

June 2005

MEDICAID FINANCING

States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight





Highlights of [GAO-05-748](#), a report to the Chairman, Committee on Finance, U.S. Senate

Why GAO Did This Study

Medicaid—the federal-state health care financing program covering nearly 54 million low-income people at a cost of \$276 billion in fiscal year 2003—is by its size and structure at risk of waste and exploitation. Because of challenges inherent in overseeing the program, administered federally by the Centers for Medicare & Medicaid Services (CMS), GAO in 2003 added Medicaid to its list of high-risk federal programs. To help administer the program, states may employ consultants in a number of roles, sometimes under contracts whereby payment is contingent upon the consultant's performance.

GAO was asked to report on states' use of contingency-fee consultants. GAO examined the extent to which (1) states are using contingency-fee consultants for projects to maximize federal Medicaid reimbursements, (2) claims from contingency-fee projects in selected states are consistent with federal law and policy, and (3) states and CMS are overseeing claims from such projects.

What GAO Recommends

GAO recommends that CMS improve oversight of contingency-fee projects and states' reimbursement-maximizing methods. In comments, CMS said its initiatives substantially respond to the recommendations, and the states said that their projects comply with law. GAO maintains that additional actions are needed.

www.gao.gov/cgi-bin/getrpt?GAO-05-748.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

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What GAO Found

As of 2004, 34 states—up from 10 states in 2002—used contingency-fee consultants to implement projects to maximize federal Medicaid reimbursements. Projects varied widely, and because of certain risk factors—including a nationwide growth in dollars—GAO focused on claims in five categories (see table). Contingency-fee consultants in the 2 states GAO reviewed, Georgia and Massachusetts, have developed projects in all five categories. From these and other projects, for state fiscal years 2000 through 2004, Georgia obtained an estimated \$1.5 billion in additional federal reimbursements and Massachusetts obtained an estimated \$570 million. These states paid contingency fees of more than \$90 million.

In Georgia, Massachusetts, or both states, GAO identified claims from contingency-fee projects in the five categories reviewed that were problematic because they appeared to be inconsistent with current policy or were inconsistent with federal law; others undermined Medicaid's fiscal integrity. For example, for services provided to children in state custody residing in private facilities, a Georgia project claimed increased federal Medicaid reimbursements on the basis of the facilities' estimated costs, which were often higher than the state's actual payments to the facilities. Problematic projects often involved categories of claims where federal law and policy were inconsistently applied, evolving, or not specific. Problematic projects also involved Medicaid payments to government entities, which can facilitate the inappropriate shifting of state costs to the federal government.

The states and CMS have provided limited oversight of claims associated with contingency-fee projects. CMS has not routinely collected information enabling it to identify claims or projects developed by contingency-fee consultants to maximize federal reimbursements, despite long-standing recognition that such claims are at risk of being inconsistent with federal requirements. Problems GAO identified illustrate the urgent need to address broader issues in oversight and financial management. CMS has taken steps to strengthen its financial oversight of Medicaid, but the agency can do more to reduce the risk of current and emerging financing schemes, including responding to prior GAO recommendations.

Five Categories of Medicaid Claims Reviewed by GAO

Category of claims	Service
Targeted case management services	Services to help a defined group of beneficiaries gain access to needed medical, social, educational, and other services
Rehabilitation services	Services to reduce a mental or physical disability and restore an individual to the best possible functional level
Supplemental payment arrangements	Payments to a class of health care providers, such as nursing homes, up to a predefined limit
School-based services	Medicaid-covered medical services provided by schools, such as diagnostic screening or physical therapy, or the administrative cost of providing these services
Administrative costs	Costs the states incur in administering their Medicaid programs

Source: GAO based on CMS information.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
DSH	disproportionate share hospital
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OIG	Office of Inspector General
OMB	Office of Management and Budget
TCM	targeted case management
UMMS	University of Massachusetts Medical School
UPL	upper payment limit

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United States Government Accountability Office
Washington, DC 20548

June 28, 2005

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

Dear Mr. Chairman:

Medicaid—the federal-state program financing health care for certain low-income children, families, and individuals who are aged or disabled—covered almost 54 million people at an estimated cost of \$276 billion in federal fiscal year 2003. By a formula established in law, the federal government paid from 50 to 77 percent of each state’s reported Medicaid expenditures that fiscal year.¹ We have previously reported that the challenges inherent in overseeing a program of Medicaid’s size, growth, and diversity put the program at high risk for waste, abuse, and exploitation and led us in 2003 to add Medicaid to our list of high-risk federal programs.² Medicaid has long been subject to states’ seeking to maximize federal reimbursement. Within broad federal guidelines, states administer their Medicaid programs by paying qualified health providers for a range of covered services provided to eligible beneficiaries and then seeking reimbursement for the federal share of those payments. States may employ consultants to serve a number of valid Medicaid-related roles, such as adding needed staff or a particular expertise, and these consultants may save both the federal government and states money by, for example, identifying when claims were paid inappropriately and are subject to recovery. Some consultants may serve under contingency-fee contracts, whereby a consultant’s fee is based, or contingent, upon performance, and these contingency fees are not eligible for federal

¹States with lower per capita incomes receive higher federal matching rates. The federal government also matches states’ costs for administering the Medicaid program, generally at 50 percent. Federal Medicaid matching rates were increased temporarily by 2.95 percentage points from April 1, 2003, through June 30, 2004, pursuant to title IV of the Jobs and Growth Tax Relief Reconciliation Act of 2003. See Pub. L. No. 108-27, § 401(a)(3), 117 Stat. 752, 764–765.

²GAO, *High-Risk Series: An Update*, [GAO-05-207](#) (Washington, D.C.: January 2005).

Medicaid reimbursement except in certain cases.³ In the current environment of steadily rising Medicaid costs straining federal and state budgets,⁴ states' use of contingency-fee consultants can be problematic, particularly if controls are inadequate to ensure that any additional federal reimbursements are allowable Medicaid expenditures.

The federal government and states each have responsibilities for administering Medicaid programs and for ensuring that Medicaid funds are spent appropriately on covered services provided to eligible beneficiaries. The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), administers Medicaid at the federal level, establishing policies and reviewing and approving state Medicaid plans, which describe how each state's program will operate. These written plans are considered to be comprehensive commitments by the states to supervise and administer their Medicaid programs. Further, when submitting claims for federal reimbursement, each state must certify that the claimed expenditures—including claims for payments the state made to providers for medical services and claims for the state's administrative expenses—are consistent with federal regulations and the state's approved Medicaid plan. We have earlier reported on the high-risk nature of the Medicaid program and on various states' use of financing schemes, some involving consultants, to inappropriately increase federal reimbursements.⁵ Some of these reports have raised questions about the appropriateness of claims for federal reimbursement developed by contingency-fee consultants and whether state and CMS oversight of claims developed by contingency-fee consultants is sufficient.

You asked us to provide information about states' use of contingency-fee consultants and whether resulting projects and claims are consistent with federal law and policy. In this report, we address the following questions:

³Contingency fees are eligible for federal Medicaid reimbursement when a contingency-fee contract (1) results in cost-avoidance savings or recoveries in which the federal government would share, (2) is competitively procured, and (3) the savings upon which the contingency-fee payment is based are adequately defined and the payments documented to the Centers for Medicare & Medicaid Services' satisfaction.

⁴We estimate that the average annual rate of growth for the Medicaid program from 1999 through 2003 was 9.2 percent.

⁵A list of related GAO products appears at the end of this report.

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1. To what extent are states using consultants on a contingency-fee basis to develop projects to help them maximize federal Medicaid reimbursements?
 2. To what extent are the claims from projects developed by contingency-fee consultants to maximize federal Medicaid reimbursements in selected states consistent with federal law and policy?
 3. To what extent do selected states and CMS oversee the claims from projects developed by contingency-fee consultants to maximize federal Medicaid reimbursements?

To examine the extent to which states are using consultants on a contingency-fee basis to develop projects to maximize Medicaid reimbursements, we obtained information from the HHS Office of Inspector General (OIG), CMS, and state officials. We also inventoried projects developed by the major contingency-fee consultants employed by two states, Georgia and Massachusetts. We selected these states in part on the basis of information provided by CMS, which indicated that the states had employed contingency-fee consultants for multiple reimbursement-maximizing projects. To assess the extent to which claims from such projects were consistent with Medicaid law and policy, we analyzed selected projects in Georgia and Massachusetts in five categories of Medicaid claims (see table 1). We concentrated on projects in these five categories because—on the basis of factors such as nationwide growth in dollars claimed, the results of our past reviews, and work by HHS OIG to assess the appropriateness of claims in these categories—we judged them to be of particularly high risk.⁶ Because of the number and complexity of contingency-fee projects in Georgia and Massachusetts, we did not review all such projects in the two states. Instead, we supplemented our present review with related work in other states, including our prior reviews and assessments by HHS OIG, CMS, and state auditors. Where HHS OIG had assessed states' claims—in particular, Massachusetts's school-based claims—we did not perform a separate assessment. To evaluate state and CMS oversight of states' claims from projects developed by contingency-fee consultants, we reviewed the policies and procedures that selected states and CMS use to monitor consultant performance. We conducted our

⁶To review growth in dollars claimed, we reviewed CMS data from states' Medicaid expenditure reports. To assess the reliability of these data, we discussed data quality control procedures and reviewed related documentation with CMS officials. We determined that the data were sufficiently reliable for the purposes of this report.

work in accordance with generally accepted government auditing standards from March 2004 through June 2005.

Table 1: Five Categories of Medicaid Claims Reviewed by GAO

Category of claims	Service
Targeted case management services	Services to help a defined group of beneficiaries gain access to needed medical, social, educational, and other services
Rehabilitation services	Services to reduce a mental or physical disability and restore an individual to the best possible functional level
Supplemental payment arrangements	Payments to a class of health care providers, such as nursing homes, up to a predefined limit
School-based services	Medicaid-covered medical services provided by schools, such as diagnostic screening or physical therapy, or the administrative cost of providing these services
Administrative costs	Costs the states incur in administering their Medicaid programs

Source: GAO based on CMS information.

Results in Brief

Most states have used contingency-fee consultants to help implement a wide range of projects to maximize federal Medicaid reimbursements. CMS reports that, according to a survey it conducted in 2004, 34 states had used contingency-fee consultants for this purpose, an increase from 10 states reported to have done so in 2002. Over the past few years, states' claims in some of the five categories we examined have grown substantially in dollar amounts. For example, during fiscal years 1999 through 2003, combined state and federal spending for one category of Medicaid services—targeted case management—increased by 76 percent, from \$1.7 billion to \$3 billion, across all states. In Georgia and Massachusetts, consultants have developed a wide range of projects across several categories of Medicaid services. Reimbursement-maximizing projects generated an estimated \$1.5 billion in additional federal reimbursements during fiscal years 2000 through 2004 in Georgia and nearly \$570 million in Massachusetts. For those additional reimbursements, Georgia paid its consultant about \$82 million in contingency fees, and Massachusetts paid its consultants about \$11 million in contingency fees.

We identified claims from projects developed by contingency-fee consultants that appeared to be inconsistent with current CMS policy, claims that were inconsistent with federal law, and claims from projects

that undermined the fiscal integrity of the Medicaid program. We identified concerns in each of the five categories of claims we reviewed, including:

- **Targeted case management:** Consultants in Georgia and Massachusetts helped the states maximize federal reimbursements by claiming costs for targeted case management (TCM) services that, under state plan amendments approved by CMS before 2002, appear to be inconsistent with CMS's current policy, which does not allow federal Medicaid reimbursement for TCM services that are an integral component of other state programs providing the services. For example, Georgia and Massachusetts claimed and received federal Medicaid reimbursement for TCM services for youths in their juvenile justice systems. Starting around 2002, CMS has disapproved proposed state plan amendments for similar TCM services in other states, stating that the costs are the responsibility of the state. In fiscal year 2004, Massachusetts received an estimated \$68 million in federal reimbursements for TCM services as a result of contingency-fee projects. Georgia received about \$12 million in fiscal year 2003 for its TCM project.
- **Rehabilitation services:** Georgia's consultant helped the state increase federal reimbursements for rehabilitation services provided through state agencies by \$58 million during state fiscal years 2001 through 2003. The consultant suggested that two state agencies—which pay private facilities for providing room and board, rehabilitation, and other services to children in state custody—base their claims for Medicaid reimbursement on the private facilities' estimated costs, instead of on what the agencies actually paid those facilities. The state agencies increased the amount claimed for Medicaid reimbursement without increasing the amount paid to the facilities. In some cases, the amount state agencies claimed for rehabilitation services alone exceeded what they paid for all the services the facilities provided to children.

Two factors shared by projects we reviewed signal areas where claims are at high risk of being problematic, that is, inconsistent with federal law or current policy or the federal-state cost-sharing structure and fiscal integrity of the Medicaid program. One factor was that the projects occurred in categories of Medicaid claims where federal policy had been inconsistently applied, was evolving, or was not specific. CMS, for example, has not consistently applied its policy when approving state plans to cover TCM expenditures eligible for federal reimbursement, and it has not clarified its guidance about appropriate supplemental payment arrangements, despite its concerns about states' claims in both these areas. A second factor was that Medicaid payments were made in many cases to state and local-government agencies as Medicaid providers, a

mechanism that can facilitate an inappropriate shift of state costs to the federal government.

The states we reviewed and CMS provided limited oversight to ensure the appropriateness of the projects and associated claims developed with assistance from contingency-fee consultants. Georgia's and Massachusetts's oversight efforts were limited and insufficient to prevent problematic claims associated with contingency-fee projects. CMS relies primarily on the states and on its own financial oversight activities to ensure the appropriateness of consultant projects and claims. Although CMS has periodically identified concerns with contingency-fee projects to maximize federal reimbursements, the agency has not routinely collected information to identify such projects and claims, and it was unaware of many of the specific projects that we reviewed. Our findings illustrate the urgent need to address broader oversight and financial management issues not limited to situations involving contingency-fee consultants. In Georgia and Massachusetts, we found problems with claims the states had submitted without consultant assistance. We also found that other states have undertaken similar reimbursement-maximizing projects on their own. CMS has taken some important actions to strengthen its oversight of state Medicaid programs, such as its initiative to hire additional financial analysts to assess each state's program, but the effectiveness of this initiative is not yet known. Moreover, CMS has not yet implemented several actions that we have previously recommended on the basis of our past work on states' financing schemes and CMS's financial management of Medicaid.

In addition to reiterating several recommendations to CMS and to Congress from our prior work, this report contains recommendations to the Administrator of CMS to improve the agency's oversight of states' use of contingency-fee consultants and to strengthen the agency's overall financial management procedures. Doing so would include developing guidance to clarify CMS policy, ensuring that such guidance is applied consistently among states, and collecting and scrutinizing information from states about payments made to units of state and local governments.

In commenting on a draft of this report, CMS stated its belief that it has already substantially met our recommendations. While acknowledging that improper Medicaid payments had unquestionably occurred, CMS provided detailed information to support why it believes that it (1) was already aware of the concerns identified in projects we examined and (2) has taken sufficient action to address these concerns and our related recommendations. Although we have added additional information on

CMS's initiatives to our report, in our view, CMS has not yet sufficiently identified or addressed the issues that we found; we believe CMS needs to do more to identify contingency-fee projects and problematic claims sooner, before large reimbursements have been made to states. CMS's current efforts to review states' financing methods—by examining them when states submit proposed state plan amendments and obtaining agreement from states to end methods the agency considers to be inappropriate—do not ensure that CMS's policies are clear or consistently applied to states. States' financing methods, for example, may not receive scrutiny if the state does not propose state plan amendments. We maintain our position that CMS needs to be more proactive and do more to clarify, communicate, and consistently apply its policies concerning high-risk areas.

We also provided a draft of this report to Georgia and Massachusetts, which commented on the importance of contingency-fee contracts and states' needs for consultants for expertise they otherwise would not have. Georgia also commented, however, that our report implied that states' use of contingency-fee consultants is somehow illegitimate. We acknowledge that use of contingency-fee contracts is allowed under law and that states can employ consultants for a number of valid Medicaid purposes, but we maintain that our close examination of projects and associated claims revealed how reimbursement-maximizing projects can be problematic. In contrast to CMS's perspective that the agency had known about and was addressing concerns with projects we reviewed in Georgia and Massachusetts, both states contend that their claims comply with the law. Although most may not be illegal, we maintain our position that, because some projects and associated claims we examined have been inconsistent with Medicaid's federal-state cost-sharing design or with current CMS policy, increased attention is needed to better ensure the fiscal integrity of the Medicaid program.

Background

Title XIX of the Social Security Act⁷ authorizes federal funding to states for Medicaid. States have considerable flexibility in designing and operating their Medicaid programs, but they must comply with federal requirements specified in Medicaid statute and regulations. Each state operates its program under a plan that CMS must approve for compliance with current

⁷42 U.S.C. §§ 1396, et seq. (2000).

law and regulations. CMS must also approve any amendments to a state's plan.

Consultants can provide a wide range of services to states, including serving state Medicaid programs. States that lack sufficient in-house resources can turn to consultants to add staff or needed expertise. Contingency-fee consultants are particularly attractive to budget-constrained states because the states do not need to pay them up front, agreeing to pay instead a percentage of any additional amounts saved or collected (the contingency fee). Consultants may also cost states less than developing in-house expertise, as states can hire them for short-term or specific projects rather than commit full-time state personnel. Consultants can also be attractive because they do not generally count against agency staffing ceilings. Regarding Medicaid, consultants can help states by performing services such as:

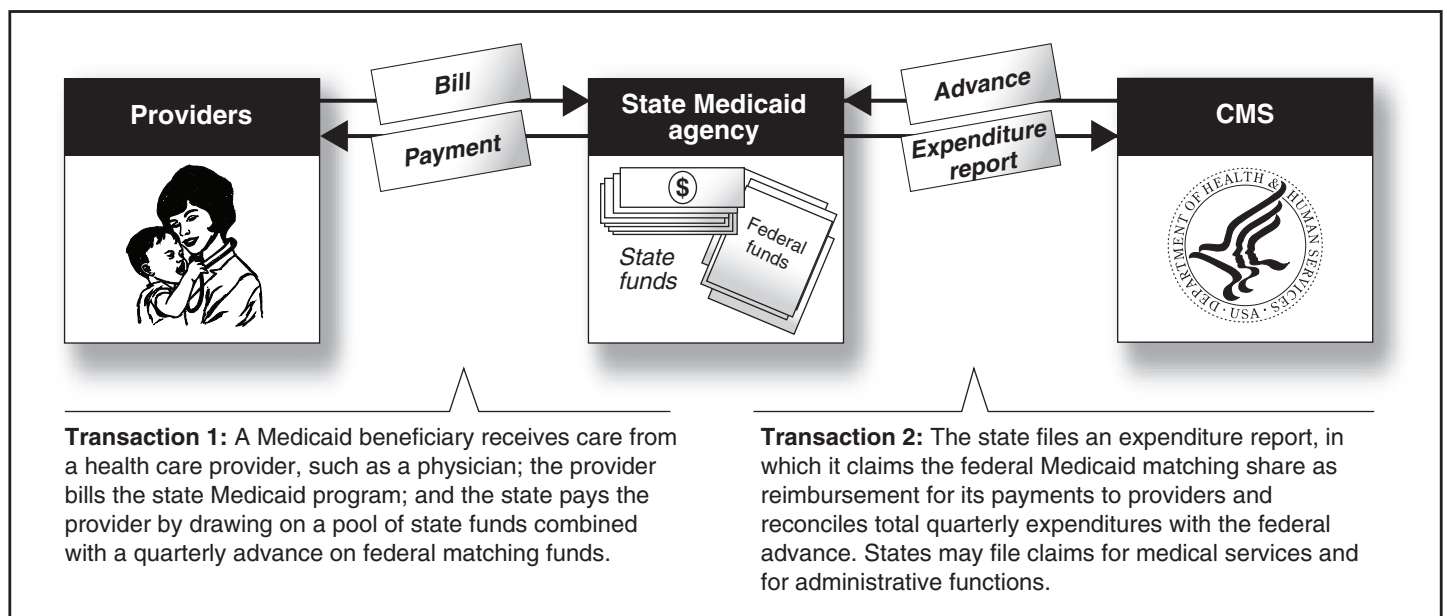
- analyzing federal and state statutory and regulatory provisions,
- developing or revising state Medicaid policies and procedures for consistency with federal requirements,
- assisting states in developing state plan amendments for federal approval,
- assisting states in determining payment rates for providers,
- developing cost allocation plans to support claims for administrative expenditures,
- training state and local staff in procedures and documentation for submitting claims for federal Medicaid reimbursement,⁸
- preparing state claims for federal Medicaid reimbursement, and
- identifying new methods or projects to maximize federal Medicaid reimbursements.

The typical Medicaid payment process is illustrated in figure 1. When a Medicaid beneficiary receives care from a health care provider such as a hospital, physician, or nursing home, the provider bills the state Medicaid program for its services. The state in turn pays the provider from a combination of state funds and federal funds, which have been advanced

⁸Throughout this report, we use the term *reimbursement* to refer to federal funds received by states from CMS for the federal share of states' claimed Medicaid expenditures. States generally receive such funds through a reconciliation process whereby an advance from CMS is reconciled with states' claimed expenditures. We use the term *payment* to refer to funds used by state Medicaid programs to pay Medicaid providers for providing Medicaid services.

by CMS each quarter.⁹ The state then files an expenditure report, in which it claims the federal share of the Medicaid expenditure as reimbursement for its payment to providers and reconciles its total expenditures with the federal advance. In addition to reimbursement for medical services, the state may claim federal reimbursement for functions it performs to administer its Medicaid program, such as enrolling new beneficiaries; reviewing the appropriateness of providers' claims; and collecting payments from third parties, that is, payers other than Medicaid, such as Medicare, that may be liable for some or all of a particular health claim.

Figure 1: The Typical Medicaid Payment Process



Source: GAO.

States' claims for federal Medicaid reimbursement—including claims prepared by or under arrangements developed by consultants—must comply with a number of federal statutes and regulations. For example, the Social Security Act requires that states provide methods to ensure that

⁹Each quarter, states submit to CMS an estimate of their Medicaid expenditures for the upcoming quarter. CMS then authorizes the states to draw on federal funds to pay the federal Medicaid share. Massachusetts officials said that the state fully funds Medicaid payments and is reimbursed by the federal government.

Medicaid payments are consistent with efficiency, economy, and quality of care.¹⁰ CMS policy further clarifies and delineates requirements with which each state must comply in administering its Medicaid program. CMS policy, for example, generally prohibits states from claiming federal matching funds on contingency-fee payments, including contingency-fee payments among state agencies.¹¹ Each state must also comply with cost principles and procedures, such as preparing a cost allocation plan to justify its administrative claims, as established in Office of Management and Budget (OMB) Circular A-87.¹²

CMS has an important role in ensuring that state claims comply with Medicaid requirements. Within CMS, the Center for Medicaid and State Operations is responsible for approving state Medicaid plans and plan amendments, working with the states on program integrity and other program administration functions and overseeing state financial management and internal control processes. The Center for Medicaid and State Operations shares Medicaid program administration and financial management responsibilities with the 10 CMS regional offices. Traditional financial management analysts in each regional office,¹³ numbering about 65 nationwide in fiscal year 2005 according to CMS officials, are responsible for reviewing states' Medicaid claims to determine if expenditures are complete, properly supported by the state's accounting

¹⁰42 U.S.C. § 1396a(a)(30) (2000).

