



Report to the Chairman, Committee on
Homeland Security and Governmental
Affairs, U.S. Senate

December 2020

MEDICAID

CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight

GAO Highlights

Highlights of [GAO-21-98](#), a report to the Chairman of the Committee on Homeland Security and Governmental Affairs, U.S. Senate

Why GAO Did This Study

Medicaid cost \$668 billion in fiscal year 2019. GAO has previously reported on concerns about states' use of various funding sources for the nonfederal share. Although such financing arrangements are allowed under certain conditions, they can also result in increasing the share of net costs paid by the federal government and decreasing reliance on state general funds.

GAO was asked to review the sources of funds states used for Medicaid and the types of payments made to providers. This report describes states' reliance on provider and local government funds for these arrangements; the estimated effect of these arrangements on the federal share of net Medicaid payments; and the extent to which CMS collects information on these arrangements. To do this work, GAO reviewed CMS information; administered a questionnaire to all state Medicaid agencies; analyzed the estimated effects of reliance on provider and local government funds; and interviewed CMS officials, as well as Medicaid officials in 11 states selected, in part, on Medicaid spending and geographic diversity.

What GAO Recommends

The Administrator of CMS should collect and document complete and consistent information about the sources of funding for the nonfederal share of payments to providers. CMS neither agreed nor disagreed with GAO's recommendation, but acknowledged the need for additional financing and payment data for Medicaid oversight.

View [GAO-21-98](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

December 2020

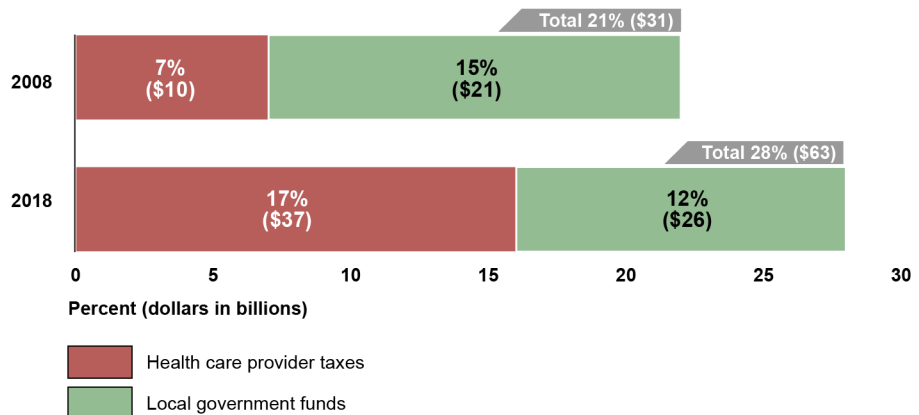
MEDICAID

CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight

What GAO Found

States and the federal government share in financing Medicaid, a health care program for low-income and medically needy individuals. States finance the nonfederal share with state general funds and other sources, such as taxes on health care providers and funds from local governments. GAO's analysis showed a change in how states finance their Medicaid programs. In particular, states relied on provider taxes and local government funds for about 28 percent, or \$63 billion, of the estimated \$224 billion total nonfederal share of Medicaid payments in state fiscal year 2018—7 percentage points more than state fiscal year 2008.

Nonfederal Share of Medicaid Payments from Provider Taxes and Local Government Funds, State Fiscal Years 2008 and 2018



Source: GAO analysis of state questionnaire data. | GAO-21-98

Note: Percentages do not add up due to rounding.

Furthermore, GAO estimated that states' reliance on provider taxes and local government funds decreased states' share of net Medicaid payments (total state and federal payments) and effectively increased the federal share of net Medicaid payments by 5 percentage points in state fiscal year 2018. It also resulted in smaller net payments to some providers after the taxes and local government funds they contribute to their payments are taken into account. While net payments are smaller, the federal government's contribution does not change. This effectively shifts responsibility for a larger portion of Medicaid payments to the federal government and away from states.

The Centers for Medicare & Medicaid Services (CMS)—which oversees Medicaid—collects some information on states' sources of funds and payments, but it is not complete, consistent, or sufficiently documented, which hinders the agency's oversight. For example, CMS does not require states to report on the source of the nonfederal share for all payments. Absent complete, consistent, and sufficiently documented information about all Medicaid payments, CMS cannot adequately determine whether payments are consistent with statutory requirements for economy and efficiency, and with permissible financing, such as the categories of services on which provider taxes may be imposed.

Contents

Letter		1
	Background	6
	Information CMS Collects about Medicaid Financing and Payment Arrangements Is Incomplete, Inconsistent, and Insufficiently Documented, Hindering Oversight	12
	States Financed 28 Percent of the 2018 Nonfederal Share of Medicaid Payments with Provider Taxes and Local Government Funds	15
	States' Reliance on Provider and Local Government Funds Effectively Increased the Federal Share of Net Medicaid Payments 5 Percentage Points in 2018	25
	Conclusions	34
	Recommendation for Executive Action	34
	Agency comments	34
Appendix I	Scope and Methodology of State Questionnaire and Analysis of Effects of States' Reliance on Funds from Health Care Providers and Local Governments	36
Appendix II	The Nonfederal Share States Financed with Provider Taxes and from Local Government Funds in State Fiscal Year 2018	42
Appendix III	Estimated Share of Net Medicaid Payments Financed by the Federal Government in State Fiscal Year 2018	49
Appendix IV	Comments from the Department of Health and Human Services	54
Appendix V	GAO Contact and Staff Acknowledgments	58
Tables		
	Table 1: Methods Used by CMS to Collect Information on Medicaid Financing and Payment Arrangements	13
	Table 2: Example of Calculating Net Medicaid Payments	41

Table 3: The Nonfederal Share of Total Medicaid Payments States Financed with Provider Taxes and Local Government Funds in State Fiscal Year 2018, by State	46
Table 4: Estimated Percentage Point Increase between the FMAP and the Share of Net Medicaid Payments Financed by the Federal Government, by Type of Medicaid Payment and by State in State Fiscal Year 2018	51

Figures

Figure 1: Federal Review and Matching of Estimated State Medicaid Expenditures	7
Figure 2: Nonfederal Share of Medicaid Payments Financed with Funds from Health Care Providers, Local Governments, States, and Other Sources in State Fiscal Year 2018	17
Figure 3: Nonfederal Share of Medicaid Payments Financed with Health Care Provider Taxes and Local Government Funds in State Fiscal Year 2018, by Payment Type	19
Figure 4: Nonfederal Share of Medicaid Payments Financed with Provider and Local Government Funds in State Fiscal Year 2018, by State and Payment Type	21
Figure 5: Provider and Local Government Funds Used to Finance the Nonfederal Share of Medicaid Payments in State Fiscal Years 2008 and 2018	23
Figure 6: Nonfederal Share of Medicaid Payments Financed by Health Care Provider Taxes and Funds from Local Governments, States, and Other Sources, State Fiscal Years 2008 and 2018, by Payment Type	24
Figure 7: Total and Net Medicaid Payments to Providers and Federal Share of These Payments under Two Scenarios	27
Figure 8: Estimated Total and Net Medicaid Payments to Providers and Federal Share of These Payments in State Fiscal Year 2018	28
Figure 9: Estimated Total and Net Medicaid Payments to Providers and Federal Share of these Payments in State Fiscal Year 2018, by Payment Type	30
Figure 10: Estimated Percentage Point Increase between the FMAP and the Share of Net Medicaid Payments Financed by the Federal Government by State and Medicaid Payment Type in State Fiscal Year 2018	32

Figure 11: The Nonfederal Share of Total Medicaid Payments States Financed with Provider Taxes and Local Government Funds in State Fiscal Year 2018, by State	43
Figure 12: The Nonfederal Share of Total Medicaid Payments States Financed with Provider Taxes and Local Government Funds in State Fiscal Year 2018, by State	45
Figure 13: Estimated Percentage Point Increase between the FMAP and the Share of Net Medicaid Payments Financed by the Federal Government for Total Medicaid Payments, by State in 2018	50

Abbreviations

CMS	Centers for Medicare & Medicaid Services
DSH	Disproportionate Share Hospital
FMAP	federal medical assistance percentage
UPL	Upper Payment Limit

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



December 7, 2020

The Honorable Ron Johnson
Chairman
Committee on Homeland Security and Governmental Affairs
United States Senate

Dear Mr. Chairman:

In fiscal year 2019, Medicaid—a jointly financed federal-state health care program for low-income and medically needy individuals—covered approximately 76 million individuals at an estimated cost of \$668 billion, about \$420 billion of which was federal spending. Federal matching funds are available to states for different types of Medicaid payments that states make according to each state's federal medical assistance percentage (FMAP).¹ States finance their share of Medicaid payments—called the nonfederal share—with state general funds and other sources of funding, such as taxes on health care providers and funds from local governments.²

In the Medicaid program, states have some flexibility in terms of the sources of funds used to finance the nonfederal share of spending and the payments they make. Our past work has found that these complex financing and payment arrangements have resulted in states being able to both increase the amount of funding from the federal government and decrease their reliance on state general funds. These types of arrangements are permissible under certain conditions. States have relied on provider funds to finance the nonfederal share to draw down billions of dollars in federal matching funds. When providers contributing nonfederal

¹The FMAP is based on a formula established by law. For fiscal year 2020, states' federal matching rates range from 50.00 to 76.98 percent. The formula is designed such that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average. The range of federal matching rates for 2020 does not include the temporary additional 6.2 percentage point increase in federal matching provided under the Families First Coronavirus Response Act.

²For purposes of this report, health care providers include both private providers, such as hospitals and nursing homes, that serve Medicaid beneficiaries, and state- or county-owned or -operated providers, including hospitals and nursing homes. Local government funds can come from local government entities, such as counties, cities, and local hospital districts, as well as directly from local-government-owned or -operated providers, such as county hospitals. For purposes of this report, local government refers to both local government entities and local-government-owned or -operated providers.

share funds subsequently receive Medicaid payments, these arrangements have the potential to increase the relative share of Medicaid costs paid by the federal government, because the federal government pays its share of the additional Medicaid payments without a commensurate increase in state general funds.

The Centers for Medicare & Medicaid Services (CMS) plays an important role in overseeing Medicaid and ensuring the fiscal integrity of the program. Its responsibilities include reviewing and approving state Medicaid plans that describe how a state will implement its Medicaid program, and ensuring federal Medicaid matching funds are provided for eligible expenditures. To fulfill these responsibilities, CMS relies on financing and payment information from two primary data reporting systems—the CMS-64 and the Transformed Medicaid Statistical Information System. In prior work we have identified issues with the completeness and consistency of information from these systems.³ In addition to the CMS-64 and Transformed Medicaid Statistical Information System, CMS relies on other data collection efforts, such as asking states to provide information on states' Medicaid financing and payment arrangements when reviewing and approving changes to their Medicaid payments.

You asked us to review states' use of Medicaid financing and payment arrangements. In this report, we

- examine the extent to which CMS's data collection efforts provide information on states' use of Medicaid financing and payment arrangements;
- describe the extent to which states rely on funds from health care providers and local governments to finance the nonfederal share of Medicaid payments; and
- describe the estimated effect of Medicaid financing and payment arrangements on the federal share of Medicaid payments providers receive.

³See GAO, *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*, [GAO-13-48](#) (Washington, D.C.: Nov. 26, 2012); *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection* [Reissued on March 13, 2015], [GAO-14-627](#) (Washington, D.C.: July 29, 2014); and *Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy*, [GAO-15-322](#) (Washington, D.C.: Apr. 10, 2015).

To examine the extent to which CMS's data collection efforts provide information on states' use of Medicaid financing and payment arrangements, we reviewed CMS guidance on collecting information on state financing and payment arrangements, as well as relevant federal regulations and guidance. Additionally, we interviewed CMS officials, including representatives from six out of 10 regional offices and Medicaid officials in a selection of 11 states. Seven states were selected, in part, to provide geographic diversity and variation in terms of the total amount of Medicaid payments the states make each fiscal year, and the extent to which the states rely on provider and local government funds to finance the nonfederal share of these payments.⁴ We also selected the four states with the largest Medicaid program spending in 2019.⁵ We interviewed the state Medicaid officials from the selected states about CMS oversight processes and Medicaid financing and payment information collection methods. We compared CMS's data collection efforts to federal internal standards for internal control related to information and communication and monitoring.⁶

To describe the extent to which states rely on funds from health care providers and local governments to finance the nonfederal share of Medicaid payments, we sent a questionnaire to all 50 states and the District of Columbia.⁷ We fielded the questionnaire from November 2019 through July 2020 and received responses from all 50 states and the District of Columbia. The questionnaire collected information on each state's use of funds from health care providers, local governments, state general funds, and other sources to finance the nonfederal share of

⁴We also ensured that our selection included at least one state that opted to expand Medicaid eligibility for certain low-income individuals as authorized under the Patient Protection and Affordable Care Act, and at least one state that made capitation payments to managed care organizations that contract with the state to provide or arrange for services to beneficiaries in return for a predetermined per person payment.

⁵We conducted interviews with Medicaid officials in 10 states. In the 11th state, New York, we obtained written responses due to Coronavirus Disease 2019.

⁶See GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

⁷For purposes of this report, states refers to the 50 states and the District of Columbia.

Medicaid in each state's fiscal year 2018.⁸ We also asked states about the type of Medicaid payments to which the funds were applied. States reported both actual amounts and estimated amounts based on the information available to them. We did not independently verify the accuracy of the data reported by states in the questionnaire; however, we reviewed published data submitted by state Medicaid programs to CMS to assess the reasonableness of the data reported in our questionnaire. We determined the data reported in our questionnaire are reliable for our purposes, in part, due to this review.

We compared states' questionnaire responses with state responses to a similar questionnaire fielded from July 2013 through November 2013 on states' reported funding sources for the nonfederal share of Medicaid payments made in state fiscal years 2008 through 2012.⁹ We received responses to our prior questionnaire from all 50 states and the District of Columbia. To learn more about how selected states financed the nonfederal share of Medicaid payments, we interviewed state Medicaid officials in our selection of 11 states, and officials representing health care provider associations in a selection of five states.¹⁰ We were unable to complete interviews with association officials in two additional states, because of Coronavirus Disease 2019.

To describe the estimated effect of Medicaid financing arrangements on the federal share of Medicaid payments providers receive, we took the following steps.

- **We calculated the amount of the federal share and total Medicaid payments.** To do this, we estimated each state's FMAP and a national FMAP and used it along with the amounts of the nonfederal

⁸For purposes of this report, state funds refers to state general funds and intra-agency funds, which are intra-agency payments, intra-agency transfers, and intra-agency certified public expenditures. Other sources of funds include tobacco settlement funds and state trust funds. Taxes on health care services, or the provision or payment for these services, are being reported separately as health care provider taxes. States' fiscal years are set by states and do not necessarily align with the federal fiscal year. Most state fiscal years start July 1 and end June 30.

⁹See [GAO-14-627](#).

¹⁰We planned to conduct interviews with officials representing health care provider associations in the seven (out of 11 total) states selected, in part, to provide geographic diversity and variation in terms of the total amount of Medicaid payments the states make each fiscal year and the extent to which the states rely on provider and local government funds to finance the nonfederal share of these payments.

share each state reported on the questionnaire during the state's fiscal year 2018.

- **We calculated states' fiscal year 2018 net Medicaid payments: the total Medicaid payments received by all providers minus the amount of funds the providers contributed to finance the nonfederal share of the Medicaid payments they receive.** To do this, we used states' questionnaire responses regarding nonfederal share financing, our earlier calculations of the amount of the federal share and total Medicaid payments, and an assumption about the percentages of provider and local government funds contributed to the state for purposes of financing the nonfederal share of Medicaid payments to those providers. To develop this assumption, we analyzed a 2017 report from the Medicaid and CHIP Payment and Access Commission that estimated these percentages.¹¹ We determined that these percentages were appropriate for our purposes based on information from Medicaid officials in states in which we conducted in-depth interviews about how much of providers' contributions were returned as part of Medicaid payments. Based on this assumption, we estimated the amount of funds the providers did not contribute to finance the nonfederal share of the Medicaid payments they receive. We added this amount to the federal share we calculated earlier to calculate net Medicaid payments.
- **We calculated the share of net Medicaid payments financed by the federal government in states' fiscal year 2018.** To do this, we divided the federal share of Medicaid payments by net Medicaid payments. (See app. I for more detail on the scope and methodology used to determine the extent to which states rely on funds from health care providers and local governments as part of their Medicaid financing and payments, and to examine the effects of states' reliance on funds from health care providers and local governments as part of their financing and payments.)

