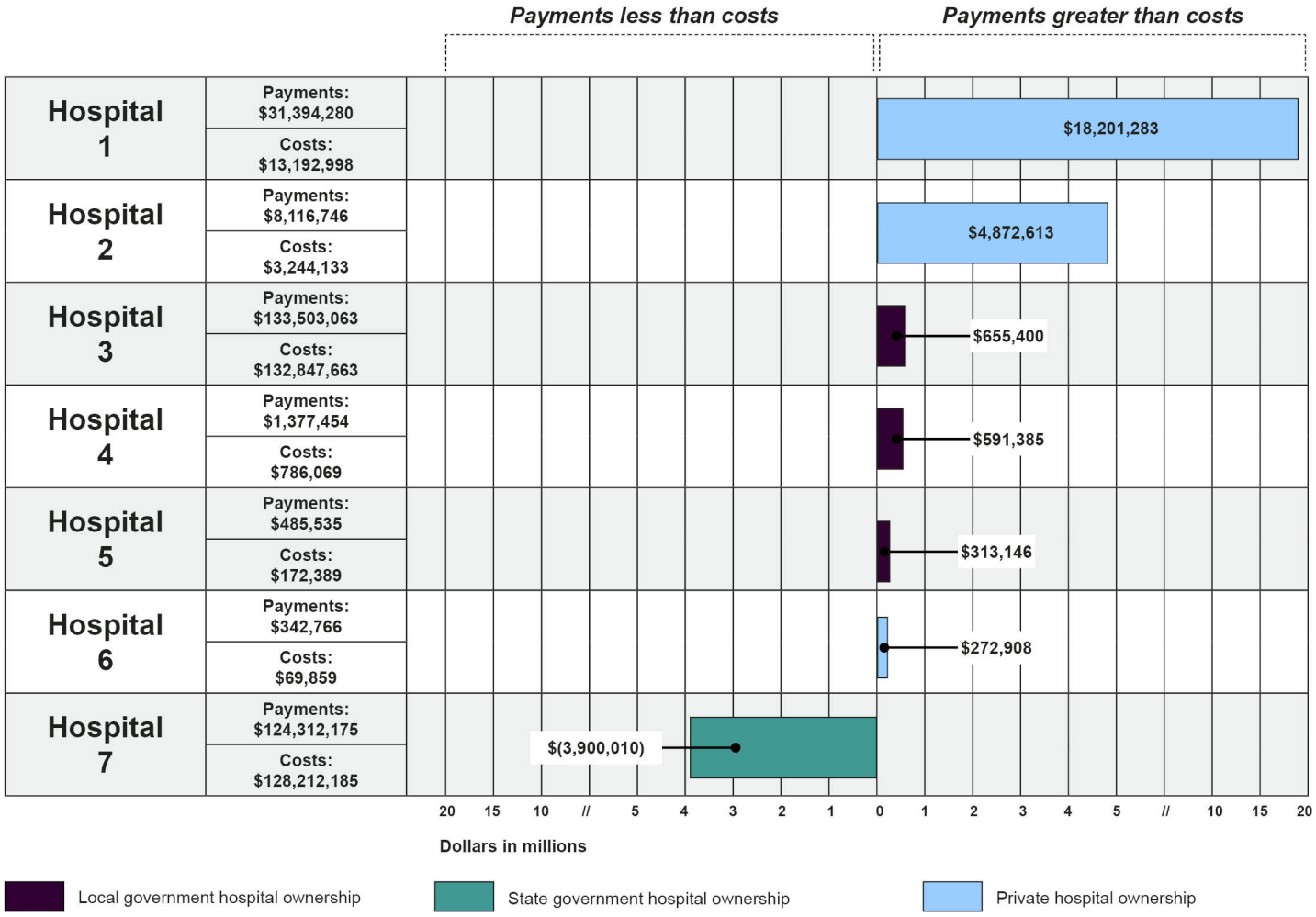
To ensure that hospitals with very low inpatient days were not skewing the average daily payments, we excluded from this analysis the hospitals that had the lowest 5 percent of inpatient days in state

fiscal year 2011 among all Illinois hospitals. As a result, we excluded 4 local government hospitals and 17 private hospitals.

When comparing the Medicaid inpatient payments—regular and UPL supplemental payments—to the costs of providing those services, estimated using cost reports prepared by hospitals, for hospitals with the highest daily payments, we found that six of the seven selected hospitals had total Medicaid inpatient payments that exceeded those hospitals' total costs of providing these services.[28] The three local government hospitals and three private hospitals had Medicaid inpatient hospital payments that exceeded costs, ranging from about $273,000 to about $18 million over costs. The one state hospital had payments that were $4 million less than costs, with $124 million in payments compared to $128 million in costs. (See fig. 5.)

[28]To compare Medicaid inpatient payments to the costs of providing those services, we selected the three hospitals in each ownership group with the highest daily payments for regular and UPL supplemental payments, for a total of seven hospitals—three local government hospitals, the state's one state government hospital, and three private hospitals. In determining these hospitals' total Medicaid inpatient payments, we included regular payments and UPL supplemental payments. We did not case-mix-adjust the regular payments to account for differences in the conditions of the patients treated at the hospitals.

Figure 5: Medicaid Payments Compared to Medicaid Costs for Inpatient Hospital Services for Selected Illinois Hospitals with the Highest Daily Payments, State Fiscal Year 2011



Source: GAO analysis of data from CMS (inpatient hospital claims) and Illinois (hospital ownership, supplemental payments, and Medicaid Cost Reports). | GAO-15-322

Notes: These hospitals were selected based on having the highest daily payments for regular payments that were adjusted to account for differences in the conditions of the patients treated at the hospitals, commonly referred to as "case-mix" adjustment, and upper payment limit (UPL) supplemental payments in each provider ownership group: local government, state government, and private. We selected a total of seven hospitals—three local government hospitals, the state's one state government hospital, and three private hospitals. In determining total Medicaid payments for inpatient services, we included nonadjusted regular payments—that is, the actual regular payments that were not adjusted for the severity of the patients' illnesses—along with the UPL supplemental payments.

Illinois Medicaid officials attributed the variation in the extent to which the inpatient payments exceeded costs to various factors. For example, except for the local government hospital with payments about $655,000 more than costs, the hospitals that had payments in excess of costs received regular Medicaid inpatient payments that were predetermined rates based on a patient's diagnosis—a Diagnosis Related Group system—and were not paid on costs. The Diagnosis Related Group payment method is intended to provide incentives for hospitals to lower costs. In addition, the officials told us that these hospitals, including the local government hospital, received UPL supplemental payments that were calculated based on 2005 data—a year in which the hospitals provided a higher volume of Medicaid inpatient services, which resulted in larger UPL supplemental payments.

In addition, for the selected hospitals in Illinois, we also compared Medicaid payments and other supplemental payments to the hospitals' total operating costs for all services and all patients and found that one of the local government hospitals received Medicaid payments that exceeded the hospital's total operating costs. For this comparison, in addition to regular inpatient and inpatient UPL supplemental patients, we included DSH supplemental payments and BIPA Medicaid supplemental payments.[29] We found that these Medicaid payments to this hospital totaled $907 million, while total operating costs were $540 million. The hospital's BIPA Medicaid supplemental payments were the cause of payments exceeding total operating costs. According to the Illinois officials, the BIPA Medicaid supplemental payments are payments that the state is authorized to make under federal law. (See app. I for information on the methodology used for comparing the selected Illinois hospitals' Medicaid payments for inpatient services to the costs of providing those services and to total operating costs, and app. V for more detailed information on the hospitals' Medicaid payments for inpatient services, the costs of providing those services, and total operating costs.)

[29]We did not include regular and supplemental payments for outpatient hospital services because, as mentioned above, we were unable to analyze Medicaid payments for outpatient hospital services.

New York Government Hospitals Received Higher Average Daily Medicaid Inpatient Payments than Private Hospitals, but Individual Hospital's Daily Payments Varied Widely, and Two Government Hospitals Received Payments That Greatly Exceeded Their Total Operating Costs

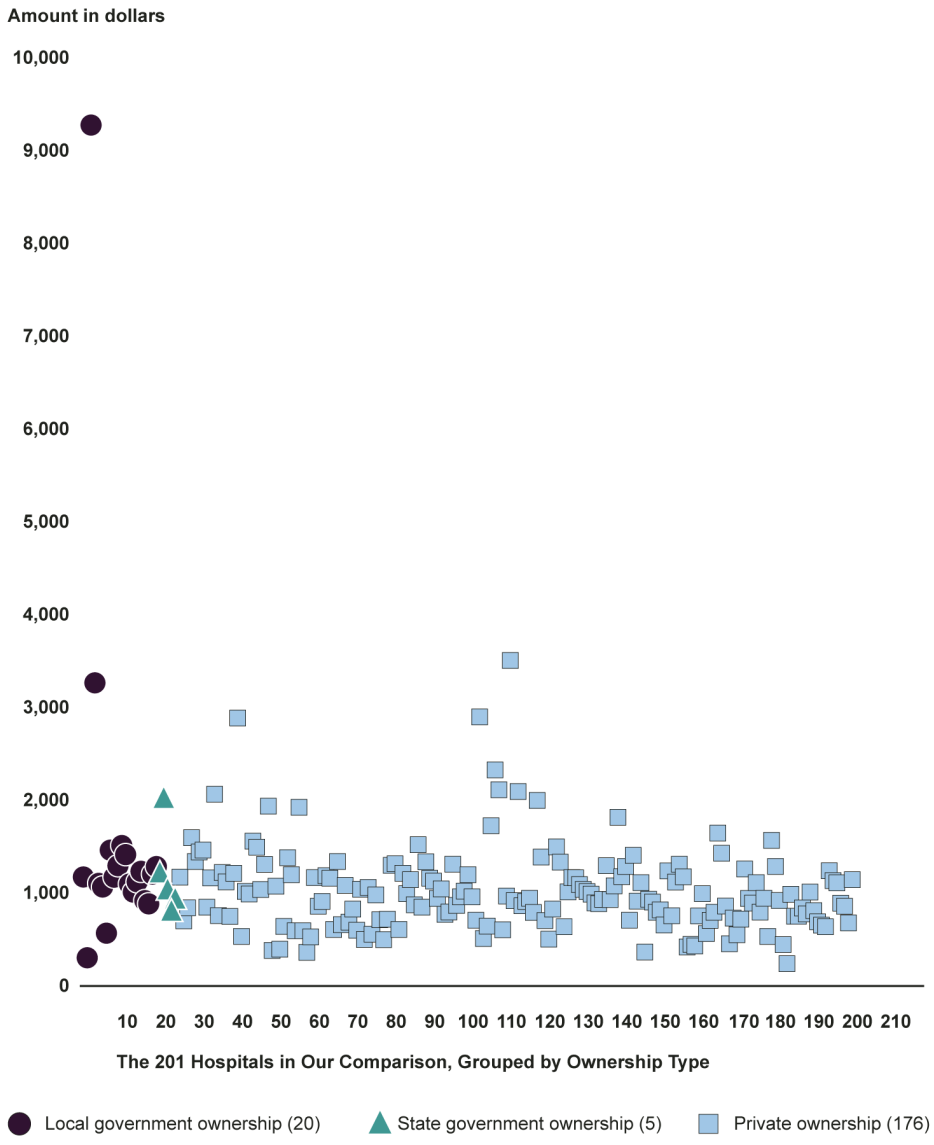
For inpatient services provided by 201 hospitals in New York in state fiscal year 2011, government hospitals had higher average daily payments than private hospitals. Local government hospitals had the highest average daily payment for the case-mix-adjusted regular and UPL supplemental payments at $1,514, compared to $933 for private hospitals.[30] However, the local government hospitals' high average daily payment was due primarily to two hospitals receiving a total of $416 million in UPL supplemental payments, inflating the average payment for all local government hospitals.

The individual hospitals' daily payments varied widely within each of the hospital ownership groups. For example, the local government hospitals' daily payments ranged from $198 to $9,176, compared to $144 to $3,413 for private hospitals.[31] (See fig. 6.) The varying daily payments make it difficult to draw conclusions about payment differences by hospital ownership, but helped in identifying individual hospitals with significantly higher daily payments compared to other hospitals. According to New York officials, these daily payments may have varied because of a variety of factors, including the geographic location of a hospital. (See app. I for information on the methodology used for comparing average daily payments for inpatient hospital services in New York by hospital ownership, and app. VI for more detailed information on the state's Medicaid payments for inpatient hospital services by hospital ownership, including the average, median, and range of the daily payments.)

[30]We case-mix-adjusted regular payments for all of New York's hospitals for which case mix information was provided—about 79 percent of New York's hospitals. In addition, to ensure that hospitals with very low inpatient days were not skewing the average daily payments, we excluded from this analysis the hospitals that had the lowest 5 percent of inpatient days in state fiscal year 2011 among all New York hospitals. As a result, we excluded 1 local government hospital and 19 private hospitals.

[31]The highest daily payment for the local government hospital was a result of a large UPL supplemental payment that significantly increased the daily payment from $614. The private hospital did not receive a UPL supplemental payment.

Figure 6: New York Hospitals' Inpatient Daily Medicaid Payments by Provider Ownership, State Fiscal Year 2011



Source: GAO analysis of data from CMS (inpatient hospital claims) and New York (provider ownership and supplemental payments). | GAO-15-322

Notes: This analysis included regular payments that were adjusted to account for differences in the conditions of the patients treated at the hospitals, commonly referred to as "case-mix" adjustment, and upper payment limit (UPL) supplemental payments. Approximately 79 percent of hospitals had regular payments that were adjusted.

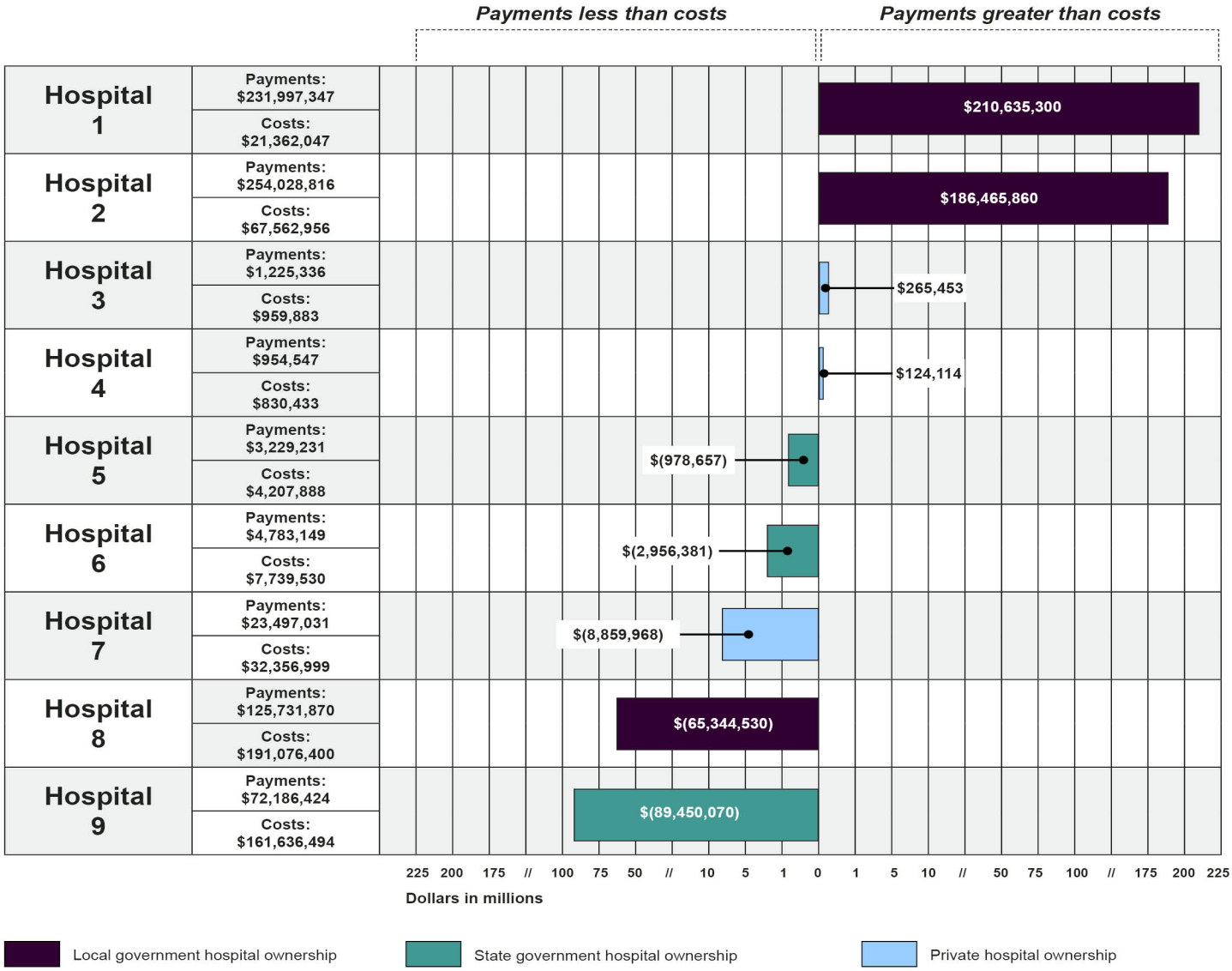
To ensure that hospitals with very low inpatient days were not skewing the average daily payment amounts, we excluded from this analysis the hospitals that had the lowest 5 percent of inpatient days

in state fiscal year 2011 among all New York hospitals. As a result, we excluded 1 local government hospital and 19 private hospitals.