¹¹State Medicaid agencies, for example, may employ other state agencies to perform administrative activities and pay them on a contingency-fee basis. CMS's guidance notes that contingency-fee payments made to another government unit for Medicaid administrative activities, whether made directly by the Medicaid agency or made by another unit and reported to CMS through the Medicaid agency, are not allowable for federal reimbursement.

¹²OMB Circular A-87 applies to federal grants to state and local governments. It establishes principles and standards to provide a uniform approach to determining allowable costs and promoting effective program delivery, efficiency, and better relationships between federal and other governmental units. The circular establishes requirements enabling states to allocate allowable central services costs to operating agencies, such as the state Medicaid agency, by developing cost allocation plans. An approved cost allocation plan allows the state to assign some of the costs of centralized administrative and support services to the agencies that use them on a reasonable and consistent basis. State agencies such as Medicaid may then claim federal reimbursement for those administrative costs as allowed by Medicaid statute.

¹³As discussed later in this report, as part of a new financial management effort, CMS has an initiative under way to hire approximately 100 new financial analysts with responsibilities different from those of CMS's traditional financial management analysts.

records, claimed at the appropriate federal matching rates, and allowable in accordance with Medicaid law and policy. In addition to CMS, external organizations such as HHS OIG and state auditors routinely conduct program and financial audits of state Medicaid programs.

In examining the appropriateness of state Medicaid agency claims for health services provided by local school districts, we have reported concerns about the role of consultants who were paid on a contingency-fee basis to maximize federal Medicaid reimbursements. In particular, in June 1999, we testified on the need for federal and state oversight of growing Medicaid reimbursements to states for Medicaid outreach and other administrative activities provided in schools.¹⁴ We found that school districts had often contracted with consulting firms to perform claims development and reporting activities and that they paid these firms fees ranging from 3 to 25 percent of the total amount of the federal Medicaid reimbursement for the schools' administrative costs. We found that poor guidance and insufficient CMS oversight permitted questionable billing practices by states and created an environment of opportunism in which inappropriate claims could generate excessive federal Medicaid outlays. Our subsequent report in April 2000 on school-based health services discussed similar concerns with growing outlays and insufficient CMS guidance and oversight to prevent improper reimbursements.¹⁵ Since our 2000 report, CMS has clarified guidance on submitting claims for school-based administrative activities, applying stricter standards and heightening review of the methods states use to identify administrative claims for school-based services.¹⁶ CMS also disallowed more than \$278 million in inappropriate claims from one state.

¹⁴GAO, *Medicaid: Questionable Practices Boost Federal Payments for School-Based Services*, [GAO/T-HEHS-99-148](#) (Washington, D.C.: June 17, 1999).

¹⁵GAO, *Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight*, [GAO/HEHS/OSI-00-69](#) (Washington, D.C.: Apr. 5, 2000).

¹⁶CMS, *Medicaid School-Based Administrative Claiming Guide* (May 2003).

Most States Have Employed Contingency-Fee Consultants in a Wide Range of Reimbursement-Maximizing Projects

An increasing number of states are using consultants on a contingency-fee basis to maximize their federal Medicaid reimbursements through a variety of projects, according to CMS. Contingency-fee consultants in the two states we reviewed—Georgia and Massachusetts—have developed reimbursement-maximizing projects in each of the five categories of claims that we reviewed, generating more than \$2 billion during state fiscal years 2000 through 2004 in additional federal Medicaid reimbursements, mainly in Georgia.

CMS Surveys Found Increasing Use of Contingency-Fee Consultants for Reimbursement-Maximizing Projects

CMS surveyed its regional offices in fiscal years 2002 and 2004 and found that an increasing number of states were using consultants on a contingency-fee basis for projects to maximize federal reimbursements. In late 2001, CMS discovered that, contrary to CMS policy prohibiting federal reimbursement for contingency fees in most instances, at least two states (New Jersey and Virginia) had inappropriately claimed federal reimbursements for such fees. Subsequently, CMS surveyed its regional offices to identify which states were using contingency-fee consultants and for which services. This first survey (spring 2002) showed that 10 states were known by regional staff to be using contingency-fee consultants for reimbursement-maximizing projects. In response, CMS issued two letters, in May 2002 and in November 2002, reminding regional offices and states that although states were allowed to employ contingency-fee consultants, the contingency fees themselves were not eligible for federal reimbursement except in certain cases.¹⁷

In June 2004, CMS again surveyed its regional offices to determine how many states had entered into contingency-fee contracts with private consulting firms to maximize federal reimbursements over the period from January 1999 through June 2004. This survey identified 34 states involved in contingency-fee contracts to help them maximize federal Medicaid reimbursements in a variety of categories. Most frequent were claims for services provided to Medicaid-eligible children in schools, a category in

¹⁷The May 2002 letter instructed CMS regional administrators to remind states that federal matching funds were generally not available for contingency-fee contracts and, where CMS had inadvertently approved such arrangements, federal matching funds would cease at the end of the remaining term. The November 2002 letter provided guidance to regional offices on criteria that states must meet to receive reimbursement for contingency fees paid to consultants.

which contingency-fee consultants have assisted states for years. CMS regional offices also reported that 11 states had contracts using contingency-fee consultants in multiple areas, some having projects in as many as four different categories (see table 2).

Table 2: CMS’s 2004 Survey Results Showing Categories of Medicaid Claims in Which States Had Projects Developed with Contingency-Fee Consultants, January 1999–June 2004

Claims category	Number of states
School-based health and administrative services	16
Reimbursement maximization (not otherwise specified)	9
Family-planning services	9
Targeted case management services	5
Mental health-related administrative services (in local-government and community clinics)	3
Supplemental payment arrangements	2
Child welfare-related services	1
Administrative cost reports	1
Multiple projects	11

Source: CMS.

Our review focused on five categories of claims that we considered at high risk of improper payments: TCM services, services for mental or physical rehabilitation, supplemental payment arrangements, school-based services, and administrative costs (see table 3). For most of these categories, CMS expenditure data show that federal reimbursement of states’ claims in recent years has grown nationwide, sometimes substantially. Although CMS’s 2004 survey gathered information on states’ use of contingency-fee consultants, it would not have captured states’ arrangements established outside the survey period. We identified one consultant, for example, who helped two states develop upper payment limit (UPL) arrangements, although CMS’s 2004 survey did not capture these particular states’ contracts. CMS does not identify the extent to which states’ Medicaid claims stem from projects using contingency-fee consultants to maximize federal reimbursements.

Table 3: Five Categories of Medicaid Claims Where Contingency-Fee Consultants Are Helping States Maximize Federal Medicaid Reimbursements

Category of Medicaid claims	Risk
<p>Targeted case management services (TCM): Case management helps beneficiaries gain access to needed medical, social, educational, and other services and coordinates beneficiaries' use of providers. TCM enables states to provide case management services to a defined group or groups of Medicaid-eligible individuals without providing the same service to all Medicaid beneficiaries statewide, as normally required by Medicaid law. Groups are targeted primarily on the basis of shared characteristics, such as location or special health needs.</p>	<p>Current CMS policy does not allow federal Medicaid reimbursement for TCM services provided by the state if those services are "an integral component" of an existing state program.^a Medicaid reimbursement, according to CMS, is intended to enable provision of new services to individuals, rather than to pay for services provided by an existing state program. CMS data show that during fiscal years 1999 through 2003, combined state and federal spending for Medicaid TCM services increased by 76 percent, from \$1.7 billion to \$3 billion.</p>
<p>Rehabilitation services: Rehabilitation services are intended for the maximum reduction of a physical or mental disability and to restore an individual to the best possible functional level. Covered services may include occupational and physical therapy, mental health services, and treatment for addiction. The benefit is optional, that is, state Medicaid programs are not required to cover the service but may do so at their own option.</p>	<p>CMS financial management officials told us that Medicaid coverage of rehabilitation services is not well defined because varied types and levels of service may be considered mental or physical rehabilitation. Because rehabilitation services are not reported separately in CMS expenditure reports, growth in claims specifically for these services is unknown. According to CMS officials, however, states' claims in this area present a high risk of abuse.</p>
<p>Supplemental payment arrangements: States' Medicaid rates are often lower than the federal Medicare rates to which Medicaid upper payment limits (UPLs) rates are tied.^b Thus, a gap often exists between the amount states actually spend to provide services to Medicaid beneficiaries and the Medicare-based UPLs. States can obtain additional federal funding for the amount under the UPL ceiling by making supplemental payments to a class of providers, such as nursing homes or hospitals.</p>	<p>As we and others have previously reported,^c some supplemental payment arrangements are inconsistent with Medicaid's fiscal integrity and federal-state partnership, in particular, those made by states to government-owned or government-operated facilities but not retained by those facilities. We consider such payments to be illusory. Although Congress and CMS have taken action to curb excessive UPL arrangements,^d states continue to operate them. The extent of states' claims for excessive UPL payments is unknown. The federal and state UPL expenditures through all UPL arrangements grew from an estimated \$10.3 billion in 28 states in fiscal year 2000 to \$11.2 billion in 45 states in fiscal year 2004. During this period, Congress and CMS acted to limit excessive UPL arrangements and associated claims.</p>
<p>School-based services: Schools can help identify Medicaid-eligible low-income children, facilitate their enrollment in Medicaid, and provide them certain Medicaid-covered services. When Medicaid-eligible children receive Medicaid services—such as diagnostic screening or physical therapy—through the school system, states can use their Medicaid programs to pay for these services. School districts may also receive Medicaid reimbursement for the administrative costs of providing school-based Medicaid services.</p>	<p>Responding to concerns about the growth and appropriateness of Medicaid claims for school-based services, CMS began tracking school-based medical and administrative services as a separate budget item in fiscal year 2002; the agency issued guidance on appropriate administrative billing in 2003. For fiscal years 2002 through 2003, total state and federal spending on school-based services grew 8 percent nationwide, from \$1.97 billion to \$2.13 billion. Nationwide, more than \$900 million (state and federal) went toward school-based administrative costs in both fiscal years 2002 and 2003.</p>

Category of Medicaid claims**Risk**

Administrative costs: The federal government will reimburse states, generally at 50 percent, for their costs of administering their Medicaid programs. To determine which administrative costs the state can attribute to Medicaid, states submit a cost allocation plan for HHS approval.⁶ This plan establishes the methods the state will use to distribute its administrative costs—for example, employee time and costs related to providing services to both Medicaid-eligible and non-Medicaid-eligible individuals—across different funding sources.

CMS found in the early 2000s that some states had inappropriately claimed contingency fees as a Medicaid administrative cost. In addition, a fiscal year 2004 CMS survey showed that at least one state was using a contingency-fee consultant to increase administrative claims. CMS data show that for fiscal years 1999 through 2003, state and federal spending for the states' Medicaid administrative costs grew 37 percent from \$9.5 billion to \$13.0 billion.⁷

Source: GAO.

⁶CMS recently reiterated its TCM policy in a 2004 Administrator's decision that denied approval of a state plan amendment requested by Maryland to provide TCM services to children in the state's foster care program. See CMS, *Disapproval of Maryland State Plan Amendment No. 02-05*, Docket No. 2003-02 (Aug. 27, 2004). The Administrator's decision was based in part on a statement in the legislative history accompanying the legislation authorizing coverage for TCM services that payment for TCM services must not duplicate payments to public agencies or private entities under other program authorities. See H.R. Rep. No. 99-453, at 546 (1985). We did not evaluate the basis for CMS's policy as part of this review.

⁷UPL is the upper bound on what the federal government will pay as its share of Medicaid costs; it is the federal government's way of placing a ceiling on federal financial participation in a state's Medicaid program. UPLs are tied to the methodology that Medicare, the federal health care program that covers seniors aged 65 and older and some disabled persons, uses to pay for comparable services.

⁸See GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, [GAO-04-228](#) (Washington, D.C.: Feb. 13, 2004) and related products cited therein.

⁹For example, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 directed CMS to issue a final regulation to limit states' ability to claim excessive federal matching funds through UPL supplemental payments.

¹⁰Unlike CMS's direct review and approval role for states' Medicaid plan amendments, CMS has an advisory review role for the plans that state Medicaid agencies prepare for allocating their administrative overhead costs; at the national level, HHS's Division of Cost Allocation takes the lead in reviewing these cost allocation plans. The division generally distributes copies of cost allocation plan sections to affected federal agencies, including CMS, for comment.

¹¹These figures include costs associated with school-based administration.

Georgia and Massachusetts Have Extensively Used Contingency-Fee Consultants

From state fiscal years 2000 through 2004, Georgia used a private consulting firm on a contingency-fee basis for multiple reimbursement-maximizing projects, including projects in the five Medicaid claims categories that we reviewed. The consultant provided numerous services on more than 20 projects, such as creating new methodologies for developing claims for federal reimbursement, obtaining legal advice to support reimbursement-maximizing claims, and pursuing retroactive reimbursement for claims that were not previously reimbursed. The consultant also helped the state to write state plan amendments and cost allocation plans. For example, for five UPL projects, the consultant developed the formulas for calculating the state's UPL, drafted the state

plan amendment to submit to CMS, and drafted provider agreements to implement the project. For a project in rehabilitation services, the consultant developed a new methodology for developing claims for federal reimbursement of payments the state made to providers. For TCM projects involving two state agencies, the consultant developed revisions to the state's payment rate; drafted the state plan amendment to implement the revised rates; drafted revisions to state policy manuals; and conducted training sessions with case managers, including identifying services that could be considered as TCM and explaining how to format their case notes to support Medicaid claims.

Georgia paid the consultant mainly from additional federal Medicaid reimbursements generated from the contingency-fee projects, although CMS determined that the state did not claim federal reimbursement for the contingency fees themselves. Initially, in 1999, Georgia and the consultant agreed on a contingency fee based on additional federal reimbursement generated by the consultant's projects. For state fiscal years 2000 through 2004, the state paid its consultant more than \$82 million in contingency fees. After UPL projects generated for Georgia more than \$1.2 billion in additional federal Medicaid reimbursements for state fiscal years 2001 through 2003, and a dispute developed between the state and the consultant about the extent to which the additional reimbursements were attributable to the consultant's project, the state and the consultant agreed upon an additional \$28 million in fees to be paid over 2 years.¹⁸ In total, the UPL arrangement and other consultant projects generated an estimated \$1.5 billion in additional federal Medicaid reimbursements for Georgia over approximately 5 years.

Massachusetts has pursued Medicaid reimbursement-maximizing and cost-avoidance projects using contingency-fee consultants since the early 1990s. The state has used various private consulting firms, but since state fiscal year 2000, it has relied primarily on a component of the University of Massachusetts Medical School (UMMS) to conduct reimbursement-maximizing and cost-avoidance projects, including projects in rehabilitation services, supplemental payments, and school-based services. UMMS has performed a number of services to implement these

¹⁸The state and the consultant disagreed on the contingency-fee payment for UPL payments to local-government hospitals and nursing homes. The state and consultant agreed to an \$81 million compromise fee in 2003. At the time of this agreement, the state had already paid the consultant about \$25 million, and the remaining \$56 million was to be paid in yearly installments of \$14 million, with the final installment due in June 2006.

reimbursement-maximizing projects, including assisting in drafting state plan amendments and preparing Medicaid claims for reimbursement.

In addition to reimbursement-maximizing projects, Massachusetts's state Medicaid agency also obtains other services from UMMS through interagency agreements to help operate its Medicaid program. UMMS performs many of the state's Medicaid administrative functions, such as analyzing claims to identify and recover improper payments paid to health providers and training state and local staff on procedures for submitting claims.¹⁹

UMMS was compensated in two ways for its services: (1) for selected projects, UMMS was paid a contingency fee that came from the additional federal funds received by the state for the particular reimbursement-maximizing or cost-avoidance project;²⁰ and (2) the state paid UMMS from the federal reimbursement for its administrative costs. Contingency fees paid to UMMS varied by project, generally from 1 to 15 percent of additional federal reimbursement generated or costs avoided. Administrative costs that were attributable to UMMS were paid by the state on the basis of UMMS's reported Medicaid-related costs, according to UMMS officials. Each quarter, UMMS reported its Medicaid-related costs to the state Medicaid agency, which in turn included these costs on the state's quarterly expenditure report to CMS. The state then reimbursed UMMS for its reported Medicaid-related administrative costs. We could not isolate the amount that UMMS received for administrative costs associated with federal Medicaid reimbursement-maximizing projects because these costs were combined with those for other Medicaid projects, such as pharmacy management and utilization review, which UMMS also conducts for the Medicaid agency. For all its Medicaid administrative activities, UMMS in state fiscal year 2004 claimed approximately \$60 million

¹⁹By ownership, UMMS is not a private consultant, although it shares several characteristics with private consultants. We included UMMS in our review because of these shared characteristics, specifically (1) CMS identified and reported UMMS as a contingency-fee consultant; (2) the consulting work UMMS does for Massachusetts is done under "interdepartmental service agreements," which state officials describe as contracts; (3) UMMS is paid a contingency fee by the state for many of its state projects; and (4) UMMS officials said the medical school serves as a contingency-fee consultant for other states and as a subcontractor for other consultants.

²⁰For example, UMMS was paid a contingency fee of \$115,000 in state fiscal year 2004 for increasing state claims for family-planning services provided by managed care organizations.

(excluding contingency fees) in state and federal Medicaid reimbursements.

Massachusetts has used other contingency-fee consultants for reimbursement-maximizing and cost-avoidance projects, including a private consultant that developed a TCM project and rate-setting proposal for the state's Department of Youth Services, among others. That private consultant still served in state fiscal year 2004 as a consultant paid on a contingency-fee basis, helping state agencies with various reimbursement-maximizing projects. For state fiscal year 2004, Massachusetts paid the private consultant about \$4 million in fees from contingency-fee agreements for generating nearly \$106 million in savings and additional federal reimbursements.

According to the Massachusetts Medicaid agency, the state paid more than \$57.5 million to contingency-fee consultants during state fiscal years 2000 through 2004 for projects that generated almost \$1.3 billion in funds for the state through all types of reimbursement-maximizing and cost-avoidance projects. Some of these projects would have accrued savings to Medicaid in which the federal government would have shared, such as program integrity efforts to ensure appropriate payments to individual providers. Most of the contingency fees (about \$37 million) were paid to UMMS; other (private) consultants were paid about \$20.5 million. From state fiscal years 2000 through 2004, reimbursement-maximizing projects generated about \$570 million in additional federal reimbursements for the state, for which Massachusetts paid consultants nearly \$11 million in contingency fees. UMMS projects accounted for \$540 million of the total, for which it was paid \$9 million in contingency fees.

Claims from Contingency-Fee Projects Are Not Always Consistent with Law or Current Policy and Can Undermine Medicaid's Fiscal Integrity

We and others have identified claims from contingency-fee consultant projects that appeared to be inconsistent with current CMS policy and claims that were inconsistent with federal law. We also identified claims from projects that undermined Medicaid's fiscal integrity. Such projects and resulting problematic claims arose in each of the five categories of claims that we reviewed, either in Georgia or Massachusetts or both. During our work we observed two factors that appeared to increase the risk of problematic claims. One factor involved federal requirements that were inconsistently applied, evolving, or not specific; the second involved Medicaid payments to government units, which can facilitate the inappropriate shifting of state costs to the federal government.

Contingency-Fee Projects in Selected States Resulted in Problematic Federal Reimbursements in Five Categories of Claims

In the five categories of Medicaid services we reviewed, we identified claims that were problematic in Georgia, Massachusetts, or both. We identified claims for TCM services that appear to be inconsistent with current CMS policy and claims for rehabilitation services that were inconsistent with federal law. In other areas, such as supplemental payments, we found claims associated with projects that undermined the fiscal integrity of the Medicaid program and the federal-state partnership. In addition to our work in Massachusetts and Georgia, we identified several reports by HHS OIG about other states, which raise issues about the appropriateness of claims stemming from contingency-fee contracts for school-based services and for administrative costs.

Targeted Case Management Services

Most of the claims for federal reimbursement of Medicaid TCM services in Georgia and Massachusetts that we reviewed appeared to be inconsistent with current CMS policy, which does not allow federal reimbursement for TCM services that are integral to other state programs.²¹ Under previously CMS-approved state plans, consultants helped Georgia and Massachusetts increase federal TCM reimbursements.²² In Georgia, the consultant assisted the state in increasing federal reimbursement for TCM services provided by two state agencies: the Department of Juvenile Justice and the Division of Family and Children's Services. The consultant assisted Georgia by streamlining the billing process, drafting a state plan amendment proposal,²³ and increasing the number of Medicaid beneficiaries for whom these two non-Medicaid state agencies billed case management services, thus reducing costs to the state for operating these agencies. In Massachusetts, contingency-fee consultants helped the state increase federal reimbursement for TCM services provided by three state agencies: the Departments of Social Services, Youth Services, and Mental Health. The consultants helped develop state plan amendments that established Medicaid coverage for the agencies' case management services

²¹See *State Medicaid Manual* §4302 and CMS, *Disapproval of Maryland State Plan Amendment No. 02-05*, Docket No. 2003-02 (Aug. 27, 2004).

²²CMS approved the states' TCM amendments before 2002.

²³The state plan amendment revised the state's existing TCM provision (approved by CMS in March 2002) to change the payment rate.

and assisted with developing and updating the rates Medicaid would pay providers for TCM services.²⁴

In analyzing the TCM projects and the basis for TCM claims, we found that Georgia and Massachusetts were claiming federal reimbursement, under their CMS-approved state plan amendments, for TCM services that appeared to be unallowable under CMS's current TCM policy. Specifically, the claims were for services that appeared to be integral components of non-Medicaid programs in these states. The states' laws, regulations, or policies called for case management services in these programs, and the case management services were provided to all Medicaid- and non-Medicaid-eligible individuals served by the programs.²⁵ For example, all children served by Massachusetts's and Georgia's child welfare agencies receive a broad range of services to promote their welfare and protect them from abuse and neglect. To fulfill this responsibility, state employees provide case management services, refer the children to others for services, and monitor their well-being and progress. CMS has denied TCM claims for similar programs in other states. In fiscal year 2002, for example, CMS denied a state plan amendment proposal to cover TCM services in Illinois, and in fiscal year 2004 it found TCM claims in Texas unallowable, in part because the TCM services claimed for reimbursement were considered integral to other state programs. As in Georgia and Massachusetts, the TCM services in Illinois were for children served by the state's juvenile justice system. In Texas, such children were served by the state's child welfare and foster care system.

In Georgia in fiscal year 2003, the state received an estimated \$17 million in federal reimbursements for TCM claims from the Department of Juvenile Justice and the Division of Family and Children's Services, of which about \$12 million was for services that appeared to be integral to non-Medicaid programs. In Massachusetts in fiscal year 2004, the state

²⁴Contingency-fee payments for TCM claims ended in 2003. According to Massachusetts officials, the consultants continued to assist the agencies in processing their TCM claims after 2003 but no longer received a contingency fee.

