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**Intergovernmental
Transfers Have Facilitated
State Financing Schemes**

Statement of Kathryn G. Allen
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and Private Health Insurance Issues



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Highlights of [GAO-04-574T](#), a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Medicaid, the federal-state health financing program for many of the nation's most vulnerable populations, finances health care for an estimated 53 million low-income Americans, at a cost of \$244 billion in 2002. Congress structured Medicaid as a shared fiduciary responsibility of the federal government and the states, with the federal share of each state's Medicaid payments determined by a formula specified by law. In 2002, the federal share of each state's expenditures ranged from 50 to 76 percent under this formula; in the aggregate, the federal share of total Medicaid expenditures was 57 percent.

Some states have used a number of creative financing schemes that take advantage of statutory and regulatory loopholes to claim excessive federal matching payments. GAO was asked to summarize prior work on how some of these schemes operated, including the role of intergovernmental transfers (IGT), which enable government entities—such as the state and local-government facilities like county nursing homes—to transfer funds among themselves. GAO was also asked to discuss these schemes' effects on the federal-state Medicaid partnership and to discuss what can be done to curtail them.

www.gao.gov/cgi-bin/getrpt?GAO-04-574T.

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

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Intergovernmental Transfers Have Facilitated State Financing Schemes

What GAO Found

For many years states have used varied financing schemes, sometimes involving IGTs, to inappropriately increase federal Medicaid matching payments. Some states, for example, receive federal matching funds on the basis of large Medicaid payments to certain providers, such as nursing homes operated by local governments, which greatly exceed established Medicaid rates. In reality, the large payments are often temporary, since states can require the local-government providers to return all or most of the money to the states. States can use these funds—which essentially make a round-trip from the states to providers and back to the states—at their own discretion.

States' financing schemes undermine the federal-state Medicaid partnership, as well as the program's fiscal integrity, in at least three ways.

- The schemes effectively increase the federal matching rate established under federal law by increasing federal expenditures while state contributions remain unchanged or even decrease. GAO estimated that one state effectively increased the federal matching share of its total Medicaid expenditures from 59 percent to 68 percent in state fiscal year 2001, by obtaining excessive federal funds and using these as the state's share of other Medicaid expenditures.
- There is no assurance that these increased federal matching payments are used for Medicaid services, since states use funds returned to them via these schemes at their own discretion. In examining how six states with large schemes used the federal funds they generated, GAO found that one state used the funds to help finance its education programs, and others deposited the funds into state general funds or other special state accounts that could be used for non-Medicaid purposes or to supplant the states' share of other Medicaid expenditures.
- The schemes enable states to pay a few public providers amounts that well exceed the costs of services provided, which is inconsistent with the statutory requirement that states ensure economical and efficient Medicaid payments. In one state, GAO found that the state's proposed scheme increased the daily federal payment per Medicaid resident from \$53 to \$670 in six local-government-operated nursing homes.

Although Congress and the Centers for Medicare & Medicaid Services have acted to curtail financing schemes when detected, problems persist. States can still claim excessive federal matching funds for payments exceeding public facilities' actual costs. GAO suggests that Congress consider a recommendation open from prior work, that is, to prohibit Medicaid payments that exceed actual costs for any government-owned facility.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you explore the issue of states' use of intergovernmental transfers in the federal-state Medicaid program. Medicaid finances health care for an estimated 53 million low-income Americans at a cost of \$244 billion.¹ Medicaid is the third-largest mandatory spending program in the federal budget and one of the largest components of state budgets, second only to education. The program fulfills a crucial national role by providing health coverage for a variety of vulnerable populations, including low-income families with children and certain people who are elderly, blind, or disabled. Congress has structured Medicaid as a shared responsibility of the federal government and the states, with the federal share of each state's Medicaid payments determined by a formula specified by law. The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), is the federal agency responsible for the program, and the states design and administer their programs with considerable discretion and flexibility.