To gather additional information on the effects of states' reliance on funds from health care providers and local governments to finance the nonfederal share of Medicaid, we interviewed a range of experts and representatives from various organizations. Specifically, we interviewed CMS officials, Medicaid officials in our selection of 11 states, and officials

¹¹See Medicaid and CHIP Payment and Access Commission, *The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending*, (Washington, D.C.: July 2017).

representing health care provider associations in five of our selected states.¹²

We conducted this performance audit from May 2019 to December 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

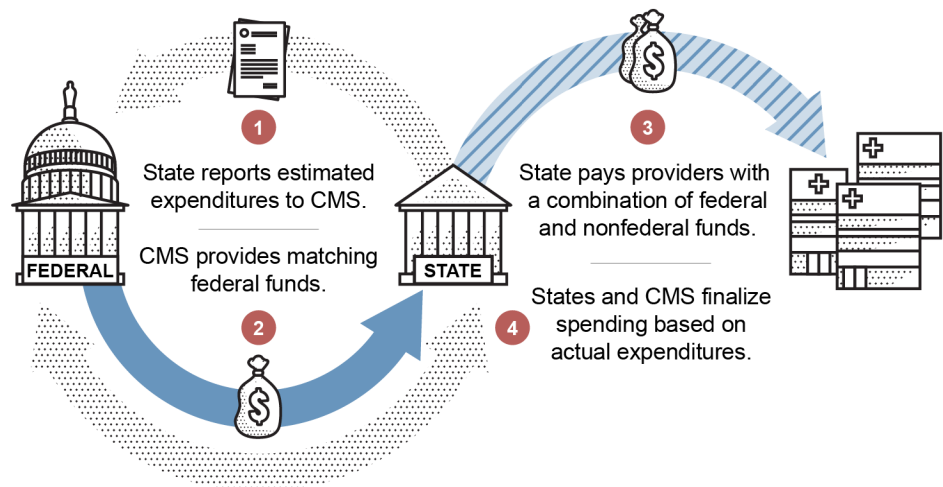
Within broad federal requirements under Title XIX of the Social Security Act, each state administers and operates its Medicaid program in accordance with a state Medicaid plan, which must be approved by CMS. A state Medicaid plan describes the groups of individuals to be covered; the methods for calculating payments to providers, including which types of providers are eligible to receive payments; and the categories of services covered, such as inpatient hospital services, nursing facility services, and physician services. Any changes a state wishes to make in its Medicaid plan, such as establishing new Medicaid payments to providers or changing methodologies for payment rates for services, must be submitted to CMS for review and approval as a state plan amendment.

Federal Funds and State Medicaid Payments

To receive federal matching funds, states estimate their quarterly Medicaid expenditures beforehand and report these estimates to CMS. CMS provides federal matching funds based on states' estimates. States use these federal matching funds to make Medicaid payments to providers. Subsequently, states report actual expenditures to CMS, which reviews and reconciles states' actual expenditures and federal funds to ensure the federal government matches only actual state expenditures. (See fig. 1.)

¹²We planned to conduct interviews with officials representing health care provider associations in the seven (out of 11 total) states selected, in part, to provide geographic diversity and variation in terms of the total amount of Medicaid payments the states make each fiscal year, and the extent to which the states rely on provider and local government funds to finance the nonfederal share of these payments. We were unable to complete interviews with association officials in two additional states, because of Coronavirus Disease 2019.

Figure 1: Federal Review and Matching of Estimated State Medicaid Expenditures



Source: GAO. | GAO-21-98

Federal matching funds are available to states for the different types of Medicaid base payments and Medicaid supplemental payments that states make.

- **Base payments** are payments for covered services. Base payments include both fee-for-service payments and managed care capitation payments. States make fee-for-service Medicaid payments directly to providers based on established payment rates for the services provided. States also make capitation payments to managed care organizations, which can vary in structure, that contract with the state to provide or arrange for services to beneficiaries in return for a predetermined per person payment. The managed care organization is responsible for paying providers. For contract rating periods beginning on or after July 1, 2017, states were able to request CMS approval to direct managed care organizations to make additional payments to providers—beyond capitation payments—under certain conditions. Among other requirements, these state-directed payments must be tied to utilization and delivery of services and advance at least one goal in the states' Medicaid managed care quality strategy.
- **Supplemental payments** are typically lump-sum payments made in addition to fee-for-service Medicaid payments. Supplemental payments are not directly tied to care for individual Medicaid beneficiaries, but may help offset remaining costs of care for beneficiaries. States have some flexibility in determining to whom they make supplemental payments. Supplemental payments include

Disproportionate Share Hospital (DSH) payments, which states are required by federal law to make to hospitals that serve large numbers of Medicaid and uninsured low-income individuals. Many states also make other supplemental payments that are not required under federal law. For the purposes of this report, we refer to these payments as non-DSH supplemental payments. One type of non-DSH supplemental payment is Medicaid Upper Payment Limit (UPL) payments, which are payments above a state's standard Medicaid payment rates, but within the estimated amount that Medicare would pay for comparable services.¹³ A second type of non-DSH supplemental payment is payments made to hospitals and other providers authorized under Medicaid demonstrations, which can provide states additional flexibilities to operate their Medicaid programs.¹⁴

Under federal law, in order to receive federal matching funds, fee-for-service and supplemental payments generally (1) must be made for covered Medicaid items and services; (2) must be consistent with economy and efficiency, and sufficient to ensure access to and quality of care; and (3) must not exceed the Medicaid UPL.

Nonfederal Sources of Funds for State Medicaid Payments

States have significant flexibility to determine which sources of funds to use to finance the nonfederal share of Medicaid payments, within certain limits.¹⁵ States finance the nonfederal share primarily with state funds, particularly state general funds appropriated directly to the state Medicaid program. In addition, states can finance the nonfederal share using funds from health care providers and local governments, including government-

¹³UPL payments generally do not have a specified statutory or regulatory purpose. They must be made for allowable Medicaid expenditures, and the limit is applied to payments to all providers rendering specific services within an ownership class and benefit category, such as state government-owned or -operated facilities that provide inpatient services.

¹⁴Under section 1115 of the Social Security Act, states may apply to and receive approval from CMS for a demonstration that allows states to deviate from their traditional Medicaid programs. Authorities under the demonstrations provide states with the ability to claim Medicaid funds for new types of expenditures, including the costs of making additional payments to providers from funding pools authorized under such demonstrations.

¹⁵For purposes of this report, sources of funds are the means (e.g., taxes) by which funds are supplied by entities (e.g., providers) to the state to be used to finance the nonfederal share of Medicaid; we do not use the term to refer to the entities themselves. In July 2020, we issued a primer with information on Medicaid financing, identifying and illustrating examples of the most common types of permissible arrangements states have used to fund their Medicaid programs. See GAO, *Medicaid: Primer on Financing Arrangements*, [GAO-20-571R](#) (Washington, D.C.: July 14, 2020).

owned or -operated providers.¹⁶ States receive these funds from the following sources:

- **Health care provider taxes and donations.** A state may levy taxes on health care providers (provider taxes) to generate revenues to finance the nonfederal share of Medicaid payments.¹⁷ Provider taxes are defined as a licensing fee, assessment, or some other mandatory payment that is related to a health care service, the provision of or authority to provide the service, or the payment for the service. Provider taxes are typically imposed on private health care providers. States may tax a wide range of services, and health care providers may be subject to more than one tax during a year.¹⁸ In addition, states may receive donations from providers under certain circumstances.
- **Intergovernmental transfers.** A state may obtain funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state that can be used to finance the nonfederal share of Medicaid payments.¹⁹
- **Certified public expenditures.** A state may obtain funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via certifications of spending that can be used to document state Medicaid spending in order to obtain federal matching funds. Certified

¹⁶For the purposes of our report, government-owned or -operated providers refers to units of state or local government, including health care providers that are units of the state or local government.

¹⁷Under federal requirements, taxes must be broad-based (i.e., imposed on all nonfederal, nonpublic providers within a category of services in the state), uniformly imposed (e.g., the tax is the same amount for all providers furnishing the services within the same category), and not hold providers harmless (e.g., must not provide a direct or indirect guarantee that providers will receive all or a portion of tax payments back). States may seek CMS approval of a waiver of either the broad-based or uniformly imposed requirements. CMS may waive these requirements only if the net impact of the tax is generally redistributive and not directly correlated with Medicaid payments to the providers subject to the tax.

¹⁸Under federal regulations, there are 18 defined categories of services on which provider taxes may be imposed, which include inpatient and outpatient hospital services, nursing facility services, physician services, and services provided through managed care organizations.

¹⁹Under agency policy, CMS requires that intergovernmental transfers occur before the state makes a Medicaid payment to the provider and that the amount of the transfer cannot be greater than the nonfederal share of the Medicaid payment amount.

public expenditures do not involve the transfer of money to be used to finance the nonfederal share; rather, the local government provider or entity certifies to the state an amount that it has expended for Medicaid-covered services provided to Medicaid beneficiaries.²⁰

States must use state funds to finance at least 40 percent of the nonfederal share of total Medicaid expenditures each year. State funds that may be used to meet this requirement include state general funds, health care provider taxes imposed by the state, provider donations received by the state, and intra-agency funds from non-Medicaid state agencies. The remaining 60 percent of the nonfederal share for total annual Medicaid expenditures can be derived from local governments; for example, via intergovernmental transfers.²¹ The limit on the percentage of the nonfederal share that may be financed by local governments is applied on the basis of total annual Medicaid program spending and not on individual payments or types of payments.

November 2019 Proposed Rule on Medicaid Financing

In November 2019, CMS issued a proposed rule on Medicaid fiscal accountability, which would establish new state reporting requirements on certain Medicaid payments and address how states finance their nonfederal share of the payments, among other things.²² In November 2020, CMS told us that it withdrew the rule from the regulatory agenda and will use this time to further consider public comments received. The agency noted, however, that, if finalized, the proposed rule would provide CMS with the regulatory authority to collect more complete and consistent financing and payment information from states.

CMS's Primary Data Reporting Systems

CMS's two primary data reporting systems—the CMS-64 and the Transformed Medicaid Statistical Information System—collect information from states; however, we have previously reported that these data reporting systems provide limited information on Medicaid financing and

²⁰A certified public expenditure represents the total costs (both the federal and the nonfederal share) incurred for the Medicaid services. The state has the flexibility to send the federal matching funds it receives to the local government or local government provider that certified the expenditure or may retain some or all of those funds.

²¹Local governments may also impose health care provider taxes or receive provider donations that may be used for the nonfederal share if they are in compliance with federal requirements. Revenue from these sources is generally transferred from the local government to the state through an intergovernmental transfer.

²²Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63,722 (Nov. 18, 2019).

payments. States are required to use the data reporting systems to regularly report to CMS some Medicaid financing and payment information.²³ For example, on the CMS-64 states report information on the total amount of Medicaid payments they make and may report information on the total amount of health care provider tax revenue they collect.²⁴ In the case of the Transformed Medicaid Statistical Information System, states report information on the amount of Medicaid payments made to providers at the provider-specific level, and states may report the source of the nonfederal share of these payments. However, in our 2014 report, CMS officials noted that states are not likely to submit information on sources of funds for the nonfederal share, because most of the states have had difficulties collecting this information at a provider-specific level.²⁵

We have longstanding concerns about the completeness and consistency of the Medicaid financing and payment information states report to CMS, as well as concerns regarding the quality of data CMS has available to oversee the Medicaid program.²⁶ Oversight challenges related to the appropriate use of Medicaid dollars and incomplete and inconsistent data are two key reasons why Medicaid remains on our High Risk List.²⁷

²³States are required to submit aggregate total quarterly Medicaid expenditures on the form CMS-64 no later than 30 days after the end of each quarter. CMS requires states to report Transformed Medicaid Statistical Information System data monthly on Medicaid expenditures and utilization.

²⁴States are required to submit information on taxes collected and donations received on the quarterly CMS-64 expenditure report. In a 2014 report, CMS officials said that the agency could not attest to the accuracy of data that states reported on their use of provider taxes and donations, but that states were likely underreporting their use of these sources of funds. We recommended that CMS take steps to ensure states report accurate and complete data on all sources of funds to finance the nonfederal share. See [GAO-14-627](#). CMS did not concur with our recommendation, but stated that it will examine efforts to improve data collection for oversight. As of October 2020, we considered the recommendation unimplemented.

²⁵See [GAO-14-627](#).

²⁶See [GAO-13-48](#); [GAO-14-627](#); [GAO-15-322](#); and GAO, *Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments*, [GAO-16-108](#) (Washington, D.C.: Feb. 5, 2016).

²⁷See GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, [GAO-19-157SP](#) (Washington, D.C.: Mar. 6, 2019).

Information CMS Collects about Medicaid Financing and Payment Arrangements Is Incomplete, Inconsistent, and Insufficiently Documented, Hindering Oversight

CMS's data collection efforts provide information on states' Medicaid financing and payment arrangements; yet, the information collected lacks completeness and consistency, and is insufficiently documented. As a result, CMS's ability to effectively oversee states' financing and payment arrangements is hindered.

CMS uses these data collection efforts to oversee states' Medicaid payments and their financing. (See table 1.) As one example, CMS requests that the state respond to a set of standard funding questions related to the source of the nonfederal share of funding, including provider taxes and intergovernmental transfers, for provider payments. CMS uses the state's responses to identify the sources of the nonfederal share and assess the permissibility of the source of the funds.²⁸ However, the information collected through the standard funding questions is incomplete and inconsistent, and not documented for use in ongoing monitoring.

²⁸States have significant flexibility to determine which sources of funds to use to finance the nonfederal share of Medicaid payments, within certain limits. For example, provider taxes may only be imposed on certain categories of services.

Table 1: Methods Used by CMS to Collect Information on Medicaid Financing and Payment Arrangements

CMS effort	Description	Issues with completeness, consistency, or sufficiency with documentation
Standard funding questions	CMS requests states answer a set of five standard funding questions when requesting CMS approval to make certain Medicaid program changes, including to state plan or demonstration programs. The funding questions are intended to help CMS assess the permissibility of the source of nonfederal share funding, such as provider taxes and intergovernmental transfers, and provider payment information at the time a program change is approved.	Financing information does not always provide information on a provider-specific basis. Information is not updated if states change the source of the nonfederal share after the state plan amendment is approved. According to CMS officials, the agency does not generally collect and document additional information associated with a state plan amendment in a centralized manner.
Annual upper payment limit (UPL) demonstration reporting	States must annually submit reports to CMS to demonstrate their compliance with UPL requirements. States submit provider-specific Medicaid payment amounts, including the amounts of supplemental payments made to providers.	States usually submit estimated information prospectively, with no subsequent reconciliation to actual Medicaid payments. States are not consistently required to identify the amount of funds contributed by individual providers. According to CMS officials, the data are not used in a centralized manner for oversight of financing and payment arrangements.
Health care provider tax waivers	States can request a waiver from the federal requirements that provider taxes be broad based and/ or uniform. The waiver provides CMS with information about which providers are included or excluded from paying the tax and the tax rate.	According to CMS, detailed information about health care provider taxes is only required and reviewed when the state is seeking a waiver. CMS officials said that while the agency maintains information on all health care related tax waivers, this information is not compiled in a consolidated manner for oversight. Officials said this limitation could make it difficult to perform in-depth national analysis.
Environmental scanning	Some CMS regional offices conduct environmental scanning, including identifying proposed state legislation and reading news reports, of their regions' state Medicaid programs to learn about potential changes to states' method of financing of the nonfederal share or to Medicaid payments.	Regional offices are inconsistent in their use of environmental scanning. CMS has no standardized requirements for environmental scanning.
Financial management reviews	Financial management reviews allow CMS to conduct in-depth reviews of state Medicaid expenditures and the sources of funding states use to finance the nonfederal share.	On an annual basis, CMS chooses one state per region for a financial management review of a CMS-identified topic area, and the review may cover topics other than financing and payment arrangements, such as emergency services for undocumented individuals. Between fiscal years 2016 and 2020, eight of the 49 financial management reviews examined state financing arrangements. CMS's use of financial management reviews for oversight has been limited due to competing priorities, decreased staff, and the agency's internal report review process.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-21-98

More recent efforts to collect payment and financing information are also incomplete and insufficiently documented. In 2017, as part of the review and approval of state-directed managed care payments, CMS began requiring states to submit a form regarding their use and how the nonfederal share of these managed care payments are financed.²⁹ For example, states are required to attest that state-directed payments are not conditioned upon intergovernmental transfers when they submit the form to CMS for approval.³⁰ However, what is known about these managed care payments and how states finance the nonfederal share of them is incomplete and insufficiently documented.³¹

- The information is incomplete, because CMS requires states to report provider-specific amounts of intergovernmental transfers used to finance state-directed managed care payments, but not other sources of the nonfederal share, such as provider taxes.
- The information is insufficiently documented. CMS officials said that while the agency maintains information on state-directed managed care payments, this information is not compiled in a consolidated manner for oversight. Officials said this limitation could make it difficult to perform in-depth national analysis.

