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MEDICAID

States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight

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Highlights of [GAO-05-836T](#), a testimony before the Committee on Finance, U.S. Senate

MEDICAID

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Why GAO Did This Study

Medicaid—the federal-state health care financing program covering almost 54 million low-income people at a cost of \$276 billion in fiscal year 2003—is by its size and structure at significant risk of waste and exploitation. Because of challenges inherent in overseeing the program, which is administered federally by the Centers for Medicare & Medicaid Services (CMS), GAO added Medicaid to its list of high-risk federal programs in 2003. Over the years, states have found various ways to maximize federal Medicaid reimbursements, sometimes using consultants paid a contingency fee to help them do so.

From earlier work and a report issued today (GAO-05-748), GAO's testimony addresses (1) how some states have inappropriately increased federal reimbursements; (2) some ways states have increased federal reimbursements for school-based Medicaid services and administrative costs; and (3) how states are using contingency-fee consultants to maximize federal Medicaid reimbursements and how CMS is overseeing states' efforts.

What GAO Recommends

GAO recommends that CMS improve oversight of contingency-fee projects and states' reimbursement-maximizing methods. Although CMS believes its recent initiatives substantially respond to the recommendations, GAO maintains that additional actions are needed.

www.gao.gov/cgi-bin/getrpt?GAO-05-836T.

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.

What GAO Found

For many years, GAO has reported on varied financing schemes and questionable methods used by states to increase the federal reimbursements they receive for operating their state Medicaid programs. These schemes and methods can undermine Medicaid's federal-state partnership and threaten its fiscal integrity. For example:

- Some states make large supplemental payments to government-owned or government-operated entities for delivery of Medicaid services while requiring these entities to return the payments to the state. This process creates the illusion of valid expenditures in order to obtain federal reimbursement, effectively shifting a portion of the state's share of program expenditures to the federal government and increasing the federal share beyond that established by formula under law.
- Medicaid funding is available for local school districts for certain health services for eligible children and for administrative costs. To claim increased federal Medicaid reimbursement, however, some states and school districts have used methods lacking sufficient controls to ensure that claims were legitimate. GAO also found funding arrangements among schools, states, and private consulting firms where some states retained up to 85 percent of reimbursements for administrative costs. In some cases, school districts paid contingency fees to consultants.

A growing number of states are using consultants on a contingency-fee basis to maximize federal Medicaid reimbursements. As of 2004, 34 states—up from 10 states in 2002—used contingency-fee consultants for this purpose. GAO identified claims in each of five categories of claims (see table) from contingency-fee projects that appeared to be inconsistent with current CMS policy, inconsistent with federal law, or that undermined the fiscal integrity of the Medicaid program. Problematic projects often were in categories where federal requirements were inconsistently applied, evolving, or not specific. CMS has taken steps to improve its fiscal management of Medicaid, but a lack of oversight and clear guidance from CMS has allowed states to develop new financing methods or continue existing ones that take advantage of ambiguity and generate considerable additional federal costs.

Five Categories of Medicaid Claims Reviewed by GAO

Category of claims	Service
Supplemental payment arrangements	Payments to a class of health care providers, such as nursing homes, up to a predefined limit
School-based services	Medicaid-covered medical services provided by schools, such as diagnostic screening or physical therapy, or the administrative cost of providing these services
Targeted case management services	Services to help a defined group of beneficiaries gain access to needed medical, social, educational, and other services
Rehabilitation services	Services to reduce a mental or physical disability and restore an individual to the best possible functional level
Administrative costs	Costs the states incur in administering their Medicaid programs

Source: GAO based on CMS information.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you explore issues relating to states' efforts to maximize federal Medicaid reimbursements and how they can affect the Medicaid program. Medicaid—the federal-state program financing health care for certain low-income children, families, and individuals who are aged or disabled—covered nearly 54 million people at an estimated total cost of \$276 billion in federal fiscal year 2003. 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. Congress has structured Medicaid as a shared financial 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.¹ 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 within broad federal guidelines. We have previously reported that the challenges inherent in overseeing a program of Medicaid's size, growth, and diversity put the program at high risk for waste, abuse, and exploitation. In 2003, we added Medicaid to our list of high-risk federal programs.²

States can design and administer their Medicaid programs in a manner that helps them ensure that they receive the maximum allowable federal share of expenditures they incur for covered services provided to eligible beneficiaries under a CMS-approved state Medicaid plan, as long as they do so within the framework of federal law, regulation, and CMS policy. To that end, states can employ consultants to assist them in performing a number of valid Medicaid-related functions that may help them to identify and implement ways to obtain additional federal funds or that may help save money for both the federal government and states. Consultants, for example, can help identify claims that are inappropriately paid or that are

¹By a formula established in law, the federal government matches from 50 to 83 percent of each state's reported Medicaid expenditures for medical assistance. States with lower per capita incomes receive higher federal matching rates. The federal government also matches states' costs for administering the Medicaid program, generally at 50 percent.

²GAO, *Major Management Challenges and Program Risks, Department of Health and Human Services*, GAO-03-101 (Washington, D.C.: January 2003).

subject to recovery from other payers.³ States may choose to pay consultants on a contingency-fee basis (that is, a percent of the additional federal reimbursements they generate for the state) to develop various types of reimbursement-maximizing projects.⁴ In the current environment of steadily rising Medicaid costs straining federal and state budgets, states' use of contingency-fee consultants to maximize federal reimbursement can be problematic if controls are inadequate to ensure that additional federal reimbursements are allowable Medicaid expenditures. We have earlier reported on (1) certain types of financing schemes that involved some states making illusory payments to government-owned or government-operated entities such as nursing homes or hospitals, often through a mechanism known as intergovernmental transfers (IGTs),⁵ to obtain increased federal reimbursements and (2) concerns with practices used by states and school districts to boost federal payments for school-based services.⁶ As part of our body of work on Medicaid financing issues, today we are releasing a report, undertaken at the Chairman's request, that addresses states' use of contingency-fee consultants to maximize federal Medicaid reimbursements.⁷

For today's hearing, you asked us to address issues we have identified in our past and current work concerning some reimbursement-maximizing strategies used by some states and CMS's oversight of them. In my testimony, I will describe: (1) how, over the years, some states have

³Consultants can provide a wide range of services to states for their Medicaid programs. States that lack sufficient in-house resources can turn to consultants to add staff or needed expertise. Contingency-fee consultants are particularly attractive to budget-constrained states because the states do not need to pay them up front. Consultants can help states by performing services such as identifying new methods or projects to maximize federal Medicaid reimbursements, training state and local staff in procedures for documenting and submitting claims, and preparing state claims for federal Medicaid reimbursement.

