



441 G St. N.W.
Washington, DC 20548

Accessible Version

July 14, 2020

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

Medicaid: Primer on Financing Arrangements

Dear Mr. Chairman:

Medicaid—a joint, federal-state program that finances health care coverage for low-income and medically needy populations—covered an estimated 76 million individuals at an estimated cost of \$668 billion in fiscal year 2019, about \$420 billion of which was federal spending. The federal government and states share responsibility for financing Medicaid expenditures. The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid, generally matches each state’s Medicaid expenditures for health care services according to a statutory formula.¹ These expenditures include payments for care provided to Medicaid beneficiaries, such as base payments and supplemental payments to providers. Unlike base payments, which include fee-for-service or capitated payments, supplemental payments are not specifically tied to care for individual enrollees, but may help offset any remaining costs of care for Medicaid enrollees.

Federal law requires that states finance at least 40 percent of their share of total Medicaid expenditures through state funds; within limits, however, they can use other funding sources as well. For example, states can finance their nonfederal share of Medicaid expenditures through funds transferred from local governments, known as intergovernmental transfers; or through local government expenditures, known as certified public expenditures. States can also finance the nonfederal share through taxes levied on providers. States can use these financing arrangements to finance any type of Medicaid expenditure. We found in past work that states rely heavily on local government expenditures and taxes on providers to finance supplemental payments, sometimes in ways that lowered the amount the state contributed to Medicaid expenditures while increasing payments to providers and shifting responsibility for a larger share of the payments to the federal government.²

You asked us to provide information describing Medicaid financing arrangements used by states. Enclosure 1 includes a primer on this topic, describing the most common types of financing arrangements used by states to fund their nonfederal shares of Medicaid expenditures. The primer provides examples of how these financing arrangements can shift the

¹The formula is designed such that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average. For fiscal year 2020, states’ federal matching rates range from 50.00 percent to 76.98 percent. The federal government reimburses states for a portion of their expenditures based on each state’s match rate.

²See 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).

magnitude or share of these expenditures to local governments, providers, and the federal government.

To describe the financing arrangements, we reviewed related GAO reports and other research published since 2012 that examined the arrangements commonly used by states.³ We also reviewed relevant federal laws, regulations, and guidance. Using that information, we produced illustrations of the financing arrangements and described their implications.

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

Agency comments

We provided a draft of this report to HHS for review and comment. HHS provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services, appropriate congressional committees, and other interested parties. In addition, the report is available at no charge on the GAO website at <https://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this correspondence. Other key contributors to this correspondence included Tom Conahan (Assistant Director), Jasleen Modi (Analyst-in-Charge), Drew Long, Kimberly Perrault, Vikki Porter, Ethiene Salgado-Rodriguez, and Emily Wilson.

Sincerely yours,



Carolyn L. Yocom
Director, Health Care

Enclosure(s) – 1

³We reviewed research by Medicaid and CHIP Payment and Access Commission, Congressional Research Services, and Kaiser Family Foundation.

Enclosure I: Medicaid: Primer on Financing Arrangements

Why this matters

This primer provides information on Medicaid financing, identifying and illustrating examples of the most common types of permissible arrangements states have used to fund their Medicaid programs. We have found that in some cases, by using certain types of payments and sources of spending, states can lower the amount they contribute to total Medicaid expenditures. We have also found that, in certain cases, states can increase the magnitude or share of federal Medicaid expenditures. Understanding these arrangements and their implications for federal spending, particularly when the payments may not be economical or efficient, is important to recognizing the risks these financing arrangements can pose to the Medicaid program.

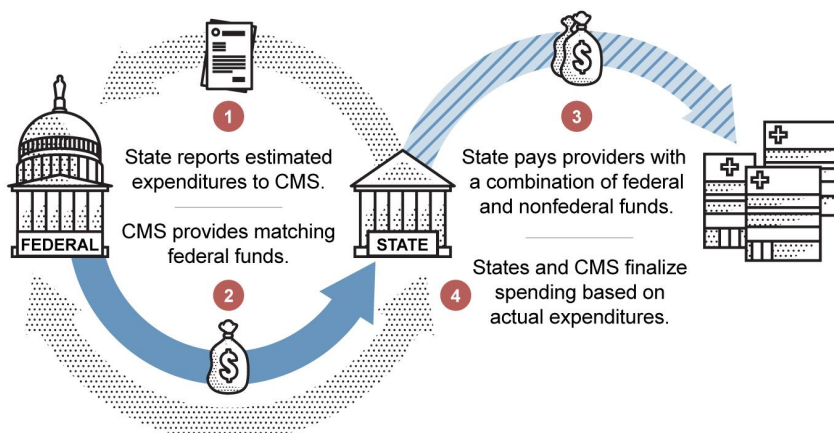
Background

The federal government generally matches each state's Medicaid expenditures for services according to a formula calculated annually. Under this formula, the federal government pays a percentage share of Medicaid expenditures; the remainder is referred to as the nonfederal share. For fiscal year 2020, states' federal matching rates range from 50.00 to 76.98 percent.⁴

States' Use of Federal Matching Funds. To receive federal matching funds, states estimate their quarterly Medicaid expenditures beforehand and report these estimates to the Centers for Medicare & Medicaid Services (CMS), which oversees Medicaid. CMS provides federal matching funds based on states' estimates. States use these federal matching funds to make Medicaid payments to providers. (See fig. 1.)

