



February 2016

MEDICAID

Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments

GAO Highlights

Highlights of [GAO-16-108](#), a report to the Committee on Finance, U.S. Senate

Why GAO Did This Study

In 2012, GAO reported that 505 hospitals received Medicaid payments that resulted in Medicaid payment surpluses—that is, payments that exceeded the costs of providing services—of about \$2.7 billion. These surpluses were due in part to the lump-sum supplemental payments hospitals received that were above their regular payments for individual services. States made them under broad Medicaid payment authorities that allow federal matching on payments up to an upper payment limit or under Medicaid demonstrations. These types of supplemental payments are authorized, but not required, by law.

GAO was asked to examine how hospitals used revenues from large supplemental payments and the states' basis for distributing the payments. For four selected states making large payments and 12 hospitals receiving them, GAO examined (1) how these hospitals used revenues from the payments and (2) the basis on which the states distributed the payments. GAO reviewed documents authorizing payments and interviewed hospital, state and federal officials. GAO also obtained payment data for 2009, the year hospitals were identified as having large payments, and for 2012, the most recent year available.

What GAO Recommends

GAO recommends that CMS issue written guidance clarifying its policies that (1) supplemental payments should be linked to the provision of Medicaid services and (2) payments should not be contingent on the availability of local financing.

View [GAO-16-108](#). For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

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Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments

What GAO Found

Not all selected hospitals in the four states GAO reviewed tracked their use of revenues from the large supplemental payments they received and tracking of revenues is generally not required. Based on information obtained from hospital officials and a review of demonstration approval documents, GAO determined that the revenues were used for a broad range of purposes. For example,

- Officials from nine selected hospitals that received large supplemental payments under three states' traditional state Medicaid programs reported using revenues—which resulted in average surpluses of about \$39 million—to cover the costs of uninsured patients as well as funding general hospital operations, maintenance, and capital purchases, such as a helicopter.
- Hospitals in two selected states that GAO reviewed that were approved to make supplemental payments under Medicaid demonstrations were subject to certain tracking requirements to ensure payment revenues were used for approved demonstration purposes. Documentation for one state showed that approved uses of revenues included hospitals' uncompensated costs of serving underinsured or uninsured individuals and operating poison control centers. In the other state, which moved during the study timeframe from making supplemental payments under a traditional Medicaid program to under a demonstration, payments were allowed for purposes such as incentivizing health care delivery system improvements and for uncompensated costs for physician and clinic services, and drugs.

Three selected states distributed Medicaid supplemental payments largely based on the availability of local government funds to finance the nonfederal share of the payments, rather than on the services the hospitals provided. Medicaid payments should be made for Medicaid services or, if under demonstrations, for demonstration purposes and be economical and efficient. GAO found that three states made supplemental payments based on the ability of hospitals, or their local governments, to finance the nonfederal share. Consequently, hospitals otherwise eligible for payments but whose local government could not finance them did not receive them. The Centers for Medicare & Medicaid Services (CMS), which oversees Medicaid, communicated in writing to one state two key principles regarding payment distribution: (1) payments should be distributed based on Medicaid or demonstration purposes, and (2) payments should not be made based on the availability of local financing. However, CMS has not provided written guidance to articulate or broadly communicate these requirements to all states. Federal internal controls standards stress the need for effective communications with external stakeholders that have a significant impact on the agency achieving its goals. The absence of written guidance may result in inconsistent application of CMS's policies among states, the distribution of supplemental payments that are counter to the agency's policies and not aligned with the program's purposes, and the potential for states to overpay or underpay providers depending on the availability of local government financing.

In commenting on a draft of this report, HHS concurred with the first recommendation and agreed with GAO's concerns regarding the second recommendation but did not explicitly concur with it.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
DSH	Disproportionate Share Hospital
HHS	Department of Health and Human Services
UPL	Upper Payment Limit

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February 5, 2016

The Honorable Orrin G. Hatch
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

Medicaid, a joint federal-state health care program that provides health care coverage for low-income and medically needy individuals, involves significant and growing expenditures for the federal government and states. In fiscal year 2015, it is estimated that Medicaid covered, on average, approximately 69 million beneficiaries at an estimated cost of \$529 billion.¹ States administer their own Medicaid programs within broad federal requirements under the oversight of the Centers for Medicare & Medicaid Services (CMS), an agency of the Department of Health and Human Services (HHS). While states establish provider payment rates for certain mandatory and optional services they may cover, the federal government provides matching funds for these services, but only for amounts up to what Medicare would pay for comparable services.² This limit on the payment amount that the federal government will match is called the Medicaid Upper Payment Limit (UPL). States make payments to hospitals for services rendered to individual Medicaid beneficiaries, but these payments are often below what Medicare would pay; consequently, many states also receive federal matching funds for supplemental payments to hospitals, which states often make to certain hospitals to increase the hospitals' payments. Such payments, commonly known as UPL supplemental payments, generally are not based on actual claims for services to individual beneficiaries.

¹Estimated Medicaid expenditures are for medical assistance payments and administration costs and, along with estimated enrollment, are based on projections for fiscal year 2015 reported in Centers for Medicare & Medicaid Services, Office of the Actuary, *2014 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2015).

²Under a statutory formula, the federal government may reimburse from 50 to 83 percent of a state's Medicaid expenditures for services. States with lower per capita incomes receive higher federal matching rates. 42 U.S.C. §§ 1396b(a), 1396d(b).

In recent years states have increasingly made other types of supplemental payments to hospitals under section 1115 of the Social Security Act. Section 1115 authorizes the Secretary of Health and Human Services to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives.³ Specifically, HHS may grant states authority to operate a Medicaid "demonstration project" under section 1115, allowing them to test new approaches for delivering health care services, by waiving certain statutory requirements and authorizing types of payments not otherwise available for federal matching funds, including through the approval of demonstration supplemental payments. Certain states have received approval to make demonstration supplemental payments and ended their UPL supplemental payments. HHS has authorized demonstration supplemental payments for purposes such as paying hospitals for uncompensated care costs and making incentive payments for broad health care improvements.

UPL and demonstration supplemental payments (collectively referred to hereafter as supplemental payments) are authorized, though not explicitly required, by law.⁴ Unlike regular claims-based payments, which are made in response to a provider's submission of a claim for the provision of a covered service to a particular patient, states have some flexibility to target these supplemental payments to a small number of providers and generally make these payments on a monthly, quarterly, or annual lump-sum basis. In fiscal year 2013, states made more than \$22 billion in these supplemental payments—an increase of about \$8 billion (58 percent) over fiscal year 2010—mainly to hospitals.⁵ We designated Medicaid as a

³42 U.S.C. § 1315(a).

⁴States are required to make, report on, and audit only one type of hospital supplemental payment—called disproportionate share hospital (DSH) payments—for hospitals that care for a disproportionate share of Medicaid and low-income uninsured patients. Under current law, total national federal DSH funding will be reduced in increasing amounts beginning in fiscal year 2018 through fiscal year 2025, for a total reduction of \$43 billion. 42 U.S.C. § 1396r-4(f)(7) (as amended by Pub. L. No. 114-10, § 412, 129 Stat. 87, 162 (Apr. 16, 2015)).

⁵CMS, FY 2013 and FY 2010 Medicaid Financial Management Reports, from the Medicaid Budget and Expenditure System, accessed August 12, 2015, <http://medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/mbes/medicaid-budget-and-expenditure-system-mbes.html>.

high-risk program in 2003 in part due to the program's size, growth, and concerns about the transparency and oversight of supplemental payments.⁶

We reported in November 2012 that 39 states made supplemental payments that resulted in 505 hospitals having Medicaid payment surpluses—that is, total Medicaid payments in excess of the hospitals' total costs of providing Medicaid services. Medicaid surpluses in the 39 states totaled about \$2.7 billion.⁷ In some cases, supplemental payments to individual hospitals resulted in Medicaid surpluses of tens of millions of dollars, raising questions about how states making such large supplemental payments determined the payment amounts and how the hospitals used the revenue associated with these large payments. Under federal requirements, Medicaid payment amounts are not limited to the providers' costs of providing services; however, unless specifically authorized for other uses under a demonstration, the payments must be for allowable Medicaid expenditures—Medicaid services provided to Medicaid beneficiaries—and federal law requires that they be economical, efficient, and sufficient to ensure that beneficiaries' access to care is comparable to that of the general population.⁸ While federal law limits the amount of federal funding available for payments to providers, providers are generally not restricted in how they use the revenue from the payments, except where a Medicaid demonstration imposes conditions on such uses to promote Medicaid objectives.

