



Testimony

Before the Committee on Homeland
Security and Governmental Affairs,
U.S. Senate

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Actions Needed to Mitigate Billions in Improper Payments and Program Integrity Risks

Accessible Version

Statement of Gene L. Dodaro
Comptroller General of the United States

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GAO Highlights

Highlights of [GAO-18-598T](#), a testimony before the Committee on Homeland Security and Governmental Affairs, U.S. Senate.

Why GAO Did This Study

Medicaid, a joint federal-state health care program overseen by CMS, is a significant component of federal and state budgets, with total estimated expenditures of \$596 billion in fiscal year 2017.

Medicaid allows significant flexibility for states to design and implement program innovations based on their unique needs. The resulting diversity of the program and its size, make the program particularly challenging to oversee at the federal level and also vulnerable to improper payments. In fiscal year 2017, estimated improper payments were \$36.7 billion in Medicaid, up from \$29.1 billion in fiscal year 2015. Further, the Medicaid program accounted for about 26 percent of the fiscal year 2017 government-wide improper payment estimate.

This testimony focuses on the (1) major risks to the integrity of the Medicaid program, and (2) actions needed to manage these risks. This testimony draws on GAO's reports issued between November 2012 and May 2018 on the Medicaid program.

What GAO Recommends

As a part of this body of work, GAO has made 83 recommendations to address shortcomings in Medicaid oversight and suggested four matters for congressional consideration. The Department of Health and Human Services and CMS have generally agreed with these recommendations and have implemented 25 of them. GAO will continue to monitor implementation of the remaining recommendations.

View [GAO-18-598T](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

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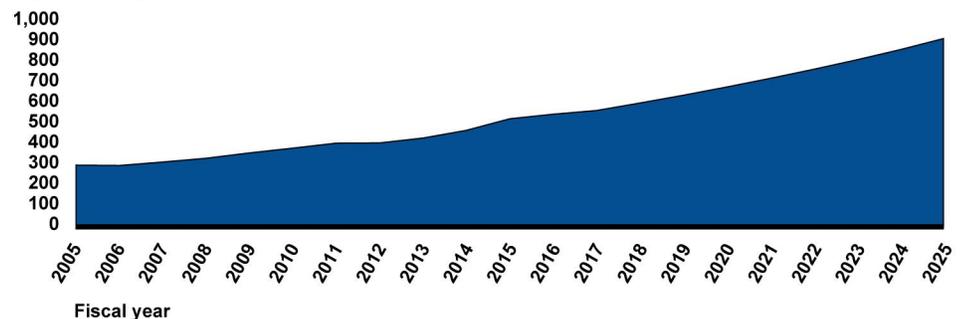
Actions Needed to Mitigate Billions in Improper Payments and Program Integrity Risks

What GAO Found

GAO's work has identified three broad areas of risk in Medicaid that also contribute to overall growth in program spending, projected to exceed \$900 billion in fiscal year 2025.

- 1) Improper payments**, including payments made for services not actually provided. Regarding managed care payments, which were nearly half (or \$280 billion) of Medicaid spending in fiscal year 2017, GAO has found that the full extent of program risk due to overpayments and unallowable costs is unknown.
- 2) Supplemental payments**, which are payments made to providers—such as local government hospitals—that are in addition to regular, claims-based payments made to providers for specific services. These payments totaled more than \$48 billion in fiscal year 2016 and in some cases have shifted expenditures from the states to the federal government.
- 3) Demonstrations**, which allow states to test new approaches to coverage. Comprising about one-third of total Medicaid expenditures in fiscal year 2015, GAO has found that demonstrations have increased federal costs without providing results that can be used to inform policy decisions.

Actual and Projected Growth Trends in Total Medicaid Spending Expenditures (dollars in billions)



Source: 2016 Actuarial Report on the Financial Outlook for Medicaid. | GAO-18-598T

GAO's work has recommended numerous actions to strengthen oversight and manage program risks.