⁴The formula is designed such that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average. The range of federal matching rates for 2020 does not include the temporary additional 6.2 percent increase in federal matching provided under the Coronavirus Aid, Relief, and Economic Security Act of 2020.

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



Source: GAO. | GAO-20-571R

Subsequently, states report actual expenditures to CMS, which reviews and reconciles states' actual expenditures and federal funds to ensure the federal government matches only actual state expenditures.

State Medicaid agencies make two primary types of payments—base payments and supplemental payments—and both can qualify for federal matching funds.

- **Base payments** are payments to providers or organizations for specific services provided to Medicaid enrollees through fee-for-service and managed care.⁵
- **Supplemental payments** are typically lump sum payments to providers that are not tied to care for individual enrollees, but may help offset remaining costs of care for Medicaid enrollees.

Under federal law, in order to receive federal matching funds, payments generally (1) must be made for covered Medicaid items and services; (2) must be consistent with economy, efficiency, and quality of care; and (3) must not exceed the Medicaid upper payment limit, which is a reasonable estimate of what Medicare would pay for comparable services.⁶

Federal law requires that states finance at least 40 percent of the nonfederal share of total Medicaid expenditures through state funds, which can include appropriations from state general funds and health care provider taxes levied by the state.⁷ States can finance the remaining 60

⁵Managed care organizations are responsible for providing services to enrollees in return for a periodic payment per enrollee.

⁶Medicare is the federal health insurance program for persons aged 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. The upper payment limit is not applied to payments to individual providers; instead, it applies on an aggregate basis to all providers rendering specific services within an ownership class, such as state government-owned or -operated facilities that provide inpatient services.

⁷Providers can also donate funds, subject to federal requirements, to the state to finance Medicaid payments; however, donations are rarely used to finance the nonfederal share of Medicaid payments. We reported in 2014 that provider

percent of the nonfederal share of Medicaid through funds transferred from local governments, known as intergovernmental transfers; or through local government expenditures, known as certified public expenditures. The limit on the percentage of the nonfederal share that may be financed by local governments is applied on the basis of total annual Medicaid program spending and not on individual payments or types of payments.

This primer illustrates the following financing arrangements:⁸

- State general funds
- State provider taxes
- Intergovernmental transfers
- Certified public expenditures.

donations constituted less than 0.1 percent of the nonfederal share of Medicaid payments. 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).

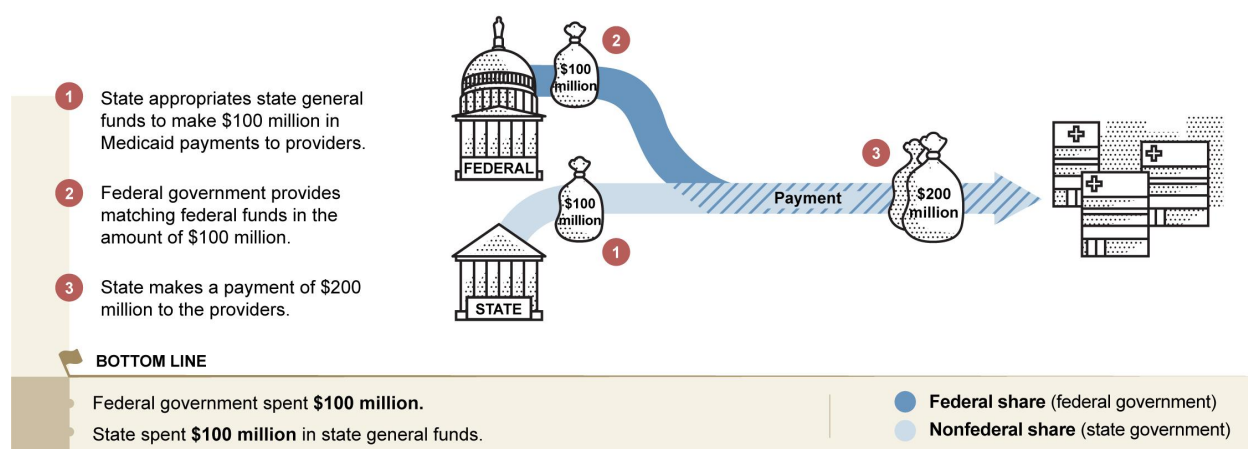
⁸In November 2019, CMS proposed regulations that, if finalized, could affect some of the arrangements we describe in this primer. See 84 Fed. Reg. 63,722 (Nov. 18, 2019).

