

March 2007

# MEDICAID FINANCING

## Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency





Highlights of [GAO-07-214](#), a report to the Committee on Finance, U.S. Senate

## Why GAO Did This Study

The costs of Medicaid—the federal-state program financing health care for about 60 million low-income people—totaled about \$317 billion in fiscal year 2005. Increasing budgetary pressures have created tension between the states and the federal government, in part because some states have used inappropriate financing arrangements to collect federal matching funds when payments were not retained by the providers. In August 2003, the federal Centers for Medicare & Medicaid Services (CMS) began an initiative to end inappropriate arrangements.

GAO was asked to examine the (1) number, and fiscal effects, of states ending particular financing arrangements; (2) extent to which CMS's initiative represents a change in agency approach or policy; and (3) transparency and consistency of the initiative. For states ending arrangements, GAO surveyed state officials, reviewed CMS documents, and interviewed CMS and state officials.

## What GAO Recommends

GAO recommends that the Administrator of CMS (1) issue guidance to clarify allowable financing arrangements and (2) explain its determinations in writing to states and interested parties. CMS said recent actions would respond to the first recommendation. Although CMS disagreed with the second recommendation, GAO believes it remains valid.

[www.gao.gov/cgi-bin/getrpt?GAO-07-214](http://www.gao.gov/cgi-bin/getrpt?GAO-07-214).

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 or [allenk@gao.gov](mailto:allenk@gao.gov).

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## What GAO Found

From August 2003 through August 2006, 29 states ended certain financing arrangements as a result of CMS's oversight initiative. The ended arrangements involved supplemental payments—those separate from and in addition to the states' standard Medicaid payments—made to government health care providers, most often government nursing homes and hospitals. According to CMS, the arrangements had to be ended because the providers did not retain all the payments made to them but returned all or a portion to the states. The fiscal effects on the states and on the federal government of ending specific arrangements were uncertain, as nearly two-thirds of states ending arrangements were seeking to continue obtaining federal reimbursements for the related supplemental payments by using different financing arrangements from those they were required to end.

CMS's initiative departs from the agency's past approach and is consistent with Medicaid payment principles—for example, that payment for services must be consistent with efficiency, economy, and quality of care. In the past, CMS limited states' inappropriate financing arrangements through means other than examining whether providers were retaining supplemental payments. Twenty-four of 29 states reported the view that CMS had changed its policy. One state has challenged CMS's disapproval of its state plan amendment, in part on the grounds that CMS changed its policy and should have gone through rule making beforehand. In another case, unrelated to the initiative, in which a state challenged a CMS disapproval, a 2005 federal court ruling upheld CMS's determination that the state's arrangement, in which providers did not fully retain payments, was inconsistent with Medicaid payment principles.

CMS has not implemented its initiative transparently, contributing to concerns about the consistency of its reviews of state financing arrangements. CMS's initiative has lacked transparency in two ways. First, in implementing its initiative, CMS did not issue written guidance about the specific approval standards for state financing arrangements, although a proposed regulation published in the *Federal Register* on January 18, 2007, when finalized, could provide such guidance. Second, CMS has not always provided states with clear, written explanations of its determinations. GAO's review of CMS documentation related to the financing arrangements ended in 29 states found that for only one-fourth of the financing arrangements did CMS explain to the affected states in writing the specific basis for determining that their financing arrangements were inconsistent with one or more Medicaid payment principles. This lack of transparency has raised questions for some states about the consistency with which states have been treated and precluded GAO from determining whether CMS has treated states consistently.

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**Figure 1: Inappropriate State Financing Arrangement in Which  
Provider Did Not Retain the Full Supplemental Payment**

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**Abbreviations**

CMS	Centers for Medicare & Medicaid Services
CPE	certified public expenditure
DSH	disproportionate share hospital
HCFA	Health Care Financing Administration
IGT	intergovernmental transfer
UPL	upper payment limit

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United States Government Accountability Office  
Washington, DC 20548

March 30, 2007

The Honorable Max Baucus  
Chairman  
The Honorable Charles Grassley  
Ranking Minority Member  
Committee on Finance  
United States Senate

Growing pressures on federal and state budgets have increased tensions between the federal government and the states regarding Medicaid, the joint federal-state health care financing program for about 60 million individuals, including low-income children, families, and aged or disabled individuals. The federal government and the states share in the cost of the program, which in fiscal year 2005 totaled about \$317 billion.<sup>1</sup> The Centers for Medicare & Medicaid Services (CMS)—the federal agency responsible for overseeing states’ programs—has an important role in ensuring that states comply with certain statutory Medicaid payment principles when claiming federal reimbursements for payments made to institutional and other providers that serve Medicaid beneficiaries. For example, Medicaid payments must be “consistent with efficiency, economy, and quality of care,”<sup>2</sup> and states must share in any reported Medicaid costs in proportions established according to a statutory formula.<sup>3</sup> In recent years, tensions have arisen between the federal government and states with regard to CMS’s actions to oversee the appropriateness of Medicaid provider payments for which states have sought federal matching reimbursement, including concerns over whether states were appropriately financing their share, that is, the nonfederal share of the payments.

We and others have reported that some states have inappropriately established financing arrangements creating the appearance of payments to government-owned or government-operated providers, such as nursing

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<sup>1</sup>This figure represents estimated combined federal and state Medicaid expenditures for provider services and administration in fiscal year 2005, the last year for which data were available.

<sup>2</sup>42 U.S.C § 1396a(a)(30)(A) (2000).

<sup>3</sup>42 U.S.C § 1396d(b) (2000).

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homes, in order to obtain additional federal matching funds.<sup>4</sup> These arrangements involved supplemental payments—payments that states made to providers that were separate from and in addition to those made at a state’s standard Medicaid payment rate. The supplemental payments connected with these arrangements were illusory, because states required the government providers to return part or all of them to the states. States could then use the money to fund the nonfederal share of other Medicaid expenditures. Such arrangements effectively increased the federal share of the states’ total Medicaid expenditures because federal funding increased without a commensurate increase in nonfederal funding. Financing arrangements involving illusory payments to Medicaid providers have had significant fiscal implications for the federal government and states. In 2003, we designated Medicaid as a program at high risk of mismanagement, waste, and abuse, in part because of concerns about inappropriate financing arrangements.<sup>5</sup> As states’ arrangements involving illusory payments have come to light, Congress and CMS have taken steps to limit them, including establishing a regulation estimated to have saved the federal government approximately \$17 billion from fiscal year 2002 through fiscal year 2006.

In August 2003, CMS launched an oversight initiative to review and evaluate the appropriateness of states’ Medicaid payments for which federal matching reimbursement was sought, by assessing whether states had financing arrangements that required providers to return payments to the states. Under this initiative, a state’s submission of a proposal to change provider payments in its state Medicaid plan—the plan approved by CMS that defines how each state will operate its Medicaid program, including which populations and services are covered and the rates at which providers will be paid for serving Medicaid beneficiaries—triggers CMS scrutiny of the appropriateness of any related financing arrangement. CMS withholds approval of a proposed state plan amendment until obtaining satisfactory assurances that a state is ending financing arrangements the agency finds to be inappropriate. As CMS has carried out this initiative, concerns have been raised that CMS’s policies have not been transparent, that is, clearly explained and available to interested parties; represent a change in policy that should have undergone a rule-making process during which a proposed regulation would have been

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<sup>4</sup>A list of related GAO products appears at the end of this report.

<sup>5</sup>GAO, *High-Risk Series: An Update*, [GAO-05-207](#) (Washington, D.C.: January 2005).

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published for public comment; and have not been implemented consistently from state to state.

You asked us to review CMS's efforts under its oversight initiative begun in August 2003, including the process the agency has used and the outcomes of that process, focusing on states that were required to end Medicaid financing arrangements that CMS found to be inappropriate. This report addresses the following questions:

1. How many states have ended Medicaid financing arrangements as a result of CMS's initiative, and what have been the fiscal effects?
2. To what extent does CMS's initiative reflect a change in approach or policy for overseeing states' Medicaid financing arrangements?
3. To what extent has CMS implemented its initiative in a transparent manner and consistently across states?

To determine the number of states among the 50 states and the District of Columbia that ended financing arrangements and the fiscal effects of ending the arrangements under CMS's oversight initiative, we obtained information from CMS on the financing arrangements that were ended from August 2003 through August 2006, reviewed CMS's files containing agency and state documents regarding the ended arrangements, and discussed with CMS officials the characteristics of and the basis for the agency's determinations concerning states' arrangements and the potential federal fiscal effects from states' ending arrangements. To ensure that we had an accurate count of states that had ended one or more financing arrangements, we verified this information with each state that, according to CMS, had ended an arrangement. In addition, we contacted all states not identified by CMS as having ended an arrangement and asked them whether they had ended certain financing arrangements as a result of CMS's initiative. We determined that the information provided by CMS about which states ended financing arrangements, coupled with confirmation provided by states, was sufficiently reliable for the purposes of our review. To learn more about the ended financing arrangements, we sent a questionnaire to, and obtained responses from 100 percent of, the subset of states that we determined had ended an arrangement from August 2003 through August 2006. Our questions sought information and associated documentation to verify the characteristics of the financing arrangements that the states had ended; the actions the states had taken or planned to take as a result of CMS's initiative, including states' proposals to implement different financing arrangements as an alternative to the

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arrangements they had ended; and the potential fiscal effects on state budgets of ending financing arrangements. We updated our information on the status of states' plans to implement alternative arrangements in October 2006. We also obtained additional information about CMS's initiative by interviewing officials from nearly two-thirds of the states receiving our questionnaire, including officials from states whose questionnaire responses required clarification or who requested an interview. We did not independently validate the information the states provided to us about fiscal effects. (See app. I for a more detailed description of our methodology for determining the number of states that ended financing arrangements.)

To examine the extent to which CMS's initiative reflects a change in approach or policy for overseeing states' Medicaid financing arrangements, we reviewed the legal and programmatic bases for CMS's initiative; reviewed relevant legal opinions and related materials; interviewed CMS officials concerning CMS's oversight in the past and under the initiative; reviewed agency and congressional actions to address states' inappropriate financing arrangements from 1994, when we first reported on these issues, through November 2006; and reviewed public statements by CMS officials and CMS documents that discussed the agency's actions under its initiative. In our questionnaire to the states that ended financing arrangements under the initiative, we asked whether each state viewed CMS's actions as a change from the agency's prior approach.

To assess the extent to which CMS's initiative has been implemented in a transparent manner, we performed a structured review of documentation contained in CMS's files for the subset of states that had ended financing arrangements, including examining correspondence and other information related to each state review under the initiative. We assessed how CMS communicated to the states that ended financing arrangements its determinations about financing arrangements and the basis for its determinations, including assessing the extent to which CMS provided states with written information on the statutory basis for its determinations under the initiative. We did not assess the validity of CMS's determinations that states must end certain financing arrangements, nor did we compare the basis for these determinations with CMS's approvals of other financing arrangements it reviewed. (See app. II for further information on our methodology for analyzing CMS's files.) Through our questionnaire to the states that ended financing arrangements, we sought information on their views of CMS's review process, including information on whether, in the opinion of state officials, CMS explained why the state should end its financing arrangement, on what basis CMS concluded that



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the state should end its financing arrangement, and what guidance—such as letters to state Medicaid directors or technical guidance manuals—CMS provided the state on financing arrangements. To assess the consistency of CMS’s reviews under the initiative, we examined information in CMS’s files for evidence of any differences in CMS’s reviews of states that ended financing arrangements, including differences in the concerns that CMS identified. Because of limitations in the file documents, however, we were unable to determine whether CMS had treated states that ended financing arrangements consistently. For example, CMS’s files did not contain records of oral discussions or explanations of relevant differences in the states’ Medicaid programs. Through our questionnaire, we sought the views of state officials on whether the states that ended financing arrangements believed CMS had been consistent across states in its reviews. In part to better understand how CMS’s reviews had affected states that ended financing arrangements, we interviewed officials in nearly two-thirds of the states that received our questionnaire and who had, for example, requested an interview or whose responses to the questionnaire needed clarification. Finally, we interviewed CMS officials about the agency’s review process under the initiative and the basis for its determinations regarding states’ financing arrangements. Our findings, conclusions, and recommendations are based on the evidence we obtained in reviewing states that ended financing arrangements as a result of CMS’s oversight initiative. We conducted our review from July 2005 through March 2007 in accordance with generally accepted government auditing standards.