Without complete, consistent, and sufficiently documented information about sources of funding for the nonfederal share and payments to providers, including state-directed managed care payments, CMS is unable to identify potentially impermissible financing and payment arrangements for further review. Further, as we have previously reported, CMS's limited information on Medicaid payment and financing information have contributed to states making payments to a few hospitals that significantly exceeded the hospitals' Medicaid costs—unknown to CMS—that increased federal spending by hundreds of millions of dollars.³² Additionally, CMS officials have acknowledged that without

²⁹The Section 438.6(c) Preprint is the form CMS requires states to submit in order to receive approval before any state-directed managed care payments may be implemented.

³⁰In particular, states are required to attest on this form that provider participation in the networks of managed care plans receiving state-directed payments is not conditioned upon the providers making intergovernmental transfers.

³¹In September 2020, CMS officials said that they have efforts underway to improve the consistency of data collected and the agency's ability to use this information in oversight.

³²See GAO, *Medicaid: Actions Needed to Mitigate Billions in Improper Payments and Program Integrity Risks*, [GAO-18-589T](#) (Washington, D.C.: June 27, 2018).

complete provider-specific payment and financing information, the agency does not have sufficient information to evaluate whether payments are economical and efficient as required under federal law. Furthermore, CMS does not have the information necessary to ensure that the nonfederal share is financed with permissible sources of funds. The lack of complete, consistent, and sufficiently documented financing and payment information are inconsistent with federal internal control standards that require federal agencies to obtain quality and relevant information, ensure it is accessible, and is used to conduct oversight and monitor changes over time.³³

States Financed 28 Percent of the 2018 Nonfederal Share of Medicaid Payments with Provider Taxes and Local Government Funds

States used provider taxes and local government funds to finance 28 percent of the nonfederal share of Medicaid payments in 2018, increasing 7 percentage points since 2008, mostly due to the states' increasing reliance on provider taxes.

³³See [GAO-14-704G](#).

States Relied on Providers and Local Governments to Finance 28 Percent of the Nonfederal Share in 2018; Reliance Was Greater for Supplemental Payments than Base Payments

Main Types of Provider and Local Government Funds

Health care provider taxes. Funds from providers via state-levied taxes on health care providers.

Intergovernmental transfers. Funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state.

Certified public expenditures. Funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via certifications of spending.

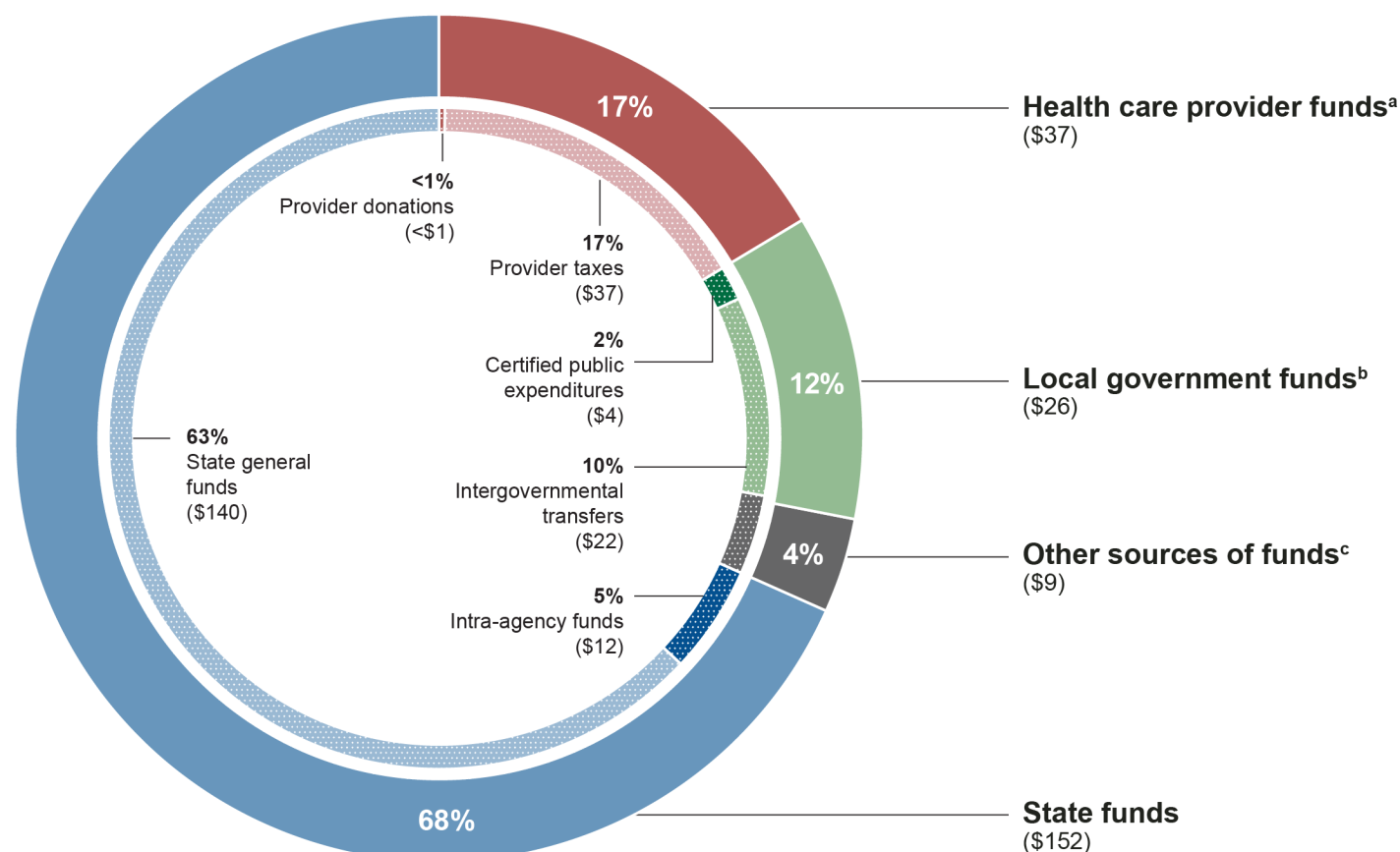
Source: GAO. | GAO-21-98

In state fiscal year 2018, states used provider taxes and local government funds (i.e., intergovernmental transfers and certified public expenditures) to finance about 28 percent, or \$63 billion, of the \$224 billion that constituted the total nonfederal share of Medicaid payments that year, according to our analysis of state questionnaire responses.³⁴ The largest single source of these funds was provider taxes, which accounted for \$37 billion of the \$63 billion. Overall, state general funds were the largest source of funds states used to finance the nonfederal share of Medicaid payments in state fiscal year 2018. (See fig. 2.)

³⁴Health care provider donations, the other source of funds from providers, accounted for less than 1 percent (\$450,000) of the nonfederal share in 2018. We refer to funds from providers as provider taxes for the remainder of the report. States' fiscal years are set by states and do not necessarily align with the federal fiscal year. Most state fiscal years start July 1 and end June 30.

Figure 2: Nonfederal Share of Medicaid Payments Financed with Funds from Health Care Providers, Local Governments, States, and Other Sources in State Fiscal Year 2018

Percentage (dollars in billions)



Source: GAO analysis of state questionnaire data. | GAO-21-98

Note: Information is based on questionnaire responses received from 50 states and the District of Columbia. Percentages rounded to the nearest whole number, and dollar amounts rounded to the nearest billion. Percentages do not add up to 100 percent due to rounding.

^aHealth care provider funds include provider taxes and provider donations. Provider taxes are funds generated from state-levied taxes on health care providers.

^bLocal government funds include certified public expenditures and intergovernmental transfers. Certified public expenditures are funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via certifications of spending. Intergovernmental transfers are funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state.

^cOther sources of funds include tobacco settlement funds and state trust funds.

Medicaid Base and Supplemental Payments

Base payments. Payments to providers or organizations for services provided through fee-for-service and managed care.

Supplemental payments. Typically lump sum payments made in addition to fee-for-service Medicaid payments. Supplemental payments are not directly tied to care for individual beneficiaries, but may help offset remaining costs of care for Medicaid beneficiaries. They include the following:

- Disproportionate Share Hospital (DSH) payments: Payments made to hospitals that serve large numbers of Medicaid beneficiaries and uninsured low-income individuals; such payments are required by federal law.
- Non-DSH supplemental payments: These payments include Medicaid Upper Payment Limit supplemental payments and payments made to hospitals and other providers authorized under Medicaid demonstrations, which are not required by federal law.

Source: GAO. | GAO-21-98

States collectively relied on provider taxes and local government funds to finance the nonfederal share of Medicaid supplemental payments to a greater extent than they did for base payments, according to our analysis of state questionnaire responses. Whereas provider taxes and local government funds financed less than 26 percent of the nonfederal share of base payments across states, provider taxes and local government funds financed 65 percent of DSH payments and 46 percent of non-DSH supplemental payments.³⁵ (See fig. 3.) As we have previously reported, supplemental payments provide states with greater payment flexibility than base payments.³⁶ Providers and local governments may be more willing to finance the nonfederal share of these payments since states can return their contributions through targeted supplemental payments. With regard to provider tax revenues, states may not hold providers harmless (e.g., provide a direct or indirect guarantee that providers will receive all or a portion of their tax payments back). However, officials we interviewed in three of our selected states said that this flexibility to make payments to contributing providers increases the likelihood that states will be able to finance the nonfederal share of these payments with provider taxes and local government funds without risk of the state needing to contribute state general funds.

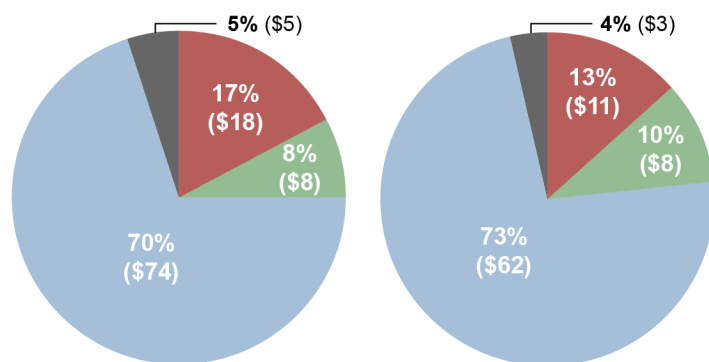
³⁵Provider taxes and local government funds were \$17 billion of the \$33 billion in nonfederal share funds for supplemental payments and \$46 billion of the \$190 billion in nonfederal share funds for base payments.

³⁶See GAO, *Medicaid: States' Use and Distribution of Supplemental Payments to Hospitals*, [GAO-19-603](#) (Washington, D.C.: July 19, 2019).

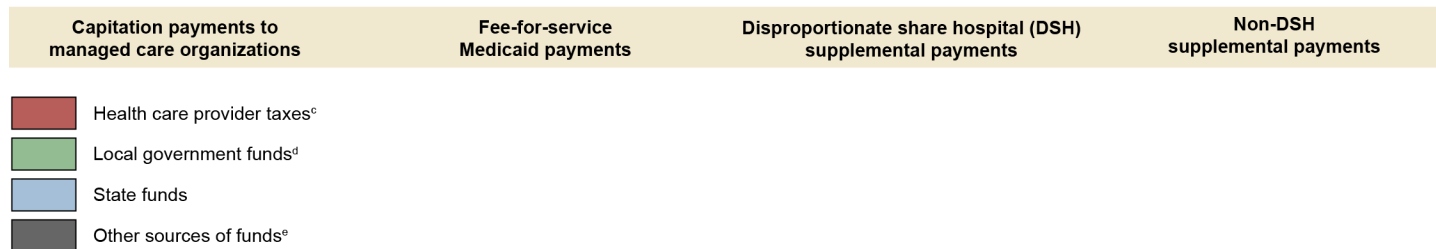
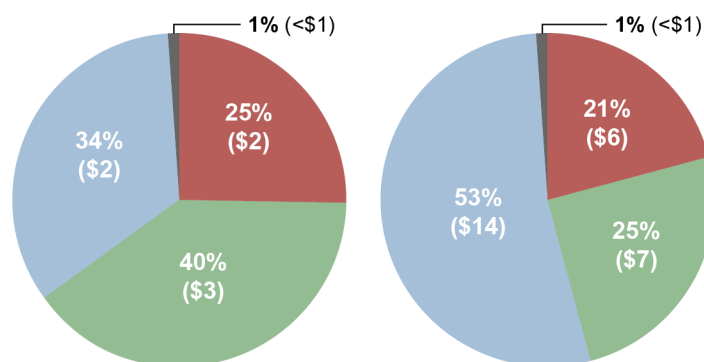
Figure 3: Nonfederal Share of Medicaid Payments Financed with Health Care Provider Taxes and Local Government Funds in State Fiscal Year 2018, by Payment Type

Percentage (dollars in billions)

BASE PAYMENTS^a



SUPPLEMENTAL PAYMENTS^b



Source: GAO analysis of state questionnaire data. | GAO-21-98

Notes: Information is based on questionnaire responses received from 50 states and the District of Columbia. Percentages rounded to the nearest whole number, and dollar amounts rounded to the nearest billion.

^aBase payments are payments to providers or organizations for services provided through fee-for-service and managed care.

^bSupplemental payments are typically lump sum payments made in addition to fee-for-service Medicaid payments. Supplemental payments are not tied to care for individual beneficiaries, but may help offset remaining costs of care for Medicaid beneficiaries. They include (1) DSH supplemental payments made to hospitals that serve large numbers of Medicaid beneficiaries and uninsured low-income individuals, which are required by federal law; and (2) non-DSH supplemental payments, which are not required by federal law.