State General Funds

States finance the nonfederal share of their Medicaid expenditures, in large part, through state general funds. (See fig. 2.) State general funds can include intra-agency funds, whereby other state agencies receiving state appropriations—for example, state mental health agencies—can supply funds to finance the nonfederal share of the Medicaid services they provide. In 2014, we reported that state general funds accounted for 62.9 percent of the nonfederal share of Medicaid expenditures in 2012.⁹

In the following figure, the state and federal government are each responsible for a share of a \$200 million Medicaid payment. In this arrangement, the state finances the nonfederal share using state general funds. The illustration assumes that at a 50 percent federal matching rate, the federal share will consist of funds amounting to half of the total payment. In this scenario, providers receive a Medicaid payment that includes contributions from the federal government and state general funds. (See fig.2.)

Figure 2: Example of a State Medicaid Payment Financed Using State General Funds and Federal Matching Funds



Source: GAO. | GAO-20-571R

Note: The Centers for Medicare & Medicaid Services matches states' estimated expenditures and subsequently reconciles federal funding against states' actual expenditures. For purposes of this figure, we have simplified the process by which the federal government matches state expenditures to show how the federal and nonfederal share contribute to a particular payment.

Using this example, the state and federal government are responsible for an equal share of the net payment—the payment received by the provider minus any funds contributed by the provider. This arrangement does not shift costs to the federal government, as changes in state general fund spending would result in corresponding changes in federal spending per the federal match.

⁹See GAO-14-627.

State Provider Taxes

States can use funds raised through provider taxes to finance the nonfederal share of their Medicaid payments.¹⁰ States may tax a wide range of health care services, and providers may be subject to more than one tax during a year.¹¹ Under federal requirements, taxes must be broad-based—i.e., imposed on all nonfederal, nonpublic providers within a category of services in the state—and uniform (e.g., the tax is the same amount for all providers furnishing the services within the same category).¹² States may not hold providers harmless (—e.g., provide a direct or indirect guarantee that providers will receive all or a portion of their tax payments back). In a 2014 report, we found that provider taxes made up 10.4 percent of the nonfederal share of Medicaid payments in 2012.¹³ In some cases, the nonfederal share of a particular payment may be paid entirely through the provider taxes, and the federal government matches payments made with these funds.

In the following figure, the state and federal government are each responsible for a share of a \$200 million Medicaid payment to providers. In this arrangement, the state imposes taxes on all providers to finance the nonfederal share of the payment to some providers. The illustration also assumes that at a 50 percent federal matching rate, the federal share will consist of funds amounting to half of the total payment. In this scenario, providers may receive a payment if they deliver Medicaid services or qualify for supplemental payments. (See fig.3.)

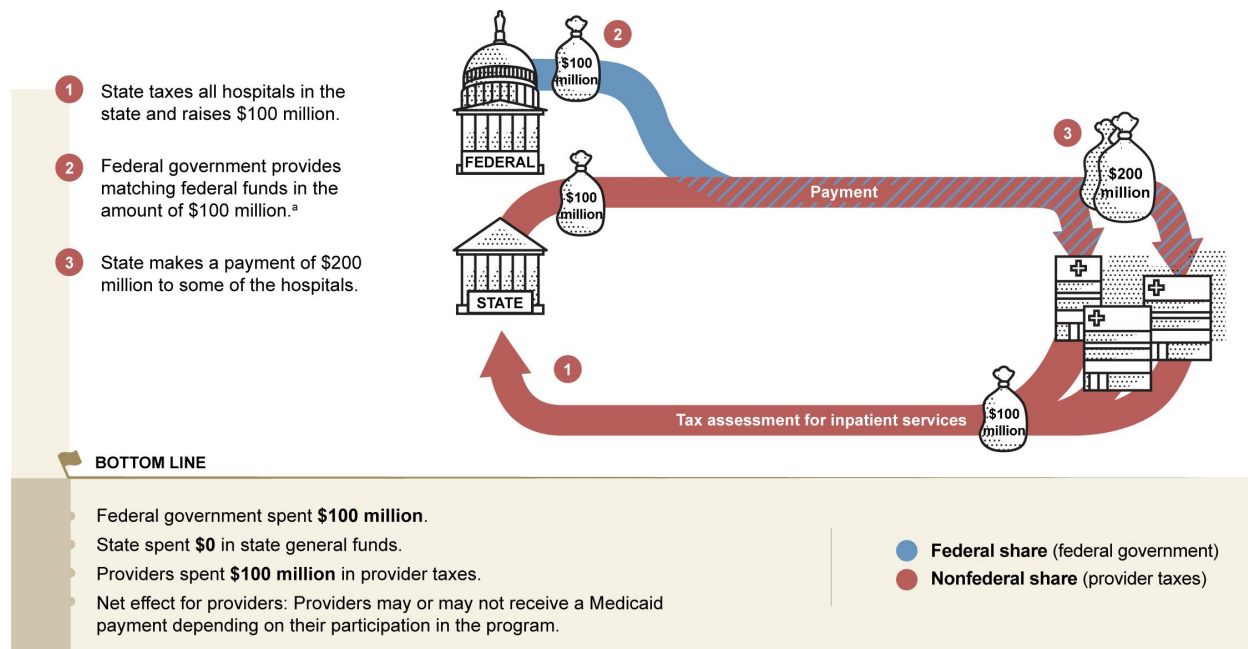
¹⁰State-imposed provider taxes constitute state funds for purposes of satisfying the requirement that states finance at least 40 percent of the nonfederal share of Medicaid expenditures with state funds. For the purposes of our report, we discuss provider taxes separately.