⁴Contingency fees generally cannot be claimed for federal Medicaid reimbursement, unless a contingency-fee contract (1) results in cost-avoidance savings or recoveries in which the federal government would share, (2) is competitively procured, and (3) the savings upon which the contingency-fee payment is based are adequately defined and the payments documented to CMS's satisfaction.

⁵Intergovernmental transfers are a tool that state and local governments use to carry out their shared governmental functions, such as collecting and redistributing revenues to provide essential government services.

⁶See related GAO products at the end of this statement.

⁷GAO, *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, [GAO-05-748](#) (Washington, D.C.: June 28, 2005).

inappropriately increased federal reimbursements, sometimes using IGTs, through varied state financing schemes; (2) how states have used questionable methods to increase federal reimbursements for school-based Medicaid services and administrative costs and the status of CMS's actions to improve oversight in this area; and (3) how states are using contingency-fee consultants to maximize federal Medicaid reimbursements and how CMS oversees states' reimbursement-maximizing strategies. My testimony is based on several previous reports and testimonies, including the report we are issuing today, assessing states' Medicaid financing methods and federal oversight of them. The work that produced these reports and testimonies was conducted from June 1993 through June 2005 in accordance with generally accepted government auditing standards.

In summary, for many years we have reported on the varied financing schemes and questionable methods that states have used to increase the federal reimbursements they receive for operating their state Medicaid programs. In our view, these methods can undermine the Medicaid federal-state partnership and threaten the fiscal integrity of the program. We previously reported that:

- Some states have used IGTs to make large supplemental payments to government-owned or government-operated providers, which have greatly exceeded the established Medicaid payment rates. Such supplemental payments create the illusion of valid expenditures for services delivered to Medicaid beneficiaries and allow states to obtain the federal reimbursement, only to have the local government providers, under agreements with the states, transfer the excessive federal and state payments back to the state. As a result, some states are able to shift a portion of their share of program expenditures to the federal government, essentially increasing the federal matching rate beyond that established under federal law.
- Some states and school districts have used questionable methods to increase federal Medicaid reimbursement for Medicaid health services and administrative costs, that is, methods that lacked sufficient controls to ensure that the claims were legitimate. Medicaid funding is available for certain health services provided by local school districts, such as diagnostic screening and physical therapy for eligible children, including those with disabilities. Medicaid reimbursement is also available for the administrative costs of providing school-based Medicaid services. We found funding arrangements in some states among schools, states, and private consulting firms that resulted in schools' receiving a small portion

of the Medicaid reimbursements, while some states retained up to 85 percent of Medicaid reimbursements for school-based health services or administrative claims. Moreover, some school districts paid contingency fees to the private consultants who assisted them in preparing and submitting Medicaid claims, further reducing the net amount the schools received.

As we are reporting today, a growing number of states are using consultants on a contingency-fee basis to maximize federal Medicaid reimbursements. As of 2004, 34 states—up from 10 states in 2002—used contingency-fee consultants for this purpose. We identified some claims from contingency-fee projects that appear to be inconsistent with current CMS policy and some that were inconsistent with federal law; we also found claims that undermined the fiscal integrity of the Medicaid program. In Georgia and Massachusetts, where we focused our review of specific projects, selected projects that involved the assistance of contingency-fee consultants generated a significant amount of additional federal reimbursements for the states: from fiscal year 2000 through 2004, an estimated \$1.5 billion for Georgia and nearly \$570 million for Massachusetts. For those additional reimbursements, Georgia paid its consultant about \$82 million in contingency fees, and Massachusetts paid its consultants about \$11 million in contingency fees. Just to be clear: any state's use of consultants—including contingency-fee consultants—or any associated growth in federal reimbursements, is not problematic, in and of itself. However, we identified concerns in each of the five categories of claims where we reviewed the states' contingency-fee projects: supplemental payment arrangements, school-based services, targeted case management, rehabilitation services, and administrative costs, in either Georgia, Massachusetts, or both states. We found that problematic projects often tended to be in areas of Medicaid claims where federal requirements were inconsistently applied, evolving, or not specific. The lack of clear CMS guidance has allowed states to develop new financing arrangements, or to continue existing ones, that take advantage of ambiguity and result in considerable additional costs to the federal government.

We believe that the continuing problems we have reported in several high-risk categories of Medicaid claims illustrate not only the need to improve oversight of claims stemming from contingency-fee projects, but also the urgent need for CMS to address certain issues in its overall financial management and oversight of Medicaid. In our report issued today, we are reiterating certain recommendations we have previously made to Congress and to the Administrator of CMS that remain open, as well as new ones to

the Administrator to improve the financial management and oversight, and fiscal integrity, of the Medicaid program.

In commenting on a draft of the report issued today, CMS stated that it has already substantially met our recommendations. While acknowledging that improper Medicaid payments had unquestionably occurred, the agency provided detailed information to support why it believes that it (1) was already aware of the concerns identified in projects we examined and (2) has taken sufficient action to address these concerns and our related GAO recommendations. In our view, however, CMS has not sufficiently identified or addressed the concerns that we identified, and we believe CMS needs to do more to identify problematic claims resulting from contingency-fee projects sooner, before large reimbursements have been made to states. We continue to believe that CMS needs to do more to clarify, communicate, and consistently apply its policies concerning certain high-risk areas of the Medicaid program.