- Improve data.** The Centers for Medicare & Medicaid Services (CMS), which oversees Medicaid, needs to make sustained efforts to ensure Medicaid data are timely, complete, and comparable from all states, and useful for program oversight. Data are also needed for oversight of supplemental payments and ensuring that demonstrations are meeting their stated goals.
- Target fraud.** CMS needs to conduct a fraud risk assessment for Medicaid, and design and implement a risk-based antifraud strategy for the program.
- Collaborate.** There is a need for a collaborative approach to Medicaid oversight. State auditors have conducted evaluations that identified significant improper payments and outlined deficiencies in Medicaid processes that require resolution.

Chairman Johnson, Ranking Member McCaskill, and Members of the Committee:

I appreciate the opportunity to be here today to discuss areas of risk to the Medicaid program and oversight efforts that can help prevent improper payments and ensure the program's fiscal integrity.¹ The federal-state Medicaid program is one of the nation's largest sources of funding for medical and health-related services. In fiscal year 2017, the program covered acute health care, long-term care, and other services for over 73 million low income and medically needy individuals. In that same year, estimated federal and state Medicaid expenditures were \$596 billion.

Medicaid has been on our high-risk list since 2003, in part, because of concerns about the adequacy of fiscal oversight and the program's improper payments—including payments made for people not eligible for Medicaid or services not actually provided.² The Medicaid program accounted for 26.1 percent of the fiscal year 2017 government-wide improper payment estimate.³ While efforts to reduce improper payments have been made by the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid, overall improper payments continue to increase. In fiscal year 2017, improper payments accounted for \$36.7 billion of Medicaid spending, up from \$29.1 billion in fiscal year 2015. Of the \$36.7 billion in improper payments, \$36.4 billion were overpayments and \$283 million were underpayments.

¹An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payment for services not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. See 31 U.S.C. § 3321 note. Office of Management and Budget guidance also instructs agencies to report as improper payments any payments for which insufficient or no documentation is found.

²See GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*. [GAO-17-317](#) (Washington, D.C.: Feb. 15, 2017).

³See GAO, *Improper Payments: Actions and Guidance Could Help Address Issues and Inconsistencies in Estimation Processes*. [GAO-18-377](#) (Washington, D.C.: May 31, 2018).

The size, complexity, and diversity of Medicaid make the program particularly challenging to oversee at the federal level. Medicaid allows significant flexibility for states to design and implement program innovations based on their unique needs; however, our prior work has found that these innovations have grown considerably over time, lack complete and accurate reporting, and do not always ensure the efficient use of federal dollars. It is critical that CMS and states take appropriate measures to reduce improper payments and ensure the fiscal integrity of Medicaid; as dollars wasted detract from the program's ability to ensure that the individuals who rely on Medicaid—including low-income children and individuals who are elderly or disabled—are provided adequate care.

My testimony today will focus on

1. major risks to the integrity of the Medicaid program, and
2. actions needed to manage these risks.

My remarks are based on our large body of work examining the Medicaid program, particularly reports issued and recommendations made from November 2012 to May 2018; these reports provide further details on our scope and methodology. (A list of related reports is included at the end of this statement.) For further context, my remarks also reference information reported by state auditors and the HHS Office of Inspector General (HHS-OIG), including information from two meetings with state auditors and Inspectors General we hosted in March and May 2018. We conducted all of the work on which this statement is based 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

Among health care programs, Medicaid is the largest as measured by enrollment (over 73 million in fiscal year 2017) and the second largest as measured by expenditures (\$596 billion in fiscal year 2017), second only to Medicare. The CMS Office of the Actuary projected that Medicaid spending would grow at an average rate of 5.7 percent per year, from fiscal years 2016 to 2025, with projected Medicaid expenditures reaching