¹¹Local governments may also impose health care provider taxes or receive provider donations that may be used for the nonfederal share if they are in compliance with federal requirements.

¹²States may seek CMS approval of a waiver of either the broad-based or uniformly imposed requirements. CMS may waive these requirements only if the net impact of the tax is generally redistributive and not directly correlated with Medicaid payments to the providers subject to the tax.

¹³See GAO-14-627.

Figure 3: Example of a State Medicaid Payment Financed Using State Provider Tax Revenue and Federal Funds



Source: GAO. | GAO-20-571R

Note: The Centers for Medicare & Medicaid Services matches states' estimated expenditures and subsequently reconciles federal funding against states' actual expenditures. For purposes of this figure, we have simplified the process by which the federal government matches state expenditures to show how the federal and nonfederal share contribute to a particular payment.

The use of provider taxes to finance the nonfederal share of a state's Medicaid expenditures has financial implications for the providers, state, and the federal government.

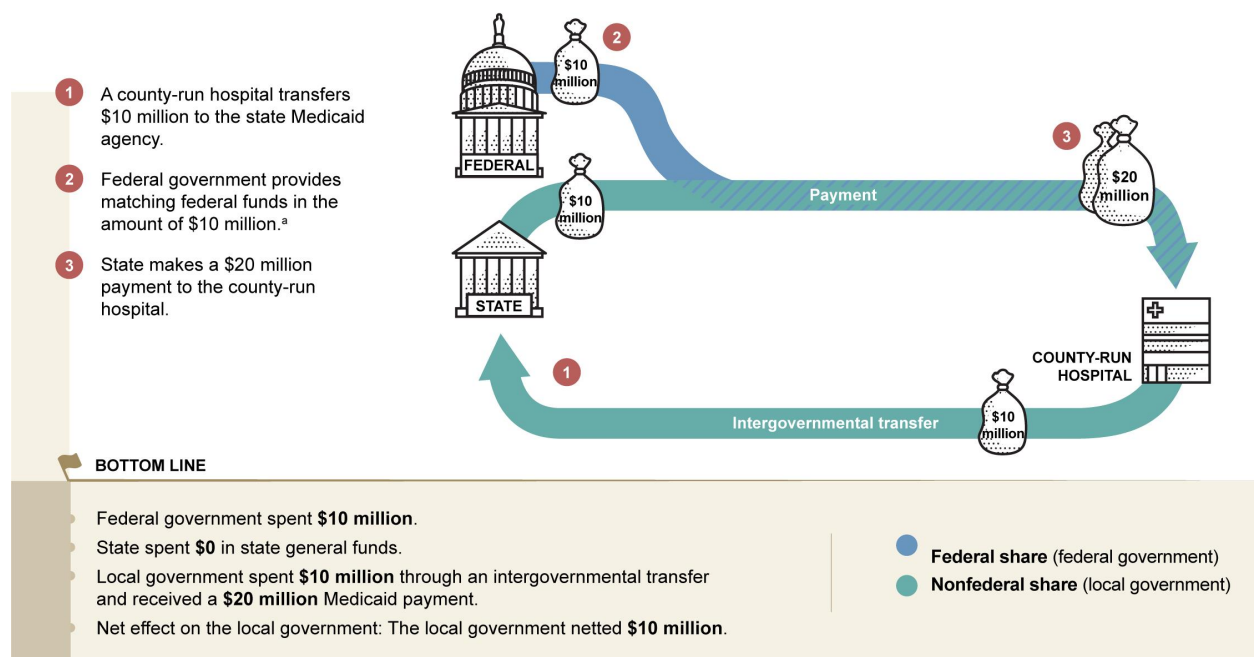
- The effects on the providers vary based on the extent to which they participate in the Medicaid program. For example, if provider taxes are used to finance a supplemental payment—which is not tied to care for individual enrollees—some providers could receive Medicaid payments that total more than the amount they were taxed, while others could be taxed and not receive any Medicaid payments.
- Additionally, a state can lower its own contribution to Medicaid spending if it imposes a provider tax to fund Medicaid payments previously funded by state general funds. In that situation, to the extent that the state replaces its contribution to Medicaid spending with provider tax revenues that return funds to some of the providers, the net payment to the providers is reduced and a greater share of the net payment to the providers would be financed by the federal government.