When comparing the Medicaid inpatient payments to the costs of providing those services, estimated using cost reports prepared by hospitals, for hospitals with the highest daily payments, we found that four of the nine selected hospitals had total Medicaid payments that exceeded those hospitals' estimated costs of providing the Medicaid inpatient services.[32] We found that two local government hospitals and two private hospitals received payments that exceeded costs. The remaining hospitals—one private hospital, one local government hospital, and the three state government hospitals—received payments that were less than costs. (See fig. 7.)

[32]To compare Medicaid inpatient payments to the costs of providing those services, we selected the three hospitals in each ownership group with the highest daily payments for regular and UPL supplemental payments, for a total of nine hospitals—three local government hospitals, three state government hospitals, and three private hospitals. In determining these hospitals' total Medicaid inpatient payments, we included actual regular payments and UPL supplemental payments. We did not case-mix-adjust the regular payments to account for differences in the conditions of the patients treated by the hospitals.

Figure 7: Medicaid Payments Compared to Medicaid Costs for Inpatient Hospital Services for Selected New York Hospitals with the Highest Daily Payments, State Fiscal Year 2011



Source: GAO analysis of data from CMS (inpatient hospital claims) and New York (hospital ownership, supplemental payments, and Medicaid Cost Reports). | GAO-15-322

Notes: These hospitals were selected based on having the highest daily payments for regular payments that were adjusted to account for differences in the conditions of the patients treated at the hospitals, commonly referred to as "case-mix" adjustment, and upper payment limit (UPL) supplemental payments in each provider ownership group—local government, state government, and private. We selected a total of nine hospitals—three local government hospitals, three state government hospitals, and three private hospitals. In determining total Medicaid payments for inpatient services to compare to costs, we included nonadjusted regular payments and UPL supplemental payments. That is, we used the actual regular payments and did not adjust for the severity of the patients' illnesses.

According to New York officials, the two local government hospitals that had payments in excess of costs received large UPL supplemental payments because they were the only two among all of the state's local government hospitals that met the qualifying criteria to receive the payments.[33] For the other selected hospitals, including those with Medicaid payments lower than costs, the New York Medicaid officials attributed the variation in whether Medicaid payments covered Medicaid costs to various factors. One factor was that regular inpatient Medicaid payments had been established based on 2005 utilization data and were not designed to cover hospitals' costs, and another factor was the differences in the mix and intensity of services provided by the hospitals.[34]

In addition, for the selected hospitals in New York, we also compared Medicaid payments to the hospitals' total operating costs for all services and all patients and found that the two local government hospitals that received the large UPL supplemental payments had total regular and UPL supplemental payments that exceeded the hospitals' total operating costs.[35] One hospital received $232 million in regular and UPL supplemental payments compared to $157 million in total operating costs for all services and all patients, while the second hospital received $254 million in regular and UPL supplemental payments compared to $185 million in total operating costs. (See app. I for more information on

[33]The following state plan provision identifies the eligibility criteria for the local government hospitals in New York that received supplemental payments in state fiscal year 2011: payments "…are authorized to government general hospitals, other than those operated… by the state or the state university hospital…receiving reimbursement for all inpatient services under Title XIX of the federal Social Security Act (Medicaid) pursuant to this Attachment of this State Plan and located in a city with a population of over one million, of up to $286 million annually, as medical assistance payments." Further, the state plan provision for determining which providers receive payments and how much an eligible hospital will receive states that payments "…shall be based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year."

[34]When we compared Medicaid payments for inpatient services to the hospitals' costs of providing those services, we included actual regular Medicaid payments made and UPL supplemental payments. That is, we did not adjust the regular payments to account for the differences in the conditions of patients served by the hospitals.

[35]We did not include regular and supplemental payments for outpatient hospital services because, as mentioned above, we were unable to analyze Medicaid payments for outpatient hospital services. In addition, neither of these hospitals received DSH supplemental payments.

the methodology used for comparing the selected New York hospitals' Medicaid payments for inpatient services to the costs of providing those services and to total operating costs, and app. VII for more detailed information on the hospitals' Medicaid payments for inpatient services, costs of providing those services, and total operating costs.)

Total Medicaid payments to the two hospitals in excess of the hospitals' total operating costs raise questions as to their appropriateness, and officials' explanations of the payments illustrate the complexities of Medicaid payment policy.

- New York Medicaid officials and an official from the New York City Health and Hospitals Corporation that, in 2011, operated these two local government hospitals as part of a larger health care system of 13 hospitals, as well as nursing homes and health care clinics, told us that the two hospitals did not retain the UPL supplemental payments they received.[36] The payments were returned to the corporation, which then redistributed the payments among the corporation's hospitals and other facilities that it operated, according to the officials. The officials said that, through this arrangement, the inpatient UPL supplemental payments ultimately served as payments for the entire health care system.
- CMS policy requires that individual providers retain the Medicaid payments they receive. However, CMS officials told us the policy may not contemplate arrangements where hospitals return payments to an entity that owns and operates multiple facilities.[37]
- State Medicaid and corporation officials said the UPL supplemental payments, in combination with DSH supplemental payments, were designed to maximize federal funding for the local government health

[36]The New York City Health and Hospitals Corporation is a public benefit corporation that was established under New York state statute. It is a separate legal entity from New York City and is overseen by a board of directors whose members included New York City officials, as well as others appointed by the mayor of New York City. The corporation operates a health care system serving New York City that consists of various health care facilities, including hospitals, nursing homes, and clinics. The state's UPL calculations submitted to CMS classified the corporation's hospitals as local government hospitals. In 2013, one of these local government hospitals was closed.

[37]CMS's policy is intended to prevent states or local governments from requiring providers to return all or a portion of their Medicaid payments to the state or local government, which could then use the returned funds as the nonfederal share to make additional Medicaid payments and claim additional federal funding.

care system. Under federal law, states are required to make DSH payments to hospitals that serve a large number of low-income Medicaid and uninsured patients. DSH payments to such hospitals are limited to an amount that, when combined with an individual hospital's total regular Medicaid and UPL supplemental payments, does not exceed the hospital's uncompensated Medicaid and uninsured costs of care.[38] Because the two hospitals were receiving excessive UPL supplemental payments, they did not have uncompensated care costs, and, therefore, were not eligible for DSH payments. The 10 other hospitals operated by the corporation were eligible for and received more than $1.1 billion in DSH supplemental payments based on having uncompensated Medicaid and uninsured costs of care, which they received subject to the individual hospital's DSH limits.[39] Any redistributed UPL supplemental payments these 10 hospitals may have received from the corporation were not considered in calculating these hospitals' DSH limits.

It was not within the scope of our review to examine how the payments returned to the corporation were used, the extent to which they were redistributed among the corporation's hospitals or other facilities, or whether the redistribution of excessive UPL payments is consistent with federal DSH limits or CMS policy regarding provider retention of Medicaid payments. However, at the conclusion of this review we brought these practices to the attention of CMS officials for their consideration. Officials agreed the payment arrangement may warrant further review.

[38]Uncompensated care costs are the costs incurred in providing services during the year to Medicaid and uninsured patients minus any payments made to the hospital for Medicaid and uninsured patients for those services. 42 U.S.C. § 1396r-4(g)(1).

[39]The remaining hospital was also not eligible for a DSH payment because it received a large outpatient UPL supplemental payment and, as a result, did not have any uncompensated care costs.

CMS Lacks Information and a Policy and Process to Oversee Medicaid Payments to Individual Providers

CMS's oversight of Medicaid payments to individual hospitals and other institutional providers is limited. The agency does not collect provider-specific payment and ownership information and lacks a policy and standard process for determining whether Medicaid payments to individual providers are economical and efficient. As a result, excessive state payments to individual providers may not be identified or examined by CMS.

Information Needed to Oversee Medicaid Payments to Government and Private Providers Is Lacking

CMS does not collect sufficient information on payments to enable it to assess payments for individual providers, which would allow the agency to ensure that payments are appropriately spent for Medicaid purposes. CMS collects information on states' Medicaid payments from its review of state plan amendment proposals and two payment data systems. However, CMS does not collect comprehensive information on provider-specific payments through these sources. As a result, it cannot identify or assess total Medicaid payments received by individual providers and the extent to which they differ among providers for similar services, and cannot review significant differences in payments among providers. In addition, CMS cannot determine whether payments to individual providers are consistent with the Medicaid criteria of efficiency and economy.[40] Federal agencies should collect accurate and complete data to monitor programs they oversee.[41]

Information describing proposed Medicaid payments and related methodologies that states submit to CMS is not adequate to provide data for assessing and overseeing Medicaid payments, including those to

[40]The Medicaid and CHIP Payment and Access Commission (MACPAC)—the commission created by Congress to study Medicaid payment and access—also reported in March 2012 on the data limitations at the federal level regarding UPL supplemental payments. It noted that these payments can be an important source of revenue for certain providers. However, because these payments are not necessarily associated with specific services or enrollees and are not reported at the provider level, MACPAC found that it is difficult for state and federal policymakers to compare total Medicaid payments across providers and to assess the extent to which they are economical and efficient. See Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (Washington, D.C.: 2012).

[41]According to *Standards for Internal Control in the Federal Government*, agencies should collect data to monitor agency progress in achieving goals and determine compliance with various laws and regulations. See GAO/AIMD-00-21.3.1.

government providers. CMS must review and approve state plan amendments before a state can make payments and claim the federal share of the payments.[42] However, according to CMS officials, while states lay out criteria for who qualifies for payment and how payments are calculated in their state plan amendments, they are not required to offer more details, such as information on which providers will receive payments. In addition, because CMS asks states to submit comprehensive descriptions of their payment methodologies, state plan amendment language describing a state's methodology for determining Medicaid payments can be complex and technical, without offering specific details on the payments that will result from the payment methods. As an example, language in a New York state plan amendment for state fiscal year 2011 UPL supplemental payments for inpatient services to local government hospitals identified the total amount authorized to be paid in UPL supplemental payments, but did not identify the amounts paid to individual hospitals.[43] Lacking these details, CMS cannot rely solely on reviews of state plan amendments to assess whether payments to specific providers are meeting Medicaid criteria of economy and efficiency.

CMS's two ways of collecting Medicaid payment information—the Medicaid Statistical Information System (MSIS), a data collection system, and the CMS-64, a quarterly expense report used to provide federal matching funds for state Medicaid expenditures—do not collect complete information on payments to government and private providers. MSIS is CMS's national eligibility and claims data system and is the agency's only

[42]CMS reviews states' proposed reimbursement methodologies in the states' Medicaid plans for consistency with the Social Security Act and other federal statutes and regulations.

[43]The state plan provision provided somewhat ambiguous criteria on hospitals eligible to receive the UPL supplemental payments for inpatient services that totaled more than $400 million: payments "…are authorized to government general hospitals, other than those operated…" by the state or the state university hospital "…receiving reimbursement for all inpatient services under Title XIX of the federal Social Security Act (Medicaid) pursuant to this Attachment of this State Plan and located in a city with a population of over one million, of up to $286 million annually, as medical assistance payments." Further, the state plan provisions for determining which providers are eligible to receive payments and how much they are eligible to receive state that payments "…shall be based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year."

source of provider-specific payment data reported by states.[44] However, states are not required to report in MSIS provider ownership information or UPL supplemental payments that are not paid on claims. As a result, analyzing payments by provider ownership groups is not possible, and assessing total payments by provider is complicated by the fact that the UPL supplemental payments, which can be significant, are not reported in MSIS. For example, according to state data, in state fiscal year 2011, Illinois and New York made about $2 billion and $3 billion, respectively, in UPL supplemental payments that were not reported in MSIS. CMS-64 was not designed to capture provider-specific information; it provides aggregate payment amounts and does not have provider-specific payment or ownership information. As mentioned previously, it captures total payments by provider ownership for a few payment types, representing 10 percent of total Medicaid payments made in federal fiscal year 2011.

More recently, another source of provider-specific payment information, including UPL supplemental payments, became available for certain providers, but it too provides limited information. Beginning in 2010, states have been required to submit audited reports annually on any hospital receiving DSH supplemental payments. Information that states are required to report separately for each DSH hospital includes the hospital's Medicaid costs, and all Medicaid payments—regular, DSH supplemental, and UPL supplemental. However, this reporting is not required for hospitals that are not eligible to receive DSH supplemental payments.[45]

Recognizing the need for better data from the states, CMS began implementing two initiatives in 2013. The first initiative, to improve its oversight of the Medicaid UPL and state UPL supplemental payments, requires additional state reporting, but gaps remain.[46] Beginning in June 2013, states were required to annually submit to CMS documentation of

[44]CMS requires states to submit, through MSIS, quarterly electronic files on their paid claims, approximately 45 days after each quarter has ended.

[45]Other providers that are not hospitals, such as nursing facilities, are also not eligible to receive DSH supplemental payments and therefore are not subject to the DSH audit and reporting requirements.

[46]See CMS, *Re: Federal and State Oversight of Medicaid Expenditures (SMDL#13-003)* (Baltimore, Md.: Mar. 18, 2013).

their Medicaid UPL calculations and provider-specific payment information.[47] Previously, CMS had performed reviews of UPL calculations only when a state submitted a proposal to revise existing payments or add new payments in its state plan. Despite the new guidance and new reporting requirements, data gaps and challenges remain that limit CMS's ability to oversee payments. CMS has not specified a standardized data reporting format, including the key data states should report on providers and payments, such as NPIs for each provider and actual supplemental payments. As a result, some states may not report actual supplemental payments they make and, without NPIs, CMS is currently unable to merge UPL supplemental payments with regular claims-based payment data in MSIS.

CMS's second initiative, to improve MSIS, is intended to collect provider-specific ownership and supplemental payment information. CMS is developing the Transformed Medicaid Statistical Information System (T-MSIS)—an enhanced Medicaid data system—to replace MSIS. T-MSIS will require states to report additional information to CMS that is not currently collected in MSIS, including provider-specific information on supplemental payments received and provider ownership.[48] The agency has cited T-MSIS as a key tool for providing the federal government and states with better information with which to manage and monitor Medicaid program integrity, including identifying waste, fraud, and abuse.[49] However, there is uncertainty about when T-MSIS will be operational. In December 2014, CMS officials reported that the agency was still working

[47]In June 2013, states were required to submit to CMS UPL calculation and payment information for payments made for inpatient hospital services, outpatient hospital services, and nursing facilities. In 2014, and annually thereafter, states are required to submit annual UPL calculations for these services and for clinics, physician services (for states that make targeted physician supplemental payments), ICF/DDs, psychiatric residential treatment facilities, and institutes for mental disease. This information is due to CMS prior to the start of a state's fiscal year, which for most states is July 1. In addition, according to CMS officials, in June 2013, CMS provided its first written guidance to the states on acceptable methods and data sources for calculating payment limits. Prior guidance was communicated through interactions between CMS regional offices and states. CMS had internal guidelines for its management but had not issued guidance for states regarding appropriate methods for calculating their UPLs.

[48]Under T-MSIS there will be approximately 1,000 data elements, as opposed to the approximately 400 data elements states report to CMS under the current Medicaid claims data system.