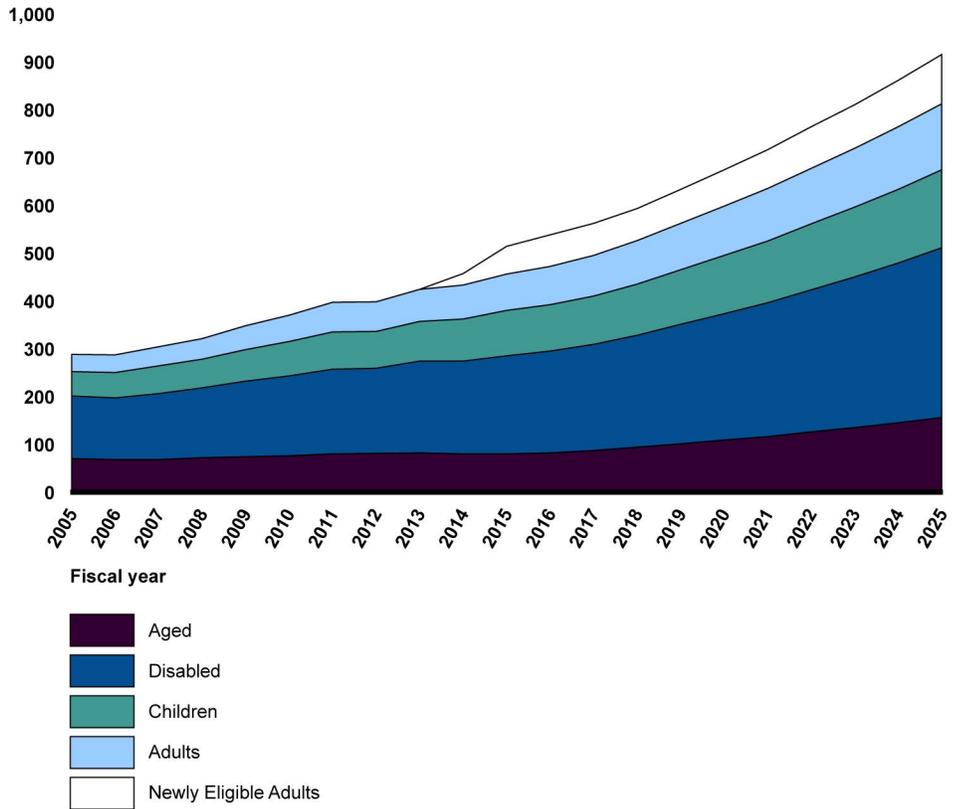
\$958 billion by fiscal year 2025.⁴ This projected growth in expenditures reflects both expected increases in expenditures per enrollee and in levels of Medicaid enrollment. Beneficiaries with disabilities and those who are elderly constitute the highest per enrollee expenditures, which are projected to increase by almost 50 percent from fiscal year 2016 to 2025. Medicaid enrollment is also expected to grow by as many as 13.2 million newly eligible adults by 2025—as additional states may expand their Medicaid programs to cover certain low-income adults under the Patient Protection and Affordable Care Act (PPACA).⁵ (See fig. 1.)

⁴Data are from the most recently issued CMS actuarial report. See Centers for Medicare & Medicaid Services, Office of the Actuary, *2016 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2016).

⁵The Patient Protection and Affordable Care Act, enacted on March 23, 2010, permits states to expand their Medicaid programs to cover nonelderly, nonpregnant adults who are not eligible for Medicare, and whose income does not exceed 133 percent of the federal poverty level. Because of the way the limit is calculated, using what is known as an “income disregard,” the level is effectively 138 percent of the federal poverty level. Pub. 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).

Figure 1: Growth Trends in Total Medicaid Spending by Eligibility Group

Expenditures (dollars in billions)



Source: GAO analysis of 2016 Actuarial Report on the Financial Outlook for Medicaid. | GAO-18-598T

Note: Data after fiscal year 2012 are projected expenditures.