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## Results in Brief

From August 2003 through August 2006, 29 states ended Medicaid financing arrangements that CMS determined to be inappropriate as a result of its oversight initiative; the fiscal effects of ending such arrangements were uncertain at the time of our review. The ended financing arrangements involved supplemental payments made to government-owned or government-operated health care providers, most often government nursing homes and hospitals. CMS officials informed us that in all the cases, they required states to end the financing arrangements because under the arrangements, government providers did not retain all of the supplemental payments made to them but instead returned part or all of the payments to the states. In more than half the cases, we identified documents in CMS’s files confirming that under the arrangements, providers retained less than the full amounts of the supplemental payments they received. The fiscal effects on the states and on the federal government of ending such arrangements remained uncertain at the time of our analysis because nearly two-thirds of states (19 of 29) that ended

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financing arrangements were either planning or implementing different arrangements for financing the nonfederal share of the related supplemental payments. For example, 10 states were adopting arrangements under which the supplemental payments would be based on funds expended by government providers and certified as allowable expenditures for providing Medicaid services to Medicaid beneficiaries. As of October 2006, only 12 of the 19 states planning or implementing alternative arrangements had begun seeking federal reimbursements, and those states faced further CMS review before obtaining reimbursements.

CMS's initiative reflects a departure from the agency's past oversight approach and is consistent with Medicaid payment principles requiring, for example, that payment for services be consistent with efficiency, economy, and quality of care. In the past, CMS limited states' inappropriate financing arrangements through means other than determining whether the individual providers involved were retaining the supplemental payments made to them. Consequently, CMS previously approved states' financing arrangements even in some cases where it was aware that the providers did not retain the full payments. Most states that ended financing arrangements view CMS's initiative as a change in CMS policy. In response to our questionnaire, officials in 24 of 29 states that ended financing arrangements reported that CMS had changed its policy on allowable state financing; in additional written comments, officials of 6 of these states expressed concern that CMS objected to provisions it had previously approved and did so without first notifying states through rule making of its policy changes. Whether CMS's initiative represents a change in policy that would require rule making was, as of February 2007, under review in federal court. In July 2004, Minnesota challenged CMS's disapproval of its state plan amendment in part on the grounds that CMS should have gone through rule making before disapproving the state's plan amendment under the initiative. CMS's disapproval was affirmed by the Administrator in July 2006. Minnesota officials in September 2006 filed an appeal of the Administrator's decision in federal court; the appeal was pending as of February 2007. In another case, unrelated to the initiative, in which a state challenged CMS's disapproval of a state plan amendment involving an inappropriate financing arrangement, a 2005 federal court ruling upheld CMS's determination that the state's financing arrangement, in which the providers did not retain Medicaid payments, was inconsistent with Medicaid payment principles.

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CMS's initiative has not been implemented in a transparent manner, contributing to concerns about the consistency of its reviews of financing arrangements across states. CMS's initiative has lacked transparency in two ways. First, under the initiative, CMS did not issue written guidance about the specific approval standards related to allowable financing methods that it was applying in reviewing states' financing arrangements. In January 2007, after receiving a draft of this report for review and comment, CMS published a proposed regulation that could, when finalized, provide guidance clarifying allowable arrangements for states to finance the nonfederal share of their Medicaid payments. Second, CMS has not always provided states that ended financing arrangements with clear, written explanations for its determinations, which could inform the directly affected states, as well as other states and interested parties, about allowable financing arrangements. In only one-fourth of the financing arrangements that states ended did CMS provide written explanations to the affected states of the specific bases for determining that their financing arrangements were inconsistent with one or more Medicaid payment principles. Although CMS officials said that their reviews of states' financing arrangements under the initiative have been consistent, the lack of transparency has contributed to some states' concerns about consistent treatment and precluded us from determining whether CMS treated states that ended financing arrangements consistently.

To improve the transparency of CMS's oversight of states' Medicaid financing arrangements, we are recommending that the Administrator of CMS issue guidance to clarify allowable arrangements for financing the nonfederal share of Medicaid payments. Such clarification could be accomplished through one of the many different avenues CMS has for providing states with guidance, including finalizing the regulation proposed on January 18, 2007. We also recommend that the Administrator provide to each state it reviews, and make available to all states and other interested parties, written explanations of agency determinations on the allowability of various arrangements for financing the nonfederal share of Medicaid payments.

In commenting on a draft of this report, CMS indicated that the agency was in the process of implementing our first recommendation and not in agreement with the second.

- CMS stated that the proposed regulation published on January 18, 2007, would respond to our first recommendation that the agency issue guidance to clarify allowable financing arrangements. We agree, and

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updated our report to recognize the publication of the proposed regulation after CMS had received a draft of our report for review and comment. We note, however, that CMS's regulation is not final, and we therefore maintain our recommendation.

- In disagreeing with our recommendation that it provide states with written explanations of the agency's determinations under the initiative, CMS raised concerns about providing details on the allowability of arrangements that states have since corrected or terminated and indicated that the proposed regulation would satisfy the recommendation on a nationwide scale. Our recommendation was not intended to be applied retroactively but, rather, to be used in ongoing and future determinations. We have clarified this intent in our report. Although we agree that the proposed regulation, when finalized, could address some concerns about the transparency of CMS's efforts, we continue to believe that specific written explanations of the agency's future determinations are also needed because they would further delineate for states and others how CMS is applying its guidance in reviewing specific arrangements. We therefore maintain our recommendation.

CMS also commented that the report overemphasized the need for transparency and overlooked the fairness of CMS's review activities. We maintain that CMS's changed oversight approach, states' concerns about the lack of guidance and consistent treatment, and the significant potential fiscal effects of CMS's determinations on states' budgets show the need for more transparency in the agency's guidance and determinations.

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## Background

Title XIX of the Social Security Act establishes Medicaid as a joint federal-state program to finance health care for certain low-income, aged, or disabled individuals.<sup>6</sup> Medicaid is an open-ended entitlement program, under which the federal government is obligated to pay its share of expenditures for covered services provided to eligible individuals under each state's federally approved Medicaid plan. States operate their Medicaid programs by paying qualified health care providers for a range of covered services provided to eligible beneficiaries and then seeking reimbursement for the federal share of those payments.<sup>7</sup> CMS provides

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<sup>6</sup>42 U.S.C. §§ 1396 et seq. (2000).

<sup>7</sup>Throughout this report, we refer to funds used by state Medicaid programs to pay providers for rendering Medicaid services as "payments." We refer to federal funds received by states from CMS for the federal share of states' Medicaid payments as "reimbursements."

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information to states about Medicaid program requirements through federal regulations; a published *State Medicaid Manual*; standard letters issued to all state Medicaid directors (known as state Medicaid directors letters), which are also available on CMS's Web site; and technical guidance manuals on particular topics.

Within broad federal requirements, each state administers and operates its Medicaid program in accordance with a state Medicaid plan, which must be approved by CMS. A state Medicaid plan details the populations a state's program serves, the services the program covers (such as physicians' services and nursing home and inpatient hospital care), and the rates of and methods for calculating payments to providers. Any changes a state wishes to make in its Medicaid program must be submitted to CMS for review and approval in the form of a proposed state plan amendment. A state plan amendment is valid indefinitely, barring any changes to federal law or policy or the state's decision to further amend that part of its state plan. Changes may range from editorial changes, such as updates for agency name changes, to substantive program changes, such as establishing new methods for developing provider payment rates, adding certain types of payments, or modifying eligibility for program services. State plan amendments may be needed to reflect developments in federal law, regulation, or case law or changes in state law, organization, policy, or operation of the Medicaid program. States are not required to submit state plan amendments on a regular basis but, rather, as needed when the states seek to change some aspect of their programs. Nor are states limited in the number of state plan amendments they may submit. In fiscal year 2005, for example, 722 state plan amendments were submitted for CMS review, with the number per state ranging from a low of 5 in three states to a high of 41 in two states.

Under a statutory formula, the federal government may pay from 50 to 83 percent of a state's Medicaid expenditures.<sup>8</sup> Certain inappropriate financing arrangements, however, have allowed some states to effectively increase the federal share of their Medicaid expenditures. Medicaid plans generally do not detail the specific arrangements a state uses to finance the nonfederal share of program spending. Title XIX of the Social Security Act allows states to derive up to 60 percent of this nonfederal share from local governments, as long as the state itself contributes at least 40

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<sup>8</sup>Under Medicaid law, states with lower per capita incomes receive higher federal matching rates. 42 U.S.C § 1396d(b) (2000).

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percent.<sup>9</sup> In the past, we and others have reported that some states were using inappropriate financing arrangements to boost the federal share of program expenditures, most recently through misuse of Medicaid upper payment limit (UPL) provisions. UPLs are the federal government's way of placing ceilings on the federal share of a state's Medicaid program; they are the upper bound on the amounts the federal government will reimburse a state for the federal share of state spending on certain services. Some states have paid certain providers supplemental payments up to the UPL, and the federal government has shared in those payments.<sup>10</sup> These supplemental payments were separate from and in addition to those made at the states' standard Medicaid payment rates, and some states required providers to return most or all of these supplemental payments to the state, thus increasing federal funding without a commensurate increase in nonfederal funding.