²⁵CMS's statements regarding TCM services do not define the phrase "integral component" but, rather, indicate that the agency considers whether the services are related to other programs. In the absence of a CMS definition, we considered (1) whether case management was called for by state law, regulation, or policy; (2) whether case management was provided to all Medicaid- and non-Medicaid-eligible clients served by the program statewide; and (3) whether the services were similar to those that were provided by states whose TCM state plan amendments or claims had been denied by CMS.

received an estimated \$68 million in federal reimbursements generated by claims from the Departments of Social Services, Youth Services, and Mental Health—the agencies whose TCM projects were developed by consultants—for services that appeared to be integral to non-Medicaid programs.²⁶ CMS officials agreed with our assessment that the claims for TCM services in these two states were problematic, and CMS officials noted that they had been aware of the potential problems in Massachusetts for some time before our review. CMS officials stated that, under an interagency agreement with HHS OIG, HHS OIG had initiated an audit of Massachusetts’s TCM claims in December 2003. At the time of our review, HHS OIG’s findings had not been released.

Rehabilitation Services

Our review of projects involving rehabilitation services found claims that were inconsistent with federal law from a project in Georgia and potentially duplicated claims for rehabilitation services in Massachusetts. Georgia’s contingency-fee consultant helped the state develop a project to increase the rates paid by Georgia’s Medicaid program to two state agencies for rehabilitation services, which in effect allowed the state to overpay these agencies for one set of services while reducing the agencies’ costs for other, non-Medicaid services. In Massachusetts, a consultant helped two state agencies increase claims for rehabilitation services, potentially duplicating other federal Medicaid reimbursements obtained by the state.

In Georgia, the Department of Juvenile Justice and the Division of Family and Children’s Services place certain children in state custody in private residential care facilities throughout the state. Under contract with these state agencies, the residential facilities provide various services, including many not covered by Medicaid, such as room and board, general supervision, and educational services. The facilities also provide rehabilitative counseling and therapy services. The facilities receive a per diem payment from the state agencies for providing all of these services. The Department of Juvenile Justice and Division of Family and Children’s Services then bill the state Medicaid agency for mental health

²⁶In examining CMS expenditure reports, we found that both Georgia and Massachusetts had categorized non-TCM services, such as rehabilitation services, as TCM. We obtained estimates from the states of the amount the states had claimed for TCM services.

rehabilitation services, one component of the services the agencies pay the private facilities to provide.²⁷

As recommended by its contingency-fee consultant, Georgia increased the rates at which the state's Medicaid agency paid the Department of Juvenile Justice and the Division of Family and Children's Services for these rehabilitation services. The per diem amount these agencies paid the private facilities, however, stayed the same. Specifically, the consultant recommended that the two state agencies claim Medicaid reimbursement on the basis of the facilities' estimated costs for rehabilitation services, rather than on the state agencies' actual per diem payment. Before the project, the state agencies sought Medicaid reimbursement for that portion of the per diem payment attributable to the facilities' estimated cost for providing rehabilitation services. As a result of the change, the state was able to shift costs it had previously covered to Medicaid. For example, for one category of children, the percentage of the state's per diem paid by Medicaid increased from 50 percent under the state's prior method to 87 percent under the new method, while the share of the per diem paid by state funds decreased from 29 percent to less than 1 percent. In some cases, the added reimbursement from the Medicaid agency covered the other state agencies' own shares of the per diem payments to the facilities—shares that covered the costs of services other than rehabilitation. For example, the portion billed to Medicaid of one agency's per diem payment to one facility increased from \$115 to \$162 while that agency's own share decreased from \$37 to \$0. In all, this project increased the federal Medicaid reimbursement to the state agencies by \$58 million during state fiscal years 2001 through 2003.²⁸

The change in the basis for the expenditures that were claimed for Medicaid reimbursement resulted in payments from Georgia's Medicaid agency to the Department of Juvenile Justice and the Division of Family

²⁷Specifically, the state Medicaid agency was billed for "therapeutic residential intervention services," which are defined by the state as comprehensive rehabilitation services consistent with the diagnosis and treatment needs of the child's condition. Therapeutic residential intervention provides mental health treatment services for emotionally disturbed and severely emotionally disturbed children. According to state officials, these rehabilitation services were covered under the state plan provision authorizing early and periodic screening, diagnostic, and treatment services, which are comprehensive screening and treatment services that states provide to children and adolescents younger than 21.

²⁸In addition to the new method for billing Medicaid, the contingency-fee project also helped Georgia expand the number of Medicaid beneficiaries and private facilities for which rehabilitation services were billed.

and Children's Services for services provided by private facilities that in some cases were higher than what the agencies paid the facilities for all contracted services combined (Medicaid- and non-Medicaid-covered). Specifically, for 82 facilities (about 43 percent of the residential facilities), the amount the state Medicaid agency reimbursed the Department of Juvenile Justice and the Division of Family and Children's Services in state fiscal year 2004 exceeded the total amount these agencies actually paid the facilities for all services, not just rehabilitation services. One facility, for example, was paid by the Division of Family and Children's Services \$37 per day per eligible child for all services covered by the per diem payment, but the state agency billed the Medicaid program \$62 per day for rehabilitation services alone.

CMS officials agreed with our conclusion that the claims from this contingency-fee project were inconsistent with federal law. Specifically, the arrangement was not in accord with the statutory requirement that payments be consistent with efficiency, economy, and quality of care. Further, federal Medicaid funds are intended for Medicaid-covered services for eligible individuals on whose behalf payments are made, not to subsidize non-Medicaid-covered services.²⁹ In discussing Georgia's reimbursement-maximizing project, CMS officials also identified a number of additional concerns, including whether the billing agencies, as well as the facilities they paid, were qualified Medicaid providers; whether the facilities' estimates of Medicaid costs were appropriate; and whether all services included in the facilities' estimates were Medicaid-covered services. After we brought it to the agency's attention, CMS initiated a review of this contingency-fee project and the allowability of associated claims for federal Medicaid reimbursement.

In Massachusetts, a contingency-fee consultant helped two state agencies increase claims for rehabilitation services that potentially duplicated federal payments the state had already received because, according to CMS officials, the services were to be paid for under the state's managed care agreement. The consultant developed and implemented a project in which the state's Department of Youth Services (the state's juvenile justice agency), for example, started billing Medicaid for rehabilitation services that the state agency was responsible for providing directly to youth it served. As with Georgia's arrangement, the Department of Youth Services billed Medicaid for payments the agency made to private facilities that

²⁹ See 42 U.S.C. §§ 1396 and 1396a(a)(30) (2000).

cared for youths in the state's juvenile justice system. To the extent that the youth served by the department were enrolled in the state's Medicaid managed care program, these payments may have duplicated payments the state had already received for rehabilitation services provided under that program. States typically accept a fixed federal payment per person per month for providing a range of services to Medicaid beneficiaries enrolled in managed care programs. Rehabilitation services are covered by the managed care payment Massachusetts receives. CMS officials agreed that it was likely that duplicate payments occurred, because a significant portion of the state's Medicaid beneficiaries are enrolled in its managed care program. CMS officials could not, however, estimate the amount of duplicate payments.

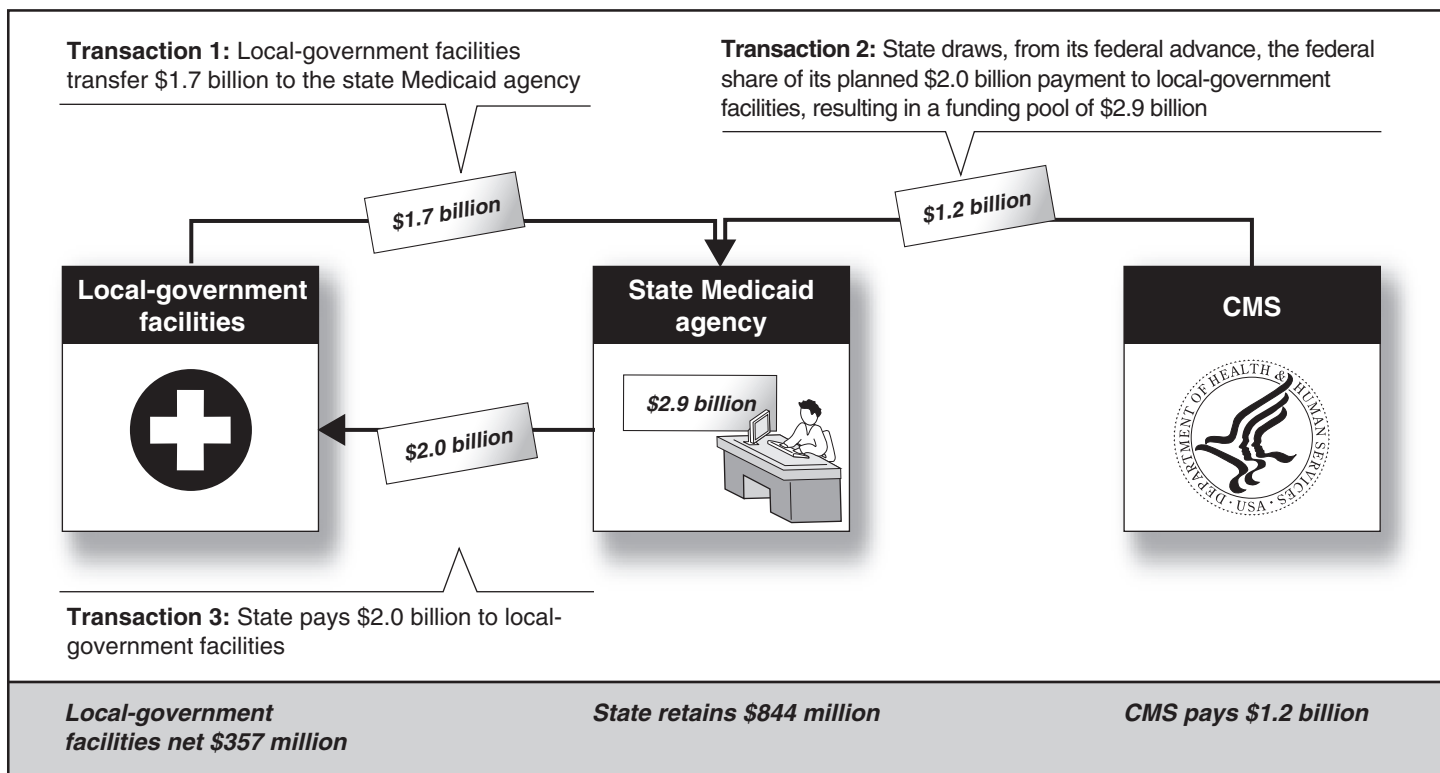
Supplemental Payments

Consultants in both Georgia and Massachusetts helped the states implement supplemental payment arrangements that claimed federal reimbursements on behalf of state and local-government facilities, which did not retain the bulk of the Medicaid payments. Although, under current law and CMS policy, states are allowed to claim federal reimbursements for supplemental payments they make to providers up to UPL ceilings, we have earlier reported that payments in excess of a provider's costs that are not retained by the provider as payment for services actually provided are inconsistent with Medicaid's federal-state partnership and fiscal integrity.³⁰ These payments can be illusory: that is, the state can benefit from the arrangements by appearing to pay the providers more than they ultimately retain while the state seeks federal reimbursement on the excess payment. Most of the additional federal Medicaid funding generated by Georgia's reimbursement-maximizing projects—\$1.2 billion during state fiscal years 2001 through 2003—came through UPL financing arrangements developed by the state's consultant. The consultant developed five arrangements—one each for local-government-operated inpatient hospitals, outpatient hospitals, and nursing homes and state-owned hospitals and nursing homes. During state fiscal years 2001 through 2003, the state made supplemental payments totaling \$2.0 billion to nursing homes and hospitals operated by local governments (see fig. 2). A sizable share of the \$2.0 billion, however, was illusory. In reality, the health facilities netted \$357 million because they had transferred \$1.7 billion to the state Medicaid

³⁰See, for example, GAO, *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes*, [GAO-04-574T](#) (Washington, D.C.: Mar. 18, 2004), and [GAO-04-228](#).

agency through a process known as an intergovernmental transfer.³¹ The state combined this \$1.7 billion with \$1.2 billion in federal funds that had been advanced to the state through the quarterly advance process. The advanced amount represented the estimated federal share of the planned supplemental payments to local-government facilities of \$2.0 billion. The state thus had a funding pool of \$2.9 billion at its disposal. From this pool, the state made the \$2.0 billion in supplemental payments to local-government providers and retained \$844 million to offset its Medicaid expenditures.

Figure 2: Georgia’s UPL Arrangement with Local-Government Health Care Providers, State Fiscal Years 2001–2003



Source: GAO.

Note: Totals may not add up because of rounding.

³¹Intergovernmental transfers are a tool that state and local governments use to carry out their shared governmental functions, such as collecting and redistributing revenues to provide essential government services.

Despite actions taken by Congress and CMS to narrow loopholes associated with UPL financing schemes, federal reimbursements for provider payments made up to the UPL are still allowed under federal law and CMS policy. Georgia's arrangement illustrates how current law and UPL policy continue to allow states to inappropriately generate excessive federal matching payments beyond standard Medicaid payments for services.

Georgia's consultant also developed a UPL arrangement with state-owned hospitals. During state fiscal years 2001 through 2003, the state made \$108 million in UPL payments to state hospitals, which included \$64 million in federal funds. The bulk of the payment, however, was illusory, in that the hospitals' net increase in payments was \$22 million. Through this arrangement, the state Medicaid agency was able to retain \$42 million in additional funds, which it used to offset its Medicaid expenditures. In commenting on a draft of this report, the state said that it had agreed with CMS to end the aspects of its UPL arrangement that resulted in federal reimbursements exceeding the state's actual payment to the providers, effective June 30, 2005.

Massachusetts's consultant similarly assisted the state with increasing federal reimbursements through a UPL arrangement. Under a May 2003 agreement between UMMS and the Massachusetts Medicaid agency, UMMS developed a UPL project involving government-owned or government-operated nursing facilities, which entailed illusory payments to providers.³² As in Georgia, Massachusetts's payments, which involved intergovernmental transfers, were illusory because the state claimed federal matching for a UPL payment of \$8.6 million when the net payment increase to the nursing homes was \$1.2 million. According to the state comptroller's office, the Medicaid agency had in August 2003 paid UMMS about \$155,000 for the project, a contingency fee of 5 percent of the \$3.1 million in additional federal Medicaid reimbursements that the project had generated for the state. As with Georgia, the state Medicaid agency agreed in August 2004 to end certain aspects of its UPL arrangement effective June 30, 2005.

³²The project description indicated that UMMS agreed to help the state "put the mechanisms in place required to carry out the related intergovernmental transfer of funds back to the state."

School-Based Health Services
and Associated Administrative
Costs

Massachusetts contracted with UMMS to implement two other types of supplemental payment arrangements (involving disproportionate share hospital payments), which we were unable to fully evaluate for their consistency with federal law and policy. The arrangements are complex, requiring substantial documentation to assess. The information we received from the state raised legal and policy questions, but the state Medicaid agency did not produce the extensive documentation we needed within the time frame of our work. We believe that a separate study of these arrangements would be required to assess their appropriateness. Where appropriate, we have referred information to CMS and HHS OIG about projects within the scope of our work that we were unable to evaluate (see app. I).

HHS OIG has identified concerns with states' school-based claims for Medicaid services in Massachusetts and in several other states that have relied on the work of contingency-fee consultants. (See app. II for a summary of selected HHS OIG reports of states that have used contingency-fee consultants.) In Massachusetts, HHS OIG reported on concerns with the adequacy of state and UMMS monitoring of claims for school-based services to ensure school districts' compliance with federal and state requirements, estimating that \$2.9 million in unallowable Medicaid claims were paid in state fiscal year 2000.³³ HHS OIG found that the state had inappropriately submitted claims for services that were not documented as delivered, provided by unqualified providers, or provided to students who were absent on the dates of the claimed services. According to state officials, after further review, CMS, which reviews HHS OIG recommendations and issues final disallowances, imposed a \$1.2 million disallowance. In a separate report on Massachusetts' claims for administrative costs related to school-based services, HHS OIG found that in state fiscal years 2000 and 2001, the state did not monitor the appropriateness of school districts' claims that were compiled by UMMS,³⁴ resulting in at least \$5 million in unallowable claims.³⁵

³³HHS OIG, *Medicaid Payments for School-Based Health Services—Massachusetts Division of Medical Assistance*, A-01-02-00009 (Washington, D.C.: July 14, 2003).

³⁴State officials, in comments on a draft of this report, noted that the state had disagreed with OIG's finding and noted that no disallowance had been issued by CMS as of June 2005.

³⁵HHS OIG, *Medicaid School-Based Health Services Administrative Costs—Massachusetts*, A-01-02-00016 (Washington, D.C.: Sept. 15, 2004).

In commenting on a draft of this report, Massachusetts officials cited a number of actions taken in response to HHS OIG's reports. To strengthen oversight of school-based claims, state efforts include enhanced training and technical assistance to school districts, expanded management reporting, new monitoring and auditing systems, and a newly established Director of School-Based Medicaid within the Office of Medicaid.

In the context of documenting Georgia's contingency-fee project related to school-based claims, we identified a concern with how Georgia was using additional federal reimbursements gained from school-based claims. Georgia's contingency-fee consultant assisted the state with Medicaid claims for school-based services in a project that generated about \$54 million in federal Medicaid reimbursements over the 3 years the consultant was paid and that, on the basis of state data, we estimate continues to generate about \$25 million annually.³⁶ We found that the school districts were not receiving all of the federal Medicaid matching funds that were generated on their behalf—a concern we noted in prior reports on state school-based claims.³⁷ According to a state official and documents provided by the state, the state retained \$3.9 million, or 16 percent, of federal reimbursements that were claimed on behalf of the school districts for state fiscal year 2003, most of which was used to pay its contingency-fee consultant and about \$1 million of which was used to cover the salaries and administrative costs of the five state employees who administered school-based claims in Georgia.

Administrative Costs

Our work in Massachusetts and Georgia found that neither state had claimed federal reimbursement for contingency fees they had paid their consultants. In examining Massachusetts's administrative claims, however, we found that, despite a major reorganization of state agencies beginning in mid-2003, the state did not submit a complete cost allocation plan—which would have provided the basis for its administrative claims—

³⁶We did not assess whether the school-based health services that the state claimed were allowable.

³⁷In particular, our earlier reports found that in some states, school districts received only a small portion of the federal funds that were claimed on their behalf because states and contingency-fee consultants shared in the reimbursements. Rather than fully reimbursing schools for their Medicaid-related costs, some states retained as much as 85 percent of federal Medicaid reimbursements. According to several state officials, because states funded a portion of local education activities, Medicaid services provided by schools were partially funded by the state. Under this reasoning, some states believed they should receive a share of the federal reimbursements claimed by school districts. See [GAO/T-HEHS-99-148](#) and [GAO/HEHS/OSI-00-69](#).

reflecting its new organization until December 2004. As of April 2005, the revised cost allocation plan had not been approved by HHS.³⁸ We also found that the state may have claimed more in administrative costs related to its contingency-fee projects than may have been warranted. For example, according to the state's claims for administrative reimbursement for UMMS's costs, 100 percent of one senior official's salary was claimed as a Massachusetts Medicaid administrative expense, even though the official had worked on UMMS projects conducted for other states. We also identified an issue related to Georgia's claims for administrative costs that we were unable to fully evaluate during our work. As discussed in appendix I, we have referred information regarding Georgia's administrative claims to CMS for further review.

HHS OIG has recently reported on unallowable administrative expenses in states other than Massachusetts related to their use of contingency-fee consultants. In October 2004, for example, HHS OIG reported that Colorado had received about \$180,000 in improper federal Medicaid reimbursement because the state had claimed about \$359,000 in consultant fees that were contingent upon reimbursements from the federal government for Medicaid family-planning claims.³⁹ The claims were made from April 2002 through December 2003. Similarly, in November 2004, HHS OIG reported that Virginia had improperly claimed as Medicaid administrative expenditures the contingency fees paid to a consultant for federal reimbursement-maximizing services also related to family-planning services. From October 2001 through April 2003, the state had claimed about \$678,000 in unallowable contingency-fee payments made to a consultant, the federal share of which was about \$339,000.⁴⁰ Both states agreed that they had improperly claimed these fees and submitted

³⁸The Massachusetts Comptroller's office proposed an interim revision to the cost allocation plan in a letter dated March 10, 2004, but reviewers in CMS region I noted that the letter spoke only of the consolidation of human resource functions and not of broader reorganization issues. In an April 2004 memo to the HHS Division of Cost Allocation, CMS regional reviewers commented that the interim revision contained inconsistencies and mathematical errors and recommended that the state revise and resubmit its proposal. Another draft submitted in September 2004 was incomplete and could not be reviewed. In December 2004, the state submitted a revision of the September draft, which was under review as of April 2005.

³⁹HHS OIG, *Contingency Fees Claimed by Colorado as Medicaid Reimbursement*, A-07-04-01009 (Washington, D.C.: Oct. 29, 2004).

⁴⁰HHS OIG, *Review of Virginia's Contingency Fee Payments for Maximizing Federal Revenues Claimed by Its Medicaid Managed Care Program*, A-03-04-00213 (Washington, D.C.: Nov. 9, 2004).

corrective adjustments. According to a CMS official, the agency recouped the states' excessive reimbursements.

In early 2005, CMS acted upon its concerns about states' Medicaid administrative claims. For example, CMS reported that, in some instances, evidence showed that states had attempted to shift administrative costs associated with other social service programs to Medicaid. The President's budget proposal for fiscal year 2006 contains an initiative to limit states' allotments for Medicaid administrative claims.⁴¹

Two Factors Increase Risk of Problematic Claims

We observed two factors in many reviewed projects that appeared to increase the risk that claims are problematic, that is, inconsistent with federal law or policy, or with Medicaid's federal-state partnership and fiscal integrity. One factor was that they came under areas of Medicaid claims where federal requirements were inconsistently applied, evolving, or not specific, at times resulting in inconsistent treatment of states by CMS. Despite CMS's long-standing concern about state financing arrangements for both TCM and supplemental payments, the agency has not issued adequate guidance to clarify expenditures allowable for federal reimbursement. Federal policy for claims in these categories has evolved over time, and the criteria that CMS applies to determine whether claims are allowable have been communicated to states mainly through state-specific state plan amendment reviews or claims disallowances, rather than through guidance or regulation. State officials, HHS OIG auditors, and CMS financial management staff have raised concerns about the lack of, and need for, improved guidance in a number of categories that we reviewed. Some officials said that the lack of clear CMS guidance has allowed states to develop new financial arrangements, or to continue existing ones, that take advantage of gray areas. In line with these concerns, we also found that existing guidance on allowable claims had been inconsistently applied, had evolved over time, or, in the case of rehabilitation services, had not been specified.

⁴¹The CMS Administrator's performance budget for fiscal year 2006 proposes to establish individual state allotments for Medicaid administrative claims. CMS's budget request notes that the open-ended financing of Medicaid administrative claims does not encourage states to administer the program as efficiently as possible. CMS estimates 5-year budget savings of \$1.1 billion from its proposal. See the Centers for Medicare & Medicaid Services' performance budget for fiscal year 2006.