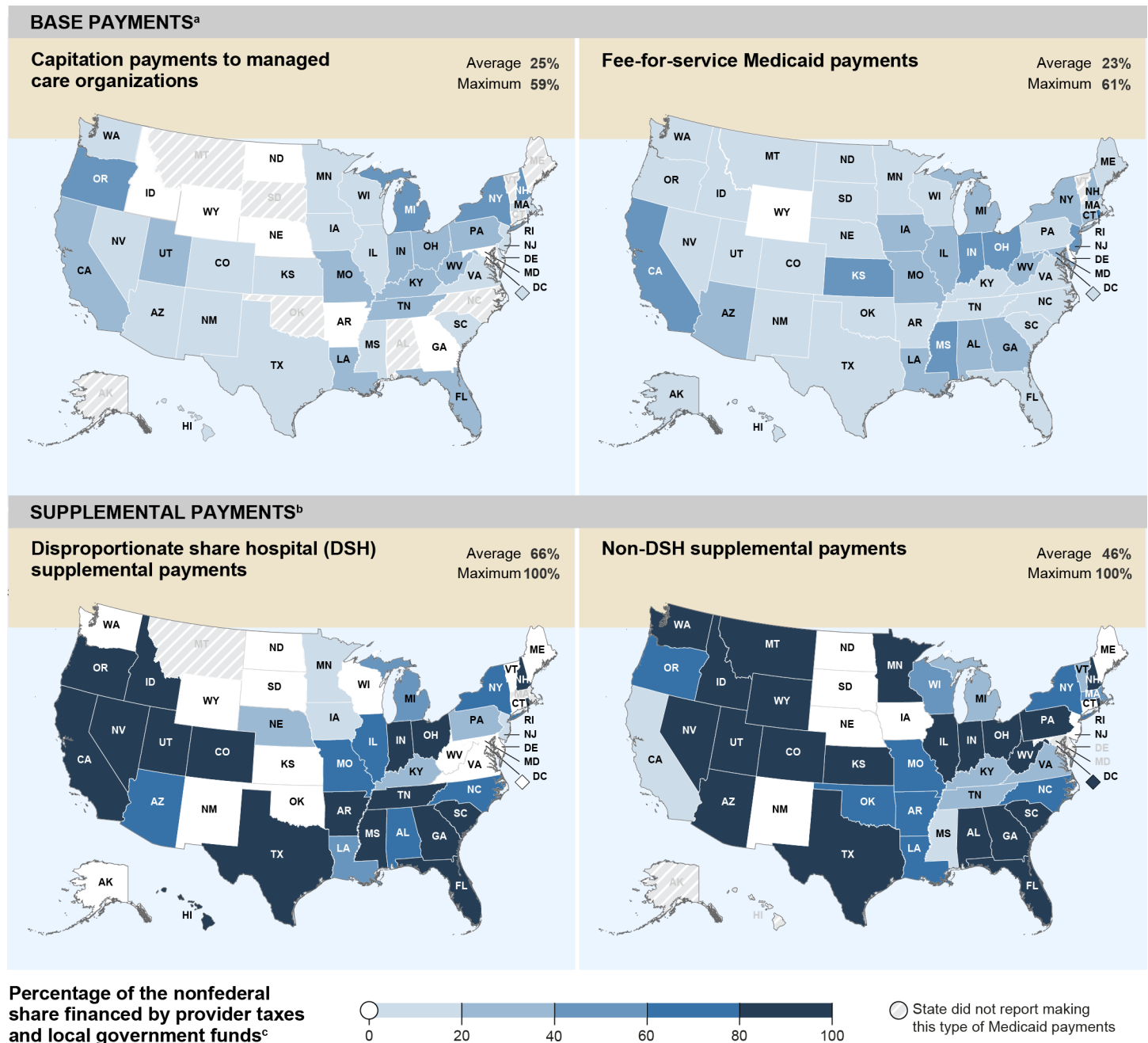
^cHealth care provider taxes are funds generated from state-levied taxes on health care providers. For purposes of this figure, they also include provider donations, which accounted for less than 1 percent (about \$450,000) of the nonfederal share in state fiscal year 2018.

^dLocal government funds are funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state (intergovernmental transfers) or certifications of spending (certified public expenditures).

^eOther sources of funds include tobacco settlement funds and state trust funds.

On a state-by-state basis, we also found that most states tended to finance a significantly higher percentage of the nonfederal share of their DSH and non-DSH supplemental payments using provider taxes and local government funds than they did for base payments, although wide variation existed in states' use of these funds to finance supplemental payments, according to our analysis of state questionnaire responses. (See fig. 4 and app. II for more information about state variation in the percentage and amount of provider taxes and local government funds used to finance the nonfederal share of Medicaid payments in 2018.)

Figure 4: Nonfederal Share of Medicaid Payments Financed with Provider and Local Government Funds in State Fiscal Year 2018, by State and Payment Type



Source: GAO analysis of state questionnaire data; Map Resources (Map). | GAO-21-98

Note: Information is based on questionnaire responses received from 50 states and the District of Columbia.

^aBase payments are payments to providers or organizations for services provided through fee-for-service and managed care.

^bSupplemental payments are typically lump sum payments made in addition to fee-for-service Medicaid payments. Supplemental payments are not tied to care for individual beneficiaries, but may help offset remaining costs of care for Medicaid beneficiaries. They include (1) DSH supplemental payments made to hospitals that serve large numbers of Medicaid beneficiaries and uninsured low-income individuals, which are required by federal law; and (2) non-DSH supplemental payments, which are not required by federal law.

^cProvider taxes are funds generated from state-levied taxes on health care providers. For purposes of this figure, they also include provider donations, which accounted for less than 1 percent (about \$450,000) of the nonfederal share in state fiscal year 2018. Local government funds are funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state (intergovernmental transfers) or certifications of spending (certified public expenditures).

State Reliance on Provider and Local Government Funds to Finance the Nonfederal Share Increased 7 Percentage Points from 2008 through 2018, Mostly Due to Provider Taxes

Comparing the state questionnaire responses we received for this review and for our 2014 report, we found that state reliance on provider taxes and local government funds increased by 7 percentage points from state fiscal year 2008 through state fiscal year 2018.³⁷ The overall percentage of the nonfederal share that states financed from these sources was 21 percent in 2008, and 28 percent in 2018.

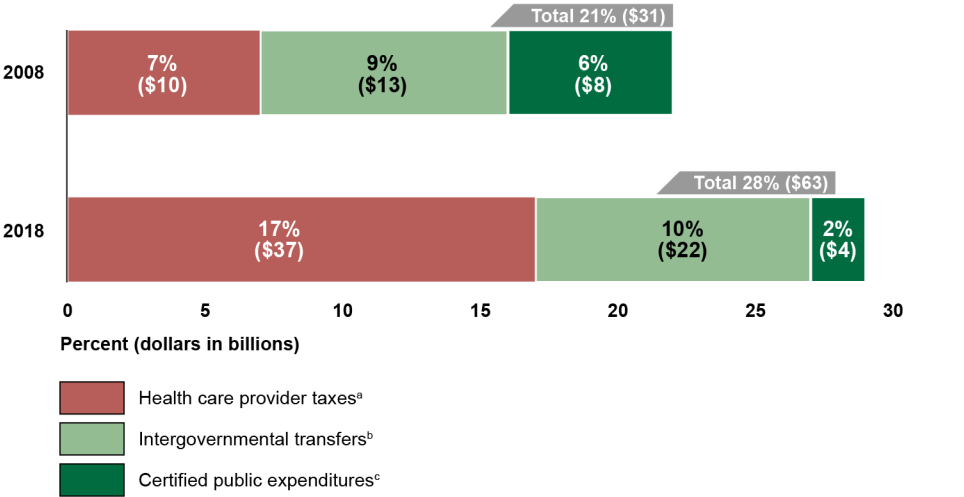
This increase was primarily due to the significant growth in states' use of provider taxes, which increased from \$10 billion to \$37 billion and covered a growing percentage of the nonfederal share—from 7 percent in 2008 to 17 percent in 2018.³⁸ (See fig. 5.) State Medicaid officials from three of our 11 selected states told us that they implemented provider taxes to maintain or increase Medicaid provider payments when budget constraints limited their states' use of state general revenue funds to finance the nonfederal share. Furthermore, officials from four health care provider associations we interviewed said that their members supported

³⁷Our prior state questionnaire collected information on the sources of funding states used to finance the nonfederal share of Medicaid payments from state fiscal years 2008 through 2012. See [GAO-14-627](#). On a state-by-state basis, the percentage of the nonfederal share of total Medicaid payments financed with provider taxes and local government funds increased from 2008 through 2018 in 40 states. Of these states, the percentage point increase was 15 percentage point or less in 32 states. Eleven states decreased the percentage of the nonfederal share of total Medicaid payments financed with provider taxes and local government funds.

³⁸The percentage of the nonfederal share states financed with funds from local governments decreased from 15 percent (\$21 billion) to 12 percent (\$26 billion) over this 11-year period. This percentage point decline is largely due to one state with a large Medicaid program reporting significantly less certified public expenditures from local government funds to finance Medicaid payments in 2018.

states’ implementation of provider taxes to offset state budgetary gaps that would have reduced their Medicaid payments.

Figure 5: Provider and Local Government Funds Used to Finance the Nonfederal Share of Medicaid Payments in State Fiscal Years 2008 and 2018



Source: GAO analysis of state questionnaire data. | GAO-21-98

Notes: Information is based on the responses of 50 states and the District of Columbia to a questionnaire on state Medicaid financing for this review and a similar questionnaire in our 2014 report. See GAO, *Medicaid Financing: States’ Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection* [Reissued on March 13, 2015], [GAO-14-627](#) (Washington, D.C.: July 29, 2014). Percentages rounded to the nearest whole number and dollar amounts rounded to the nearest billion. Percentages and dollar amounts for financing sources do not add up to the total percentage and amount due to rounding.

^aHealth care provider taxes are generated from state-levied taxes on health care providers. For purposes of this figure, they also include provider donations, which accounted for less than 1 percent (about \$450,000) of the nonfederal share in state fiscal year 2018.

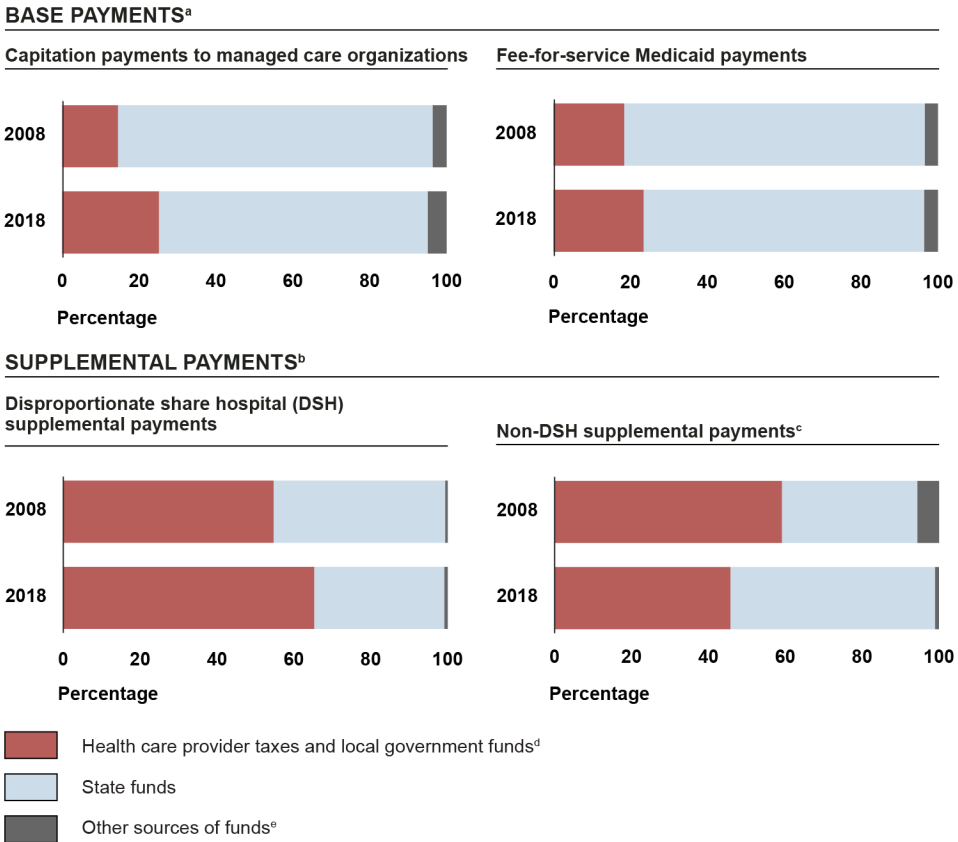
^bIntergovernmental transfers are funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state.

^cCertified public expenditures are funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via certifications of spending.

Comparing the state questionnaire responses we received for this review and for our 2014 report, we also found that states increased their reliance on provider taxes and local government funds to finance the nonfederal share of most Medicaid payment types from 2008 through 2018. Specifically, the percentage of these sources used to finance the nonfederal share increased by at least 5 percentage points during this 11-year period for three Medicaid payment types—capitation payments to

managed care organizations, fee-for-service payments, and DSH payments. For non-DSH supplemental payments, states' reliance on these funding sources decreased by 13 percentage points, falling from 59 percent in 2008 to 46 percent in 2018, largely due to one state reporting significantly less local government funds to finance these payments in 2018.³⁹ (See fig. 6.)

Figure 6: Nonfederal Share of Medicaid Payments Financed by Health Care Provider Taxes and Funds from Local Governments, States, and Other Sources, State Fiscal Years 2008 and 2018, by Payment Type



Source: GAO analysis of state questionnaire data. | GAO-21-98

³⁹One state reported an \$800 million decrease in local government funds used to finance non-DSH supplemental payments from 2008 to 2018. For all states, the total amount of the nonfederal share of funds used to finance these payments increased from \$1 billion to \$12 billion during the same time. However, given the increase in overall Medicaid spending during this time period, this resulted in a relative decline of 68 percentage points in the use of local government funds from 2008 to 2018.

Notes: Information is based on the responses of 50 states and the District of Columbia to a questionnaire on state Medicaid financing for this review and a similar questionnaire in our 2014 report. See GAO, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection* [Reissued on March 13, 2015], [GAO-14-627](#) (Washington, D.C.: July 29, 2014).

^aBase payments are payments to providers or organizations for services provided through fee-for-service and managed care.

^bSupplemental payments are typically lump sum payments made in addition to fee-for-service Medicaid payments. Supplemental payments are not directly tied to care for individual beneficiaries, but may help offset remaining costs of care for Medicaid beneficiaries. They include (1) DSH supplemental payments made to hospitals that serve large numbers of Medicaid beneficiaries and uninsured low-income individuals, which are required by federal law; and (2) non-DSH supplemental payments, which are not required by federal law.

^cThe decline in the percentage of provider taxes and local government funds states used to finance the nonfederal share of non-DSH supplemental payments is largely due to one state reporting significantly less local government funds to finance these payments in 2018.

^dHealth care provider taxes are generated from state-levied taxes on health care providers. For purposes of this figure, they also include provider donations, which accounted for less than 1 percent (about \$450,000) of the nonfederal share in state fiscal year 2018. Local government funds are funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state (intergovernmental transfers) or certifications of spending (certified public expenditures).

^eOther sources of funds include tobacco settlement funds and state trust funds.

States' Reliance on Provider and Local Government Funds Effectively Increased the Federal Share of Net Medicaid Payments 5 Percentage Points in 2018

State reliance on provider taxes and local government funds to finance the nonfederal share of Medicaid payments effectively increases the federal government's share of the net Medicaid payments providers receive; it also results in some providers receiving a smaller net Medicaid payment overall after the provider taxes and local government funds they contribute are taken into account. According to our estimates, overall reliance on provider taxes and local government funds resulted in a 5 percentage point increase in the share of net Medicaid payments financed by the federal government, with a greater increase for certain payment types and in some states. In prior reports, we have found that reliance on these funding sources can lead to excess payments to a few providers, raising questions about the appropriateness of some financing and payment arrangements.

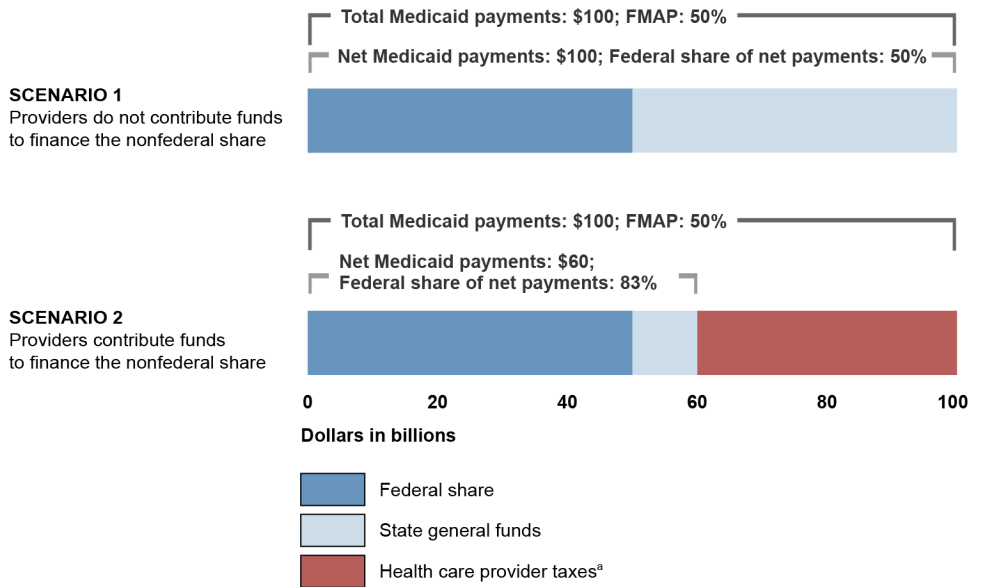
States' Reliance on Providers and Local Governments to Finance the Nonfederal Share Has Fiscal Implications for States, Providers, and the Federal Government

States' reliance on health care provider taxes and local government funds to finance part or all of the nonfederal share affects states' contributions and share of Medicaid payments. This reliance can also result in smaller net Medicaid payments to some providers (i.e., the total Medicaid payments received by providers minus any funds these providers contributed to the state for purposes of financing the nonfederal share of Medicaid payments to these providers). States can use these financing arrangements to decrease their share of net Medicaid payments to providers. Despite the fact that the federal government's contribution remains the same, states' reliance on provider taxes and local governments to finance the nonfederal share effectively shifts responsibility for a larger portion of net Medicaid payments to the federal government.