When government entities were involved, states were able to increase federal funding inappropriately because supplemental payments could be returned to the state through a mechanism known as an intergovernmental transfer, or IGT. An IGT is a legitimate feature in state finance that enables state and local governments to carry out their shared governmental functions, for example, through the transfer of revenues between governmental entities. Some state supplemental payments involving IGTs, however, have been part of inappropriate financing arrangements in which states received federal Medicaid reimbursements based on payment amounts that were greater than the amounts actually retained by the providers for Medicaid purposes—effectively shifting Medicaid program costs to the federal government. Figure 1 illustrates one such example. In this case, the state made a \$41 million supplemental payment to a local-government hospital. Under its Medicaid matching formula, the state paid \$10.5 million and CMS paid \$30.5 million as the federal share of the supplemental payment. After receiving the supplemental payment, however, the hospital transferred back to the state approximately \$39 million of the \$41 million payment, retaining \$2 million. Essentially, the state created the illusion of a \$41 million supplemental hospital

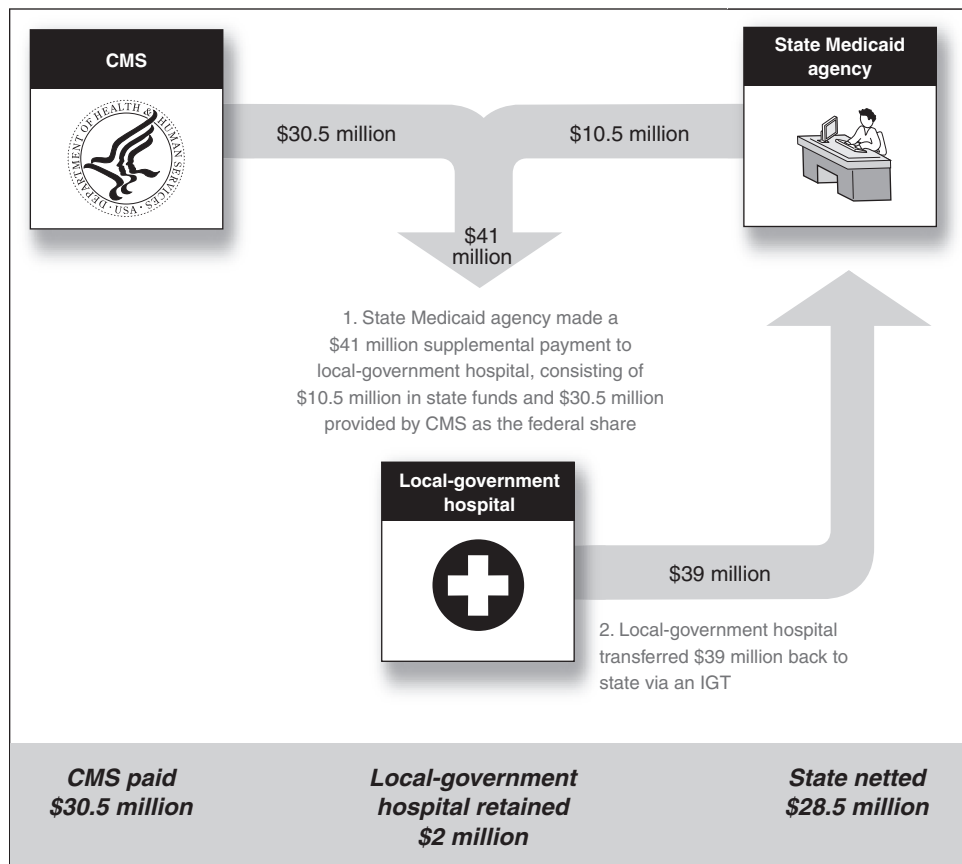
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<sup>9</sup>42 U.S.C § 1396a(a)(2) (2000).

<sup>10</sup>UPLs are based on the amounts that Medicare, the federal health care program that covers seniors aged 65 and older and some disabled persons, pays for comparable services. Because states' standard Medicaid payment rates are often lower than Medicare rates for the same services, some states calculated the difference between what they actually paid providers using standard Medicaid rates and the UPL, and then made a supplemental payment for the difference to a few government providers.

payment when only \$2 million was actually retained by the provider. This illusory payment netted the state tens of millions of dollars in excess federal funds.

**Figure 1: Inappropriate State Financing Arrangement in Which Provider Did Not Retain the Full Supplemental Payment**



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

This type of financing arrangement is inappropriate for at least two reasons. First, it enables states to obtain additional federal reimbursements, effectively without contributing a nonfederal share; in this case, the state actually netted \$28.5 million as a result of the arrangement. Second, it makes federal Medicaid reimbursements available for other purposes. In some cases, states have used the returned funds as the nonfederal share of additional Medicaid payments to providers to seek

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still more federal reimbursements, thus recycling federal funds to produce additional federal funds.

CMS's initiative was undertaken as part of the agency's efforts to strengthen financial oversight and ensure payment accuracy and the fiscal integrity of the Medicaid program. Under this initiative, whenever a state submitted to CMS for review and approval a proposed state plan amendment revising a section of the state plan related to payments to providers, CMS officials asked the state five standard funding questions intended to gauge the appropriateness of the state's financing arrangement. Specifically, CMS asked states to describe

- whether Medicaid providers would retain all Medicaid payments made to them, including the federal and nonfederal shares, or whether any portion would be returned to the state, local-government entity, or other organization;
- sources of state funds used to make the Medicaid payments, for example, whether the nonfederal share came from appropriations from the legislature or from IGT arrangements or other sources;
- the total amount of any supplemental payments made to each Medicaid provider;
- the methods used by the state to estimate the UPL for different types of providers; and
- whether total Medicaid payments to government providers exceeded the providers' costs of providing services to Medicaid beneficiaries.

Under the initiative, a state typically responds to CMS's questions, which starts a series of communications between state and CMS officials via e-mail, telephone, or formal letters and culminates in a decision by CMS as to the appropriateness of the state's financing arrangements related to the Medicaid payments. If CMS determines that providers are not fully retaining payments they received from the state, CMS withholds approval of state plan amendments until the state provides assurances that it will end inappropriate financing arrangements. After ending the arrangement, the state may, with CMS approval, continue making the related supplemental payments under a different financing arrangement.



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## Twenty-nine States Ended Financing Arrangements, with Uncertain Fiscal Effects

As a result of CMS's oversight initiative, 29 states ended arrangements for financing Medicaid supplemental payments to government providers, most often nursing homes and hospitals, from August 2003 through August 2006. According to CMS, under each of the ended arrangements, government providers retained less than the full payment amounts. At the time of our review, 19 of the 29 states that ended financing arrangements were planning or implementing alternative ways to finance the nonfederal share of the supplemental payments, but they had not begun receiving federal reimbursements under those alternatives. Hence, the fiscal effects of the ended financing arrangements remained uncertain.

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## Ended Arrangements Involved Supplemental Payments Not Fully Retained by Government Providers

From August 2003 through August 2006, 29 states ended one or more financing arrangements, each of which involved supplemental payments to health care providers—most often nursing homes and hospitals—that were owned or operated by government entities, such as states and counties. According to CMS, all of these arrangements were inconsistent with Medicaid payment principles because the related payments were not retained in full by these government providers. CMS completed many reviews that did not result in a state's ending a financing arrangement. Specifically, according to CMS data, 19 of the 29 states that ended an arrangement had other arrangements that had been reviewed with no objections from CMS. In addition, 18 states other than the 29 that ended arrangements underwent reviews of one or more financing arrangements that met with CMS's approval and therefore did not have to be ended.<sup>11</sup>

In total, the 29 states ended 55 financing arrangements involving supplemental payments made to government providers for various Medicaid services identified in states' Medicaid plans. States most frequently ended arrangements to finance supplemental payments made to government-operated nursing homes (for example, county nursing homes) and hospitals (such as county, municipal, and state university hospitals). For example, one state supplemented its standard Medicaid payments with quarterly payments to county nursing homes. The state noted in a letter to CMS that in state fiscal year 2003, two eligible county nursing homes received supplemental payments totaling \$18 million, of which the nursing homes retained \$509,000. Combined, arrangements for financing nursing

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<sup>11</sup>On the basis of information from CMS and our contacts with the states, we determined that the three remaining states and the District of Columbia had not ended a financing arrangement as a result of CMS's initiative.

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home payments and hospital payments for inpatient services (42 percent and 24 percent, respectively) represented about two-thirds of all 55 ended arrangements in the 29 states. The remaining one-third of ended financing arrangements most often involved disproportionate share hospital, or DSH, payments<sup>12</sup> (20 percent) and hospital payments for outpatient hospital services (11 percent). See table 1 for a summary of the financing arrangements ended by states from August 2003 through August 2006.

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<sup>12</sup>DSH payments are separate Medicaid payments states make to hospitals. Under Medicaid law, states are required to make special hospital payments to supplement standard Medicaid payment rates and help offset costs for hospitals that serve a disproportionate share of low-income or uninsured patients; these payments came to be known as disproportionate share hospital, or DSH, payments. States have some discretion in designating which hospitals, including hospitals owned or operated by local governments, qualify for DSH payments. In response to inappropriate state financing arrangements involving DSH payments in the early 1990s, Congress passed provisions capping the amount of DSH payments a hospital may receive and limiting the total amount of DSH payments a state may make to all hospitals. 42 U.S.C. § 1396r-4(f)-(g) (2000).

**Table 1: Financing Arrangements Ended, by State and Type of Supplemental Provider Payment Involved, from August 2003 through August 2006**

State	Type of supplemental payment involved in ended arrangement					
	Nursing home	Inpatient hospital	Disproportionate share hospital	Outpatient hospital	Home health	Physician
Alabama	●	●	●		●	
Alaska		●				
Arkansas	●	●				
California		●	●			
Georgia	●	●	●	●		
Iowa	●	●	●			
Kansas	●		●			
Kentucky	●	●				●
Louisiana	●	●		●		
Massachusetts	●	●		●		
Michigan	●		●			
Minnesota		●				
Mississippi			●			
Missouri	●					
Montana	●					
Nebraska	●					
New Hampshire	●					
New Jersey	●					
New York	●	●	●	●		
North Carolina			●			
Oklahoma		●		●		
Oregon	●					
Pennsylvania	●					
South Carolina	●		●			
South Dakota	●					
Tennessee	●					
Virginia	●	●		●		
Washington	●		●			
Wisconsin	●					
<b>Total (29)</b>	<b>23</b>	<b>13</b>	<b>11</b>	<b>6</b>	<b>1</b>	<b>1</b>

Source: CMS and states.

Note: Data from GAO analysis of CMS documents and state responses to GAO's questionnaire.

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Although the specific details of the ended financing arrangements differed from state to state, in more than half of all cases (31 of 55), we identified documents in CMS's files confirming that under the arrangements, providers retained less than the full amount of the supplemental payments they received. For example:

- One state explained in its responses to CMS's standard funding questions that a portion of the supplemental payments to non-state-government-owned hospitals for inpatient services was returned to the state. Payments were made to the hospitals, which retained an amount equal to 3 percent of the payments plus 50 percent of the federal share of the payment. The remaining funds were transferred by the hospitals to their county governments. The counties transferred these funds back to the state via an IGT. The transferred funds were allocated to the state's Medicaid program to fund additional Medicaid services.
- An official from another state noted in an e-mail to CMS that facilities participating in the state's UPL program transferred an amount that exceeded the nonfederal share of certain payments. For example, as explained in a response from a CMS official to the state, under the state's arrangement for supplemental nursing home payments, providers were required to transfer to the state the nonfederal share of the supplemental payments plus approximately an additional 43 percent, which the state used to fund other Medicaid expenditures. CMS concluded that under such an arrangement, the nursing homes netted only 57 percent of the total supplemental payment reported by the state.

In the remaining cases, we could not conclusively determine from reviewing CMS's documentation whether the involved providers retained less than the full amount of the supplemental payment. CMS reported to us, however, that in all of the arrangements states ended, providers retained less than the full amount of the supplemental payments they received because the states required providers to either (1) return a portion of the payment to the state through an IGT or (2) transfer to the state more than the nonfederal share of the payment before the state made the payment to providers and sought federal reimbursement.

In about two-thirds of cases, states ended financing arrangements by removing or revising the pertinent supplemental payment provisions in their state plans. Specifically, states added provisions to their state plan amendments that would, as of a given date (most often, it was the end of the states' fiscal year 2005), end the type of supplemental payments under CMS review. As CMS explained to one state, providing such an end date in

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writing assured CMS that the state would not continue the payments in question (in this case, supplemental payments to local-government hospitals) under the inappropriate financing arrangement; moreover, if the state did not agree to end the arrangement, CMS would not approve the state's proposed state plan amendment. In response, the state resubmitted its amendment, adding a provision ending its supplemental payments to local-government hospitals as of June 30, 2005, and in its cover letter to CMS noted that the state would resume making such payments only under an arrangement acceptable to CMS. In another case, CMS required a state to end its arrangements for certain supplemental payments as a condition for approving the state's section 1115 waiver proposal.<sup>13</sup> Under the waiver agreement, CMS required the state to end, by amending its state plan, the supplemental inpatient hospital payments, nursing home payments, and DSH payments for which providers did not retain the full amounts. This process—in which CMS required states to remove from their state plans provisions governing certain supplemental payments, thereby ending the inappropriate financing arrangements—was the typical approach that CMS took with states under the initiative. In some cases (5 of 55), however, CMS accepted from states written assurance that the state would end an inappropriate financing arrangement. For example, one state wrote to CMS that it would in the future revise its arrangement to comply with CMS's current policy.