Background

Title XIX of the Social Security Act⁸ authorizes federal funding to states for Medicaid, which finances health care for certain low-income children, families, and individuals who are aged or disabled. Although states have considerable flexibility in designing and operating their Medicaid programs, they must comply with federal requirements specified in Medicaid statute and regulation. For example, states must provide methods to ensure that payments for services are consistent with economy, efficiency, and quality of care.⁹ Medicaid is an entitlement program: 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.

Our prior and current work addresses five categories of Medicaid claims where we are aware that states have reimbursement-maximizing strategies. Our current work in particular concentrated on these five categories because—on the basis of factors such as nationwide growth in dollars claimed, the results of our past reviews, and work by HHS's Office of Inspector General (OIG) to assess the appropriateness of claims in these categories—we judged them to be of particularly high risk. Over the

⁸42 U.S.C. §§ 1396, et seq. (2000).

⁹42 U.S.C. § 1396a(a)(30) (2000).

past few years, states' claims in some of these categories have grown significantly in dollar amounts. The five categories of claims we examined, and recent trends in claimed expenditures, are described in table 1.

Table 1: Five Categories of Medicaid Claims Reviewed by GAO Where States Are Maximizing Federal Medicaid Reimbursements and Trends in Reported Expenditures

Category of Medicaid claims	Trends in reported expenditures
<p>Supplemental payment arrangements: A common supplemental payment arrangement is known as the upper payment limit, or UPL, arrangement. UPL is the upper bound on what the federal government will pay as its share of Medicaid costs; it is the federal government's way of placing a ceiling on federal financial participation in a state's Medicaid program. UPLs are tied to the methodology that Medicare, the federal health care program that covers seniors aged 65 and older and some disabled persons, uses to pay for comparable services. The rates that states pay their Medicaid service providers are often lower than the federal Medicare rates to which Medicaid UPL rates are tied. Thus, a gap often exists between the amount states actually spend to provide services to Medicaid beneficiaries and the Medicare-based UPLs. States can obtain additional federal funding for the amount under the UPL ceiling by making supplemental payments to a class of providers, such as nursing homes or hospitals.</p>	<p>Federal and state UPL expenditures through all UPL arrangements grew from an estimated \$10.3 billion in 28 states in fiscal year 2000 to \$11.2 billion in 45 states in fiscal year 2004. During this time period, Congress and CMS acted to limit excessive UPL arrangements and associated claims.^a</p>
<p>School-based services: Schools can help identify Medicaid-eligible low-income children, facilitate their enrollment in Medicaid, and provide them certain Medicaid-covered services. When Medicaid-eligible children receive Medicaid services—such as diagnostic screening or physical therapy—through the school system, states can use their Medicaid programs to pay for these services. School districts may also receive Medicaid reimbursement for the administrative costs of providing school-based Medicaid services.</p>	<p>For fiscal years 2002 through 2003, combined federal and state spending on school-based services grew 8 percent nationwide, from \$1.97 billion to \$2.13 billion. Nationwide, more than \$900 million (federal and state) went toward school-based administrative costs in both fiscal years 2002 and 2003.</p>
<p>Targeted case management services (TCM): Case management helps beneficiaries gain access to needed medical, social, educational, and other services and coordinates beneficiaries' use of providers. TCM enables states to provide case management services to a defined group or groups of Medicaid-eligible individuals without providing the same service to all Medicaid beneficiaries statewide, as normally required by Medicaid law. Current CMS policy does not allow federal Medicaid reimbursement for TCM services provided by the state if those services are "an integral component" of an existing state program.^b</p>	<p>For fiscal years 1999 through 2003, combined federal and state spending for Medicaid TCM services increased by 76 percent, from \$1.7 billion to \$3 billion.</p>
<p>Rehabilitation services: Rehabilitation services are intended for the maximum reduction of a physical or mental disability and to restore an individual to the best possible functional level. Covered services may include occupational and physical therapy, mental health services, and treatment for addiction. The benefit is optional, that is, state Medicaid programs are not required to cover the service but may do so at their own option.</p>	<p>Because rehabilitation services are not reported separately in CMS expenditure reports, the trend in expenditures for these services is unknown.</p>
<p>Administrative costs: The federal government reimburses states, generally at 50 percent, for their costs of administering their Medicaid programs. To determine which administrative costs the state can attribute to Medicaid, states submit a cost allocation plan for HHS approval.^c This plan establishes the methods the state will use to distribute its administrative costs—such as employee time and costs related to providing services to both Medicaid-eligible and non-Medicaid-eligible individuals—across different funding sources.</p>	<p>For fiscal years 1999 through 2003, combined federal and state spending for the states' Medicaid administrative costs grew 37 percent, from \$9.5 billion to \$13.0 billion.^d</p>

Source: GAO.

^aFor example, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 directed CMS to issue a final regulation to limit states' ability to claim excessive federal reimbursements through UPL supplemental payments.

^bCMS recently reiterated this policy in a 2004 Administrator's decision that denied approval of a state plan amendment requested by Maryland to provide TCM services to children in the state's foster care program. See CMS, *Disapproval of Maryland State Plan Amendment No. 02-05*, Docket No. 2003-02 (Aug. 27, 2004). The Administrator's decision was based in part on a statement in the legislative history accompanying the legislation authorizing coverage for TCM services that payment for TCM services must not duplicate payments to public agencies or private entities under other program authorities. See H.R. Rep. No. 99-453, at 546 (1985). We did not evaluate the legal basis for CMS's policy as part of this review.

^cUnlike CMS's direct review and approval role for states' Medicaid plan amendments, CMS has an advisory review role for the plans that state Medicaid agencies prepare for allocating their administrative overhead costs; at the national level, HHS's Division of Cost Allocation instead takes the lead in reviewing these cost allocation plans. The division generally distributes copies of cost allocation plan sections to affected federal agencies, including CMS, for comment.

