



October 2015

MEDICAID

Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds

Accessible Version

GAO Highlights

Highlights of [GAO-16-53](#), a report to congressional requesters

Why GAO Did This Study

Historically, Medicaid eligibility has been limited to certain categories of low-income individuals, but PPACA, enacted on March 23, 2010, gave states the option to expand coverage to nearly all adults with incomes at or below 133 percent of the federal poverty level, beginning January 1, 2014. States that do so are eligible for increased federal matching rates for enrollees receiving coverage through the state option to expand Medicaid under PPACA, and where applicable, enrollees in states that expanded coverage prior to PPACA's enactment.

GAO was asked to examine Medicaid enrollment and expenditures, and CMS oversight of the appropriateness of federal matching funds. This report examines (1) Medicaid enrollment and spending in 2014 by different eligibility groups; and (2) how CMS ensures states are accurately determining eligibility, and that expenditures are appropriately matched. GAO analyzed enrollment and expenditure data for enrollee eligibility groups submitted by states to CMS, examined relevant federal laws and regulations, internal control standards, CMS guidance and oversight tools, and interviewed CMS officials.

What GAO Recommends

GAO recommends that CMS (1) review federal determinations of Medicaid eligibility for accuracy, and (2) use the information obtained from the eligibility reviews to inform the expenditure review, and increase assurances that expenditures for the different eligibility groups are correctly reported and appropriately matched. In its response, the agency generally concurred with these recommendations.

View [GAO-16-53](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov

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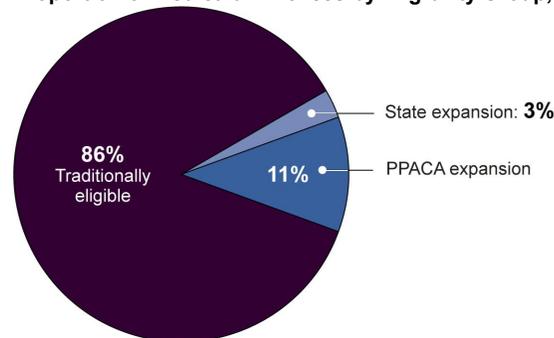
MEDICAID

Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds

What GAO Found

PPACA-expansion and state-expansion enrollees—individuals who were not eligible under historic Medicaid eligibility rules but are eligible under (1) a state option to expand Medicaid under the Patient Protection and Affordable Care Act (PPACA), or (2) a state's qualifying expansion of coverage prior to PPACA's enactment—comprised about 14 percent of Medicaid enrollees and about 10 percent of Medicaid expenditures at the end of 2014. According to GAO's analysis of state reported data, of the approximately 69.8 million individuals recorded as enrolled in Medicaid, about 60.1 million were traditionally eligible enrollees, comprising about 86 percent of the total; about 7.5 million (11 percent of all Medicaid enrollees) were PPACA-expansion enrollees, and 2.3 million (3 percent of all Medicaid enrollees) were state-expansion enrollees. With regard to expenditures, states had reported \$481.77 billion in Medicaid expenditures for services in calendar year 2014. Of this total, expenditures for traditionally eligible enrollees were \$435.91 billion (about 90 percent of total expenditures), expenditures for PPACA-expansion enrollees were about \$35.28 billion (7 percent of total expenditures), and expenditures for state-expansion enrollees were \$10.58 billion (2 percent of total expenditures).

Proportion of Medicaid Enrollees by Eligibility Group, Last Quarter of Calendar Year 2014



Source: GAO analysis of Centers for Medicare & Medicaid Services enrollment data, as of June 2, 2015. | GAO-16-53

The Centers for Medicare & Medicaid Services (CMS), which oversees Medicaid, has implemented interim measures to review the accuracy of state eligibility determinations and examine states' expenditures for different eligibility groups, for which states may receive up to three different federal matching rates. However, CMS has excluded from review federal Medicaid eligibility determinations in the states that have delegated authority to the federal government to make Medicaid eligibility determinations through the federally facilitated exchange. This creates a gap in efforts to ensure that only eligible individuals are enrolled into Medicaid and that state expenditures are correctly matched by the federal government. In addition, CMS reviews of states' expenditures do not use information obtained from the reviews of state eligibility determination errors to better target its review of Medicaid expenditures for the different eligibility groups. An accurate determination of these different eligibility groups is critical to ensuring that only eligible individuals are enrolled, that they are enrolled in the correct eligibility group, and that states' expenditures are appropriately matched with federal funds for Medicaid enrollees, consistent with federal internal control standards. Consequently, CMS cannot identify erroneous expenditures due to incorrect eligibility determinations, which also limits its ability to ensure that state expenditures are appropriately matched with federal funds.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
FFE	federally facilitated exchange
FMAP	Federal Medical Assistance Percentage
FPL	federal poverty level
HCERA	Health Care and Education Reconciliation Act of 2010
HHS	Department of Health and Human Services
MBES	Medicaid Budget and Expenditure System
MEQC	Medicaid Eligibility Quality Control
PCI	per capita income
PERM	Payment Error Rate Measurement
PPACA	Patient Protection and Affordable Care Act
SBE	state-based exchange

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October 16, 2015

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

States and the federal government share in the financing of the Medicaid program—a joint federal-state health care financing program for certain low-income and medically needy individuals—with the federal government matching most state expenditures for Medicaid services on the basis of a statutory formula known as the Federal Medical Assistance Percentage (FMAP).¹ Historically, Medicaid eligibility has been limited to certain categories of low-income individuals—such as children, parents, pregnant women, persons with disabilities, and individuals age 65 and older. However, under the Patient Protection and Affordable Care Act (PPACA), enacted on March 23, 2010, states may opt to expand their Medicaid programs by covering nearly all adults with incomes at or below 133 percent of the federal poverty level (FPL) beginning January 1, 2014.² Twenty-six states and the District of Columbia opted to expand their Medicaid programs for 2014.³ States that choose to expand their

¹The FMAP is calculated using a statutory formula based on the state's per capita income, with the federal government paying a larger portion of Medicaid expenditures in states with low per capita incomes relative to the national average, and a smaller portion for states with higher per capita incomes.

²Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010). For purposes of this report, references to PPACA include the amendments made by HCERA. PPACA also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases this income level to 138 percent of the FPL. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), (e)(14)(I).

³An additional three states—Alaska, Indiana, and Pennsylvania—opted to expand their Medicaid programs for 2015. In addition, as of July 2015, Montana's proposed Medicaid expansion is pending federal approval.

programs receive an increased federal match for expenditures incurred as a result of providing services to individuals whom the state had not previously covered. Some of these states may also receive an increased federal matching rate for another eligibility group, provided the state covered this eligibility group as of December 1, 2009, for example, through a state-funded expansion. In order to receive a federal match for expenditures, states are required to provide to the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid, data on Medicaid enrollment and expenditures for review. In addition to expanding eligibility standards, PPACA also required the establishment of a coordinated eligibility and enrollment process for Medicaid and the health insurance exchanges to streamline the eligibility determination process.⁴ These changes, which shift the process toward a more automated approach, necessitated the adoption of new policies and information technology systems by the states that allow for the exchange of data to ensure that applicants are enrolled in the program for which they are eligible, regardless of the program for which they applied. During fiscal year 2013, Medicaid covered about 72 million individuals at a cost of approximately \$431.1 billion, with the federal share of \$247.7 billion comprising 57 percent of costs, and the state share of \$183.4 billion comprising 43 percent.⁵ Given the significant effect these eligibility, funding, and process changes could have on Medicaid enrollment and expenditures, you asked us to review 2014 Medicaid enrollment and expenditures, and CMS's oversight of the appropriateness of federal matching funds. This report examines

1. the enrollment and spending for individuals who enrolled in Medicaid in 2014 by different eligibility groups; and
2. CMS efforts to ensure the accuracy of Medicaid eligibility determinations, and that state expenditures for Medicaid enrollees in different eligibility groups are appropriately matched.

⁴PPACA required the establishment of health insurance exchanges in each state by January 1, 2014, to allow individuals in that state to compare and purchase health insurance coverage using a single, streamlined form that may be used to apply for Medicaid.

⁵The number of enrollees represents the total number of individuals ever enrolled in the program in 2013; there were about 58 million individuals enrolled in the program at any one point in time. Medicaid and CHIP Payment and Access Commission (MACPAC), *MACStats: Medicaid and CHIP Program Statistics*, March 2014.