For more than a decade, states have used a number of creative financing schemes to inappropriately increase the federal share of Medicaid expenditures. Intergovernmental transfers, or IGTs, are one of the tools that have enabled them to do so. State and local governments use IGTs to carry out their shared governmental functions, such as collecting and redistributing revenues to provide essential government services. But by using IGTs, states can also transfer funds to or from local-government entities, such as government-owned nursing homes, as part of complex financing schemes that inappropriately boost the federal share of Medicaid costs. In my testimony today, I will (1) describe how some state financing schemes have operated, including the role of IGTs in these schemes; (2) discuss how such financing schemes compromise the federal-state partnership that is the foundation of the Medicaid program; and (3) discuss what can be done to further curtail state financing schemes. My testimony today is based on our prior work assessing state financing schemes and federal oversight of them. We conducted this body of work

¹Estimated federal-state cost is for fiscal year 2002, the latest year for which data are available.

from June 1993 through January 2004 in accordance with generally accepted government auditing standards.²

In summary, for many years states have used varied financing schemes, sometimes involving IGTs, to inappropriately increase federal matching payments. Taking advantage of statutory and regulatory loopholes, some states, for example, have made large Medicaid payments to certain providers, such as nursing homes operated by local governments, which have greatly exceeded the established Medicaid payment rate. These state expenditures would enable states to claim large federal matching payments. Such transactions create the illusion of valid expenditures for services delivered by local-government providers to Medicaid-eligible individuals. In reality, the spending is often only temporary because states require the local governments to return all or most of the money to the states through IGTs. Once states receive the returned funds, they can use them to supplant the states' own share of future Medicaid spending or even use them for non-Medicaid purposes. Because such arrangements effectively increase the federal Medicaid share above what is set under law, they violate the fiscal integrity of Medicaid's federal-state partnership. As new schemes have come to light, Congress and CMS have taken legislative and regulatory actions to curtail them; nonetheless, problems remain. We believe Congress and CMS should continue their efforts to preclude states' ability to claim excessive federal Medicaid payments, and we suggest that Congress consider a recommendation that remains open from our prior work, that is, to prohibit Medicaid payments that exceed actual costs for any government-owned facility.

Background

Title XIX of the Social Security Act authorizes federal funding to states for Medicaid, which finances health care services including acute and long-term care for certain low-income, aged, or disabled individuals. States have considerable flexibility in designing and operating their Medicaid programs. Within broad federal requirements, each state determines which services to cover and to what extent, establishes its own eligibility requirements, sets provider payment rates, and develops its own administrative structure. In addition to groups for which federal law requires coverage—such as children and pregnant women at specified income levels and certain persons with disabilities—states may choose to expand eligibility or add benefits that the statute defines as optional.

²See related GAO products at the end of this statement.

Medicaid is an open-ended entitlement: states are generally obligated to pay for covered services provided to eligible individuals, and the federal government is obligated to pay its share of a state's expenditures under a CMS-approved state Medicaid plan. The federal share of each state's Medicaid expenditures is based on a statutory formula linked to a state's per capita income in relation to national per capita income. In 2002, the specified federal share of each state's expenditures ranged from 50 percent to 76 percent; in the aggregate, the federal share of total Medicaid expenditures was 57 percent.³ The Social Security Act provides that up to 60 percent of the state share of Medicaid spending can come from local-government revenues and sources.⁴ Some states design their Medicaid programs to require local governments to contribute to the programs' costs.

Some State Financing Schemes Have Used IGTs to Create the Illusion of Valid Medicaid Expenditures

For more than a decade, some states have used various financing schemes, some involving IGTs, to create the illusion of a valid state Medicaid expenditure to a health care provider. This payment has enabled states to claim federal matching funds regardless of whether the program services paid for had actually been provided. As various schemes have come to light, Congress and CMS⁵ have taken actions to curtail them (see table 1). Many of these schemes involve payment arrangements between the state and government-owned or government-operated providers, such as local-government-operated nursing homes.