You asked us to provide information on how hospitals have used supplemental payments and how states determined how much in supplemental payments to pay hospitals. For selected states and hospitals with large Medicaid surpluses that resulted from supplemental payments, this report provides information on:

⁶See GAO, *High-Risk Series: An Update*, [GAO-13-283](#) (Washington, D.C.: February 2013). A list of related GAO products can be found at the end of this report.

⁷GAO, *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*, [GAO-13-48](#) (Washington, D.C.: Nov. 26, 2012). That report was based on 2007 Disproportionate Share Hospital audit report data, the most recent available at the time.

⁸42 U.S.C. §1396a(a)(30)(A).

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- (1) hospitals' use of revenues from large UPL and demonstration supplemental payments they received, and
 - (2) the basis on which selected states distributed UPL and demonstration supplemental payments to hospitals.

To address our objectives, we selected a nongeneralizable sample of four states based on an analysis of disproportionate share hospital (DSH) payment audit report data, the only federal data source with facility-specific supplemental payment information, which we obtained from CMS for 2009 (the most recently available audited data showing Medicaid surpluses at the time of our selection).⁹ We selected two states whose hospitals had the highest aggregate Medicaid surplus (Florida and Texas) and two states whose hospitals had the highest average Medicaid surplus per hospital (New Mexico and Oklahoma).¹⁰

To determine how hospitals used the revenues from large supplemental payments they received, we first identified and selected the three hospitals within each selected state with the highest total Medicaid surplus stemming from supplemental payments. We interviewed officials from these hospitals about how they used the revenues from the supplemental payments they received in 2009 (the base year for selecting states and hospitals) and 2012 (the most recent year for which we estimated that, at the time of our work, hospital Medicaid cost and

⁹Federal regulations require that each audit report must be completed no later than the last day of the federal fiscal year ending 3 years after the Medicaid state plan rate year under audit. 42 C.F.R. § 455.304(b) (2014). CMS officials said the agency reviews states' submitted audit reports for completeness and accuracy, and works with states on any needed clarifications prior to making them publicly available. DSH audit reports do not, however, capture supplemental payments to hospitals that did not receive DSH payments.

¹⁰Florida's and Texas's aggregate Medicaid surplus in 2009 was about \$380 and \$566 million, respectively. New Mexico's and Oklahoma's average Medicaid surplus per hospital was about \$12 million and \$25 million, respectively. To calculate each hospital's Medicaid surplus from states' 2009 DSH audit reports, we subtracted the hospitals' Medicaid costs from its Medicaid payments, including fee-for-service payments, payments to managed care organizations for those Medicaid beneficiaries enrolled in managed care plans, and UPL and demonstration supplemental payments. We did not include DSH payments in our calculations of Medicaid surplus since they are not solely intended for Medicaid beneficiaries but also for uninsured patients. Our estimates of states' aggregate and average Medicaid surplus included only hospitals that had a Medicaid surplus due to supplemental payments—that is, we excluded hospitals that received a Medicaid surplus on the basis of regular Medicaid payments alone. When we looked at hospitals nationwide, we found that for hospitals that received a DSH payment, Medicaid surpluses due to UPL and demonstration supplemental payments totaled about \$2.3 billion in 2009.

payment data would be available) and obtained and reviewed available payment and cost information and other relevant data on state supplemental payments for the two review years. In 2009, three of the four selected states—New Mexico, Oklahoma, and Texas—administered their Medicaid supplemental payment programs under state plan authority and made UPL supplemental payments to 9 selected hospitals. The remaining state, Florida, operated under the terms and conditions of a Medicaid demonstration and made demonstration supplemental payments to 3 selected hospitals. Beginning in fiscal year 2012, one selected state (Texas) was approved by HHS to end its UPL payments and begin making supplemental payments under the authority of a Medicaid demonstration. During 2012, 6 of 12 selected hospitals received payments under a demonstration. For these two states, we also reviewed the terms and conditions of their demonstrations to identify any requirements for tracking, reporting on, and approved uses of the payments.

To examine the basis on which selected states distributed hospital payments, we interviewed state Medicaid officials about their distribution methodologies and reviewed relevant state documents, including documents authorizing the payments, state regulations and policies related to supplemental payments, and state summary reports on their allocation methodologies. We also analyzed state data on the amounts paid to individual hospitals for both 2009 and 2012.¹¹ We determined that the data we obtained from CMS and the states were reliable for purposes of our review by checking the data for discrepancies and omissions, comparing the data to other publicly available data, and communicating with officials to resolve any identified discrepancies. As part of our review, we also examined the extent to which CMS's oversight of states' distribution methods was consistent with standards for internal control in the federal government—specifically, the standard related to information and communications.¹² We also reviewed federal laws, regulations, and agency policy documents, and interviewed CMS officials.

¹¹Data for 2009 were obtained through states' DSH audit reports and data for 2012 were provided to us by the selected states. The four states collectively made about \$3.6 billion in UPL and demonstration supplemental payments in 2009 and about \$5.6 billion in 2012.

¹²GAO, *Internal Control: Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

We conducted this performance audit from October 2013 to February 2016 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, each state administers and operates its Medicaid program in accordance with a Medicaid state plan, which must be approved by CMS. A state 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. Federal law identifies broad categories of services that states must cover, such as inpatient hospital services, nursing facility services, and physician services, and also many categories of services that states can cover at their own option, such as home- and community-based long-term care services, physical therapy, or optometry.¹³ Any changes a state wishes to make in its Medicaid plan, such as establishing new Medicaid payments (including supplemental 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. In reviewing state plan amendments to ensure that state provisions are consistent with federal Medicaid requirements, CMS reviews and approves payment methodologies and does not review actual payments for individual providers. CMS communicates Medicaid program requirements to states through federal regulations, a published State Medicaid Manual, standard letters issued to all state Medicaid directors, and technical guidance on particular topics.

Under federal Medicaid requirements, federal Medicaid matching funds are available for state payments made for Medicaid-covered services

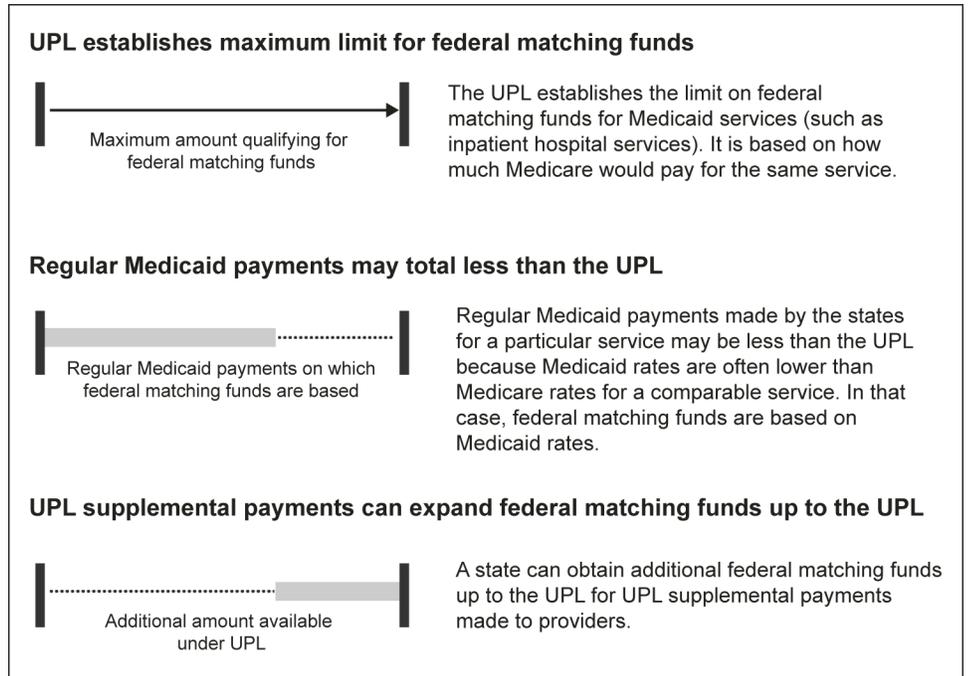
¹³The federal government shares in the cost of state Medicaid payments for 15 mandatory and 27 optional categories of medical service specified in federal law. See 42 U.S.C. 1396d(a). See CMS's list of mandatory and optional services at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html>.

provided to Medicaid beneficiaries.¹⁴ While payments are not limited to the costs of providing services, payments made to a provider under a state plan must be economical and efficient and within the Medicaid UPL, which is the ceiling on the amount of federal matching funds a state can claim for certain services.¹⁵ The UPL is based on an estimate of what Medicare would have paid for comparable services. Because states' regular Medicaid payments are often lower than what Medicare would pay for similar services, states are able to make UPL supplemental payments, and the federal government shares in the payments to the maximum amount allowed under the UPL (see figure 1).