Intergovernmental Transfers

Intergovernmental transfers (IGTs) are transfers of funds from local governments, including providers owned or operated by local governments (e.g., county-run hospitals or nursing homes), to the state Medicaid agency to finance the nonfederal share of Medicaid payments.¹⁴ In a 2014 report, we found that intergovernmental transfers made up 10.1 percent of the nonfederal share of Medicaid payments in 2012.¹⁵ In some cases, a state's nonfederal share may be paid entirely through an IGT, and the federal government matches this transfer at the applicable matching rate.

In the following figure, the state and federal government are each responsible for a share of a \$20 million Medicaid payment. In the example, the state uses an IGT to finance the nonfederal share of the payment. The illustration also assumes that at a 50 percent federal matching rate, the federal share will consist of funds amounting to half of the total payment. In this scenario, the county-run hospital receives a Medicaid payment that includes contributions from the federal government and local government funds. (See fig.4.)

Figure 4: Example of a State Medicaid Payment Financed by an Intergovernmental Transfer and Federal Funds



Source: GAO. | GAO-20-571R

¹⁴Under agency policy, CMS requires that IGTs occur before the state makes a Medicaid payment to the provider and that the amount of the transfer cannot be greater than the nonfederal share of the Medicaid payment amount. CMS took this action to curtail states' ability to claim federal matching funds on large Medicaid payments made to certain government providers that were then returned to the state in the form of IGTs. In addition to the state imposing taxes on providers, local governments may tax providers and revenue from the taxes are generally transferred to the state through an IGT.

¹⁵See GAO-14-627.

Note: The Centers for Medicare & Medicaid Services matches states' estimated expenditures and subsequently reconciles federal funding against states' actual expenditures. For purposes of this figure, we have simplified the process by which the federal government matches state expenditures to show how the federal and nonfederal share contribute to a particular payment.

The use of IGTs to finance a state's nonfederal share of Medicaid expenditures has implications for local governments and the federal government. Using the above example, for example,

- When IGTs are used to finance supplemental payments—which are not directly tied to services for individual enrollees—they can increase federal spending and payments to county-run hospitals without being clearly linked to care for Medicaid enrollees.
- The county-run hospital initially incurs costs in making an IGT, but subsequently receives the same amount from the state in the form of a Medicaid payment along with federal matching funds. In the example above, the county-run hospital receives \$10 million more than it spent through the IGT, and the net Medicaid payment to the hospital is funded entirely by the federal government.
- IGTs can increase the magnitude of federal spending without a commensurate increase in state spending, because as the local government increases the nonfederal share, the federal government continues to match these increases.