To determine the enrollment and expenditures for individuals who enrolled in Medicaid in 2014 by different eligibility groups, we examined data submitted to CMS by states as part of their enrollment and expenditure reporting.⁶ These data included information from new enrollment forms developed by CMS and used by states to report the number of enrollees by eligibility group, as well as expenditure data. States submitted these data to CMS by means of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program—also known as the form CMS-64—within the Medicaid Budget and Expenditure System (MBES). We reviewed data for each quarter in calendar year 2014.⁷ We also interviewed knowledgeable CMS officials in the Center for Medicaid and CHIP Services about data available on Medicaid enrollment and expenditures, as well as steps they take to ensure data reliability. Based on our interviews, we determined that these data were sufficiently reliable for our purposes. (See appendix II for more details about our methodology for the first objective.)

To examine CMS efforts to ensure that states are accurately verifying eligibility, and that expenditures for Medicaid enrollees in different eligibility groups are appropriately matched by federal funds, we examined (1) relevant laws and federal regulations and CMS policy documents describing the different eligibility groups; (2) guidance to states on eligibility and expenditure reviews; and (3) instructions for eligibility and expenditure reviews conducted by states and CMS. We also reviewed the results of CMS's CMS-64 expenditure reviews, state

⁶This report focuses on the 50 states and the District of Columbia, although the U.S. territories also receive federal funds for Medicaid. For the purposes of this report, we include the District of Columbia as a state.

⁷CMS-64 data are comprised of data collected from several different forms. CMS implemented a new form within CMS-64 to collect enrollment data—called the “CMS-64.Enroll” form—by eligibility type beginning January 1, 2014. We extracted enrollment data from this form, and expenditure data from the CMS-64 net expenditures financial management report, from MBES on June 2, 2015. These expenditure data may be subject to adjustment by states or by CMS and may not have been reviewed by CMS. CMS data are reported at a state aggregate level. Therefore, these data do not tie expenditures to services provided to particular individuals during the reporting period.

eligibility reviews, and regional office reports for nine selected states.⁸ In evaluating this information, we considered GAO's *Standards for Internal Control in the Federal Government*, which provide guidance to federal agencies on ensuring accountability.⁹ In addition, we interviewed CMS officials about CMS's eligibility and expenditure reviews.

We conducted this performance audit from October 2014 to October 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Both the federal government and the states share responsibility for administering the Medicaid program. At the federal level, CMS is responsible for overseeing states' design and operation of their Medicaid programs, and ensuring that federal funds are appropriately spent. The federal government sets broad federal requirements for Medicaid—such as requiring that state Medicaid programs cover certain populations and benefits—while states administer their respective Medicaid programs' day-to-day operations under their state plans.¹⁰ State responsibilities include, among other things, determining eligibility, enrolling beneficiaries, and adjudicating claims.

⁸We selected states to review based on their expansion status; size of the program as indicated by recent enrollment and expenditure reports; whether the state established its own state-based exchange (SBE), as authorized by PPACA, or used an exchange established by HHS, known as a federally facilitated exchange (FFE), and geographic diversity. The states we selected were California, Hawaii, Kentucky, Minnesota, New Mexico, New York, North Dakota, Ohio, and West Virginia.

⁹GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

¹⁰Each state develops its Medicaid state plan, describing how it will administer its Medicaid program, and submits the plan to CMS for approval.

Medicaid Funding

Medicaid is funded jointly by the federal government and states. The federal government's share of most Medicaid expenditures is based on a statutory formula—the FMAP. Under the FMAP, the federal government pays a share of Medicaid expenditures based on each state's per capita income relative to the national average. The formula is designed such that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes (PCI) relative to the national average.¹¹ Regular FMAP rates have a statutory minimum of 50 percent and a statutory maximum of 83 percent. For fiscal year 2014, regular FMAP rates ranged from 50.00 percent to 73.05 percent. Under PPACA, state Medicaid expenditures for certain Medicaid enrollees are subject to higher federal matching percentages.

Medicaid Funding for Different Eligibility Groups

States generally must meet certain minimum requirements for establishing Medicaid eligibility for individuals. Historically, eligibility has been based on a variety of categorical and financial requirements. In particular, prior to PPACA, Medicaid eligibility was limited to certain categories of low income individuals, such as pregnant women, parents and children, individuals who are aged, and individuals with disabilities.¹² States could use their own funds to expand Medicaid coverage to other populations—such as childless adults—but they could not claim federal matching funds except under the authority of a Medicaid demonstration under section 1115 of the Social Security Act.¹³ As of December 1, 2009, about four months before PPACA's enactment on March 23, 2010, 11 states had expanded Medicaid coverage through state-funded programs

¹¹A state's FMAP is calculated using the following formula: $\text{State FMAP} = 1.00 - 0.45 (\text{State PCI} / \text{U.S. PCI})^2$. We refer to FMAPs that are calculated using this formula as regular FMAP rates.

¹²In addition to meeting categorical and financial requirements, applicants must also meet immigration and residency requirements.

¹³Section 1115 of the Social Security Act authorizes the Secretary of HHS to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives. For example, states may test ways to obtain savings or efficiencies in how services are delivered in order to cover otherwise ineligible services or populations.

or demonstrations to include parents and nonpregnant childless adults with incomes of at least 100 percent of the FPL.¹⁴ This population was subsequently deemed eligible under PPACA if the state opted to expand Medicaid under PPACA.

The 2014 Medicaid enrollees consist of:

1. Traditionally eligible enrollees—individuals who are eligible under historic eligibility standards; states receive their regular FMAP for incurring expenditures related to this population.
2. PPACA-expansion enrollees—individuals who would not have been eligible under the rules in effect on December 1, 2009, and whose coverage began after their state opted to expand Medicaid as authorized by PPACA,¹⁵ and
3. State-expansion enrollees—individuals who were not traditionally eligible, but were covered by Medicaid under a state-funded program or pre-existing state demonstration as of December 1, 2009, in states that subsequently opted to expand Medicaid as authorized under PPACA.¹⁶

In states that choose to expand their Medicaid programs as authorized by PPACA, the federal government will provide an FMAP of 100 percent beginning in 2014 to cover expenditures for the PPACA-expansion enrollees. The increased FMAP will gradually diminish to 90 percent by 2020. States will also receive an FMAP above the state's regular match for their Medicaid expenditures for the state-expansion enrollees, ranging from 75-92 percent in 2014. This FMAP will gradually increase and will eventually equal the FMAP for the PPACA-expansion enrollees beginning

¹⁴See 42 U.S.C. § 1396d(z)(3). The 11 states were Arizona, Delaware, Hawaii, Maine, Massachusetts, Minnesota, New York, Pennsylvania, Vermont, Washington, and the District of Columbia. For the purposes of this report, we include the District of Columbia as a state. There were additional states that had expanded Medicaid coverage prior to PPACA but did not meet the criteria outlined in § 1396d(z)(3).

¹⁵This group is referred to in CMS data as the newly eligible enrollees. This group also includes individuals who would have been eligible for Medicaid coverage under a state demonstration as of December 1, 2009, but could not be enrolled for such coverage due to limited or capped enrollment.

¹⁶This group is referred to in CMS data as the not newly eligible enrollees.

in 2019.¹⁷ (See table 1.) Consequently, a state that chooses to expand its Medicaid program could potentially receive three different FMAPs for its different types of Medicaid enrollees.¹⁸

Table 1: Federal Medical Assistance Percentage (FMAP) Rates for Different Medicaid Populations, by Fiscal Year

Population	2014	2015	2016	2017	2018	2019	2020+
Traditionally eligible enrollees	50%-83%	50%-83%	50%-83%	50%-83%	50%-83%	50%-83%	50%-83%
PPACA-expansion enrollees	100%	100%	100%	95%	94%	93%	90%
State-expansion enrollees	75%-92%	80%-93%	85%-95%	86%-93%	90%-93%	93%	90%

Source: GAO analysis of Congressional Research Service information. | GAO-16-53

Notes: Traditionally eligible enrollees are eligible for Medicaid under historic eligibility standards. Patient Protection and Affordable Care Act (PPACA)-expansion enrollees are individuals whose coverage began after their state opted to expand Medicaid as authorized by PPACA. State-expansion enrollees are individuals who were not traditionally eligible but were covered by Medicaid under a state-funded program or state demonstration as of December 1, 2009 in states that subsequently opted to expand Medicaid as authorized by PPACA.

Expenditures for traditionally eligible enrollees receive the federal match calculated using the traditional FMAP formula, which we refer to as the regular FMAP. It can range from 50 percent (the statutory minimum) to 83 percent (the statutory maximum). The FMAP rate is published annually, and for fiscal year 2014 it ranged from 50.00 percent to 73.05 percent; for fiscal year 2015 it ranged from 50.00 percent to 73.58 percent; and for fiscal year 2016 it ranged from 50.00 percent to 74.17 percent. The FMAP rates for fiscal year 2017 and beyond had not yet been published at the time of our work.

