November 3, 2015

GAO Highlights

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

MEDICAID

Improving Transparency and Accountability of Supplemental Payments and State Financing Methods

Why GAO Did This Study

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

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

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

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

What GAO Found

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

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