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- **Inconsistently applied policy for allowable TCM services:** Although CMS began to deny proposed state plan amendments that sought approval for Medicaid coverage of TCM services that were the responsibility of other state agencies in 2002, states with such arrangements then in place, such as Georgia and Massachusetts, were allowed to continue them. For other states, CMS had determined that such arrangements were not eligible for federal Medicaid reimbursement for several reasons: (1) the services were typically integral to existing state programs, (2) the services were provided to beneficiaries at no charge, and (3) beneficiaries' choice of providers was improperly limited.⁴² CMS, however, had approved Georgia's and Massachusetts's state plan amendments for TCM services before 2002. Although CMS has since applied these criteria to deny TCM arrangements or claims—for example, in Maryland, Illinois, and Texas—it has not yet sought to address similar, previously approved TCM arrangements that are inconsistent with these criteria. CMS regional officials told us they could not reconsider the TCM claims from two agencies in Georgia and four in Massachusetts because they were waiting for new guidance that the agency was preparing.⁴³ CMS has been working on new TCM guidance for more than 2 years, according to agency officials, and as of May 2005 this guidance had not been issued. CMS's fiscal year 2006 budget submission identifies savings that could be achieved by clarifying allowable TCM services, but CMS had not published a specific proposal at the time we completed our work.⁴⁴
 - **Evolving policy for allowable supplemental payment arrangements:** For several years, we and others have reported on state financing arrangements that allow states to inappropriately generate federal Medicaid reimbursement without a corresponding state expenditure. While Congress and CMS have taken steps to curb these abuses, states can still develop arrangements enabling them to make illusory payments to gain federal reimbursements for their own purposes. CMS has recognized that states can gain from supplemental, such as UPL, payment

⁴²A CMS Administrator's decision denying a proposed state plan amendment from Maryland to cover TCM services articulated criteria that CMS has applied to evaluate state TCM plan amendments. See CMS, *Disapproval of Maryland State Plan Amendment No. 02-05*, Docket No. 2003-02 (Aug. 27, 2004).

⁴³A CMS official stated that the agency's most recent guidance on TCM, issued in January 2001, contained problems and errors that caused confusion regarding appropriate TCM claims when non-Medicaid state agencies were involved.

⁴⁴The CMS Administrator's performance budget for fiscal year 2006 proposes to clarify allowable TCM services and align federal reimbursement for TCM services with an administrative matching rate of 50 percent. CMS estimates 5-year budget savings of \$1 billion from reducing the reimbursement for TCM to the administrative matching rate.

arrangements through intergovernmental transfers. Since fiscal year 2003, for example, CMS has worked with individual states to address such arrangements and, under this effort, CMS had identified and made agreements with Georgia and Massachusetts to change how their UPL arrangements operated.⁴⁵ At the same time, the agency has not issued guidance stating its policy on acceptable approaches for supplemental payment arrangements, including the allowed methods for funding the state's share of the Medicaid program. CMS's budget for fiscal year 2006 proposes to achieve federal Medicaid savings by curbing financing arrangements that have been used by a number of states to inappropriately obtain federal reimbursements. The specific proposal, however, had not been published at the time we completed our review.⁴⁶

- **Unspecified policy on allowable Medicaid rehabilitation payments to other state agencies:** CMS has not issued policy guidance that addresses situations where Medicaid payments are made by a state's Medicaid agency to other state agencies for rehabilitation services. CMS financial management officials told us that states' claims for rehabilitation services posed an increasing concern, in part because officials believed that states were inappropriately filing claims for services that were the responsibility of other state programs. CMS does not specify whether claims for the cost of rehabilitation services that are the responsibility of non-Medicaid state agencies are allowable. CMS's fiscal year 2006 budget submission identifies savings that could be achieved by clarifying

⁴⁵In commenting on a draft of this report, CMS said that 23 states had agreed to terminate one or more financing practices that increased the federal share of the cost of providing Medicaid services, effective with the end of their state fiscal year 2005. CMS had identified an additional 10 states with similar financing mechanisms that are in the process of terminating such arrangements. Assessing the provisions of CMS agreements with individual states is part of an ongoing GAO review.

⁴⁶The budget proposes to build on CMS's efforts to curb questionable financing practices by (1) recovering federal funds claimed for covered services but retained by the state and (2) capping payments to government providers at no more than the cost of furnishing services to Medicaid beneficiaries. CMS estimates 5-year budget savings of \$5.9 billion from this proposal. GAO has recommended since 1994 that Congress consider legislation to prohibit Medicaid payments to government providers that exceed the providers' actual costs. See GAO, *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*, [GAO/HEHS-94-133](#) (Washington, D.C.: Aug. 1, 1994).

appropriate methods for claiming rehabilitation services. CMS had not published a specific proposal at the time we completed our review.⁴⁷

Another factor shared by the reimbursement-maximizing projects we examined was that they increased Medicaid payments from state Medicaid agencies to other state or local-government agencies—that is, to non-Medicaid agencies that may serve Medicaid beneficiaries—a mechanism that can facilitate an inappropriate shift of state costs to the federal government. Medicaid reimbursement to government agencies serving Medicaid beneficiaries is allowable in cases where the claims apply to covered services and the amounts paid are consistent with economy and efficiency. In contrast, the projects and associated claims we reviewed showed that reimbursement-maximizing projects often involved services and circumstances that Medicaid should not pay for—such as illusory payments to government providers.

Limited State and CMS Oversight of Claims from Contingency-Fee Projects Raises Concerns about Medicaid Financial Management

Georgia, Massachusetts, and CMS provided limited oversight of claims associated with projects developed with the aid of contingency-fee consultants to ensure that they were consistent with Medicaid requirements. The two states' measures to oversee contingency-fee projects were insufficient to prevent inappropriate claims, and CMS officials were not always aware of states' specific projects to maximize federal reimbursement. Problems we found with CMS's oversight of states' reimbursement-maximizing projects and associated claims illustrate the need to address broader financial management issues, especially as more states adopt reimbursement-maximizing strategies without hiring consultants.

States Have Taken Some Steps to Ensure Appropriate Claims, but Problems Remain

Georgia and Massachusetts have taken some steps to oversee the contingency-fee consultants they have engaged for reimbursement-maximizing projects. Georgia's oversight was conducted primarily through a steering committee, formed by the state in 1999, with project review and approval responsibility. Specifics of implementing the projects were

⁴⁷The CMS Administrator's budget for fiscal year 2006 further clarifies CMS's concern that states have attempted to shift costs associated with other social service programs to Medicaid. The budget proposes to clarify allowable services that may be claimed as rehabilitation. CMS estimates 5-year budget savings of \$2 billion from its proposal to clarify allowable TCM and rehabilitation services. See the Centers for Medicare & Medicaid Services' performance budget for fiscal year 2006.

delegated to the state agencies that generated the enhanced reimbursements. In some cases, the state Medicaid agency and the steering committee disapproved proposed projects because they did not comply with Medicaid law or policy. For example, the consultant proposed that two state agencies be allowed to bill for TCM for a particular client in a given month. The state agency determined that this proposal would result in an inappropriate duplicate billing and chose to allow only one state agency to bill for TCM services per client per month. In addition, although Georgia was not required to notify CMS when a new project was developed by the state's consultant—and generally did not do so because it believed the authority to implement various projects was already included in the state's existing approved Medicaid plan—on occasion, it sought the advice of CMS's regional office about a project.

Despite Georgia's review of the consultant's proposed projects, however, the state's oversight did not identify problems with some of the projects we reviewed. For example, Georgia made several changes in its rehabilitation program, including a change in how payment rates to private facilities were calculated. As discussed in the rehabilitation services section of this report, we believe the revised rates were not in accord with requirements that payments be consistent with efficiency and economy. CMS officials—who had not been asked to approve the states' revised rates—agreed, and during our review began an investigation to determine the extent of the problem.

In Massachusetts, oversight for Medicaid reimbursement-maximizing projects has been shared by the state Medicaid agency, which is now in the Executive Office of Health and Human Services, and the Office of the State Comptroller. The Medicaid agency is responsible for ensuring that the state's claims for federal reimbursement are consistent with federal requirements. The Comptroller's office reviews and approves specific reimbursement-maximizing projects proposed by the Medicaid agency, manages the accounts that receive reimbursements generated by the projects, verifies and pays the contingency fees, and reports program results annually to the state legislature. The Comptroller's review has focused on the financial implications of proposals, more than on program implications. Recent state legislation authorized the Medicaid agency to enter into contingency-fee contracts with UMMS without the Comptroller's prior approval and to pay contingency fees up to a ceiling of \$30 million for state fiscal year 2005.

The Massachusetts Medicaid agency engaged UMMS to perform many ongoing operational functions of its Medicaid program. In February 2004,

when the Executive Office of Health and Human Services was designated as the single state Medicaid agency, and staff of the Medicaid and other state agencies were relocated under UMMS, UMMS has assisted the state Medicaid agency in carrying out many of its functions. UMMS in 2004 had major responsibilities for administering significant operational aspects of the Medicaid program, such as conducting program integrity and utilization reviews⁴⁸ and compiling the state's Medicaid claims for school-based services, including ensuring the appropriateness of such claims.⁴⁹ At the same time, UMMS has also been paid contingency fees by the state Medicaid agency for numerous reimbursement-maximizing activities, such as those related to school-based claims.

In addition to its agreements with the Massachusetts Medicaid agency to operate portions of the Medicaid program, UMMS also served as a contingency-fee consultant to other Massachusetts entities to enhance federal Medicaid reimbursements. UMMS officials told us that they have contracted on a contingency-fee basis with about 86 of the state's 356 local school districts to develop their school-based Medicaid administrative claims and with about 75 local districts to develop school-based health services claims. UMMS therefore administers significant operational aspects of the state's system for school-based Medicaid services, including overseeing the appropriateness of claims, and acts as a contingency-fee consultant to prepare some of those claims for some school districts.⁵⁰ In

⁴⁸State Medicaid agencies are required to implement program integrity and utilization reviews to ensure the proper and efficient administration of their programs by preventing, detecting, and controlling fraud and abuse. Program integrity reviews focus on ensuring the accuracy of payments to providers, including detection and recovery of overpayments that may result from billing errors, failures in computerized claims processing systems, or fraud. Utilization reviews generally include surveillance and analysis of Medicaid service-use patterns to ensure that the services are used appropriately, according to the state Medicaid plan, and that beneficiaries are not receiving either too many or too few services.

⁴⁹Among several provisions in the interdepartmental services agreement for school-based services, UMMS agreed to “[e]stablish and maintain procedures for claiming medical service costs related to Medicaid spending at local schools”; “establish and maintain procedures for claiming costs at local schools associated with the administration of the Medicaid program”; “review and perform quality-control measures on local school cost information, prior to the compilation of such data for the quarterly submission to CMS”; and “make quarterly policy and program recommendations to EOHHS for the school based provider group.”

⁵⁰Under its agreement to administer the state's school-based services program, UMMS is responsible for establishing procedures and training district staff, reviewing and submitting claims, and compiling administrative costs. For this work, UMMS is paid a contingency fee of 1 percent of federal reimbursements generated, up to \$950,000 per fiscal year, and it is reimbursed for 50 percent of its costs via the state's Medicaid administrative claims.

audits of Massachusetts's claims for school-based health services, HHS OIG cited inadequate oversight by both the state Medicaid agency and UMMS. HHS OIG audited health claims and administrative expenditures from eight school districts and found improper claims in both categories.⁵¹ In our view, this dual role—assisting with Medicaid program administration, including quality control, and consulting with local school districts on a contingency-fee basis—creates an appearance of conflict of interest for UMMS, raising questions about UMMS's incentives for ensuring that claims for federal Medicaid reimbursement are appropriate.⁵²

The oversight measures that Massachusetts Medicaid officials told us they had in place to ensure that reimbursement-maximizing claims compiled by UMMS were consistent with federal requirements were insufficient to prevent inappropriate claims. The officials told us, for example, that they relied on edits in the state's Medicaid Management Information System—the computer system that processes provider claims for payment—to ensure that the processed Medicaid claims were allowable. According to the CMS financial management officials who reviewed Massachusetts's claims, however, claims from some reimbursement-maximizing projects were not subject to computer-based edits. The officials estimated that about 30 percent of the state's Medicaid claims, including some of those for managed care and supplemental payments, are processed off system—that is, not through the state's computerized Medicaid Management Information System—and these off-system claims pose a greater concern, they told us, because inaccuracies are more common in them.

CMS Has Limited Oversight of Contingency-Fee Projects and Associated Claims

CMS did not routinely review projects in Georgia and Massachusetts that used contingency-fee consultants and in fact was unaware of some of the specific projects to increase federal reimbursements that we reviewed. CMS oversight of such projects and the associated claims was limited because the agency did not routinely request that states indicate on state plan amendments or expenditure reports whether consultants were involved in their development. CMS officials told us they relied primarily

⁵¹See HHS OIG A-01-02-00009 (July 14, 2003), and HHS OIG A-01-02-00016 (Sept. 15, 2004).

⁵²We identified another potential concern, outside the scope of our review, related to UMMS subcontracts with an organization with which UMMS officials were affiliated. Three UMMS officials sit on the boards of directors of two related nonprofit corporations. In state fiscal years 2003 and 2004, UMMS paid one of these related corporations more than \$2.4 million for subcontracted work. We notified CMS regional officials of our concerns.

on the states to ensure that projects and claims were appropriate. Although CMS surveyed its regional offices in fiscal year 2004 to identify contingency-fee consultant projects by state, our work in Georgia and Massachusetts identified more projects developed with assistance from contingency-fee consultants than CMS's survey reported. CMS officials told us that they became aware of Georgia's contract with its consultant when a local newspaper reported a dispute between the state and the consultant. CMS officials overseeing the Massachusetts Medicaid program told us they had not examined the relationships between the Medicaid agency and UMMS, but they told us that during the time of our review they had asked HHS OIG to investigate the appropriateness of the state's Medicaid administrative claims, which included those attributable to UMMS. HHS OIG's investigation was under way when we completed our work.

CMS has stated that it lacks authority to require states to disclose contingency-fee arrangements when states are not seeking federal reimbursement for the fees. CMS officials clarified, however, that they can request information about the assistance of a contingency-fee consultant when agency officials are reviewing state submissions such as state plan amendments, cost allocation plans, or expenditure reports. Officials said that they did not routinely request such information in conjunction with these reviews. In Georgia and Massachusetts, we found CMS reviews limited in the extent to which they identified concerns with contingency-fee projects and associated claims in three areas:

- **CMS review of state plan amendments:** Because states' proposals for changes to their state plans through amendments might be general in nature, CMS may not have details to identify the specific changes that would increase claims. Georgia, for example, did not submit a state plan amendment about its project to increase payment rates for rehabilitation services to children in the state's juvenile justice and child protection systems because it had concluded that it could change how it claimed Medicaid reimbursement without changing the state plan section that authorized the payments. When we discussed this example with CMS officials, they told us that when a state's plan is broadly written, the state may not always submit amendments to change the plan provisions. The CMS officials told us that even in cases where a contingency-fee consultant was involved in drafting a state plan amendment—for example, to establish new coverage or payment rates—they might not be aware of a

consultant's involvement because states do not routinely disclose this information to CMS.⁵³

- **CMS review of cost allocation plans:** As previously discussed, Massachusetts did not submit a complete draft cost allocation plan to CMS, reflecting its major reorganization, until December 2004. As of April 2005, the revised cost allocation plan had not been approved. CMS officials did not explain why Massachusetts was allowed to continue claiming federal Medicaid reimbursement for administrative costs on the basis of an outdated cost allocation plan, other than to say that several other states did not have current plans. Massachusetts's officials told us they did not expect major changes as a result of the revised cost allocation plan, but the extent of any changes cannot be verified until a revised plan is approved.
- **CMS review of Medicaid quarterly expenditure reports:** Nothing in the quarterly expenditure report indicates when a contingency-fee consultant has assisted in developing specific categories of claims, making it difficult to identify such claims. CMS regional financial analysts responsible for reviewing Massachusetts's expenditure reports told us that it was standard practice to defer payment to allow further investigation of any claims for new services when they knew that a consultant had been involved.⁵⁴ In such cases, they requested and analyzed further information from the state. The ability of CMS regional officials to identify potential problems with states' claims by analyzing quarterly expenditure reports was limited. Regional CMS officials responsible for Massachusetts told us they used standard trend and variance analyses to review the reports and also conducted some analyses of their own, but they were not confident that these reviews were adequate to identify problems. CMS regional analysts are able to conduct only a few focused reviews each year of potential problems with states' claims identified through their analyses of the quarterly expenditure reports, and, they told us, random reviews are not feasible.⁵⁵

⁵³Another problem with state plan amendment reviews, which CMS has taken steps to rectify, arose because regional offices used to have responsibility for reviewing and approving state plan amendments, and review criteria were not always consistently applied among the regional offices. Since July 2002, CMS has taken several actions to centralize its reviews and approvals of many state plan amendments.

⁵⁴The officials also told us that since 2004, any deferrals of claims must be approved by the CMS central office.

⁵⁵When regional CMS officials identified an area of concern, they told us they typically referred it to the regional OIG office for in-depth audit; each regional office can conduct only a few focused reviews each year to quickly assess the nature and scope of potential problems.

In the CMS regional offices managing Medicaid claims from Georgia and Massachusetts, available agency resources—especially in terms of experienced analysts relative to the scale and variety of claims—have constrained the conduct of financial reviews. Although Georgia claims federal Medicaid reimbursements totaling approximately \$1.7 billion per quarter, CMS has had only one financial analyst assigned to review those claims; for Massachusetts, three CMS analysts are responsible for reviewing quarterly claims of more than \$2 billion.

Our work in Georgia and Massachusetts also identified an area where consultants were advising states and where CMS does not have any oversight mechanism. CMS does not review the payment rates that state agencies other than the Medicaid agency bill to the Medicaid program for services such as TCM. In Massachusetts, each of the four non-Medicaid agencies providing TCM services developed its own rate for billing the services to Medicaid, in some cases with the assistance of the agency's consultant. In state fiscal year 2004, these four agencies billed Medicaid a monthly fee for TCM services that ranged from \$178 per person in the Department of Mental Retardation to \$454 in the Department of Youth Services, according to state officials. Although CMS approved a general rate-setting provision as part of the original state plan amendments for these agencies' case management services, the actual payment amounts are generally reviewed and approved only by a division of the Massachusetts Medicaid agency. CMS does not review these state-approved payment amounts, and the HHS Division of Cost Allocation reviews cost allocation plans related only to administrative, not service, claims.

Problems Illustrate Need to Improve the Financial Management of Medicaid

The concerns we identified with the appropriateness of states' Medicaid claims stemming from contingency-fee projects illustrate the urgent need to address the issues we have identified with CMS's overall financial management of the Medicaid program.⁵⁶ We identified problems with claims in states other than Georgia and Massachusetts that have undertaken reimbursement-maximizing activities, without employing consultants, in categories of long-standing concern, such as supplemental payment arrangements. In March 2004, for example, when one state sought consultants for reimbursement-maximizing services for Medicaid and other programs, the proposed scope of work specifically excluded activities that the state already had under way, including Medicaid UPL claims, school-based administrative and service claims, eligibility for foster children, and TCM services.⁵⁷ CMS and HHS OIG officials in the Atlanta regional office told us about reimbursement-maximizing projects in two states in the region that were developed without the use of consultants.

CMS relies on its standard financial management controls to identify or correct any unallowable Medicaid claims that states may submit, including those that might be associated with reimbursement-maximizing contingency-fee projects. In assessing the appropriateness of claims generated from contingency-fee projects in Georgia and Massachusetts, we found other examples of potentially unallowable claims that CMS's financial management controls had failed to uncover. For example, when we discussed Georgia's contingency-fee project for rehabilitation services, CMS officials not only agreed with our assessment that the additional reimbursements from the project were inconsistent with federal law, but also identified concerns about whether the state agencies and facilities

⁵⁶See, for example, GAO, *Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed*, GAO-02-300 (Washington, D.C.: Feb. 28, 2002). This report found that CMS's systems for financial oversight of state Medicaid programs were limited. We recommended a range of approaches to strengthen internal controls and target limited resources, including that CMS revise its existing risk-assessment efforts to more effectively and efficiently target oversight resources to areas most vulnerable to improper payments. An ongoing GAO review is assessing CMS's progress in implementing related recommendations. Also, in a 2004 report on state financing schemes (see GAO-04-228) we recommended that CMS improve oversight of state UPL projects, including issuing guidance to states and setting forth acceptable methods to calculate UPLs. These recommendations remain open.

⁵⁷See *The State of Arizona Request for Proposals for Revenue Maximization Services*, Solicitation # AD040501, as amended, <https://spirit.az.gov/applications/spirit./pro.nsf/docnum/adsm-5xfr40?open> (downloaded May 20, 2005).

were qualified providers, cost estimates were appropriate, and all services were covered by Medicaid.⁵⁸ Similarly, we identified Medicaid billing concerns in Massachusetts that did not stem from the contingency-fee projects:

- One state agency—the Department of Mental Retardation, which was not assisted by a contingency-fee consultant—was billing Medicaid for TCM services without appropriate documentation. According to department officials, the agency automatically bills Medicaid a monthly fee of \$178 for each Medicaid-eligible beneficiary in its TCM caseload. The department does not verify its billing records with its case managers' records to ensure that each beneficiary received a covered service each month. Automatic billing for case management services is not allowed under Medicaid: to claim federal reimbursement, states must document a specific service delivered on a specific date.⁵⁹ The Department of Mental Retardation received about \$19 million in federal reimbursement for its TCM claims in 2004, according to state officials. In commenting on a draft of this report, state officials acknowledged that contacts with clients do not necessarily occur each month and that the Department of Mental Retardation's billing for TCM was an area for improvement. Officials said that a new management information system planned for state fiscal year 2006 would allow electronic documentation of contacts with clients and automated verification during the billing process.
- Three other Massachusetts agencies—the Departments of Social Services, Youth Services, and Mental Health—billed Medicaid for TCM services even though the agencies could have been serving some of the same beneficiaries. A foster child served by the Department of Social Services, for example, could also be a juvenile offender served by the Department of Youth Services. State Medicaid officials permitted each state agency to bill Medicaid for TCM services and told us they did not consider this practice duplicate billing, because they believed the agencies provided different services. The officials told us that the CMS-approved state plan amendments authorizing TCM services for these agencies would show that the services differed. Our review of the documents provided by state officials, however, showed that for two agencies, the TCM service

⁵⁸Federal Medicaid reimbursements to the state in fiscal year 2003 for these services totaled about \$38 million.

⁵⁹Documentation for TCM claims must include the date of service; name of recipient; name of provider agency and person providing the service; nature, extent, or units of service; and place of service. See Section 4302.2 (L) of the *State Medicaid Manual*.

descriptions were identical⁶⁰ and for all four agencies, including the Department of Mental Retardation, the service descriptions were similar.⁶¹ State officials acknowledged that overlap in eligibility occurred among the agencies but said they were unaware of the number of Medicaid beneficiaries for whom two or more TCM services were claimed per month or the amount of reimbursements claimed for those beneficiaries. In Georgia, in contrast, only one agency is allowed to bill for TCM services in a given month for a given beneficiary.

CMS lacks clear, consistent policies to guide the states' and its own financial oversight activities. Furthermore, CMS officials have expressed concerns about the agency's ability to review states' activities in all high-risk areas that the agency has identified. We found that CMS has known for some time that two high-risk categories we identified—claims generated from consultants paid on a contingency-fee basis to maximize reimbursements and claims generated from arrangements where state Medicaid programs are paying other state agencies or government providers—were problematic. For example, CMS had listed these two categories on a financial tracking sheet of high-risk areas as of 2000.⁶² At an October 2003 congressional hearing, the CMS Administrator expressed concern that the Medicaid program was understaffed and that consultants

⁶⁰Specifically, the state plan sections for both the Department of Youth Services and the Department of Social Services defined TCM services in exactly the same language to include the following case manager activities: "collection of assessment data; development of an individualized plan of care; coordination of needed services and providers; home visits and collateral contacts as needed; maintenance of case records; and monitoring and evaluation of client progress and service effectiveness." (Collateral contacts include family members and others involved in the beneficiary's care.)