Medicaid Enrollment

States are primarily responsible for verifying eligibility and enrolling Medicaid beneficiaries. These responsibilities include verifying and validating individuals' eligibility at the time of application and periodically thereafter, and promptly disenrolling individuals who are not eligible.¹⁹

¹⁷The formula used to calculate the state-expansion FMAP rates is based on a state's regular FMAP rate so the enhanced FMAP rate will vary from state to state until 2019, and will be between a state's regular and PPACA-expansion FMAPs.

¹⁸During 2014 and 2015, an alternative FMAP rate increase of 2.2 percentage points is available for states that previously expanded Medicaid coverage if the Secretary of HHS determines the state will not receive any FMAP rate increase for its state-expansion enrollees and the state has not been approved to use Medicaid disproportionate share hospital (DSH) funds to pay for the cost of health coverage under a demonstration in effect as of July 2009. One state, Vermont, is eligible to receive an additional "expansion" FMAP of 2.2 percent in 2014 and 2015.

¹⁹Factors that states verify include, among others, citizenship, immigration status, age (date of birth), Social Security number, income, residency and household composition.

Although states have the flexibility to use different sources of information and processes to verify eligibility factors, CMS guidelines call upon states to maximize automation and real-time adjudication of Medicaid applications through the use of electronic verification policies and the use of multiple application channels, including health insurance exchanges—whether federally facilitated exchanges (FFE) or state-based exchanges (SBE)—to implement PPACA’s coordinated eligibility determination process.²⁰ Under this process, individuals can apply for health coverage through their state’s Medicaid agency or its health insurance exchange, whether an FFE or an SBE, and regardless of which route they choose, their eligibility will be determined for coverage under the appropriate program. Consequently, FFEs and SBEs are designed to make assessments of Medicaid eligibility. As of November 6, 2014, 17 states had SBEs and 34 states had FFEs. Of these 34 FFE states, 10 had delegated authority to the FFEs to make Medicaid eligibility determinations for individuals applying through the exchanges.²¹ In the remaining states, an FFE’s assessment that an applicant may be eligible for Medicaid is subject to a final eligibility determination by the state Medicaid agency, which is also the process followed in the SBE states.

Moreover, PPACA required states to use third party sources of data to verify eligibility to the extent practicable. Consequently, states have had to make changes to their eligibility systems including implementing electronic systems for eligibility determination and coordinating systems to share information.²² In addition, states have had to make changes to reflect new sources of documentation and income used for verification.

²⁰If a state elected not to create and operate its own exchange, or SBE, PPACA directed HHS to establish and operate an exchange, or FFE in the state. Currently, 17 states, including the District of Columbia, have established SBEs.

²¹See <http://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-and-the-marketplace/medicaid-chip-marketplace-interactions.html>, accessed July 7, 2015. Within these 10 states, the state Medicaid agencies continue to determine eligibility for individuals who applied through the state Medicaid program, as is the case in all states.

²²For additional information on states’ changes to their eligibility systems, see GAO, *Medicaid: Federal Funds Aid Eligibility IT System Changes, but Implementation Challenges Persist*, [GAO-15-169](#), (Washington, D.C.: Dec. 12, 2014).

Federal regulations require states to develop and submit their Medicaid eligibility verification plans to CMS for approval.²³

CMS Oversight of Medicaid Enrollment and Expenditures

As part of its oversight role, CMS oversees state enrollment of beneficiaries and reporting of expenditures. In addition to reviewing state verification plans for assessing Medicaid eligibility, CMS requires states to conduct certain reviews to assess the accuracy of states' Medicaid eligibility determination processes through its Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs.

- MEQC is overseen by CMS and requires states to report to CMS every six months on the accuracy of their Medicaid eligibility determination processes. States can choose to participate in traditional MEQC or MEQC pilots, with the majority of states choosing to participate in the MEQC pilots. While the traditional MEQC requires states to report error rates for 6 month periods, MEQC pilots can be for a year and—for the annual pilots— states are required to report on an annual basis by August 1st of each year. Pilots that are less than a year have 60 days from the end of the pilot to report findings.
- CMS implemented the PERM to measure improper payments in Medicaid—including payments made for treatments or services that were not covered by program rules, that were not medically necessary, or that were billed for but never provided—in response to the requirements of the Improper Payments Information Act of 2002, as amended.²⁴ Under the PERM, CMS measures and reports to Congress improper payment rates in three component areas: (1) fee-for-service claims, (2) managed care, and (3) eligibility. To assess improper payments attributable to erroneous eligibility determinations, the PERM includes state-conducted eligibility reviews that are reported to CMS.

²³42 C.F.R. § 435.945(j).

²⁴Pub. L. No. 107-300, 116 Stat. 2350 (2002), as amended by the Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, 124 Stat. 2224 (2010) and the Improper Payments Elimination and Recovery Improvement Act of 2012, Pub. L. No. 112-248, 126 Stat. 2390 (2013) (codified, as amended, at 31 U.S.C. § 3321 note).

Under the MEQC and PERM, state Medicaid staff were required to review all the documentation for a sample of both positive and negative eligibility cases—that is, both individuals who were determined to be eligible, and those determined to be ineligible and thus denied enrollment—and identify any improper payments for services.²⁵

In light of the changes to Medicaid eligibility standards and state eligibility systems necessitated by PPACA, CMS announced that the agency has suspended the MEQC program and the eligibility portion of the PERM until fiscal year 2018. During this period, according to CMS, PERM managed care and fee-for-service payment reviews will continue uninterrupted, and CMS will continue to report Medicaid improper payment rates based on that data. In addition, CMS will report an estimated improper payment rate for the eligibility component based on historical data.

As a temporary replacement to the MEQC and PERM eligibility reviews, CMS implemented a pilot eligibility review to assess states' determination of eligibility and eligibility type for fiscal year 2014 through fiscal year 2017. States develop their own approaches to testing their eligibility determinations under the pilot eligibility review, but must submit descriptions of their proposed methodology to CMS for review and approval. According to CMS's instructions for the pilot eligibility reviews, at a minimum, states must draw a sample of at least 200 eligibility determinations, including both positive and negative determinations.²⁶ For these sample cases, states must review all caseworker action taken from initial application to the final eligibility determination. Among other factors, for each case reviewed, states must assess the correctness of decisions relating to program eligibility and eligibility group (i.e., whether an enrollee was correctly identified as a traditionally eligible enrollee, a PPACA-expansion enrollee or a state-expansion enrollee). For each error identified, states are required to develop a corrective action plan to avoid similar errors in the future. States were required to have one round of the pilot eligibility reviews completed by the end of June 2014, a second

²⁵The Medicaid and CHIP Payment and Access Commission (MACPAC) examined both MEQC and PERM and identified areas of overlap between the programs in its June 2013 report to Congress (see the June 2013 MACPAC report <http://www.macpac.gov>.)

²⁶As an additional component of the pilot eligibility review, CMS requires the states to assess their automated eligibility determination processes by running test cases—hypothetical applicants and scenarios—to identify any errors in their processes.

round completed by the end of December 2014, and subsequent reviews to be completed in 2015, 2016, and 2017.

As part of its oversight responsibilities, CMS also conducts CMS-64 expenditure reviews. As we have previously reported, the agency collects and reviews aggregate quarterly expenditure information from the states through its CMS-64 form, which is used to reimburse states for their Medicaid expenditures.²⁷ The CMS-64 data set contains program-benefit costs and administrative expenses at a state aggregate level—such as a state’s total expenditures for such categories as inpatient hospital services and prescription drugs—and these reported expenditures are not linked to individual enrollees. State Medicaid agencies typically submit this information to CMS 30 days after a quarter has ended. CMS regional office staff review expenditures submitted through CMS-64 for reasonableness and to determine whether reported expenditures are allowable in accordance with Medicaid rules, and use the data to compute the federal share for each state’s Medicaid program expenditures. If, during the CMS-64 expenditure review, CMS is uncertain as to whether a particular state expenditure is allowable, then CMS regional offices may recommend that CMS defer the expenditure pending further review.