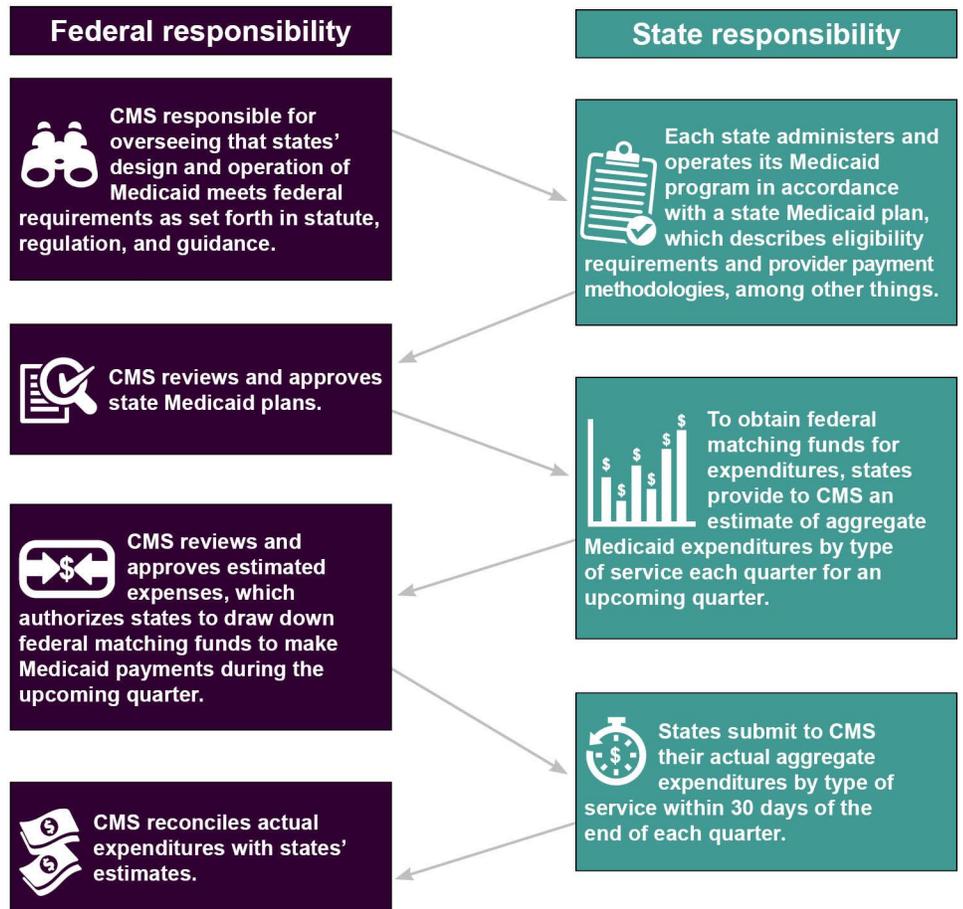
Accessible Data for Figure 1: Growth Trends in Total Medicaid Spending by Eligibility Group

Fiscal year	Aged	Blind/Disabled	Children	Adults	Newly Eligible Adults
2005	70	131	51	36	0
2006	68	129	53	37	0
2007	68	138	58	40	0
2008	72	146	60	43	0
2009	74	158	66	50	0
2010	76	167	72	55	0
2011	80	177	78	62	0

Fiscal year	Aged	Blind/Disabled	Children	Adults	Newly Eligible Adults
2012	81	178	77	62	0
2013	82	192	83	67	0
2014	80	194	88	71	24
2015	80	205	95	76	58
2016	82	213	97	80	66
2017	87	222	101	85	67
2018	94	234	107	91	67
2019	101	250	114	97	71
2020	109	264	122	103	76
2021	116	280	129	110	81
2022	126	297	138	116	87
2023	135	315	146	123	91
2024	145	334	154	131	97
2025	156	355	163	138	103