⁶¹For example, all four state agencies covered TCM services whose purpose was facilitating clients' access to services, conducting assessments or collecting assessment data, and monitoring and evaluating client progress.

⁶²In 2001, CMS asked each regional office to complete a risk assessment to identify the extent to which states in each region had attributes warranting closer CMS financial oversight and scrutiny. The identified risk factors that regional staff were asked to assess included areas where federal policy was unclear, states' use of a contingency-fee consultant to maximize reimbursements, and payments to public providers in which state Medicaid agencies may lack an incentive to monitor and control expenditures. Regional officials were to base their assessment of these and other risk factors on their working knowledge of each state.

in the states were “way ahead of” CMS in helping states take advantage of the Medicaid system.⁶³

CMS has undertaken several important steps to improve its financial management of the Medicaid program. A major component of the agency’s initiative is hiring, training, and deploying approximately 100 new financial analysts, mainly to regional offices. These analysts will be responsible for identifying state sources of Medicaid funding and contributing to the review of state budget estimates and expenditure reports. As of April 2005, CMS reported that 85 new financial analysts had been hired for the regions, and 10 new analysts were on duty in the central office. According to CMS, the new analysts have received initial training in the central office; two meetings per year are planned to bring all new analysts together for continuing education; and monthly conference calls take place with all new analysts and regional and central office officials. In addition, each region has its own conference call every 2 weeks with officials of CMS’s new Division of Reimbursement and State Financing. This new division, which was created in January 2005 to centralize and coordinate federal oversight of Medicaid reimbursement and financial issues, comprises the two nationwide review teams for state plan amendments and the 10 new central office funding specialists. Expectations for the new division and its analysts are high and their responsibilities broad; it is too soon, however, to assess their overall accomplishments.

Conclusions

Because of its size, complexity, and federal-state structure, the Medicaid program has been subject to waste, abuse, and exploitation. Our work has found that projects developed by consultants who are paid a fee contingent upon additional federal reimbursements that they generate pose a financial risk to the program. It is not possible, however, to quantify the magnitude of this financial risk, because CMS does not routinely request information regarding states’ use of contingency-fee consultants to assist with reimbursement-maximizing projects and associated claims.

Reimbursement-maximizing projects have generated huge reimbursements for states—more than \$2 billion in total over a 5-year period for the two states we reviewed. Large reimbursements such as these place heavy

⁶³Thomas Scully, Administrator, CMS, responding to questions at a hearing, *Challenges Facing the Medicaid Program in the 21st Century: Hearing before the Subcommittee on Health, House Committee on Energy and Commerce*, 108th Cong., 1st Sess., Oct. 8, 2003.

responsibility on CMS to monitor the many complex financing arrangements and claims arising from contingency-fee consultants' reimbursement-maximizing activities. The concerns we have identified with claims from consultants' projects and concerns with states' submitting claims that have not been reflected in state plan amendments and cost allocation plans illustrate the urgent need for CMS to address certain issues in its oversight of states' contingency-fee consultant projects and in its overall financial management. In addition, many of the problematic financing arrangements we examined involved payments to units of state and local government—which states have long used to maximize federal Medicaid funding—suggesting that greater CMS attention is needed to payments among these units, regardless of whether consultants are involved.

For more than a decade, we have reported on the various methods some states have used to inappropriately maximize federal Medicaid reimbursement and have made recommendations to end such schemes. CMS has taken several steps to respond to our recommendations and to address other issues it has identified, including taking steps to hire 100 new financial analysts and developing budget proposals for fiscal year 2006 to clarify policies for allowable claims in several high-risk areas. Nevertheless, specific proposals have not yet been set forth, approved, or implemented. We continue to encourage CMS to take steps to identify and curb opportunistic financing schemes before they become a staple of state financing, and further erode the integrity of the federal-state Medicaid partnership, and to do so in a manner that ensures that policies are clear and consistently applied. With regard to specific projects we examined for this report, we commend CMS and HHS OIG for steps they have taken to examine claims from these projects, including the potential for identifying unallowable claims that may involve recovery of federal funds. In addition, addressing our prior recommendations to Congress and CMS that remain open could also help resolve some of the issues identified in this report.

- Because states continue to take advantage of financing schemes relying on payments to units of state and local government, we believe that our earlier recommendation to Congress—to prohibit Medicaid payments to government providers that exceed their costs—is still valid and would help safeguard federal Medicaid funds.⁶⁴

⁶⁴[GAO/HEHS-94-133](#).

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- Because states, often with the assistance of consultants, continue to make illusory payments by establishing excessive UPL payment arrangements, we reiterate three earlier recommendations that remain open: that the Administrator of CMS (1) establish uniform guidance for states, setting forth acceptable methods to calculate UPLs; (2) expedite financial management reviews of states with UPL arrangements;⁶⁵ and (3) improve state reporting on these arrangements.⁶⁶

States should not be held solely responsible for inappropriately seeking reimbursements where policies have not always been clear or clearly communicated. Although CMS has taken steps in recent years to minimize the federal financial risk involved in inappropriate financing schemes, the agency must also ensure that its policies are clear and consistently applied across states. Otherwise, CMS is at risk of treating states inconsistently and of placing undue burdens on states to comply. Because of the potential for a significant financial impact on states that may have relied on excessive federal funding for certain services, those states found out of compliance with CMS policy may need to be granted a transition period for coming into compliance with clarified CMS requirements.

Recommendations for Executive Action

To improve CMS's oversight of projects involving contingency-fee consultants and any associated claims for federal Medicaid reimbursements, we recommend that the Administrator of CMS take the following two actions:

- Routinely request that states disclose their use of contingency-fee consultants when submitting state Medicaid documents, such as state plan amendment proposals, cost allocation proposals, and expenditure reports, and, in the event that states do not voluntarily provide this information, seek legislative authority to require disclosure.
- Enhance CMS review of state Medicaid documents for which states have used a contingency-fee consultant and take appropriate action to prevent or recover federal reimbursements associated with unallowable claims.

⁶⁵In commenting on a draft of this report, CMS said that its fiscal year 2005 work plan includes plans to conduct many of these reviews.

⁶⁶[GAO-04-228](#).

To strengthen CMS's overall financial management of state Medicaid activities, we recommend that the Administrator of CMS take the following five actions:

- Require that states identify—in Medicaid-related documents such as state plan amendments and expenditure reports—arrangements or claims for payments that involve payments to units of state or local government, such as state- and local-government-owned or -operated facilities.
- Enhance CMS review of states' Medicaid documents, such as state plan amendments, cost allocation plans, and expenditure reports, specifically reviewing payments states make to units of government, including the methodology behind payment rates to government units and the basis for any related claims, and take appropriate action to prevent or recover unallowable claims.
- Establish or clarify and then communicate CMS policies on TCM, supplemental payment arrangements, rehabilitation services, and Medicaid administrative costs and ensure that the policies are applied consistently across all states.
- Ensure that states submit cost allocation plans as required and establish a procedure for their prompt review.
- On the basis of the findings of this report regarding specific projects and billing practices, follow up with states' associated claims and recover federal reimbursements of unallowable claims as appropriate in Georgia and Massachusetts.

Agency and State Comments and Our Evaluation

We provided a draft of this report for comment to CMS, Georgia, and Massachusetts. Each provided written comments, which we summarize and evaluate below.

CMS's Comments and Our Evaluation

CMS commented that the draft report did not accurately reflect the many activities the agency has taken to address the issues raised in the report and that recommendations in the report have already substantially been met. CMS believes that many of the problems that the draft report highlighted, including those with the projects in the five high-risk categories of claims that we selected to review in Georgia and Massachusetts, were already known to CMS as problematic. For example, CMS said that the five high-risk categories we cited were highlighted in the President's budget for fiscal year 2006 as areas in need of reform. CMS discussed many steps it had taken in recent years to improve the financial management of Medicaid, which it said were omitted from the report.

Although CMS stated that federal dollars have been supplanting state dollars and that the Medicaid program is unquestionably paying for things it should not pay for, the agency also said it was addressing this problem through work with individual states to reach agreements to ensure use of appropriate financing mechanisms and to end inappropriate ones.

We acknowledge that CMS has taken important actions in recent years to improve the financial management of Medicaid. We believe our draft report recognized these efforts, including CMS's creation of the central financial review body called the Division of Reimbursement and State Financing, and on the basis of CMS's comments, we have added further information to the report. We also acknowledge that we selected the two states in our review, Georgia and Massachusetts, because of the wide variety of contingency-fee projects in these states that CMS's survey had identified, including projects in areas where claims were thought to be at high risk or growing in dollar amounts in recent years. Although CMS suggested that the scope of our work was limited to these two states, we did draw upon our prior work and that of HHS OIG to extend our findings. Moreover, we believe that conducting detailed work in two states helped us identify systemic issues extending well beyond these two states. We further note that we established the scope of our work, including areas we considered to be high risk, before publication in 2005 of the President's fiscal year 2006 budget that reflected CMS's initiatives for improving its policy in these same high-risk categories of claims. We believe this nexus of our work and CMS's stems from our shared objective of protecting Medicaid's fiscal integrity. At the same time, we also note that we have raised concerns about certain inappropriate financing methods in these high-risk areas for many years, that some prior recommendations remain open, and that problems remain. In addition to the important steps CMS has taken in recent years to improve its policies and oversight, we believe that more can and should be done to better ensure the program is operating as Congress intended—that is, as a shared federal-state partnership providing health care resources for covered services for eligible beneficiaries.

CMS also commented on our specific recommendations, and these comments are summarized, along with our response, below.

- Regarding our recommendations for improved agency oversight of states' use of contingency-fee consultants, CMS stated that it does not have authority to require states to disclose their use of contingency-fee consultants, although it believes it can request such information. Consequently, we have adjusted our recommendation to suggest that CMS

routinely request, rather than require, that states disclose such information, and seek legislative authority to require such disclosure if states do not do so. CMS also stated that it recognizes that contingency-fee consultants are a potential risk factor and that it is committed to fully assessing the basis for claims in accordance with all relevant requirements.

- Regarding our recommendations that CMS take certain steps to improve its overall financial management of state Medicaid activities, including taking certain steps to improve oversight of states' claims for payments made to units of government, CMS discussed its initiative started in August 2003. Under this initiative, CMS requests information from states on their financing methods and terminates those that the agency deems are not consistent with the statutory federal-state financial partnership. CMS said that, as of June 10, 2005, 23 states had agreed to terminate one or more financing practices. Although our draft report acknowledged that CMS had undertaken this effort, we have added further information to the report about CMS's initiative. We maintain, however, that CMS's current state-by-state approach to reviewing states' financing methods—by examining them when states submit proposed state plan amendments and obtaining agreement from states to end them—does not ensure that its policies are clear to states or are consistently applied. For example, a state's financing methods may not be reviewed if the state does not submit a proposed state plan amendment. We maintain our position and associated recommendations that CMS do more to clarify, communicate, and consistently apply its policies regarding areas that both CMS and we have identified as high risk.
- Regarding our recommendation that CMS establish or clarify and communicate its policies on TCM, supplemental payment arrangements, rehabilitation services, and Medicaid administrative costs and ensure that the policies are applied consistently across states, CMS responded that the fiscal year 2006 President's budget proposals would do so. Our draft report acknowledged these proposals but also noted that the specific proposals had not been released as of June 2005. In the absence of concrete proposals and actions to implement them, we believe our recommendation remains valid.
- Regarding our recommendation that CMS ensure that states submit cost allocation plans as required, CMS cited existing requirements for states to submit cost allocation plans. CMS's comments were not fully responsive because our recommendation did not address the need to develop new requirements but to ensure compliance with existing requirements. We therefore maintain this recommendation.

Regarding our recommendation from prior work that Congress prohibit Medicaid payments to government providers that exceed their costs, CMS

noted that it included this proposal in the President's fiscal year 2006 budget. Regarding our prior recommendation that CMS take steps to improve its oversight of states' UPL arrangements, CMS noted its current state plan amendment review process and its financial management review plan for fiscal year 2005 to review high-risk UPL arrangements as examples of how it has already responded to our prior recommendations. Our draft report described CMS's proposal, which parallels the recommendation we made to Congress in 1994,⁶⁷ and CMS's initiative. We revised the report to acknowledge CMS's plans to implement our earlier recommendation to review high-risk UPL arrangements and note that not all specific recommendations have been implemented.

Regarding our discussion in the draft report about our recommendation from prior work that CMS should more effectively and efficiently target oversight resources toward areas most vulnerable to improper payments, CMS strongly disagreed that its current approach is not effective, and it listed numerous actions it has taken since our 2002 report making these recommendations. We agree that CMS has taken numerous actions since 2002. Because we have an ongoing review of CMS's financial management of Medicaid related to our 2002 report findings, we revised the report to remove references to our earlier recommendations.

See appendix III for CMS's written comments.

State Comments and Our Evaluation

Georgia and Massachusetts commented on the importance of contingency-fee contracts and states' use of consultants in helping states secure resources they otherwise would not have. Massachusetts commented that seeking federal resources for people in need when those resources are lawfully available is the fiscally responsible thing for states to do. The state noted that nothing in law prohibits contingency-fee contracts and that in themselves, "contingency-fee contracts do not let states off the hook for determining what is and what is not appropriate under Medicaid." Georgia commented that the complexity of the Medicaid program can and does compel states to turn to expert consultants for assistance and said that the report inaccurately suggests that states' use of contingency-fee consulting is somehow illegitimate. We acknowledge that use of contingency-fee contracts is allowed under law and that states can employ consultants for a number of valid Medicaid purposes, and our report has

⁶⁷See [GAO/HEHS-94-133](#).

made these points. Our key findings, however, focus on the need to ensure that financing methods and associated claims that stem from contingency-fee projects are consistent with federal law, policy, and the fiscal integrity and federal-state partnership of the Medicaid program. Our work identified concerns with claims from contingency-fee projects that were problematic in these respects.

The two states also commented that the language of the law related to coverage of the categories of claims we reviewed—rehabilitation, targeted case management, Medicaid administration, school-based services, and supplemental payments—is broad or complex, and they suggested that they have made good-faith efforts to comply with ever evolving federal regulations and policy. Both states believe that their claims comply with the law. Regarding claims for payments made above what the state was paying individual facilities for rehabilitation services, Georgia indicated that one specific example we provided was an exceptional case. Nevertheless, when we sought clarification from the state on its comments, the state’s explanation did not address our overall concern about the underlying method for setting Medicaid payment rates. We revised the report to reflect the state’s comments and our continuing concern. Massachusetts noted that little in the way of regulation narrows the broad definitions in federal law of covered services; that the state’s definitions of what Medicaid covers within the categories of claims we reviewed fall within long-standing federal interpretations; and that GAO’s finding the state’s definitions questionable does not make them illegal or improper.

Massachusetts agreed with our conclusion that CMS policy in many of the areas that we reviewed has been unclear, either because it has been inconsistently applied, evolving, or is not specific. At the same time, although most methods and resulting claims we question may not be illegal, we believe they are inconsistent with the program’s federal-state cost-sharing design, fiscal integrity, or with current CMS policy. For example, some methods used by states, in our view, in effect increase the federal share of the Medicaid program beyond what has been established by a formula in law and are therefore inappropriate. In the report, we clarified the basis for our concerns about problematic projects and associated claims we identified.

Georgia’s and Massachusetts’s written comments, and our more detailed responses, appear in appendix IV and appendix V, respectively. State officials also provided us with technical comments, which we have incorporated as appropriate.

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

If you or your staff members have any questions, please contact me at (202) 512-7118. Another contact and major contributors are included in appendix VI.

Sincerely yours,



Kathryn G. Allen
Director, Health Care Issues

Appendix I: Description of Contingency-Fee Projects Referred for Additional Review

This appendix addresses three contingency-fee projects that we included in but could not fully assess during the time frames of our review. On the basis of the information we obtained during our review, we believe that separate studies of these three projects are warranted. We have referred information about these projects to the Centers for Medicare & Medicaid Services (CMS) and Department of Health and Human Services' (HHS) Office of Inspector General (OIG) for additional review.

In addition to the projects discussed in this report, the University of Massachusetts Medical School (UMMS) helped Massachusetts develop two supplemental payment arrangements to increase federal reimbursements. One project involved supplemental financing known as disproportionate share hospital (DSH) arrangements, and one involved federal Medicaid reimbursement for medical services to inmates of state correctional facilities.

States are required to make DSH payments to hospitals that care for a disproportionate number of low-income patients. By statute, hospitals qualifying for DSH payments are subject to a limit on the amount of supplemental DSH payments they may receive.¹ As with upper payment limit (UPL) arrangements, supplemental payments made to government providers through DSH arrangements can be illusory: that is, the state can benefit from the arrangements by appearing to pay the providers more than they ultimately retain and seeking federal reimbursement on the excessive payments. In part because of concerns that large DSH payments were not being used to support certain hospitals but were instead being used for general state financing, Congress passed legislation in 1993 and 1997 to restrict states' ability to make excessive DSH payments.² After these restrictions were put in place, combined state and federal DSH payments declined, totaling approximately \$14 billion in fiscal year 2003, down from \$16 billion in fiscal year 1999.

¹DSH payments were an early Medicaid payment area subject to inappropriate state financing arrangements. As in UPL arrangements, states made unusually large DSH payments to certain hospitals, which then returned the bulk of the payments to the states. In response to these arrangements, Congress capped the amount of DSH payments that each hospital could receive and limited the total amount of DSH payments that each state could make to all hospitals. *See* 42 U.S.C. 1396r-4(f) and (g) (2000).

²Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13621, 107 Stat. 312, 629-32; Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4721, 111 Stat. 251, 511.

One Massachusetts contingency-fee project helped the state increase DSH supplemental payments made to four state-owned hospitals. Massachusetts's consultant developed projects to take advantage of a temporary DSH increase—which increased federal reimbursements by an estimated \$17 million annually. The consultant calculated new DSH limits under the federal rules,³ which allowed temporary payments up to 175 percent of unreimbursed costs. To increase the amount of DSH payments the state could make to each hospital, the consultant also helped the state reduce its standard Medicaid payment rates for services provided in these hospitals. This action increased the amount of supplemental payments that the state could make and potentially require the hospitals to return.

A second project involved helping Massachusetts to increase federal Medicaid reimbursements for medical services to inmates of state correctional facilities. Payment records indicated that in state fiscal year 2002, the state Medicaid agency paid UMMS nearly \$300,000 (a contingency fee of 6 percent of about \$5 million in additional federal Medicaid reimbursement) for its work on the project. Generally, medical care for prison inmates is not covered by Medicaid.⁴ HHS OIG reported that a contingency-fee consultant in another state, New Jersey, had prepared inappropriate claims that New Jersey used to obtain federal reimbursement for DSH claims for state prisoners.⁵ Over a 4-year period, New Jersey inappropriately claimed more than \$11 million in federal Medicaid reimbursements for DSH payments made on behalf of prisoners. HHS OIG determined that these payments were unallowable because the state's Medicaid plan specifically prohibited DSH payments for inmate hospital care. Because medical care for prison inmates can be covered by Medicaid under certain circumstances, we sought additional information from Massachusetts officials to determine if Massachusetts's arrangement was allowable, but we did not receive information within the time frames of our review.

³In 2000, Congress generally increased the DSH limit for certain hospitals from 100 percent to 175 percent of unreimbursed costs, for a 2-year period effective as of state fiscal years beginning after September 30, 2002. *See* Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act, Pub. L. No. 106-554, App. F, § 701(c), 114 Stat. 2763A-463, 2763A-571.

⁴*See* 42 C.F.R. 435.1008(a)(1).

⁵HHS OIG, *Review of Acute Care Hospital Prison Inmate Expenditures Claimed by New Jersey to the Disproportionate Share Hospital Program for the Period July 1, 1997, through June 30, 2001*, A-02-02-01028 (Washington, D.C.: Jan. 9, 2004).

In addition to the contingency-fee projects in Georgia discussed in this report, Georgia's consultant also helped the state seek additional federal reimbursements for administrative costs. In particular, the state Medicaid agency began claiming federal reimbursement for the costs of certain activities carried out by county public health departments. Using a rate developed by the consultant, the Medicaid agency claimed reimbursement for the costs of a variety of health department activities serving the public, including school-based presentations, presentations to community groups, mass health screening events, public information campaigns, and events mobilizing community partnerships.⁶ Costs associated with general health education programs promoting healthy lifestyles are not allowable under Medicaid, even if a portion of the participants served by the program are on Medicaid. The state's description of the activities for which claims were made raised questions, but we did not receive information we needed within the time frame of our review to make a full assessment.

Because we believe that separate studies of these three projects would be required to assess their appropriateness, we have referred information about these projects to CMS and HHS OIG for additional review.

⁶We earlier reported a similar concern related to school-based services. In reviewing states' approaches to billing for school-based services, we found that CMS (then called the Health Care Financing Administration, or HCFA) had found states inappropriately seeking Medicaid reimbursement for school-based activities, including general health screenings, communication with families, and staff training. HCFA interviews with a sample of staff who had charged their time to these activities showed that staff members did not know what Medicaid covered, where or how to apply for Medicaid, or who might qualify for coverage. See [GAO/HEHS/OSI-00-69](#). We have also reported a concern that provider payments for school-based services in several states were not specifically linked to the receipt of services because claims for reimbursement were triggered simply by school attendance. See GAO, *Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit*, [GAO/T-HEHS/OSI-00-87](#) (Washington, D.C.: Apr. 5, 2000).

Appendix II: Summary of Selected HHS OIG Reports on School-Based Claims in States Employing Consultants

The Department of Health and Human Services' (HHS) Office of Inspector General (OIG) has completed reviews of school-based claims in 18 states from November 2001 through June 2005. Although these reviews were not specifically targeted at the role of consultants paid on a contingency-fee basis, several of the reports found concerns with the appropriateness of claims from consultants' projects (see table 4). In fiscal year 2005, HHS OIG initiated a review specifically of consultants' contingency-fee projects in all categories of claims.