^dThese figures include costs associated with school-based administration.

States Have Used Intergovernmental Transfers to Facilitate Financing Schemes That Inappropriately Increase Federal Medicaid Reimbursements

For many years, states have used varied financing schemes, sometimes involving IGTs, to inappropriately increase federal Medicaid reimbursements. 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 transactions create the illusion of valid expenditures for services delivered by local-government providers to Medicaid-eligible individuals and enable states to claim large federal reimbursements. 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 for non-Medicaid purposes.

As various schemes involving IGTs have come to light, Congress and CMS have taken actions to curtail them, but as one approach has been restricted, others have often emerged. Table 2 describes some of the states' financing schemes over the years and how Congress and CMS have responded to them.

Table 2: Medicaid Financing Schemes Used to Inappropriately Generate Federal Reimbursements 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	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, *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes*, GAO-04-574T (Washington, D.C.: Mar. 18, 2004). Before June 2001, CMS was known as the Health Care Financing Administration (HCFA).

A leading variant of these illusory financing arrangements today involves states' taking advantage of Medicaid's upper payment limit (UPL) provisions. Although states are allowed, under law and CMS policy, to claim federal reimbursements for supplemental payments they make to providers up to the UPL ceilings, we have reported earlier that payments in excess of the provider's costs that are not retained by the provider as reimbursement for services actually provided are inconsistent with

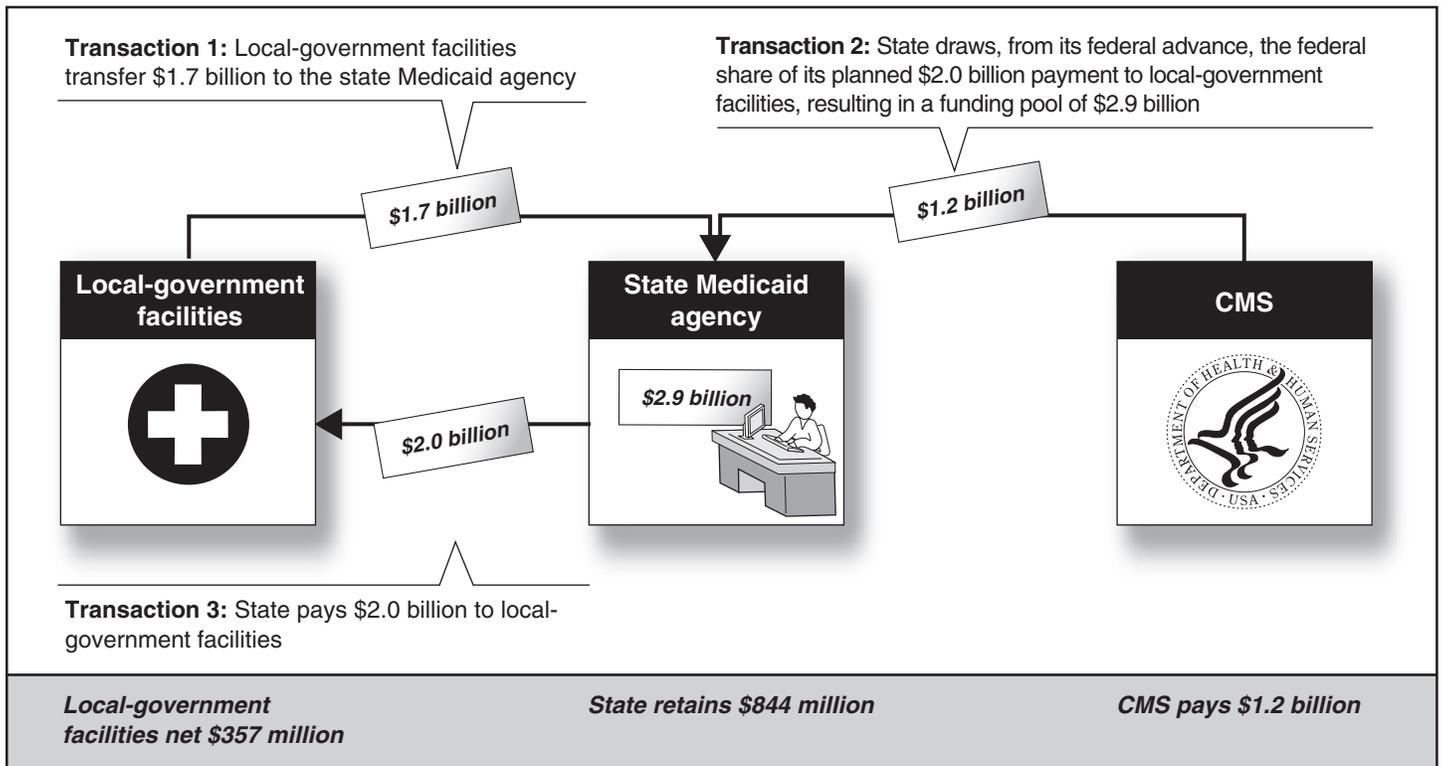
Medicaid’s federal-state partnership and fiscal integrity.¹⁰ For example, we have reported that by paying nursing homes and hospitals owned by local governments much more than the established Medicaid payment rate and requiring the providers to return, through IGTs, the excess state and federal payments to the state, states obtain excessive federal Medicaid reimbursements while their own state expenditures remain unchanged or even decrease.¹¹ Such round-trip payment arrangements can be accomplished via electronic wire transfer in less than an hour. States have then used the returned funds to pay their own share of future Medicaid spending or to fund non-Medicaid programs.