PPACA- and State-Expansion Enrollees Comprised about 14 Percent of 2014 Medicaid Enrollees and about 10 Percent of Expenditures

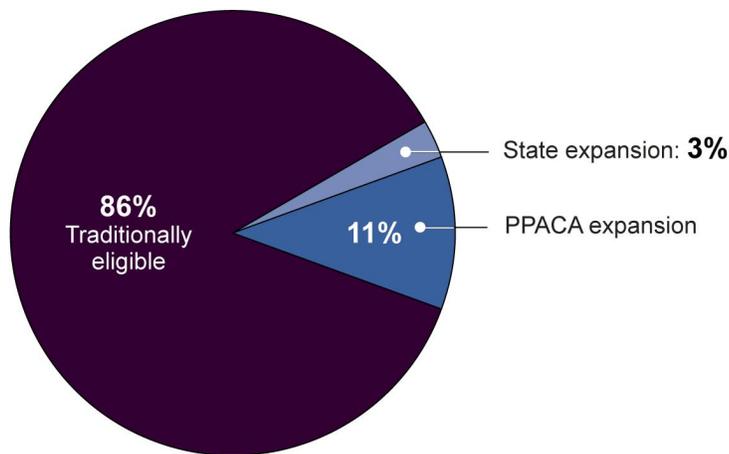
PPACA- and state-expansion enrollees comprised about 14 percent of Medicaid enrollees at the end of the last quarter in calendar year 2014. Additionally, these enrollees comprised about 10 percent of total Medicaid expenditures for 2014 enrollees.

²⁷GAO, *Medicaid: Data Sets Provide Inconsistent Picture of Expenditures*, [GAO-13-47](#) (Washington, D.C.: Oct. 29, 2012).

PPACA- and State-Expansion Enrollees Comprised about 14 Percent of 2014 Medicaid Enrollees

As of June 2, 2015, approximately 69.8 million individuals were recorded as enrolled in Medicaid at the end of the last quarter of calendar year of 2014. Most of these individuals—about 60.1 million—were traditionally eligible enrollees—comprising about 86 percent of total enrollees. About 9.7 million of the 2014 enrollees—approximately 14 percent—were PPACA-expansion or state-expansion enrollees, with 7.5 million (11 percent of all Medicaid enrollees) as PPACA-expansion enrollees and 2.3 million (3 percent of all Medicaid enrollees) as state-expansion enrollees. (See figure 1 for information on Medicaid enrollment in the last quarter of calendar year 2014 and appendix III for information comparing enrollment for all four quarters in 2014.)

Figure 1: Proportion of Medicaid Enrollees by Eligibility Group, Last Quarter of Calendar Year 2014



Source: GAO analysis of Centers for Medicare & Medicaid Services enrollment data, as of June 2, 2015. | GAO-16-53

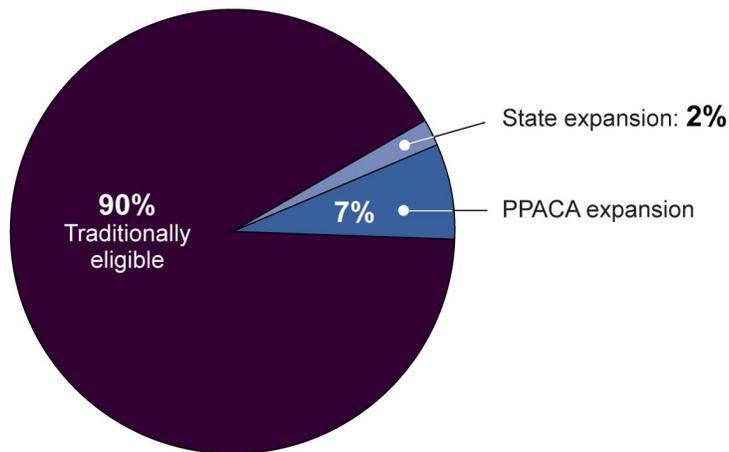
Notes: Figure excludes totals reported for the U.S. territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, whose total federal Medicaid spending is subject to an annual cap, and which did not report numbers of enrollees for all eligibility types.

Traditionally eligible enrollees are eligible under historic eligibility standards. Patient Protection and Affordable Care Act (PPACA)-expansion enrollees are individuals whose coverage began after their state opted to expand Medicaid as authorized by PPACA. State-expansion enrollees are individuals who were not traditionally eligible, but were covered by Medicaid under a state-funded program or a state demonstration as of December 1, 2009 in states that subsequently opted to expand Medicaid as authorized by PPACA.

Expenditures for PPACA- and State-Expansion Enrollees Comprised about 10 Percent of Spending for 2014 Medicaid Enrollees

As of June 2, 2015, states had reported \$481.77 billion in Medicaid expenditures for services in calendar year 2014.²⁸ Of this total, expenditures for traditionally eligible enrollees were \$435.91 billion (comprising about 90 percent of total expenditures), about \$35.28 billion (7 percent of total expenditures) was for PPACA-expansion enrollees and \$10.58 billion (2 percent of total expenditures) was for state-expansion enrollees. (See figure 2 and appendix IV for more information on 2014 Medicaid expenditures.)

Figure 2: Total Medicaid Expenditures for Calendar Year 2014 by Enrollee Eligibility Group



Source: GAO analysis of Centers for Medicare & Medicaid Services expenditure data, as of June 2, 2015. | GAO-16-53

Notes: Percentages do not total 100 due to rounding.

Figure excludes totals reported for the U.S. territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, whose total federal Medicaid spending is subject to an annual cap, and which did not report expenditures for all eligibility types.

Traditionally eligible enrollees are eligible under historic eligibility standards. Patient Protection and Affordable Care Act (PPACA)-expansion enrollees, are individuals whose coverage began after their state opted to expand Medicaid as authorized by PPACA. State-expansion enrollees are individuals who were not traditionally eligible, but were covered for Medicaid under a state-funded program or a

²⁸These data were extracted from the CMS-64 net Financial Management Report for calendar year 2014, and exclude administrative expenditures.

state demonstration as of December 1, 2009 in states that subsequently opted to expand Medicaid as authorized by PPACA.

Overall, the federal share of Medicaid expenditures was approximately 61 percent of spending for Medicaid services in 2014. For traditionally eligible enrollees, the percentage of federal spending was 58 percent of total Medicaid expenditures for this population. For PPACA-expansion enrollees, the overall proportion of federal spending was 100 percent, and for state-expansion enrollees, the overall proportion of federal spending was 74 percent.

Limitations in Eligibility and Expenditure Reviews Hamper CMS's Ability to Ensure the Appropriateness of Federal Matching Funds

CMS has implemented reviews that (1) assess the accuracy of eligibility determinations, and (2) examine states' expenditures to ensure they are attributed to the correct eligibility group. However, both reviews contain gaps that limit CMS's ability to ensure that expenditures for the different eligibility groups are appropriately matched with federal funds.

A Gap Exists in CMS's Interim Efforts to Assess the Accuracy of Eligibility Determinations

CMS has implemented interim efforts to assess states' Medicaid eligibility determinations by requiring states to conduct pilot eligibility reviews. States conduct these reviews to assess the correctness of their decisions related to program eligibility and eligibility group, which defines the amount of federal matching funds for eligible individuals. To implement the changes required by PPACA to streamline and automate the Medicaid enrollment process, states had to make significant changes to their systems and develop new policies and procedures.²⁹ In recognition of the states' need to redesign their Medicaid business operations and systems, CMS designed these pilot eligibility reviews to provide more timely feedback on the accuracy of states' eligibility determinations than

²⁹For example, states must adopt a single streamlined application that can be submitted via multiple channels—such as mail, in-person, phone, or online; use a HHS-managed data services hub to access federal verification sources; and facilitate account transfers and data-sharing between the exchanges and Medicaid.

under previous assessments, and allow for quicker corrective action. According to CMS, the pilot eligibility reviews (1) provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility; (2) identify strengths and weaknesses in operations and systems leading to errors; and (3) test the effectiveness of corrections and improvements in reducing or eliminating those errors.³⁰

States have completed the initial round of pilot eligibility reviews, which showed wide variation in both the design and the results among the states—reflecting, in part, the latitude they were given in designing their review methodology.³¹ Although the results varied, pilot eligibility reviews for eight of the nine states we examined identified eligibility determination errors, improper payments associated with those errors, and described the states' plans for corrective action to prevent similar errors. For subsequent rounds, CMS revised its guidance. For example, CMS updated instructions for the second round to include standard definitions for errors and deficiencies, and to require the inclusion of eligibility redeterminations in the review, and plans to further refine the instructions for future rounds. Based on these updated instructions, the results of the future rounds of pilot eligibility reviews may result in more comparable information.

However, the pilot eligibility reviews do not include a review of the accuracy of federal eligibility determinations in certain states that delegated authority to the federal government to make Medicaid eligibility determinations through the FFE.³² Officials from the National Association of Medicaid Directors told us that states had raised concerns earlier that federal determinations were incorrect, citing challenges related to

³⁰For each error identified, states are required to develop a corrective action plan to avoid similar errors in the future.