As illustrated in figure 7, using a 50 percent FMAP, financial implications for the state, providers, and the federal government change depending on how the state finances the nonfederal share of Medicaid payments.

- When the state finances the nonfederal share of a \$100 million payment entirely with state general funds (scenario 1), the net Medicaid payment to providers is \$100 million and the federal share is \$50 million, or 50 percent of the net Medicaid payment. The state's use of state general funds to finance the nonfederal share results in commensurate federal spending per the federal match.
- In contrast, when the state finances the nonfederal share of a \$100 million payment with a combination of state general funds (\$10 million) and health care provider tax revenues from providers receiving the payment (\$40 million) (scenario 2), the state effectively reduces its share of the payment. The arrangement results in a net Medicaid payment of \$60 million to the state's Medicaid providers (\$100 million payment minus \$40 million in provider tax revenues the state used to pay the nonfederal share). As a result, while the federal government's contribution is the same as in scenario 1 (\$50 million), the amount now represents 83 percent of the \$60 million net payment—effectively shifting responsibility for a larger portion of Medicaid payments to the federal government.
- As a result of the state's reliance on provider taxes to finance \$40 million of the nonfederal share in scenario 2, providers' net Medicaid payments are \$60 million, or \$40 million less than the \$100 million they receive when the states finance their share of Medicaid with state general funds only.

Figure 7: Total and Net Medicaid Payments to Providers and Federal Share of These Payments under Two Scenarios



Source: GAO. | GAO-21-98

Note: For purposes of this figure, we assume the federal medical assistance percentage (FMAP) is 50 percent.

^aHealth care provider taxes are funds generated from state-levied taxes on health care providers.

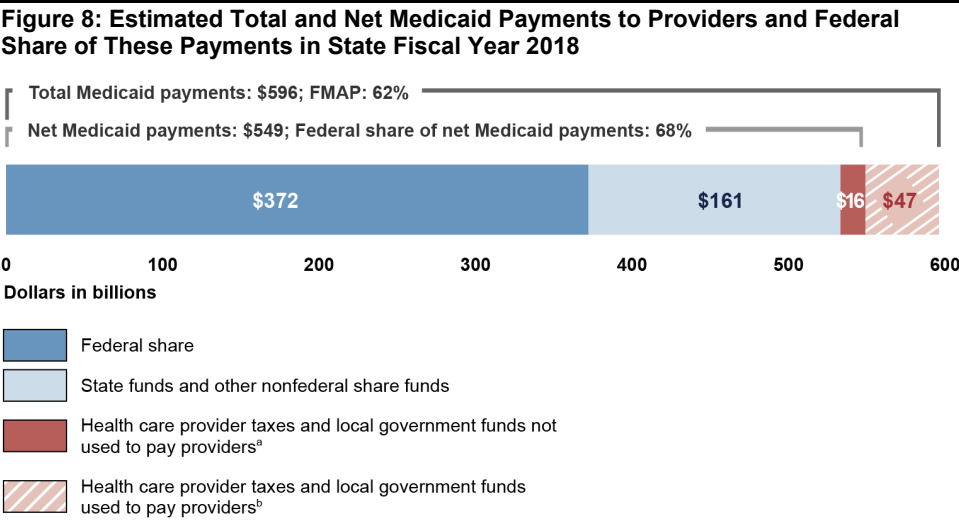
Reliance on Taxes and Local Government Funds Effectively Increased the Federal Share for State Fiscal Year 2018

States' reliance on provider taxes and local government funds to finance the nonfederal share resulted in net Medicaid payments to providers of \$549 billion, which is \$47 billion less than total Medicaid payments, effectively increasing the federal share of net payments by an estimated 5 percentage points, according to our analysis.⁴⁰ This analysis is based on states' questionnaire responses, our assumption about the percentage of provider taxes and local government funds made to providers contributing those funds, and our estimates of a 62 percent national FMAP:⁴¹

⁴⁰The estimated 5 percentage point increase in the federal share does not match the difference in the estimated national FMAP (62 percent) and the federal share of net Medicaid payments (68 percent) due to rounding.

⁴¹To estimate a national FMAP, we analyzed quarterly reporting of Medicaid payments on the CMS-64 during state fiscal year 2018. For more information about our analysis methodology, see appendix I.

- In state fiscal year 2018, we estimate that the states made about \$596 billion in Medicaid payments, with \$224 billion in nonfederal share and \$372 billion in federal share.
- Of the \$63 billion in nonfederal share that states financed with provider taxes and local government funds, based on our analysis of state questionnaire responses for state fiscal year 2018, we assumed that \$47 billion was used to make total Medicaid payments to providers contributing these funds.⁴²
- After subtracting this amount from total Medicaid payments, we calculated net Medicaid payments of \$549 billion.
- As a result, while the federal government’s contribution remains \$372 billion, that amount now represents 68 percent of net Medicaid payments. (See fig. 8.)



Notes: Percentages rounded to the nearest whole number, and dollar amounts rounded to the nearest billion.

Information is based on questionnaire responses received from 50 states and the District of Columbia. Net Medicaid payments are the total Medicaid payments received by all providers minus any funds providers contributed to the state for purposes of financing the nonfederal share of

⁴²To determine the percentages of provider and local government funds contributed to the state for purposes of financing the nonfederal share of Medicaid payments to those providers, we analyzed a 2017 report from the Medicaid and CHIP Payment and Access Commission that estimated these percentages. See Medicaid and CHIP Payment and Access Commission, *The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending* (Washington, D.C.: July 2017). For more information about our analysis methodology, including how we assessed the reliability of Medicaid and CHIP Payment and Access Commission estimates, see appendix I.

Medicaid payments to these providers. To determine the percentages of provider and local government funds contributed to the state for purposes of financing the nonfederal share of Medicaid payments to those providers, we analyzed a 2017 report from the Medicaid and CHIP Payment and Access Commission that estimated these percentages. See Medicaid and CHIP Payment and Access Commission, *The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending* (Washington, D.C.: July 2017). We determined that these percentages were appropriate for our purposes based, in part, on information from Medicaid officials in states in which we conducted in-depth interviews about how much of providers' contributions were returned as part of Medicaid payments.

Overall we estimated that the amount of the federal share of total 2018 Medicaid payments, which we refer to as the federal medical assistance percentage (FMAP), was 62 percent. To estimate this national FMAP, we analyzed the amount of the nonfederal share each state reported on the questionnaire and quarterly reporting of Medicaid payments reported to the Centers for Medicare & Medicaid Services during state fiscal year 2018.

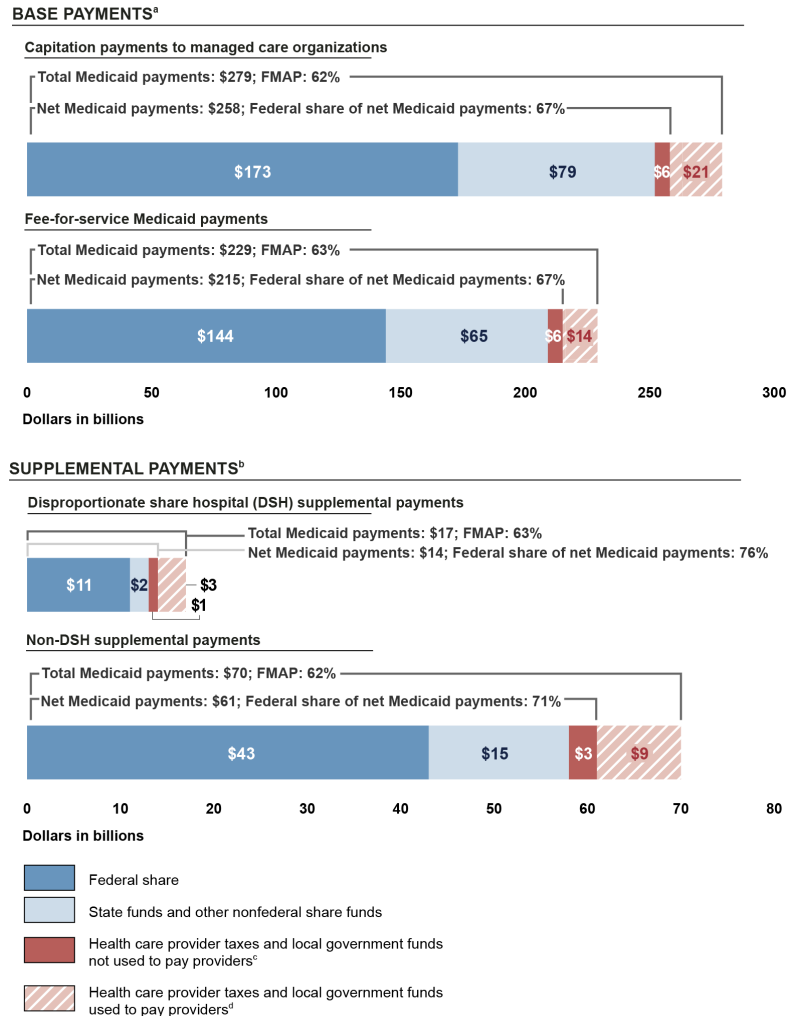
^aProvider taxes are funds generated from state-levied taxes on health care providers, as well as provider donations. Local government funds are funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state (intergovernmental transfers) or certifications of spending (certified public expenditures). The amount of provider taxes and local government funds not used to make total Medicaid payments to providers contributing these funds was \$16 billion. This amount is not subtracted from total Medicaid payments to calculate net payments.

^bThe amount of provider taxes and local government funds used to make total Medicaid payments to provider contributing these funds was \$47 billion. This amount is subtracted from total Medicaid payments to calculate net Medicaid payments.

Estimated Increase in Federal Share of Net Medicaid Payments Is Greater for Supplemental Payments than for Base Payments, and Varies by State

The increase in the federal share of net Medicaid payments was greater for supplemental payments than base payments in state fiscal year 2018, according to our analysis. Because states relied on provider taxes and local government funds to finance a larger percentage of the nonfederal share of supplemental payments than base payments in 2018, this resulted in a larger effective increase in the federal share of net Medicaid supplemental payments financed by the federal government. For example, the effective increase in the federal share of net DSH supplemental payments was about 13 percentage points (from 63 percent to 76 percent), compared with a 4 percentage point increase for net fee-for-service Medicaid payments (from 63 percent to 67 percent), which are base Medicaid payments. (See fig. 9.)

Figure 9: Estimated Total and Net Medicaid Payments to Providers and Federal Share of these Payments in State Fiscal Year 2018, by Payment Type



Source: GAO analysis of state Medicaid data. | GAO-21-98

Notes: Percentages rounded to the nearest whole number, and dollar amounts rounded to the nearest billion. Information is based on questionnaire responses received from 50 states and the District of Columbia. Net Medicaid payments are the total Medicaid payments received by all providers minus any funds providers contributed to the state for purposes of financing the nonfederal share of Medicaid payments to these providers. To determine the percentages of provider and local government funds contributed to the state for purposes of financing the nonfederal share of Medicaid payments to those providers, we analyzed a 2017 report from the Medicaid and CHIP Payment and Access Commission, *The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending* (Washington, D.C.: July 2017). We determined that these percentages were appropriate for our purposes based, in part, on information from Medicaid officials in states in which we conducted in-depth interviews about how much of providers' contributions were returned as part of Medicaid payments.

We estimated the amount of the federal share of each Medicaid payment type in 2018, which we refer to as the federal medical assistance percentage (FMAP), resulting in an FMAP that is not the same for each payment type. To estimate these national FMAPs, we analyzed the amount of the nonfederal share each state reported on the questionnaire and quarterly reporting of Medicaid payments reported to the Centers for Medicare & Medicaid Services during state fiscal year 2018.

^aBase payments are payments to providers or organizations for services provided through fee-for-service and managed care.

^bSupplemental payments are typically lump sum payments made in addition to fee-for-service Medicaid payments. Supplemental payments are not tied to care for individual beneficiaries, but may help offset remaining costs of care for Medicaid beneficiaries. They include (1) DSH supplemental payments made to hospitals that serve large numbers of Medicaid beneficiaries and uninsured low-income individuals, which are required by federal law; and (2) non-DSH supplemental payments, which are not required by federal law.

^cProvider taxes are funds generated from state-levied taxes on health care providers, as well as provider donations. Local government funds are funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state (intergovernmental transfers) or certifications of spending (certified public expenditures). The amount of provider taxes and local government funds not used to make total Medicaid payments to providers contributing these funds is not subtracted from total Medicaid payments to calculate net payments.

^dThe amount of provider taxes and local government funds used to make total Medicaid payments to providers contributing these funds is subtracted from total Medicaid payments to calculate net Medicaid payments.

The estimated increase in the federal share of net Medicaid payments varied widely by state in state fiscal year 2018. This variation is also greater for supplemental payments than for base payments, according to our analysis. For example, the estimated increase in the federal share of net Medicaid payments was 15 percentage points or more in at least 19 states for each supplemental payment type, while the increase was less than 10 percent in 39 states or more for each base payment type. (See fig. 10 and table 3 in app. III for more information the estimated percentage point increase between the FMAP and the share of net Medicaid payments financed by the federal government.)

BASE PAYMENTS^a

Capitation payments to managed care organizations

Fee-for-service Medicaid payments

SUPPLEMENTAL PAYMENTS^b

Disproportionate share hospital (DSH) supplemental payments

Non-DSH supplemental payments

The figure consists of four maps of the United States, each showing Medicaid payment policies by state. The maps are color-coded to represent different payment types: blue for capitation payments, purple for fee-for-service payments, pink for DSH supplemental payments, and green for non-DSH supplemental payments. States are labeled with their two-letter abbreviations. The maps show a clear regional and policy-based distribution of these payment types across the country.

A horizontal number line with an arrow pointing to the right. It is marked with numbers 0, 1, 5, 10, and 15. A small circle is drawn at the 0 mark.

Notes: Information is based on questionnaire responses received from 50 states and the District of Columbia. Net Medicaid payments are the total Medicaid payments received by all providers minus

any funds providers contributed to the state for purposes of financing the nonfederal share of Medicaid payments to these providers. To determine the percentages of provider and local government funds contributed to the state for purposes of financing the nonfederal share of Medicaid payments to those providers, we analyzed a 2017 report from the Medicaid and CHIP Payment and Access Commission that estimated these percentages. See Medicaid and CHIP Payment and Access Commission, *The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending* (Washington, D.C.: July 2017). We determined that these percentages were appropriate for our purposes based, in part, on information from Medicaid officials in states in which we conducted in-depth interviews about how much of providers' contributions were returned as part of Medicaid payments.

We estimated the amount of the federal share of each Medicaid payment type in 2018, which we refer to as the federal medical assistance percentage (FMAP), for each state resulting in an FMAP that is not the same for each state. To estimate these state FMAPs, we analyzed the amount of the nonfederal share each state reported on the questionnaire and quarterly reporting of Medicaid payments reported to the Centers for Medicare & Medicaid Services during state fiscal year 2018.

^aBase payments are payments to providers or organizations for services provided through fee-for-service and managed care.

^bSupplemental payments are typically lump sum payments made in addition to fee-for-service Medicaid payments. Supplemental payments are not tied to care for individual beneficiaries, but may help offset remaining costs of care for Medicaid beneficiaries. They include (1) DSH supplemental payments made to hospitals that serve large numbers of Medicaid beneficiaries and uninsured low-income individuals, which are required by federal law; and (2) non-DSH supplemental payments, which are not required by federal law.

States' increasing reliance on provider taxes and local government funds to finance the nonfederal share of supplemental payments continues to raise questions about the appropriateness of state financing and payment arrangements. As we have found in past reports, financing and payment arrangements can create incentives for states to maximize federal payments by making large supplemental payments to a small number of providers.⁴³ These arrangements raise questions about whether these payments are economical or efficient, or used for Medicaid-covered items and services. For example, in prior reports we have found the following:

- One state made supplemental and base payments to a hospital that were \$241 million above that hospital's cost of providing Medicaid services.⁴⁴
- Thirty-nine states had made supplemental payments to more than 500 hospitals that, along with their regular Medicaid payments, exceeded those hospitals' total costs of providing care to Medicaid beneficiaries by \$2.7 billion.⁴⁵

⁴³See [GAO-14-627](#) and [GAO-15-322](#).