Problems with excessive supplemental payment arrangements remain, despite congressional and CMS action to curtail financing schemes. For example, in our current review of states’ use of contingency-fee consultants, we found an example in Georgia that illustrates how current law and policy continue to allow states to generate excessive federal reimbursements beyond established Medicaid provider payments for covered services. Georgia and its consultant developed five UPL arrangements using IGTs—one each for local-government-operated inpatient hospitals, outpatient hospitals, nursing homes and for state-owned hospitals and nursing homes. Over the 3-year period of state fiscal years 2001 through 2003, the state made supplemental payments totaling \$2.0 billion to nursing homes and hospitals operated by local governments (see fig. 1). A sizable share of the \$2.0 billion payments was illusory, however. In reality, the nursing homes and hospitals netted only \$357 million because they had initially transferred \$1.7 billion to the state Medicaid agency, through IGTs, under an agreement with that agency. The state combined this \$1.7 billion with \$1.2 billion in federal funds, which represented the estimated federal share of its supplemental payments to local-government facilities of \$2.0 billion. The state thus had a funding pool of \$2.9 billion at its disposal. From this pool, the state made the \$2.0 billion in supplemental payments to local-government providers and retained \$844 million to offset its other Medicaid expenditures.

¹⁰See, for example, [GAO-04-574T](#) and *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, [GAO-04-228](#) (Washington, D.C.: Feb. 13, 2004).

¹¹In another approach, 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.

Figure 1: Georgia's UPL Arrangement with Local-Government Health Care Providers, State Fiscal Years 2001–2003



Source: GAO.

Note: Totals may not add up because of rounding. See [GAO-05-748](#).

In our view, the inappropriate use of IGTs in schemes such as UPL financing arrangements violates the fiscal integrity of Medicaid's federal-state partnership 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. We previously estimated that one state effectively increased the federal 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.¹²

¹²[GAO-04-228](#).

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- There is no assurance that these increased federal reimbursements 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, we previously 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.¹³
 - 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 provide for methods that ensure that Medicaid payments are consistent with economy and efficiency. We previously reported that, in one state, the state's proposed scheme increased the daily federal payment per Medicaid resident from \$53 to \$670 in six local-government-operated nursing homes.¹⁴

Questionable Methods Have Boosted Federal Reimbursements for School-Based Claims

Another category of claims where states have used questionable practices to maximize federal reimbursements is services provided to children in schools and associated administrative costs. Medicaid is authorized to cover services to, for example, Medicaid-eligible children with disabilities who may need diagnostic, preventive, and rehabilitative services; speech, physical and occupational therapies; and transportation. School districts may also receive Medicaid reimbursement for the administrative costs of providing school-based Medicaid services. Our work in this area has addressed claims for Medicaid school-based health services and administration. In 1999, we found a need for federal oversight of growing Medicaid reimbursements to states for Medicaid school-based administrative services, including outreach activities to enroll children in Medicaid.¹⁵ In April 2000, we reported that Medicaid expenditures for school-based health services totaled about \$1.6 billion for services provided by schools in 45 states and the District of Columbia, while Medicaid administrative expenditures were about \$712 million for costs

¹³GAO-04-228.

¹⁴GAO, *Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes*, GAO-02-147 (Washington, D.C.: Oct. 30, 2001).

¹⁵GAO, *Medicaid: Questionable Practices Boost Federal Payments for School-Based Services*, GAO/T-HEHS-99-148 (Washington, D.C.: June 17, 1999).

billed by schools in 17 states.¹⁶ We found that some of the methods used by school districts and states to claim reimbursement for school-based health services did not ensure that the services paid for were provided: some claims, for example, were made solely on the basis of at least one day's attendance in school, rather than on documentation of any actual service delivery. Methods used by school districts to claim Medicaid reimbursement failed in some cases to take into account variations in service needs among children.

With regard to Medicaid school-based administrative costs, we found that some methods used by school districts and states did not ensure that administrative activities were properly identified and reimbursed. Poor controls resulted in improper payments in at least two states, and there were indications that improprieties could have been occurring in several other states. We further found that, in some states, funding arrangements among schools, states, and private consulting firms created adverse incentives for program oversight and caused schools to receive a small portion—as little as \$7.50 for every \$100 in Medicaid claims—of Medicaid reimbursement for school-based administrative and service claims. We reported that 18 states retained a total of \$324 million, or 34 percent, of federal funds intended to reimburse schools for their Medicaid administrative and service claims; for 7 of the states, this amounted to 50 to 85 percent of federal Medicaid reimbursement for school-based health services claims. In addition, contingency fees, which some school districts paid to private consultants for their assistance in preparing and submitting Medicaid claims, ranged from 3 to 25 percent of the federal reimbursement, further reducing the net amount that schools received.

In response to recommendations we made to the Administrator of CMS, CMS has clarified guidance for states on submitting claims for school-based administrative activities.¹⁷ Subsequent to our work, HHS OIG conducted reviews of school-based claims in 18 states from November

¹⁶GAO, *Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight*, GAO/HEHS/OSI-00-69 (Washington, D.C.: Apr. 5, 2000). States were asked to provide school-based claims data for the most recent fiscal year for which they were available, which for approximately half the states was state fiscal year 1999. Most of the remaining states provided data for state fiscal year 1998, federal fiscal year 1998, or calendar year 1998; three states provided data for periods before July 1997.

¹⁷CMS, *Medicaid School-Based Administrative Claiming Guide* (May 2003).

2001 through June 2005, several of which have identified issues with the appropriateness of claims related to consultants' projects.¹⁸

In our own most recent work, we determined that Georgia was retaining a share of the additional federal reimbursements gained from its claims for Medicaid school-based services. Georgia's contingency-fee consultant assisted the state with its Medicaid claims for school-based services in a project that generated about \$54 million in federal Medicaid reimbursements over the 3 years the consultant was paid and that, on the basis of state data, we estimate continues to generate about \$25 million annually.¹⁹ As before, we found that the school districts were not receiving all of the federal Medicaid reimbursements that were generated on their behalf. According to a state official and documents provided by the state, the state retained \$3.9 million, or 16 percent, of federal reimbursements that were claimed on behalf of the school districts for state fiscal year 2003, most of which was used to pay its contingency-fee consultant and about \$1 million of which was used to cover the salaries and administrative costs of the five state employees who administered school-based claims in Georgia.²⁰

¹⁸See, for example, HHS OIG, *Medicaid Payments for School-Based Health Services—Massachusetts Division of Medical Assistance*, A-01-02-00009 (Washington, D.C.: July 14, 2003); and HHS OIG, *Medicaid School-Based Health Services Administrative Costs—Massachusetts*, A-01-02-00016 (Washington, D.C.: Sept. 15, 2004). See [GAO-05-748](#), app. II, for other HHS OIG reports on school-based services and administration.