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**Fiscal Effects Are Uncertain Because Most States Were Seeking Continued Federal Reimbursements under Alternative Arrangements**

The state and federal fiscal effects of states' ending their financing arrangements were unclear because most of the states (19 of 29 states) were planning or implementing alternative arrangements to continue obtaining federal reimbursements for the related supplemental payments. As of October 2006, only 12 of the 19 states that were planning or implementing different financing arrangements had resumed seeking federal matching funds. Until states begin to obtain federal matching funds under the alternative arrangements, the fiscal effects of the initiative will remain unclear.

The 29 states we contacted provided us estimates of potential annual reductions in federal reimbursement related to ended arrangements—

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<sup>13</sup>Section 1115 of the Social Security Act allows the Secretary of Health and Human Services, in connection with experimental, pilot, or demonstration projects likely to promote program objectives, to waive certain statutory Medicaid requirements and provide federal matching funds for expenditures for which federal matching funds would not otherwise be available. 42 U.S.C. § 1315 (2000).

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most frequently based on the amount of federal reimbursement under the ended arrangements in their fiscal year 2005—that totaled nearly \$1.9 billion and ranged from \$0 to approximately \$382 million among the states. Of the 29 states, 14 states chose not to continue making the supplemental payments related to one or more ended arrangements.<sup>14</sup> For example, one state discontinued its supplemental payments to public nursing homes at the end of its fiscal year 2005 and, as a result, would no longer receive federal reimbursement for such payments—reimbursement totaling nearly \$5 million in state fiscal year 2004. The 14 states that were not taking steps to continue obtaining comparable federal reimbursement estimated that they would each annually receive from \$0 to \$69 million less in federal matching funds.<sup>15</sup>

Most states' estimates were preliminary as of October 2006, because 19 states were planning or implementing different arrangements for financing the related supplemental payments from those that CMS had required them to end. Doing so would allow the states to continue to seek federal reimbursement for those payments. To obtain such federal reimbursement, however, states were subject to CMS review of their alternative arrangements for financing the nonfederal share of their payments. Several states were continuing to use an IGT to fund the nonfederal share, but with changes that they expected to meet with CMS approval; specifically, under a revised IGT, providers would retain in full the supplemental payments made to them. Other states were planning or implementing other arrangements, such as increasing appropriations or generating new revenues by imposing taxes on certain providers, to continue making supplemental payments. The alternative chosen by the largest number of states—10 of the 19 states adopting alternative arrangements—was an approach based on government providers' certifying their Medicaid expenditures to the state. Such certified public expenditures, or CPEs, do not involve an actual transfer of funds by

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<sup>14</sup>Four states that ended more than one financing arrangement chose to discontinue supplemental payments related to one of the ended arrangements. However, these states were also planning to use an alternative financing arrangement to continue making payments related to another of the ended arrangements. As a result, we counted the four states in the total number of states discontinuing payments related to an ended financing arrangement and in the total number of states continuing payments under an alternative arrangement.

<sup>15</sup>The state that estimated a potential reduction of \$69 million in federal matching funds also reported that approximately \$58 million would be offset by new federal funding made available under a section 1115 demonstration project that included federal funding for health care expenditures previously paid with state and local funds.

government providers to the state.<sup>16</sup> Table 2 describes these alternatives and the number of states planning or implementing each one.

**Table 2: Number of States Planning or Implementing Certain Alternative Arrangements for Financing the Nonfederal Share of Payments, as of October 2006**

Alternative arrangement	Number of states	Description	Example
Medicaid certified public expenditure (CPE)	10	Government provider, such as a county hospital, certifies to a state the amount of expenditures for a Medicaid-covered service provided to a Medicaid beneficiary. The state obtains federal Medicaid matching funds based on the amount of the expenditure.	Under one state proposal, 22 government hospitals would be paid in advance for the full cost of providing services to indigent individuals, including Medicaid beneficiaries. The hospitals would certify the total amount of Medicaid expenditures to the state, and the state would then seek federal reimbursement on the basis of the certified amount. <sup>a</sup>
Revised intergovernmental transfer (IGT)	8	Continued use of IGTs with revisions agreed to by CMS. Specifically, CMS is requiring that (1) IGTs from providers to a state occur before supplemental payments are made and (2) the amount of an IGT not exceed the nonfederal share of the Medicaid costs. This approach provides some assurance that government providers are contributing only toward the nonfederal share of a state's Medicaid costs, as prescribed by federal statute.	During state fiscal year 2006, one state will continue using IGTs for inpatient hospital services. Transfers will be limited to the nonfederal share of the Medicaid supplemental payment. The state will obtain assurances from entities making IGTs that all payments will remain with the hospitals.
Provider tax	4	A tax, fee, assessment, or other mandatory payment, imposed on health care services or providers. States may use resulting revenue to pay their nonfederal share of Medicaid costs under statutorily specified circumstances. <sup>b</sup>	One state legislature passed an act authorizing the state to implement a provider tax on public, non-state-government hospitals to fund the nonfederal share of Medicaid payments for inpatient and outpatient services, effective July 2007.
State appropriation	3	State revenue set aside to pay for the nonfederal share of Medicaid spending.	One state partially replaced the portion of the nonfederal share previously funded by an IGT with state appropriations.

Source: CMS and states.

<sup>16</sup>Under a CPE arrangement, government providers certify their Medicaid expenditures to the state, and the state then obtains federal reimbursement on the basis of the certified expenditures. Medicaid law allows states to finance the nonfederal share of payments with CPEs as long as the funds are (1) derived from state or local tax revenue and (2) certified by units of local or state government as eligible for federal reimbursement. 42 U.S.C. § 1396b(w)(6) (2000). States are responsible for ensuring that expenditures are eligible for federal reimbursement by reviewing standard cost reports filed annually by each government provider.

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Notes: Data from GAO analysis of CMS and state documents, state responses to GAO questionnaire, and information reported by state officials. Numbers do not sum to 19—the number of states reporting that they were planning or implementing alternative arrangements for financing the nonfederal share—because some states were using a combination of alternatives.

<sup>a</sup>This state received CMS approval to use CPEs to finance the nonfederal share of supplemental inpatient and DSH payments and to restructure Medicaid payments for all inpatient hospital services under a waiver of Medicaid requirements granted under section 1115 of the Social Security Act, 42 U.S.C. § 1315 (2000).

<sup>b</sup>42 U.S.C. § 1396b(w)(6) (2000). States may receive federal matching funds for provider taxes only if such taxes are broad-based (i.e., imposed on all items or services in the class of services or providers thereof); uniformly imposed (i.e., all items or services in the class or providers thereof pay the same rate of tax); and do not result in any taxpayers being held harmless (i.e., receiving state funds to reduce the net payment to the state to below the amount of the tax). 42 U.S.C. § 1396b(w)(3) (2000). When the tax rate is higher than 6 percent, CMS will consider the hold-harmless requirement violated if 75 percent or more of the taxpayers receive 75 percent or more of the taxes paid back from the state in enhanced Medicaid or other state payments. 42 C.F.R. § 433.68(f)(3) (2006).

States had differing views about the potential fiscal effects of adopting alternative arrangements for financing the nonfederal share of supplemental payments. Half of the states using CPEs (5 of 10) expected CPEs to result in federal reimbursement comparable to what they had received under their ended financing arrangements. For example, officials from one state explained that under its previous arrangement, DSH payments had been limited to costs, and under the state's CPE arrangement (approved by CMS in December 2005), the state would continue obtaining the same amount of federal reimbursement. In contrast, officials from the remaining 5 states using CPEs expressed concern that CPEs could yield less in federal funds than the arrangements they replaced, in part because CPEs must be based on the documented facility-specific costs of providing Medicaid services to Medicaid beneficiaries. An official from 1 of the 5 states explained that, under a prior financing arrangement, the state sought federal reimbursement on amounts up to the UPL, regardless of the facilities' actual costs for providing services. In using CPEs, however, the state will seek federal reimbursement for the lower of either a facility's UPL or its actual Medicaid expenditures, and some facilities' expenditures were less than the UPL.

The fiscal effects of states' replacing their ended financing arrangements with alternative arrangements, such as CPEs, were uncertain as of October 2006 because several states had not fully implemented the alternatives and others faced further CMS review before receiving federal matching funds. Specifically, 1 of the 19 states was still planning its approaches; 6 states reported having implemented alternative arrangements but had not begun seeking federal reimbursements; and the remaining states (12 of 19 states) had made payments under their alternative arrangements and had begun



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seeking federal reimbursements. Those 12 states, however, faced further CMS review before receiving reimbursements. CMS officials informed us that CMS had efforts under way to monitor states' use of alternative arrangements as the states resumed seeking federal reimbursement. CMS's efforts may affect the amount of federal reimbursements the states receive. For example, CMS deferred paying close to \$2 million in federal matching funds to a state that resumed seeking reimbursement for supplemental hospital payments under a revised IGT arrangement. As of October 2006, the state and CMS were still working to resolve CMS's concerns with the state's alternative arrangement. CMS also plans to review other types of alternative arrangements. For example, in its approvals granted from December 2005 through April 2006 of 3 states' plans to use CPEs, CMS informed the states that it planned to conduct financial reviews to ensure that the states' reported expenditures were accurate and that all supplemental payments to certifying facilities had appropriate nonfederal funding.<sup>17</sup>

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## CMS's Initiative Departs from Past Approach and Is Consistent with Medicaid Payment Principles

CMS's initiative is a departure from the agency's past oversight approach and is consistent with Medicaid payment principles. In the past, CMS's approach to inappropriate state financing arrangements did not involve any assessment of whether individual providers were retaining the supplemental payments they received from states. As a result, before the initiative, CMS authorized some states to make supplemental payments even when the agency was aware that providers were not retaining the full payment amount. States that ended financing arrangements view CMS's initiative as a change in policy. One state, Minnesota, challenged CMS's disapproval of its state plan amendment in July 2004. Minnesota argued, in part, that CMS had departed from its past interpretation of Medicaid requirements and should have gone through the process of proposing and receiving comments on a regulation (known as "notice-and-comment rule making") before disapproving the amendment.<sup>18</sup> In July 2006, this argument was rejected, and the disapproval was upheld by the CMS

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<sup>17</sup>In addition to these efforts, CMS identified CPEs as an issue for focused financial reviews in the last 3 fiscal years, 2004 through 2006. See GAO, *Medicaid Financial Management: Steps Taken to Improve Federal Oversight, but Other Actions Needed to Sustain Efforts*, [GAO-06-705](#) (Washington, D.C.: June 22, 2006).

<sup>18</sup>Notice-and-comment rule making (also referred to as informal rule making) is a process in which an agency publishes a proposed rule in the *Federal Register* for public comment. After considering the comments received, the agency issues a final rule.

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Administrator.<sup>19</sup> The state filed an appeal in federal court in September 2006, and as of February 2007, this appeal was pending. In another case, unrelated to CMS's initiative, in which a state challenged CMS's disapproval of a state plan amendment involving an inappropriate financing arrangement, a 2005 federal court ruling upheld CMS's determination that the state's financing arrangement, in which the providers did not retain Medicaid payments, was inconsistent with Medicaid payment principles.<sup>20</sup>

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### CMS's Initiative Departs from Past Oversight Approach

CMS's requirement that states end financing arrangements in which providers do not retain the full payment represents a departure from the agency's past oversight approach to ensuring that states adhere to Medicaid payment principles. Before 2003, CMS's most recent approach for addressing inappropriate state financing arrangements curtailed such arrangements by restricting states' ability to combine, or "aggregate," the amount of payments they could make under the UPL to different types of providers. CMS placed this restriction by revising Medicaid's UPL

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<sup>19</sup>*In re The Disapproval of the Minnesota State Plan Amendment 03-006*, No. 2004-04 at 15, note 36 (CMS Administrator, July 12, 2006).