[49]See CMS, *Re: Transformed Medicaid Statistical Information System (T-MSIS) Data (SMDL#13-004)* (Baltimore, Md.: Aug. 23, 2013).

on stabilizing its data systems to begin accepting state claims data through T-MSIS as states pass testing and are found by CMS to be ready to transition to T-MSIS. In December 2014, 18 states were in the final testing phases, and, depending on the nature of remaining issues with their data, these states could be ready for full implementation in 2 months. However, officials were uncertain when all states would be capable of reporting claims and payment information via T-MSIS. In addition, it is uncertain when states will be able to report all of the new data required under T-MSIS. According to CMS officials, some states have had problems reporting some of this information, particularly provider ownership information.[50] Officials were also uncertain about whether all of the issues we encountered with the existing claims data submitted by states through MSIS would be addressed when T-MSIS was fully operational. For example, when we reported that some states were reporting state-assigned provider numbers rather than NPIs, reporting multiple NPIs for one provider, or reporting incorrect and inaccurate NPIs, officials said that under T-MSIS there will be a cross-walk between provider NPIs and state-issued provider identification numbers that states use in processing claims. However, beyond looking for obvious errors in formatting of the NPI numbers, such as incorrect values or provider numbers that are too short or too long, CMS will not identify erroneous NPI numbers. Officials said errors involving providers with multiple NPIs or NPIs assigned to the wrong provider are identified when the data are analyzed for oversight and monitoring purposes.

In addition to these two initiatives, CMS officials told us they are also considering ways to improve data for overseeing payments at the provider level. As part of this effort, in May 2014, CMS contracted a study to, among other things, (1) analyze documentation on regular and UPL supplemental payments that states began submitting in 2013 to determine opportunities for improvement in CMS oversight; (2) store that information in a standardized format to enable analysis to be performed at both the aggregate and the provider-specific levels; and (3) assess the utility of T-MSIS data for the purpose of assisting CMS oversight of Medicaid UPL payments. The officials expect to receive the first report from the study in early 2015, and based on this report, will determine any

[50]According to the CMS officials, ownership information historically has typically been collected manually when providers applied for Medicaid eligibility. States have found it challenging to put this information in an electronic, standardized format for T-MSIS submission.

additional actions the agency will take to enhance the information it collects for oversight purposes.

CMS's Oversight of Medicaid Payments to Individual Providers Is Limited Because CMS Lacks a Policy and Process for Assessing Whether Payments to Individual Providers Are Economical and Efficient

CMS cannot ensure that Medicaid payments to individual providers are economical and efficient[51] because the agency does not have a standard policy delineating criteria for when payments made to individual providers are economical or efficient, nor does it have a process to identify payments to individual providers that appear questionable. Instead, the agency reviews payment methodologies, relies on states to provide justification for unclear methodologies, and follows up on payments that are identified as questionable by oversight reviews conducted by oversight agencies, such as HHS's Office of Inspector General. However, even when CMS identifies cases of payments to individual providers for further review, it does not have established criteria for determining whether these payments are economical and efficient. According to officials, to determine state compliance with the statutory requirement that Medicaid payments are economical and efficient,[52] CMS primarily relies on ensuring that states comply with Medicaid's UPL regulations. The UPL regulations establish a ceiling on the amount of federal matching funds a state can claim. The UPL, which is based on how much Medicare would pay for the same service, is an aggregate limit that applies to groups of

[51]In May 2014, CMS issued a State Medicaid Director Letter (SMDL) indicating that CMS may question payments to individual providers that exceed usual and customary charges or other measures of reasonableness, absent clear justification that they benefit the Medicaid program. For example, CMS may question proposed payments to one or more providers that are significantly higher than payments to other providers of the same services. However, according to CMS officials, the policy described in the May 2014 letter is limited to payments involving states' use of prohibited provider-related donations and certain types of public-private arrangements, under which the private entities assume obligations to provide donated services or other transfers of value. According to CMS officials, there is no agency policy to review payments made to individual providers to ensure payments are economical and efficient beyond this SDML. See Centers for Medicare & Medicaid Services, *Re: Accountability #2: Financing and Donations* (SMDL#14-004) (Baltimore, Md.: May 9, 2014).

[52]42 U.S.C. § 1396a(a)(30)(A).

providers based on a category of service and provider ownership.[53] While the UPL limits payments to a group of providers, it does not limit the amount of payment a particular provider can receive, provided the aggregate payment amount to the group does not exceed the UPL.

CMS's focus on the aggregate UPL hinders its ability to determine whether payments to individual providers are economical and efficient, as states can comply with an aggregate UPL but target UPL supplemental payments to a small number of providers. To illustrate, CMS reviewed and approved a state plan amendment authorizing the state of New York to make more than $400 million in inpatient hospital UPL supplemental payments to qualifying local government hospitals. The UPL supplemental payment amount represented the difference between regular Medicaid payments to the 21 local government hospitals subject to the UPL and what Medicare would have paid for inpatient services to these hospitals in the aggregate. However, we found in July 2014 that the aggregate UPL supplemental payments the state estimated it could make based on the workload of all 21 local government hospitals in New York, were actually made to only 2 of the 21 hospitals.[54] In approving the state plan amendment authorizing the UPL supplemental payment, CMS determined that the payment would not exceed the applicable aggregate UPL. The state plan amendment did not specify the number or names of hospitals that were eligible for payments under the amendment, and CMS did not obtain information on which of the 21 local government hospitals would receive UPL supplemental payments. The state submitted hospital-specific information showing the difference between each hospital's estimated regular Medicaid payments and the UPL, which is what Medicare would pay for comparable services.[55] The state used this information to calculate the aggregate UPL for the local government hospitals. Figure 8 compares the difference between regular payments

[53]UPLs exist for three provider ownership types—local government, state government, and private. Within each ownership category, separate UPLs exist for inpatient hospital services; outpatient hospital services; nursing facility services; physician and other practitioner services; and intermediate care facilities for the developmentally disabled (ICF/DD) services. See 42 CFR §§ 447.272, 447.321 (2014). Although federal regulations do not specify an upper payment limit for physician and other practitioner services, CMS has imposed limits on supplemental payments to these providers.

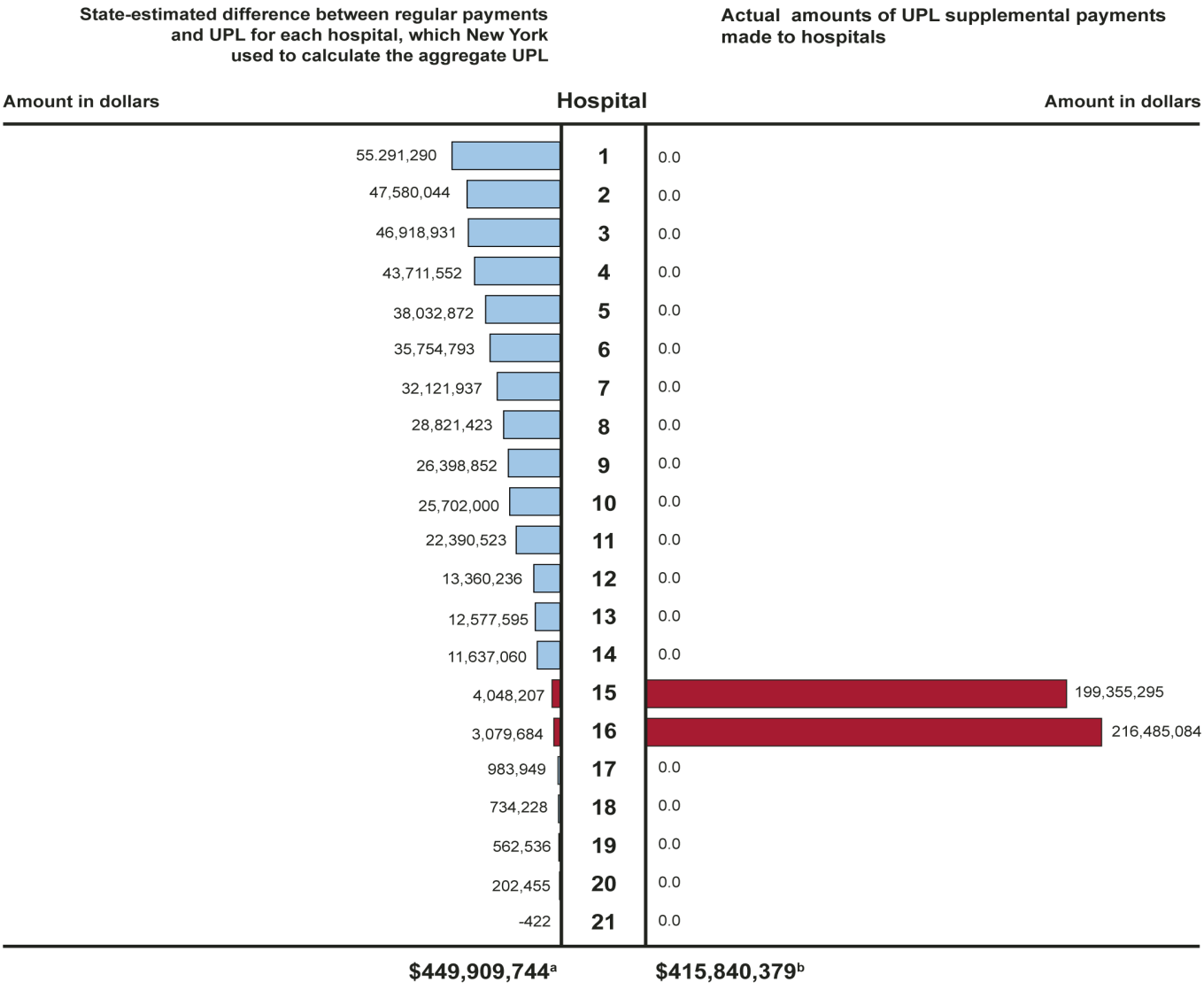
[54]See GAO-14-817T.

[55]The state estimated that payments based on Medicare payment methods for the two hospitals would have totaled about $100 million.

and the UPL that New York estimated for each hospital to the actual amounts of UPL supplemental payments made.[56]

[56]While states calculate individual providers' UPLs, which they then sum to determine the aggregate UPL, payments to individual providers are not subject to these provider-specific calculated UPLs.

Figure 8: Comparison of State-Estimated Differences between Regular Payments and the Upper Payment Limit (UPL) and Actual Amounts of UPL Supplemental Payments Made for 21 Local Government Hospitals That Provided Inpatient Services, in New York, by Hospital Fiscal Year 2011



Source: GAO analysis of New York state data. | GAO-15-322

Note: We have numbered the hospitals 1 through 21, according to the amount of the state-estimated difference between regular payments and UPL for each hospital, from high to low.

[a]The state of New York estimated the aggregate local government inpatient hospital UPL at $449,909,744 by calculating, for each hospital, the difference between Medicaid regular payment rates and what Medicare would pay for inpatient services, and then summing each hospital's UPL. CMS ultimately approved UPL supplemental payments for local government hospitals totaling $445,115,542.

[b]The $415,840,379 in supplemental UPL payments excludes $29,275,163 in health care service taxes. New York state levies a tax on health care services. The tax is collected by the state Medicaid agency and private insurers. The state Medicaid agency and private insurers pay the amount of the tax to the administrator of the fund in which taxes collected are deposited. However, the state claimed federal matching on the total UPL supplemental payment amount of $445,115,542 approved by CMS, which included the amounts withheld and collected as part of the health services tax.

In addition, we found a similar concentration of UPL supplemental payments for outpatient hospital services made to local government hospitals in state fiscal year 2011. Specifically, CMS approved New York to make about $154 million in UPL supplemental payments for outpatient hospital services for the 21 local government hospitals. Similar to the case for UPL supplemental payments for inpatient services, the state made a UPL supplemental payment for outpatient hospital services to only one local government hospital.[57]

CMS has recently taken actions to reduce the supplemental payment amounts paid to the three hospitals, indicating that the payments were excessive, but had not, as of January 2015, made a formal determination as to what payment amount would have been appropriate for the local government hospitals. According to CMS officials, because their reviews focus on the aggregate UPL, they were not aware of the distribution of these payments to specific hospitals. However, after we informed them of these payments, they initiated a review of the payments and, according to CMS officials, were in the process of working with the state to lower future payments the state would make to the three local government hospitals identified as receiving large supplemental payments in this review. As of January 2015, CMS had not provided details on the amount of payment reductions for the three hospitals. CMS officials told us they recognized the need for a strategy to oversee Medicaid payments to individual providers and the agency was considering ways to improve the agency's oversight of Medicaid payments and payment limits, including how to better assess payments to individual providers.

[57]We have reported similar issues in the past. In 2004, we reported that some states made relatively large UPL supplemental payments to relatively small numbers of government providers, which were then sometimes required to return these payments to the states, resulting in an inappropriate increase in federal matching funds. GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO-04-228 (Washington D.C.: Feb. 13, 2004). In 2012, we found that a small proportion of Disproportionate Share Hospitals in each of 39 states studied received a large proportion of total UPL supplemental payments made to the Disproportionate Share Hospitals and that these payments were not always aligned with the hospitals' uncompensated Medicaid costs. GAO-13-48.

Conclusions

Medicaid represents significant expenditures for the federal government and states and is the source of health care for tens of millions of vulnerable individuals. Its long-term sustainability is critical, and will require effective federal oversight to ensure that Medicaid payments are economical and efficient, and are made for covered Medicaid items and services. The longstanding concerns we have raised about some states' excessively large Medicaid payments to certain institutional providers continue. Further, our analysis showing the wide ranges in hospitals' average daily payments, and high payments over costs to certain government and private hospitals, raises further questions about federal oversight of states' payments to individual institutional providers, both government and private. Provider payments that are tens of millions of dollars, and in some cases hundreds of millions of dollars, greater than providers' costs raise questions about whether such payments are consistent with economy and efficiency as required by law and the extent to which the payments are ultimately used for Medicaid purposes. Medicaid payments that exceed the total costs of operating the hospital raise, even further, questions as to their appropriateness. Moreover, the fact that CMS is largely unaware of the extent to which state Medicaid payments exceed Medicaid costs to certain providers highlights the shortcoming of its current approach to overseeing state Medicaid payments. To oversee state Medicaid payments to individual providers, CMS needs accurate and complete provider payment data, as well as a policy and process for reviewing payments made to individual providers. While CMS has taken some steps to improve payment data it receives from the states, it does not have the comprehensive data for oversight, and future data improvements are uncertain. In addition, CMS does not have a policy and process for assessing the economy and efficiency of payments at the provider level. Without good data on payments to individual providers, a policy and criteria for assessing whether the payments are economical and efficient, and a process for reviewing such payments, the federal government could be paying states hundreds of millions, or billions, more than what is appropriate.

Recommendations for Executive Action

To improve CMS's oversight of Medicaid payments, we recommend that the Administrator of CMS take the following three actions:

- Take steps to ensure that states report accurate provider-specific payment data that include accurate unique national provider identifiers (NPI).

- Develop a policy establishing criteria for when such payments at the provider level are economical and efficient.
- Once criteria are developed, develop a process for identifying and reviewing payments to individual providers in order to determine whether they are economical and efficient.

To ensure the appropriateness of Medicaid payments to providers in New York, we recommend that the Administrator of CMS take the following fourth action:

- expedite the formal determination of the appropriateness of New York's payment arrangements and ensure future payments to local government hospitals are consistent with all Medicaid requirements.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment. In its written response, HHS concurred with our recommendations and noted efforts to address them. HHS stated that it is evaluating ways to improve its oversight, including gathering information from states to better inform future policies. HHS noted that information being collected will better inform the agency regarding efforts to establish criteria, policies, and procedures to evaluate whether payments at the provider level are economical and efficient.

HHS comments are reprinted in appendix VIII. HHS also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report 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. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

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

Katherine M. Iritani
Director, Health Care

List of Requesters

The Honorable Jason Chaffetz
Chairman
Committee on Oversight and Government Reform
House of Representatives

The Honorable Jim Jordan
Chairman
Subcommittee on Health Care, Benefits and Administrative Rules
Committee on Oversight and Government Reform
House of Representatives

The Honorable James Lankford
Chairman
Subcommittee on Regulatory Affairs and Federal Management
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Darrell E. Issa
House of Representatives

Appendix I: Scope and Methodology for Analyzing Medicaid Payments and Hospital Costs

To determine what the Centers for Medicare & Medicaid Services (CMS) Medicaid expenditure reports include about payments by provider ownership nationwide, we analyzed CMS's quarterly Medicaid expenditure reports for federal fiscal year 2011—the most recent year for which complete data were available at the time of our analysis. To determine, for selected states, how state Medicaid payments to government hospitals compare to state Medicaid payments to private hospitals, we used federal Medicaid claims data and data provided by the states. To determine, in the selected states, how the state Medicaid payments to selected hospitals compare to the hospitals' Medicaid costs and to hospitals' total operating costs, we used the federal Medicaid claims data and data and Medicaid cost reports provided by the states.