¹⁴See CMS, *Re: Medicaid Payment for Services Provided without Charge (Free Care) (SMD#14-006)* (Dec. 15, 2014).

¹⁵42 U.S.C. § 1396a(a)(30)(A). The Medicaid UPL, which is established in regulations, is based on an estimate of what Medicare would have paid for comparable services within certain categories, such as hospital inpatient or outpatient services. See, e.g., 42 C.F.R. §§ 447.272, 447.321 (2014). The UPL applies to payments made on a fee-for-service basis, where providers render services and submit claims for payments to the state Medicaid agency. Services delivered and paid for under managed care are not subject to the UPL and not included in states' UPL calculations. Under Medicaid, states may contract with managed care organizations to provide or arrange for medical services and prospectively pay the organizations a fixed monthly rate, or capitation payment, per enrollee. Federal regulations prohibit payments by a state Medicaid agency to providers for services rendered under contract with a managed care organization. This prohibition extends to UPL payments. See 42 C.F.R. § 438.60 (2014).

Figure 1: Overview of How States Make UPL Supplemental Payments in Addition to Regular Medicaid Payments



Source: GAO. | GAO-16-108

Note: The upper payment limit (UPL) applies to regular fee-for-service Medicaid payments and UPL supplemental payments and does not include Disproportionate Share Hospital (DSH) supplemental payments. DSH supplemental payments are made to cover the hospitals' uncompensated care costs for inpatient and outpatient hospital services provided to Medicaid and uninsured patients and have separate payment limits.

The UPL is not a provider-specific limit but instead is applied on an aggregate basis for certain provider ownership types and categories of services.¹⁶ Each state must calculate a separate UPL for each combination of provider ownership type and category of service to determine the maximum amount of UPL payments that it can make for

¹⁶Specifically, the UPL is applied on an aggregate basis to three ownership types—local government, state government, and private. Separate UPLs exist for providers of inpatient hospital services, outpatient hospital services, nursing facility services, and physician and other practitioner services, and for services provided in intermediate care facilities for the developmentally disabled. Although federal regulations do not specify an upper payment limit for physician and other practitioner services, CMS has imposed limits on supplemental payments to these providers. See, e.g., 42 C.F.R. §§ 447.272, 447.321 (2014).

each ownership-service type combination. States may establish multiple UPL supplemental payment programs and hospitals may receive UPL supplemental payments from more than one of these programs.¹⁷ Approval to make new payments and apply other eligibility criteria is obtained through the state plan amendment process, which requires CMS review and approval. CMS's review and approval role does not extend to reviewing the specific manner in which states distribute payments, including which individual providers receive payments, the amount of the payments, or how providers spend the payments they receive. Under the flexibility of the Medicaid UPL, some states have targeted UPL supplemental payments to a small number of hospitals within a particular category. For example, in 2012, we reported that a large share of UPL supplemental payments were concentrated on a small number of hospitals and in many cases resulted in Medicaid surpluses. We concluded that payments that greatly exceeded Medicaid costs raised questions about the purpose of the payments, including how they related to Medicaid services and if they are economical and efficient.¹⁸ In 2015, we reported that CMS lacked a policy and process to determine if payments to individual providers are economical and efficient, and we recommended that CMS develop criteria to assess payments to individual providers and develop a process to identify and review them. HHS agreed and reported that the agency is taking action to respond to our recommendation.¹⁹

States may also administer parts of their Medicaid programs under the authority of section 1115 of the Social Security Act, which authorizes the Secretary to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives. In recent

¹⁷UPL supplemental payment programs are separate payments for different categories and service types; and a single hospital may qualify for payments under multiple categories. For example, a local government hospital may receive supplemental payments under both the inpatient and outpatient UPL. States may also apply other eligibility criteria, such as location in a rural area or status as a trauma center, further concentrating the aggregate UPL for each ownership-service type combination to a qualifying subset of providers.

¹⁸See [GAO-13-48](#).

¹⁹GAO, *Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy*, [GAO-15-322](#) (Washington, D.C: April 10, 2015).

years an increasing number of states have received permission from HHS to make supplemental payments under Medicaid demonstrations. Supplemental payments under a Medicaid demonstration are made according to the terms and conditions approved by HHS for the demonstration and may include reporting or other requirements that do not apply to UPL supplemental payments authorized under the Medicaid state plan.

States and the federal government share in the financing of Medicaid payments according to a formula established in law. States finance the nonfederal share of their Medicaid programs primarily with state funds, particularly state general funds appropriated to the state Medicaid agency. Within certain limits, however, states may also use other sources of funds—including funds from local government providers, such as county-owned or county-operated hospitals, or from local governments on behalf of government providers.²⁰ For example, local government providers and local governments can provide Medicaid funding to the state via fund transfers, known as intergovernmental transfers. Federal law allows states to finance up to 60 percent of the nonfederal share from local government funds.²¹ This limit is applied in the aggregate—that is, across each state’s entire Medicaid program—and not for individual payments or categories of service. Under federal law, states cannot lower the amount, duration, scope, or quality of Medicaid services provided due to a lack of funds from local sources.²² We recently reported that states have increasingly relied on local governments to fund the nonfederal share of state Medicaid payments, particularly for supplemental payments.²³

²⁰In addition to funds appropriated to the state Medicaid agency and intergovernmental transfers of local funds, the nonfederal share of Medicaid payments may be financed through intra-agency transfers from other state agencies, taxes levied on health care providers, and certifications of spending incurred by local governments or local government providers.

²¹42 U.S.C. § 1396a(a)(2), 42 C.F.R. § 433.53(b) (2014).

²²42 U.S.C. § 1396a(a)(2), 42 C.F.R. § 433.53(c)(2) (2014).

²³We reported that in state fiscal year 2012, across all states, 70 percent of the nonfederal share of UPL supplemental payments was financed by funds from local governments, including local government hospitals, which represented an increase of 13 percentage points since state fiscal year 2008. See *GAO, Medicaid Financing: States Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, [GAO-14-627](#) (Washington, D.C.: July 29, 2014).