³In May 2003, Congress passed the Jobs and Growth Tax Relief Reconciliation Act, which appropriated \$10 billion for a temporary increase in the federal matching rate for states. This across-the-board increase of 2.95 percent was effective from April 1, 2003, through June 30, 2004.

⁴See 42 U.S.C. § 1396a(a)(2) (2000).

⁵In June 2001, the Health Care Financing Administration (HCFA) was renamed the Centers for Medicare & Medicaid Services (CMS). We continue to refer to HCFA throughout this testimony where agency actions were taken under its former name.

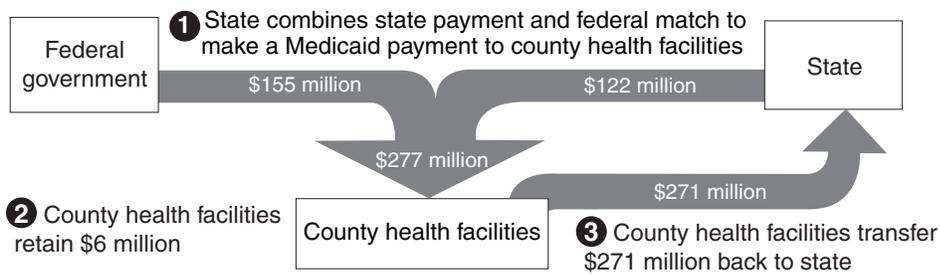
Table 1: Medicaid Financing Schemes Used to Inappropriately Generate Federal Payments and Federal Actions to Address Them

Financing arrangement	Description	Action taken
Excessive payments to state health facilities	States made excessive Medicaid payments to state-owned health facilities, which subsequently returned these funds to the state treasuries.	In 1987, the Health Care Financing Administration (HCFA) issued regulations that established payment limits specifically for inpatient and institutional facilities operated by states.
Provider taxes and donations	Revenues from provider-specific taxes on hospitals and other providers and from provider “donations” were matched with federal funds and paid to the providers. These providers could then return most of the federal payment to the states.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 essentially barred certain provider donations, placed a series of restrictions on provider taxes, and set other restrictions for state contributions.
Excessive disproportionate share hospital (DSH) payments	DSH payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the state and federal funds to the state.	The Omnibus Budget Reconciliation Act of 1993 placed limits on which hospitals could receive DSH payments and capped both the amount of DSH payments states could make and the amount individual hospitals could receive.
Excessive DSH payments to state mental hospitals	A large share of DSH payments were paid to state-operated psychiatric hospitals, where they were used to pay for services not covered by Medicaid or were returned to the state treasuries.	The Balanced Budget Act of 1997 limited the proportion of a state’s DSH payments that can be paid to state psychiatric hospitals.
Upper payment limit (UPL) for local government health facilities	In an effort to ensure that Medicaid payments are reasonable, federal regulations prohibit Medicaid from paying more than a reasonable estimate of the amount that would be paid under Medicare payment principles for comparable services. This UPL applies to payments aggregated across a class of facilities and not for individual facilities. As a result of the aggregate upper limit, states were able to make large supplemental payments to a few local public health facilities, such as hospitals and nursing homes. The local government health facilities then returned the bulk of the state and federal payments to the states.	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required HCFA to issue a final regulation that established a separate payment limit for each of several classes of local government health facilities. In 2002, CMS issued a regulation that further lowered the payment limit for local public hospitals.

Source: GAO.

A variant of these creative financing arrangements involves states' exploitation of Medicaid's upper payment limit (UPL) provisions.⁶ These schemes share certain characteristics, including IGTs, with other financing schemes from prior years (see table 1). In particular, these arrangements create the illusion that a state has made a large Medicaid payment—separate from and in addition to Medicaid expenditures that providers have already received for covered services—which enables the state to obtain a federal matching payment. In reality, the large payment is temporary, since the funds essentially make a round-trip from the state to the Medicaid providers and back to the state. As a result of such round-trip arrangements, states obtain excessive federal Medicaid matching funds while their own state expenditures remain unchanged or even decrease. Figure 1, which is based on our earlier work, illustrates how this mechanism operated in one state (Michigan).⁷

Figure 1: One State's Arrangement to Increase Federal Medicaid Payments Inappropriately



Source: GAO analysis.