Methodology for Analyzing Medicaid Expenditure Reports

To examine what information CMS Medicaid expenditure reports include about payments by provider ownership nationwide, we used the quarterly Medicaid expenditure reports—referred to as the CMS-64—that states use to report their Medicaid expenditures for purposes of receiving federal matching funds.[1] We determined based on the expenditure reports that states reported payments by provider ownership for six categories of service for upper payment limit (UPL) supplemental payments and two categories of service for regular payments. The six categories of service for UPL supplemental payments reported by provider ownership include (1) inpatient hospital, (2) outpatient hospital, (3) nursing facility, (4) physician and surgical, (5) other practitioner, and (6) intermediate care facilities for the developmentally disabled (ICF/DD). The two categories of service for regular payments that are reported by provider ownership include (1) ICF/DD and (2) school-based services.

For each state, we compiled payments for the categories of service reported by provider ownership that were provided in federal fiscal year 2011—the most recent year for which complete data were available at the time of our analysis—by excluding those payments for services that were reported in federal fiscal year 2011 but were provided in prior years, and including payments for services provided in federal fiscal year 2011 but were reported in federal fiscal years 2012 or 2013. We used two main CMS-64 expenditure reports to compile this information. One report—the CMS-64 Base Report—includes payments for services provided in federal

[1]For purposes of this report, states include the 50 states and the District of Columbia.

fiscal year 2011, as well as payments and adjustments for prior years. It does not include payments or payment adjustments for services provided in federal fiscal year 2011 that were reported in federal fiscal years 2012 or 2013. The other key report—the Financial Management Report Net Expenditure Reports—includes payments for services provided in federal fiscal year 2011 and includes payments made in 2011 that were for prior years. It also includes payments or payment adjustments for services provided in federal fiscal year 2011 that were reported in federal fiscal years 2012 or 2013. By using these two reports in combination, we determined total payments for services provided in federal fiscal year 2011 for the categories of service reported by provider ownership. For these six categories of service for UPL supplemental payments, we used more-detailed feeder forms for the two reports, which the states use to report the UPL supplemental payments by provider ownership.

To assess the reliability of the CMS expenditure reports, we conducted interviews with CMS officials on how the agency uses the data and any known data reliability issues, reviewed related documentation, and conducted logic tests on the expenditure data. We determined that these data were sufficiently reliable for the purposes of our report. The results of this analysis were limited, however, in that states report their CMS-64 expenditure data at an aggregate state level and not by provider or by claim. Therefore, we could not determine the extent to which the difference in payments to government providers versus private providers was due to a higher volume of services provided or a larger number of providers in the ownership group.

Methodology for Comparing Medicaid Payments by Provider Ownership in Selected States

To determine how, in selected states, state Medicaid payments to government hospitals compare to state Medicaid payments to private hospitals, we selected a nongeneralizable sample of three states—California, Illinois, and New York. We selected these states based on the following criteria:

- having large Medicaid programs as determined by spending for Medicaid services,[2]

[2]In federal fiscal year 2011, these three states' total Medicaid payments represented 29 percent of total national Medicaid payments.

- making large amounts of certain supplemental Medicaid payments, and
- geographic diversity.

We determined that for California the data needed for our analysis were not reliable and, therefore, we could not compare the state's payments by provider ownership. For Illinois and New York we analyzed Medicaid payments for inpatient services provided in state fiscal year 2011 by three hospital ownership groups—local government, state government, and private.[3] We analyzed payments for state fiscal year 2011 because it was the most recent year for which data on regular, claims-based payments were available.

To compare Medicaid payments by hospital ownership in Illinois and New York, we combined federal inpatient hospital Medicaid claims data from the Medicaid Statistical Information System (MSIS)—the federal system through which states report Medicaid claims—with data provided by the states, which included additional payment data and hospital ownership information not included in MSIS. Specifically,

- From MSIS we compiled regular, claims-based payments for inpatient hospital services by identifying the states' fee-for-service claims for services provided by hospitals, including general acute care, children's, and cancer hospitals. We excluded psychiatric hospitals, all managed care claims,[4] claims for patients covered by a separate State Children's Health Insurance Program,[5] and any Medicare "crossover" claims—where Medicare was the primary payer. We used all four quarters of MSIS claims from state fiscal years 2011 and 2012

[3]Illinois has a state fiscal year that starts on July 1 and ends on June 30. We analyzed payments for services during the July 1, 2010, through June 30, 2011, time period. New York's state fiscal year begins on April 1 and ends on March 31. We analyzed payments for services during the April 1, 2010, through March 31, 2011, time period.

[4]Under a Medicaid managed care program, states contract with managed care organizations to provide or arrange for medical services, and prospectively pay the plans a fixed monthly rate, per enrollee. States receive federal reimbursement for these payments, and the plans pay providers for services provided to Medicaid enrollees.

[5]The State Children's Health Insurance Program (CHIP) provides health coverage to children in low-income families whose incomes are too high to qualify for Medicaid. States can administer CHIP through a Medicaid expansion program or through a separate state program.

to identify those claims where the beginning date of service indicated the service was provided in state fiscal year 2011. We adjusted the regular fee-for-service claims to account for differences in the conditions of the patients treated by the hospitals, commonly referred to as "case-mix" adjustment, using case-mix data provided by the states.

- From the states we obtained provider-specific UPL supplemental payments and hospital ownership information. In addition, we obtained provider-specific Disproportionate Share Hospital (DSH) supplemental payment amounts from both states, and payment amounts for an additional Medicaid supplemental payment made to certain Illinois hospitals under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).[6] However, because it was unclear what portion of DSH supplemental payments was related to the cost of providing Medicaid services and because BIPA payments are not for specified Medicaid services or related to the cost of providing Medicaid services, we did not include these payments when calculating Medicaid payment amounts for government and private hospitals.

We combined the inpatient MSIS payment and day data with the state-provided supplemental payment and hospital ownership data using unique hospital identification numbers, such as the National Provider Identifier (NPI)—a national, unique 10-digit identification number assigned to health care providers. After combining the MSIS and state-provided data, we performed two calculations. First, we calculated a Medicaid daily payment amount for each hospital by dividing the hospital's total inpatient service payments (regular claims-based payments and UPL supplemental payments) by the total Medicaid days of inpatient services the hospital provided. Second, we calculated an average daily payment amount for each hospital ownership group by summing the daily payment amounts of every hospital in each ownership group and dividing it by the number of hospitals in the ownership group. To ensure that hospitals with very low inpatient days were not skewing the average daily payment amounts, we

[6]Hospitals eligible to receive the supplemental payments authorized under BIPA are those that, as of October 1, 2000, (1) are state- or local-owned or -operated, (2) are not receiving Medicaid Disproportionate Share Hospital (DSH) supplemental payments, and (3) have a low income utilization rate in excess of 65 percent. Pub. L. No. 106-554, § 701(d), 114 Stat. 2763, 2763A-571 (Dec. 1, 2000).

excluded from this analysis the hospitals that had the lowest 5 percent of inpatient days in state fiscal year 2011.

To assess the reliability of the MSIS claims data and data provided by the states, we reviewed relevant data documents and interviewed agency officials. For the MSIS data, we reviewed the CMS data dictionary and a report on identified issues with the state fiscal year 2011 MSIS claims, conducted logic tests, and interviewed CMS officials on how the data are used by the agency and any known data reliability issues. We also interviewed state Medicaid officials to determine how the states report their MSIS data to CMS. We determined that the MSIS data were reliable for our purposes. For the state-provided data on payments not reported in MSIS and on hospital ownership, we conducted logic tests and interviewed state Medicaid officials. While we determined through our assessments that the data provided by both Illinois and New York were reliable for our purposes, we determined that California's state-provided data on payments not reported in MSIS and hospital identification numbers were not reliable and, therefore, we could not compare this state's payments by provider ownership.

Methodology for Comparing Selected Hospitals' Medicaid Payments to Medicaid Costs for Inpatient Services and to Total Operating Costs

To compare Medicaid payments for inpatient hospital services to Medicaid costs for these services in Illinois and New York, we selected hospitals that had the highest daily payment amounts in each of the three ownership groups in state fiscal year 2011. We selected seven hospitals in Illinois, because the state had only one state government hospital, and nine hospitals in New York.

For each of the selected hospitals in both states, we compared Medicaid payments for inpatient services to Medicaid costs for inpatient services. We calculated the total Medicaid payments for inpatient services—regular and UPL supplemental payments—based on payment data from CMS's Medicaid claims data and the state-provided data on supplemental payments. For purposes of comparing payments to costs, we did not case-mix-adjust the regular payments for differences in the conditions of the patients treated by the hospitals.

To estimate Medicaid inpatient costs, we used inpatient Medicaid costs that each hospital reported to the state on standard cost reports for state

fiscal year 2011.[7] For the selected Illinois hospitals, the inpatient Medicaid costs were reported on the Medicaid cost report. For the selected New York hospitals, we determined inpatient Medicaid costs by first calculating the percentage of each hospital's total inpatient days that were Medicaid inpatient days and then applying that percentage to the total inpatient service costs to get an initial Medicaid inpatient cost estimate.[8] For the selected hospitals in both states, to account for differences between the days for inpatient services that were reported on the cost reports compared to the days reported in the CMS claims data, we calculated a daily Medicaid cost amount and then multiplied the daily cost amount by the number of days for inpatient services from CMS's Medicaid claims data. To calculate the daily cost amount, we used the costs and days reported on the Medicaid cost reports; we divided each hospital's total Medicaid inpatient costs by Medicaid total inpatient days.

For each of the selected hospitals in both Illinois and New York, we also compared Medicaid payments for inpatient services and related supplemental payments to the hospital's total operating costs for all services and all patients. For the selected hospitals in Illinois, we included in this comparison regular inpatient[9] and inpatient UPL supplemental payments, as well as Disproportionate Share Hospital (DSH) supplemental payments and an additional Medicaid supplemental payment that was authorized under BIPA.[10] For the selected hospitals in New York, we included in this comparison the regular inpatient and inpatient UPL supplemental payments, as well as DSH supplemental payments. For both states, we did not include regular and supplemental payments for outpatient services because we were unable to analyze Medicaid payments for outpatient services. We identified each of the

[7]For some hospitals, the dates covered in the cost reports did not align with the state fiscal year—July 1, 2010, through June 30, 2011, in Illinois, and April 1, 2010, through March 31, 2011, in New York. In these cases, we used the two cost reports that did cover all months in the state fiscal year and then prorated the Medicaid inpatient costs and associated days based on the number of months in each cost report that were relevant to the state fiscal year.

[8]This is the methodology the state uses in determining Medicaid costs and was reviewed by state Medicaid officials for accuracy.

[9]The regular payments we included in this analysis were not case-mix adjusted for differences in the conditions of the patients treated by the hospitals.

[10]One of the three selected local government hospitals received the BIPA supplemental payment.

hospitals' total operating costs for all services and all patients on the hospital's cost report.[11] The hospitals' Medicaid cost reports include costs and days for Medicaid, and also include total costs for all patients.

To determine the reliability of the selected Illinois and New York hospitals' cost reports, we interviewed state Medicaid officials on how the cost data are compiled and used by the agency and whether there were any known data reliability issues. We also compared Medicaid costs and patient days from the selected hospitals' cost reports from state fiscal year 2009 to the hospital's DSH report—an independently audited report that states are required to submit to CMS annually for every hospital that receives a DSH supplemental payment—from state fiscal year 2009, the most recent year for which DSH reports were available. Based on these assessments, we determined that the cost report data were sufficiently reliable for our purposes.

[11]For those hospitals where the dates covered in the cost reports did not align with the state fiscal year, we used the two cost reports that did cover all of the months in the state fiscal year and prorated the total operating costs based on the number of months in each cost report that were relevant to the state fiscal year.

Appendix II: Past GAO Concerns about Medicaid Payments

Over the past 20 years, we have reported a number of concerns about Medicaid payments—particularly supplemental payments—that states have made to a small number of providers. Specifically, we have found that by making large supplemental payments to providers that are concurrently supplying funds to the state for the nonfederal share (through such financing arrangements as providers' taxes and intergovernmental transfers), states have been able to obtain billions of dollars in additional federal matching funds without a commensurate increase in state funds used to finance the nonfederal share. For example, in 2004 and 2005 we found that some states' excessive payments to a few government providers facilitated the inappropriate shifting of state costs to the federal government.[1] In addition, we found that a lack of uniform guidance on setting Medicaid payment limits and the flexibility given to states under existing federal rules concerning the distribution of supplemental payments allowed states to make large Medicaid payments to a few government providers. We also found that a lack of transparency in how such payments were made allowed for potentially inappropriate Medicaid payments to certain providers and hindered the ability of the Centers for Medicare & Medicaid Services (CMS) to oversee such payments. Table 1 summarizes past issues we have found regarding state Medicaid payments made to providers and actions taken by Congress and CMS to address these concerns.

[1]GAO, *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes*, GAO-04-574T (Washington, D.C.: Mar. 18, 2004); and *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Oversight*, GAO-05-748 (Washington, D.C.: June 28, 2005).

Table 1: CMS and Congressional Actions Taken in Response to Prior Issues Identified by GAO Related to Medicaid Payments

Medicaid payment issue	Description	Action taken
Excessive payments to state health providers	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, now called the Centers for Medicare & Medicaid Services or CMS) issued regulations that established payment limits specifically for inpatient and institutional providers 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 Amendment of 1991 imposed restrictions on provider donations and provider taxes.
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 Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 imposed state-specific and national limits on DSH expenditures. 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. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required states to submit annual, independent DSH-certified audits of their DSH programs and annually report information on their DSH audits to HHS. CMS published the final rule implementing this requirement in December 2008.
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 for mental disease and other mental health facilities.
Excessive upper payment limit (UPL) supplemental payments for local government health providers	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 aggregate payment limit for local government health facilities. HCFA issued its final regulation on January 12, 2001. In 2002, CMS issued a regulation that further lowered the payment limit for local government hospitals.

Source: GAO. | GAO-15-322

Partially in response to concerns about excessive supplemental payments to government providers, CMS issued a proposed rule in early 2007 to limit state upper payment limit (UPL) supplemental payments to government providers to their cost of providing Medicaid services. However, concerns were raised that it would harm certain providers, and on May 24, 2007, Congress passed a one-year moratorium on the finalization or implementation of the proposed rule.[2] CMS issued the rule in final form on May 25, 2007, the date on which the President signed the law containing the moratorium.[3] In 2008, a federal district court found the agency's finalization of the rule violated the moratorium and vacated the rule, and CMS formally rescinded the rule in 2010.[4]

[2]Pub. L. No. 110-28, § 7002(a), 121 Stat. 112, 187 (2007).

[3]The final cost limit rule was put on public display with the Office of the Federal Register on May 25, 2007, and was published in the Federal Register on May 29, 2007. 72 Fed. Reg. 29748 (May 29, 2007) (amending 42 CFR Part 433, 447, and 457).

[4]*Alameda County Medical Center. v. Leavitt,* 559 F. Supp. 2d 1 (D.D.C. May 23, 2008).

Appendix III: Analysis Results for Medicaid Expenditure Reports

This appendix provides results of our analysis of Centers for Medicare & Medicaid Services (CMS) CMS-64 Medicaid expenditure reports for payments by provider ownership, both state-by-state and nationwide,[1] for federal fiscal year 2011. Specifically, the appendix includes expenditures for Medicaid payments for the categories of service reported by provider ownership, including six categories of service for upper payment limit (UPL) supplemental payments and two categories of service for regular payments.

- Table 2 shows total Medicaid expenditures, expenditures reported by provider ownership, the percentage of total expenditures that were reported by provider ownership, expenditures for payments to government providers and private providers, and government provider expenditures and private provider expenditures as a percentage of total expenditures reported by provider ownership.
- Tables 3 through 8 show total UPL supplemental payments and the payments and related percentages by three provider ownership groups—local government, state government, and private—for the six categories of service for UPL supplemental payments that are reported by provider ownership.
- Tables 9 and 10 show total regular payments and the payments by the three provider ownership groups for the two categories of service for regular payments that are reported by provider ownership.

[1]For purposes of this report, nationwide states include the 50 states and the District of Columbia.