Not All Selected Hospitals Tracked How They Used Revenues from Their Supplemental Payments, but Described Uses Included Uninsured Costs and Capital Purchases

Selected hospitals that received large UPL supplemental payments under state plans in three of four selected states did not account specifically for the use of revenue from these payments in their financial systems, as they were not required to do so. But hospital officials described various uses of the revenue, such as defraying the costs of treating the uninsured and the costs of capital purchases. Selected hospitals that received large Medicaid payments in two of four selected states were required to track spending and allowed to use payments for purposes such as uninsured costs.²⁴

Selected Hospitals Receiving Large UPL Payments Did Not Track Specific Use of Revenues; Officials Described Non-Medicaid Uses Such As Uninsured Costs and Equipment Purchases

Officials from all nine of our selected hospitals that received large UPL supplemental payments under state plans in three of the four states in our review reported that they did not track how they used the excess revenue from the UPL payments they received, nor were they required to do so. These surpluses reflect the amount that total Medicaid payments, which include regular Medicaid and supplemental payments, exceeded Medicaid costs and were significant for the selected hospitals. For example, in 2009, the Medicaid surpluses for the nine hospitals ranged from \$400,000 to more than \$77 million, with average Medicaid surpluses of about \$39 million. Although supplemental payments to these hospitals amounted to tens or hundreds of millions annually and are generally paid on a lump sum, quarterly, or annual basis, officials told us that their financial systems do not separately identify the supplemental payment

²⁴Supplemental payments under a Medicaid demonstration are made according to the terms and conditions approved by HHS for the demonstration and may include reporting or other requirements that do not apply to UPL supplemental payments authorized under the Medicaid state plan. Although our review encompassed 12 selected hospitals in four selected states, numbers do not always total because one state (Texas) was approved to change the authority under which it made supplemental payments between selected years. In 2009, three of the four selected states—New Mexico, Oklahoma, and Texas—made UPL supplemental payments to 9 selected hospitals under state plan authority. The remaining state, Florida, made supplemental payments to 3 selected hospitals under a Medicaid demonstration. Beginning in fiscal year 2012, Texas was approved by HHS to end its UPL payments under its state plan and begin making supplemental payments under the authority of a Medicaid demonstration. As a result, during 2012, 6 of 12 selected hospitals were operating under a demonstration in two of the four selected states.

revenues or track the costs to which supplemental payments are applied. Rather, these officials said the UPL supplemental payments are treated as revenue along with other payments the hospital receives, and revenues are not segregated for specific purposes. Although hospitals did not track the UPL supplemental payment revenues, hospital officials were able to describe some of the general purposes for which the revenues, including the Medicaid surpluses resulting from the large payments, were used. Hospital officials described purposes such as defraying the costs of treating uninsured patients, contributing to specific capital purchases, and making general improvements to community access to care and services. Officials from several hospitals described more than one purpose for which the UPL supplemental payments and resulting Medicaid surpluses were used. (See table 1.)

Table 1: Uses of Medicaid Upper Payment Limit Supplemental Payments, As Described by Officials from Selected Hospitals

	Services for uninsured patients	General hospital operations and maintenance	Capital projects and equipment purchases	Community access to care and services ^a
New Mexico				
Hospital 1	✓	✓		
Hospital 2	✓		✓	✓
Hospital 3	✓			
Oklahoma				
Hospital 1				✓
Hospital 2				✓
Hospital 3	✓			✓
Texas				
Hospital 1	✓	✓	✓	✓
Hospital 2	✓			
Hospital 3	✓			
Total	7	2	2	5

Source: GAO interviews with officials from selected hospitals. | GAO-16-108

Notes: Responses from New Mexico and Oklahoma hospitals reflect both 2009 and 2012. Responses from Texas hospitals reflect only 2009 because the state shifted its supplemental payments to a Medicaid demonstration beginning fiscal year 2012.

^aHospital officials described uses that broadly benefited community access to care and services, such as expanding services in underserved areas and in homeless shelters.

Hospital officials from seven of nine selected hospitals in these three states said they used the revenues from the large UPL supplemental payments they received in part to cover the costs of providing services to

uninsured patients. Federal Medicaid law explicitly authorizes one type of Medicaid supplemental payment—Medicaid DSH supplemental payments—for which states can claim federal matching funds for the costs of treating uninsured patients.²⁵ The amount of federal funding each state may claim for DSH supplemental payments is limited by federal law, as each state is subject to a federal DSH allotment that establishes the maximum federal funding available for DSH payments. These limits, however, do not restrict hospitals from using available revenues to cover the costs of providing services to uninsured patients. While officials with the seven hospitals were unable to specify how much of their UPL supplemental payments, including their Medicaid surpluses, were used to cover the costs of uninsured patients, the amount of federal funds above the states' federal DSH allotments that were available to the hospitals for spending on the uninsured could be significant. For example, for New Mexico, Oklahoma, and Texas, statewide Medicaid surpluses due to UPL supplemental payments exceeded \$400 million in federal funds in 2009, which is significant compared to these states' DSH allotments of just over \$1 billion in the same year. In New Mexico and Oklahoma, the federal share of Medicaid surpluses due to UPL payments actually exceeded the states' federal DSH allotments. (See table 2.)

²⁵See 42 U.S.C. §§ 1396a(a)(13)(A), 1396r-4. States are required by federal law to make DSH payments to certain hospitals. These payments are designed to help offset these hospitals' uncompensated care costs for serving large numbers of Medicaid and uninsured low-income individuals. DSH payments to individual hospitals cannot exceed a hospital's annual uncompensated care costs for Medicaid and uninsured patients. Uncompensated care costs are the costs incurred in providing inpatient and outpatient services during the year to Medicaid and uninsured patients minus any payments made to the hospital for those services to Medicaid and uninsured patients.

Table 2: Selected States' DSH Allotments and Federal Share of Medicaid Surpluses Due to UPL Supplemental Payments, 2009

State	Maximum federal Medicaid funding available for uncompensated care costs, including uninsured patients (DSH allotments)	Federal share of statewide Medicaid surpluses due to UPL supplemental payments^a
New Mexico	\$20,531,604	\$50,353,178
Oklahoma	\$36,500,627	\$49,956,378
Texas	\$963,850,841	\$336,154,257
Total	\$1,020,883,072	\$436,463,813

Source: GAO analysis of 2009 Disproportionate Share Hospitals (DSH) audit report data (total Medicaid surpluses); federal register (DSH allotments). | GAO-16-108

Note: We did not report data for 2012, the other year for which payments were analyzed, because not all states were able to provide data needed to determine the amount of any Medicaid surpluses.

^aTotals represent the sum of the federal share of all Medicaid surpluses due to supplemental payments made under the Medicaid upper payment limit (UPL) among hospitals that received a DSH payment in 2009.

Several hospital officials described other uses of revenues from UPL supplemental payments, including funding general hospital operations and maintenance; capital projects, such as new facilities; and equipment purchases, such as new imaging equipment. Although hospital officials were able to describe multiple purposes for which they used revenues from Medicaid surpluses resulting from large UPL supplemental payments, they were unable to specify how much was used for each purpose they described. Examples of specific expenses cited by hospital officials include the following:

- A New Mexico hospital official described a variety of capital expenses for which revenues from UPL payments, in part, were used. Examples included constructing new medical office buildings, constructing a new cancer treatment center, opening a new health clinic, purchasing a new CT scanner, purchasing a new X-ray imaging system, and purchasing a new helicopter to transport patients. Although hospital officials could not estimate how much of the Medicaid surplus was devoted to capital investment, the surplus was significant compared to the amount of its capital investments. For example, in 2009 this hospital had a Medicaid surplus of about \$16 million.²⁶ The budget for its capital investments totaled \$24.6 million that year. The hospital reported an overall profit exceeding \$5 million each in 2009 and 2012.

²⁶We calculated the Medicaid surplus amount based on the state DSH audit report for 2009, which included data on hospitals' total Medicaid costs and payments.

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- Officials with a Texas hospital described the establishment of new outpatient clinics for both primary care and some specialty services, extension of clinic hours, and capital expenses as the types of services and projects that it would not have been able to provide or complete without the supplemental payments it received. Although hospital officials could not estimate how much of the Medicaid surplus was devoted to capital investment, the surplus was significant compared to its capital investments. For example, in 2009, this hospital had a Medicaid surplus of nearly \$78 million. That same year the hospital spent \$100 million for construction of a new patient tower that included new operating rooms, emergency rooms, examination rooms, isolation rooms, three floors of patient rooms, administration offices, and waiting rooms.