Table 4: Selected States' Consultant Projects Leading to Improper School-Based Medicaid Claims, as Reported by HHS OIG

State and HHS OIG report	Consultants' role	HHS OIG finding
Florida <i>Review of Administrative Costs Claimed by the Florida Medicaid Agency for School-Based Health Services, CIN A-04-00-02-160 (Mar. 22, 2001)</i>	Consultants were hired by school districts to handle billing for districts' school-based administrative claims	Improper administrative claims: In state fiscal year 1999, the state did not sufficiently oversee school districts' claims. HHS OIG auditors identified more than \$10 million in unallowable or insufficiently documented costs that were in part allocated to Medicaid.
Massachusetts <i>Medicaid Payments for School-Based Health Services—Massachusetts Division of Medical Assistance, A-01-02-00009 (July 14, 2003), and Medicaid School-Based Health Services Administrative Costs—Massachusetts, A-01-02-00016 (Sept. 15, 2004)</i>	The state Medicaid agency contracted with University of Massachusetts Medical School (UMMS) to administer the school-based health services portion of state's Medicaid program	Improper health services claims: In state fiscal year 2000, the state and UMMS did not adequately monitor claims for school-based services to ensure the districts' compliance with federal and state regulations and guidance, resulting in an estimated \$2.9 million in unallowable federal Medicaid claims. ^a Unallowable claims included claims for services that were (1) not documented as delivered; (2) provided by unqualified providers; (3) claimed more than once—in particular, one district claimed some salaries and fringe benefits twice—or (4) provided to students who were absent on the days of the claimed services. Improper administrative claims: In state fiscal years 2000 and 2001, the state did not monitor the appropriateness of school districts' claims developed by UMMS, claiming some salaries and fringe benefits twice, resulting in \$5 million or more in overstated claims.
Rhode Island <i>Medicaid School-Based Health Services Administrative Costs—Rhode Island, A-01-03-00010 (June 7, 2004)</i>	The state Medicaid agency contracted with UMMS to administer the school-based health services portion of state's Medicaid program	Improper administrative claims: In state fiscal year 2001, UMMS did not calculate administrative costs in accordance with OMB Circular A-87, and the state did not adequately monitor quarterly claims prepared by UMMS. UMMS's errors both understated and overstated school-based administrative costs, resulting in a net overpayment of \$123,010 in unallowable federal Medicaid claims.
Washington <i>Review of Washington State's Administrative Costs Claimed for Medicaid School-Based Health Services, A-10-01-00011 (May 29, 2002)</i>	Consultants were hired by school districts and paid a percentage of the total amount claimed; district officials relied on consultants to ensure proper claiming of administrative costs	Improper administrative claims: In state fiscal year 2000, the state did not properly implement or monitor the school-based health services program, resulting in more than \$500,000 in unallowable federal Medicaid claims.

Source: GAO based on HHS OIG information.

^aCMS subsequently disallowed \$1.2 million in unallowable claims.

Appendix III: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

DATE: JUN 21 2005

Administrator
Washington, DC 20201

TO: Kathryn G. Allen
Director, Health Care
Government Accountability Office

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

SUBJECT: Government Accountability Office's (GAO) Draft Report: *MEDICAID FINANCING: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight* (GAO-05-748)

We appreciate the opportunity to respond to the above referenced draft report dated June 1, 2005. We are concerned that, as currently drafted, the report does not accurately reflect the many activities undertaken by the Agency to address the issues that are raised. We believe that over the 14 month period of this review, we have provided significant documentation that demonstrates the recommendations in the report have indeed already been substantially met.

GAO started the review with three questions about contingency fee contracts and drew conclusions based on their 14 month, two state, case studies. On draft **page 48**, GAO states, "[m]oreover, many of the problematic financing arrangements we examined involved payments to state and local government agencies and providers—which states have long used to maximize federal Medicaid financing—suggesting that greater CMS attention is needed to payments among these state and local government entities regardless of whether consultants are involved."

Response— We are at a loss to discern what "greater CMS attention" is being requested. The Massachusetts case study on which this report is based was originally identified through CMS action. The 10 CMS Regional Offices were asked by Central Office to make recommendations for the FY 2004 supplemental audit program. The Massachusetts Targeted Case Management (TCM) audit was one of 27 supplemental audits to be approved. Under an intra-agency agreement between CMS and the Office of the Inspector General, the OIG initiated the Massachusetts TCM audit on December 23, 2003. A recommendation that CMS (or OIG, or other partners in program integrity) should do *more* reviews, might be understandable, but quantity is determined by resources that are provided.

On **page 6**, GAO states, "Although CMS has periodically identified concerns with contingency-fee federal reimbursement-maximizing projects, the agency has not routinely collected information to identify such projects and claims *and was unaware of many of the specific projects that we reviewed* (emphasis added). Given that CMS had in fact identified the Massachusetts TCM issue as a potential problem and had requested

Now page 44.

that the OIG initiate an audit three months prior to GAO beginning this study, we cannot help but take exception to this statement.

Continuing on **page 6**, GAO goes further to state, “[t]he problems *we* (emphasis added) identified with claims from such projects and limited CMS oversight and guidance illustrate the urgent need to address broader oversight and financial management weaknesses.”

Response—This clearly leaves the reader with the impression GAO found the Massachusetts TCM issue all on their own with CMS evidently uninformed or uninterested. The facts are otherwise.

On **page 7**, GAO repeats a 2002 recommendation to “strengthen the agency’s overall financial management procedures.”

Response—On the previous page (**page 6**), GAO acknowledges that “CMS has taken some actions to strengthen its oversight of state Medicaid programs, such as its initiative to hire additional financial analysts to assess each state’s programs ...” but then goes on to say, “but the effectiveness of this initiative is not yet known. Moreover, CMS has not yet implemented several actions that we have previously recommended on the basis of our work on states’ financing schemes and CMS’ financial management of Medicaid.”

- GAO mentions only the hiring of the financial analysts but fails to acknowledge the creation and evolution of the central financial review body now called the Division of Reimbursement and State Finance (DRSF). It fails to acknowledge the consideration and disposition of more than 800 state plan amendments (SPAs) that deal with provider reimbursement. It fails to acknowledge that as a result of these reviews more than 20 states have agreed to revise their intergovernmental transfer (IGT) mechanisms by removing recycling arrangements. This is an ongoing review process; as states submit new SPAs, CMS continues to review them to ensure they include appropriate financing mechanisms.

In **pages 12 through 15**, GAO describes five categories of Medicaid claims where contingency-fee consultants are helping states maximize federal Medicaid reimbursements. These include targeted case management (TCM), rehabilitation services, supplemental payment arrangements, school-based services, and administrative costs.

Response—CMS has taken action in each of these areas since the 2002 GAO recommendation, including disallowances, disapproval of state plan amendments, and legislative recommendations to Congress.

On **page 21**, GAO “found that the two states were claiming federal reimbursement for TCM services that would likely not be allowed under CMS’s current TCM policy.” On **page 22**, GAO writes, “CMS officials agreed with our assessment that the claims for TCM in these two states were problematic.”

Now pages 20 and 21.

Now page 21.

Response—It would be more accurate to say GAO agrees with CMS. As the Report switches to Rehabilitation Services at **page 22**, it would be appropriate to inform the reader that last year during discussions on Medicaid legislation, CMS alerted Congressional Committees with jurisdiction over Medicaid that the rise in TCM expenditures was a subject of abuse and it would be appropriate to curb the growth. Furthermore, the President's Budget includes a legislative recommendation to address this problem.

Now pages 24 to 27.

In its section on Supplemental Payments on **pages 26 to 29**, GAO describes the use of contingency fee contractors to develop "illusory" financing arrangements but barely acknowledges the work done by CMS in this area. CMS has reduced the number of states with problematic funding arrangements from more than 30 to 10. The Administration has agreed with GAO's recommendation to Congress to enact legislation to prevent these arrangements permanently. The President's current FY 2006 budget, as well as previous budgets, includes proposals to end these practices as previously recommended by GAO.

Now page 33.

On **page 36**, GAO begins a new section called "Limited State and CMS Oversight of Claims from Consultant Projects Raises Concerns About Medicaid Financial Management." On the following page (**page 37**), GAO labels a subsection, "States Take Some Steps to Ensure Appropriate Claims, But Problems Remain," a generally positive description that suggests progress and responsiveness. By contrast, on **page 44**, GAO attaches a rather negative label, "Weaknesses in CMS Oversight Raise Concerns About the Financial Management of Medicaid" and states, "[t]he concerns we identified with the appropriateness of states' Medicaid claims stemming from contingency-fee projects illustrate the urgent need to address weaknesses that we identified with CMS's overall financial management of the Medicaid program."

Now page 40.

Now page 43.

Response—CMS has been addressing inappropriate financing mechanisms for over two and a half years. CMS is ending inappropriate financing methods; it is disapproving state plans to prevent inappropriate claiming; it has increased disallowances substantially over the previous Administration; third party collections and cost avoidance have increased by more than \$6 billion between 2002 and 2004; the Administration has proposed legislation on TCM, rehabilitative services, limiting public providers to cost, and net expenditures. On page 47, GAO reports that "CMS has undertaken several steps to improve its financial management of the Medicaid program," but the next page (**page 48**) flatly states, "it is too soon, however, to assess their accomplishments."

Now page 44.

In its conclusions on **page 48**, GAO states "the urgent need for CMS to address weaknesses," yet makes no concrete recommendations for what this means. On the same page (**page 48**), GAO calls for "greater CMS attention ..." but has apparently paid little attention to what has been accomplished.

We do not dismiss the notion that the involvement of contingency-fee consultants, (CFCs) in generating Medicaid claims may be a factor in assessing risk. In that regard,

CMS will continue to fully consider that as one of many significant factors in our oversight of the Medicaid program, including our review of states' Medicaid claims.

Specifically, **page 3** of the draft report (and by extension in its recommendations) addresses and seeks to determine the answers to three questions. First, what is the extent of states' use of CFCs in generating federal Medicaid claims? Second, to what extent are such claims consistent with Federal requirements? Finally, how much do selected states and CMS provide oversight for such claims? In a June 3, 2005 exit teleconference with CMS, the GAO made a point of recognizing the positive and appropriate use of consultants by states. **Page 8** of the report explicitly reiterates this and lists a number of services that consultants perform to "help states." However, the basic question and premise of the report, regarding states' use of consultants (CFCs or otherwise), is ultimately not answered in the report. For example, the proportion of the total state claims (even for the two states which were the main subject of the report) associated with the use of consultants that are inappropriate is not indicated. Rather, the approach taken by GAO is to identify claims with CFC involvement that were already known or suspected to be inappropriate in order to support its final recommendations. However, the report does not demonstrate this relationship.

We reiterate that there are a number of factors associated with risk in the Medicaid program, one of which may be the involvement of CFCs. This has been the subject of other GAO reports as well, and we do recognize and appreciate GAO's efforts in this regard.

As discussed below, over the past few years, in part using GAO's work, CMS has enhanced its oversight efforts. As indicated in our response, CMS will continue those efforts.

Examples of CMS fiscal oversight activities that are omitted from this report include, but are not limited to the following:

- During the GAO's review, CMS provided detailed information to the GAO regarding a more stringent CMS Medicaid State plan review process, which began in August of 2003. This review process effectively facilitated the termination of State Medicaid UPL payment programs that redirected Medicaid funding for other uses including non-Medicaid purposes (i.e., "illusory payments"), which has been illogically addressed in this report as a continuing fiscal oversight problem. Moreover, the strengthening of CMS fiscal oversight under the Medicaid State plan review process was articulated in an April 28, 2004 letter to the Honorable Senator Charles E. Grassley, several weeks after the GAO began its review. During that review, details of that letter and the details of this review process were shared by CMS with the GAO. Unfortunately, this improved CMS State plan review process and its ultimate success is omitted from the subject draft report, which includes recommendations as if the GAO was aware of such activities.

- CMS provided the GAO with our FY 2005 financial management review work plan, which included the planned financial management reviews of many of the financing arrangements with which this report takes issue. Again, the subject draft report makes no mention of these activities and makes recommendations as if the GAO was not aware of such activities.
- CMS informed the GAO that the President's FY 2006 Budget includes a provision limiting Medicaid payments to government providers to cost. However, the GAO references findings from an earlier report continuing to support the need for such legislation as if it was unaware of the provision already included in the FY 2006 budget.
- During this review, CMS carefully explained to the GAO that uniform UPL guidance would not deter what the GAO refers to as "illusory payments", and that addressing the permissibility of the non-Federal share (i.e., State share) of these payments through the state plan amendment review process is the effective mechanism to end "illusory payments." However, the GAO's continues to reiterate the need for such guidance which clearly demonstrates a complete misunderstanding of the fiscal issues.

In addition, we are providing these comments on the specific recommendations contained in the report:

I. CMS' oversight of projects involving contingency-fee consultants and associated claims for Federal Medicaid reimbursement.

This section of the draft report recommends that CMS (page 50):

- (i) Require States to disclose their use of contingency-fee consultants when relevant to State submission of State Medicaid documents, such as State plan amendment proposals, cost allocation proposals, and expenditure reports; and,
- (ii) Enhance CMS review of State Medicaid documents for which States have used a contingency-fee consultant and take appropriate action to prevent or recover Federal reimbursements associated with unallowable claims.

CMS Response:

- (i) Although CMS does not have the authority to require States to disclose their use of contingency-fee consultants (CFCs) in their submissions of State plan amendments (SPAs), cost allocation plans (CAPs), and expenditure reports, we fully recognize that they can be a factor associated with risk in the program. In that regard, although we do not generally require the disclosure of CFC arrangements, we are committed to reviewing these submissions to the fullest extent possible under our authority to determine the allowability of states' claims and programs when relevant. We would suggest that GAO

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recommend legislation to require states to disclose their use of CFCs as a direct way of curbing their inappropriate use.

- (ii) CMS and the Department of Health and Human Services does have explicit authority and the mandate under statute and/or regulation to review states' claims as contained or relate to their SPA, CAP, and expenditure report submittals. In those review processes, we can request any documentation deemed necessary in order for us to determine whether such claims are consistent with all relevant federal requirements. Again, we recognize that CFCs are a potential risk factor and are committed to fully assess the basis for claims in accordance with all relevant requirements.

II. CMS' overall financial management of State Medicaid activities.

This section of the draft report recommends that CMS (page 51):

- (i) Require States to identify—in Medicaid-related documents such as SPAs, CAPs, and expenditure reports—claims for payments made to units of government, such as State-and local-government-owned or-operated facilities and related organizations; and,
- (ii) Enhance CMS review of States' Medicaid documents, such as SPAs, CAPs, and expenditure reports, specifically reviewing payments States are making to units of government, including the methodology for the rates paid to government units and the basis for any related claims, and take appropriate action to prevent or recover unallowable claims.

CMS Response:

Since August 2003, CMS has been requesting information from states regarding detail on how states are financing their share of the Medicaid program costs under the Medicaid reimbursement SPA review process. This examination is applied consistently and equally to all states under the SPA review process. New SPA proposals will not be approved until CMS has determined that the state is securing appropriate non-federal funding to finance its share of its Medicaid program or has agreed to terminate financing practices that do not appear consistent with the statutory federal-state financial partnership.

During that SPA review process, CMS has discovered that some states utilize financing techniques that do not comport with the statutory requirements that establish the federal-state partnership. Specifically, CMS has discovered that several states make claims for federal matching funds associated with Medicaid payments to health care providers, even though the health care providers are not ultimately allowed to receive or retain these payments. Instead, through the "guise" of intergovernmental transfers (IGTs), state and/or local governments require the health care provider to forgo and/or return certain

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Medicaid payments to the state (on the same day in many instances), which effectively shifts the cost of the Medicaid program to the federal taxpayer.

The result of such an arrangement is that the health care provider is unable to retain the full Medicaid payment amount to which it was entitled (even though federal funding was made available based on the full payment), and the state and/or local government may use the funds returned by the health care provider for costs outside the Medicaid program and/or to help draw additional Federal dollars for other Medicaid program costs. The net effect of this re-direction of Medicaid payments is that the federal government bears a greater level of actual Medicaid program costs than the federal statute authorizes.

Through our state plan amendment reviews, we have determined that in some instances states are using Federal Medicaid dollars to supplant the required state share for their Medicaid programs, and in other instances are re-directing the Federal Medicaid dollars to otherwise pay for care associated with non-Medicaid uninsured populations. Once the effective Federal share (FMAP) is raised through various financing and transfer mechanisms, however, it becomes impossible to determine what items and programs are now being financed with Medicaid dollars. Federal dollars are supplanting state dollars and the Medicaid program is unquestionably paying for things that it should not be paying for. A Federal dollar "recycled" to supplant the non-Federal Medicaid dollar means that the non-Federal dollar is available for spending for other state purposes (including traditional state responsibilities such as roads, bridges, foster care or schools).]

As of June 10, 2005, CMS has reviewed over 800 Medicaid reimbursement SPAs under the process outlined above. Twenty-three states have agreed to terminate one or more financing practices that increase the federal share of the cost of providing Medicaid services, effective with the end of their State fiscal year 2005. CMS has identified an additional ten states with similar financing mechanisms that are in the process of terminating such arrangements.

This section of the draft report further recommends that CMS (page 51):

- (i) Establish or clarify, and communicate CMS policy on targeted case management (TCM), supplemental payment arrangements, rehabilitation services, and Medicaid administrative costs and ensure that the policies are applied consistently across all States.

CMS Response:

- (i) With respect to TCM and rehabilitation services, the FY 2006 President's budget contains proposals which would clarify the definitions for such services such that payment would be precluded under Medicaid for the costs of activities which are an integral part of other services or inherent to the operation of other Federal or state programs. This will ensure a more consistent application of such policies nationwide. Additionally, this proposal

Now page 46.

would reduce the federal matching rate to 50 percent for TCM services. Note, for the period April 2002 through April 2004, CMS disapproved seven TCM and one rehabilitation SPA on the basis that the activities were integral components of other programs services such as in the areas of case management, foster care and juvenile justice. Over the same period, 8 states withdrew their TCM proposals, understanding the potential for them not being approved.

As indicated in the draft report, the claiming by states for administrative costs involves the process of submittal by the state of cost allocation plan (CAP) amendments in accordance with requirements contained in federal regulations. Furthermore, since the CAP, by definition relates to costs which cut across a number of state programs, the CAP submission and review process typically involves the coordination of CMS and the Department of Health and Human Services at the federal central office and regional office levels, as well as across state and local governmental units. As indicated, in the regulations, the federal government and in particular the Division of Cost Allocation in the Department has explicit authority and mandate to review states' CAP proposals. CMS is committed to working with all our partners and stakeholders involved in this process, to clarify the requirements and the CAP process, and to ensure that states submit the CAPs in accordance with these requirements.

Now page 46.

Finally, this section of the draft report recommends that CMS (page 51):

- (i) Ensure that States submit cost allocation plans and State plan amendments as required and establish a procedure for their prompt review; and,
- (ii) On the basis of the findings of our report regarding specific projects and billing practices, conduct follow-up of States' associated claims and recover Federal reimbursements of unallowable claims as appropriate.

CMS Response:

- (i) The authority, requirements, and conditions under which States must submit CAPs and SPAs are explicitly contained in statute and regulations. For example, the Code of Federal Regulations at 45 CFR 95 subpart E, containing the regulatory provisions for CAPs, requires States to submit a cost allocation plan which describes the procedures for allocating costs, must be in conformance with OMB Circular A-87, and contains sufficient information in such detail to permit a determination on the allowability of costs submitted. These provisions also require the States to promptly amend their CAPs and submit them to the Department if there are changes relevant to the related costs under the plan. As indicated, the requirements to submit CAPs and/or amendments already exist. Under the current operational process with respect to CAPs that involve the Medicaid program, CMS has primary responsibility

to review and provide its assessment to the Department. Furthermore, CMS is committed to working with all our partners and stakeholders involved in this process, to clarify the requirements and the CAP process, and to ensure that states submit the CAPs in accordance with these requirements.

- (ii) Our Boston and Atlanta Regional Offices are already working in conjunction with the Office of Inspector General to pursue the particular findings as relates to the associated claims by the States in order to identify and recover any unallowable claims, in accordance with all relevant Federal requirements.

III. GAO's reference to prior recommendations as a solution to curb Medicaid financing schemes

This section of the draft report recommends that CMS (page 49):

- (i) Because States continue to take advantage of financing schemes relying on payments to State and local government agencies and providers, CMS's earlier recommendation to Congress—to prohibit Medicaid payments to government providers that exceed their costs—is valid and would help safeguard Federal Medicaid funds;
- (ii) Because States, often with the assistance of consultants, continue to make illusory payments by establishing excessive UPL payment arrangements, we restate three earlier recommendations that remain open: that the Administrator of CMS (1) establish uniform guidance for States that would set forth acceptable methods to calculate UPLs; (2) expedite financial management reviews of States with UPL arrangements; and, (3) improve State reporting on these arrangements; and,
- (iii) Because CMS does not have an effective strategy for focusing its resources on areas of high risk, we reiterate recommendations we made in our 2002 report that the Administrator of CMS take actions to more effectively and efficiently target oversight resources towards areas most vulnerable to improper payments.

Now pages 44 and 45.

CMS Response:

- (i) As explained in detail above, States are not receiving SPA approval related to financing schemes on payments to State and local government agencies and providers. In addition, under the CMS SPA review process, States are required to terminate existing arrangements by the end of their FY 2005. Moreover, CMS informed the GAO that the President's FY 2006 Budget **already** includes a provision limiting Medicaid payments to government providers to cost.
- (ii) As of June 10, CMS has reviewed over 800 Medicaid reimbursement SPAs under a review process that requires the termination of any financing mechanisms that contradict the intent of the Federal-State partnership. Twenty three states have agreed to terminate one or more financing practices that contradict the intent of the Federal-State partnership and ten (10) States with similar financing mechanisms are in the process of terminating such arrangements.

In addition, we have included a financial management review for each of the above mentioned UPL arrangements in our FY 2005 work plan, which was shared with the GAO during this review. We believe such activities respond completely to this prior (and now current) recommendation and we are confused by the lack of attention devoted to such activities in this draft report.

- (iii) We strongly disagree with the characterization throughout the report and in this recommendation that CMS does not have an effective strategy for financial management and oversight of the program, and in particular, for focusing our resources on such activities. The following highlights the many activities demonstrating the CMS oversight approach:
 - There is multi-tiered strategy for developing, focusing and enhancing our resources in the oversight of Medicaid program:
 - Beginning with FY 2002, CMS developed and institutionalized a structured Regional Office (RO) Financial Management (FM) work plan; this incorporated intensive planning with a consistent and centralized national approach for reviewing states claims.
 - This work plan approach, in explicit response to GAO recommendations, incorporates risk assessment and explicitly was for the purpose of focusing FM resources.
 - An integral component of the work plan is identifying areas of high risk and performing RO focused FM reviews on such areas
 - Beginning with FY 2003 CMS developed an interagency (IA) agreement with OIG for the express purpose of conducting additional FM reviews in high risk areas as identified in a coordinated approach with CMS and the OIG.

Appendix III: Comments from the Centers for Medicare & Medicaid Services

- OIG, in coordination with CMS, develops its own FY work plan which focuses on areas of high risk.
- Formation of the Division of Reimbursement & State Financing which provides a central means for CMS to review states' financing arrangements while ensuring consistent policy application.
- PERM Project.
- Refinement of State Plan Process and incorporation of "5 funding questions," providing for a national consistent strategy in reviewing and approving state plans.
- Hiring of "100 FTEs" for express purpose of FM and funding reviews.
- National training efforts of new and existing FM staff.

Appendix IV: Comments from the State of Georgia and GAO's Response



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Tim Burgess, Commissioner

Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.communityhealth.state.ga.us

June 14, 2005

Kathryn G. Allen
Director, Health Care
United States Government Accountability Office
Washington, D. C. 20548

Re: MEDICAID FINANCING: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight (GAO-05-748).

Dear Ms. Allen:

Thank you for the opportunity to respond to the draft report *MEDICAID FINANCING: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight* (GAO-05-748).