³¹For example, in the initial round, CMS did not define errors and permitted each state to define its own errors resulting in variation across the states, with some states only reporting as errors factors that resulted in an incorrect eligibility determination, while other states reported factors that did not result in an incorrect determination.

³²The state Medicaid agencies in these 10 states continue to determine eligibility for individuals who applied through the state Medicaid program, and these state determinations of eligibility are subject to review under the pilot eligibility review. In the 24 states whose FFEs make an eligibility assessment, the FFEs may recommend a positive or negative eligibility determination, but the states retain final authority to make the determination. According to CMS officials, these state determinations are included in the scope of the states' pilot eligibility reviews.

transferring information between federal exchanges and state systems. Additionally, we recently reported that states using FFEs experienced challenges transferring applications and transmitting information between state and federal data sources, which contributed to enrollment delays.³³

CMS has established another mechanism—termed the eligibility support contractor pilot program—to assist in developing new methodologies for assessing eligibility determinations; however, the eligibility support contractor program generally does not assess federal determinations for accuracy. Therefore, for the states in which the federal government performs eligibility determinations, there is a gap in assuring that the determinations are accurate.³⁴ According to CMS officials, the purpose of the eligibility support contractor program—along with the pilot eligibility reviews—is to inform revisions to the eligibility component of the PERM, which will be resumed in 2018. In the interim, CMS uses the eligibility support contractor to assist CMS in developing a methodology for the future PERM eligibility review, including a methodology for assessing federal eligibility determinations. The contractor will make recommendations to CMS on necessary changes to the methodology used to test eligibility determinations for the MEQC and PERM.

As a result, under the current process, CMS will not be able to assess the accuracy of federal eligibility determinations until 2018, thereby creating the potential risk for improper payments in the states that have delegated authority to the federal government to make eligibility determinations through the FFEs. Federal internal control standards require that federal agencies identify and assess risks associated with achieving agency objectives.³⁵ One method for identifying the risk of inaccurate eligibility determinations could include consideration of findings from audits and

³³See [GAO-15-169](#). In that report, we found that although the ability to transfer information between federal and state data sources has improved, the capability to conduct real time application transfers of information for immediate eligibility determinations remains elusive.

³⁴CMS permits the states to work with the eligibility support contractor in developing a methodology to review eligibility determinations and submit the results in place of the pilot eligibility review results. Two states that have delegated authority to their FFEs to make Medicaid eligibility determinations—Alabama and Montana—have elected to work with the eligibility support contractor and include federal determinations in the scope of their review.

³⁵See [GAO/AIMD-00-21.3.1](#)

other assessments. However, neither of the interim measures—the pilot eligibility reviews or the eligibility support contractor program—implemented by CMS will identify risks for improper payments due to erroneous federal determinations. According to CMS officials, the agency excluded federal determinations from the pilot eligibility reviews states must conduct because these states do not have the resources to fully review the federal determinations. Moreover, CMS officials noted that a review of federal determinations—which are independent of a state’s own process—would not assist states in correcting their own eligibility determination processes. However, a review of federal eligibility determinations would help CMS assess whether the FFEs are appropriately determining an applicant’s eligibility for Medicaid.

CMS’s Expenditure Reviews Cannot Identify Eligibility-Related Errors, Limiting Assurance that Expenditures Are Appropriately Matched with Federal Funds

CMS modified its standard quarterly review of CMS-64 expenditures to examine expenditures for both categories of the expansion population.³⁶ As part of this modified review, CMS staff must select a sample of different types of enrollees—including at least 25 PPACA-expansion eligible enrollees, 10 state-expansion eligible enrollees (where applicable), and 5 traditionally eligible enrollees—and examine their expenditures to ensure that they were reported as expenditures for the correct eligibility type. According to CMS officials, the expenditure review is primarily intended to ensure that states are correctly grouping expenditures for the different eligibility groups as initially determined, not whether the determination is correct. For example, the review assesses whether the expenditures for someone the state has determined to be a PPACA-expansion enrollee are submitted for the PPACA-expansion eligibility group.

In our review of the pilot eligibility reviews, we found that eight of the nine states we reviewed reported errors that reflected both incorrect eligibility

³⁶States that did not expand Medicaid are not subject to the special expenditure review.

determinations and errors in the eligibility determination process that did not result in an incorrect determination.³⁷ For example

- Eight of the nine states reported errors that resulted in incorrect eligibility determinations, including enrollment of individuals with insurance or incomes exceeding Medicaid standards. Total improper payment amounts among these states ranged from \$20 to approximately \$48,000 across their samples of approximately 200-300 eligibility determinations.
- One of the eight states reported as an error its failure to send out notification letters to some enrollees within the correct timeframe—but this error did not affect the accuracy of the eligibility determination.

We found that errors were often related to income verification, inadequately trained staff, or challenges transmitting information between exchange and Medicaid databases. States described the corrective actions they planned to take for each error identified in their pilot eligibility reviews.

Although the changes CMS has made to the CMS-64 expenditure review have enabled the agency to identify certain types of erroneous expenditures for the expansion population, these reviews may not be able to identify expenditures that are erroneous due to incorrect eligibility determinations, such as those identified in the state pilot eligibility review examples above. As a result, CMS's expenditure review cannot provide assurance that states' expenditures are correctly matched based on enrollees' eligibility categories.³⁸ CMS officials told us that the CMS-64 expenditure review process is not informed by the findings of the pilot eligibility reviews. Thus, if a state's pilot eligibility review identified errors in the state's eligibility determinations or automated eligibility systems, CMS is not using that information to target its CMS-64 review of that

³⁷We were unable to calculate an error rate for each state because states were permitted to develop their own definitions of errors. Consequently, some states included as errors factors that did not result in erroneous eligibility determinations.

³⁸For example, in its deferral report for the fourth quarter of fiscal year 2014 for all states, CMS had identified erroneously reported expenditures for the expansion population in two states. One state had included, as part of its reporting of expenditures for PPACA-expansion enrollees, expenditures for services that pre-dated the implementation of the expansion and a second state had erroneously included expenditures for dual-eligible beneficiaries as PPACA-expansion enrollee expenditures. These two states were not among the nine states we reviewed.

state's expenditures for PPACA-expansion enrollees. For example, none of the eight states we examined that reported eligibility determination errors in their pilot eligibility reviews were identified as having eligibility-related expenditure errors by CMS regional offices. As a result, CMS is missing the opportunity to better assure that the appropriate federal matching rate is being applied to states' expenditures. Federal internal control standards require that federal agencies identify and assess risks associated with achieving agency objectives. In addition, such information should be communicated to others within the agency to enable them to carry out their internal control responsibilities. Although the purposes of the CMS-64 expenditure review are distinct from the eligibility review, the information gained from the pilot eligibility reviews on state eligibility determination errors could be useful in identifying potentially erroneous expenditures that require further review by CMS.

Conclusions

PPACA authorized many significant changes to the Medicaid program, such as expanded eligibility and streamlined eligibility processes between Medicaid and the exchanges. However, implementing these changes requires states to adapt their systems, policies, and procedures, resulting in a complex realignment of processes, and necessitating careful review by CMS to ensure that determinations of eligibility and the reporting of expenditures are accurate. As CMS redesigns its oversight and monitoring tools to better capture the changes brought about by PPACA to Medicaid eligibility and federal matching funds, the agency has implemented measures to inform its processes for assessing states' eligibility determinations and reporting of expenditures.

However, in the short term, CMS is missing opportunities to better ensure the accuracy of eligibility determinations in all states, and also ensure that Medicaid expenditures for different eligibility groups are appropriately matched with federal funds. By excluding Medicaid eligibility determinations made by the FFEs from its pilot eligibility reviews, CMS has created a gap in efforts to ensure that only eligible individuals are enrolled into the Medicaid program. Furthermore, although CMS has a process for assessing the accuracy of eligibility determinations in the states, CMS does not use the results of these eligibility reviews, which have the potential to provide valuable information on state eligibility determinations, to better target its review of Medicaid expenditures for different eligibility groups. Using the eligibility reviews to inform its reviews of state-reported expenditures may assist CMS in identifying payments

made on behalf of ineligible or incorrectly enrolled individuals, thereby reducing the risk of improper payments in the Medicaid program.

Recommendations for Executive Action

To improve the effectiveness of its oversight of eligibility determinations, we recommend that the Administrator of CMS conduct reviews of federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary.

To increase assurances that states receive an appropriate amount of federal matching funds, we recommend that the Administrator of CMS use the information obtained from state and federal eligibility reviews to inform the agency's review of expenditures for different eligibility groups in order to ensure that expenditures are reported correctly and matched appropriately.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment. In its written comments, HHS highlighted the actions the department has taken to ensure the accuracy of Medicaid eligibility determinations made through the exchanges, citing the multi-layer verification processes in place to assess applicant eligibility, and also noted that it conducts reviews of expenditure data submitted by the states. HHS agreed with our first recommendation and agreed with the concept of our second recommendation.