⁶The UPL sets the ceiling on what the federal government will pay as its share of the Medicaid costs for different classes of covered services and often exceeds what states actually pay providers for Medicaid-covered services. States were able to exploit the UPL loophole by paying nursing homes and hospitals owned by local governments much more than the established Medicaid payment rate and requiring the providers to return, through IGTs, the excess payments to the state.

⁷See U.S. General Accounting Office, *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*, GAO/HEHS-94-133 (Washington, D.C.: Aug. 1, 1994), and *Major Management Challenges and Program Risks: Department of Health and Human Services*, GAO-03-101 (Washington, D.C.: January 2003).

As shown in figure 1, the state made Medicaid payments totaling \$277 million to certain county health facilities; the total included \$155 million in federal funds and \$122 million in state funds (step 1). On the same day that the county health facilities received the funds, they transferred all but \$6 million back to the state, which retained \$271 million (steps 2 and 3). From this transaction, the state realized a net gain of \$149 million over the state's original outlay of \$122 million. In cases like this, local-government facilities can use IGTs to easily return the excessive Medicaid payments to the state via electronic wire transfers. We have found that these round-trip transfers can be accomplished in less than 1 hour. The IGT is critical, because if the payment does not go back to the state, the state gains no financial benefit and actually loses from the arrangement because it has simply paid the provider more than its standard Medicaid payment rate for the services. In a variant of this practice, some states require a few counties to initiate the transaction, by taking out bank loans for the total amount the states determined they can pay under the UPL. The counties wire the funds to the states, which then send most or all of the funds back to the counties as Medicaid payments. The counties use these "Medicaid payments" to repay the bank loans. Meanwhile, the states claim federal matching funds on the total amount.

Consistent with past actions, Congress and CMS have taken steps to curtail UPL financing schemes when they have come to light. At the direction of Congress,⁸ the agency—then called the Health Care Financing Administration (HCFA)—finalized a regulation in 2001 that significantly narrowed the UPL loophole by limiting the amount of excessive funds states could claim.⁹ HCFA estimated that its 2001 regulation would reduce the federal government's financial liability due to inappropriate UPL arrangements by \$55 billion over 10 years;¹⁰ a related 2002 regulation was

⁸The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 directed HCFA to issue a final regulation to limit states' ability to claim excessive federal matching funds through UPL arrangements. See Pub. L. No. 106-554, App. F, § 705(a), 114 Stat. 2763A-463, 575-576 (2000).

⁹Specifically, HCFA eliminated states' ability to combine, or aggregate, UPLs across private and local-government providers. Before this regulation, a state could claim excessive payments on the basis of the combined amount potentially payable to all private and local-government providers in the state. The regulation established separate UPLs for separate classes of non-state-government facilities (those owned by local governments), including inpatient hospitals, nursing homes, and intermediate care facilities for the mentally retarded. See 66 Fed. Reg. 3148 (2001) (codified at 42 C.F.R. part 447 (2002)).

¹⁰HCFA's estimate covered UPL arrangements for nursing homes, inpatient hospital services, and outpatient hospital services.

estimated to yield an additional \$9 billion over 5 years.¹¹ CMS recognized that some states had developed a long-standing reliance on these excessive UPL funds, and the law and regulation authorized transition periods of up to 8 years for states to come into compliance with the new requirements.¹² As we recently reported,¹³ however, even under the new regulations, states can still aggregate payments to all local-government nursing homes under one UPL to generate excessive federal matching payments beyond their standard Medicaid claims. For example, CMS information about states complying with the new regulation indicates that, through UPL arrangements with public nursing homes and other public facilities, states can still claim about \$2.2 billion annually in federal matching funds exceeding their standard Medicaid claims.