Medicaid is an extremely complex program. The Medicaid statute has been called "among the most completely impenetrable texts within human experience. . . . Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase." *Rehabilitation Ass'n v. Kozlowski*, 42 F. 3d 1444, 1450 (4th Cir. 1994). It is nearly impossible for state Medicaid agency staff to keep abreast of the multitude of both new requirements and new opportunities that result from Congress' frequent amendments to the Medicaid law. I can only imagine that CMS itself also has difficulty keeping up with the changes and trying to appropriately administer the program, since on the one hand they are expected to keep a rein on federal spending, while on the other they are expected to provide technical assistance to the states to enable them to access any available federal funds.

This complexity can and does compel states to turn to expert consultants for assistance. I believe that states would require the assistance of consultants even if they could not pay for the consultants' services on the basis of contingent fees (the federal share of non-contingent fees is clearly chargeable to the federal government). Moreover, state Medicaid agency officials, who have an obligation to protect state treasuries, would be remiss if they did not avail themselves of expert assistance to improve the administration of their Medicaid programs. CMS itself makes widespread use of consultants in designing innovations in the Medicare program and other programs it administers, and there is nothing inappropriate about the states' similar activities.

While Georgia understands that your office was asked by Senator Grassley to review the use of contingency-fee arrangements, the draft report really has little to do with states' use of Medicaid consultants, regardless of how they are paid. Rather, the consistent theme in the report is the manner in which CMS applies policy and monitors states' compliance with such. GAO's concerns would be no different if states had initiated policy and reimbursement changes with a consultant paid by a non-contingent fee, or even without the aid of a consultant. It seems unfair to circulate a report that inaccurately suggests that states' use of contingent-fee consulting

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arrangements is somehow illegitimate (especially given the fact, which the draft report confirms, that in most cases, including Georgia's, states have not asked the federal government to share in the cost of such contracts, but have paid the consultants exclusively with non-federal funds).

That being said, your report reviewed five specific Medicaid categories. I'll address each one of them, as they relate to Georgia, separately:

1. Targeted Case Management – Georgia disagrees with your contention that CMS can or should disallow claims for targeted case management (TCM) on the ground that the case management activities have been paid for under (or are an “integral” part of) state programs. Congress specifically directed, through section 8435 of Public Law 100-647 (1988), that CMS “may not fail or refuse to approve an amendment to a State plan . . . that provides for coverage of case-management services described in section 1915(g)(2) . . . or to deny payment to a State for such services . . . on the basis that the State had paid or is paying for such services from non-Federal funds.” CMS approved Georgia's state plan amendment to cover these services, as it was required to do by federal law. Any agency efforts, by “stated policy” or otherwise, to restrict TCM by child welfare and juvenile justice staff at this point not only would be contrary to approved State plans but cannot be squared with the statutory guarantee that recipients may receive a covered service from *any* qualified provider that undertakes to provide the service. Georgia has not “inappropriately shifted state costs to the federal government.”
2. Rehabilitation Services - Medicaid coverage of rehabilitation services is authorized by federal regulations that permit states to cover “any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.” 42 C.F.R. § 440.130(d). The state, per an approved state plan amendment, determines the cost of rehabilitation services based on actual cost reports and time study information submitted by each participating provider. The state has not and is not asking for FFP for amounts in excess of cost. Your example of one facility that was paid \$37 per day for all services, while Medicaid was billed \$62 per day for the rehabilitation services, was an exceptional circumstance; this inadvertent practice has been ended.
3. Supplemental Payment Arrangements – As cited in your report, Congress and CMS have taken action to curb inappropriate Upper Payment Limit (UPL) arrangements. While Georgia asserts it has historically administered the state's UPL programs in compliance with existing federal regulations, the state has agreed to make changes to the financing of its UPL programs beginning in state fiscal year 2006. By preexisting agreement with CMS, as of July 2005, the state will no longer require participating facilities to transfer an amount of intergovernmental transfers (IGT's) larger than the amount necessary to cover the non-federal share of their supplemental payments.

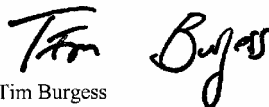
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4. School-Based Services – It is incorrect to report that Georgia has withheld 16% (or any amount) of federal reimbursements from school systems participating in the Medicaid program. School systems receive 100% of federal funds associated with their Medicaid claims. The state charges a 16% fee that is used to support the administrative costs necessary to ensure all participating school systems are complying with program requirements; however, that fee is paid exclusively from local funds. Those efforts include ensuring that claims are based solely on Medicaid-eligible students; that the provision of Medicaid-eligible services are appropriately documented; that parents have provided permission for the school system to bill Medicaid for their child's services; and that billed services are included in the child's individualized education plan. All of these monitoring activities are necessary to satisfy CMS that the state's program is appropriately reimbursing school systems for medically necessary services provided to Medicaid-eligible children. CMS recently completed a review of the state's program and we have been informed that CMS was satisfied that Georgia was in compliance with all applicable federal regulations and CMS policies.
5. Administrative Costs – As you noted, Georgia has not claimed federal reimbursement for contingency fees paid to our consultants. It is incorrect to suggest that Georgia paid its consultants from additional federal Medicaid reimbursements generated from contingency fee projects. Contingency fees have been paid from state or local funds only.

The state believes it has made a good-faith effort to comply with ever-evolving federal regulations and policy and makes no apologies for the legitimate use of state-funded consultants in aiding the state in its administration of the Medicaid program. Again, I appreciate the opportunity to respond.

Sincerely,



Tim Burgess

CC: Abel Ortiz, Health Policy Director, Governor's Office, State of Georgia
Tim Connell, Director, Office of Planning and Budget, State of Georgia
B.J. Walker, Commissioner, Department of Human Resources, State of Georgia
Albert Murray, Commissioner, Department of Juvenile Justice, State of Georgia

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The following is our response to the State of Georgia's comments.

GAO's Response to the State of Georgia's Comments

Our responses to Georgia's comments are numbered below to correspond with the state's various points (reproduced on pp. 67–69). Georgia generally stated that (1) the state's claims for targeted case management (TCM), rehabilitation services, and supplemental payments were made under state plan provisions approved by the Centers for Medicare & Medicaid Services (CMS) and (2) we incorrectly concluded that the state used federal funds generated from reimbursement-maximizing projects to pay consultants. We have revised the draft to indicate that claims were made under approved state plans. Also, we noted in the draft report that Georgia complied with federal requirements in that it did not claim federal reimbursement for the contingency-fee payments. As discussed below, however, state documents indicated that additional federal funds generated by reimbursement-maximizing projects were the source of the state's contingency-fee payments to its consultant.

The state provided us with specific comments in five areas, which we summarize and respond to as follows:

1. Georgia commented that we were incorrect in contending that CMS can or should disallow Medicaid claims for TCM because they are an integral part of other state programs. Georgia stated that a statute provides that CMS may not deny payment to a state on the basis that the state was paying for the services from nonfederal funds, and it also said that CMS had approved Georgia's state plan amendment to cover these services. We based our evaluation of Georgia's TCM claims on CMS's current policy, including the agency's actions in disallowing TCM claims or state plan amendments in other states, and we have focused our concerns on the inconsistent application of CMS's TCM policy. In applying this policy, CMS had considered arguments similar to those raised by Georgia, and the CMS Administrator's decision (September 2004) upheld the application of CMS's current TCM policy. Although we did not evaluate the legal basis for CMS's TCM policy, we maintain our position that CMS's policy should be clarified and consistently applied among states.
2. Regarding rehabilitation services, Georgia stated that it has not and is not asking for federal matching funds in excess of costs. We disagree. We found that in some cases the state agencies' claims to Medicaid were based on facilities' costs exceeding the agencies' actual payments to individual facilities. This situation resulted from the agencies' decision to base claims for payment on the facilities' estimated costs,

rather than on the per diem rate they paid to these facilities. According to the state, one example described in the report of a Medicaid claim that exceeded payments to the facility for all services, was an exceptional circumstance. The state also indicated that this inadvertent practice was ended for all facilities as of April 1, 2004. Although we sought clarification from the state on its comments, the state did not address our finding that the underlying methods for setting Medicaid payment rates was flawed.

3. Regarding supplemental payments, Georgia asserted that it has historically administered its upper payment limit (UPL) program in compliance with existing federal regulations and also stated that it has agreed with CMS to change the financing of its UPL programs beginning in state fiscal year 2006. The state said that, as of July 2005, it will no longer continue the practice we described in our draft report. We revised the report to reflect the state's agreement with CMS regarding the state's supplemental payments to government providers.
4. Regarding school-based claims, Georgia commented that we erred in reporting that the state withheld 16 percent of the federal reimbursements from the reimbursement-maximizing project involving claims for services and administrative costs of schools. The state also said the schools receive 100 percent of the federal reimbursements generated and that state fees, which support the administrative costs necessary to ensure that all participating school systems are complying with program requirements, are paid exclusively from local funds. During our review, however, the state provided us a written explanation and a spreadsheet showing what was paid to schools, indicating that it had withheld 16 percent of the federal reimbursements from the school-based project and that participating schools received 84 percent of the federal reimbursements.
5. Regarding administrative claims, Georgia commented that we incorrectly suggested that the state paid its consultants from additional federal Medicaid reimbursements generated from contingency-fee projects. We disagree. Our conclusion was based on the contract that the state signed with its reimbursement-maximizing consultant. The contract states that the contractor (consultant) acknowledges and agrees that no payment is due from the state agencies or the state of Georgia under the contract from state-appropriated funds. Further, the contract explicitly states that the "Contractor's only source of compensation shall be funds (in the percentage specified in Contractor's Proposal) generated from Contractor's performance under this Contract."

**Appendix IV: Comments from the State of
Georgia and GAO's Response**

The state also provided us with technical comments, which we have incorporated as appropriate.

Appendix V: Comments from the Commonwealth of Massachusetts and GAO's Response



MITT ROMNEY
Governor
KERRY HEALEY
Lieutenant Governor
RONALD PRESTON
Secretary

*The Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, MA 02108*

June 15, 2005

Ms. Kathryn Allen
Director, Health Care
US Government Accountability Office
Washington, DC 20548

Dear Ms. Allen:

Enclosed are the Commonwealth's comments on your draft report entitled "Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight" (GAO-05-748).

I appreciate the opportunity to comment on your Draft Report, and your willing participation in telephone conversations last week. I note that you agreed with a number of our points and anticipate that they will be reflected in your next draft.

Eleven years as the Associate Regional Administrator for Medicaid in Boston gives me considerable empathy for CMS's concerns with contingency-fee contracts and coverage for rehabilitation, case management, administration, school-based services and supplemental payments. I regularly ordered auditing of consultant-generated claims, and I regularly fretted over the breadth of these services.

Still, I had to acknowledge then and I trust CMS acknowledges now that nothing in the law prohibits contingency-fee contracts, as long as the rates fall within broad requirements for the efficient administration of Medicaid. Also, in many instances, these contracts provide states with resources they otherwise would not have for vital administrative tasks to ensure services to Medicaid beneficiaries. In themselves, contingency-fee contracts do not let states off the hook for determining what is and what is not appropriate under Medicaid. In Massachusetts' case, to ensure compliance with federal law, our legal and program staffs review what our contractors do and how they do it.

As for rehabilitation, case management, administration, school-based services and supplemental payments – Medicaid covers these, and the language of the law is broad.

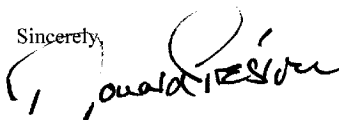


**Appendix V: Comments from the
Commonwealth of Massachusetts and GAO's
Response**

There's little in the way of regulation to narrow these definitions. With regard to these and other areas, not only is it appropriate, it's the fiscally responsible thing to do for states to seek federal resources for people in need when those resources are lawfully available. In Massachusetts' case, our definitions of these five areas fall within longstanding federal interpretations. I appreciate there are arguments that Medicaid coverage should be narrower than it is or more narrowly interpreted than it has been. However, considering the many years of existing practice and policy interpretations, if CMS wants more restrictive coverage, legislation must narrow the law or regulations must narrow the interpretation of the law.

I trust GAO will distinguish between questionable federal policy and what is improper under federal law. GAO may find contingency-fee contracts and broad coverage in these five areas to be questionable policy, but that does not make them illegal or improper. In that the federal rules are broad, states should apply them broadly.

Sincerely,



Ronald Preston
Secretary
Executive Office of Health and Human Services

Enclosure

**Appendix V: Comments from the
Commonwealth of Massachusetts and GAO's
Response**

**Massachusetts Executive Office of Health and Human Services (EOHHS)
Comments on: *Medicaid Financing: States' Use of Contingency-Fee Consultants to
Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight
(GAO-05-748)***

The Executive Office of Health and Human Services (EOHHS) appreciates the opportunity to comment on the GAO's Draft Report. We have addressed specific findings in detail below. However, first we wish to identify a number of overriding concerns that we raised with you in the course of our extensive telephone conversations during the week of June 6. We note that you have acknowledged the validity of a number of our points and anticipate that these points may be reflected in a subsequent draft of your report. These overarching concerns are as follows:

See comment 1.

- The GAO's description and understanding of a 'typical' Medicaid payment process (Draft Report, pp. 8, 9) does not accurately describe the process followed in Massachusetts. In this state, the legislature appropriates the full sum of expenditures to be made for Medicaid purposes. The state advances both the non-federal and federal share of Medicaid payments. When FFP is received by the state, it is used to reimburse the state for its outlay of federal funds. Under this payment process, all Medicaid payments appropriately are made to providers of services – whether public or private – and are used to support necessary health care to the indigent and uninsured.
- It is equally important to recognize that in each of the specific areas on which you focused in the report: targeted case management, rehabilitation services, supplemental payments, etc., Massachusetts funded and arranged for the provision of vital health care services that benefited the eligible recipients who received them. The legitimate issues regarding lack of clarity of federal requirements should not diminish our recognition of the importance of the Medicaid program to meeting the essential health needs of our citizens.

See comment 2.

- The report does not sufficiently distinguish between what you consider to be "inappropriate" but lawful activities from those that contravene specific provisions of federal statutes or regulations. In our phone conversations, you indicated – and we appreciate – that you would attempt to modify the Draft Report in a way that clearly makes this distinction.
- With regard to those state practices that you consider "inappropriate" but lawful, we believe that the proper course for effecting a change of those practices is to change the federal law that permits such practices rather than accusing states of wrongdoing or attempting to enforce policies where there have not been duly promulgated regulations.

See comment 3.

- In determining the "appropriateness" of Massachusetts' claiming practices, the GAO appears to look to CMS' activities in *other* states to define the applicable CMS

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**Appendix V: Comments from the
Commonwealth of Massachusetts and GAO's
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See comment 4.

policy, and fails to account for the fact that Massachusetts is acting in accordance with *Massachusetts* State Plan provisions that CMS affirmatively has approved. In our phone conversations, you indicated – and we appreciate – that you would attempt to modify the Draft Report in a way that acknowledges that Massachusetts practices are in accordance with the CMS approved Massachusetts State Plan.

- The GAO's findings regarding activities that are "inappropriate" or inconsistent with federal law or policy are generally conclusory and fail to cite the specific law or authoritative policy forming the basis of such findings. The absence of such support places the state at a disadvantage in addressing the GAO's findings.

Now page 12.

The following sections address the specific findings in the GAO report.

GAO Finding: *Most states have employed consultants on a contingency-fee basis to help implement a wide range of reimbursement-maximizing projects (Draft Report, p. 11).*

See comment 5.

Like most other states, Massachusetts employs consultants in many capacities, including reimbursement-maximizing projects. The GAO's focus on increased claiming fails to take into account that much of those spending increases are a result of increased service costs and utilization. The GAO's criticism also inadequately recognizes that the federal government appropriately should be sharing in such legitimate spending increases. The contingency consultants perform a valuable service by identifying such legitimate expenditures for which federal support should be available. Consultants provide important expertise to state agencies in a variety of areas. In its effort to cost-avoid inappropriate claims and maximize reimbursement, EOHHS contracts with several private consultants and works closely with the University of Massachusetts Medical School (UMMS).

See comment 6.

It's important to note that GAO collected information on all of the contingency fee related projects in Massachusetts, including several projects involving the coordination of benefits. GAO chose to only discuss those in the five categories discussed in the Draft Report. These five categories are areas of concern raised by GAO in the past and have been highlighted in the President's budget proposal.

One of the major purposes of contingency fee contracting in Massachusetts is to assist in the identification of third party liability and coordination of benefits. From FY2000 to FY2004, the Commonwealth and federal government recovered or avoided over \$720 million in costs due to these efforts. None of this work would be accomplished without the assistance of contingency consultants. GAO does not highlight these contingency arrangements in their Draft Report.

See comment 7.

As noted in a footnote of the GAO Draft Report (p. 17), UMMS is not a private consultant but a state entity that provides a variety of services to EOHHS under an interdepartmental service agreement (ISA). EOHHS has been authorized by the

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Legislature to contract with UMMS to perform federal revenue claiming and cost avoidance activities and to compensate UMMS for some of those activities through contingency fee arrangements. The GAO Report implies that the very nature of the contingency fee payment method creates an incentive for "opportunistic" profit making by the vendors receiving contingency fees. The GAO does not appear to recognize, however, that contingency payments from one state entity to another do not result in a benefit to any other party.

In addition to cost avoidance and revenue maximization projects, UMMS provides a number of clinical services for the Medicaid program, including but not limited to disability evaluation services, drug utilization review, prior authorization and utilization management. UMMS also performs valuable administrative activities on behalf of EOHHS and in furtherance of EOHHS' administration of the Massachusetts Medicaid Program (or MassHealth).

GAO Finding: *Claims for consultant services are not always consistent with federal law or CMS policy and can undermine Medicaid's fiscal integrity (Draft Report, p. 19)*

We agree with and support the GAO's conclusion that CMS' policies regarding Targeted Case Management (TCM), rehabilitation services, and supplemental payments have been inconsistently applied, are in a state of flux, or are not specific. (Draft Report, pp. 6, 35, 50) The Draft Report explicitly states that "[w]ithout clear and consistent communication of its policies...CMS is at risk of treating states inconsistently and of placing undue burdens on states to comply with policies which had not been widely communicated or known." (Draft Report, p. 50) Again, we strongly agree with this conclusion but believe that by finding that Massachusetts has failed to comply with CMS policy, the GAO is engaging in the very activity for which it criticizes CMS.

Targeted Case Management (TCM) – GAO finds that "most claims for federal reimbursement of Medicaid TCM services we reviewed in Massachusetts were likely not consistent with CMS policy, which does not allow federal reimbursement for TCM services that are integral to other state programs." (Draft Report, p. 20)

Massachusetts TCM claiming conforms to approved state plan amendments as well as applicable federal law. Since 1988, CMS has approved state plan amendments establishing five active target groups for TCM: 1) adults with serious and persistent mental illness and children with serious mental illness or severe emotional disturbance (approved 1988); 2) abused and neglected children or children at risk of abuse and neglect (approved 1994); 3) Medicaid recipients diagnosed with AIDS and living in congregate housing (Approved 1996); 4) individuals with mental retardation (approved 1997); and 5) children in the Commonwealth's juvenile correctional facilities (approved 1998). During the state plan approval processes, CMS reviewed the state's method of developing rates for targeted case management services for each target group. Since that time, CMS has accepted all FFP claims for each TCM service.

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Now page 18.

See comment 8.

Now pages 5, 30, and 45.

Now page 45.

Now page 19.

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Now page 5.

Now footnote 43,
page 31.

See comment 9.

We strongly agree with the GAO (and CMS) that CMS policy with regard to claiming for TCM services has been inconsistently applied, is evolving and is not specific. (Draft Report, p. 6) In particular, the state agrees with concerns raised by a CMS official to GAO concerning subregulatory guidance CMS issued in January 2001 (January Letter) on TCM claiming. (CMS SMCL 01-013) The state agrees with the CMS official that this guidance "contained problems and errors that caused confusion regarding appropriate TCM claims when non-Medicaid state agencies were involved." (Draft Report footnote 25) Furthermore, it is important to note that CMS emphasized that it would follow "notice and comment rulemaking" to implement "clarification of existing policies". As GAO notes in its report, CMS has not yet done so. CMS also emphasized in the January Letter that during the state plan approval process, HCFA (CMS) would provide guidance to determine Medicaid billable activities. CMS provided guidance directly to the state during the Massachusetts state plan approval process and did not provide any additional guidance to the state following the January Letter.

Moreover, the January Letter was expressly limited to "clarify[ing] HHS policy regarding State Plan case management and Title IV-E foster care programs" and specifically provides that states *may* claim for TCM services when these activities are "embedded in another social program." GAO now misplaces its reliance on that letter as supporting a description of CMS' current policy to not allow claiming for TCM services provided by the state if those services are an "integral component of an existing state program." (Draft Report Table 3). The plain language of the January Letter compels a very different conclusion.

Furthermore, according to GAO officials, and apparently after conversations with CMS representatives, GAO developed its own set of factors to determine that Massachusetts' TCM claiming "would likely not be allowed" under CMS policy. The factors that GAO created are: (1) whether case management was established by state law, regulation or policy, and (2) whether case management was provided to all Medicaid and non-Medicaid clients state wide. (Draft Report Footnote 25). The state notes that CMS policy and the first factor developed by GAO, at least, appear inconsistent with federal law. Specifically, Section 8435 of the Technical and Miscellaneous Revenue Act of 1988 (also referred to as Section 8435 of Public Law 100-647) provides as follows:

The Secretary ... may not fail or refuse to approve an amendment to a state plan under title XIX ... that provides for coverage of case management services... or deny payment to a State for such services...on the basis that the State is required to provide such services from State law or...that the State had paid or is paying for such services from nonfederal funds...

The state notes that proper rulemaking with notice and an opportunity for comment CMS would have an opportunity to receive and consider comments such as those the state is making in response to the Draft Report. Such rulemaking is required by the federal administrative procedure act, ensures the states receive due process, and would have the effect of ensuring that states' and their contracted vendors know, understand and comply with CMS TCM claiming requirements.

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See comment 10.

Now page 23.

Rehabilitative Services – GAO finds that “increased claims for rehabilitation services potentially duplicated federal payments the state had received because, according to CMS officials, the services were to be paid for under the state’s managed care agreement.” (Draft Report, p. 22)

We disagree with this finding. The state is not duplicating payments to state agencies and managed care organizations for rehabilitative services provided by the Department of Youth Services (DYS).

The children served by DYS are automatically enrolled in the MassHealth Primary Care Clinician Plan Behavioral Health Plan. The Behavioral Health Plan (BHP) is a Prepaid Health Insurance Plan (PHIP) that is paid a capitation rate developed by an actuarial consulting firm and represents the expected costs to be incurred in the course of providing all contractually-defined, medically necessary Covered Services to enrolled members. Other services provided to children in the care or custody of DYS are provided on a fee-for-service basis. The claims data used in this rate setting process for the BHP is based on the BHP’s reported financial submissions to MassHealth and does not include the cost of rehabilitative services provided by state agencies. The BHP does not have any subcontracts with state agencies as service providers. Rehabilitative services are provided by these state agencies through contracts procured and directly managed by those state agencies.

See comment 11.

Now page 24.

Supplemental Payments -- GAO finds that “consultants in Georgia and Massachusetts helped the states implement supplemental payment arrangements that claimed federal reimbursements on behalf of state and local-government facilities that did not retain the bulk of the Medicaid payments.” (Draft Report, p. 26)

Massachusetts’s supplemental payment program for nursing facilities is part of its approved Title XIX state plan and has been in place since January 1, 2002. The plan provides for an enhancement payment up to the Medicare upper payment limit (UPL) for government-owned nursing facilities that have executed an intergovernmental transfer agreement with the state Medicaid agency.

