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MEDICAID

Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments

GAO Highlights

Highlights of GAO-16-108, a report to the Committee on Finance, U.S. Senate

Why GAO Did This Study

In 2012, GAO reported that 505 hospitals received Medicaid payments that resulted in Medicaid payment surpluses—that is, payments that exceeded the costs of providing services—of about $2.7 billion. These surpluses were due in part to the lump-sum supplemental payments hospitals received that were above their regular payments for individual services. States made them under broad Medicaid payment authorities that allow federal matching on payments up to an upper payment limit or under Medicaid demonstrations. These types of supplemental payments are authorized, but not required, by law.

GAO was asked to examine how hospitals used revenues from large supplemental payments and the states' basis for distributing the payments. For four selected states making large payments and 12 hospitals receiving them, GAO examined (1) how these hospitals used revenues from the payments and (2) the basis on which the states distributed the payments. GAO reviewed documents authorizing payments and interviewed hospital, state and federal officials. GAO also obtained payment data for 2009, the year hospitals were identified as having large payments, and for 2012, the most recent year available.

What GAO Recommends

GAO recommends that CMS issue written guidance clarifying its policies that (1) supplemental payments should be linked to the provision of Medicaid services and (2) payments should not be contingent on the availability of local financing.

View GAO-16-108. For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

Not all selected hospitals in the four states GAO reviewed tracked their use of revenues from the large supplemental payments they received and tracking of revenues is generally not required. Based on information obtained from hospital officials and a review of demonstration approval documents, GAO determined that the revenues were used for a broad range of purposes. For example,

- Officials from nine selected hospitals that received large supplemental payments under three states' traditional state Medicaid programs reported using revenues—which resulted in average surpluses of about $39 million—to cover the costs of uninsured patients as well as funding general hospital operations, maintenance, and capital purchases, such as a helicopter.
- Hospitals in two selected states that GAO reviewed that were approved to make supplemental payments under Medicaid demonstrations were subject to certain tracking requirements to ensure payment revenues were used for approved demonstration purposes. Documentation for one state showed that approved uses of revenues included hospitals' uncompensated costs of serving underinsured or uninsured individuals and operating poison control centers. In the other state, which moved during the study timeframe from making supplemental payments under a traditional Medicaid program to under a demonstration, payments were allowed for purposes such as incentivizing health care delivery system improvements and for uncompensated costs for physician and clinic services, and drugs.

Three selected states distributed Medicaid supplemental payments largely based on the availability of local government funds to finance the nonfederal share of the payments, rather than on the services the hospitals provided. Medicaid payments should be made for Medicaid services or, if under demonstrations, for demonstration purposes and be economical and efficient. GAO found that three states made supplemental payments based on the ability of hospitals, or their local governments, to finance the nonfederal share. Consequently, hospitals otherwise eligible for payments but whose local government could not finance them did not receive them. The Centers for Medicare & Medicaid Services (CMS), which oversees Medicaid, communicated in writing to one state two key principles regarding payment distribution: (1) payments should be distributed based on Medicaid or demonstration purposes, and (2) payments should not be made based on the availability of local financing. However, CMS has not provided written guidance to articulate or broadly communicate these requirements to all states. Federal internal controls standards stress the need for effective communications with external stakeholders that have a significant impact on the agency achieving its goals. The absence of written guidance may result in inconsistent application of CMS's policies among states, the distribution of supplemental payments that are counter to the agency's policies and not aligned with the program's purposes, and the potential for states to overpay or underpay providers depending on the availability of local government financing.

In commenting on a draft of this report, HHS concurred with the first recommendation and agreed with GAO's concerns regarding the second recommendation but did not explicitly concur with it.