Selected Hospitals Receiving Large Medicaid Demonstration Supplemental Payments Were Required to Track Spending and Allowed to Use Payments for Purposes Such As Uninsured Costs

Under Medicaid demonstrations, states were approved to make Medicaid supplemental payments to hospitals for costs and activities not otherwise covered under Medicaid to promote Medicaid objectives, and hospitals were required to track how they used these payments. Specifically, the two states in our review that operated under demonstrations, Florida and Texas, were authorized to make new types of supplemental payments to hospitals for hospitals' uncompensated care costs associated with Medicaid-enrolled and uninsured patients, and Texas was also authorized to make incentive payments for broadly targeted improvements to hospitals' health care delivery systems.²⁷ Florida began its Medicaid demonstration in fiscal year 2006 and Texas began its demonstration in fiscal year 2012. When the states began making demonstration supplemental payments to hospitals, they ended the hospitals' UPL

²⁷As part of the terms of Florida's demonstration, a subset of its demonstration supplemental payments for uncompensated care costs was tied to the completion of health care improvement projects by 15 hospitals receiving the largest payments. Unlike Texas's incentive payments, which are payments specifically for improvements to health care delivery systems, the payments to Florida hospitals for similar improvement projects must still be supported by hospitals' documented uncompensated care costs.

supplemental payments, although they continued to make DSH payments.²⁸

Hospitals in both states receiving demonstration supplemental payments for uncompensated care costs were subject to certain payment limits and reporting requirements, and overall spending approved for uncompensated care costs was higher than the federal limits would have been without the demonstration. In addition, the terms of the demonstrations allowed the states to include costs not otherwise eligible for Medicaid reimbursement under the demonstration. The terms and conditions of the demonstrations established a facility-specific limit on hospital payments. In particular, hospitals could not receive more in payments than their actual uncompensated care costs, including new costs allowed under the demonstration. The Texas demonstration allowed hospitals to include uncompensated care costs beyond those that the state could have covered without the demonstration, including uncompensated costs for physician services, clinic services, and prescription drugs. Further, the Florida demonstration allowed hospitals to include uncompensated care costs for underinsured individuals with private insurance as well as for the cost of operating poison control centers, costs that the state could not have covered without the demonstration. Hospitals were required to report their estimated Medicaid and uninsured costs and payments to the state, using an approved methodology, as a condition of receiving payment, so that the amount of uncompensated care costs could be determined.²⁹ Hospitals are subject to a verification of actual costs and payments when final data for the year become available, and any payments above costs are required to be returned to the state. The federal spending levels approved by HHS under demonstrations in Florida and Texas for 2012 allowed additional uncompensated care spending that was more than double the amount of

²⁸In addition to obtaining approval to make supplemental payments, both Florida and Texas increased under their demonstrations the use of managed care to deliver Medicaid services. In general, the use of managed care to deliver Medicaid services precludes states from making UPL payments to providers because states are prohibited from making such payments for services provided under a managed care contract. Each state's demonstration allowed the states to continue to make supplemental payments that otherwise would not be allowed. See 42 C.F.R. § 438.60 (2014).

²⁹States were required to issue protocols in advance of payments, subject to CMS approval, that established how hospitals' uncompensated care costs were to be calculated, including allowable costs, such as inpatient and outpatient services, and offsetting revenue.

each state's DSH allotment—the statutory limit on the amount of federal funds a state may receive for hospital uncompensated care that would have applied had the demonstration not been approved.³⁰

Hospitals in Texas receiving incentive payments for health care delivery system improvements under that state's Medicaid demonstration were required to develop an implementation plan and report their progress in meeting designated milestones. To receive the incentive payments, referred to as Delivery System Reform Incentive Payments (Incentive Payments), participating hospitals must develop a plan, subject to CMS and state approval, that identifies the specific projects that they plan to implement, from a menu of options, along with data-driven milestones that hospitals must reach in order to receive full payment. Incentive payments could be made for various projects, such as improving care for patients with certain conditions or increasing delivery system capacity.³¹ The terms and conditions of the demonstration included specific reporting requirements to track incentive payments—for example, reports to CMS that include both hospital-specific incentive payment amounts and summary information about the delivery system improvements the payments incentivized. A March 2015 report conducted for the Medicaid and CHIP Payment and Access Commission found that: comprehensive data was lacking to evaluate the outcomes from state spending on incentive payments, states have pursued incentive payment programs to preserve the federal matching funds from their UPL supplemental payment programs, and supplemental payment spending under

³⁰In addition, although the use of funding for Medicaid demonstrations is based on HHS's determination that the spending is budget neutral to the federal government, we have previously found that for both states HHS did not ensure that the approved demonstration spending was budget neutral. See [GAO-08-87](#) and [GAO-13-384](#).

³¹Specifically, incentive payment projects in Texas were divided into four main categories, with multiple project options within each: (1) Infrastructure development, including options such as expanding primary care capacity and workforce training; (2) Program innovation and redesign, such as expanding the use of medical homes and chronic care management models; (3) Quality improvement, such as implementing projects that address preventable hospital admissions; and (4) Population focused improvements, under which hospitals report progress in required areas, such as reductions in emergency department use.

demonstrations on incentive payments has exceeded prior levels of spending on UPL supplemental payments in some states.³²

Three Selected States Made Supplemental Payments Based on Ability of Hospitals or Local Governments to Finance the Payments; Federal Written Guidance On Appropriate Basis for Such Payments Is Lacking

The bulk of supplemental payments in three of four selected states we reviewed were distributed to hospitals based on the availability of funding from hospital or local government contributions toward the nonfederal share of the payments, rather than the volume of services each hospital provided. We also identified instances in which actual payments to providers were contingent on the availability of such funding. However, CMS has not issued written guidance to articulate and broadly communicate its policy regarding the appropriate basis for states' distribution of supplemental payments or regarding the practice of making payments contingent on the availability of local financing.

Three of Four Selected States Largely Based Their Supplemental Payments on the Availability of Local Financing Rather Than on Medicaid Services Provided

Our review of state documentation shows that in three of four selected states—New Mexico, Texas, and Florida—the bulk of the supplemental payments to hospitals were made contingent on these hospitals or the relevant local governments providing funds to finance the nonfederal share of the payments the hospitals received, rather than Medicaid services they provided. Each of these states had multiple supplemental payment programs—that is, separate payments for different ownership types and categories of service—and the rules regarding which hospitals would receive payments and the amounts of the payments were established through a combination of Medicaid state plan provisions, state administrative code provisions, other state requirements, or, in the case of states operating under Medicaid demonstrations, through the funding protocols approved for the demonstration. Specifically:

³²National Academy for State Health Policy, *State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools*. (Washington D.C.: March, 2015). This report was commissioned by the Medicaid and CHIP Payment and Access Commission.

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- In New Mexico, the amount of a hospital's UPL supplemental payment from two of the five supplemental payment programs in the state was determined by the amount of local government funds provided to finance the nonfederal share. The New Mexico state plan established that, to be eligible for the payments, hospitals must provide a "valid request" to the state Medicaid agency. To be valid, this request had to include a letter from the local government authority indicating its level of financial support, up to a maximum limit, which determined the amount of each hospital's supplemental payment. The state plan section for New Mexico's largest supplemental payment program stated that if the hospital does not submit a valid request, then the hospital is not eligible for a supplemental payment even if the hospital was otherwise eligible. In 2009, a total of about \$207 million of the state's supplemental payments was distributed based on the availability of local funding, and, in 2012, \$233 million in supplemental payments was distributed based on these requirements. In contrast, the state distributed about \$39 and \$38 million in supplemental payments in 2009 and 2012 through three other supplemental payment programs for which the nonfederal share was funded by state revenue, according to state officials. These payment programs distributed payments based on measures related to the purpose of the payments, such as the number of medical residents.
 - In Texas, the state's administrative code specified that payments from the state's three largest UPL supplemental payment programs in 2009 were to be distributed based on the amount of local funding provided. Specifically, the Texas Administrative Code specified that for these supplemental payments the nonfederal share of the payments will be obtained through intergovernmental transfer of public funds and the amount of the payment to the hospital will be calculated in proportion to the amount of the funds transferred by the hospital to the state. In 2009, about \$2.3 billion in supplemental payments was distributed under these three programs.³³¹ The remaining \$100 million in supplemental payments that year was distributed through two smaller, state-funded supplemental payment programs based in part on each hospital's level of Medicaid services provided. In 2012, Texas made two types of supplemental payments under a Medicaid demonstration—uncompensated care payments and incentive

³³¹ Tex. Admin. Code § 355.8068-.8070 (2010). Texas shifted its supplemental payments from the state plan to a demonstration beginning in fiscal year 2012. The state regulations that governed the state's discontinued payment programs are no longer in effect.

payments for health care delivery system improvements—and the terms and conditions of the demonstration established that the nonfederal share for both types of payments would be financed by funds from local government hospitals or local governments, such as counties or hospital districts. The terms established that hospitals receiving payments for uncompensated care costs or incentive payments must be part of an organization called a Regional Healthcare Partnership, which is led by a public hospital or a local governmental entity that provides local funding of the nonfederal share. The local government hospitals or entities were required to submit a plan showing how much funding they could provide, with payment amounts determined by the amount of funds contributed for the nonfederal share.