The supplemental payment arrangement for government-owned nursing facilities is explicitly described in Massachusetts’ Title XIX state plan; that plan was approved by CMS. Regulations at 42 C.F.R. § 447.272 provide that a state may make Medicaid payments up to the amount that would have been paid the under Medicare payment principles to private facilities, state-owned facilities, and other non-state governmental entities. Regulations at 42 C.F.R. § 433.51(b) state that public funds may be transferred to the state Medicaid agency from other public agencies. The state is in compliance with both these regulations, and disputes the implication in the GAO report that it discontinued aspects of these supplemental payments because they were ‘inappropriate’ or that these payments were ‘illusory’. Massachusetts has consistently asserted and continues to maintain that these payments and their funding were (and, in fact, continue to be) permitted by, and fully compliant with, federal law.

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See comment 12.

Now pages 27 and 28.

Massachusetts is one of a number of states that have such supplemental payment arrangements in place, and until recently, CMS had repeatedly taken the position that these arrangements “fit within” its rules. However, CMS recently changed its policy about permissible supplemental payment arrangements without adopting any new regulation and without any change in the law.

School-Based Health Services – The GAO notes that, in separate audits, “the HHS OIG raised concerns about the adequacy of state and UMMS monitoring of claims for school-based services...estimating that \$2.9 million in unallowable Medicaid claims were paid in SFY 2000.” In addition, with respect to claims for administrative cost, “the HHS OIG found that in SFY 2000 and SFY 2001, the state did not monitor the appropriateness of school districts’ claims that were prepared by UMMS, resulting in at least \$5 million in unallowable claims.” (Draft Report, pp. 29-30)

We note initially that the claims subject to the two OIG reports were prepared almost five or more years ago; the OIG’s findings bear little relationship to the current school-based claiming program. In the state’s response to each of the OIG’s reports, the state catalogued a series of steps it had taken to enhance monitoring and oversight of claims. Those steps included enhanced training and technical assistance to school districts, expanded management reporting, implementation of monitoring and audit systems and development of new informational materials for schools. The state has continued with those efforts, establishing a Director of School-Based Medicaid within the Office of Medicaid, introducing documentation standards for service claims, re-issuing guidance to schools regarding the calculation of Medicaid eligibility rates and conducting a number of statewide trainings for participating districts. The state has, and will continue to respond to the unique challenges raised by this aspect of the Medicaid program.

Regarding the school-based service audit, on March 5, 2004 the CMS Region 1 Office made a final determination regarding the OIG’s recommendations. The CMS office did not accept the OIG’s major finding on the adequacy of service documentation and issued a disallowance in the amount of \$1.2 million, not \$2.9 million. The disallowed amount did not reflect a particular issue with the use of contingency-fee consultants. More than half the disallowed amount (54%) involved claims filed by three school districts that did not use consultants to help them with claim preparation; 40% was related to four school districts that used private sector consultants and 5% was related to one school district for whom UMMS provided claim preparation services.

Regarding the administrative cost audit, the major OIG finding related to the calculation of the Medicaid share percentage of students in a district. As reflected in the state’s response to the OIG report, the state believes that the methodology OIG used to arrive at this finding is subject to error. The state also indicated that it had conducted a direct match for Medicaid-eligible students in each of the five districts for whom a finding in this area had been made; a direct match has been acknowledged by the OIG as the most accurate method. The match results reflect a questionable claim amount that is less than half of OIG’s recommendation. No disallowance has been issued to date by CMS.

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See comment 13.

We also disagree with the GAO statement that UMMS' dual roles – providing administrative supports to the state Medicaid agency and providing claim preparation services to schools is a conflict of interest. The state Medicaid agency has an interest in maintaining a school-based services program under which the local government assumes the costs of the state share, and enlists UMMS to help in that effort. UMMS' work with local school districts facilitates those districts participation in the program. Thus, UMMS' work reflects a unified interest in assuring appropriate public funding for Medicaid-reimbursable services provided to special education students.

See comment 14.
Now pages 28 and 29.

Administrative Costs – The report states that the “state had claimed administrative costs related to contingency-fee projects, which were inappropriate.” (Draft Report, p. 31)

We disagree with this finding. As stated in the GAO report, Massachusetts did not claim federal reimbursement for any contingency fee payments. The two examples cited in your case include assumptions of inappropriate claiming that are not supported by facts. One of the examples involved a senior official about whom the GAO asserts that 100% of his time was claimed as a Massachusetts Medicaid administrative expense. The GAO indicates that this employee has claimed 100% of his time despite stating that he worked on out-of-state projects. However, the employee does not recall making such a statement. The time sheets supplied to the GAO are an attestation of the actual work performed in a given month. The monthly time sheets for this employee were for an entire fiscal year of which some months indicated 100% claimable time and others did not indicate 100% claimable time. In addition, for most of the time period reviewed by the GAO, this employee was working under the terms of a Memorandum of Understanding developed between the Massachusetts Medicaid agency and UMMS. Under the MOU, this UMMS employee was directed to perform all of the job duties he had maintained while he was in the employ of the state's Medicaid agency. He continued to fulfill his prior duties until a successor was appointed.

Reference is made in the report to another senior official who had claimed 97% of his time as a Massachusetts Medicaid administrative expense despite overseeing projects in other states. We disagree with this finding. First, it is incorrect that such projects were maintained in 15 states; that number includes a number of states where project work had already been completed or where UMMS' status was that of a consultant listed on a state's qualified vendor list, although no project work was actually being performed. UMMS has 218 employees who work on projects involving the payment of a contingency fee; of that number only 22 employees (10%) work on projects that are out-of-state. Of those 22 employees, well under half their reportable time is devoted to out-of-state work. Thus, the 97% time allocation reported is appropriate.

Now page 33.
See comment 15.

GAO Finding: Limited State and CMS oversight of claims from consultant projects raises concerns about Medicaid financial management. (Draft Report, p. 36)

EOHHS is always looking to improve its program integrity operations. To that end, we have currently engaged a consultant to review our current program integrity activities and Governor Romney requested \$1.5 million in new funds for these activities in his FY2006

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budget request. However, the Draft Report seems to focus on policies and not operations. We disagree that our policies are inappropriate. As stated in our telephone conference last week, EOHHS (and, formerly, the Division of Medical Assistance) has an extensive internal review process for new policies -- including legal review for consistency with applicable federal law. Additionally, all state plan amendments are, of course, subject to CMS review and approval.

GAO recommends that CMS improve its financial management controls and that greater oversight is needed. We do not agree that greater oversight from CMS will solve some of the issues discussed in the Draft Report. The primary solution should be the clarification of the policies as discussed above.

DMR TCM Billing: GAO finds that "one state agency—the Department of Mental Retardation, which was not assisted by a contingency-fee consultant—was billing Medicaid for TCM services without appropriate documentation." (Draft Report, p. 45)

The Department of Mental Retardation (DMR) does maintain documentation of the delivery of TCM services in each client's case record. However, contact with clients does not necessarily occur every month. DMR's current information systems do not allow for electronic documentation of monthly contacts and a manual verification of documentation each month is not feasible given the volume of claims. In response, DMR and EOHHS utilize an averaging methodology when setting the TCM claiming rate that calculates the rate based on number of contacts (as opposed to number of clients served). This averaging method, which essentially sets a much lower rate, allows for a standard monthly billing process and yet prevents over-claiming by DMR.

EOHHS and DMR agree with the GAO that this is an area that can be improved. In SFY06, a new management information system will be launched that will allow for electronic documentation of contacts and automated verification during the billing process. At that time, DMR will revise its rate calculation methodology to be based on clients served.

Note also as a technical correction that DMR received approximately \$19 million in federal reimbursement for its TCM claims in 2004, not \$30 million as reported in the Draft Report.

TCM Duplicate Claiming Issue: GAO finds that "three other Massachusetts agencies billed Medicaid for TCM services even though they could have been serving the same beneficiaries." (Draft Report, p. 45)

GAO appears to imply that Massachusetts is inappropriately "double-billing" for TCM services for certain clients. We disagree with the GAO's implication and reaffirm that we are claiming for TCM services in accordance with federal law.

As we discussed with the GAO during their review, although we agree that the state plan descriptions of TCM services are similar for each of the three target groups, the services

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Now page 41.

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Now page 41.

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that actually are delivered differ among the agencies providing those services because those agencies are serving different needs. For example, the target groups associated with DSS and DYS consumers both describe “developing an individualized plan of care” and “coordination of needed services and providers” as TCM services. However, the process by which a plan of care is developed for a child who has been abused by their parents and the needs the plan of care is meant to address are very different from that of a juvenile offender. One is addressing the plan to ensure the child is safe in their environment. The other is addressing the plan to ensure the child does not present a danger to himself. The state agencies serving these children are addressing two different case management needs—even for the same child. The same argument can be made for the type of services and providers that need to be coordinated and for the rest of the services described within the state plan amendments. The case management needs are different based on which target group the client falls into and, thus, which agency is providing the service. Accordingly, we believe that there is no “double-billing” in claiming for the same beneficiary in the same month where that individual falls within more than one defined target group.

Lastly, we disagree with the implication that because Georgia chooses not to bill for the same client if they fall into two different groups that Massachusetts should follow suit. We have no data that informs us how Georgia has organized its delivery of health and human services to its citizens. It is quite possible that Georgia needs to limit its billing to one agency per month because the organizational structure does not provide for the difference in services as Massachusetts does. Conversely, Georgia might be taking an unduly conservative approach to their TCM claiming.

Appendix I. Contingency Fee Project Referred for Separate Study

Prisoner Health Services: The GAO audit report states, with respect to a Disproportionate Share Hospital claim filed in SFY 2002 for medical services to inmates of state correctional facilities, that the GAO could not “determine if the Massachusetts’ arrangement was allowable.” (Draft Report, p. 54-55)

The OIG report for New Jersey cited by the GAO (reference footnote 72) determined that New Jersey’s Medicaid state plan specifically prohibited claiming these costs as disproportionate share hospital expenditures. However, at the time this claim was filed, inmate care expenditures were allowable DSH expenditures under the Massachusetts state plan.

The New Jersey OIG report referenced by the GAO also cited a CMS policy clarification, issued on August 16, 2002, as further evidence that prisoner health costs were ineligible for federal Medicaid reimbursement as DSH expenditures. The Massachusetts DSH expenditures referred for separate study by the GAO were claimed on the Commonwealth’s March 2002 CMS 64 expenditure report, prior to the issuance of the CMS clarification. Since the receipt of the CMS policy clarification, Massachusetts has

Now page 53.

Now footnote 5, page 53.

See comment 18.

not submitted additional DSH claims for expenditures related to medical services for inmates of state correctional facilities.

175% DSH Rule Project: The GAO audit report states, "As with UPL arrangements, supplemental payments made to governmental providers through DSH arrangements can be illusory: that is the state can benefit from these arrangements by appearing to pay providers more than they ultimately receive and seek reimbursement on the excessive payment." We disagree with this finding.

Section 1923 (g) of the Social Security Act states, in part, "payment adjustments to state hospitals for their disproportionate share expenditures during the two state fiscal years commencing on July 1, 2003 and July 1, 2004 are made at 175 percent of the uncompensated cost of care to Medicaid-eligible and uninsured individuals." GAO's opinion that these DSH payments were illusory supplemental payment arrangements is an inaccurate characterization of this claim. Federal reimbursement sought and received for these expenditures were based upon the costs of state hospitals and complied with the approved state plan and any federal rules regarding disproportionate payments. Additionally, the federal reimbursement received was used to fund medical services for eligible individuals and was not used for general state financing.

Now footnote 3, page 53.

As referenced in footnote 70 of the GAO report, Congress permitted states to claim unreimbursed Medicaid and uninsured costs at 175% of total costs as a DSH expenditure. Massachusetts submitted a State Plan amendment in September 2003 that described the methodology for calculating disproportionate share costs under this new rule. The amendment was approved in June 2004.

The following section includes the Commonwealth's response to certain recommendations included in the Draft Report.

GAO Recommendation: *Establish uniform guidance for state that would set forth acceptable methods to calculate UPLs; Expedite financial management reviews of state with UPL arrangements; Improve state reporting on these arrangements*

We agree with this recommendation. EOHHS would welcome duly promulgated regulations defining acceptable methods to calculate UPLs.

GAO Recommendation: *Require states to disclose their use of contingency-fee consultants when relevant to states' submission of state Medicaid documents, such as state plan amendment proposals, cost allocation proposals and expenditure reports.*

Enhance CMS review of state Medicaid documents for which state have used a contingency-fee consultant, and take appropriate action to prevent or recover federal reimbursements associated with unallowable claims.

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EOHHS is very willing to share contingency consultant information with CMS when requested. However, as stated in the response to the Draft Report findings, we believe that unclear CMS policies are the root of the problem in many of these areas, not the states' use of contingency consultants.

GAO Recommendation: *Require states to identify-in Medicaid-related documents such as state plan amendments, cost allocation plans, and expenditures reports-claims for payments made to units of state or local government, such as state- and local-government owned or operated facilities and related organizations.*

States' submit a significant amount of information to CMS on a regular basis. CMS requires States submit all their eligibility and claims data to CMS on a quarterly basis through the Medicaid Statistical Information System (MSIS). The MSIS data set includes public and private provider information.

GAO Recommendation: *Establish or clarify, and communicate CMS policy on TCM, supplemental payment arrangements, rehabilitation services, and Medicaid administrative costs and ensure that the policies are applied consistently across states.*

As stated above, we agree with and support the GAO's conclusion that CMS' policy regarding TCM, rehabilitation services, and supplemental payments has been inconsistently applied, is in a state of flux, or is not specific. We support establishing or clarifying these policies through duly promulgated regulations.

GAO Recommendation: *Ensure that states submit cost allocation plans and state plan amendments as required and establish a procedure for their prompt review.*

We agree that the Division of Cost Allocation and CMS could improve their review of cost allocation plans. EOHHS submitted its revised cost allocation plan in September 2004 and its financials in December 2004. Questions were received from DCA in April 2005.

GAO Recommendation: *On the basis of the findings of our report regarding specific projects and billing practices conduct follow-up of states' associated claims and recover federal reimbursements of unallowable claims as appropriate.*

As stated above, we believe that the claims mentioned in the Draft Report are allowable under federal law and approved state plans. With regard to state practices that the GAO considers "inappropriate" – though lawful – we believe that the proper course for effecting a change of those practices is to change the federal law that allows such practices—not to accuse the state of wrongdoing, or attempt to enforce policy that has not been duly promulgated and may, itself, be inconsistent with federal law.

GAO's Response to the Commonwealth of Massachusetts's Comments

Our responses to Massachusetts's comments are numbered below to correspond with the state's various points (reproduced on pp. 73–85). Massachusetts generally stated that (1) nothing in the law prohibits contingency-fee contracts, as long as rates fall within broad requirements for the efficient administration of Medicaid; (2) contingency-fee contracts provide states with resources they otherwise would not have for vital administrative tasks; (3) states remain responsible for ensuring compliance with Medicaid requirements; (4) Medicaid statute and regulations are broadly stated; and (5) states have the responsibility to seek federal resources to help people in need when those resources are lawfully available. The state also provided us with updated information, which we have incorporated in our report.

Massachusetts's detailed comments and our responses follow.

General Comments

1. Massachusetts noted that the state's funding methods differed from the typical payment process we describe in the report's "Background" section. We revised the report to reflect that the state advances from state funds both the federal and nonfederal share of Medicaid payments and then seeks federal reimbursement for those expenditures.
2. Massachusetts commented that we did not sufficiently distinguish between "inappropriate, but lawful" activities and activities that violate specific statutes or regulations. We revised the report to clarify our concerns related to the projects we examined and to more clearly distinguish the basis for our concerns related to the projects that we reviewed.
3. Massachusetts commented that it was acting in accord with its state plan approved by the Centers for Medicare & Medicaid Services (CMS). We revised the report to clarify that CMS had approved Massachusetts's state plan amendments for targeted case management (TCM) services for each of the four state agencies providing these services. We did not, however, assess whether each of the four agencies' activities were consistent with the approved state plan. In addition, we described projects in other states to illustrate the inconsistent application of CMS policy.
4. See response 2.

Comments on States' Use
of Contingency-Fee
Consultants

5. Massachusetts commented that we focused too much on increased claiming and did not adequately consider the reasons for spending increases and the role of contingency-fee consultants. We disagree. Our presentation of increased federal expenditures was descriptive and was one factor we considered in selecting categories of claims to review. In this section of the report, we drew no conclusions regarding the appropriateness of state claims. As we stated in the draft report, we agree that consultants can have a legitimate role in helping states administer their Medicaid programs.
6. Massachusetts commented that we discussed projects only in five selected areas. On the basis of additional information provided by the state, we revised our report to include summary financial information on other University of Massachusetts Medical School (UMMS) projects, including third-party liability and coordination of benefits activities. Nevertheless, in response to the congressional request for this review, our scope was to include contingency-fee projects in revenue-maximizing areas; more detailed review of other projects was therefore beyond our scope.
7. Massachusetts commented that contingency-fee payments from one state agency to another do not benefit any other party. Our concern is not that one state agency may profit from another. Rather, we are concerned that the two state agencies operating in concert could inappropriately generate additional federal funds.

Comments on Consistency
of Contingency-Fee
Projects with Law or
Policy

8. Massachusetts commented that we are applying CMS policies that have not been well articulated and that CMS has approved its state plan amendments for TCM programs. We use Massachusetts's TCM programs to illustrate the difficulties states encounter when dealing with unclear CMS guidance and potential disparate treatment by CMS. We acknowledge that CMS approved Massachusetts's state plan amendments for its TCM programs and clarified the report accordingly. Our concern remains, however, that these TCM programs do not appear to be consistent with CMS's current TCM policy and are similar to proposals from other states that CMS is currently denying.
9. Massachusetts commented that we relied on a January 2001 letter as CMS policy and that we used criteria—whether the service was authorized by state law, regulation, or policy—that appear inconsistent with provisions of the Technical and Miscellaneous Revenue Act of 1988. We did not rely on CMS's January 2001 letter as CMS policy. We

used the *State Medicaid Manual* (§4302) and the September 2004 Administrator's decision (Docket No. 2003-02) as CMS policy in this area. In addition, because CMS has not defined services that are integral to another state program, we used the existence of state law, regulation, or policy as an indicator, not a determinant, that TCM services were integral to non-Medicaid programs.

10. Massachusetts commented that managed care payments for children served by the Department of Youth Services do not include rehabilitation provided by state agencies; thus, payments to state agencies for rehabilitation services for these children would not be duplicative. As described in the draft report, we continue to be concerned about the potential duplication of coverage because (1) rehabilitation services are included in the statewide managed care program, which includes children served by other state agencies, and (2) it is unclear whether the Department of Youth Services' managed care rates include rehabilitation services provided by private providers (as opposed to state agencies), so Medicaid could be paying both private and public providers for the same service. CMS officials agreed with our concerns.
11. Massachusetts did not agree that certain aspects of its upper payment limit (UPL) arrangement—those the state agreed with CMS to end in June 2005—were inappropriate. While the state's documentation did not provide sufficient detail for us to assess the aspects of the UPL arrangement that it had agreed to end, we revised our characterization of the state's agreement. Nevertheless, we maintain our view that illusory supplemental payments in which providers net only a small portion of the supplemental payments—such as those made in Massachusetts—are inconsistent with Medicaid's federal-state partnership.
12. Massachusetts commented that it had undertaken a number of efforts to strengthen oversight of school-based Medicaid claims and provided additional information on two reports from the Department of Health and Human Services' (HHS) Office of Inspector General (OIG). We revised the report to reflect Massachusetts's efforts to improve oversight of its school-based claims. We also revised the report to clarify that, upon further review, CMS did not impose the full HHS OIG-recommended disallowance of \$2.9 million but, rather, imposed a \$1.2 million disallowance.
13. Massachusetts disagreed with our view that UMMS's role as a contingency-fee consultant working for school districts to prepare their claims and as a contingency-fee consultant working for the state

to monitor school district claims creates the appearance of a conflict of interest. On the basis of our discussions with UMMS and state Medicaid agency officials and our review of state documents, we maintain our view but revised the report to more specifically show UMMS's role in ensuring the integrity of those claims submitted by schools, including reviewing and performing quality-control measures on local school cost information.

14. Massachusetts disagreed with our finding in the draft report that UMMS had inappropriately charged salaries for two senior UMMS officials as Medicaid administrative expenditures, providing an agreement between the Medicaid agency and UMMS as support. Regarding one official, we maintain our view that UMMS charged excessive time as a Massachusetts Medicaid administrative expenditure. Although UMMS charged 100 percent of the official's salary as a Massachusetts expenditure, time sheets provided by the state Medicaid agency showed that in some months, the UMMS official charged from 2 to 5 percent of his time to "out-of-state" projects. Whether the official worked for the Medicaid agency or UMMS, time spent on out-of-state projects should not be claimed as a Massachusetts Medicaid administrative expenditure. Regarding discussion of a second official's time charges, we removed references to this official in the report on the basis of additional information provided by the state.

Comments on State and
CMS Oversight of
Contingency-Fee Projects

15. Massachusetts commented that the draft report focused on state Medicaid agency policy, not operations, and that it disagreed that state policies are inappropriate. In our review of individual projects and state Medicaid agency oversight, we examined and reported on both the procedures and the policies the state Medicaid agency had in place to oversee the activities of its contingency-fee consultants. We maintain our view that some state Medicaid agency policies, such as those allowing multiple agencies to bill Medicaid for the same service for the same beneficiary each month and supplemental payments that do not fully accrue to providers, are inappropriate.
16. Massachusetts commented that the Department of Mental Retardation's contact with clients does not necessarily occur each month, although we found the department had automatically billed Medicaid for its TCM caseload each month. The state agreed that the agency's billing was an area that can be improved and that a new management information system planned for state fiscal year 2006 would allow automated verification of client contacts during the billing

process. We revised the report to reflect the updated figure for the department's claims in state fiscal year 2004.

17. Massachusetts commented that its policy of allowing multiple agencies to bill Medicaid for TCM services for the same beneficiary each month did not constitute inappropriate double-billing. We reviewed information provided by the state during our review and concluded that the state did not provide convincing evidence that the TCM services provided by the four state agencies were unique. We discussed the matter with CMS and HHS OIG officials, and they concurred with our conclusion. We continue to believe that further review is needed.

18. Massachusetts commented that its project for supplemental disproportionate share hospital (DSH) payments was authorized by Congress and approved by CMS and that the state disagreed with our view that such payments can be illusory. We did not question the state's authority to make supplemental DSH payments up to 175 percent of unreimbursed costs, consistent with statutory authority to do so for a 2-year period. Rather, our concern was that hospitals should benefit from increased federal reimbursements and Massachusetts's arrangement appeared to result in lower payments to hospitals, despite increased claims for federal reimbursement. Because we did not fully assess the state's DSH payment process and net payments to hospitals, our concerns remain, and we believe that further review is warranted.

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

Katherine Iritani (206) 287-4820

Acknowledgments

Major contributors included Terry Saiki, Tim Bushfield, Jill M. Peterson, Ellen M. Smith, Ellen W. Chu, Helen Desaulniers, and Kevin Milne.

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