HHS concurred with our first recommendation to conduct reviews on federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary. HHS noted that federal eligibility determinations in two states are currently being reviewed by the eligibility support contractor, and stated that federal determinations will be included as part of the future PERM eligibility review. However, the eligibility component of the PERM will not be resumed until 2018, and in the interim, without a systematic assessment of federal eligibility determinations, we remain concerned that CMS lacks a mechanism to identify and correct federal eligibility determination errors and associated payments. Given the program benefits and federal dollars involved, we urge CMS to look for an

opportunity to identify erroneous federal eligibility determinations and implement corrective actions as soon as possible.

With regard to our second recommendation, HHS agreed that ensuring accurate eligibility determinations and correct expenditure reporting is an important safeguard for the Medicaid program but did not state whether it specifically concurred with the recommendation. HHS further noted that eligibility and expenditure reviews are two distinct, but complementary oversight processes, with different timeframes. In consideration of HHS's comments, we adjusted our recommendation to take into account the differences in the timeframes for these two types of reviews. We continue to believe that using the information obtained from state and federal eligibility reviews to inform the agency's review of expenditures for different eligibility groups will help ensure that expenditures are reported correctly and matched appropriately. Eligibility reviews are conducted on a different timeframe than the expenditure reviews, and because states are required to identify errors and develop corrective action plans to address these errors, it is anticipated that, over time, the eligibility reviews will support HHS's efforts to appropriately match state expenditures.

HHS's comments are reproduced in appendix I. HHS also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of CMS, appropriate congressional committees, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions regarding 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 report. GAO staff who made key contributions to this report are listed in appendix V.



Carolyn L. Yocom
Director, Health Care

Appendix I: Comments from the Department of Health and Human Services

Appendix I: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

SEP 29 2015

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

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds*" (GAO-16-53).

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

Sincerely,

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

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL EFFORTS NEEDED TO ENSURE THAT STATE SPENDING IS APPROPRIATELY MATCHED WITH FEDERAL FUNDS (GAO-16-53)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report. HHS is committed to working with states to accurately determine Medicaid eligibility and verify that expenditures are appropriately matched.

Both the Medicaid and the Marketplaces play a critical role in achieving one of the Affordable Care Act's (ACA) core goals: reducing the number of uninsured Americans by providing affordable, high-quality health coverage. Since Medicaid expansion has taken effect, the number of individuals enrolled in Medicaid and Children's Health Insurance Program (CHIP) programs who are receiving comprehensive benefits has grown from 57.8 million enrollees (July-September 2013) to 72 million enrollees in June 2015, which represents a 22.7 percent growth in enrollment. In addition to the growth of Medicaid and CHIP, about 11.7 million Americans selected plans or were automatically re-enrolled in coverage through the Marketplaces during Open Enrollment for 2015. As of June 30, 2015, about 9.9 million consumers had "effectuated" coverage which means those individuals paid for Marketplace coverage and still had an active policy on that date.

HHS works continuously to provide accurate eligibility determinations for enrollment in Medicaid and has implemented various internal controls to verify applicants' eligibility. In addition, HHS conducts various reviews of expenditure data to make sure state spending is appropriately matched with federal funds.

Regarding eligibility determinations, the Marketplaces have a multi-layer verification process for applications, including checking applicants' eligibility for Qualified Health Plans (QHP), Medicaid, and financial assistance in real-time using the Data Services Hub and trusted sources. If the Marketplace is not able to promptly determine that the information in a consumer's application is reasonably compatible with trusted sources, the Marketplace must seek additional information or documentation from the consumer, as outlined in the law. For the portion of consumers whose applications do not match trusted sources, HHS works with them to obtain supporting documentation to verify eligibility, including, as applicable, citizenship or immigration status, or income information. When there is a data matching issue, States must adhere to strict requirements regarding supporting documentation and completing the eligibility determinations. Additionally, consumers completing the application also attest under penalty of perjury that the information provided is correct. Knowingly and willfully providing false information is a violation of federal law and can be subject to up to a \$250,000 fine.

As the GAO notes in its draft report, HHS oversees state enrollment of Medicaid beneficiaries and the reporting of expenditures by requiring states to conduct multiple reviews to assess the accuracy of states' Medicaid eligibility determinations and payment rates. HHS also implemented a pilot eligibility review to assess states' determination of Medicaid eligibility and eligibility groups. States must report on the accuracy of determinations for a selected sample of applications and develop a corrective action plan for any errors found in the eligibility determination process. In addition, federal determinations of Medicaid eligibility will be included as part of the future Payment Error Rate Measurement (PERM) eligibility review.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL EFFORTS NEEDED TO ENSURE THAT STATE SPENDING IS APPROPRIATELY MATCHED WITH FEDERAL FUNDS (GAO-16-53)

In addition to the eligibility reviews, HHS conducts reviews of expenditure data submitted by states through the Medicaid Budget and Expenditure System (MBES). On a quarterly basis, states report summarized Medicaid expenditures through MBES on the Form CMS-64 which serves as the basis for the amount of Federal Financial Participation (FFP) paid to states to fund their respective Medicaid program. As part of their submission, states certify that their reported expenditures are actual expenditures allowable under federal requirements. HHS performs various financial management oversight activities to make sure expenditures reported by states are allowable under federal requirements.

The Centers for Medicare and Medicaid Services (CMS) has provided significant training and guidance to make sure that states have mechanisms and systems to track and report new adult group expenditures appropriately. Additionally, CMS has placed special emphasis on determining that FFP paid to states for the new adult group is accurate, including conducting enhanced quarterly reviews of new adult group expenditures to make sure that the expenditures are claimed at the appropriate federal matching rate. HHS has the authority to defer questionable expenditures or disallow improper expenditures as a result of its oversight activities.

GAO Recommendation 1

To improve the effectiveness of its oversight of eligibility determinations, GAO recommends that the Administrator of CMS conduct reviews of federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary.

HHS Response 1

HHS concurs with GAO's recommendation. To check the accuracy of eligibility determinations, the Marketplaces have a multi-layer verification process for applications, including checking applicants' eligibility for Qualified Health Plans (QHP), Medicaid, and financial assistance in real-time using the Data Services Hub and trusted sources. If the Marketplace is not able to promptly determine that the information in a consumer's application is reasonably compatible with trusted sources, the Marketplace must seek additional information or documentation from the consumer, as outlined in the law. States have established practices for resolving inconsistencies, including verification through state data sources and obtaining documentation from applicants, if necessary. Subsequent to their final determination, states are required to notify the Marketplace of the individual's eligibility or ineligibility for Medicaid/CHIP

In the interim, HHS is utilizing pilots to review Federal determinations of Medicaid eligibility in two of the nine states that delegated determination authority to the federal marketplace. Federal determinations of Medicaid eligibility will also be included as part of the future PERM eligibility review.

GAO Recommendation 2

To increase assurances that states receive an appropriate amount of federal matching funds, GAO recommends that the Administrator of CMS use the results of any eligibility determination reviews to inform the agency's review of the expenditures for different eligibility groups as reported by the states on the CMS-64.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL EFFORTS NEEDED TO ENSURE THAT STATE SPENDING IS APPROPRIATELY MATCHED WITH FEDERAL FUNDS (GAO-16-53)

HHS Response 2

CMS agrees that providing accurate eligibility determinations and reviewing expenditure data to make sure funds for Medicaid enrollees are allocated appropriately are important safeguards for the Medicaid program. To perform optimal oversight of the Medicaid program, HHS designed processes for eligibility determination reviews and CMS-64 expenditure reviews as two separate, but complementary processes.

The Medicaid and CHIP Eligibility Review Pilots consist of detailed testing that serves as HHS' oversight of Medicaid and CHIP eligibility determinations during initial years of the Affordable Care Act implementation. Conversely, the CMS-64 expenditure reviews are a series of management controls and validation activities that serve as oversight of states claiming the new adult group expenditure to ensure federal funding is provided at the appropriate Federal Medical Assistance Percentage (FMAP). Further, the two distinct oversight activities address errors through separate corrective action and/or recovery processes and are conducted according to different timelines. These two distinct oversight processes allow HHS to target its activities more directly to address the oversight needs and goals of the Medicaid program.