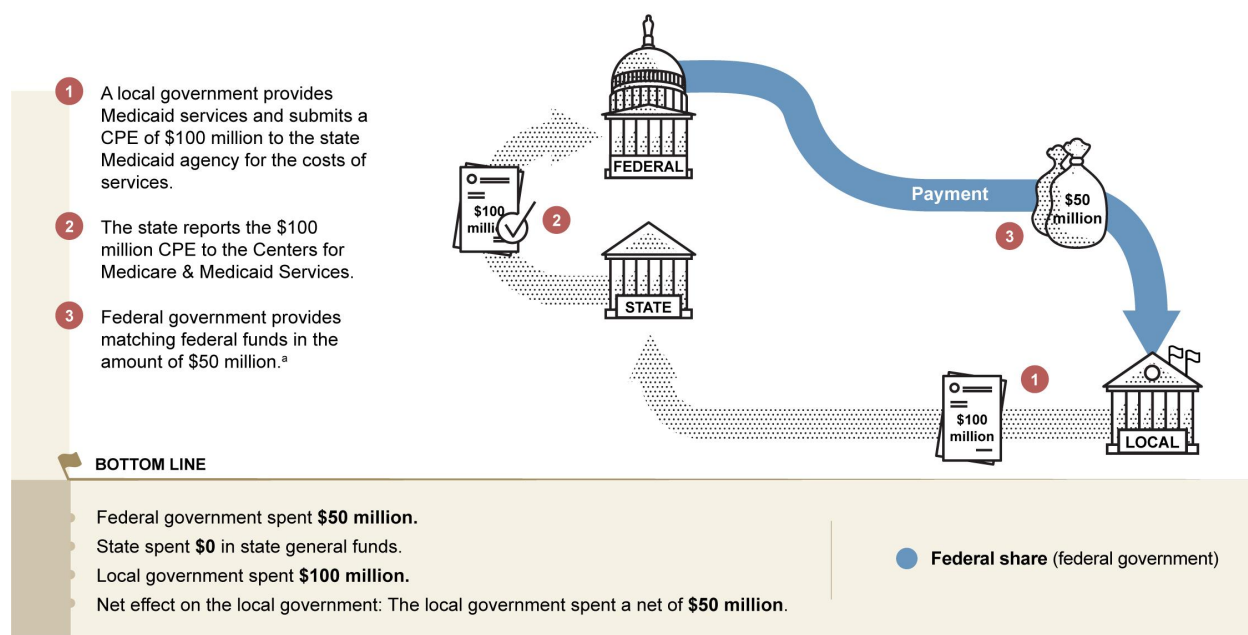
Certified Public Expenditures

Using certified public expenditures (CPE), a state may document Medicaid spending from local governments, hospitals, or other providers, and these entities can receive federal matching funds. In a 2014 report, we found that certified public expenditures made up 5.4 percent of the nonfederal share of Medicaid payments in 2012.¹⁶

CPEs do not involve the transfer of money to the state in order to finance the nonfederal share; rather, a local government certifies that government funds were used to pay for the cost of providing Medicaid services. The federal government matches the CPE under the federal matching rate for the state. The state has the flexibility to retain some or all of the matching federal funds.

In the following figure, the local government submits a \$100 million CPE to the state Medicaid agency for the total cost of all Medicaid services provided, including those eligible for federal matching funds. In this figure, assuming a 50 percent federal matching rate, the federal government provides a payment amounting to half of the total cost of the certified Medicaid expenditures. In this scenario, the local government receives a Medicaid payment that includes only the federal share of Medicaid expenditures. (See fig.5.)

Figure 5: Example of a State Medicaid Payment Financed Using Certified Public Expenditures and Federal Funds



Source: GAO. | GAO-20-571R

Note: The Centers for Medicare & Medicaid Services matches states' estimated expenditures and subsequently reconciles federal funding against states' actual expenditures. For purposes of this figure, we have simplified the process by which the federal

¹⁶See GAO-14-627.

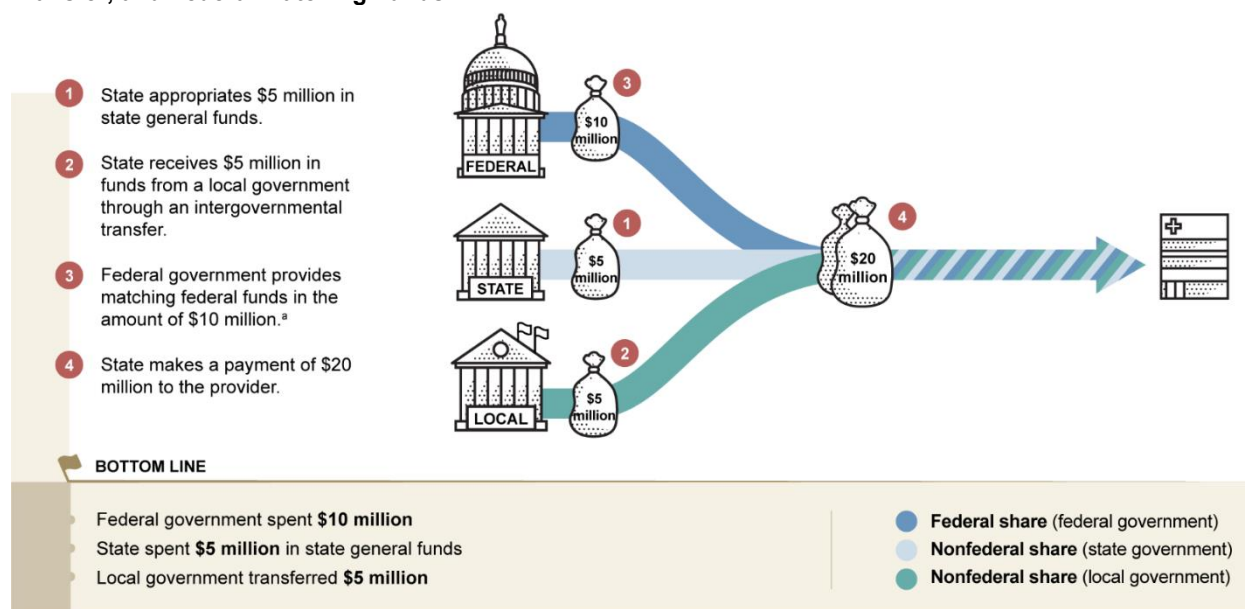
government matches state expenditures. The federal government provides matching federal funds to the state, which forwards all or part of the federal funds to the local government.

