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MEDICAID FINANCING

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

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Highlights

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.

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.

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.