Appendix II: Scope and Methodology

To determine the enrollment and spending for individuals who enrolled in Medicaid in 2014, and the extent to which these individuals were identified as eligible under the Patient Protection and Affordable Care Act (PPACA), we examined data submitted to the Centers for Medicare & Medicaid Services (CMS) by states as part of their enrollment and expenditure reporting.¹ These data included information from new enrollment forms developed by CMS that are used by states to report the number of enrollees by eligibility type, as well as expenditure data, to CMS by means of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program—also known as the form CMS-64—within the Medicaid Budget and Expenditure System (MBES). We reviewed data for each quarter in calendar year 2014 and relevant guidance and documentation where available. We also interviewed knowledgeable CMS officials in the Center for Medicaid and CHIP Services about data available on Medicaid enrollment and expenditures, and what steps they take to ensure data reliability. Based on these discussions, we determined that these data were sufficiently reliable for our purposes.

About CMS-64 Submission through MBES

States submit total enrollment and aggregate actual total quarterly Medicaid expenditures on the CMS-64 no later than 30 days after the end of each quarter. However, states may continue to submit additional data for each quarter on a continual basis and make adjustments to the previous three quarters submitted. States may report expenditures up to a period of two years (possibly more) after the date of the original service payment. Because these are point-in-time estimates, the data are current

¹In this report, we use the term “state” to refer to the 50 states and the District of Columbia. We excluded Medicaid administrative expenditures and data reported by the U.S. territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, whose total federal Medicaid spending is subject to an annual cap, and which did not report numbers of enrollees and expenditures for all eligibility types.

as of the date we pulled the data from MBES.² CMS-64 data are reported at a state aggregate level, and therefore do not include individual expenditure data on the state's enrollees or the services they received under Medicaid.

We obtained enrollment and expenditure data for calendar year 2014—the first full year that states had the option of expanding Medicaid under PPACA. This includes the first through fourth quarters of the 2014 calendar year (ending March, June, September, and December 2014, respectively). Because data are reported for each month, we use the last month of the quarter to report for that quarter. For example, we used the numbers reported for March 2014 as the numbers reported by states for the first quarter of 2014. We extracted these data from the MBES on June 2, 2015. We reviewed the data for reasonableness and consistency, including screening for missing data, outliers, and obvious errors. While enrollment data may be identified for a particular month in a quarter, expenditure data may not be identified for a particular month in a quarter because it is reported cumulatively for each quarter and added each subsequent quarter in the year.

Enrollment data

Beginning in January 2014, states and territories also began reporting enrollment data. CMS implemented a new form—the CMS-64.Enroll form—to collect information on total enrollment and enrollment eligibility type (e.g., PPACA-expansion enrollees and state-expansion enrollees). These data show the numbers of beneficiaries who were enrolled at any time during each month. This would include, for example, beneficiaries who may have been enrolled at the beginning of June and were no longer enrolled at the end of June. Because the enrollment data are point-in-time estimates, we were unable to add the numbers of enrollees across

²States do not necessarily report consistently for each eligibility or service category or quarter. For example, at the time of our review of the data, of the 28 states that had expanded Medicaid, 21 had reported enrollment data for PPACA-expansion eligible enrollees for December 2014 and 14 had reported enrollment data for the state-expansion individuals for December 2014. Some states had reported data for both groups.

quarters to obtain the total number of Medicaid enrollees for the year.³ Individuals might be enrolled continuously and adding up each month would count the same individuals multiple times.

Expenditure data

The CMS-64 data are used to reimburse the states for the applicable federal share of Medicaid expenditures.⁴ As we previously stated, CMS reviews these submissions, and the data are the most reliable accounting of total Medicaid expenditures.⁵ We extracted expenditure data from the CMS-64 net expenditures Financial Management Report for calendar year 2014. The Financial Management Report is an annual account of states' program and administrative Medicaid expenditures, including federal and state expenditures by expenditure category. This source includes expenditures under Medicaid demonstrations, as well as adjustments by states or CMS and collections.⁶ Expenditure data from the CMS-64 may not have been reviewed by CMS. Additionally, these data

³Since there is much turnover in the Medicaid program, Medicaid enrollment measured in different ways can produce vastly different enrollment figures. Medicaid enrollment could be measured by "ever enrolled" persons (i.e., the number of people covered by Medicaid for any period of time during the year); "person-year equivalents" (i.e., the average enrollment over the course of the year); and "point-in-time" (i.e., the number of Medicaid enrollees at a specified date). We used these data to reflect point-in-time estimates—enrollment in the program as of the last month of each quarter.

⁴CMS uses CMS-64 data to reconcile actual aggregate expenditures reported by states with estimated expenditures reported by states prior to the quarter in the CMS-37 form.

⁵As we previously reported, CMS has another data set that reports state Medicaid expenditures, but it has a different purpose and limitations. The Medicaid Statistical Information System (MSIS) was established as a national eligibility and claims data set, and can provide CMS a summary of expenditures linked to specific beneficiaries on the basis of their medical claims for care. CMS reviews these data for reliability, and uses these data for policy analysis, program utilization, and forecasting expenditures. See GAO, *Medicaid: Data Sets Provide Inconsistent Picture of Expenditures*, [GAO-13-47](#) (Washington, D.C.: Oct. 29, 2012). Because claims data would not yet be submitted or complete for PPACA-expansion enrollees (who received coverage under Medicaid beginning January 1, 2014) during the time period of our analysis, MSIS data were not appropriate for our analysis.

⁶Adjustments are made by states to correct overpayments, underpayments, or reporting errors to spending reported in prior quarterly reports. Collections include reimbursement from private or public insurance plans or third parties that are liable for some portion of enrollees' health care costs, as well as recoveries made through efforts to reduce fraud, waste, and abuse.

do not tie expenditures to services provided to particular individuals during the reporting period.

Appendix III: Medicaid Enrollment in 2014

Table 2 shows the number of individuals enrolled in Medicaid at any time during the last month of each quarter in 2014, by eligibility group. As shown, Patient Protection and Affordable Care Act (PPACA)-expansion enrollees and state-expansion enrollees comprised a small portion of total enrollees in all quarters of 2014. These are point-in-time estimates—that is, counts of enrollees for the last month in each quarter. These numbers should not be added across quarters to obtain the total number of Medicaid enrollees for the year because doing so might count the same enrollees multiple times.

Table 2: Medicaid Enrollment Data (in millions), 2014

n/a	First quarter (ending March 2014)		Second quarter (ending June 2014)		Third quarter (ending September 2014)		Fourth quarter (ending December 2014)	
	States reporting	Enrollees (percentage of total)	States reporting	Enrollees (percentage of total)	States reporting	Enrollees (percentage of total)	States reporting	Enrollees (percentage of total)
Total enrollees	51	61.2 (100%)	50	66.0 (100%)	48	56.9 (100%)	47	69.8 (100%)
Traditionally eligible ^a	n/a	55.4 (90%)	n/a	58.7 (89%)	n/a	50.2 (88%)	n/a	60.1 (86%)
PPACA-expansion	23	4.1 (7%)	23	5.6 (8%)	22	4.6 (8%)	23	7.5 (11%)
State-expansion	13	1.7 (3%)	14	1.7 (3%)	15	2.0 (4%)	16	2.3 (3%)

Source: GAO analysis of Centers for Medicare & Medicaid Services enrollment data, as of June 2, 2015. | GAO-16-53

Notes: Numbers may not add to total due to rounding.

We excluded totals reported for the U.S. territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, whose total federal Medicaid spending is subject to an annual cap, and which did not report numbers of enrollees for all eligibility groups. For the purposes of this report, we include the District of Columbia as a state.

Traditionally eligible enrollees are eligible under historic eligibility standards. Patient Protection and Affordable Care Act (PPACA)-expansion enrollees are individuals whose coverage began after their state opted to expand Medicaid as authorized by PPACA. State-expansion enrollees are individuals who were not traditionally eligible, but were covered by Medicaid under a state-funded program or state demonstration as of December 1, 2009 in states that subsequently opted to expand Medicaid as authorized by PPACA.

^aWe calculated the number of traditionally eligible enrollees by subtracting the number of PPACA-expansion and state-expansion enrollees from the number of total enrollees. Traditionally eligible

enrollees are comprised of different categories of enrollees including pregnant women, aged, blind, or disabled individuals, and states did not consistently report numbers for these groups. For example, most states reported enrollment for at least one eligibility category, but did not necessarily report for all categories across all quarters. Because we calculated this number, we do not have the number of states reporting this number.

Appendix IV: Medicaid Expenditures in 2014

Table 3 reflects Medicaid expenditures paid by eligibility group, in 2014. As shown, expenditures for Patient Protection and Affordable Care Act (PPACA)-expansion enrollees and state-expansion enrollees comprised a small portion of total Medicaid expenditures in 2014.