<sup>20</sup>*Alaska Dep't of Health & Soc. Servs. v. Ctr. for Medicare & Medicaid Servs.*, 424 F.3d 931, 939-40 (9th Cir. 2005).

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regulation in 2001.<sup>21</sup> The revision took place after some states were found taking advantage of the UPL by making supplemental payments to government facilities at rates much higher than established Medicaid rates and then requiring the facilities to return most or all of the supplemental payments to the state.<sup>22</sup> CMS determined that these financing arrangements were not consistent with Medicaid's principle of efficiency and economy and restricted states' ability to aggregate payments across different types of providers. The revised regulation did not address the use of IGTs—the transfer of funds between states and local-government providers—or whether providers were retaining the Medicaid payments made under the new limits. At the time it issued the regulation, CMS determined that the best option for reducing excessive federal reimbursements was to revise the UPL regulation to limit the extent to which aggregated supplemental payments could be made. CMS recognized the possibility that excessive federal funds could still be obtained under the new regulation. In the preamble to its 2001 regulation, CMS reported that it was concerned about how some states used fund transfers between states and local governments and noted that, if problems continued in the

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<sup>21</sup>Before the 2001 regulation, separate UPLs existed for different classes of Medicaid services, such as inpatient hospital services, outpatient hospital services, and nursing facility services. 42 C.F.R. § 447.272 (2000). Within the different provider types—state-government-operated facilities, local-government-operated facilities, and private facilities—only state-operated facilities had separate UPLs for each class of service, with the exception of outpatient hospital services, which did not have a separate UPL for state-government facilities. As a result, within each service class, some states sought federal reimbursement for large supplemental payments by combining—or aggregating—the payment amount allowed under their UPLs for the entire group of local-government and private facilities, even if the actual payment was made to only a handful of selected government facilities. In December 2000, Congress directed the Health Care Financing Administration (HCFA, the former name for CMS) to issue a final regulation to revise the UPL regulation and limit states' ability to obtain excessive federal reimbursements. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, app. F, § 705(a), 114 Stat. 2763, 2763A-575–2763A-576. In January 2001, HCFA issued the final UPL regulation, which established separate UPLs for private facilities and for local-government facilities for different classes of services, including inpatient hospital services, outpatient hospital and clinic services, and nursing facility services. 66 Fed. Reg. 3,148 (Jan. 12, 2001). The final rule also contained provisions that set the UPL for hospitals operated by local governments at 150 percent of what Medicare would pay, rather than 100 percent, which allowed states to make larger supplemental payments to such hospitals. In January 2002, CMS issued another final UPL regulation that replaced the 150 percent UPL for local-government hospitals with a 100 percent UPL. 67 Fed. Reg. 2,602 (Jan. 28, 2002).

<sup>22</sup>For additional information, see GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, [GAO-04-228](#) (Washington, D.C.: Feb. 13, 2004).

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future, further actions could be needed to ensure that federal funds were used to match bona fide expenditures.

In the months after CMS issued its 2001 regulation and before its initiative, CMS approved some states' financing arrangements that entailed the transfer of Medicaid supplemental payments from government providers back to the state. CMS's efforts after issuing the 2001 UPL regulation focused on ensuring that states were not seeking excessive federal reimbursements based on aggregated local-government and private-facility UPLs, as states had done before the regulation. Otherwise, CMS did not curtail financing arrangements, even when they involved providers' not retaining all of the payments made to them.<sup>23</sup> After the 2001 UPL regulation went into effect and before the initiative began, CMS approved states' Medicaid plan amendments establishing supplemental payments to government providers even when the agency was aware that providers were not retaining the supplemental payments. Subsequently, however, CMS determined that these approved arrangements were inappropriate because the providers were not retaining the payments. For example:

- On March 13, 2002, CMS approved one state's proposal to establish a supplemental payment for inpatient hospital services provided by local-government hospitals. During CMS's review of this proposal, the state informed CMS via letter that it was likely that the majority of the payments would be returned by the providers to the state. In state fiscal year 2002, the state's estimated supplemental payments to local-government providers totaled about \$22 million. On October 23, 2003, however, after submitting a state plan amendment to adjust its standard Medicaid payment rates for hospitals, the state received CMS's standard funding questions under the initiative. CMS's subsequent review resulted in the state's ending the previously approved supplemental payment involving local-government hospitals.
- On May 19, 2003, CMS approved another state's supplemental payment for inpatient hospital services provided in government hospitals. During the agency's review of the state plan amendment for these payments, the state

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<sup>23</sup>On numerous occasions, we have reported concerns related to CMS's oversight of states' UPL arrangements, including concerns that CMS was approving new state financing arrangements that were inappropriate and allowing states to continue claiming excessive federal reimbursements that were not consistent with the purpose of CMS's UPL regulations. See, for example, GAO, *Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes*, [GAO-02-147](#) (Washington, D.C.: Oct. 30, 2001), and [GAO-04-228](#).

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informed CMS in writing that this proposal would use state plan language similar to the state's supplemental county nursing home payment. CMS had approved this nursing home payment in 2001, even though the agency had been informed when the payment was proposed that the underlying financing arrangement involved bank loans and wire transfers among counties. Less than 2 months before the state submitted its state plan amendment for the supplemental payment to government hospitals, CMS was informed that the county nursing homes would retain little of the supplemental payments made to them.<sup>24</sup> Nevertheless, CMS approved the similar request involving supplemental payments for inpatient hospital services in local-government hospitals. On August 21, 2003, the state received CMS's standard questions under the initiative after it had submitted a nonsupplemental inpatient hospital state plan amendment to CMS for review. CMS's subsequent review led to the state's ending its supplemental payments to the local-government hospitals.

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### States Report That CMS Has Changed Certain of Its Policies on State Financing Arrangements

Twenty-four of the 29 states that ended financing arrangements and that we contacted reported that under its initiative, CMS has changed its policies on what is an appropriate state financing arrangement. Four states reported that they had no basis to judge whether CMS has changed its policy, 1 state responded that CMS's actions do not represent a change in policy, and 1 state did not respond to this question.<sup>25</sup> Officials of 6 states expressed concerns that before objecting to state plan provisions comparable to what it had approved in the past, CMS should have used a rule-making process to enable states to comment on any proposed changes.<sup>26</sup> According to CMS, however, the agency did not adopt a new policy but is scrutinizing states' payments and their underlying financing arrangements more closely to ensure that they comport with existing laws and regulations and that federal reimbursement is justified.

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<sup>24</sup>In October 2001, we reported that the state's financing arrangements for supplemental county nursing home payments inappropriately generated hundreds of millions of dollars in federal matching funds without a corresponding nonfederal share or an actual payment for services. See [GAO-02-147](#).

<sup>25</sup>The number of states totals 30 in this instance because 1 state provided a different response for each of the two financing arrangements it ended.

<sup>26</sup>The questions we sent to the states did not ask about rule making; some states, however, volunteered this information in narrative comments on CMS's initiative.

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One state, Minnesota, challenged CMS's disapproval under the initiative of a state plan amendment<sup>27</sup> by formally requesting that the CMS Administrator reconsider the disapproval.<sup>28</sup> In its July 2004 reconsideration request, the state argued, among other points, that the disapproval of its state plan amendment to increase supplemental payments to county-operated nursing homes was based on a new policy that constituted a major departure from past CMS policy.<sup>29</sup> The state noted that CMS reviewed and approved the county nursing home payment on two previous occasions without asking any questions about whether the nursing homes retained the funds they were paid.<sup>30</sup> According to the state, CMS changed its policy without going through notice-and-comment rule making, and thus the agency's post-August 2003 policy could not be used to disapprove the state's plan amendment. The Administrator upheld CMS's disapproval on July 12, 2006, finding the state's argument that CMS was required to use notice-and-comment rule making unsupported. The Administrator's decision stated that CMS is required to administer the Medicaid program in a manner consistent with statute, and applying the law correctly does not require notice-and-comment rule making. In September 2006, the state

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<sup>27</sup>On June 1, 2004, CMS sent the Minnesota Medicaid agency a letter disapproving Minnesota's state plan amendment to increase supplemental payments to county nursing homes. Before this disapproval, the state and CMS had had numerous exchanges orally and in writing about details of the state's existing supplemental payments to county nursing homes. These exchanges were triggered by CMS's August 5, 2003, letter to the state requesting responses to CMS's standard funding questions. In its June disapproval letter, CMS explained that the state had not provided assurances to CMS that county nursing homes would retain the increased payments and had also failed to demonstrate that the proposed amendment would be consistent with Medicaid principles, including providing a nonfederal share for the payments and ensuring that payments would be economical and efficient.

<sup>28</sup>Under Medicaid law and regulation, states can request the Administrator of CMS to reconsider disapprovals of state plan amendments. 42 U.S.C § 1316 (2000) and 42 C.F.R. § 430.18 (2006). These appeals typically result in a hearing before a CMS hearing officer, who reviews the evidence and arguments presented by the appealing state and CMS and then makes a recommendation to the CMS Administrator. The Administrator makes the final administrative decision on whether to uphold the agency's disapproval. If the CMS Administrator upholds a disapproval, the state may then appeal in federal circuit court.

<sup>29</sup>The state also argued in its appeal that the state plan amendment met all the statutory and regulatory requirements for approval. For example, the state argued, the amendment would result in efficient and economical payments because the payments did not exceed the UPL for local-government nursing homes. The state also argued that CMS violated the Social Security Act by insisting that the state eliminate the intergovernmental transfers of funds from the counties that owned and operated the nursing homes receiving the payments.

<sup>30</sup>The supplemental payment to county nursing homes was established by a state plan amendment approved in 1994, and a state plan amendment was submitted and approved in 2002 to increase the payment.

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appealed the decision to a federal circuit court; the appeal was pending as of February 2007.

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### A Federal Court Found a Similar Action to Be Within CMS's Authority and Consistent with Medicaid Payment Principles

A 2005 court case found that CMS acted appropriately in disapproving one state's proposed plan amendment in which providers would retain only 10 percent of the payments they received. While this disapproval did not result from CMS's initiative, the basis for CMS's actions in the case shared key characteristics with CMS's basis for ending states' financing arrangements under its initiative.<sup>31</sup> In a September 12, 2005, ruling, the United States Court of Appeals for the Ninth Circuit upheld CMS's disapproval of a state plan amendment that was estimated to increase federal reimbursements by \$50 million a year even though providers would retain only \$5 million of the payments that had been made to them.<sup>32</sup> CMS disapproved the state's proposal, finding that it would result in payments that were not consistent with Medicaid's principle of efficiency, economy, and quality of care because the providers would return the bulk of the payment to the state. The court found that CMS had an obligation to ensure that the Medicaid statute was satisfied before approving a state plan amendment and that CMS correctly applied the Medicaid statute in disapproving the plan amendment. Specifically, the court upheld CMS's determination that the state's proposed payment was not consistent with the principle that provider payments be efficient and economical.