Table 2: Total Medicaid Expenditures and Medicaid Expenditures Reported by Provider Ownership in Federal Fiscal Year 2011, by State

State	Total expenditures for Medicaid payments	Expenditures reported by provider ownership (percentage of total expenditures)	Expenditures for payments by provider ownership (percentage of total expenditures reported by provider ownership[a])	
			Government providers	Private providers
Alabama	$4,865,499,484	$250,819,652 (5%)	$96,605,774 (39%)	$154,213,878 (61%)
Alaska[b]	1,304,988,102	2,247,396 (0)	-492,240 (N/A)	2,739,636 (N/A)
Arizona	8,989,836,258	35,668,377 (0)	35,668,377 (100)	0 (0)
Arkansas	4,006,189,187	503,055,130 (13)	209,987,737 (42)	293,067,393 (58)
California	54,906,617,863	9,512,557,341 (17)	4,291,636,859 (45)	5,220,920,482 (55)
Colorado	4,381,469,329	830,754,287 (19)	326,052,598 (39)	504,701,689 (61)
Connecticut	6,045,650,945	303,615,486 (5)	238,966,732 (79)	64,648,754 (21)
Delaware	1,406,371,361	40,994,246 (3)	32,897,549 (80)	8,096,697 (20)
District of Columbia	2,140,659,040	69,778,374 (3)	3,139,170 (4)	66,639,204 (96)
Florida	18,279,668,609	1,576,985,111 (9)	896,523,477 (57)	680,461,634 (43)
Georgia	8,110,756,566	184,874,963 (2)	178,035,336 (96)	6,839,627 (4)
Hawaii	1,619,624,237	66,320,215 (4)	57,119,508 (86)	9,200,707 (14)
Idaho	1,534,805,388	172,033,673 (11)	65,598,532 (38)	106,435,141 (62)
Illinois	12,996,894,073	2,763,300,068 (21)	726,689,229 (26)	2,036,610,839 (74)
Indiana	6,606,338,982	1,194,940,811 (18)	627,210,201 (52)	567,730,610 (48)
Iowa	3,384,196,117	398,926,655 (12)	235,111,348 (59)	163,815,307 (41)
Kansas	2,692,883,785	172,947,047 (6)	127,891,217 (74)	45,055,830 (26)
Kentucky	5,720,243,597	332,675,902 (6)	304,219,172 (91)	28,456,730 (9)
Louisiana	6,663,612,323	1,031,438,147 (15)	295,344,684 (29)	736,093,463 (71)
Maine	2,377,497,777	91,646,057 (4)	26,297,124 (29)	65,348,933 (71)
Maryland	7,467,992,128	99,554,943 (1)	99,517,977 (100)	36,966 (0)
Massachusetts	13,233,475,052	1,183,403,058 (9)	476,954,660 (40)	706,448,398 (60)
Michigan	12,145,731,696	1,301,707,704 (11)	531,062,520 (41)	770,645,184 (59)
Minnesota	8,423,382,345	295,592,065 (4)	138,550,500 (47)	157,041,565 (53)
Mississippi	4,457,131,271	696,070,214 (16)	436,667,907 (63)	259,402,307 (37)
Missouri	8,091,097,754	340,775,234 (4)	125,526,256 (37)	215,248,978 (63)
Montana	960,976,008	47,667,466 (5)	47,613,887 (100)	53,579 (0)
Nebraska	1,679,626,256	33,085,721 (2)	10,994,838 (33)	22,090,883 (67)
Nevada	1,565,010,499	73,597,200 (5)	66,084,157 (90)	7,513,043 (10)
New Hampshire	1,365,145,781	92,598,139 (7)	2,991,337 (3)	89,606,802 (97)
New Jersey	10,579,344,565	683,032,630 (6)	629,068,207 (92)	53,964,423 (8)

State	Total expenditures for Medicaid payments	Expenditures reported by provider ownership (percentage of total expenditures)	Expenditures for payments by provider ownership (percentage of total expenditures reported by provider ownership[a])	
			Government providers	Private providers
New Mexico	3,395,240,714	158,375,331 (5)	131,203,732 (83)	27,171,599 (17)
New York	53,882,237,738	5,627,031,752 (10)	4,153,000,839 (74)	1,474,030,913 (26)
North Carolina	10,546,984,914	692,493,272 (7)	306,683,693 (44)	385,809,579 (56)
North Dakota	708,383,241	91,478,414 (13)	26,328,872 (29)	65,149,542 (71)
Ohio	15,709,320,002	899,626,621 (6)	327,101,435 (36)	572,525,186 (64)
Oklahoma	4,269,462,234	152,724,775 (4)	88,909,089 (58)	63,815,686 (42)
Oregon	4,432,660,837	5,234,571 (0)	5,234,571 (100)	0 (0)
Pennsylvania	20,532,721,737	1,619,257,055 (8)	1,022,521,062 (63)	596,735,993 (37)
Rhode Island	2,111,549,255	125,368,000 (6)	39,595,649 (32)	85,772,351 (68)
South Carolina	5,128,430,661	276,033,993 (5)	225,607,400 (82)	50,426,593 (18)
South Dakota	759,165,233	29,770,447 (4)	29,770,447 (100)	0 (0)
Tennessee	8,026,152,278	940,511,397 (12)	495,411,926 (53)	445,099,471 (47)
Texas	28,565,381,384	4,112,919,160 (14)	2,067,195,458 (50)	2,045,723,702 (50)
Utah	1,765,665,893	115,148,247 (7)	83,407,337 (72)	31,740,910 (28)
Vermont	1,297,463,029	139,559 (0)	139,559 (100)	0 (0)
Virginia	7,009,277,400	321,874,339 (5)	256,558,147 (80)	65,316,192 (20)
Washington	7,446,985,322	182,071,165 (2)	149,278,084 (82)	32,793,081 (18)
West Virginia	2,758,168,958	292,762,443 (11)	142,828,781 (49)	149,933,662 (51)
Wisconsin	6,960,737,560	350,004,538 (5)	270,259,092 (77)	79,745,446 (23)
Wyoming	534,377,585	63,241,390 (12)	51,236,663 (81)	12,004,727 (19)
Total	**413,843,082,353**	**40,438,729,781 (10)**	**21,211,806,466 (52)**	**19226923315 (48)**

Legend: N/A indicates not available.

Source: GAO analysis of CMS data. | GAO-15-322

Note: The CMS-64 expenditure data used in this analysis included regular payments, upper payment limit (UPL) supplemental payments made to hospitals, nursing facilities, and other providers, and other supplemental payments made under the authority of Medicaid Section 1115 waiver demonstration programs.

[a]In some instances, a state's reported payment for a given hospital ownership is low compared to the total reported payment. As a result, the percentage of the total payment for the hospital ownership is zero due to rounding.

[b]For federal fiscal year 2011, Alaska reported no payments to government providers for the categories of service that are reported by provider ownership. However, the state reported a negative adjustment for payments to government providers. The negative adjustment was a recoupment by CMS in 2011 for disallowed payments from a prior year.

Table 3: Expenditures Reported for Inpatient Hospital Upper Payment Limit (UPL) Supplemental Payments for Federal Fiscal Year 2011, by State

State	Total expenditures for UPL payments for inpatient hospital services	Expenditures for UPL supplemental payments[a] by hospital ownership (percentage of total expenditures for UPL payments for inpatient hospital services[b])		
		Local government hospitals	State government hospitals	Private hospitals
Alabama	$202,327,486	$0 (0%)	$63,008,874 (31%)	$139,318,612 (69%)
Alaska	0	0 (0)	0 (0)	0 (0)
Arizona	0	0 (0)	0 (0)	0 (0)
Arkansas	259,562,040	14,604,159 (6)	12,960,863 (5)	231,997,018 (89)
California	6,046,910,601	2,414,927,671 (40)	20,897,772 (0)	3,611,085,158 (60)
Colorado	536,720,832	142,975,209 (27)	39,877,531 (7)	353,868,092 (66)
Connecticut	0	0(0)	0 (0)	0 (0)
Delaware	0	0 (0)	0 (0)	0 (0)
District of Columbia	0	0 (0)	0 (0)	0 (0)
Florida	979,699,130	647,774,218 (66)	19,413 (0)	331,905,499 (34)
Georgia	58,837,026	36,446,786 (62)	21,658,300 (37)	731,940 (1)
Hawaii	30,337,962	0 (0)	30,337,962 (100)	0 (0)
Idaho	12,416,785	1,514,263 (12)	0 (0)	10,902,522 (88)
Illinois	1,251,154,137	7,500,655 (1)	145,576 (0)	1,243,507,906 (99)
Indiana	488,574,622	325,621,842 (67)	0 (0)	162,952,780 (33)
Iowa	12,375,000	0 (0)	12,375,000 (100)	0 (0)
Kansas	25,437,679	2,758,065 (11)	0(0)	22,679,614 (89)
Kentucky	190,338,518	0 (0)	188,838,518 (99)	1,500,000 (1)
Louisiana	464,869,471	0 (0)	60,237,138 (13)	404,632,333 (87)
Maine	0	0 (0)	0 (0)	0 (0)
Maryland	0	0 (0)	0 (0)	0 (0)
Massachusetts	573,843,229	63,467,812 (11)	0 (0)	510,375,417 (89)
Michigan	443,824,508	69,476,508 (16)	0 (0)	374,348,000 (84)
Minnesota	36,860,271	36,860,271 (100)	0 (0)	0 (0)
Mississippi	411,516,300	143,970,621 (35)	57,545,388 (14)	210,000,291 (51)
Missouri	0	0 (0)	0 (0)	0 (0)
Montana	0	0 (0)	0 (0)	0 (0)
Nebraska	0	0 (0)	0 (0)	0 (0)
Nevada	36,887,503	26,889,823 (73)	9,997,680 (27)	0 (0)
New Hampshire	57,794,508	0 (0)	0 (0)	57,794,508 (100)
New Jersey	42,614,954	0 (0)	0 (0)	42,614,954 (100)

State	Total expenditures for UPL payments for inpatient hospital services	Expenditures for UPL supplemental payments[a] by hospital ownership (percentage of total expenditures for UPL payments for inpatient hospital services[b])		
		Local government hospitals	State government hospitals	Private hospitals
New Mexico	109,004,256	109,004,256 (100)	0 (0)	0 (0)
New York	1,160,855,008	771,721,610 (66)	0 (0)	389,133,398 (34)
North Carolina	146,273,634	0 (0)	0 (0)	146,273,634 (100)
North Dakota	1,135,794	0 (0)	0 (0)	1,135,794 (100)
Ohio	93,739,261	25,891,535 (28)	9,999,626 (11)	57,848,100 (62)
Oklahoma	16,241,999	25,992 (0)	8,938,416 (55)	7,277,591 (45)
Oregon	0	0 (0)	0 (0)	0 (0)
Pennsylvania	206,287,980	191,866,884 (93)	14,421,096 (7)	0 (0)
Rhode Island	0	0 (0)	0 (0)	0 (0)
South Carolina	49,030,054	49,030,054 (100)	0 (0)	0 (0)
South Dakota	0	0 (0)	0 (0)	0 (0)
Tennessee	747,256,798	362,305,379 (48)	31,833,568 (4)	353,117,851 (47)
Texas	2,887,525,075	1,079,955,230 (37)	96,024,389 (3)	1,711,545,456 (59)
Utah	0	0 (0)	0 (0)	0 (0)
Vermont	0	0 (0)	0 (0)	0 (0)
Virginia	0	0 (0)	0 (0)	0 (0)
Washington	0	0 (0)	0 (0)	0 (0)
West Virginia	151,358,510	2,309,537 (2)	46,169,592 (31)	102,879,381 (68)
Wisconsin	19,061,157	1,429,066 (7)	0 (0)	17,632,091 (93)
Wyoming	12,674,431	12,674,431 (100)	0 (0)	0 (0)
Total	**17,763,346,519**	**6,541,001,877 (37)**	**725,286,702 (4)**	**10,497,057,940 (59)**

Source: GAO analysis of CMS data. | GAO-15-322

Note: The CMS-64 expenditure data used in this analysis included UPL supplemental payments made to hospitals and other supplemental payments made under the authority of Medicaid Section 1115 waiver demonstration programs.

[a]UPL supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services.

[b]In some instances, a state's reported payment for a given hospital ownership is low compared to the total reported payment. As a result, the percentage of the total payment for the hospital ownership is zero due to rounding.

Table 4: Expenditures Reported for Outpatient Hospital Upper Payment Limit (UPL) Supplemental Payments for Federal Fiscal Year 2011, by State

State	Total expenditures for UPL payments for outpatient hospital services	Expenditures for UPL supplemental payments[a] by hospital ownership (percentage of total expenditures for UPL payments for outpatient hospital services)		
		Local government hospitals	State government hospitals	Private hospitals
Alabama	$15,829,014	$0 (0%)	$3,525,318 (22%)	$12,303,696 (78%)
Alaska	0	0 (0)	0 (0)	0(0)
Arizona	0	0 (0)	0 (0)	0 (0)
Arkansas	39,937,490	29,408,210 (74)	0 (0)	10,529,280 (26)
California	2,159,832,461	1,017,395,674 (47)	92,367,786 (4)	1,050,069,001 (49)
Colorado	147,844,347	51,874,816 (35)	17,978,410 (12)	77,991,121 (53)
Connecticut	0	0 (0)	0 (0)	0 (0)
Delaware	0	0 (0)	0 (0)	0 (0)
District of Columbia	0	0 (0)	0 (0)	0 (0)
Florida	0	0 (0)	0 (0)	0 (0)
Georgia	65,965,454	61,302,808 (93)	3,736,371 (6)	926,275 (1)
Hawaii	26,780,610	0 (0)	26,780,610 (100)	0 (0)
Idaho	8,260,795	1,510,601 (18)	0 (0)	6,750,194 (82)
Illinois	431,097,396	18,698,956 (4)	0 (0)	412,398,440 (96)
Indiana	258,762,325	176,715,105 (68)	0 (0)	82,047,220 (32)
Iowa	0	0 (0)	0 (0)	0 (0)
Kansas	18,784,901	4,973,485 (26)	4,889,771 (26)	8,921,645 (47)
Kentucky	0	0 (0)	0 (0)	0 (0)
Louisiana	103,831,040	0 (0)	15,060,460 (15)	88,770,580 (84)
Maine	0	0 (0)	0 (0)	0 (0)
Maryland	0	0 (0)	0 (0)	0 (0)
Massachusetts	382,816,817	190,541,091 (50)	0 (0)	192,275,726 (50)
Michigan	113,883,459	16,433,041 (14)	964,667 (1)	96,485,751 (85)
Minnesota	14,167,178	14,167,178 (100)	0 (0)	0 (0)
Mississippi	0	0 (0)	0 (0)	0 (0)
Missouri	0	0 (0)	0 (0)	0 (0)
Montana	0	0 (0)	0 (0)	0 (0)
Nebraska	0	0 (0)	0 (0)	0 (0)
Nevada	0	0 (0)	0 (0)	0 (0)
New Hampshire	31,812,294	0 (0)	0 (0)	31,812,294 (100)
New Jersey	0	0 (0)	0 (0)	0 (0)

State	Total expenditures for UPL payments for outpatient hospital services	Expenditures for UPL supplemental payments[a] by hospital ownership (percentage of total expenditures for UPL payments for outpatient hospital services)		
		Local government hospitals	State government hospitals	Private hospitals
New Mexico	0	0 (0)	0 (0)	0 (0)
New York	370,969,047	370,969,047 (100)	0 (0)	0 (0)
North Carolina	0	0 (0)	0 (0)	0 (0)
North Dakota	0	0 (0)	0 (0)	0 (0)
Ohio	44,329,272	3,835,325 (9)	0 (0)	40,493,947 (91)
Oklahoma	0	0 (0)	0 (0)	0 (0)
Oregon	0	0 (0)	0 (0)	0 (0)
Pennsylvania	0	0 (0)	0 (0)	0 (0)
Rhode Island	78,909,928	0 (0)	0 (0)	78,909,928 (100)
South Carolina	20,587,862	20,587,862 (100)	0 (0)	0 (0)
South Dakota	0	0 (0)	0 (0)	0 (0)
Tennessee	0	0 (0)	0 (0)	0 (0)
Texas	65,854,745	35,450,710 (54)	0 (0)	30,404,035 (46)
Utah	0	0 (0)	0 (0)	0 (0)
Vermont	0	0 (0)	0 (0)	0 (0)
Virginia	0	0 (0)	0 (0)	0 (0)
Washington	0	0 (0)	0 (0)	0 (0)
West Virginia	0	0 (0)	0 (0)	0 (0)
Wisconsin	4,000,000	1,166,666 (29)	0 (0)	2,833,334 (71)
Wyoming	18,398,087	18,398,087 (100)	0 (0)	0 (0)
Total	**4,422,654,522**	**2,033,428,662 (46)**	**165,303,393 (4)**	**2,223,922,467 (50)**

Source: GAO analysis of CMS data. | GAO-15-322

Note: The CMS-64 expenditure data used in this analysis included UPL supplemental payments made to hospitals and other supplemental payments made under the authority of Medicaid Section 1115 waiver demonstration programs.

