MEDICAID

CMS Has Taken Steps, but Further Efforts Are Needed to Control Improper Payments

What GAO Found

GAO’s prior work has identified four Medicaid program integrity issues—where the program is vulnerable to improper payments such as those made for services that were not covered, were not medically necessary, or were not provided—as well as actions taken by the Centers for Medicare & Medicaid Services (CMS) to address the issues and additional actions that should be taken.

- **Enrollment Verification:** In response to the Patient Protection and Affordable Care Act (PPACA), CMS established a more rigorous approach for verifying financial and nonfinancial information needed to determine Medicaid beneficiary eligibility. Despite CMS’s efforts, however, there continue to be gaps in efforts to ensure that only eligible individuals are enrolled into Medicaid, and that Medicaid expenditures for enrollees—particularly those eligible as a result of the PPACA expansion—are matched appropriately by the federal government.

- **Oversight of Medicaid Managed Care:** CMS has provided states with additional guidance on their oversight of Medicaid managed care. Oversight of managed care is increasing in importance and improvements in measuring the improper payment rate are needed. For example, the estimated improper payment rate for managed care is based on a review of payments made to managed care organizations, and does not review any underlying medical documentation. GAO and the Department of Health and Human Services (HHS) Office of Inspector General have identified incomplete and untimely managed care encounter data—data that managed care organizations are expected to report to state Medicaid programs, allowing states to track the services received by beneficiaries enrolled in managed care.

- **Provider Eligibility:** PPACA included multiple provisions aimed at strengthening the screening of providers who enroll to participate in Medicaid. While the act requires that all providers and suppliers be subject to licensure checks, it gave CMS discretion to establish a risk-based application of other screening procedures, such as fingerprint-based criminal-background checks for high-risk providers. Also, CMS regulations now require that all Medicaid managed care providers enroll with the state Medicaid agency, which has the potential to improve oversight of providers in managed care. However, GAO’s work based on 2 states and 16 health plans identified challenges screening providers for eligibility, partially due to fragmented information.

- **Coordination between Medicaid and the Exchange:** CMS implemented a number of policies and procedures to ensure that individuals do not have duplicate coverage (enrolled in both Medicaid and in subsidized coverage through an exchange, which is a marketplace where eligible individuals may compare and purchase private health insurance). CMS has conducted checks to identify individuals with duplicate coverage, and plans to complete these checks at least twice times per coverage year, which has the potential to save federal—as well as beneficiary—dollars. However, CMS has not developed a plan for assessing whether the checks and other procedures—such as thresholds for the level of duplicate coverage deemed acceptable—are sufficient to prevent and detect duplicate coverage.