Financing Schemes Undermine Medicaid's Federal-State Partnership

States' use of these creative financing mechanisms undermines the federal-state Medicaid partnership as well as the program's fiscal integrity in at least three ways.

First, state financing schemes effectively increase the federal matching rate established under federal law by increasing federal expenditures while state contributions remain unchanged or even decrease. For example, for one state we analyzed (Wisconsin), we estimated that by obtaining excessive federal matching payments and using these funds as the state share of other Medicaid expenditures, the state effectively increased the federal matching share of its total Medicaid expenditures from 59 percent to 68 percent in state fiscal year 2001.¹⁴ The state did so by generating nearly \$400 million in excessive federal matching funds via round-trip arrangements with three counties. Similarly, the HHS Office of the Inspector General found that a comparably structured arrangement in

¹¹The 2002 regulation reduced the upper limit for local-government hospitals from 150 percent to 100 percent.

¹²The length of a state's transition period was to be based in part on how long the state had had in place a UPL arrangement meeting certain specified criteria. During the assigned transition period—established in 1-, 2-, 5-, or 8-year intervals—excessive UPL payments were to be phased out.

¹³See U.S. General Accounting Office, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, [GAO-04-228](#) (Washington D.C.: Feb. 13, 2004).

¹⁴U.S. General Accounting Office, *Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes*, [GAO-02-147](#) (Washington D.C.: Oct. 30, 2001), and [GAO-04-228](#).

Pennsylvania effectively increased that state's statutorily determined matching rate from 54 percent to about 65 percent.¹⁵

Second, CMS has no assurance that these increased federal matching payments are used for Medicaid services. Federal Medicaid matching funds are intended for Medicaid-covered services for the Medicaid-eligible individuals on whose behalf payments are made.¹⁶ Under state financing schemes, however, states can use funds returned to them at their own discretion. We recently examined how six states with large UPL financing schemes involving nursing homes used the federal funds they generated.¹⁷ As in the past, some states in our review deposited excessive funds from UPL arrangements into their general funds, which the states may or may not use for Medicaid purposes. For example, one state (Oregon) has used funds generated by its UPL arrangement to help finance education programs. Table 2 provides further information on how states used their UPL funds in recent years, as reported by the six states we reviewed.

¹⁵U.S. Department of Health and Human Services, Office of the Inspector General, *Review of the Commonwealth of Pennsylvania's Use of Intergovernmental Transfers to Finance Medicaid Supplementation Payments to County Nursing Facilities*, A-03-00-00203 (Washington, D.C.: 2001).

¹⁶See 42 U.S.C. § 1396 and § 1396d(a).

¹⁷[GAO-04-228](#).