The use of CPEs to finance a state's nonfederal share of Medicaid expenditures can have implications for the local, state, and federal governments. Currently, a state has the flexibility to retain some or all of the matching federal funds instead of reimbursing the entity providing the CPE. If the state retains some or all of the federal matching funds, the local government receives a smaller Medicaid payment. Using the example above, if the state government were to retain a portion—\$10 million—of the total Medicaid payment, then the total payment to the local government would be \$40 million. Under these circumstances, the local government would have spent \$100 million and received \$40 million in federal matching funds instead of \$50 million.

Oversight Risks

States may—and typically do—use a combination of different strategies and sources to finance a Medicaid payment. In the following figure, the state and federal government are each responsible for a share of a \$20 million Medicaid payment. The state finances the nonfederal share using both state general funds and an IGT. The illustration assumes that at a 50 percent federal matching rate, the federal share will consist of funds amounting to half of the total payment. In this scenario, the Medicaid payment includes contributions from the federal government, state general funds and local government funds. (See fig.6.)

Figure 6: Example of a State Medicaid Payment Financed Using State General Funds, Intergovernmental Transfer, and Federal Matching Funds



Source: GAO. | GAO-20-571R

Note: The Centers for Medicare & Medicaid Services matches states' estimated expenditures and subsequently reconciles federal funding against states' actual expenditures. For the purposes of this figure, we have simplified the process by which the federal government matches state expenditures to show how the federal and nonfederal share contribute to a particular payment.

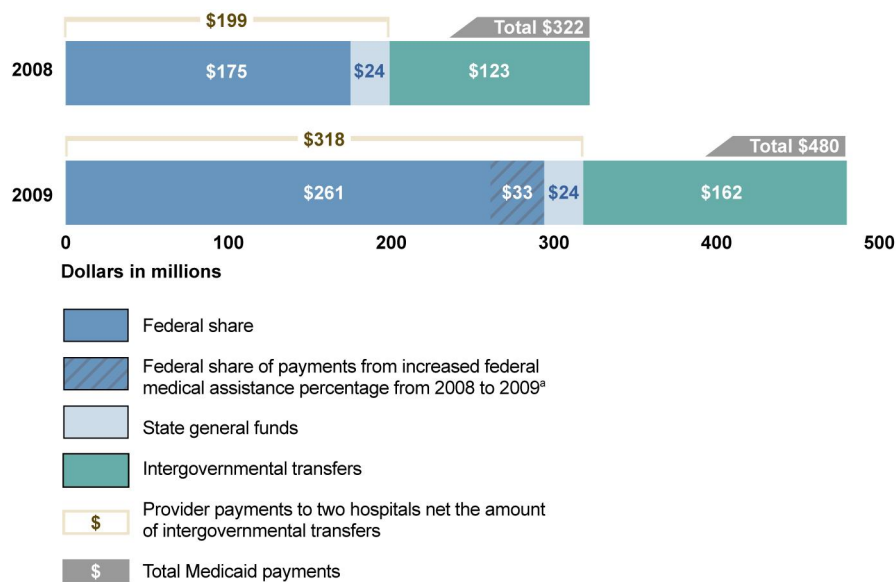
Our past work has found that states rely heavily on local government funds and provider taxes to finance supplemental payments, which states often direct to the public providers providing the IGT or to the class of providers paying the taxes. In doing this, states are able to shift to the federal government the responsibility for financing a greater net share of Medicaid payments.¹⁷

¹⁷In 2012, local government funds and provider taxes supplied 18 percent of the nonfederal share of regular Medicaid base payments, but over 70 percent of supplemental payments. See GAO-14-627.

For example, as we reported in 2014, one state was able to significantly increase supplemental Medicaid payments with no commensurate increase in spending from state general funds.¹⁸ To finance the increased supplemental payments, the state relied on IGTs from the local government that owned and operated the two hospitals receiving the supplemental payments. In both 2008 and 2009—the year before and after the state increased supplemental payments—the state relied on IGTs from the local government to finance most of the nonfederal share, while the amount of Medicaid spending from state general funds—\$24 million—did not change. As a result, net provider payments increased from \$199 million in 2008 to \$318 million in 2009. This \$119 million increase was effectively comprised entirely of federal funds, which increased from \$175 million in 2008 to \$294 million in 2009.¹⁹

By relying on IGTs to finance the increased supplemental payment, in this instance, the state increased the magnitude and share of federal spending for the Medicaid payment. (See fig. 7.)

Figure 7: Example of Change in Federal Spending as a Result of a State’s Use of Intergovernmental Transfers to Finance Increased Supplemental Payments to Two Hospitals



Source: GAO. | GAO-14-627.

¹⁸The state accomplished this by lowering its base Medicaid payment for inpatient hospital services in 2009. With the reduction in base payments, the state could make larger supplemental payments. See GAO-14-627.