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### CMS's Initiative Lacks Transparency, Raising Concerns about Consistent Review of State Financing Arrangements

As implemented, CMS's oversight initiative has lacked transparency and raised concerns about consistency in CMS's reviews of states that ended financing arrangements. The initiative has not been transparent in that CMS did not issue written guidance about its specific approval standards related to allowable financing methods under the initiative—that is, the conditions upon which the agency would or would not approve a state's financing arrangement. CMS published a proposed regulation in the *Federal Register* on January 18, 2007, that could, when finalized, provide guidance clarifying allowable arrangements for financing the nonfederal share of Medicaid payments. In addition, CMS has not always clearly

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<sup>31</sup>While the case involved Medicaid payments to tribal facilities and not facilities owned and operated by state or local-government entities, CMS's disapproval was based on the same standard that the agency applied under its initiative, specifically, that providers did not retain the full payment amount.

<sup>32</sup>*Alaska Dep't of Health & Soc. Servs.*, 424 F.3d 931, 939–40.

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communicated in writing its review determinations to individual states that ended financing arrangements or provided to all states a record of its determinations under the initiative. Although CMS officials said that their reviews have been consistent because the same funding questions have been asked consistently of all states, the lack of transparency has prompted states to raise questions about the consistency of CMS's reviews and precluded us from determining whether CMS treated states that ended financing arrangements consistently.

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### CMS's Initiative Has Lacked Transparency

CMS's initiative has lacked transparency in two ways. First, the agency did not issue written guidance explaining the specific standards it used for reviewing and approving states' financing arrangements. Consequently, officials in several of the 29 states that ended financing arrangements told us that it was unclear exactly what financing arrangements CMS would and would not allow and why arrangements approved in the past were no longer allowed. Second, CMS did not always explain in writing to the states that ended financing arrangements the specific bases for its determinations, nor did it make available for the benefit of other states and interested parties any record of its determinations that certain arrangements were unallowable.

### CMS Did Not Provide Guidance about Its Specific Approval Standards under the Initiative

CMS did not, before or under the initiative, provide guidance to the states about its specific approval standards, something it had done for some previous oversight actions. For example, before the agency took actions in 2001 and 2002 to further limit states' UPL-related financing arrangements, CMS issued a letter to state Medicaid directors. In each case, the letters communicated the problems the agency had identified with existing UPL regulations and associated financing arrangements, the problems' effect on the Medicaid program and why action was needed, and the type of action the agency proposed to take. In contrast, for the 2003 oversight initiative, CMS did not issue a state Medicaid directors letter or other written guidance that would explain the nature of the agency's intent to address the problem or its specific standards for allowable financing methods, such as allowable use of IGTs. Rather, CMS began asking states submitting state plan amendments for review to answer the five standard questions about how they financed the nonfederal share of their payments.

The lack of CMS guidance to explain the specific standards used under the initiative has resulted in confusion among states about allowable financing arrangements. When states did receive guidance, it was more likely to be oral than written. Only 8 of the 29 states (28 percent) we contacted that had ended financing arrangements reported they had received written



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guidance or clarification from CMS, before or during the review process, regarding appropriate and inappropriate financing arrangements. States told us it was not always clear what financing arrangements CMS would allow and why arrangements approved in the past would no longer be approved. Officials in several states that ended financing arrangements told us that CMS did not provide the guidance they needed about such topics, including appropriate and inappropriate use of IGTs and CPEs. For example, officials from one state commented that they did not understand why CMS would no longer approve the financing arrangement involving transfer payments with local-government providers that the state had used for more than a decade. Officials from another state remarked that the distinction between IGTs and CPEs, and the reasons CMS appeared to approve of CPEs over IGTs, were not always clear. According to CMS officials, the agency has provided guidance on CPEs by working with states individually as the states have developed their proposed financing arrangements.

During our review, a senior CMS official informed us that the agency was considering providing guidance to all states on proper methods for financing the nonfederal share of Medicaid payments, including clarification on issues such as IGTs and CPEs. On January 18, 2007, after it received a draft of this report for review and comment, CMS published a notice of proposed rule making to expressly limit Medicaid payments to government providers to the providers' actual Medicaid costs.<sup>33</sup> The proposed regulation also includes additional guidance related to state financing arrangements and, when finalized, could provide states with needed clarifications.

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<sup>33</sup>See 72 Fed. Reg. 2,236 (Jan. 18, 2007). In budget proposals for fiscal years 2005 and 2006, the administration proposed that Congress pass legislation to specifically prohibit federal reimbursement for state payments to government providers that exceeded the providers' actual costs of providing Medicaid services, but Congress did not pass such legislation. CMS's January proposed rule sought to implement this limitation administratively. According to CMS officials, the administration has authority to implement such limits administratively but proposed the legislation to ensure the program's fiscal integrity over time. CMS's proposal is consistent with an earlier recommendation we made to Congress: to pass legislation to specifically prohibit Medicaid payments to any government facility that exceed 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).

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CMS Did Not Always Document Its Determinations or Make Them Available to States

CMS did not communicate with states in clear, specific terms in writing that the states' financing arrangements were inconsistent with Medicaid payment principles or why they were inconsistent and should be ended. We reviewed case files obtained from CMS to assess how the agency communicated its determinations to the 29 states that ended 55 arrangements under the initiative. In more than half the cases (30 of 55 arrangements, or 52 percent), we found no documentation that CMS communicated to the states in writing the reasons that a state's arrangement was inconsistent, and in another 10 cases (17 percent), we found only general explanations of CMS's concerns with the financing arrangement in question.<sup>34</sup>

In only one-fourth of the cases did CMS communicate in writing to a state the specific basis for its concerns with that state's financing arrangement. Specifically, for 14 of the 55 arrangements (25 percent) the states ended, CMS informed the state in writing that its arrangement was inconsistent with particular Medicaid payment principles and explained why it was inconsistent. The following example illustrates one of the cases where CMS communicated its determinations in writing to the state, including the basis for its determination:

- First, CMS clearly identified in writing the statutory provisions with which it found the state's financing arrangement to be inconsistent: "the State is claiming Federal matching funds for payments to non-state public hospitals for which a significant portion of the payments are returned to the State. CMS considers this funding arrangement to be inconsistent with Sections 1902(a)(2), 1902(a)(30), and 1903(a) of the Social Security Act."
- Second, CMS discussed each statutory provision cited above to explain why the state's financing arrangement was not consistent with a given principle. For example, CMS wrote about section 1902(a)(30)(A): "The supplemental payments are not consistent with the requirement under section 1902(a)(30)(A) of the Act that payment rates must be consistent with 'efficiency, economy and quality of care.' In light of the State's admission that the facilities are refunding a significant portion of the supplemental payments, the proposed payment rate is not consistent with

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<sup>34</sup>In the case of 1 of the 55 ended financing arrangements, CMS communicated to the state in writing—but only in general terms—that the state's financing arrangement was or appeared to be inconsistent with Medicaid payment principles. CMS also provided the state a written explanation specifying why the arrangement was inconsistent with Medicaid payment principles in general, without specifying which principle or principles.

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either efficiency or economy. The refund requirement indicates that the State itself has determined that the full payment amount is not required by the facilities to ensure Medicaid beneficiaries' access to services. Moreover, the proposed payment rate is not consistent with either economy or quality of care because it exceeds the funding actually made available to support the provision of services to Medicaid beneficiaries." In most cases, CMS did not provide states with similar written explanations of the basis for its determinations. For 30 of the 55 financing arrangements that we reviewed and that CMS determined were unallowable under the initiative, we found no evidence that CMS communicated in writing to the states, even in general terms, that the states' arrangements were inconsistent with Medicaid payment principles or why. For 10 arrangements, either CMS provided a general written explanation that the state's arrangement was inconsistent with a payment principle and why, or CMS's written communications were incomplete or difficult to interpret. For example, CMS wrote in a letter to one state that its financing arrangement for nursing home payments appeared to be inconsistent with portions of the Social Security Act, but the agency did not further explain why.

CMS has not made its determinations about any particular state's financing arrangement known or available to other states, as has been done in other contexts. The Department of Health and Human Services' Food and Drug Administration, for example, maintains on its Web site various directories of guidance documents it has issued, including an annual comprehensive list with links to the documents themselves, and a searchable docket management system that provides access to the agency's official repository for administrative proceedings and other materials. In another example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003<sup>35</sup> requires the Department of Health and Human Services to make publicly available the factors it considers in making national Medicare coverage determinations—that is, whether an item or service is reasonable and necessary and thus eligible for Medicare coverage. These determinations are posted on CMS's Web site, where they are available for public comment. CMS has noted that such coverage guidance documents represent the agency's current thinking on a particular topic but do not create or confer any rights for any individual and do not bind CMS or the public. In contrast, under CMS's initiative— involving substantial state and federal Medicaid dollars—CMS does not

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<sup>35</sup>Pub. L. No. 108-173, § 731(a), 117 Stat. 2066, 2349–51.

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have any similar procedure in place for publicizing its case-by-case determinations on financing arrangements.

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### Lack of Transparency Has Raised Concerns among States about Consistent Review of State Financing Arrangements

The lack of information to states on the basis for CMS's determinations under the initiative has raised concerns among the states we contacted about whether CMS has treated them consistently; from CMS's point of view, however, the agency has taken several steps to ensure consistent application of the review process. The lack of written guidance appears to have resulted in differences in states' understanding of what CMS would approve. For example, several states understood that they were required to end the use of IGTs, while other states understood that they would be able to continue using IGTs with revisions that met with CMS approval. Determining whether such differences of understanding resulted from inconsistent treatment by CMS is difficult without a complete and clear written record of CMS's discussions with states about appropriate and inappropriate financing arrangements. Some of the states that responded to our questionnaire, or that we interviewed, expressed concerns about perceived differences in how CMS had reviewed state financing arrangements and allowed states to deal with arrangements that the agency found to be inconsistent with Medicaid payment principles. Officials of one state observed, "Because the decisions and reasoning are not written and issued to all states, we have no way of ensuring that CMS decisions are made consistently across all states."

Six of the 29 states that ended financing arrangements and responded to our questionnaire expressed the opinion that CMS's case-by-case review process was not implemented consistently across states; another 17 states responded that they had no basis for judging whether CMS treated states consistently; and only 3 states responded that CMS had been consistent.<sup>36</sup> Officials of one state added that while CMS had attempted to apply a consistent review technique by asking the same standard funding questions about each plan amendment that each state submitted, the results of the reviews seemed to vary across states: some states were required to return funds, while others were required to end their financing arrangements. The Medicaid director of another state remarked that asking the standard funding questions every time a state submits a plan amendment was a waste of time and duplicative, and, moreover, the CMS

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<sup>36</sup>Two of the three remaining states responded "other" without providing an explanation, and the last state did not answer the question.

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review process had not been applied consistently because states had been able to negotiate different deals with CMS to replace their IGTs with other financing arrangements.

A September 2006 report prepared for the Department of Health and Human Services' Office of Inspector General, which reviewed CMS's financial management oversight of the Medicaid program, raised concerns about the need for transparency and clear guidelines in CMS's process for reviewing and approving state plan amendments. The report recommended, among other things, that CMS "to the extent possible, provide visibility into the program administration activities, including judgments regarding individual state operations, which can help ensure that decisions are made transparently and consistently across jurisdictions recognizing the unique nature of each local Medicaid program. Because routine judgments or interpretations may have long-term funding consequences, a process to assess which decisions merit further visibility should be developed and implemented."<sup>37</sup>

CMS officials told us that the agency had several controls in place to ensure that its review of state financing arrangements was implemented consistently. Officials told us that they followed CMS's established state plan amendment review procedures and asked the same standard funding questions about each plan amendment submitted by each state. In addition, in early 2005, after the initiative was under way, CMS created a unit to centralize responsibility for reviewing and approving state plan amendments related to reimbursement. This central office unit, the Division of Reimbursement and State Financing, also directs about 90 funding specialists hired from late 2004 through April 2006 to help CMS (1) gain a better understanding of how states budget for and finance their portion of Medicaid expenditures and (2) actively identify state financing arrangements that could result in inappropriate claims for federal reimbursement or increased federal costs. A major activity of the funding specialists during their first year was to complete state Medicaid program profiles, which describe the sources of each state's nonfederal share of Medicaid funds, state payment methodologies, and financing-related concerns that may need to be addressed. CMS officials told us that routine review of states' quarterly Medicaid expenditure reports and focused

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<sup>37</sup>See Department of Health and Human Services, Office of Inspector General, Ernst & Young Final Report, *Review of the Centers for Medicare & Medicaid Services' Medicaid Financial Management Oversight* (Washington, D.C.: Sept. 25, 2006).