¹⁹We did not assess whether the school-based health services that the state claimed were allowable.

²⁰[GAO-05-748](#).

States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight

A growing number of states are using consultants on a contingency-fee basis to maximize federal Medicaid reimbursements. CMS reported that, according to a survey it conducted in 2004, 34 states had used consultants on a contingency-fee basis for this purpose, an increase from 10 states reported to have such arrangements in 2002. In the 2 states where we examined selected projects that involved the assistance of contingency-fee consultants, Georgia and Massachusetts, we found that the projects generated a significant amount of additional federal reimbursements for the states: from fiscal year 2000 through 2004, an estimated \$1.5 billion in Georgia and nearly \$570 million in Massachusetts. For those additional reimbursements, Georgia paid its consultant about \$82 million in contingency fees, and Massachusetts paid its consultants about \$11 million in contingency fees. We identified claims from contingency-fee consultant projects that appear to be inconsistent with current CMS policy and claims that are inconsistent with federal law; we also identified claims from projects that undermine Medicaid's fiscal integrity. Such projects and resulting problematic claims arose in each of the five categories of claims that we reviewed in Georgia, Massachusetts, or for some categories, both states. We observed two factors common to many projects that we believe increase their risk. First, many projects were in categories of Medicaid claims where federal requirements for the services have been inconsistently applied, are evolving, or were not specific. Second, many projects involved states' shifting costs to the federal government through Medicaid reimbursements to other state or local-government entities.

Some Contingency-Fee Projects in Georgia and Massachusetts Resulted in Problematic Federal Reimbursements

For the five categories of claims we reviewed where states frequently used contingency-fee consultants to maximize their federal Medicaid reimbursements, we identified problematic claims in each category in either Georgia or Massachusetts or in both states. These projects resulted in claims that appear to be inconsistent with current CMS policy and that, for one project, were inconsistent with federal law. We also identified claims that were inconsistent with the fiscal integrity of the Medicaid program. I have already discussed our current findings regarding Georgia's use of IGTs in UPL supplemental payment arrangements and its project to increase claims for school-based Medicaid services and administrative costs. We also reviewed Georgia's and Massachusetts's use of contingency-fee consultants to increase federal reimbursements for targeted case management services, rehabilitation services for mental or physical disabilities, and states' claims for administering their Medicaid programs. In these two states, our findings were most significant in the areas of targeted case management and rehabilitation services.

Targeted Case Management

Georgia and Massachusetts—with the help of their contingency-fee consultants—developed approaches to maximize federal Medicaid reimbursements by claiming costs for targeted case management (TCM) services under state plan amendments that CMS had approved prior to 2002. Georgia’s consultant assisted the state in increasing federal Medicaid reimbursement for TCM services provided by two state agencies: the Department of Juvenile Justice and the Division of Family and Children’s Services.²¹ In Massachusetts, contingency-fee consultants helped the state increase federal reimbursement for TCM services provided by three state agencies: the Departments of Social Services, Youth Services, and Mental Health. These case management services in Georgia and Massachusetts appear integral to the states’ own programs; the states’ laws, regulations, or policies called for case management services in these programs, and the case management services were provided to all Medicaid- and non-Medicaid-eligible children served by the programs.²² More recently, CMS has denied coverage for comparable services by other states because CMS determined that the services are an integral component of the state programs providing the services. For example, in fiscal year 2002, CMS denied a state plan amendment proposal to cover TCM services in Illinois and in fiscal year 2004 it found TCM claims in Texas unallowable, in part because the TCM services claimed for reimbursement were considered integral to other state programs. As in Georgia and Massachusetts, the TCM services in Illinois were for children served by the state’s juvenile justice system. In Texas, such children were served by the state’s child welfare and foster care system.

In fiscal year 2003, we estimate that Georgia received \$17 million in federal reimbursements for claims for TCM services provided by its two state agencies, of which about \$12 million was for services that appear to be integral to non-Medicaid programs. In fiscal year 2004, Massachusetts received an estimated \$68 million in federal reimbursements for services that appear to be integral to non-Medicaid programs in the three state

²¹The consultant assisted Georgia by streamlining the billing process, drafting state plan amendment proposals, and increasing the number of Medicaid beneficiaries for whom these two non-Medicaid state agencies billed case management services, thus reducing costs to the state for operating these agencies.

²²For example, all children served by Georgia’s and Massachusetts’s child welfare agencies receive a broad range of services to promote their welfare and protect them from abuse and neglect. To fulfill this responsibility, state employees provide case management services, refer the children to others for services, and monitor their well-being and progress.

agencies whose TCM projects were developed by consultants.²³ CMS officials agreed with our assessment that the claims for TCM services in these two states were problematic.

Rehabilitation Services

Our review of projects involving rehabilitation services found concerns with methods and claims in Georgia. Georgia's consultant helped the state increase federal Medicaid reimbursements for rehabilitation services provided through two state agencies by \$58 million during state fiscal years 2001 through 2003. The consultant suggested that state agencies—which pay private facilities under a per diem rate for providing room and board, rehabilitation counseling and therapy, educational, and other services to children in state custody—base their claims for Medicaid reimbursement on the private facilities' estimated costs, instead of on what the state agencies actually paid those facilities. The state agencies increased their claims for Medicaid reimbursement without increasing their payments to the facilities. In some cases, the state agencies' Medicaid claims for rehabilitation services alone exceeded the amount paid by the agencies for all the services the facilities provided to children. Specifically, for 82 of the residential facilities (about 43 percent), the amount the state Medicaid agency reimbursed the two agencies in state fiscal year 2004 exceeded the total amount these agencies actually paid the residential facilities for all services, not just rehabilitation services. One facility, for example, was paid by the Division of Family and Children's Services \$37 per day per eligible child for all services covered by the per diem payment, but the state agency billed the Medicaid program \$62 per day for rehabilitation services alone. CMS officials agreed with our conclusion that claims from this contingency-fee project were not in accord with the statutory requirement that payments be efficient and economical.