¹⁹See GAO-14-627. In this report we reviewed data from years 2008 through 2012 to determine the extent to which selected states relied on funds from health care providers and local governments to finance the nonfederal share of Medicaid and extent to which states’ reliance sources changed over time. The state received an increased federal matching rate under the American Recovery and Reinvestment Act of 2009, which accounted for \$33 million of the \$294 million in federal spending for supplemental payments to the two hospitals. Pub. L. No. 111-5, § 5001, 123 Stat. 115, 496 (Feb. 17, 2009).

Data table for Figure 7: Example of Change in Federal Spending as a Result of a State’s Use of Intergovernmental Transfers to Finance Increased Supplemental Payments to Two Hospitals

Dollars in millions (percentage from total)

	Federal share	State general funds	FMAP for federal	Intergovernmental transfers
2008	\$175	\$24	\$0	\$123
2009	\$261	\$24	\$33	\$162

^aDuring this time period, states received an increased federal matching rate under the American Recovery and Reinvestment Act of 2009, which accounted for \$33 million in federal spending in year 2. 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).

As we have described in past reports, the potential for effectively shifting Medicaid expenditures is facilitated by different financing arrangements and, in particular, can create incentives for states to maximize supplemental payments.²⁰ We have highlighted the importance of oversight to ensure that Medicaid supplemental payments are being made for Medicaid purposes in an economical and efficient fashion.²¹ For example, our past work identified instances where supplemental payments have exceeded hospitals’ costs, and we have raised questions about whether these payments are economical or efficient:

- As reported in November 2012, we found that the majority of states—39—had made supplemental payments to over 500 hospitals that, along with their regular Medicaid payments, exceeded those hospitals’ total costs of providing care to Medicaid enrollees by \$2.7 billion.²²
- In some cases, payments greatly exceeded costs; for example, in 2012 we reported that one hospital received almost \$320 million in supplemental payments and \$331 million in regular Medicaid payments, which exceeded the \$410 million in costs reported for the hospital for providing Medicaid services by about \$241 million.²³

In our prior work, we have also found that CMS oversight of supplemental payments is limited, in part, because the agency:

²⁰See GAO-14-627; *CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy*, GAO-15-322 (Washington, D.C.: April 10, 2015); and *Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives*, GAO-15-239 (Washington, D.C.: April 13, 2015).

²¹Under federal law, to receive federal matching funds, payments generally (1) must be made for covered Medicaid items and services; (2) must be consistent with economy, efficiency, and quality of care; and (3) must not exceed the Medicaid upper payment limit, which is a reasonable estimate of what Medicare would pay for comparable services. The upper payment limit is not applied to payments to individual providers; instead, it applies on an aggregate basis to all providers rendering specific services within an ownership class, such as state government-owned or -operated facilities that provide inpatient services.

²²See GAO, *More Transparency of and Accountability for Supplemental Payments Are Needed*. GAO-13-48 (Washington, D.C.: Nov. 26, 2012).

²³See GAO-13-48

- does not collect sufficient information on supplemental payments to providers; consequently, the full extent of spending on supplemental payments remains unknown; and
- does not have a policy and standard process for determining whether Medicaid payments to individual providers are economical and efficient.

We have made several recommendations to CMS to strengthen its oversight of financing and supplemental payments.²⁴ In particular, we have recommended that CMS:

- improve data collection on the financing of supplemental payments, and
- develop policies and standards to assess whether payments are economical or efficient.

CMS disagreed with the first recommendation and agreed with the second. As of May 2020, these recommendations remained unimplemented. Without good data on financing and criteria for assessing whether the payments are economical and efficient, the federal government could be paying states hundreds of millions, or billions, of dollars more than what is appropriate.

In our prior work, we also identified a matter for congressional consideration to improve oversight of Medicaid expenditures related to supplemental payments. In particular, in 2012, we asked the Congress to consider broadening supplemental payment reporting and auditing requirements to improve transparency and strengthen oversight of their use and impact on the Medicaid program.²⁵ Supplemental payments are a significant and growing component of Medicaid spending, and improving oversight of supplemental payments is essential for ensuring the sustainability of the Medicaid program.

²⁴ See GAO-15-322, and *High Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*. GAO-19-157SP (Washington, D.C.: Mar. 6, 2019). Since designating Medicaid as a high-risk area in 2003, we have made at least 55 recommendations related to the appropriate use of program dollars, 15 of which were open as of May 2020.

²⁵ GAO-13-48. As of February 2020, there has not been any related legislation enacted; however, CMS has taken some administrative actions, including releasing a proposed rule, intended to improve its oversight of supplemental payments.

Selected GAO Work

Medicaid States' Use and Distribution of Supplemental Payments to Hospitals. GAO-19-603. Washington, D.C.: July 19, 2019.

High Risk Series: Substantial Efforts needed to Achieve Greater Progress on High-Risk Areas. GAO-19-157SP. Washington, D.C.: Mar. 6, 2019.

Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy. GAO-15-322. Washington, D.C.: April 10, 2015

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.

Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed.

GAO-13-48. Washington, D.C.: Nov 26, 2012.