⁴⁴See [GAO-13-48](#).

⁴⁵See [GAO-13-48](#).

-
- In a 2016 report examining how 12 hospitals used their excessive payments, nine hospitals had average Medicaid surpluses—Medicaid payments above cost—of about \$39 million, and used the revenues to cover the costs of uninsured patients, as well as funding general hospital operations, maintenance, and capital purchases, such as a helicopter.⁴⁶

Conclusions

Understanding the extent and nature of state financing and payment arrangements is critical to ensuring the fiscal integrity of Medicaid's federal-state partnership. This partnership is based on the state and federal government sharing in the cost of Medicaid as set in law, with states making payments that are consistent with economy and efficiency. CMS has data collection efforts that provide some information on financing and payment arrangements, such as its five standard funding questions when states submit state plan amendments. However, the information is not complete, consistent, and sufficiently documented. This is in addition to similar limitations we have found with the agency's two data reporting systems—the CMS-64 and the Transformed Medicaid Statistical Information System. Without complete, consistent, and sufficiently documented information about sources of funding for the nonfederal share and payments to providers, CMS lacks the ability to effectively oversee states' Medicaid programs and identify potentially impermissible financing and payment arrangements, including state-directed managed care payments, for additional review.

Recommendation for Executive Action

The Administrator of CMS should collect and document complete and consistent provider-specific information about Medicaid payments to providers, including new state-directed managed care payments, and states' sources of funding for the nonfederal share of these payments. (Recommendation 1)

Agency comments

We provided a draft of this report to HHS for comment, and its comments are reprinted in appendix IV. HHS also provided technical comments, which we incorporated as appropriate.

HHS neither agreed nor disagreed with the recommendation. The agency acknowledged the need for additional state Medicaid financing and payment data to enable oversight of the Medicaid program. HHS noted that CMS has begun work to improve the collection of financing and payment information, and that CMS will explore additional actions to do

⁴⁶See [GAO-16-108](#).

so. CMS's current actions include the agency's November 2019 proposed rule on Medicaid fiscal accountability and a revised form regarding state-directed managed care payments that will collect more complete and consistent financing and payment information from states. As of November 2020, these actions have not been completed.

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. 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 key contributions to this report are listed in appendix V.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Carolyn L. Yocom", with a stylized flourish at the end.

Carolyn L. Yocom
Director, Health Care

Appendix I: Scope and Methodology of State Questionnaire and Analysis of Effects of States' Reliance on Funds from Health Care Providers and Local Governments

To describe the extent to which states rely on funds from health care providers and local governments as part of their Medicaid financing and payments, we conducted a web-based questionnaire sent to Medicaid officials in all 50 states and the District of Columbia.¹ To describe the estimated effect on the federal share of net Medicaid payments resulting from states' using funds from health care providers and local governments to help finance the nonfederal share of payments, we analyzed questionnaire responses, quarterly state reporting to CMS, and assumptions regarding the amount of funds contributed by providers and local governments that states use as the nonfederal share of payments to these providers.

Information on Funds Used to Finance the Nonfederal Share

To provide information about the extent to which states rely on funds from health care providers and local governments to finance the nonfederal share of Medicaid payments, we analyzed data from our web-based questionnaire. The questionnaire asked about states' use of various sources of funds to finance the nonfederal share of Medicaid expenditures during state fiscal year 2018. Specifically, the questionnaire requested data on the total amount of funds from each of the following sources used to finance the nonfederal share:

- **State funds.** State general funds and intra-state agency payments, transfers, and certified public expenditures.
- **Funds from providers.** Health care provider taxes, fees, and assessments; and provider donations.
- **Funds from local governments.** Intergovernmental transfers and certified public expenditures.
- **Other funding sources.**

The questionnaire also requested data on the total amount of funding from these sources that were used to finance the following two types of base Medicaid payments and two types of supplemental Medicaid payments:

- **Base Medicaid payments.** Capitation payments to managed care organizations and fee-for-service Medicaid payments.

¹For purposes of this report, states refers to the 50 states and the District of Columbia.

- **Supplemental Medicaid payments.** Medicaid Disproportionate Share Hospital (DSH) payments and non-DSH supplemental payments.²

During the development of our questionnaire, we pretested it with state Medicaid officials from three states—Hawaii, Nevada, and Ohio—to ensure that our questions and response choices were clear, appropriate, and answerable. The states selected for the pretest were diverse with respect to the size of their Medicaid programs and geography. After pretesting, we finalized the questionnaire and began fielding it on November 19, 2019. We received the final state response on July 31, 2020. We received responses from all 50 states and the District of Columbia.

The questionnaire was not subject to sampling error, because we included Medicaid officials in all 50 states and the District of Columbia. However, the practical difficulties of fielding any questionnaire may introduce errors, commonly referred to as nonsampling errors. For example, differences in how a particular question was interpreted, in the sources of information that were available to respondents, or in how the data were entered into a database or were analyzed could introduce unwanted variability, or bias, into the questionnaire results. We encountered instances of nonsampling error in our analysis of the questionnaire responses; in some instances, respondents provided conflicting, unclear, or incomplete information. We generally addressed these errors by contacting the state Medicaid officials involved and clarifying their responses.

We did not independently verify the data reported by states in the questionnaire; however, we reviewed published data submitted by state Medicaid programs to the Centers for Medicare & Medicaid Services (CMS) to assess the reasonableness of the data reported. We believe the data are reliable for our purposes.

²Non-DSH supplemental payments include supplemental payments made under the Upper Payment Limit; special funding pool payments made under Medicaid demonstrations; and episodic or bundled payments.

Analysis of the Effects on
the Federal Share of Net
Medicaid Payments
Resulting from States'
Reliance on Funds from
Health Care Providers and
Local Governments

To describe the estimated effect of Medicaid financing arrangements on the federal share of Medicaid payments providers receive, we took the steps outlined below to calculate the amount of the federal share and total Medicaid payments based on questionnaire responses, as well as net Medicaid payments and the share of net Medicaid payments financed by the federal government. These calculations were performed for each Medicaid payment type and for overall Medicaid payments (the sum of the amounts for the four payment types) for each state and nationally (the sum of each state's amounts).

Calculating Amount of Federal
Share and Total Medicaid
Payments Based on
Questionnaire Responses

States reported the amount of funds used to finance the nonfederal share for each of four types of Medicaid payments on our web-based questionnaire. However, states were not asked to report the federal share of these Medicaid payments or the total amount of these Medicaid payments (i.e., the nonfederal share plus the federal share). As a result, we used the amount of the nonfederal share each state reported on the questionnaire and each state's estimated federal medical assistance percentage (FMAP) to calculate both the federal share and total amount of Medicaid payments for each Medicaid payment type.³

Specifically, we used the total amount of the nonfederal share reported by the state on our web-based questionnaire (A), and the amount of the nonfederal share as a percentage of total Medicaid payments to impute the total amount of Medicaid payments (B).⁴ We then subtracted the amount of the nonfederal share from the amount of total payments (B minus A) to calculate the amount of the federal share (C). For example, if a state reported \$2 million in nonfederal share funds for fee-for-service Medicaid payments and we estimated a 60 percent FMAP, the total

³To estimate each state's FMAP and a national FMAP, we analyzed quarterly reporting of Medicaid payments on the CMS-64 during each state's fiscal year 2018. The estimated state and national FMAPs were used for each Medicaid payment type and for overall Medicaid payments. States' fiscal years are set by states and do not necessarily align with the federal fiscal year. Most states' fiscal years begin on July 1 and end on June 30, with the exception of Alabama, the District of Columbia, and Michigan (October 1 through September 30), New York (April 1 through March 31), and Texas (September 1 through August 31). States report Medicaid payments quarterly. Our estimate of each state's FMAP and a national FMAP takes into account the increased FMAPs available for certain low-income individuals in states that opted to expand Medicaid eligibility as authorized under the Patient Protection and Affordable Care Act.

⁴The percentage of the nonfederal share is 100 percent minus the estimated FMAP.

Calculating Net Medicaid
Payments and the Share of
Net Medicaid Payments
Financed by the Federal
Government

amount of Medicaid payments would be \$5 million and the amount of the federal share would be \$3 million, based on the methodology we used:

- **Amount of nonfederal share:** \$2 million (A)
- **Total amount of Medicaid payments:** \$2 million (A) / (100 percent – 60 percent FMAP) = \$5 million (B)
- **Amount of federal share:** \$5 million (B) - \$2 million (A) = \$3 million (C)

To calculate the net Medicaid payments providers received, we used the amounts of the nonfederal share from the web-based questionnaire, the assumptions about the amount of funds providers and local governments contributed to finance the nonfederal share of Medicaid payments they received, and the federal share we calculated earlier.⁵ After we determined the net payments—the total Medicaid payments received by providers minus funds they contributed to finance the nonfederal share of these payments—we calculated the share of net Medicaid payments financed by the federal government and then compared this percentage to the state's estimated FMAP.

Our assumptions regarding the amount of funds contributed by providers and local governments that states use as the nonfederal share of payments to these providers were obtained from a 2017 Medicaid and CHIP Payment and Access Commission report.⁶ According to the Medicaid and CHIP Payment and Access Commission, the following assumptions about the percentages of provider and local government funds to subtract from total Medicaid payments to calculate net Medicaid payments were based on analysis of financing policies and practices in 10 states and reviewed by experts familiar with Medicaid financing:⁷

⁵For purposes of our analysis, local government funds contributed to states that are used as the nonfederal share of Medicaid payments to local government providers are considered contributions from those providers.

⁶See Medicaid and CHIP Payment and Access Commission, *The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending* (Washington, D.C.: July 2017).

⁷State general funds, intra-agency funds, and other sources of funds—such as tobacco settlement funds and state trust funds—are not contributions from providers or local governments and, therefore, are not subtracted from total payments to calculate net payments.

- 80 percent of the funds providers contributed from provider taxes and donations were returned to the same providers as part of a Medicaid payment;
- 75 percent of the funds local governments contributed from intergovernmental transfers were returned to local government providers as part of a Medicaid payment; and
- 25 percent of funds local governments contributed from certified public expenditures were not returned to local government providers as part of a Medicaid payment.⁸

To determine the appropriateness of these percentages, we asked Medicaid officials in states in which we conducted in-depth interviews about how much of providers' contributions were returned as part of Medicaid payments. We also reviewed findings from one of our past reports and a report from the Department of Health and Human Services Office of the Inspector General.⁹ We determined that these percentages were appropriate for our purposes.

To calculate the net Medicaid payments providers received, we used the total amount of the nonfederal share reported by the state on our web-based questionnaire (D), the assumptions about the amounts of funds providers and local governments contributed to finance the nonfederal share of Medicaid payments they received (E), and the federal share we calculated earlier (C). We subtracted from the amount of the nonfederal share the amount of funds providers and local governments contributed to finance the nonfederal share of Medicaid payments they received (D minus E) to calculate the amount of funds providers did not contribute to finance the nonfederal share of their payments (F). For example, a state reports the following sources and amounts for its \$2 million in nonfederal share for fee-for-service Medicaid payment (D): state general funds (\$1

⁸A certified public expenditure represents the total costs (both the federal and the nonfederal share) incurred for the Medicaid services. The state has the flexibility to send the federal matching funds it receives to the local government or local government provider that certified the expenditure, or may retain some or all of those funds. A smaller net Medicaid payment occurs, for example, if the state retains any of the federal matching funds. Consistent with the Medicaid and CHIP Payment and Access Commission's analysis, we consider these retained funds to be nonfederal share funds local governments contributed from certified public expenditures that were not returned to local government providers as part of a Medicaid payment for purposes of our analysis.

⁹See [GAO-14-627](#) and Department of Health and Human Services Office of Inspector General, *Although Hospital Tax Programs in Seven States Complied with Hold-Harmless Requirements, The Tax Burden on Hospitals was Significantly Mitigated*, A-03-16-00202 (Washington, D.C.: November 2018).

million), health care provider taxes (\$500,000), intergovernmental transfers (\$400,000), and certified public expenditures (\$100,000). Based on this illustrative example and our assumptions about the amount of the nonfederal share from funds providers and local governments contributed to finance the nonfederal share of Medicaid payments they received:

- the total amount of the nonfederal share would be \$2 million (D);
- the amount of funds providers and local governments contributed to finance the nonfederal share of Medicaid payments they received would be \$725,000 (E); and
- the amount of funds providers did not contribute to finance the nonfederal share of their payments would be \$1,275,000 (F). (See table 2.)

We then added \$1,275,000 (F) to the \$3 million in federal share we calculated earlier (C) to calculate net Medicaid payments of \$4.275 million (G). Finally, we divided the \$3 million in federal share of Medicaid payment (C) by the \$4.275 million (G) to calculate the share of net Medicaid payments financed by the federal government. The share of net Medicaid payments financed by the federal government is about 70 percent. This is about 10 percentage points higher than the estimated 60 percent FMAP noted above.

Table 2: Example of Calculating Net Medicaid Payments

Sources of the nonfederal share	Amounts of the nonfederal share (dollars)	Funds providers and local governments contributed to finance the nonfederal share of Medicaid payments they received (dollars)	Amount of funds providers did not contribute to finance the nonfederal share of their payments (dollars)
State general funds	1,000,000	$1,000,000 \times 0 \text{ percent} = 0$	1,000,000
Health care provider taxes	500,000	$500,000 \times 80 \text{ percent} = 400,000$	100,000
Intergovernmental transfers	400,000	$400,000 \times 75 \text{ percent} = 300,000$	100,000
Certified public expenditures	100,000	$100,000 \times 25 \text{ percent} = 25,000$	75,000
Total	2,000,000 (D)	725,000 (E)	1,275,000 (F)

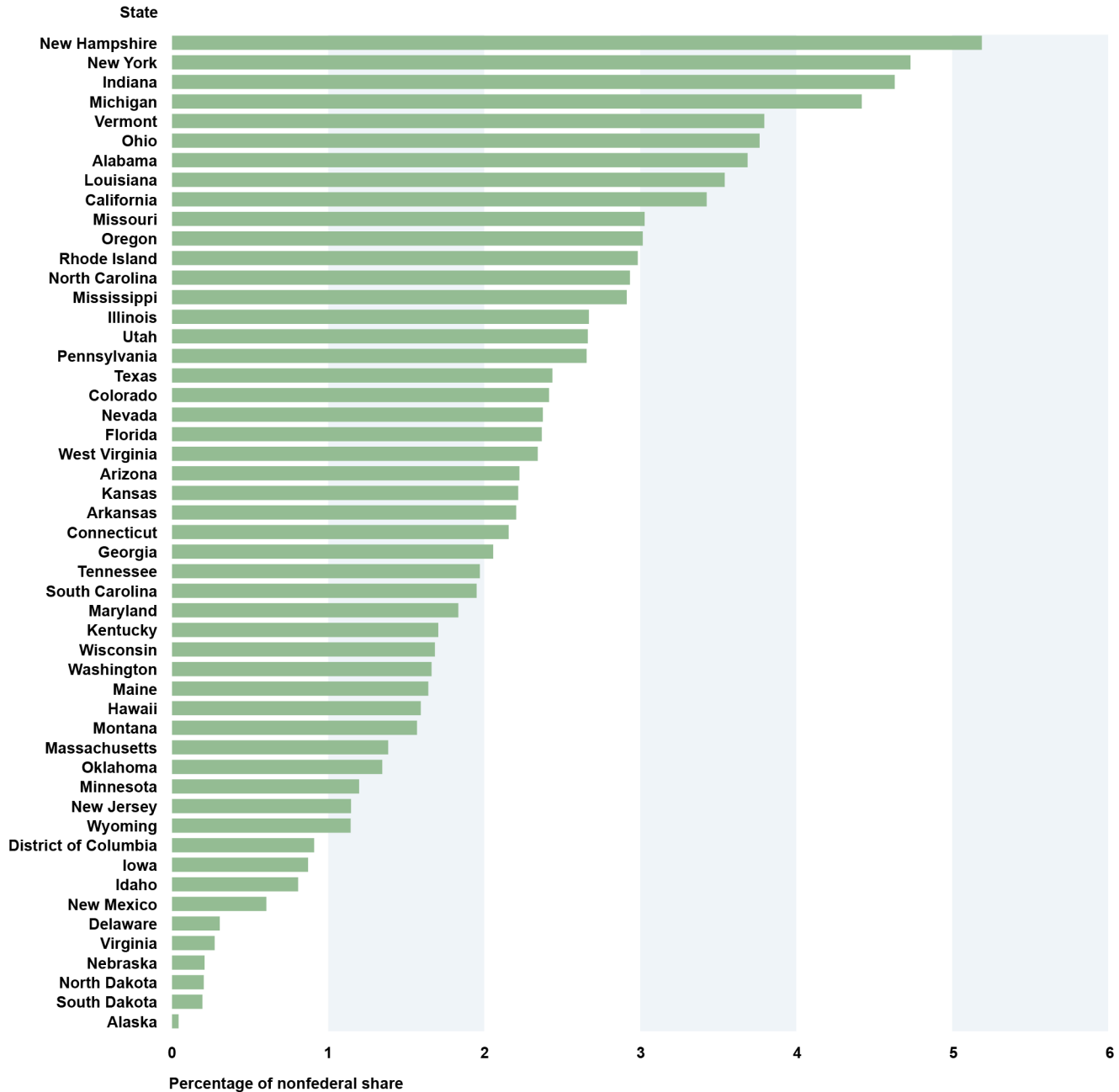
Source: GAO. | GAO-21-98

Appendix II: The Nonfederal Share States Financed with Provider Taxes and from Local Government Funds in State Fiscal Year 2018

Figures 11 and 12, and table 3 provide information on states' reliance on provider taxes and local government funds to finance the nonfederal share of Medicaid payments in state fiscal year 2018, according to our analysis of state responses to a web-based questionnaire sent to Medicaid officials in all 50 states and the District of Columbia.