Two Factors Increase Risk of Problematic Claims

During our work we observed two factors that appear to increase the risk of problematic claims. One factor involved federal requirements that were inconsistently applied, evolving, or not specific; the second involved states' claiming Medicaid reimbursement for services provided by other state or local-government agencies. Despite CMS's long-standing concern about state financing arrangements for both TCM and supplemental payments, for example, the agency has not issued adequate guidance to

²³In examining CMS expenditure reports, we found that both Georgia and Massachusetts had categorized non-TCM services, such as rehabilitation services, as TCM. We obtained estimates from the states of the amount the states had claimed for TCM services.

clarify expenditures allowable for federal reimbursement. Federal TCM and supplemental payment policy for allowable claims in these categories has evolved over time, and the criteria that CMS applies to determine whether claims are allowable have been communicated to states primarily through state-specific state plan amendment reviews or claims disallowances, rather than through formal guidance or regulation.

- **Inconsistently applied policy for allowable TCM services.** In 2002, CMS began to deny proposed state plan amendments that sought approval for Medicaid coverage of TCM services that were the responsibility of other state agencies. CMS had determined that such arrangements were not eligible for federal Medicaid reimbursement for several reasons: (1) the services were typically integral to existing state programs, (2) the services were provided to beneficiaries at no charge, and (3) beneficiaries' choice of providers was improperly limited.²⁴ However, CMS approved Georgia's and Massachusetts's state plan amendments for TCM services before 2002. Although CMS has been applying these criteria to deny new TCM arrangements—for example, in Maryland, Illinois, and Texas—it has not yet sought to address similar, previously approved TCM arrangements that are inconsistent with these criteria. CMS regional officials told us they could not reconsider the TCM claims from two agencies in Georgia and four in Massachusetts because they were waiting for new guidance that the agency was preparing.²⁵ CMS has been working on new TCM guidance for more than 2 years, according to agency officials. As of May 2005, however, this guidance had not been issued. CMS's fiscal year 2006 budget submission identifies savings that could be achieved by clarifying allowable TCM services, but CMS had not published a specific proposal at the time we completed our work.²⁶

²⁴CMS most recently explained its policy and rationale in a September 2004 Administrator's decision denying a proposed state plan amendment from Maryland to cover TCM services. This decision articulated the criteria that CMS has applied to deny state TCM plan amendments.

²⁵A CMS official stated that the agency's most recent guidance on TCM, issued in January 2001, contained problems and errors that caused confusion regarding appropriate TCM claims when non-Medicaid state agencies were involved.

²⁶The CMS Administrator's performance budget for fiscal year 2006 proposes to clarify allowable TCM services and align federal reimbursement for TCM services with an administrative matching rate of 50 percent. CMS estimates 5-year budget savings from reducing the reimbursement for TCM to the administrative matching rate of \$1 billion.

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- **Evolving policy for allowable supplemental payment arrangements.** For several years, we and others have reported on state financing schemes that allow states to inappropriately generate federal Medicaid reimbursement without the state's paying its full share. Although Congress and CMS have taken steps to curb these abuses, states can still develop arrangements enabling them to make illusory payments to gain federal reimbursements for their own purposes. Recognizing that states can unduly gain from supplemental payment arrangements, such as UPL payment arrangements that use IGTs, since fiscal year 2003 CMS has worked with individual states to address such arrangements. At the same time, the agency has not issued guidance stating its policy on acceptable approaches for UPL payment arrangements, specifically the use of IGTs and the relationship to state share of spending. CMS's budget for fiscal year 2006 proposes to achieve federal Medicaid savings by curbing financing arrangements that have been used by a number of states to inappropriately obtain federal reimbursements. The specific proposal, however, had not been published at the time we completed our review.²⁷
 - **Unspecified policy on allowable Medicaid rehabilitation payments to other state agencies.** CMS has not issued policy guidance that addresses situations where Medicaid payments are made by a state's Medicaid agency to other state agencies for rehabilitation services. CMS financial management officials told us that states' claims for rehabilitation services posed an increasing concern, in part because officials believed that states were inappropriately filing claims for services that were the responsibility of other state programs. CMS does not specify whether claims for the cost of rehabilitation services that are the responsibility of non-Medicaid state agencies are allowable. CMS's fiscal year 2006 budget submission identifies savings that could be achieved by clarifying

²⁷The budget proposes to build on CMS's efforts to curb questionable financing practices by (1) recovering federal funds claimed for covered services but retained by the state and (2) capping payments to government providers at no more than the cost of furnishing services to Medicaid beneficiaries. CMS estimated 5-year budget savings of \$5.9 billion from this proposal. CMS's proposal is consistent with a recommendation that we first made to Congress in 1994 to consider legislation to prohibit Medicaid payments to government providers that exceed the providers' actual costs. See *GAO, Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*, GAO/HEHS-94-133 (Washington, D.C.: Aug. 1, 1994).

appropriate methods for claiming rehabilitation services. CMS had not published a specific proposal at the time we completed our review.²⁸

The second factor we observed that increased the financial risk to the federal government of reimbursement-maximizing projects was that the projects shifted state costs to the federal government by claiming Medicaid reimbursement for services provided by other non-Medicaid state or local government agencies. Medicaid reimbursement to government agencies serving Medicaid beneficiaries is allowable in cases where the claims apply to covered services and the amounts paid are consistent with economy and efficiency. However, the projects and associated claims we reviewed showed that reimbursement-maximizing projects often involved services and circumstances that Medicaid should not pay for—such as illusory payments to government providers.