- In Florida, for most hospitals receiving supplemental payments under its demonstration in 2009 and 2012, supplemental payments were largely distributed based on the availability of funding for the nonfederal share from the local government hospitals or local governments on their behalf. The terms and conditions of the state's Medicaid demonstration established that local government funding was an allowed source of funds for the nonfederal share of the supplemental payments but did not specify how hospitals' payment amounts would be determined. Florida created a complex funding relationship between large public hospitals that funded the entire nonfederal portion of estimated payments (for all hospitals, including those that are not required to fund the nonfederal share) and other hospitals that might receive payments, according to state officials.³⁴ Based on 2012 payment data provided by the state, we found that hospitals that provided intergovernmental transfers of funds for their nonfederal share received significantly more, on average, in total payments than hospitals that were not required to finance the payments. The hospitals providing intergovernmental transfers of funds received supplemental payments equal to the nonfederal share plus a small percentage of the federal share. The state used the

³⁴In Florida, a committee established by the state legislature makes annual recommendations to the state legislature on payment amounts for each hospital, although the legislature is not required to follow the recommendations of the committee. Hospitals receive the amount of funds they provided the state through intergovernmental transfers plus a certain percentage of the federal share, which varies by year (20 percent in 2009, 11 percent in 2012). The remaining amount is divided among hospitals whose percentage of inpatient days represented by Medicaid, charity care, and bad debt equals or exceeds 10 percent.

remaining portion of the federal share to fund the nonfederal share of demonstration supplemental payments for other hospitals—usually smaller, private, or rural hospitals, according to state officials. These other payments were distributed to the hospitals based on factors other than the availability of local funding, such as Medicaid patient volume. In 2009, a total of about \$712 million of the state’s supplemental payments was distributed based on the availability of local funding, and, in 2012, \$823 million in supplemental payments was distributed based on these requirements. In contrast, the state distributed about \$140 million and \$96 million in supplemental payments in 2009 and 2012, respectively, to hospitals that were not required to provide the nonfederal share of the payments.

In contrast to these three states, the fourth state we reviewed, Oklahoma, did not base hospital payment amounts on the availability of local government funds to finance the nonfederal share, according to state officials. The state had multiple supplemental payment programs in which payments were based on hospitals’ Medicaid workload or other factors.³⁵ According to state officials, state general funds were used to finance the nonfederal share for all but one of the state’s supplemental payment programs. For the remaining supplemental payment program, the nonfederal share was financed by revenue from a hospital provider tax, and each hospital’s supplemental payment was based on its relative Medicaid workload.³⁶

In the three states that based supplemental payments on the availability of local funds—Florida, New Mexico, and Texas—we found that over 90 percent of the total amount of supplemental payments in 2009 and 2012 was made based on the availability of local funds to finance the

³⁵Medicaid workload reflects the amount of services the hospital provides to Medicaid patients. It can be measured as the volume of Medicaid patients, Medicaid-covered services, or Medicaid costs per hospital, and each hospital’s totals as a share of state totals.

³⁶This supplemental payment program is called the Supplemental Hospital Offset Payment Program and the state makes payments to two groups of hospitals: Critical Access Hospitals, whose payments are based on hospitals’ Medicaid costs, and all other eligible hospitals (excluding state-owned and -operated and certain specialty and other hospitals), whose payments are allocated to each hospital based on each hospital’s proportional share of total regular claims-based Medicaid payments for all hospitals receiving these payments. The nonfederal share is financed by a 3 percent tax (as of 2015) on net hospital revenue, including Medicaid revenue.

nonfederal share. Specifically, based on our review of state documents governing the distribution of supplemental payments, we found that in 2009, over \$3.2 billion, or 92 percent of the total \$3.5 billion in supplemental payments the three states made that year, was based on the contribution of local funds; in 2012, \$4.9 billion, or 97 percent of the total \$5.0 billion in supplemental payments, was based on the contribution of local funds. The amount and proportion of supplemental payments made by states that were distributed to hospitals based on the availability of local funds varied among the three states, although in each state the large majority of payments was distributed in this manner. (See table 3.)

Table 3: Amount and Percent of Medicaid Supplemental Payments Distributed on the Basis of Local Government Funding of the Nonfederal Share in Three Selected States, 2009 and 2012

State	Year	Amount of supplemental payments distributed on the basis of local government funding (millions of dollars)	Total supplemental payments (millions of dollars)	Percent of supplemental payments distributed based on local funding
Florida	2009	712	852	83.6
	2012	823	919	89.6
New Mexico	2009	207	246	84.0
	2012	233	272	85.9
Texas	2009	2,317	2,417	95.8
	2012	3,839	3,839	100
Total	2009	3,236	3,515	92.0
	2012	4,895	5,030	97.3

Source: GAO analysis of 2009 and 2012 payment data from states. | GAO-16-108

Notes: Florida's supplemental payments were made under a section 1115 demonstration in both 2009 and 2012. New Mexico's supplemental payments were made as UPL payments in both 2009 and 2012. Texas's supplemental payments were made as UPL payments in 2009, and under a section 1115 demonstration in 2012.

Distributing payments only to hospitals that are capable of financing the nonfederal share of the payment can result in payments that are not made to otherwise eligible hospitals that lack the ability to finance the expected nonfederal share of the payment, or to obtain local government support for such financing. Because most of the supplemental payments to hospitals in the three states were made to hospitals only if there was local funding to support the nonfederal share of the payment, some hospitals that would otherwise have been eligible for the payments did not receive them. We found examples in New Mexico and Texas of hospitals that did not receive a payment, or received a smaller payment, because the hospital or local government did not provide an intergovernmental

transfer of funds, or provided a smaller contribution to the nonfederal share than expected. For example, several hospitals in New Mexico received no UPL supplemental payment, or smaller supplemental payments than usual, from the state in 2012 because of the inability of certain local counties to provide the nonfederal share.³⁷ In Texas, there have been several hospitals each year that did not receive a payment, or received a partial payment, due to their lack of local funds to provide a contribution to the nonfederal share, according to Texas Medicaid officials. In 2009, when Texas was still making UPL supplemental payments to rural hospitals, there were 18 rural hospitals that were otherwise eligible for the payments but that did not receive a payment because, according to state officials, local funding was not provided for the nonfederal share.³⁸ In 2012, after Texas converted its supplemental payments to a demonstration, there were 7 hospitals for which the state did not make a demonstration supplemental payment for uncompensated care because, according to state officials, these hospitals did not provide local funding for the nonfederal share.

This method of distributing payments may also result in payments that are not necessarily aligned with the level of hospitals' low-income patient workloads, as measured by their hospitals' patient volume or costs associated with serving low-income or uninsured individuals. In the case of demonstration supplemental payments for hospitals' Medicaid and uninsured uncompensated care costs, some hospitals with large uncompensated costs associated with serving the Medicaid and low-income population received relatively little in demonstration supplemental payments for uncompensated care. Other hospitals with relatively low

³⁷According to state officials, the counties' lack of funds stemmed from concerns CMS had with the state's use of funds from certain private hospitals to finance the nonfederal share of supplemental payments provided under New Mexico's Sole Community Provider program. Federal law restricts the use of provider donations to finance the nonfederal share. CMS required the state to end the use of private donations, and required the state to return the federal share of payments that had been funded by private donations, according to agency officials. State officials told us that the counties now provide the nonfederal share, as is typically the case in New Mexico. The counties were required to pay back a portion of the federal funds that were drawn down based on impermissible private donations, and they redirected local funds to pay back the federal funds, which in turn reduced or eliminated the funding they could dedicate to the nonfederal share of continued payments, according to CMS officials. As a result, several hospitals received no payment or a smaller payment than expected.