Appendix II: The Nonfederal Share States
Financed with Provider Taxes and from Local
Government Funds in State Fiscal Year 2018

Figure 11: The Nonfederal Share of Total Medicaid Payments States Financed with Provider Taxes and Local Government Funds in State Fiscal Year 2018, by State



Source: GAO analysis of state questionnaire data. | GAO-21-98

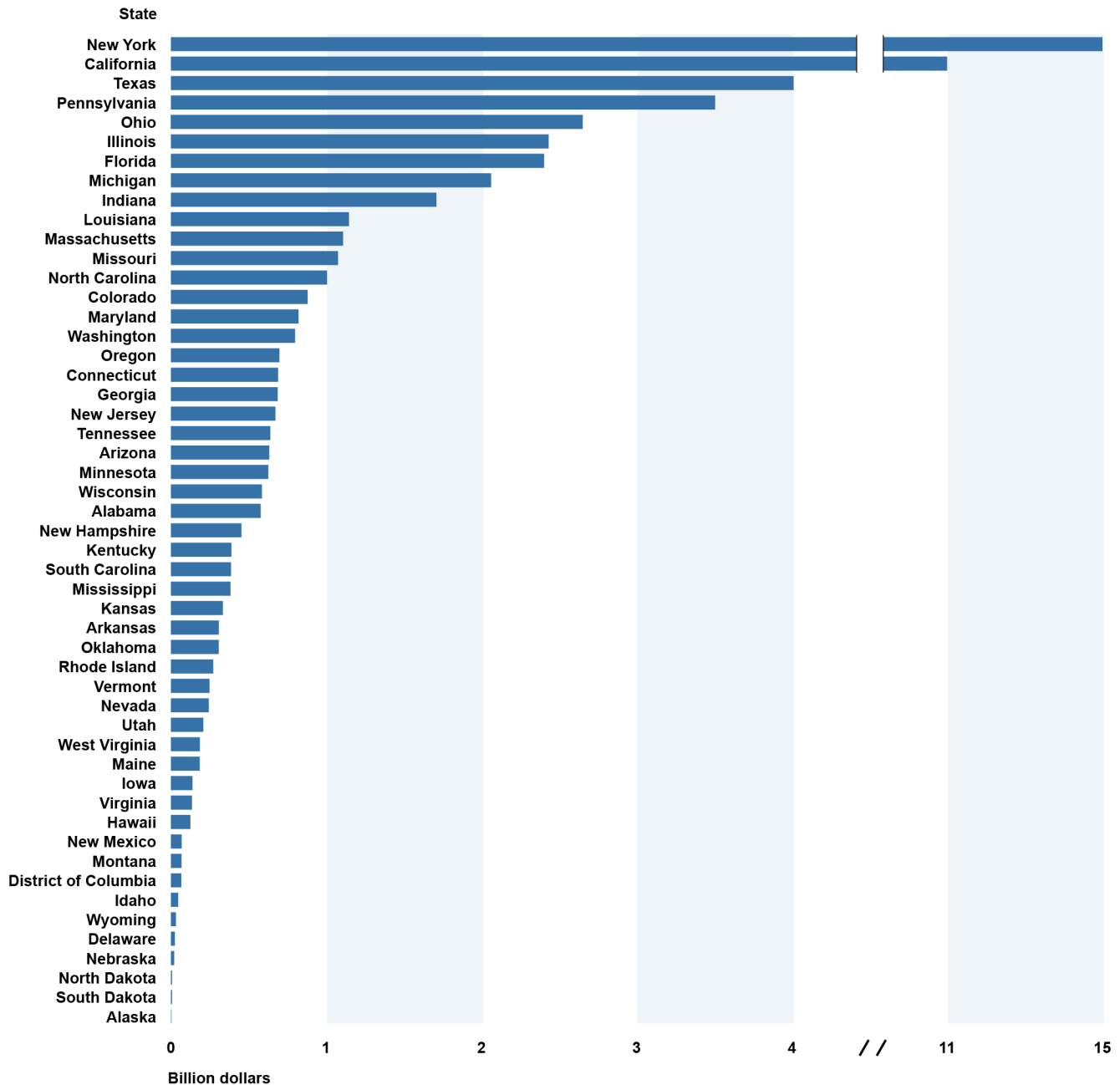
Notes: Health care provider taxes are funds generated from state-levied taxes on health care providers. For purposes of this figure, they also include provider donations, which accounted for less than 1 percent (about \$450,000) of the nonfederal share in state fiscal year 2018. Local government

**Appendix II: The Nonfederal Share States
Financed with Provider Taxes and from Local
Government Funds in State Fiscal Year 2018**

funds are funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state (intergovernmental transfers) or certifications of spending (certified public expenditures).

Appendix II: The Nonfederal Share States
Financed with Provider Taxes and from Local
Government Funds in State Fiscal Year 2018

Figure 12: The Nonfederal Share of Total Medicaid Payments States Financed with Provider Taxes and Local Government Funds in State Fiscal Year 2018, by State



Source: GAO analysis of state questionnaire data. | GAO-21-98

Notes: Health care provider taxes are funds generated from state-levied taxes on health care providers. For purposes of this figure, they also include provider donations, which accounted for less than 1 percent (about \$450,000) of the nonfederal share in state fiscal year 2018. Local government

**Appendix II: The Nonfederal Share States
Financed with Provider Taxes and from Local
Government Funds in State Fiscal Year 2018**

funds are funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state (intergovernmental transfers) or certifications of spending (certified public expenditures).

Table 3: The Nonfederal Share of Total Medicaid Payments States Financed with Provider Taxes and Local Government Funds in State Fiscal Year 2018, by State

State	Medicaid payment type									
	Total payments		Capitation payments to managed care organizations ^a		Fee-for-service payments ^b		DSH supplemental payments ^c		Non-DSH supplemental payments ^d	
	(dollars in millions)		(dollars in millions)		(dollars in millions)		(dollars in millions)		(dollars in millions)	
	Amount ^e	Percent ^f	Amount ^e	Percent ^f	Amount ^e	Percent ^f	Amount ^e	Percent ^f	Amount ^e	Percent ^f
Alabama	578	37	N/A ^g	N/A ^g	315	25	107	77	156	82
Alaska	2	0	N/A ^g	N/A ^g	2	0	0	0	N/A ^g	N/A ^g
Arizona	634	22	427	18	89	27	34	79	84	96
Arkansas	308	22	0	0	185	15	17	95	106	71
California	11,789	34	5,782	38	3,942	54	284	94	1,781	15
Colorado	880	24	23	5	184	8	91	100	582	88
Connecticut	690	22	N/A ^g	N/A ^g	690	23	0	0	0	0
Delaware	25	3	25	4	0	0	0	0	N/A ^g	N/A ^g
District of Columbia	67	9	35	17	26	5	0	0	5	100
Florida	2,403	24	1,596	26	341	10	130	95	336	100
Georgia	688	21	0	0	466	22	115	83	107	89
Hawaii	125	16	115	15	0	1	10	100	N/A ^g	N/A ^g
Idaho	47	8	0	0	11	2	15	100	21	100
Illinois	2,433	27	972	20	699	21	151	74	610	100
Indiana	1,710	46	446	36	887	43	26	100	351	89
Iowa	139	9	87	6	46	29	5	18	0	0
Kansas	334	22	268	20	36	54	0	0	30	86
Kentucky	390	17	299	20	68	9	20	37	3	27
Louisiana	1,146	35	617	37	306	28	192	43	31	76
Maine	185	16	N/A ^g	N/A ^g	185	17	0	0	0	0
Maryland	822	18	0	0	822	34	0	0	N/A ^g	N/A ^g
Massachusetts	1,108	14	268	10	226	6	N/A ^g	N/A ^g	614	46
Michigan	2,063	44	1,436	59	348	30	68	51	211	23
Minnesota	627	12	335	12	248	10	1	3	43	100
Mississippi	384	29	127	19	199	43	55	100	2	2
Missouri	1,076	30	271	34	561	23	207	73	37	71

**Appendix II: The Nonfederal Share States
Financed with Provider Taxes and from Local
Government Funds in State Fiscal Year 2018**

State	Medicaid payment type									
	Total payments		Capitation payments to managed care organizations ^a		Fee-for-service payments ^b		DSH supplemental payments ^c		Non-DSH supplemental payments ^d	
	(dollars in millions)		(dollars in millions)		(dollars in millions)		(dollars in millions)		(dollars in millions)	
	Amount ^e	Percent ^f	Amount ^e	Percent ^f	Amount ^e	Percent ^f	Amount ^e	Percent ^f	Amount ^e	Percent ^f
Montana	68	16	N/A ^g	N/A ^g	45	11	N/A ^g	N/A ^g	23	100
Nebraska	21	2	0	0	15	3	6	32	0	0
Nevada	244	24	11	7	48	7	25	100	160	100
New Hampshire	454	52	131	48	140	34	112	100	72	88
New Jersey	673	11	225	5	408	48	40	11	0	0
New Mexico	69	6	65	8	4	6	0	0	0	0
New York	15,085	47	7,565	47	4,633	39	1,102	69	1,785	73
North Carolina	1,006	29	N/A ^g	N/A ^g	246	10	97	64	663	76
North Dakota	7	2	0	0	7	2	0	0	0	0
Ohio	2,653	38	1,074	28	1,192	42	234	87	152	93
Oklahoma	308	13	N/A ^g	N/A ^g	108	5	0	0	200	75
Oregon	699	30	539	45	43	4	26	100	91	62
Pennsylvania	3,505	27	2,260	29	723	16	126	31	396	80
Rhode Island	272	30	34	6	159	61	68	100	10	100
South Carolina	387	19	120	15	108	11	144	89	15	100
South Dakota	7	2	N/A ^g	N/A ^g	7	2	0	0	0	0
Tennessee	640	20	527	22	12	2	11	100	90	30
Texas	4,011	24	410	4	242	8	641	100	2,718	98
Utah	209	27	117	30	49	14	7	87	36	88
Vermont	248	38	N/A ^g	N/A ^g	N/A ^g	N/A ^g	0	0	248	39
Virginia	135	3	4	0	10	0	0	0	121	34
Washington	800	17	29	2	358	14	0	0	412	100
West Virginia	186	23	51	21	120	23	0	0	15	100
Wisconsin	586	17	271	17	295	16	0	0	20	41
Wyoming	32	11	0	0	0	0	0	0	32	100
Total	62,961	28	26,562	25	19,858	23	4,169	65	12,372	46

Source: GAO analysis of state questionnaire data. | GAO-21-98

Notes: Health care provider taxes are funds generated from state-levied taxes on health care providers. For purposes of this figure, they also include provider donations, which accounted for less than 1 percent (about \$450,000) of the nonfederal share in state fiscal year 2018. Local government funds are funds from local governments (e.g., counties or cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state (intergovernmental transfers) or certifications of spending (certified public expenditures).

^aCapitation payments to managed care organizations are predetermined per person payments states make to organizations that contract with state Medicaid programs to provide or arrange for providing services to beneficiaries. The managed care organization is responsible for paying providers.

**Appendix II: The Nonfederal Share States
Financed with Provider Taxes and from Local
Government Funds in State Fiscal Year 2018**

^bFee-for-service payments are payments states make directly to providers based on established Medicaid payment rates for the services provided

^cDisproportionate Share Hospital (DSH) payments are payments made to hospitals that serve large numbers of Medicaid beneficiaries and uninsured low-income individuals, which are required by federal law.

^dNon-DSH supplemental payments are payments such as Medicaid Upper Payment Limit supplemental payments and payments made to hospitals and other providers authorized under Medicaid demonstrations, which are not required by federal law.

^eDollar amounts rounded to the nearest million.

^fPercentages of total Medicaid payments states financed with provider taxes and local government funds rounded to the nearest whole number.

^gState did not report making this type of Medicaid payment.

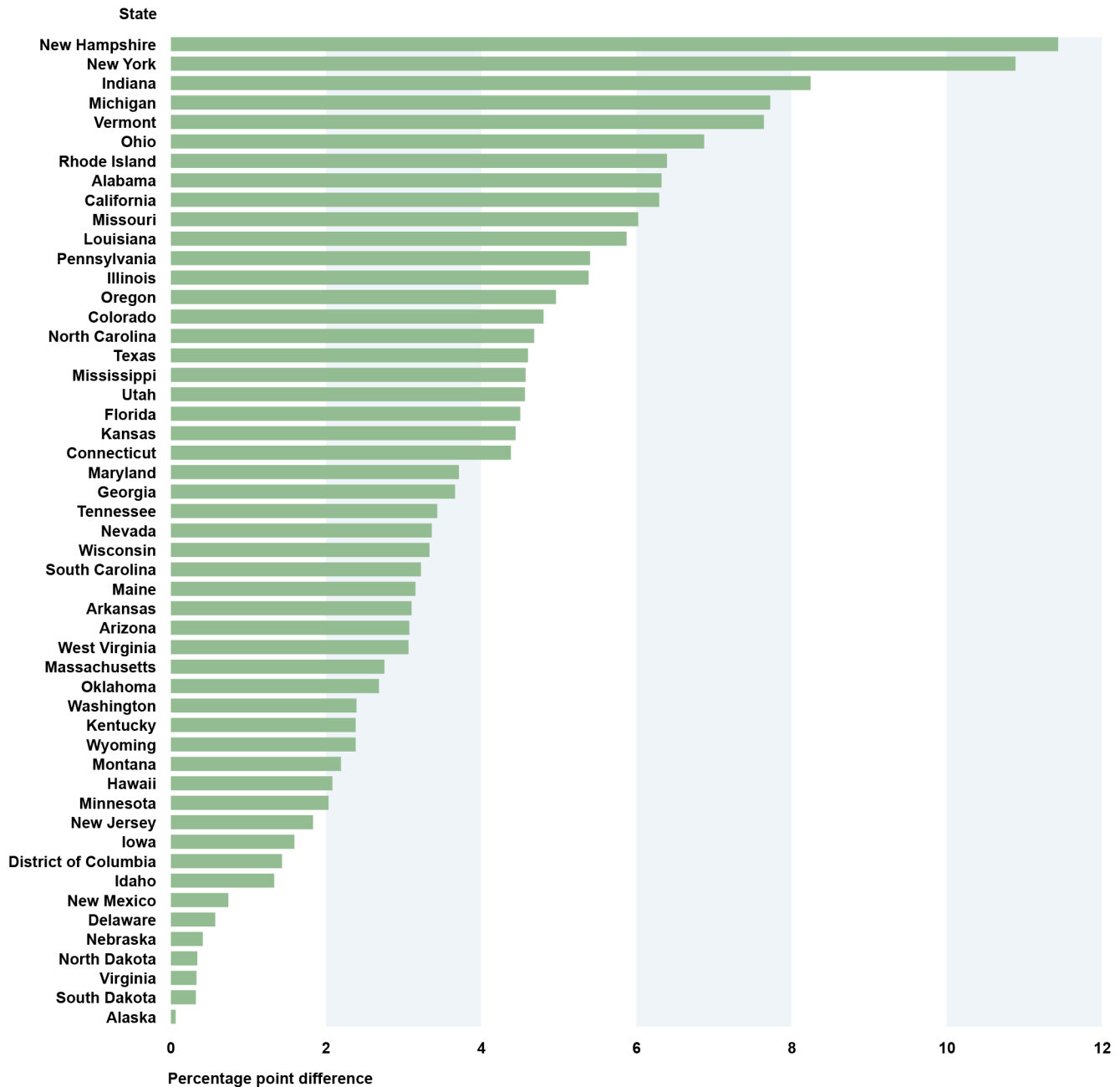
Appendix III: Estimated Share of Net Medicaid Payments Financed by the Federal Government in State Fiscal Year 2018

Figure 13 and table 4 provide information on the share of net Medicaid payments—the total Medicaid payments received by providers minus any funds these providers contributed to the state for purposes of financing the nonfederal share of Medicaid payments to these providers. We estimated percentage point increases between the federal medical assistance percentage (FMAP) and the share of net Medicaid payments financed by the federal government. Our estimates are based on our analysis of state responses to a web-based questionnaire sent to Medicaid officials in all 50 states and the District of Columbia regarding state fiscal year 2018 Medicaid financing, assumptions about the amount of funds providers and local governments contributed to finance the nonfederal share of Medicaid payments they received, and each state's estimated FMAP from CMS's quarterly expenditure data reports.