Problems Illustrate Need to Improve the Financial Management of Medicaid

As we describe in the report issued today, the problems we identified with states' Medicaid claims stemming from contingency-fee projects illustrate the urgent need to address certain issues in CMS's overall financial management of the Medicaid program. These issues, however, are not limited to situations that involve contingency-fee consultants. We have identified problems with claims in states other than Georgia and Massachusetts that have undertaken reimbursement-maximizing activities, without employing consultants, in categories of long-standing concern, such as supplemental payment arrangements. CMS relies on its standard financial management controls to identify any unallowable Medicaid claims that states may submit, including those that might be associated with reimbursement-maximizing contingency-fee projects. However, CMS lacks clear, consistent policies to guide the states' and its own financial oversight activities. Furthermore, in our previous work on CMS's financial management, we found that the agency did not have a strategy for

²⁸The CMS Administrator's budget for fiscal year 2006 expresses CMS's concern that states have attempted to shift costs associated with other social service programs to Medicaid. The budget proposes to clarify allowable services that could be claimed as rehabilitation. For its proposal to clarify allowable TCM and rehabilitation services that could be claimed, CMS estimates 5-year budget savings of \$2 billion. See Centers for Medicare & Medicaid Services' performance budget proposal for fiscal year 2006.

focusing its resources most effectively on areas of high risk.²⁹ In our current work, we found that CMS has known for some time that two high-risk categories we identified—claims generated from consultants paid on a contingency-fee basis to maximize reimbursements and claims generated from arrangements where state Medicaid programs are paying other state agencies or government providers—were problematic. For example, CMS had listed these two categories on a financial tracking sheet of high-risk areas as of 2000.³⁰ At an October 2003 congressional hearing, the CMS Administrator expressed concern that the Medicaid program was understaffed and that consultants in the states were “way ahead of” CMS in helping states take advantage of the Medicaid system.³¹

CMS has undertaken important steps to improve its financial management of the Medicaid program. A major component of the agency’s initiative is hiring, training, and deploying approximately 100 new financial analysts, mainly to regional offices. These analysts are responsible for identifying state sources of Medicaid funding and contributing to the review of state budget estimates and expenditure reports. Expectations for CMS’s new Division of Reimbursement and State Financing and for the 100 new financial analysts are high and their responsibilities broad. It is too soon, however, to assess their accomplishments.

²⁹See, for example, GAO, *Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed*, GAO-02-300 (Washington, D.C.: Feb. 28, 2002). This February 2002 report found that CMS’s systems for financial oversight of state Medicaid programs were limited. We recommended a range of approaches to strengthen internal controls and target limited resources, including that CMS revise its existing risk-assessment efforts to more effectively and efficiently target oversight resources to areas most vulnerable to improper payments. An ongoing GAO review is assessing CMS’s progress in implementing related recommendations. Also, in a report on state financing schemes (see GAO-04-228), we recommended that CMS improve oversight of state UPL projects, including issuing guidance to states setting forth acceptable methods to calculate UPLs. These recommendations remain open.

³⁰In 2001, CMS asked each regional office to complete a risk assessment to identify the extent to which states in each region have attributes warranting closer CMS financial oversight and scrutiny. The identified risk factors that regional staff were asked to assess included: areas where federal policy was unclear, states’ use of a contingency-fee consultant to maximize reimbursements, and payments to public providers in which state Medicaid agencies may lack an incentive to monitor and control expenditures. Regional officials were to base their assessment of these and other risk factors on their working knowledge of each state.

³¹Thomas Scully, Administrator, Centers for Medicare & Medicaid Services, responding to questions at a hearing, *Challenges Facing the Medicaid Program in the 21st Century: Hearing before the Subcommittee on Health, House Committee on Energy and Commerce*, 108th Cong., 1st Sess., October 8, 2003.

Conclusions

For more than a decade, we and others have reported on the methods states have used to inappropriately maximize federal Medicaid reimbursement and have made recommendations to end financing schemes. CMS has taken important steps in recent years to improve its financial management. Yet more can be done.

Many of the problematic methods we examined involved categories of claims where CMS policy has been inconsistently applied, evolving, or unspecified. They have also involved increasing payments to units of state and local government—which states have long used to maximize federal Medicaid funding, in part because IGTs can help facilitate illusory payments—suggesting that greater CMS attention is needed to payments among levels of government, regardless of whether consultants are involved. We believe that it is important to act promptly to curb opportunistic financing schemes before they become a staple of state financing and further erode the integrity of the federal-state Medicaid partnership. Addressing recommendations that remain open from our prior work on state financing schemes and on CMS's financial management could help resolve some of these issues. In addition, in the report being issued today, we are making new recommendations to the Administrator of CMS to improve the agency's oversight of states' use of contingency-fee consultants and to strengthen certain of the agency's overall financial management procedures. These recommendations address developing guidance to clarify CMS policy on TCM, supplemental payment arrangements, rehabilitation services, and Medicaid administrative costs; ensuring that such guidance is applied consistently among states; and collecting and scrutinizing information from states about payments made to units of state and local governments.

Understandably, states that have relied on certain practices to increase federal funds as a staple for the state share of Medicaid spending are concerned about the 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 fiscal integrity of the program. States should not be held solely responsible for developing arrangements that inappropriately maximize federal reimbursements where policies have not been clear or clearly communicated or where CMS has known of risks for some time and has not acted to mitigate them. Without clear and consistent communication of policies regarding allowable claims in high-risk areas, such as those for TCM and UPL where billions of dollars are claimed each

year, CMS is at risk of treating states inconsistently and of placing undue burdens on states to understand federal policy and comply with it.

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

Contact and Acknowledgments

For future contacts regarding this testimony, please call Kathryn G. Allen at (202) 512-7118. Katherine Iritani, Ellen M. Smith, Helen Desaulniers, and Kevin Milne also made key contributions to this testimony.

Related GAO Products

Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight. [GAO-05-748](#). Washington, D.C.: June 28, 2005.

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