Table 2: Selected States' Use of Funds Generated through UPL Arrangements

State	Use
Michigan	Funds generated by the state's UPL arrangement are deposited in the state's general fund but are tracked separately as a local fund source. These local funds are earmarked for future Medicaid expenses and used as the state match, effectively recycling federal UPL matching funds to generate additional federal Medicaid matching funds.
New York	Funds generated by the state's UPL arrangement are deposited into its Medical Assistance Account. Proceeds from this account are used to pay for the state share of the cost of Medicaid payments, effectively recycling federal funds to generate additional federal Medicaid matching funds.
Oregon	Funds generated by the state's UPL arrangement are being used to help finance education programs and other non-Medicaid health programs. UPL matching funds recouped from providers are deposited into a special UPL fund. Facing a large budget deficit, a February 2002 special session of the Oregon legislature allocated the fund balance, about \$131 million, to finance kindergarten to 12th grade education programs. According to state budget documents, the UPL funds are being used to replace financing from the state's general fund.
Pennsylvania	Funds generated by the state's UPL arrangement are used for a number of Medicaid and non-Medicaid purposes, including long-term care and behavioral health services. In state fiscal years 2001–2003, the state generated \$2.4 billion in excessive federal matching funds, of which 43 percent was used for the state share of Medicaid expenses (recycled to generate additional federal matching funds), 6 percent was used for non-Medicaid purposes, and 52 percent was unspent and available for non-Medicaid uses. (Percentages do not total 100 percent because of rounding.)
Washington	Funds generated by the state's UPL arrangement are commingled with a number of other revenue sources in a state fund. The fund is used for various state health programs, including a state-funded basic health plan, public health programs, and health benefits for home care workers. A portion of the fund is also transferred to the state's general fund. The fund is also used for selected Medicaid services and the State Children's Health Insurance Program, which effectively recycles the federal funds to generate additional federal Medicaid matching funds.
Wisconsin	Funds generated by the state's UPL arrangement are deposited in a state fund, which is used to pay for Medicaid-covered services in both public and private nursing homes. Because the state uses these payments as the state share, the federal funds are effectively recycled to generate additional federal Medicaid matching funds.

Source: GAO.

Third, these state financing schemes undermine the fiscal integrity of the Medicaid program because they enable states to make to providers payments that significantly exceed their costs. In our view, this practice is inconsistent with the statutory requirement that states ensure that Medicaid payments are economical and efficient.¹⁸ Under UPL financing arrangements, some states pay a few public providers excessive amounts, well beyond the cost of services provided. We found, for example, that Virginia's proposed arrangement would allow the state to pay six local-government nursing homes, on average, \$670 in federal funds per Medicaid nursing home resident per day—more than 12 times the \$53 daily federal payment these nursing homes normally received, on average, per Medicaid resident.¹⁹

Further Federal Action Would Help Address Continuing Concerns with State Financing Schemes

Although CMS and the Congress have often acted to curtail states' financing schemes, problems persist. Improved CMS oversight and additional congressional action could help address continuing concerns with UPL financing schemes and other inappropriate arrangements.

We recently reported that CMS has taken several actions to improve its oversight of state UPL arrangements, including forming a team to coordinate its review of states' proposed and continuing arrangements, drafting internal guidelines for reviewing state methods for calculating UPL amounts, and conducting financial reviews that have identified hundreds of millions of dollars in improper claims.²⁰ Starting in August 2003, when considering states' proposals to change how they would pay nursing homes or other institutions, CMS also began to ask states to provide previously unrequested information. The information includes sources of state matching funds for supplemental payments to Medicaid providers, the extent to which total payments would exceed providers' costs, how a state would use the additional funds, and whether a state required providers to return payments (and, if so, how the state planned to spend such funds). As of October 2003, CMS indicated that it had asked 30 states with proposed state Medicaid plan amendments to provide additional information, and the agency was in the process of receiving and reviewing states' initial responses.

¹⁸See 42 U.S.C. § 1396a(a)(30)(A).

¹⁹[GAO-02-147](#).

²⁰[GAO-04-228](#).

We also reported, however, that CMS's efforts do not go far enough to ensure that states' UPL claims are for Medicaid-covered services provided to eligible beneficiaries. Moreover, we remain concerned that in carrying out its oversight responsibilities, CMS at times takes actions inconsistent with its stated goals for limiting states' use of these arrangements. For example, we previously reported that while the agency was attempting to narrow the glaring UPL loophole in 2001, it was allowing additional states to engage in the very schemes it was trying to shut down, at a substantial cost to the federal government.²¹ More recently, we reported that CMS's granting two states the longest available transition period of 8 years, for phasing out excessive claims under their UPL arrangements, was not consistent with the agency's stated goals. We estimated that, as a result of these decisions, these two states can claim about \$633 million more in federal matching funds under their 8-year transition periods than they could have claimed under shorter transition periods consistent with CMS's stated policies and goals.²²