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financial management reviews help ensure that high-risk financing arrangements that have not been reviewed under the initiative's state plan amendment process also receive scrutiny.

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## Conclusions

We have long been concerned about states' financing arrangements that inappropriately boost the federal share of Medicaid program costs without providing corresponding state dollars, thus undermining the fiscal integrity of the federal-state partnership. CMS's initiative is a direct attempt to address these long-standing problems and to better ensure that states' financing arrangements are consistent with Medicaid payment principles.

The basis for CMS's determinations under this high-profile initiative, however—with substantial state and federal dollars at stake—has not been transparent to states. CMS did not provide written guidance to states; did not always explain to each state in writing the basis for its determinations; and did not make its determinations available to other states and interested parties as a means of communicating its standards for allowable arrangements, as it has done for other programs. A case-by-case review of financing arrangements used in states' Medicaid programs is not only appropriate but warranted in a program as complex and diverse across states as Medicaid. Nevertheless, determinations that can affect a state's Medicaid budget by tens of millions, or even billions, of dollars over a number of years demand a clear basis and an open process. The lack of transparency under CMS's initiative has contributed to concerns about whether states have been treated consistently; such concerns are likely to continue unless CMS alters its oversight approach. Further, many states have been seeking to resume supplemental payments to government providers by seeking to make changes that respond to CMS's objections, yet they have had little written guidance from CMS on what changes are needed or few explanations for determinations that CMS has made. In this federal-state Medicaid partnership, it is appropriate that the federal government review and act upon concerns affecting the program's fiscal integrity—and equally appropriate for states to expect and receive a clear explanation of what federal policy allows.

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## Recommendations for Executive Action

To enhance the transparency of CMS oversight and clarify and communicate the types of allowable state financing arrangements, we recommend that the Administrator of CMS take the following two actions:

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1. Issue guidance to clarify allowable financing arrangements, consistent with Medicaid payment principles.
  2. Provide each state CMS reviews under its initiative with specific and written explanations regarding agency determinations on the allowability of various arrangements for financing the nonfederal share of Medicaid payments and make these determinations available to all states and interested parties.

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## Agency Comments and Our Evaluation

We provided a draft of this report to CMS for comment on January 3, 2007, and received a written response from the agency (reproduced in app. III). In commenting on the report, CMS indicated that ongoing actions would respond to our first recommendation that the agency issue guidance to states. CMS disagreed with our second recommendation to provide states with explanations regarding the agency's determinations.

CMS reported that the regulation proposed on January 18, 2007, would respond to our first recommendation, that the agency issue guidance to clarify allowable state financing arrangements. CMS said that when finalized, the regulation will provide states with guidance to clarify appropriate sources of nonfederal Medicaid funds, including the use of IGTs and CPEs, and reaffirm agency policy that health providers must retain in full the Medicaid payments they receive. We agree that the regulation, when finalized, could help clarify for states the allowability of certain financing arrangements and respond to our recommendation. We updated our report to recognize publication of the proposed regulation after CMS received a draft of our report for review and comment. Nevertheless, because the regulation has been proposed but not finalized, we have maintained our recommendation in the report.

CMS did not agree with our second recommendation to enhance the transparency of its oversight initiative by providing states with specific, written explanations of agency determinations on the allowability of financing arrangements and by making these determinations available to all states and interested parties. CMS disagreed with the conclusion that the agency had not implemented its initiative transparently, stating that the agency communicated its concerns to each involved state and that its process was as transparent as possible given variation among states' financing arrangements. CMS cited several specific reservations about the report's findings regarding the lack of transparency and concerns of inconsistency and about this associated recommendation.

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- CMS commented that the report confused the regulatory state plan review process with a lack of transparency in its reviews and determinations. CMS stated it followed the appropriate parameters of the review process and held conference calls to understand states' financing arrangements and discuss remaining issues. CMS also stated that it is not standard practice to document each communication during these processes. CMS questioned the benefit of documenting all discussions between CMS and states and of making them publicly available, particularly for states that have already ended arrangements.
  - CMS commented that the reported concerns about the consistency of CMS's review are misleading and generally unfair. Highlighting the report draft's finding that CMS's initiative was consistent with Medicaid payment principles, CMS assumed that this conclusion meant that states were treated in the same manner.
  - CMS commented that the statistics in the report based on states' "opinions" have little merit without supporting evidence. CMS also said that GAO overlooked a "strong indication" that most states do not believe they were treated unfairly or inequitably, since only one state has appealed a determination made under the initiative.

We do not agree with CMS's view that the report confuses the state plan review process with a lack of transparency or that the report suggests that CMS should maintain and make publicly available detailed records of all its discussions and communications with state officials. The report clearly relates concerns about transparency to the lack of information to states about the specific bases for CMS's determinations that particular arrangements were unallowable. We provide specific examples in which CMS clearly communicated this information to some but not all states and also report that such clear written communication occurred in only one-fourth of the cases. We did not intend to suggest, as CMS understood, that CMS communicate the basis for its determinations retroactively, and we have clarified this point in our report's recommendation.

We also do not agree with CMS's view that our conclusion that the agency's initiative was consistent with Medicaid payment principles suggests that all states were treated consistently. This finding was related to the broader initiative and based on what CMS officials reported as the overall basis for their determinations. As we stated in the draft report, however, we were unable to determine to what extent the initiative was implemented consistently for individual states because, in most cases, a written record of the basis for CMS's determinations did not exist.



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With regard to CMS's concerns about the reporting of states' opinions without supporting evidence, we point to the evidence provided in the draft report of CMS's changed approach. For example, the draft report cited instances in which CMS had, before its initiative, reviewed and approved states' plan amendments even though the amendments clearly showed that the financing methods involved were the same as those CMS later questioned under its initiative. Finally, with regard to CMS's view that states believe they were treated fairly because only one state appealed its determination, we note that states could choose not to appeal a determination for many reasons, including the time and costs involved in doing so, and point to the states' many reported concerns about the initiative's transparency. We found that states' reported concerns were remarkably consistent, and we maintain that our reporting on matters such as states' receipt of explanations and guidance from CMS is valid.

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As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of the 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. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IV.



Kathryn G. Allen  
Director, Health Care

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# Appendix I: Methodology for Determining the Number of States Ending Financing Arrangements

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Our process for determining the number of states that ended Medicaid financing arrangements, and for determining the number of arrangements each of the states ended as a result of the Centers for Medicare & Medicaid Services' (CMS) oversight initiative, involved three phases. First, we obtained from CMS its list of the states that had ended financing arrangements; second, we contacted all 50 states and the District of Columbia to verify CMS's data; and, finally, we took several steps to resolve discrepancies, identified in our review, between CMS data and information provided by states. We limited the scope of our review to those states we determined to have ended a financing arrangement during the period August 2003 through August 2006.

We obtained from CMS a one-page summary spreadsheet that identified the states that as of July 2005 had ended financing arrangements and the particular arrangements ended. For example, the spreadsheet indicated that several states ended arrangements for both nursing home and hospital payments. As noted by a CMS official, the summary spreadsheet was an internal document used for tracking the results of the initiative and was updated periodically. During our review, we obtained periodic updates of this list from CMS. From July 2005 through August 2006, CMS added two states to its list of those that had ended a financing arrangement, and we included those states in the scope of our review.

To assess the accuracy of the summary list provided by CMS, we sent a standard questionnaire via e-mail to those states that CMS identified as having ended a financing arrangement and, as part of the questionnaire, asked the states to confirm the data provided by CMS.<sup>1</sup> Specifically, we asked whether the state had ended the particular arrangement or arrangements reported by CMS and whether the state had ended any other arrangements not identified in CMS's list. In addition, we interviewed officials from two groups of states: five states that CMS suspected were using one or more inappropriate financing arrangements that had not been ended and three states that, according to CMS, had not submitted a

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<sup>1</sup>We later also sent our standard questionnaire to the two states CMS added to its list from July 2005 through August 2006.

proposal to amend their state Medicaid plans and thus had not undergone a CMS review.<sup>2</sup>

In analyzing the data provided by CMS, states' responses to our questionnaire, and interviews with state officials, we found one discrepancy that could potentially have affected our findings. Specifically, in our interviews with states, officials from one state reported that their state had ended an arrangement, although CMS's list indicated that it had not. According to data provided by CMS, the state has not claimed federal reimbursement for the arrangement in the last 4 years. A CMS official told us, however, that the agency did not consider the state's arrangement ended because the state had not revised its state plan. For the purposes of our review, we concluded that the state had ended the arrangement and included the state in our count.

Because of the differences we found between CMS's original data provided to us and what we learned from some of the states, we contacted all states, including those that received our questionnaire or participated in interviews, to further test the reliability of the information in CMS's summary list. In spring 2006, we sent a short set of questions by e-mail to all 50 states and the District of Columbia, asking them to confirm whether CMS had reviewed certain financing arrangements and to indicate the outcomes of any reviews conducted. The states' responses did not identify additional financing arrangements ended by states. We determined that the information provided by CMS about the states—coupled with information provided by the states through our questionnaire, confirmation e-mail, and interviews—was sufficiently reliable for the purposes of our review.

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<sup>2</sup>When we contacted the states CMS identified as not having submitted any proposals to change their state Medicaid plans, officials from the three states told us that their states had submitted proposals and undergone several CMS reviews. These differences did not affect our findings, however, because the state officials confirmed that their states had not ended a payment arrangement as a result of review under CMS's initiative.

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# Appendix II: Methodology for Analyzing CMS Case Files

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To evaluate how CMS implemented its initiative and, in particular, the extent to which the initiative was implemented in a transparent manner, we examined copies of CMS case files, provided by the agency, for each review under the initiative that resulted in a state's ending a financing arrangement. The files included CMS and state documents, such as official letters between CMS and states and records of e-mail correspondence, relevant to CMS's review of the ended arrangements. We carried out a structured content analysis of each case file to identify how and to what extent CMS communicated in writing to the state the basis for its determination that a state's financing arrangement was not appropriate.

The objectives of our content analysis of CMS's files for each state were to determine the extent to which CMS communicated in writing to the state (1) that it found the state's financing arrangement inconsistent with statutory or regulatory Medicaid payment principles and (2) the reasons for CMS's determination. For each of these two objectives, we assessed whether CMS's written communications to the states, contained in the case files, could be classified as *specific* or *general*.

- In regard to finding that a state's financing arrangement was inconsistent with Medicaid payment principles, we classified CMS's communication as *specific* if the agency wrote to state officials in a letter or e-mail to inform them that the state's financing arrangement was inconsistent with Medicaid payment principles, and the agency specified the particular Medicaid statute, regulation, or policy with which it was not consistent. If, on the other hand, CMS informed the state in writing that its arrangement was inconsistent with Medicaid payment principles but did not specify which principle or principles, we classified the communication as *general*.
- In regard to explaining the reason for its determination, we classified CMS's communication as *specific* if the agency communicated in writing to the state the reasons the state's financing arrangement was or appeared to be inconsistent with Medicaid payment principles. If a CMS file contained documents that (1) described CMS's concern about a state financing arrangement but did not clearly indicate that the arrangement was inconsistent with Medicaid payment principles or (2) identified or alluded to concerns with a state's financing arrangement but did not link the concerns with any agency determination, we classified CMS's communication as *general*.