³⁸Rural public hospitals in Texas were eligible to receive supplemental payments under the state plan if they were located in a county of less than 100,000 population.

uncompensated care costs received large supplemental payments relative to those costs. Still others received uncompensated care payments under the Medicaid demonstration even though they had no uncompensated care costs before receiving the payment. For example:

- In 2012, one hospital in Florida had about \$352 million in uncompensated care costs and received \$384 million in demonstration supplemental payments for those costs, for which local funding of the nonfederal share was provided on the hospital's behalf, in addition to \$77 million in DSH payments. In contrast, another hospital with about \$121 million in uncompensated care costs—which was the fourth-highest amount of uncompensated care costs among hospitals that year—had no local funding provided on its behalf and received no such payments.
- In 2012, among Texas hospitals that had uncompensated Medicaid and uninsured costs and were eligible to receive a demonstration supplemental payment for uncompensated care, the extent to which the hospitals' uncompensated care costs were covered by the payments varied widely based on the availability of local funding, from 0 percent for the 7 hospitals that were otherwise eligible but did not receive a payment, to more than 100 percent for 44 other hospitals, based on data provided by the state.

CMS Has Not Clearly or Broadly Communicated Written Guidance to Clarify Its Policy Regarding the Appropriate Distribution of Supplemental Payments

CMS guidance regarding the basis on which states can distribute both demonstration and UPL supplemental payments is lacking. CMS has not issued written guidance articulating its policy regarding appropriate bases for making such payments to ensure they are linked to Medicaid purposes.³⁹ While CMS has recently acted to curtail one state's demonstration supplemental payments because the state based the payments on the availability of local financing, it has not taken steps to clarify and broadly communicate to all states guidance regarding appropriate payment distribution methodologies. Specifically, in April of 2015, CMS sent a letter to Florida raising concerns about the state's demonstration supplemental payments, including concerns that the state's supplemental payments were being distributed based on access to

³⁹Federal standards for internal control of an agency's operations stress that in addition to the need for effective internal communications within an agency, management should also ensure there are adequate means of communicating with external stakeholders that may have a significant impact on the agency's achieving its goals. See [GAO/AIMD-00-21.3.1](#).

local government funds and not distributed based on services provided to Medicaid patients. In a May 2015 letter, CMS stated that it will work with the state to develop a distribution methodology for demonstration supplemental payments that more closely aligns with providers' roles in serving the Medicaid population and in providing other uncompensated care authorized under the demonstration. Florida officials told us that CMS officials worked closely with the state to develop a distribution methodology that ensured the payments were not contingent on local financing and were made only for covered demonstration services, including raising regular payment rates for all hospitals and reducing the size of the supplemental payments that were targeted to those hospitals financing the nonfederal share.

According to CMS officials, the May 2015 letter represents a developing national policy regarding demonstration supplemental payments—that is, that they should be based on the provision of services to Medicaid and uninsured individuals rather than on the availability of local funding. CMS stated that it had contacted affected states with demonstrations that include supplemental payments for uncompensated care to articulate the policy principles the agency would use when reviewing the states' demonstrations for potential renewal. CMS also said it articulated the types of independently conducted impact analyses and information that a state would need to provide, as part of any request to renew the demonstration, in order for CMS to assess the role supplemental payments had in promoting Medicaid objectives. Apart from communicating directly with these states, CMS's communication of its policy at a national level has consisted of posting the Florida letter on its website. CMS officials have not said whether they plan to issue guidance more broadly that would provide clarity around its policy and how it is applied for all states, including states that may be contemplating seeking demonstration authority for similar arrangements.

For UPL supplemental payments made under state Medicaid plans rather than demonstrations, CMS officials also told us that the agency has not issued guidance on how states should distribute these payments. Although CMS has not issued guidance to the states, CMS officials told us that, when approving state plan provisions, they expect states to include a Medicaid metric, such as Medicaid volume, in their supplemental payment distribution methodology. CMS officials told us the agency plans to issue a proposed rule later in the spring of 2016 to

specify appropriate methodologies for state distribution of UPL supplemental payments to ensure the payments are consistent with economy and efficiency.⁴⁰ Because the proposed rule was under development as of December 2015, details regarding the payment distribution methodologies that will be articulated in the rule were not available at the time of our review.⁴¹

CMS also lacks guidance regarding how states demonstrate that supplemental payments are not contingent on the availability of local financing. CMS officials told us that the agency interprets federal law and regulation as prohibiting states from making payments contingent on the availability of local funding. In particular, federal law requires a state plan to provide assurances that a lack of funds from local sources to finance the nonfederal share will not result in lowering the amount, duration, scope, or quality of Medicaid services provided under the plan in any part of the state.⁴² Officials told us that in reviewing state plan amendments, they require states to remove language that would make providers' receipt of a payment contingent on local funding of the nonfederal share. However, as shown by our review, there are instances in which supplemental payments to providers under state plans are being made contingent on the availability of local financing, suggesting that states lack a common understanding of CMS's interpretation of the law as prohibiting this practice. According to CMS officials, the agency has not issued written guidance articulating to states that payments should not be contingent on the availability of local funds. Officials said the agency instead instructs states to remove contingent financing language from

⁴⁰CMS's plans to issue a proposed rule are set forth in the *Spring 2015 Unified Agenda of Federal Regulatory and Deregulatory Actions (Unified Agenda)*, which identifies the rulemakings that are planned or underway throughout the federal government. See *Spring 2015 Unified Agenda of Federal Regulatory and Deregulatory Actions*, Department of Health and Human Services, Medicaid State Payment Adjustment (CMS-2393-P), RIN 0938-AS61, accessed November 2, 2015, <http://www.reginfo.gov>.

⁴¹According to the *Unified Agenda*, the proposed rule under development "would require all supplemental payments be distributed proportional to the volume or cost of services delivered or be tied to meeting performance benchmarks, place a time limit on all supplemental payments, and require States to report additional details regarding supplemental payments when submitting claims of State Medicaid expenditures for Federal Financial Participation to provide a consistent and comprehensive data source by which the benefit or the value added to the Medicaid program can be assessed."

⁴²42 U.S.C. § 1396a(a)(2). Federal regulations mirror the statutory prohibition. See 42 C.F.R. § 433.53(c)(2) (2014).

their state plans. CMS officials stated that they would expect providers to alert them if payments are not sufficient to ensure access and providers have generally not done so.

The absence of written guidance to states is inconsistent with federal standards for internal control. Specifically, federal information and communications standards state that for an entity to run and control its operations, it must have relevant, reliable, and timely communications relating to internal as well as external events. Information is needed throughout the agency to achieve all of its objectives, and effective communication should occur in a broad sense, with information flowing down, across, and up the organization.⁴³ In addition to internal communications, management should ensure there are adequate means of communicating with, and obtaining information from, external stakeholders who may have a significant impact on the agency achieving its goals. The lack of guidance may result in inconsistent application of CMS's policy among states with overpayments to some providers and underpayments to others due to the unavailability of local funding.

Conclusions

Under broad federal requirements, Medicaid payments are to be made for Medicaid-covered services delivered to Medicaid beneficiaries and should be economical and efficient and sufficient to ensure beneficiaries' access to care. States are not required to limit their hospital payments to hospitals' costs, and we have previously found that CMS lacks criteria to determine when payments to individual providers, such as hospitals, are economical and efficient. This review illustrates further concerns with CMS oversight, as states have made extremely large supplemental payments that resulted in total Medicaid payments well in excess of Medicaid costs and allowed for significant hospital spending on equipment, construction projects, and services not directly related to Medicaid. This can be partly attributed to the fact that CMS has not issued guidance to clearly articulate its policy for states on how they should be distributing supplemental payments or that payments should not be contingent on the availability of financing for the nonfederal share. As a result, CMS cannot ensure that states' payments are based on the provision of Medicaid services or for demonstration purposes, and not based on the availability of provider and local government financing.

⁴³ [GAO/AIMD-00-21.3.1](#).

Lacking guidance from CMS, states have distributed supplemental payments to hospitals based on the availability of hospital and local government contributions and, in some cases, have reduced or not made payments to providers that were unable to provide the expected nonfederal share. The absence of CMS guidance around how to distribute Medicaid supplemental payments may be leading to inconsistent application among states and the distribution of supplemental payments that are counter to agency policies, resulting in some providers for which local financing was provided being overpaid while others for which local financing was not available being underpaid relative to the Medicaid services they provide.