[a]UPL supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services.

Table 5: Expenditures Reported for Nursing Facility Upper Payment Limit (UPL) Supplemental Payments for Federal Fiscal Year 2011, by State

State	Total expenditures for UPL payments for nursing facility services	Expenditures for UPL supplemental payments[a] by facility ownership (percentage of total expenditures for UPL payments for nursing facility services[b])		
		Local government facilities	State government facilities	Private facilities
Alabama	$0	$0 (0%)	$0 (0%)	$0 (0%)
Alaska	0	0 (0)	0 (0)	0 (0)
Arizona	0	0 (0)	0 (0)	0 (0)
Arkansas	0	0 (0)	0 (0)	0 (0)
California	78,097,703	72,318,238 (93)	0 (0)	5,779,465 (7)
Colorado	83,178,326	4,892,764 (6)	6,368,110 (8)	71,917,452 (86)
Connecticut	0	0 (0)	0 (0)	0 (0)
Delaware	0	0 (0)	0 (0)	0 (0)
District of Columbia	0	0 (0)	0 (0)	0 (0)
Florida	4,620,065	3,080,043 (67)	0 (0)	1,540,022 (33)
Georgia	0	0 (0)	0 (0)	0 (0)
Hawaii	0	0 (0)	0 (0)	0 (0)
Idaho	41,970,755	2,173,921 (5)	1,262,868 (3)	38,533,966 (92)
Illinois	0	0 (0)	0 (0)	0 (0)
Indiana	77,633,872	77,633,872 (100)	0 (0)	0 (0)
Iowa	0	(0)	0 (0)	0 (0)
Kansas	8,965,702	(0)	8,965,702 (100)	0 (0)
Kentucky	412,500	137,500 (33)	275,000 (67)	0 (0)
Louisiana	0	0 (0)	0 (0)	0 (0)
Maine	0	0 (0)	0 (0)	0 (0)
Maryland	30,205,525	0 (0)	30,205,525 (100)	0 (0)
Massachusetts	0	0 (0)	0 (0)	0 (0)
Michigan	312,999,628	55,018,621 (18)	0 (0)	257,981,007 (82)
Minnesota	0	0 (0)	0 (0)	0 (0)
Mississippi	14,765,888	14,765,888 (100)	0 (0)	0 (0)
Missouri	0	0 (0)	0 (0)	0 (0)
Montana	0	0 (0)	0 (0)	0 (0)
Nebraska	0	0 (0)	0 (0)	0 (0)
Nevada	0	0 (0)	0 (0)	0 (0)
New Hampshire	0	0 (0)	0 (0)	0 (0)
New Jersey	0	0 (0)	0 (0)	0 (0)

State	Total expenditures for UPL payments for nursing facility services	Expenditures for UPL supplemental payments[a] by facility ownership (percentage of total expenditures for UPL payments for nursing facility services[b])		
		Local government facilities	State government facilities	Private facilities
New Mexico	0	0 (0)	0 (0)	0 (0)
New York	295,778,035	295,778,035 (100)	0 (0)	0 (0)
North Carolina	0	0 (0)	0 (0)	0 (0)
North Dakota	0	0 (0)	0 (0)	0 (0)
Ohio	0	0 (0)	0 (0)	0 (0)
Oklahoma	0	0 (0)	0 (0)	0 (0)
Oregon	0	0 (0)	0 (0)	0 (0)
Pennsylvania	557,214,061	21,186,414 (4)	255,492,548 (46)	280,535,099 (50)
Rhode Island	0	0 (0)	0 (0)	0 (0)
South Carolina	0	0 (0)	0 (0)	0 (0)
South Dakota	0	0 (0)	0 (0)	0 (0)
Tennessee	0	0 (0)	0 (0)	0 (0)
Texas	0	0 (0)	0 (0)	0 (0)
Utah	0	0 (0)	0 (0)	0 (0)
Vermont	125,000	125,000 (100)	0 (0)	0 (0)
Virginia	0	0 (0)	0 (0)	0 (0)
Washington	5,178,217	3,613,867 (70)	1,564,350 (30)	0 (0)
West Virginia	0	0 (0)	0 (0)	0 (0)
Wisconsin	37,590,800	2,241,396 (6)	1,380(0)	35,348,024 (94)
Wyoming	12,004,727	0 (0)	0 (0)	12,004,727 (100)
Total	**1,560,740,804**	**552,965,559 (35)**	**304,135,483 (19)**	**703,639,762 (45)**

Source: GAO analysis of CMS data. | GAO-15-322

Note: The CMS-64 expenditure data used in this analysis included UPL supplemental payments made to nursing facilities and other supplemental payments made under the authority of Medicaid Section 1115 waiver demonstration programs.

[a]UPL supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services.

[b]In some instances, a state's reported payment for a given hospital ownership is low compared to the total reported payment. As a result, the percentage of the total payment for the hospital ownership is zero due to rounding.

Table 6: Expenditures Reported for Physician and Surgical Upper Payment Limit (UPL) Supplemental Payments for Federal Fiscal Year 2011, by State

State	Total expenditures for UPL payments for physician and surgical services	Expenditures for UPL supplemental payments[a] by facility ownership (percentage of total expenditures for UPL payments for physician and surgical services)	
		Government facilities	Private facilities
Alabama	$0	$0 (0%)	0 (0%)
Alaska	0	0 (0)	0 (0)
Arizona	0	0 (0)	0 (0)
Arkansas	28,140,514	0 (0)	0 (0)
California	271,045,671	86,117,694 (32)	28,140,514 (100)
Colorado	3,072,164	3,072,164 (100)	184,927,977 (68)
Connecticut	0	0 (0)	0 (0)
Delaware	0	0 (0)	0 (0)
District of Columbia	0	0 (0)	0 (0)
Florida	253,264,343	143,506,514 (57)	109,757,829 (43)
Georgia	0	0 (0)	0 (0)
Hawaii	0	0 (0)	0 (0)
Idaho	0	0 (0)	0 (0)
Illinois	0	0 (0)	0 (0)
Indiana	66,069,564	40,600,000 (61)	25,469,564 (39)
Iowa	0	0 (0)	0 (0)
Kansas	13,927,604	13,927,604 (100)	0 (0)
Kentucky	0	0 (0)	0 (0)
Louisiana	25,841,828	13,623,627 (53)	12,218,201 (47)
Maine	367,141	0 (0)	367,141 (100)
Maryland	0	0 (0)	(0)
Massachusetts	3,764,491	0 (0)	3,764,491 (100)
Michigan	167,474,436	125,644,010 (75)	41.830.426 (25)
Minnesota	20,020,550	20,020,550 (100)	0 (0)
Mississippi	0	0 (0)	0 (0)
Missouri	0	0 (0)	0 (0)
Montana	0	0 (0)	0 (0)
Nebraska	0	0 (0)	0 (0)
Nevada	3,165,171	3,165,171 (100)	0 (0)

State	Total expenditures for UPL payments for physician and surgical services	Expenditures for UPL supplemental payments[a] by facility ownership (percentage of total expenditures for UPL payments for physician and surgical services)	
		Government facilities	Private facilities
New Hampshire	0	0 (0)	0 (0)
New Jersey	0	0 (0)	0 (0)
New Mexico	13,418,731	9,447,472 (70)	3.971.259 (30)
New York	0	0 (0)	0 (0)
North Carolina	0	0 (0)	0 (0)
North Dakota	0	0 (0)	0 (0)
Ohio	0	0 (0)	0 (0)
Oklahoma	2,078	0 (0)	2.078 (100)
Oregon	0	0 (0)	0 (0)
Pennsylvania	0	0 (0)	0 (0)
Rhode Island	0	0 (0)	0 (0)
South Carolina	50,426,593	0 (0)	50.426.593 (100)
South Dakota	0	0 (0)	0 (0)
Tennessee	0	0 (0)	0 (0)
Texas	85,286,026	78,787,948 (92)	6.498.078 (8)
Utah	25,431,099	25,431,099 (100)	0 (0)
Vermont	0	0 (0)	0 (0)
Virginia	21,238,006	21,238,006 (100)	0 (0)
Washington	43,046,281	16,435,635 (38)	26.610.646 (62)
West Virginia	28,528,607	28,528,607 (100)	0 (0)
Wisconsin	0	0 (0)	0 (0)
Wyoming	0	0 (0)	0 (0)
Total	**1,123,530,898**	**629,546,101 (56)**	**493,984,797 (44)**

Source: GAO analysis of CMS data. | GAO-15-322

Note: The CMS-64 expenditure data used in this analysis included UPL supplemental payments made to providers and other supplemental payments made under the authority of Medicaid Section 1115 waiver demonstration programs.

[a]UPL supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services. CMS also permits states to make UPL supplemental payments for physician services that are based on the average commercial rate, which is the amount that commercial payers pay for the same services.

Table 7: Expenditures Reported for Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Upper Payment Limit (UPL) Supplemental Payments for Federal Fiscal Year 2011, by State

State	Total expenditures for UPL payments for ICF/DD services	Expenditures for UPL supplemental payments[a] by facility ownership (percentage of total expenditures for UPL payments for ICF/DD services)		
		Local government facilities	State government facilities	Private facilities
Alabama	$0	$0 (0%)	$0 (0%)	$0 (0%)
Alaska	0	0 (0)	0 (0)	0 (0)
Arizona	0	0 (0)	0 (0)	0 (0)
Arkansas	0	0 (0)	0 (0)	0 (0)
California	0	0 (0)	0 (0)	0 (0)
Colorado	0	0 (0)	0 (0)	0 (0)
Connecticut	0	0 (0)	0 (0)	0 (0)
Delaware	0	0 (0)	0 (0)	0 (0)
District of Columbia	0	0 (0)	0 (0)	0 (0)
Florida	0	0 (0)	0 (0)	0 (0)
Georgia	0	0 (0)	0 (0)	0 (0)
Hawaii	0	0 (0)	0 (0)	0 (0)
Idaho	0	0 (0)	0 (0)	0 (0)
Illinois	0	0 (0)	0 (0)	0 (0)
Indiana	0	0 (0)	0 (0)	0 (0)
Iowa	0	0 (0)	0 (0)	0 (0)
Kansas	0	0 (0)	0 (0)	0 (0)
Kentucky	0	0 (0)	0 (0)	0 (0)
Louisiana	0	0 (0)	0 (0)	0 (0)
Maine	0	0 (0)	0 (0)	0 (0)
Maryland	0	0 (0)	0 (0)	0 (0)
Massachusetts	0	0 (0)	0 (0)	0 (0)
Michigan	0	0 (0)	0 (0)	0 (0)
Minnesota	0	0 (0)	0 (0)	0 (0)
Mississippi	0	0 (0)	0 (0)	0 (0)
Missouri	0	0 (0)	0 (0)	0 (0)
Montana	0	0 (0)	0 (0)	0 (0)
Nebraska	0	0 (0)	0 (0)	0 (0)
Nevada	0	0 (0)	0 (0)	0 (0)
New Hampshire	0	0 (0)	0 (0)	0 (0)
New Jersey	0	0 (0)	0 (0)	0 (0)
New Mexico	0	0 (0)	0 (0)	0 (0)

State	Total expenditures for UPL payments for ICF/DD services	Expenditures for UPL supplemental payments[a] by facility ownership (percentage of total expenditures for UPL payments for ICF/DD services)		
		Local government facilities	State government facilities	Private facilities
New York	0	0 (0)	0 (0)	0 (0)
North Carolina	0	0 (0)	0 (0)	0 (0)
North Dakota[b]	-481,014	0 (0)	0 (0)	-481,014 (N/A)
Ohio	0	0 (0)	0 (0)	0 (0)
Oklahoma	0	0 (0)	0 (0)	0 (0)
Oregon	0	0 (0)	0 (0)	0 (0)
Pennsylvania	0	0 (0)	0 (0)	0 (0)
Rhode Island	0	0 (0)	0 (0)	0 (0)
South Carolina	0	0 (0)	0 (0)	0 (0)
South Dakota	0	0 (0)	0 (0)	0 (0)
Tennessee	0	0 (0)	0 (0)	0 (0)
Texas	0	0 (0)	0 (0)	0 (0)
Utah	0	0 (0)	0 (0)	0 (0)
Vermont	0	0 (0)	0 (0)	0 (0)
Virginia	0	0 (0)	0 (0)	0 (0)
Washington	0	0 (0)	0 (0)	0 (0)
West Virginia	0	0 (0)	0 (0)	0 (0)
Wisconsin	312,000	0 (0)	0 (0)	312,000 (100)
Wyoming	0	0 (0)	0 (0)	0 (0)
Total	**- 169,014**	**0 (0)**	**0 (0)**	**- 169,014 (N/A)**

Legend: N/A indicates not available.

Source: GAO analysis of CMS data. | GAO-15-322

Note: The CMS-64 expenditure data used in this analysis included UPL supplemental payments made to ICF/DD facilities and other supplemental payments made under the authority of Medicaid Section 1115 waiver demonstration programs.

[a]UPL supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services.

[b]For federal fiscal year 2011, North Dakota reported UPL supplemental payments to intermediate care facilities for the developmentally disabled (ICF/DD), but also reported a negative adjustment for payments made in a prior year. The negative adjustment—a recoupment by CMS in 2011 for disallowed payments from a prior year—was greater than the total UPL supplemental ICF/DD payments the state otherwise made, and, as a result, the total payments for this category of service were negative.

Table 8: Expenditures Reported for Other Practitioner Upper Payment Limit (UPL) Supplemental Payments for Federal Fiscal Year 2011, by State

State	Total expenditures for UPL payments for other practitioner services	Expenditures for UPL supplemental payments[a] by facility ownership (percentage of total expenditures for UPL payments for other practitioner services)	
		Government facilities	Private facilities
Alabama	$0	$0 (0%)	$0 (0%)
Alaska	0	0 (0)	0 (0)
Arizona	0	0 (0)	0 (0)
Arkansas	0	0 (0)	0 (0)
California	0	0 (0)	0 (0)
Colorado	0	0 (0)	0 (0)
Connecticut	0	0 (0)	0 (0)
Delaware	0	0 (0)	0 (0)
District of Columbia	0	0 (0)	0 (0)
Florida	0	0 (0)	0 (0)
Georgia	0	0 (0)	0 (0)
Hawaii	0	0 (0)	0 (0)
Idaho	0	0 (0)	0 (0)
Illinois	0	0 (0)	0 (0)
Indiana	0	0 (0)	0 (0)
Iowa	0	0 (0)	0 (0)
Kansas	1,024,260	1,024,260 (100)	0 (0)
Kentucky	0	0 (0)	0 (0)
Louisiana	0	0 (0)	0 (0)
Maine	742,476	0 (0)	742,476 (100)
Maryland	0	0 (0)	0 (0)
Massachusetts	0	0 (0)	0 (0)
Michigan	0	0 (0)	0 (0)
Minnesota	0	0 (0)	0 (0)
Mississippi	0	0 (0)	0 (0)
Missouri	0	0 (0)	0 (0)
Montana	0	0 (0)	0 (0)
Nebraska	0	0 (0)	0 (0)
Nevada	0	0 (0)	0 (0)

State	Total expenditures for UPL payments for other practitioner services	Expenditures for UPL supplemental payments[a] by facility ownership (percentage of total expenditures for UPL payments for other practitioner services)	
		Government facilities	Private facilities
New Hampshire	0	0 (0)	0 (0)
New Jersey	0	0 (0)	0 (0)
New Mexico	0	0 (0)	0 (0)
New York	0	0 (0)	0 (0)
North Carolina	0	0 (0)	0 (0)
North Dakota	0	0 (0)	0 (0)
Ohio	0	0 (0)	0 (0)
Oklahoma	0	0 (0)	0 (0)
Oregon	0	0 (0)	0 (0)
Pennsylvania	0	0 (0)	0 (0)
Rhode Island	0	0 (0)	0 (0)
South Carolina	0	0 (0)	0 (0)
South Dakota	0	0 (0)	0 (0)
Tennessee	0	0 (0)	0 (0)
Texas	0	0 (0)	0 (0)
Utah	0	0 (0)	0 (0)
Vermont	0	0 (0)	0 (0)
Virginia	0	0 (0)	0 (0)
Washington	0	0 (0)	0 (0)
West Virginia	0	0 (0)	0 (0)
Wisconsin	0	0 (0)	0 (0)
Wyoming	0	0 (0)	0 (0)
Total	**1,766,736**	**1,024,260 (58)**	**742,476 (42)**

Source: GAO analysis of CMS data. | GAO-15-322

Note: The CMS-64 expenditure data used in this analysis included UPL supplemental payments made to providers and other supplemental payments made under the authority of Medicaid Section 1115 waiver demonstration programs.