Table 3: Medicaid Expenditures (in billions) by Eligibility Group, 2014

n/a Eligibility Type	n/a Number of states reporting	Total		Medicaid federal share		State share	
		Dollars	Percentage of total	Dollars	Percentage of total	Dollars	Percentage of total
Totals	51	\$481.77	100%	\$295.98	100%	\$185.03	100%
Traditionally eligible ^a	27	\$435.91	90%	\$252.87	85%	\$182.37	99%
PPACA-expansion	25	\$35.28	7%	\$35.28	12%	\$0.00	0%
State-expansion	17	\$10.58	2%	\$7.83	3%	\$2.66	1%

Source: GAO analysis of Centers for Medicare & Medicaid Services expenditure data as of June 2, 2015. | GAO-16-53

Notes: Numbers may not add to total due to rounding.

We excluded totals reported for the U.S. territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, whose total federal Medicaid spending is subject to an annual cap, and which did not report expenditures for all eligibility groups. For the purposes of this report, we include the District of Columbia as a state.

Traditionally eligible enrollees are eligible under historic eligibility standards. Patient Protection and Affordable Care Act (PPACA)-expansion enrollees, are individuals whose coverage began after their state opted to expand Medicaid as authorized by PPACA. State-expansion enrollees are individuals who were not traditionally eligible, but were eligible for Medicaid under a state-funded program or a state demonstration as of December 1, 2009 in states that subsequently opted to expand Medicaid as authorized by PPACA.

^aStates did not report expenditures for the traditionally eligible. We calculated this group by subtracting the reported expenditures for PPACA-expansion and state-expansion enrollees from the reported total expenditures. Not all states reported expenditures for both groups.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov

Staff Acknowledgments

In addition to the contact named above, Robert Copeland, Assistant Director; Christine Davis; Sandra George; Giselle Hicks; Drew Long; Jasleen Modi; Giao N. Nguyen; and Emily Wilson made key contributions to this report.

Appendix VI: Accessible Data

Agency Comment Letter

Accessible Text for Appendix I: Comments from the
Department of Health and Human Services

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DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation

Washington, DC 20201

SEP 29 2015

Carolyn Yocom

Director, Health Care

U.S. Government Accountability Office

441 G Street NW

Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds*" (GAO-16-53).

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

Sincerely,

Assistant Secretary for Legislation

Attachment

Page 2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL EFFORTS NEEDED TO ENSURE THAT STATE SPENDING IS APPROPRIATELY MATCHED WITH FEDERAL FUNDS (GAO-16-53)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report. HHS is committed to working with states to accurately determine Medicaid eligibility and verify that expenditures are appropriately matched.

Both the Medicaid and the Marketplaces play a critical role in achieving one of the Affordable Care Act's (ACA) core goals: reducing the number of uninsured Americans by providing affordable, high-quality health coverage. Since Medicaid expansion has taken effect, the number of individuals enrolled in Medicaid and Children's Health Insurance Program (CHIP) programs who are receiving comprehensive benefits has grown from 57.8 million enrollees (July- September 2013) to 72 million enrollees in June 2015, which represents a 22.7 percent growth in enrollment. In addition to the growth of Medicaid and CHIP, about 11.7 million Americans selected plans or were automatically re-enrolled in coverage through the Marketplaces during Open Enrollment for 2015. As of June 30, 2015, about 9.9 million consumers had "effectuated" coverage which means those individuals paid for Marketplace coverage and still had an active policy on that date.

HHS works continuously to provide accurate eligibility determinations for enrollment in Medicaid and has implemented various internal controls to verify applicants' eligibility. In addition, HHS conducts various reviews of expenditure data to make sure state spending is appropriately matched with federal funds.

Regarding eligibility determinations, the Marketplaces have a multi-layer verification process for applications, including checking applicants' eligibility for Qualified Health Plans (QHP), Medicaid, and financial assistance in real-time using the Data Services Hub and trusted sources.

If the Marketplace is not able to promptly determine that the information in a consumer's application is reasonably compatible with trusted sources, the Marketplace must seek additional information or documentation from the consumer, as outlined in the law. For the portion of consumers whose applications do not match trusted sources, HHS works with them to obtain supporting documentation to verify eligibility, including, as applicable, citizenship or immigration status, or income information. When there is a data matching issue, States must adhere to strict requirements regarding supporting documentation and completing the eligibility determinations. Additionally, consumers completing the application also attest under penalty of perjury that the information provided is correct. Knowingly and willfully providing false information is a violation of federal law and can be subject to up to a \$250,000 fine.

As the GAO notes in its draft report, HHS oversees state enrollment of Medicaid beneficiaries and the reporting of expenditures by requiring states to conduct multiple reviews to assess the accuracy of states' Medicaid eligibility determinations and payment rates. HHS also implemented a pilot eligibility review to assess states' determination of Medicaid eligibility and eligibility groups. States must report on the accuracy of determinations for a selected sample of applications and develop a corrective action plan for any errors found in the eligibility determination process. In addition, federal determinations of Medicaid eligibility will be included as part of the future Payment Error Rate Measurement (PERM) eligibility review.

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL EFFORTS NEEDED TO ENSURE THAT STATE SPENDING IS APPROPRIATELY MATCHED WITH FEDERAL FUNDS (GAO-16-53)

In addition to the eligibility reviews, HHS conducts reviews of expenditure data submitted by states through the Medicaid Budget and Expenditure System (MBES). On a quarterly basis, states report summarized Medicaid expenditures through MBES on the Form CMS-64 which serves as the basis for the amount of Federal Financial Participation (FFP) paid to states to fund their respective Medicaid program. As part of their submission, states certify that their reported expenditures are actual expenditures allowable under federal requirements. HHS performs various financial management oversight activities to make sure

expenditures reported by states are allowable under federal requirements.

The Centers for Medicare and Medicaid Services (CMS) has provided significant training and guidance to make sure that states have mechanisms and systems to track and report new adult group expenditures appropriately. Additionally, CMS has placed special emphasis on determining that FFP paid to states for the new adult group is accurate, including conducting enhanced quarterly reviews of new adult group expenditures to make sure that the expenditures are claimed at the appropriate federal matching rate. HHS has the authority to defer questionable expenditures or disallow improper expenditures as a result of its oversight activities.

GAO Recommendation 1

To improve the effectiveness of its oversight of eligibility determinations, GAO recommends that the Administrator of CMS conduct reviews of federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary.

HHS Response 1

HHS concurs with GAO's recommendation. To check the accuracy of eligibility determinations, the Marketplaces have a multi-layer verification process for applications, including checking applicants' eligibility for Qualified Health Plans (QHP), Medicaid, and financial assistance in real-time using the Data Services Hub and trusted sources. If the Marketplace is not able to promptly determine that the information in a consumer's application is reasonably compatible with trusted sources, the Marketplace must seek additional information or documentation from the consumer, as outlined in the Jaw. States have established practices for resolving inconsistencies, including verification through state data sources and obtaining documentation from applicants, if necessary. Subsequent to their final determination, states are required to notify the Marketplace of the individual's eligibility or ineligibility for Medicaid/CHIP

In the interim, HHS is utilizing pilots to review Federal determinations of Medicaid eligibility in two of the nine states that delegated determination authority to the federal marketplace. Federal determinations of Medicaid eligibility will also be included as part of the future PERM eligibility review.

GAO Recommendation 2

To increase assurances that states receive an appropriate amount of federal matching funds, GAO recommends that the Administrator of CMS use the results of any eligibility determination reviews to inform the agency's review of the expenditures for different eligibility groups as reported by the states on the CMS-64.

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL EFFORTS NEEDED TO ENSURE THAT STATE SPENDING IS APPROPRIATELY MATCHED WITH FEDERAL FUNDS (GAO-16-53)

HHS Response 2

CMS agrees that providing accurate eligibility determinations and reviewing expenditure data to make sure funds for Medicaid enrollees are allocated appropriately are important safeguards for the Medicaid program. To perform optimal oversight of the Medicaid program, HHS designed processes for eligibility determination reviews and CMS-64 expenditure reviews as two separate, but complementary processes.

The Medicaid and CHIP Eligibility Review Pilots consist of detailed testing that serves as HHS' oversight of Medicaid and CHIP eligibility determinations during initial years of the Affordable Care Act implementation. Conversely, the CMS-64 expenditure reviews are a series of management controls and validation activities that serve as oversight of states claiming the new adult group expenditure to ensure federal funding is provided at the appropriate Federal Medical Assistance Percentage (FMAP). Further, the two distinct oversight activities address errors through separate corrective action and/or recovery processes and are conducted according to different timelines. These two distinct oversight processes allow HHS to target its activities more directly to address the oversight needs and goals of the Medicaid program.

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