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If we found no evidence that CMS communicated in writing its determination or the reasons for its determination, we classified such cases as ones in which CMS did not communicate to the state in writing in either general or specific terms.

Our content analysis approach was validated by GAO's research methods staff, and a random sample of our assessments was reviewed by GAO's general counsel staff.

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

**DATE:** FEB 16 2007

*Administrator*  
Washington, DC 20201

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

**FROM:** Leslie V. Norwalk, Esq.  
Acting Administrator

**SUBJECT:** Government Accountability Office's (GAO) Draft Report: *MEDICAID FINANCING: Federal Oversight Initiative is consistent with Medicaid Payment Principles but Needs Greater Transparency* (GAO-07-214).

We appreciate the opportunity to respond to the above referenced draft report dated January 3, 2007. The draft report is in response to your review of the Centers for Medicare & Medicaid Services' (CMS) oversight of Medicaid State financing. As noted in your report, since August 2003, CMS has been ensuring that States finance their share of the Medicaid program with permissible funding sources and that health care providers are allowed to retain the payments made to them for providing services to Medicaid individuals. We are pleased that GAO has found that our exercise of our oversight responsibilities is consistent with Medicaid payment principles. As GAO notes, GAO has urged action since at least 1994 to end financing arrangements it has labeled "illusory." Our actions are consistent with long standing GAO recommendations.

We disagree with the conclusion that CMS did not implement its initiative transparently. After determining that greater scrutiny of State payment provisions was necessary, CMS informed each State that submitted an institutional payment provision of its concerns through standard questions designed to elicit relevant information. These questions were submitted as part of requests for additional information that are authorized by statute, and did not reflect any change in the overall State plan review procedure. Furthermore, the overall standards for approval of State payment provisions were also unchanged; these are set by statute. The quality, extent and content of the information received from States varied widely. Upon receiving information from each State, CMS then had to determine the appropriate response to that State's individual circumstances. In other words, CMS' process was as transparent as possible given the variation among States.

We are also concerned that the report appears to place greater emphasis on "transparency" and process rather than outcome. We are not certain to whom the process of State plan amendment review should be more transparent. The States themselves have sought to protect their financing methodologies from scrutiny, have not been forthcoming with information, and have kept these matters from the public eye. Many of the discussions between States and the Federal Government have been extremely delicate. We strongly doubt that a process that would have opened States to greater public criticism would have yielded a more positive result than what has been achieved.

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The GAO has also overlooked a strong indication of the fairness of CMS review activities. Only one State has appealed a determination made in this CMS initiative, which is an indication that States generally do not believe they were treated unfairly or inequitably in CMS State plan review processes. We also note that the process includes State appeals to Federal court. The GAO does not offer any recommendations that suggest that we could have achieved more positive results than we have.

Under the subject review, which spanned an 18-month period, GAO examined the following: (1) the number and fiscal impacts of States ending particular financing arrangements; (2) the extent to which CMS' initiative represents a change in Agency approach of policy; and, (3) the transparency and consistency of CMS' initiative.

The draft report concludes that:

- Twenty-nine States ended financing arrangements but the fiscal impact is uncertain at the time the draft report was released;
- CMS' initiative departs from the Agency's past approach and is consistent with Medicaid payment principles; and,
- CMS has not implemented its initiative transparently, contributing to concerns about consistency of its reviews of State financing arrangements.

We agree with the GAO finding that, at the time this draft report was released, 29 States ended at least one financing arrangement under CMS' oversight initiative.

We further agree that the fiscal impacts of these arrangements were uncertain because States were seeking to continue obtaining Federal matching funds under alternative financing arrangements. Specifically, for the Medicaid State plan payments that were financed in a manner inconsistent with the Federal Medicaid statute, CMS' oversight initiative applied a nationally consistent end date for the financing arrangements in question, which was the end of each affected State's fiscal year (FY) 2005. Based on that nationally consistent application, all affected States that sought to continue obtaining Federal funds through alternative financing arrangements had not yet completed their final claiming applicable to their State FY 2006. This is critically important to note, in that the majority of the affected States sought to utilize certified public expenditures as the alternative financing arrangement, which requires cost identification, as well as interim and final reconciliation of such costs.

We agree with the GAO finding that CMS' initiative added an additional level of scrutiny to the review of Medicaid reimbursement State plan amendments, within the statutory procedural framework. As highlighted in the draft report, in August of 2003, CMS began asking States five questions related to the State's share (non-Federal) of Medicaid payment obligations under CMS' review of Medicaid reimbursement State plan amendments. This additional layer to the review of Medicaid reimbursement State plan amendments ensures that States finance their share of the Medicaid program in a manner

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consistent with the Federal Medicaid statute, including the confirmation that providers that serve the Medicaid population are able to fully retain the Medicaid payments made to them for such services.

We also agree with the GAO finding that CMS' initiative is consistent with Medicaid payment principles. CMS' approach of requiring the termination of payment arrangements whereby providers of Medicaid services were not able to fully retain the Medicaid payments made to them was based on the information provided to CMS by the affected States in response to the five funding questions. In no instance did CMS allow for the approval of a Medicaid State plan amendment whereby, under the CMS oversight initiative, it was discovered that a State utilized a financing arrangement that was inconsistent with the Medicaid statute until such time that the affected State agreed to terminate such financing arrangement by the end of its State FY 2005.

However, we are concerned that, as currently drafted, the report confuses the Federal regulatory State plan review process by which CMS reviewed Medicaid State financing with a lack of transparency to such review and determination. The parameters of the State plan review process are defined in Federal regulation and allow CMS one opportunity to formally request additional information from States prior to rendering a decision on the Medicaid State plan amendment proposal. Under our oversight initiative, CMS included a standard set of five questions related to Medicaid financing through formal request(s) for additional information from the States. As highlighted in the draft report, these five questions were an additional level of scrutiny. But these questions were not inconsistent with CMS' oversight responsibilities, and were made in accordance with the regulatory review process.

Only when CMS received a State's response to the formal request for additional information under the Federal regulatory State plan amendment review process, did evidence exist in the affected States that certain State financing arrangements appeared inconsistent with the Medicaid statute. In some instances, the responses provided by the State to the standard funding questions were incomplete.

In an effort to expedite the State plan review process, CMS often held conference calls with States to understand the State's financing and to discuss remaining issues. Independent of even the oversight initiative, it is not a standard practice for CMS to document each communication with a State during the State plan amendment review process.

Under this oversight initiative, CMS properly documented the results of such communications through the revisions made by an affected State to its Medicaid State plan and to the related financing in question. This is further documented through the ultimate approval by CMS of such State plan amendment, which included all relevant statutory sections under which the Medicaid State plan review was conducted. The Medicaid State plan process does not lend itself to CMS providing detailed written



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explanation to States on approvals of State plan amendments nor does Federal law or regulations require such detailed explanation. Despite this process, in instances where States asked for written guidance on certain financing arrangements, CMS obliged.

Moreover, GAO performed a massive review of all relevant Medicaid State plan files provided by CMS, information of which clearly supports the nationally consistent application of CMS policy regarding proper Medicaid State financing. The information CMS provided to GAO represents substantial evidence that all States were treated consistently through approach/review process and policy application. Consistent with the review of that evidence, the draft report recognizes that the application of CMS policy was consistent with Medicaid payment principles. Moreover, the draft report does not indicate that CMS actually applied policy inconsistently; it only concludes that because each State did not receive formal written explanations as to why requiring providers to retain less than the total Medicaid payment claimed was inconsistent with the statute, concerns exist about consistent policy application.

We believe the conclusion or “potential” inconsistency reference is misleading and generally unfair. Specifically, we believe the GAO should reconsider the position of potential inconsistency for the following reasons:

1. The GAO reviewed all relevant CMS State plan amendment files;
2. The GAO questioned the affected States;
3. The GAO reports that CMS application of CMS policy was consistent with Medicaid payment principles.

Based on the review of all relevant information from both CMS and the affected States and in consideration of the conclusion in this draft report that CMS application of policy was consistent with Medicaid payment principles, any question of inconsistent application in a particular State or State plan amendment review becomes illogical. The draft report highlights that 25 percent of the affected States received clear written explanations of CMS’ determination. For the remaining States that did not receive written explanations, we would assume GAO’s conclusion that the application of CMS policy was consistent with Medicaid payment principles means that these States were treated in the same manner as the States that received detailed explanations.

Finally, while the GAO performed a thorough examination of the evidence provided by CMS to support a nationally consistent application, the GAO apparently only asked affected States for their “opinion” on the CMS oversight initiative. The statistics provided in the report based on State “opinion” have little merit absent supporting evidence. Moreover, to suggest that States made changes to certain Medicaid financing arrangements without a clear understanding as to why the financing in question was not consistent with Federal law falls short. The GAO has many clear indications that States were often not forthcoming about financial arrangements initially and made changes when the facts were established. States often requested meetings with CMS to discuss

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the financing issues and questions. The majority of those States did not request that CMS provide them with written detailed explanations surrounding those financing arrangements. Moreover, CMS has spent countless hours with affected States trying to assist in developing alternative financing arrangements that meet the requirements of the Medicaid statute.

**GAO Recommendation**

*Issue guidance to clarify allowable financing arrangements, consistent with Medicaid payment principles.*

**CMS Response**

On January 18, 2007, CMS issued a notice of proposed rulemaking, which, in part, would clarify the appropriate Medicaid State financing sources, including the use of intergovernmental transfer and certified public expenditures. The proposed regulation also would reaffirm the retention of payment requirements, consistent with the CMS oversight initiative. Once the final rule is issued, this recommendation will be met.

**GAO Recommendation**

*Provide each state review under its initiative with specific and written explanations regarding agency determinations on the allowability of various arrangements for financing the nonfederal share of Medicaid payments. and make these determinations available to all states and interested parties.*

**CMS Response**

We disagree. Under CMS' oversight initiative, all States were treated in a consistent manner with respect to the review process and the policy application. The GAO concludes in this report that the treatment of States was consistent with Medicaid payment principles. The affected States have subsequently moved to alternative methods of financing or have terminated certain payment arrangement altogether. We have no evidence to support going back to States now and providing detailed articulation on arrangements that the States themselves may not desire to be made public. Moreover, while the GAO's draft report identifies numerous details about certain financing arrangements and certain opinions in States regarding CMS' oversight initiative, the anonymity of the specific State(s) in the draft report is remarkably noticeable.

In sum, the proposed regulation discussed in response to recommendation number one appears to satisfy this recommendation on a national scale for all States and interested parties.

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

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We also believe that the results bear witness to the professional manner in which difficult situations, that if subject to making all information “available to all states and interested parties” could have fractured Federal-State relationships and State-State relationships as well, were resolved. We believe the process itself, which is criticized by GAO for lack of transparency, in fact, contributed to successful resolution.

Once again, we thank you for the opportunity to review this report.

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# Appendix IV: GAO Contact and Staff Acknowledgments

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## GAO Contact

Kathryn G. Allen, (202) 512-7118 or [allenk@gao.gov](mailto:allenk@gao.gov).

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## Staff Acknowledgments

In addition to the contact named above, Katherine Iritani, Assistant Director; Susan Barnidge; Tim S. Bushfield; Ellen W. Chu; Helen Desaulniers; Ellen M. Smith; and Craig Winslow made key contributions to this report.

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# Related GAO Products

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