[a]UPL supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services. CMS also permits states to make UPL supplemental payments for qualified practitioner services that are based on the average commercial rate, which is the amount that commercial payers pay for the same services.

Table 9: Expenditures Reported for Intermediate Care for the Developmentally Disabled (ICF/DD) Regular Payments for Federal Fiscal Year 2011, by State

State	Total expenditures for regular payments for ICF/DD services	Expenditures for regular payments by facility ownership (percentage of total expenditures for regular payments for ICF/DD services[a])	
		Government facilities	Private facilities
Alabama	$32,663,152	$30,071,582 (92%)	$2,591,570 (8%)
Alaska[b]	2,247,396	-492,240 (N/A	2,739,636 (N/A)
Arizona	0	0 (0)	0 (0)
Arkansas	156,748,162	134,347,581 (86)	22,400,581 (14)
California	698,011,299	328,952,418 (47)	369,058,881 (53)
Colorado	40,257,118	39,332,094 (98)	925,024 (2)
Connecticut	284,020,016	219,371,262 (77)	64,648,754 (23)
Delaware	40,994,246	32,897,549 (80)	8,096,697 (20)
District of Columbia	66,639,204	0 (0)	66,639,204 (100)
Florida	329,999,412	92,741,128 (28)	237,258,284 (72)
Georgia	60,072,483	54,891,071 (91)	5,181,412 (9)
Hawaii	9,200,707	0 (0)	9,200,707 (100)
Idaho	73,714,981	23,466,522 (32)	50,248,459 (68)
Illinois	893,419,844	512,715,351 (57)	380,704,493 (43)
Indiana	299,056,863	1,795,817 (1)	297,261,046 (99)
Iowa	323,152,424	159,337,117 (49)	163,815,307 (51)
Kansas	69,532,900	56,078,329 (81)	13,454,571 (19)
Kentucky	135,213,449	108,256,719 (80)	26,956,730 (20)
Louisiana	436,895,808	206,423,459 (47)	230,472,349 (53)
Maine	65,648,093	1,408,777 (2)	64,239,316 (98)
Maryland	1,453,527	1,416,561 (97)	36,966 (3)
Massachusetts	160,519,485	160,486,721 (100)	32,764 (0)
Michigan	13,756,992	13,756,992 (100)	0 (0)
Minnesota	166,901,149	9,859,584 (6)	157,041,565 (94)
Mississippi	267,462,556	218,060,540 (82)	49,402,016 (18)
Missouri	340,775,234	125,526,256 (37)	215,248,978 (63)
Montana	12,355,113	12,301,534 (100)	53,579 (0)
Nebraska	27,583,942	5,493,059 (20)	22,090,883 (80)
Nevada	18,490,052	10,977,009 (59)	7,513,043 (41)

State	Total expenditures for regular payments for ICF/DD services	Expenditures for regular payments by facility ownership (percentage of total expenditures for regular payments for ICF/DD services[a])	
		Government facilities	Private facilities
New Hampshire	2,991,337	2,991,337 (100)	0 (0)
New Jersey	640,417,676	629,068,207 (98)	11,349,469 (2)
New Mexico	25,004,113	1,803,773 (7)	23,200,340 (93)
New York	3,685,657,786	2,600,760,271 (71)	1,084,897,515 (29)
North Carolina	492,816,202	253,280,257 (51)	239,535,945 (49)
North Dakota	88,901,875	24,407,113 (27)	64,494,762 (73)
Ohio	723,804,818	249,621,679 (34)	474,183,139 (66)
Oklahoma	128,814,436	72,278,419 (56)	56,536,017 (44)
Oregon	55,339	55,339 (100)	0 (0)
Pennsylvania	593,913,663	277,712,769 (47)	316,200,894 (53)
Rhode Island	11,304,164	4,441,741 (39)	6,862,423 (61)
South Carolina	136,350,495	136,350,495 (100)	0 (0)
South Dakota	26,776,854	26,776,854 (100)	0 (0)
Tennessee	193,254,599	101,272,979 (52)	91,981,620 (48)
Texas	1,074,253,314	776,977,181 (72)	297,276,133 (28)
Utah	65,443,808	33,702,898 (51)	31,740,910 (49)
Vermont	0	0 (0)	0 (0)
Virginia	285,193,690	219,877,498 (77)	65,316,192 (23)
Washington	129,437,996	123,255,561 (95)	6,182,435 (5)
West Virginia	62,024,336	14,970,055 (24)	47,054,281 (76)
Wisconsin	139,766,877	116,146,880 (83)	23,619,997 (17)
Wyoming	20,164,145	20,164,145 (100)	0 (0)
Total	**13,553,133,130**	**8,245,388,243 (61)**	**5,307,744,887 (39)**

Legend: N/A indicates not available.

Source: GAO analysis of CMS data. | GAO-15-322

Note: The CMS-64 expenditure data used in this analysis included regular payments made to ICF/DD facilities and other supplemental payments made under the authority of Medicaid Section 1115 waiver demonstration programs.

[a]In some instances, a state's reported payment for a given hospital ownership is low compared to the total reported payment. As a result, the percentage of the total payment for the hospital ownership is zero due to rounding.

[b]For federal fiscal year 2011, Alaska reported a negative adjustment for regular payments to government providers for ICF/DD services. The negative adjustment was a recoupment by CMS in 2011 for disallowed payments from a prior year.

Table 10: Expenditures Reported for School-Based Regular Payments for Federal Fiscal Year 2011, by State

State	Total expenditures for regular payments for school-based services	Expenditures for regular payments by facility ownership (percentage of total expenditures for regular payments for school-based services)	
		Government facilities	Private facilities
Alabama	$0	$0 (0%)	$0 (0%)
Alaska	0	0(0)	0 (0)
Arizona	35,668,377	35,668,377 (100)	0 (0)
Arkansas	18,666,924	18,666,924 (100)	0 (0)
California	258,659,606	258,659,606 (100)	0 (0)
Colorado	19,681,500	19,681,500 (100)	0 (0)
Connecticut	19,595,470	19,595,470 (100)	0 (0)
Delaware	0	0 (0)	0 (0)
District of Columbia	3,139,170	3,139,170 (100)	0 (0)
Florida	9,402,161	9,402,161 (100)	0 (0)
Georgia	0	0 (0)	0 (0)
Hawaii	936	936 (100)	0 (0)
Idaho	35,670,357	35,670,357 (100)	0 (0)
Illinois	187,628,691	187,628,691 (100)	0 (0)
Indiana	4,843,565	4,843,565 (100)	0 (0)
Iowa	63,399,231	63,399,231 (100)	0 (0)
Kansas	35,274,001	35,274,001 (100)	0 (0)
Kentucky	6,711,435	6,711,435 (100)	0 (0)
Louisiana	0	0 (0)	0 (0)
Maine	24,888,347	24,888,347 (100)	0 (0)
Maryland	67,895,891	67,895,891 (100)	0 (0)
Massachusetts	62,459,036	62,459,036 (100)	0 (0)
Michigan	249,768,681	249,768,681 (100)	0 (0)
Minnesota	57,642,917	57,642,917 (100)	0 (0)
Mississippi	2,325,470	2,325,470 (100)	0 (0)
Missouri	0	0 (0)	0 (0)
Montana	35,312,353	35,312,353 (100)	0 (0)
Nebraska	5,501,779	5,501,779 (100)	0 (0)
Nevada	15,054,474	15,054,474 (100)	0 (0)
New Hampshire	0	0 (0)	0 (0)

State	Total expenditures for regular payments for school-based services	Expenditures for regular payments by facility ownership (percentage of total expenditures for regular payments for school-based services)	
		Government facilities	Private facilities
New Jersey	0	0 (0)	0 (0)
New Mexico	10,948,231	10,948,231 (100)	0 (0)
New York	113,771,876	113,771,876 (100)	0 (0)
North Carolina	53,403,436	53,403,436 (100)	0 (0)
North Dakota	1,921,759	1,921,759 (100)	0 (0)
Ohio	37,753,270	37,753,270 (100)	0 (0)
Oklahoma	7,666,262	7,666,262 (100)	0 (0)
Oregon	5,179,232	5,179,232 (100)	0 (0)
Pennsylvania	261,841,351	261,841,351 (100)	0 (0)
Rhode Island	35,153,908	35,153,908 (100)	0 (0)
South Carolina	19,638,989	19,638,989 (100)	0 (0)
South Dakota	2,993,593	2,993,593 (100)	0 (0)
Tennessee	0	0 (0)	0 (0)
Texas	0	0 (0)	0 (0)
Utah	24,273,340	24,273,340 (100)	0 (0)
Vermont	14,559	14,559 (100)	0 (0)
Virginia	15,442,643	15,442,643 (100)	0 (0)
Washington	4,408,671	4,408,671 (100)	0 (0)
West Virginia	50,850,990	50,850,990 (100)	0 (0)
Wisconsin	149,273,704	149,273,704 (100)	0 (0)
Wyoming	0	0 (0)	0 (0)
Total	**2,013,726,186**	**2,013,726,186 (100)**	**0 (0)**

Source: GAO analysis of CMS data. | GAO-15-322

Note: The CMS-64 expenditure data used in this analysis included regular payments made to facilities and other supplemental payments made under the authority of Medicaid Section 1115 waiver demonstration programs.

Appendix IV: Results of Analysis of Medicaid Inpatient Payments for Government Hospitals and Private Hospitals in Illinois

This appendix provides the results of our analysis of Medicaid payments for inpatient services provided in state fiscal year 2011 in Illinois by hospital ownership.

- Table 11 shows, by hospital ownership, the Illinois hospitals' average daily payment, minimum and maximum daily payment, and median daily payment for regular and upper payment limit (UPL) supplemental payments combined.
- Table 12 shows, by hospital ownership, Illinois hospitals' state fiscal year 2011 inpatient service Medicaid regular payments, UPL supplemental payments, Disproportionate Share Hospital supplemental payments, and a third type of Medicaid supplemental payment that three local government hospitals received.

Table 11: Illinois Hospitals' Average, Minimum, Maximum, and Median Daily Payments for Medicaid Inpatient Hospital Services in State Fiscal Year 2011, by Hospital Ownership

	Regular and upper payment limit (UPL) supplemental payments[a]			
Hospital ownership (number of hospitals)	**Average daily payment**	**Minimum daily payment**	**Maximum daily payment**	**Median daily payment**
Local government (21)	$2,640	$552	$9,822	$2,244
State government (1)	2,666	2,666	2,666	2,666
Private (171)	2,620	754	11,2 39	2,423

Source: GAO analysis of data from CMS (inpatient hospital claims) and Illinois (provider ownership and supplemental payments). | GAO-15-322

Notes: The regular payments included in this table were adjusted to account for differences in the conditions of the patients treated at the hospitals. Approximately 76 percent of hospitals had regular payments that were adjusted.

To calculate the average daily payment for each hospital ownership group, we first calculated each hospital's daily payment amount by dividing total Medicaid inpatient hospital payments—regular and UPL supplemental payments combined—by total Medicaid inpatient hospital days. Then, by ownership group, we added together the relevant hospitals' daily payment amounts and divided that by the number of hospitals in the ownership group.

[a]UPL supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services.

Table 12: Illinois Medicaid Payments for Inpatient Hospital Services in State Fiscal Year 2011, by Hospital Ownership

Hospital ownership (number of hospitals)	Regular Medicaid payments	Upper Payment Limit supplemental payments[a]	Disproportionate Share Hospital supplemental payments[b]	BIPA Medicaid supplemental payments[c]
Local government (21)	$192,566,491	$9,138,694	$303,740,571	$747,123,624
State government (1)	120,904,234	3,407,941	26,697,843	0
Private (171)	2,273,215,246	1,362,416,307	4,191,104	0

Source: GAO analysis of data from CMS (inpatient hospital claims) and Illinois (provider ownership and supplemental payments). | GAO-15-322

Note: The regular payments included in this table were adjusted to account for differences in the conditions of the patients treated at the hospitals. Approximately 76 percent of hospitals had regular payments that were adjusted.

[a]Upper payment limit (UPL) supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services.

[b]Disproportionate Share Hospital (DSH) supplemental payments are designed to help offset a hospital's uncompensated care costs—costs incurred in providing services to Medicaid and uninsured patients, minus any payments made for the Medicaid and uninsured patients—for hospitals that serve large numbers of Medicaid and uninsured low-income individuals. States are required by federal law to make these payments to certain hospitals. See 42 U.S.C. §§ 1396a(13)(A), 1396r-4.

[c]The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) authorizes Medicaid supplemental payments for hospitals that, as of October 1, 2000, (1) are state- or local-owned or -operated, (2) are not receiving Medicaid DSH supplemental payments, and (3) have a low income utilization rate in excess of 65 percent. Pub. L. No. 106-554, § 701(d), 114 Stat. 2763, 2763A-571 (Dec. 1, 2000). According to CMS officials, while eligibility for BIPA supplemental payments includes the requirement that a hospital must not have been receiving DSH supplemental payments on October 1, 2000, hospitals could subsequently receive DSH supplemental payments and remain eligible for BIPA supplemental payments.

Appendix V: Results of Analysis of Medicaid Payments and Costs for Selected Illinois Hospitals

This appendix provides the results of our analysis comparing seven selected Illinois hospitals' Medicaid payments for inpatient services to their Medicaid costs for inpatient services and total operating costs in state fiscal year 2011.

- Table 13 compares, for each of the seven selected Illinois hospitals, Medicaid payments for inpatient services—including regular payments, upper payment limit (UPL) supplemental payments, and the total regular and UPL supplemental payments—to total estimated Medicaid costs for providing inpatient services in state fiscal year 2011.
- Table 14 compares, for the seven selected Illinois hospitals, Medicaid inpatient service payments to total estimated operating costs for all services and all patients for state fiscal year 2011. Medicaid payments include regular and UPL supplemental payments for hospital inpatient services, total Disproportionate Share Hospital supplemental payments, and Medicaid supplemental payments authorized under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).

Table 13: Medicaid Payments and Costs for Inpatient Services for Seven Selected Illinois Hospitals, State Fiscal Year 2011

Hospital	Hospital ownership	Hospital type	Regular payments	UPL supplemental payments[a]	Regular and UPL supplemental payments	Estimated Medicaid costs for inpatient services	Difference between Medicaid payments and estimated Medicaid costs
1	Private	Acute care hospital	$20,709,564	$10,684,716	$31,394,280	$13,192,998	$18,201,283
2	Private	Acute care hospital	4,057,516	4,059,230	8,116,746	3,244,133	4,872,613
3	Local government	Acute care hospital	132,508,720	994,343	133,503,063	132,847,663	655,400
4	Local government	Acute care hospital	519,948	857,506	1,377,454	786,069	591,385
5	Local government	Acute care hospital	76,375	409,160	485,535	172,389	313,146
6	Private	Acute care hospital	25,646	317,120	342,766	69,859	272,908
7	State government	Acute care hospital	120,904,234	3,407,941	124,312,175	128,212,185	-3,900,010

Source: GAO analysis of data from CMS (inpatient hospital claims) and Illinois (provider ownership, supplemental payments, and Medicaid cost reports). | GAO-15-322

Note: These hospitals were selected based on having the highest daily payment amounts—including regular payments that were adjusted to account for differences in the conditions of the patients treated at the hospitals, commonly referred to as "case-mix" adjustment, and upper payment limit (UPL) supplemental payments—in each provider ownership group: local government, state government, and private. We selected a total of seven hospitals—three local government hospitals, the state's one state government hospital, and three private hospitals. In determining total Medicaid payments for inpatient services, we included nonadjusted regular payments—that is, the actual regular payments that were not adjusted for the severity of the patients' illnesses—along with the UPL supplemental payments.

[a]UPL supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services.