- Figure 13 provides the estimated percentage point increase between the FMAP and the share of net Medicaid payments financed by the federal government for total Medicaid payments.
- Table 4 provides the estimated percentage point increase between the FMAP and the share of net Medicaid payments financed by the federal government for each of four Medicaid payment types.

Appendix III: Estimated Share of Net Medicaid
Payments Financed by the Federal
Government in State Fiscal Year 2018

Figure 13: Estimated Percentage Point Increase between the FMAP and the Share of Net Medicaid Payments Financed by the Federal Government for Total Medicaid Payments, by State in 2018



Source: GAO analysis of state Medicaid data. | GAO-21-98

Notes: Information is based on questionnaire responses received from 50 states and the District of Columbia. Net Medicaid payments are the total Medicaid payments received by all providers minus any funds providers contributed to the state for purposes of financing the nonfederal share of

Appendix III: Estimated Share of Net Medicaid Payments Financed by the Federal Government in State Fiscal Year 2018

Medicaid payments to these providers. To determine the percentages of provider and local government funds contributed to the state for purposes of financing the nonfederal share of Medicaid payments to those providers, we analyzed a 2017 report from the Medicaid and CHIP Payment and Access Commission that estimated these percentages. See Medicaid and CHIP Payment and Access Commission, *The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending* (Washington, D.C.: July 2017). We determined that these percentages were appropriate for our purposes based, in part, on information from Medicaid officials in states in which we conducted in-depth interviews about how much of providers' contributions were returned as part of Medicaid payments.

We estimated the amount of the federal share of Medicaid payments for each state in 2018, which we refer to as the federal medical assistance percentage (FMAP), resulting in an FMAP that is not the same for each state. To estimate each state's FMAP, we analyzed the amount of the nonfederal share each state reported on the questionnaire and quarterly reporting of Medicaid payments reported to the Centers for Medicare & Medicaid Services during state fiscal year 2018.

Table 4: Estimated Percentage Point Increase between the FMAP and the Share of Net Medicaid Payments Financed by the Federal Government, by Type of Medicaid Payment and by State in State Fiscal Year 2018

State	Percentage point increase			
	Capitation payments to managed care organizations ^a	Fee-for-service payments ^b	DSH supplemental payments ^c	Non-DSH supplemental payments ^d
Alabama	N/A ^e	4.2	14.6	15.9
Alaska	N/A ^e	0.1	0.0	N/A ^e
Arizona	2.6	3.3	4.9	15.9
Arkansas	0.0	2.1	14.7	11.1
California	8.1	8.0	11.7	3.0
Colorado	0.9	1.2	28.6	23.5
Connecticut	N/A ^e	4.8	0.0	0.0
Delaware	0.7	0.0	0.0	N/A ^e
District of Columbia	2.8	0.8	0.0	19.6
Florida	5.2	1.6	16.3	24.8
Georgia	0.0	4.0	16.6	18.2
Hawaii	1.9	0.0	24.7	N/A ^e
Idaho	0.0	0.3	21.3	21.3
Illinois	4.0	3.7	17.3	28.8
Indiana	6.6	7.6	20.5	17.2
Iowa	1.2	5.3	3.2	0.0
Kansas	4.2	5.3	0.0	23.4
Kentucky	2.9	1.3	5.1	3.6

**Appendix III: Estimated Share of Net Medicaid
Payments Financed by the Federal
Government in State Fiscal Year 2018**

State	Percentage point increase			
	Capitation payments to managed care organizations ^a	Fee-for-service payments ^b	DSH supplemental payments ^c	Non-DSH supplemental payments ^d
Louisiana	6.6	4.6	5.8	14.0
Maine	N/A ^e	3.4	0.0	0.0
Maryland	0.0	7.3	0.0	N/A ^e
Massachusetts	2.0	1.1	N/A ^e	9.9
Michigan	10.8	5.3	9.4	3.0
Minnesota	2.5	1.2	0.5	27.2
Mississippi	2.9	7.0	18.4	0.2
Missouri	6.8	4.5	16.5	16.2
Montana	N/A ^e	1.5	N/A ^e	16.5
Nebraska	0.0	0.7	6.8	0.0
Nevada	0.9	0.8	17.4	17.7
New Hampshire	10.9	7.0	28.8	18.0
New Jersey	1.0	7.8	0.7	0.0
New Mexico	1.0	0.3	0.0	0.0
New York	10.9	8.7	17.8	18.5
North Carolina	N/A ^e	1.3	3.7	16.1
North Dakota	0.0	0.4	0.0	0.0
Ohio	5.2	7.4	19.1	20.9
Oklahoma	N/A ^e	1.0	0.0	18.7
Oregon	7.8	0.7	19.7	10.6
Pennsylvania	6.1	2.8	6.3	20.6
Rhode Island	1.2	14.8	28.8	28.8
South Carolina	2.5	1.8	18.2	5.5
South Dakota	N/A ^e	0.3	0.0	0.0
Tennessee	3.7	0.4	24.7	5.7
Texas	0.8	0.5	27.1	25.9
Utah	5.2	2.4	16.9	17.1
Vermont	N/A ^e	N/A ^e	0.0	7.8
Virginia	0.0	0.1	0.0	4.2
Washington	0.3	1.1	0.0	26.7
West Virginia	2.9	2.9	0.0	16.1
Wisconsin	3.5	3.2	0.0	3.4
Wyoming	0.0	0.0	0.0	32.3

Source: GAO analysis of state Medicaid data. | GAO-21-98.

**Appendix III: Estimated Share of Net Medicaid
Payments Financed by the Federal
Government in State Fiscal Year 2018**

Notes: Information is based on questionnaire responses received from 50 states and the District of Columbia. Net Medicaid payments are the total Medicaid payments received by all providers minus any funds providers contributed to the state for purposes of financing the nonfederal share of Medicaid payments to these providers. To determine the percentages of provider and local government funds contributed to the state for purposes of financing the nonfederal share of Medicaid payments to those providers, we analyzed a 2017 report from the Medicaid and CHIP Payment and Access Commission that estimated these percentages. See Medicaid and CHIP Payment and Access Commission, *The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending* (Washington, D.C.: July 2017). We determined that these percentages were appropriate for our purposes based, in part, on information from Medicaid officials in states in which we conducted in-depth interviews about how much of providers' contributions were returned as part of Medicaid payments.

We estimated the amount of the federal share of each Medicaid payment type in 2018, which we refer to as the federal medical assistance percentage (FMAP), for each state resulting in an FMAP that is not the same for each state. To estimate these state FMAPs, we analyzed the amount of the nonfederal share each state reported on the questionnaire and quarterly reporting of Medicaid payments reported to the Centers for Medicare & Medicaid Services during state fiscal year 2018.

^aCapitation payments to managed care organizations are predetermined, per person payments states make to organizations that contract with state Medicaid programs to provide or arrange for providing services to beneficiaries. The managed care organization is responsible for paying providers.

^bFee-for-service payments are payments states make directly to providers based on established Medicaid payment rates for the services provided

^cDisproportionate Share Hospital (DSH) payments are payments made to hospitals that serve large numbers of Medicaid beneficiaries and uninsured low-income individuals, which are required by federal law.

^dNon-DSH supplemental payments are payments such as Medicaid Upper Payment Limit supplemental payments and payments made to hospitals and other providers authorized under Medicaid demonstrations, which are not required by federal law.

^eState did not report making this type of Medicaid payment.

Appendix IV: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

November 16, 2020

Carolyn L. Yocom
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*MEDICAID: CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight*" (Job code 103531/GAO-21-98).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Sarah C.
Arbes -S

Digitally signed by
Sarah C. Arbes -S
Date: 2020.11.16
14:34:41 -05'00'

Sarah C. Arbes
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN
SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED – MEDICAID: CMS NEEDS MORE INFORMATION ON
STATES' FINANCING AND PAYMENT ARRANGEMENTS TO IMPROVE
OVERSIGHT (GAO-21-98)**

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on the GAO's draft report on states' use of Medicaid financing and payment arrangements.

The Centers for Medicare & Medicaid Services (CMS) understands the need for available, timely and adequate state Medicaid payment and financing data to enable the most effective oversight of the Medicaid program. CMS has already begun taking action to improve oversight of Medicaid supplemental payment programs and, in November 2019, issued the proposed Medicaid Fiscal Accountability Rule (CMS-2393-P) in order to strengthen the fiscal integrity of the Medicaid program. CMS intends to help ensure that state supplemental payments, payments made to providers that are in addition to the base payment the provider receives for services furnished, are transparent and value-driven. The proposed rule, if finalized, would require states to report provider-specific payment information on supplemental payments in Fee-for-Service Medicaid received for state plan services and through demonstration programs, as well as identify the specific authority for these payments, as well as the source of the non-federal share for these payments. CMS recently withdrew the final rule from the regulatory agenda and will use this time to further consider the public comments received.

The foundation of the Medicaid federal-state shared responsibility is that the state must participate in the financial burdens and risks of the program, which provides the state with an interest in operating and monitoring its Medicaid program in a manner that results in receiving the best value for the funds expended. Of the permissible means for financing the non-federal share of Medicaid expenditures, the most common is through state general funds, typically derived from tax revenue appropriated directly to the Medicaid agency. As described in the GAO's report, other financing sources for the non-federal share include health care-related taxes, provider-related donations, intergovernmental transfers (IGTs), and certified public expenditures (CPEs).

Revenue derived from health care-related taxes must meet federal statutory requirements at section 1903(w) of the Social Security Act (the Act) and implementing regulations. Provider-related donations to the state must be "bona fide," which means truly voluntary and not part of an arrangement that effectively repays the donation to the provider, in accordance with section 1903(w) of the Act and implementing regulations. Additionally, these authorities require states to assure that a lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of services or level of administration under the plan in any part of the state. Section 1903(w)(6)(A) of the Act specifically permits state and local units of government to share in financing the Medicaid program through IGTs and CPEs. Such local participation is inherent in the Medicaid program and recognizes the shared role that state and local government units can play in delivering Medicaid services. CMS currently employs various oversight mechanisms to review state methods for funding the non-federal share of Medicaid payments including, but not limited to, reviews of proposed State Plan Amendments, proposed state directed payment preprints, quarterly financial reviews of state expenditures, focused financial

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MEDICAID: CMS NEEDS MORE INFORMATION ON STATES' FINANCING AND PAYMENT ARRANGEMENTS TO IMPROVE OVERSIGHT (GAO-21-98)

management reviews, and reviews of state health care-related tax and provider-related donation proposals and waiver requests.

Within a managed care delivery system, states have the option to implement delivery system and provider payment initiatives under Medicaid managed care contracts, including those with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs). These types of payment arrangements, collectively referred to as “state directed payments,” permit states to direct specific payments made by managed care plans to providers under certain circumstances and can assist states in furthering the goals and priorities of their Medicaid programs. Currently, all state directed payments included in Medicaid managed care contracts under 42 C.F.R. § 438.6(c) require prior approval and must be based on the utilization and delivery of services to Medicaid beneficiaries covered under the contract in order to be approved, and these payments must be directed equally, using the same terms of performance across a class of providers. Further, provider participation in these state directed payments cannot be conditioned upon the provider entering into or adhering to intergovernmental transfer agreements. It is important to note that during CMS’ review and approval process, which has been implemented through a required preprint submission from states, CMS collects from states information related to the payment arrangements, including the financing of state directed managed care payments.

Recommendation

The Administrator of CMS should collect and document complete and consistent provider-specific information about Medicaid payments to providers, including new state directed managed care payments, and states’ sources of funding for the nonfederal share of these payments.

HHS Response

CMS has already issued the proposed Medicaid Fiscal Accountability Rule (CMS-2393-P) and while it is currently withdrawn from the regulatory agenda, if finalized, it would provide CMS with the regulatory authority to collect more complete and consistent financing and payment information from states. It is important to note that during CMS’ review and approval process of state directed payments, which has been implemented through a required preprint submission from states, CMS currently collects from states information related to state directed payment arrangements, including the financing of state directed managed care payments. Currently, all state directed payments included in Medicaid managed care contracts under 42 C.F.R. § 438.6(c) require prior approval and must be based on the utilization and delivery of services to Medicaid beneficiaries covered under the contract in order to be approved, and these payments must be directed equally, using the same terms of performance across a class of providers. CMS already has several actions underway to collect more information from states regarding state directed payments, including more information on provider-specific reimbursement and the financing of the nonfederal share of these payments. These actions include: (1) a revised state directed payments preprint that will collect more complete and consistent information from states regarding state directed payments during CMS’ review and approval process; (2) written

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN
SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED – MEDICAID: CMS NEEDS MORE INFORMATION ON
STATES' FINANCING AND PAYMENT ARRANGEMENTS TO IMPROVE
OVERSIGHT (GAO-21-98)**

guidance from CMS that will provide greater clarity on the federal requirements for state directed payments, including specific documentation standards that CMS will require as part of our continued review and approval of state directed payments; and (3) potential future rulemaking to provide CMS with more authority in collecting and reviewing information, such as to require that states submit provider-specific payment information for state directed payments as part of CMS' ongoing monitoring and oversight of managed care payment arrangements. Prior to the GAO's report, CMS had begun work to improve the collection of financing and payment information in Fee-for-Service delivery systems, and following the GAO's report, will explore additional actions to improve the collection of financing and payment information in managed care delivery systems.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Tim Bushfield (Assistant Director), Peter Mangano (Analyst-in-Charge), Julie Flowers, Taneeka Hansen, Drew Long, Mandy Pusey, Ethiene Salgado-Rodriguez, Kendra Sippel-Theodore, and Emily Wilson Schwark made key contributions to this report.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through our website. Each weekday afternoon, GAO posts on its [website](#) newly released reports, testimony, and correspondence. You can also [subscribe](#) to GAO's email updates to receive notification of newly posted products.

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, <https://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on [Facebook](#), [Flickr](#), [Twitter](#), and [YouTube](#).
Subscribe to our [RSS Feeds](#) or [Email Updates](#). Listen to our [Podcasts](#).
Visit GAO on the web at <https://www.gao.gov>.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact FraudNet:

Website: <https://www.gao.gov/fraudnet/fraudnet.htm>

Automated answering system: (800) 424-5454 or (202) 512-7700

Congressional Relations

Orice Williams Brown, Managing Director, WilliamsO@gao.gov, (202) 512-4400,
U.S. Government Accountability Office, 441 G Street NW, Room 7125,
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

Strategic Planning and External Liaison

Stephen J. Sanford, Acting Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
Washington, DC 20548



Please Print on Recycled Paper.