Recommendations for Executive Action

To promote consistency in the distribution of supplemental payments among states and with CMS policy, we recommend that the Administrator of CMS take the following two actions:

- (1) issue written guidance clarifying its policy that requires a link between the distribution of supplemental payments and the provision of Medicaid-covered services, and
- (2) issue written guidance clarifying its policy that payments should not be made contingent on the availability of local funding.

Agency Comments

We received written comments on a draft of this report from HHS, which are reprinted in appendix I. In its comments, HHS concurred with the first recommendation and agreed with our concerns regarding the second recommendation.

HHS concurred with our recommendation to clarify in written guidance the agency's current policy that supplemental payments support the provision of services to Medicaid and low-income uninsured individuals. HHS cited the rule it plans to propose in the spring of 2016 that would set forth additional requirements to ensure that supplemental payments are consistent with the statutory principles of economy, efficiency, and quality of care. HHS also noted that it has begun an effort to apply its demonstration supplemental payment policy principles to the approval of demonstrations that contain such payments for uncompensated care, which it has communicated to Florida and other affected states. CMS did not comment that it planned to more broadly communicate guidance regarding its policy to all states.

In responding to the second recommendation, HHS agreed that the issue of Medicaid supplemental payments being contingent on the availability of local funding is a concern. HHS also referenced its plans to issue a proposed rule in spring of 2016 and indicated that the rule will highlight the issue. Although HHS did not explicitly concur with the recommendation, HHS did state it is considering additional options to address the issue.

We encourage HHS, in light of our report findings and recommendations, to issue explicit guidance on these two issues.

HHS also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of the report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human 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 staffs have any questions about this report, please contact me at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of the report. GAO staff who made key contributions to this report are listed in appendix II.



Katherine M. Iritani
Director, Health Care

Appendix I: 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

JAN 12 2016

Katherine Iritani
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments*" (GAO-16-108).

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

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: FEDERAL GUIDANCE NEEDED TO ADDRESS CONCERNS ABOUT DISTRIBUTION OF SUPPLEMENTAL PAYMENTS (GAO-16-108)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS takes seriously its responsibility for the accountability, fiscal integrity, and funding of the Medicaid program.

The Medicaid program plays a critical role in achieving one of the Affordable Care Act's (ACA) core goals: reducing the number of uninsured Americans by providing affordable, high-quality health coverage. Since Medicaid expansion has taken effect, Medicaid enrollment has grown from 57.8 million enrollees to 72.3 million enrollees in August 2015, which represents over 20 percent growth in enrollment.

Within broad federal requirements, each State administers and operates its Medicaid program in accordance with a State Medicaid Plan, which must be approved by HHS. A State Medicaid plan details the populations that are served, the categories of services that are covered, and the methods of calculating payments to providers. The State Medicaid plan also describes the supplemental payments established by the State and specifies which providers are eligible to receive supplemental payments and what categories of services are covered. States may also receive approval from HHS for a waiver from certain Medicaid requirements in order to conduct a Medicaid demonstration under section 1115(a) of the Social Security Act (section 1115 demonstration), and these demonstrations may include supplemental payments. These section 1115 demonstrations give States additional flexibility to design and evaluate innovative policy approaches to improve their Medicaid programs, including expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible, authorizing different provider payment methodologies, and using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

HHS has taken several steps over the past few years to improve the transparency of supplemental payments. Beginning in 2013, HHS began collecting annual Upper Payment Limit (UPL) data, which includes provider specific information. This data improves the ability of HHS to review States' payment methodologies to determine compliance with statutory and regulatory requirements, and to determine if additional information or justification is needed to establish compliance. In addition, HHS has enlisted the resources of a contractor to help organize the data in order to inform future policy directions.

To further improve the accountability and transparency of supplemental payments, HHS has placed objectives for a potential notice of proposed rulemaking (NPRM) onto the Unified Agenda of Federal Regulatory and Deregulatory Actions. The proposed rule under development would set forth additional requirements to ensure supplemental payments made for all Medicaid services are consistent with principles of efficiency, economy, and quality of care. In addition, HHS has implemented several changes in its review procedures, reflected in new regulations to enhance transparency of section 1115 demonstrations, including posting on its website for public access all section 1115 demonstration applications, approvals, and special terms and conditions. HHS has also provided guidance to States regarding policies to ensure that supplemental payments authorized under section 1115 demonstration projects are consistent with the objectives of the Medicaid program. In May of 2015, CMS issued a letter to the State of Florida, which was posted publicly and shared with other States, which provided guidance on the

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principles HHS would use to assess Florida's request to extend and amend the low income pool (LIP) supplemental payment program under its section 1115 demonstration. This letter describes three principles applicable to HHS' review of proposals relating to uncompensated care pools authorized under section 1115 demonstrations. The three principles are: (1) health coverage is the best way for low income individuals to access health care and uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion; (2) Medicaid payments should support the provision of services to Medicaid beneficiaries and low-income uninsured individuals; and (3) provider payment rates must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care. In addition to sharing Florida's letter with other affected States when it was issued in May 2015, CMS issued similar letters in November 2015 reiterating the same principles to the remaining States with uncompensated care supplemental payment programs under section 1115 demonstrations.

Policies regarding the accountability of supplemental payments are an important HHS priority. HHS has taken steps to make sure these payments appropriately serve the Medicaid population and other low-income beneficiaries, and foster innovative service delivery systems that improve care, increase efficiency, and reduce costs. We look forward to working with GAO on these issues.

GAO Recommendation

The Government Accountability Office (GAO) recommends that the Administrator of the Centers for Medicare & Medicaid Services (CMS) issue written guidance clarifying its policy that requires a link between the distribution of supplemental payments and the provision of Medicaid-covered services.

HHS Response

HHS concurs with GAO's recommendation. CMS has taken into consideration previous GAO reports on supplemental payments in guiding refinements to the program. Currently, the distribution of supplemental payments approved in the State Medicaid plan must be tied to the provision of Medicaid services. Consistent with GAO's recommendation, CMS has publicly communicated, on its website, its principles regarding future approval of supplemental payments as part of section 1115 demonstrations, one of which is that these payments be used to support services provided to Medicaid beneficiaries and low-income uninsured individuals. CMS has specifically communicated these principles to affected States.

GAO Recommendation

The Government Accountability Office (GAO) recommends that the Administrator of the Centers for Medicare & Medicaid Services (CMS) issue written guidance clarifying its policy that payments should not be made contingent on the availability of local funding.

HHS Response

CMS agrees that payments being made contingent on the availability of local funding continues to be concerning and appreciates the GAO's efforts in this area. As mentioned in the report, CMS plans to issue a proposed rule later in calendar year 2016 which will highlight the impact of

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local funding on supplemental payments and is considering additional options to address this issue. Similarly, in Medicaid managed care delivery systems, CMS is concerned about payments being made contingent on the availability of local funding. In the CMS managed care notice of proposed rulemaking (CMS-2390-P, FR 31098), CMS proposed to: 1) maintain the prohibition on States' ability to condition incentive arrangements with managed care organizations on intergovernmental transfer agreements; and 2) not permit states to require managed care organizations to implement provider incentives or value-based purchasing arrangements that are conditioned on provider-based intergovernmental transfer agreements.

In addition, CMS will not approve a State plan amendment (SPA) that expressly provides payments to providers that are contingent on local funding of the non-federal share. Such an arrangement would not be consistent with section 1902(a)(2) of the Social Security Act. To determine compliance with section 1902(a)(2) of the Social Security Act, CMS requires that States include details regarding the source of the required non-federal share of the proposed payments during the SPA process. The non-federal share may be financed in a variety of ways such as through intergovernmental transfers (IGTs) or from health care-related taxes. However, once the SPA is approved, States are required to make supplemental payments to providers regardless of the availability of local revenue to fund the non-federal share.

Appendix II: GAO Contact and Staff Acknowledgments

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Staff Acknowledgments

In addition to the contact named above, Tim Bushfield, Assistant Director; Christine Davis; Iola D'Souza; Sandra George; Laurie Pachter; Ashley Nurhussein; and Perry Parsons made key contributions to this report.

Related GAO Products

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