Table 14: Medicaid Payments for Inpatient Services and Related Supplemental Payments and Total Operating Costs for Seven Selected Illinois Hospitals, State Fiscal Year 2011

Hospital	Hospital ownership	Regular and UPL supplemental payments[a]	DSH supplemental payments[b]	BIPA Medicaid supplemental payments[c]	Total Medicaid payments (regular, UPL supplemental, DSH supplemental, and BIPA supplemental payments)	Estimated operating costs	Difference between Medicaid payments and total operating costs
1	Private	$31,394,280	$56,280	$0	$31,450,561	$110,199,043	-$78,748,438
2	Private	8,166,746	0	0	8,116,746	42,534,656	-34,417,910
3	Local government	133,503,063	243,783,486	529,717,021	907,003,570	540,135,755	366,867,815
4	Local government	1,377,454	0	0	1,377,454	21,528,494	-20,151,040
5	Local government	485,535	0	0	485,535	16,716,245	-16,230,710
6	Private	342,766	0	0	342,766	18,182,646	-17,839,880
7	State government	124,312,175	26,697,843	0	151,010,018	486,449,483	-335,439,465

Source: GAO analysis of data from CMS (inpatient hospital claims) and Illinois (provider ownership, supplemental payments, and Medicaid cost reports). | GAO-15-322

Note: These hospitals were selected based on having the highest daily payment amounts—including regular payments that were adjusted to account for differences in the conditions of the patients treated at the hospitals, commonly referred to as "case-mix" adjustment, and upper payment limit (UPL) supplemental payments—in each provider ownership group: local government, state government, and private. We selected a total of seven hospitals: three local government hospitals, the state's one state government hospital, and three private hospitals. In determining Medicaid payments for inpatient services and related supplemental payments, we included nonadjusted regular payments—that is, we used the actual regular payments and did not adjust for the severity of the patients' illnesses, UPL supplemental payments, Disproportionate Share Hospital (DSH) supplemental payments, and Medicaid supplemental payments authorized under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). We did not include regular and supplemental payments for outpatient services because we were unable to analyze Medicaid payments for outpatient services.

[a]UPL supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services.

[b]DSH supplemental payments are designed to help offset a hospital's uncompensated care costs—costs incurred in providing services to Medicaid and uninsured patients, minus any payments made for the Medicaid and uninsured patients—for hospitals that serve large numbers of Medicaid and uninsured low-income individuals. States are required by federal law to make these payments to certain hospitals. See 42 U.S.C. §§ 1396a(13)(A), 1396r-4.

[c]The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) authorizes Medicaid supplemental payments for hospitals that, as of October 1, 2000, (1) are state- or local-owned or -operated, (2) are not receiving Medicaid DSH supplemental payments, and (3) have a low income utilization rate in excess of 65 percent. Pub. L. No. 106-554, § 701(d), 114 Stat. 2763, 2763A-571 (Dec. 1, 2000). According to CMS officials, while eligibility for BIPA supplemental payments includes the requirement that a hospital must not have been receiving DSH supplemental payments on October 1, 2000, hospitals could subsequently receive DSH supplemental payments and remain eligible for BIPA supplemental payments.

Appendix VI: Results of Analysis of Medicaid Inpatient Payments for Government Hospitals and Private Hospitals in New York

This appendix provides the results of our analysis of Medicaid payments for inpatient services provided in state fiscal year 2011 in New York by hospital ownership.

- Table 15 shows, by hospital ownership, the New York hospitals' average daily payment, minimum and maximum daily payment, and median daily payment for regular and upper payment limit (UPL) supplemental payments combined.
- Table 16 shows, by hospital ownership, New York hospitals' state fiscal year 2011 inpatient service Medicaid regular payments, UPL supplemental payments, and Disproportionate Share Hospital supplemental payments.

Table 15: New York Hospitals' Average, Minimum, Maximum, and Median Daily Payments for Medicaid Inpatient Hospital Services in State Fiscal Year 2011, by Hospital Ownership

	Regular and upper payment limit (UPL) supplemental payments[a]			
Hospital ownership (number of hospitals)	**Average daily payment**	**Minimum daily payment**	**Maximum daily payment**	**Median daily payment**
Local government (20)	$1,514	$198	$9,176	$1,068
State government (5)	1,140	742	1,958	972
Private (176)	933	144	3,414	850

Source: GAO analysis of data from CMS (inpatient hospital claims) and New York (provider ownership and supplemental payments). | GAO-15-322

Notes: The regular payments included in this table were adjusted to account for differences in the conditions of the patients treated at the hospitals. Approximately 79 percent of hospitals had regular payments that were adjusted.

To calculate the average daily payment for each hospital ownership group, we first calculated each hospital's daily payment by dividing total Medicaid inpatient hospital payments—regular and UPL supplemental payments combined—by total Medicaid inpatient hospital days. Then, by ownership group, we added together the relevant hospitals' daily payments and divided that by the number of hospitals in the ownership group.

[a]UPL supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services.

Table 16: New York Medicaid Payments for Inpatient Hospital Services in State Fiscal Year 2011, by Hospital Ownership

Hospital ownership (number of hospitals)	Regular Medicaid payments	Upper payment limit (UPL) supplemental payments[a]	Disproportionate Share Hospital (DSH) supplemental payments[b]
Local government (20)	$ 1,239,274,125	$415,840,379	$ 1,381,651,361
State government (5)	129,979,572	0	250,225,895
Private (176)	2,787,792,243	235,137,644	670,227,877

Source: GAO analysis of data from CMS (inpatient hospital claims) and New York (provider ownership and supplemental payments). | GAO-15-322

Note: The regular payments included in this table were adjusted to account for differences in the conditions of the patients treated at the hospitals. Approximately 79 percent of hospitals had regular payments that were adjusted.

[a]UPL supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services.

[b]DSH supplemental payments are designed to help offset a hospital's uncompensated care costs—costs incurred in providing services to Medicaid and uninsured patients, minus any payments made for the Medicaid and uninsured patients—for hospitals that serve large numbers of Medicaid and uninsured low-income individuals. States are required by federal law to make these payments to certain hospitals. See 42 U.S.C. §§ 1396a(13)(A), 1396r-4.

Appendix VII: Results of Analysis of Medicaid Payments and Costs for Selected New York Hospitals

This appendix provides the results of our analysis comparing nine selected New York hospitals' Medicaid payments for inpatient services to their Medicaid costs for inpatient services and total operating costs in state fiscal year 2011.

- Table 17 compares, for each of the nine selected New York hospitals, Medicaid inpatient service payments—including regular payments, upper payment limit (UPL) supplemental payments, and total regular and UPL supplemental payments—to total estimated Medicaid costs for providing inpatient services in state fiscal year 2011.
- Table 18 compares, for the nine selected New York hospitals, Medicaid inpatient service payments to total estimated operating costs for all services and all patients for state fiscal year 2011. Medicaid payments include regular and UPL supplemental payments for hospital inpatient services and total Disproportionate Share Hospital supplemental payments.

Table 17: Medicaid Payments and Costs for Inpatient Services for Seven Selected New York Hospitals, State Fiscal Year 2011

Hospital	Hospital ownership	Hospital type	Regular payments	UPL supplemental payments[a]	Regular and UPL supplemental payments	Estimated Medicaid costs for inpatient services	Difference between Medicaid payments and estimated Medicaid costs
1	Local government	Long term care hospital	$15,512,263	$216,485,084	$231,997,347	$21,362,047	$210,635,300
2	Local government	Long term care hospital	54,673,521	199,355,295	254,028,816	67,562,956	186,465,860
3	Private	Acute care hospital	957,574	267,762	1,225,336	959,883	265,453
4	Private	Acute care hospital	954,547	0	954,547	830,433	124,114
5	State government	Acute care hospital	3,229,231	0	3,229,231	4,207,888	-978,657
6	State government	Acute care hospital[b]	4,783,149	0	4,783,149	7,739,530	-2,956,381
7	Private	Acute care hospital[b]	23,144,226	352,805	23,497,031	32,356,999	-8,859,968
8	Local government	Acute care hospital	125,731,870	0	125,731,870	191,076,400	-65,344,530
9	State government	Acute care hospital	72,186,424	0	72,186,424	161,636,494	-89,450,070

Source: GAO analysis of data from CMS (inpatient hospital claims) and New York (provider ownership, supplemental payments, and Medicaid cost reports). | GAO-15-322

Notes: These hospitals were selected based on having the highest daily payments—including regular payments that were adjusted to account for differences in the conditions of the patients treated at the hospitals, commonly referred to as "case-mix" adjustment, and upper payment limit (UPL) supplemental payments in each provider ownership group—local government, state government, and private. We selected a total of nine hospitals—three local government hospitals, three state government hospitals, and three private hospitals. In determining total Medicaid payments for inpatient services to compare to costs, we included nonadjusted regular payments and UPL supplemental payments. That is, we used the actual regular payments and did not adjust for the severity of the patients' illnesses.

[a]UPL supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services.

[b]This hospital is an acute care hospital that is also a designated cancer hospital.

Table 18: Medicaid Payments for Inpatient Services and Related Supplemental Payments and Total Operating Costs for Nine Selected New York Hospitals, State Fiscal Year 2011

Hospital	Hospital ownership	Regular and UPL supplemental payments[a]	DSH supplemental payments[b]	Medicaid payments for regular, UPL supplemental, and DSH supplemental payments	Estimated operating costs	Difference between Medicaid payments—regular, UPL supplemental, and DSH supplemental—and estimated costs
1	Local government	$231,997,347	$0	$231,997,347	$156,958,974	$75,038,373
2	Local government	254,028,816	0	254,028,816	185,104,147	68,924,670
3	Private	1,225,336	245,176	1,470,512	39,357,997	-37,887,485
4	Private	954,547	7,621,320	8,575,867	113,995,061	-105,419,194
5	State government	3,229,231	1,016,857	4,246,088	73,993,349	-69,747,261
6	State government	4,783,149	5,972,983	10,756,132	419,448,706	-408,692,574
7	Private	23,497,031	10,255,247	33,752,278	1,486,212,262	- 1,452,459,984
8	Local government	125,731,870	110,467,791	236,199,661	511,174,539	- 274,974,878
9	State government	72,186,424	92,350,303	164,536,727	541,711,851	- 377,175,124

Source: GAO analysis of data from CMS (inpatient hospital claims) and New York (provider ownership, supplemental payments, and Medicaid cost reports). | GAO-15-322

Notes: These hospitals were selected based on having the highest daily payment amounts—including regular payments that were adjusted to account for differences in the conditions of the patients treated at the hospitals commonly referred to as "case-mix" adjustment, and upper payment limit (UPL) supplemental payments—in each provider ownership group: local government, state government, and private. We selected a total of nine hospitals: three local government hospitals, three state government hospitals, and three private hospitals. In determining Medicaid payments for inpatient services and related supplemental payments, we included nonadjusted regular payments—that is, we used the actual regular payments and did not adjust for the severity of the patients' illnesses, UPL supplemental payments and Disproportionate Share Hospital (DSH) supplemental payments. We did not include regular and supplemental payments for outpatient services because we were unable to analyze Medicaid payments for outpatient services.

[a]UPL supplemental payments are Medicaid payments that are above the regular Medicaid payments but within the UPL, which is a reasonable estimate of what Medicare—the federal health program that covers seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons—would pay for comparable services. These payments are defined as the estimated amount that Medicare would pay for comparable services.

[b]DSH supplemental payments are designed to help offset a hospital's uncompensated care costs—costs incurred in providing services to Medicaid and uninsured patients, minus any payments made for the Medicaid and uninsured patients—for hospitals that serve large numbers of Medicaid and uninsured low-income individuals. States are required by federal law to make these payments to certain hospitals. See 42 U.S.C. §§ 1396a(13)(A), 1396r-4.

Appendix VIII: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

MAR 18 2015

Katherine Iritani
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, *"MEDICAID: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy"* (GAO-15-322).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: CMS OVERSIGHT OF PROVIDER PAYMENTS IS HAMPERED BY LIMITED DATA AND UNCLEAR POLICY (GAO-15-322)

The U.S. Department of Health and Human Services (HHS) appreciates the Government Accountability Office (GAO) for the opportunity to review and comment on this draft report.

HHS takes seriously our responsibility to assure that Federal Medicaid funds are appropriately spent. Oversight of states' financial management of their Medicaid programs is a critical component of the Centers for Medicare & Medicaid Services' (CMS) work. To promote efficiency, economy, and quality of care, HHS sets an outer bound, the Medicaid Upper Payment Limit (UPL), for how much states can pay providers under certain fee-for-service arrangements. The UPL for institutional providers such as hospitals and nursing facilities is not a limit on payments to individual providers, but is calculated in the aggregate for each affected category of Medicaid services and for each provider type (private, non-state government, and state-government-owned).

HHS has taken several steps over the past few years to improve transparency into supplemental payments. For the first time, beginning in 2013, HHS began collecting annual Upper Payment Limit (UPL) data which includes provider specific information as well as the Disproportionate Share Hospital (DSH) specific reporting information. HHS reviews payment methodologies to determine compliance with statutory requirements and requires additional information or justification if needed. Provider ownership information is collected through survey and certification systems and HHS is exploring ways to efficiently incorporate this information into the review process.

In addition, HHS is required to follow the statutory provisions currently in place related to supplemental payments, including allowing states the option to make supplemental payments on top of the base payments that in the aggregate, would be measured only against the Upper Payment Limit (UPL) for the service type. In 2007, HHS issued a final regulation that would have limited Medicaid payments made to government providers to the actual cost incurred by the provider for Medicaid covered services. However, Congress placed a moratorium on the regulation and then passed that it was the Sense of Congress that the regulation not be finalized. As a result, HHS rescinded the regulatory guidance.

Turning to the GAO's findings, HHS is currently working with New York to evaluate payment methodologies and individual payment levels. It is important to note that the overall UPL room based upon HHS review of information is accurate, however, the state's distribution of payments continues to be evaluated by HHS. Illinois is currently working to modernize its inpatient and outpatient reimbursement methodologies. In a State Plan Amendment (SPA) submitted in 2014, the state is changing a portion of its reimbursement methodology to a base payment that is adequate for access and quality of services and is transitioning to lowering or eliminating some of the supplemental payments. Prior to this SPA submission, the hospitals' base payments were under-funded and the state used supplemental payments to make up for these shortfalls. In addition, the selection of California, Illinois and New York may not be representative of state Medicaid programs overall. These states rely heavily on supplemental payments and not all states utilize the same type of reimbursement approaches. By examining only these very large state programs, the report does not reveal the national scope of the issues raised in its review.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: CMS OVERSIGHT OF PROVIDER PAYMENTS IS HAMPERED BY LIMITED DATA AND UNCLEAR POLICY (GAO-15-322)

GAO Recommendation #1
GAO recommends that CMS take steps to ensure states report accurate provider-specific payment data that includes accurate unique national provider identifiers (NPI).

HHS Response
HHS concurs with the GAO's recommendation. HHS requires states to provide NPIs on all claims, encounters and financial transactions. In addition, states are expected to provide a crosswalk of state-specific provider identifiers to NPIs as part of their provider file submissions. HHS is considering an enhancement of its review of the state-submitted Provider File submissions, including NPIs, by comparing the states' submissions to the National Plan & Provider Enumeration System (NPPES) Data Dissemination File or direct interface to NPPES for all providers who have NPIs. Potential anomalies will be identified and follow-up actions initiated with the affected states.

GAO Recommendation #2
GAO recommends (1) CMS develop a policy establishing criteria for when such payment at the provider level are economical and efficient and (2) that after criteria are developed that CMS develop a process for identifying and reviewing payments to individual providers in order to determine whether they are economical and efficient.

HHS Response
HHS concurs with the GAO's recommendation. HHS has taken steps to gather additional information on provider specific payments and has enlisted the resources of a contractor to help discern the voluminous amount of payment information in order to inform future policy direction. As indicated in the draft report, HHS is evaluating ways to improve its oversight.

HHS is gathering information from states' annual UPL and DSH audit submissions to better inform individual provider level payment criteria and establish policies and procedures to evaluate whether payments at the provider level are economic and efficient.

GAO Recommendation #3
To ensure the appropriateness of Medicaid Payments to providers in New York and in view of the findings in this report, we recommend that the Administrator of CMS expedite the formal determination of the appropriateness of New York's payment arrangements and ensure future payments to local government hospitals are consistent with all Medicaid requirements.

HHS Response
HHS concurs with the GAO's Recommendation. HHS continues to work with the state to ensure the appropriateness of payments and has worked with the state to ensure that payments are reasonable. There have been several modifications to proposals from the state to achieve equity and adherence to fee-for-service state plan requirements.

Appendix IX: GAO Contact and Staff Acknowledgments

GAO Contact

Katherine M. Iritani, (202) 512-7114 or iritanik@gao.gov

Staff Acknowledgments

In addition to the contact named above, Tim Bushfield (Assistant Director), Pauline Adams, Elizabeth Conklin, Iola D'Souza, Julianne Flowers, Vikki Porter, Roseanne Price, and Sandra George made key contributions to this report.

Related GAO Products

High-Risk Series: An Update. GAO-15-290. Washington, D.C.: February 11, 2015.

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

Medicaid: Completed and Preliminary Work Indicates That Transparency around State Financing Methods and Payments to Providers Is Still Needed for Oversight. GAO-14-817T. Washington, D.C.: July 29, 2014.

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

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

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