In our view, additional congressional action also could help address continuing concerns about Medicaid financing schemes. Although Congress and CMS have taken significant steps to help curb inappropriate UPL arrangements and other financing schemes, states can still claim federal matching funds for more than a public provider's actual costs of providing Medicaid-covered services. As long as states are allowed to make payments exceeding a facility's actual costs, the loophole remains. A recommendation open from one of our earlier reports would, if implemented, close the existing loophole and thus mitigate these continuing concerns. We previously recommended that Congress consider prohibiting Medicaid payments that exceed actual costs for any government-owned facility.²³ If this recommendation were implemented, a facility's payment would be limited to the reasonable costs of covered services it actually provides to eligible beneficiaries, thus eliminating the possibility of the exorbitant payments that are now passed through individual facilities to states. The Administration appears to support such legislative action; the President's budget for fiscal year 2005 sets forth a legislative proposal to cap Medicaid payments to government providers

²¹[GAO-02-147](#).

²²[GAO-04-228](#).

²³U.S. General Accounting Office, *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*, [GAO/HEHS-94-133](#) (Washington D.C.: Aug. 1, 1994).

(such as public hospitals or county-owned nursing homes) to the actual cost of providing services to Medicaid beneficiaries.²⁴

Conclusions

The term “IGTs” has come to be closely associated—if not synonymous—with the abusive financing schemes undertaken by some states in connection with illusory payments for Medicaid services to claim excessive federal matching funds. IGTs are a legitimate state budget tool and not problematic in themselves. But when they are used to carry out questionable financial transactions that inappropriately shift state Medicaid costs to the federal government, they become problematic.

We believe the problem goes beyond IGTs. An observation we made in our first report on this issue in 1994 is as valid today as it was then: in our view, the Medicaid program should not allow states to benefit from arrangements where federal funds purported to benefit providers are given to providers with one hand, only to be taken back with the other.²⁵ State financing schemes, variants of which have been applied for a decade or longer, circumvent the federal and state funding balance set under law. They have also resulted in the diversion of federal funds intended to pay for covered services for Medicaid-eligible individuals to whatever purpose a state chooses.

Although Congress and CMS have often acted to address Medicaid financing schemes once they become apparent, new variations continue to emerge. Experience shows that some states are likely to continue looking for creative means to supplant state financing, making a compelling case for the Congress and CMS to sustain vigilance over federal Medicaid payments. Understandably, states that have relied on federal funding as a staple for their own share of Medicaid spending are feeling the budgetary pressure from the actual or potential loss of these funds. The continuing challenge remains to find the proper balance between states’ flexibility to administer their Medicaid programs and the shared federal-state fiduciary responsibility to manage program finances efficiently and economically in a way that ensures the program’s fiscal integrity.

²⁴U.S. Department of Health and Human Services, *Budget in Brief FY 2005* (Washington, D.C.: Mar. 1, 2004), <http://www.hhs.gov/budget/docbudget.htm> (downloaded Mar. 15, 2004).

²⁵[GAO/HEHS-94-133](#).

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Subcommittee may have.

Contact and Acknowledgments

For future contacts regarding this testimony, please call Kathryn G. Allen at (202) 512-7118. Katherine Iritani, Tim Bushfield, Ellen W. Chu, Helen Desaulniers, Behn Miller Kelly, and Terry Saiki also made key contributions to this testimony.

Related GAO Products

Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed. [GAO-04-228](#). Washington, D.C.: February 13, 2004.

Major Management Challenges and Program Risks: Department of Health and Human Services. [GAO-03-101](#). Washington, D.C.: January 2003.

Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes. [GAO-02-147](#). Washington, D.C.: October 30, 2001.

Medicaid: State Financing Schemes Again Drive Up Federal Payments. [GAO/T-HEHS-00-193](#). Washington, D.C.: September 6, 2000.

State Medicaid Financing Practices. [GAO/HEHS-96-76R](#). Washington, D.C.: January 23, 1996.

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