The partnership between the federal government and states is a central tenet of the Medicaid program. CMS provides oversight and technical assistance for the program, and states are responsible for administering their respective Medicaid programs’ day-to-day operations—including determining eligibility, enrolling individuals and providers, and adjudicating claims—within broad federal requirements. Federal oversight includes ensuring that the design and operation of state programs meet federal requirements and that Medicaid payments are made appropriately. (See fig. 2 for a diagram of the federal-state Medicaid partnership framework.) Joint financing of Medicaid is also a fixture of the federal-state partnership, with the federal government matching most state Medicaid expenditures using a statutory formula based, in part, on each state’s per capita income in relation to the national average per capita income.

Figure 2: Federal-State Medicaid Partnership Framework



Source: GAO. | GAO-18-598T

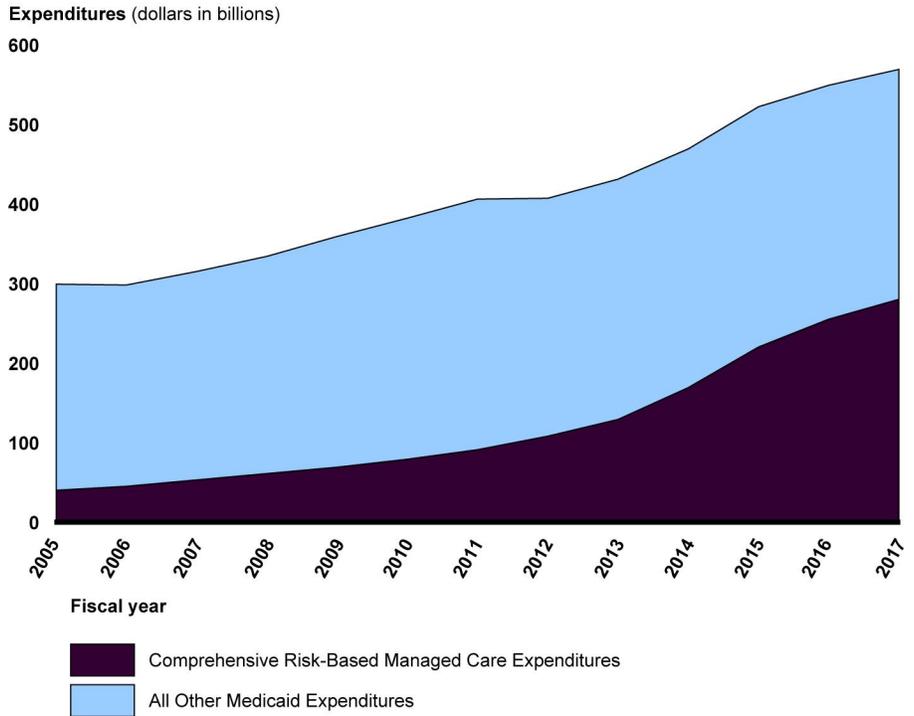
Note: If a state wishes to make amendments to its state Medicaid plan, it must seek approval from the Centers for Medicare & Medicaid Services (CMS). Similarly, a state that desires to change its Medicaid program in ways that deviate from certain federal requirements may seek to do so through a Medicaid demonstration waiver approved under section 1115 of the Social Security Act, which is outside of its state Medicaid plan. States must submit an application describing the proposed section 1115 demonstration to CMS for review. CMS will specify the special terms and conditions that encompass the requirements for an approved demonstration.

States have flexibility in determining how their Medicaid benefits are delivered. For example, states may (1) contract with managed care organizations to provide a specific set of Medicaid-covered services to beneficiaries and pay the organizations a set amount, generally on a per beneficiary per month basis; (2) pay health care providers for each service they provide on a fee-for-service basis; or (3) rely on a

combination of both delivery systems.⁶ Managed care continues to be a growing component of the Medicaid program. In fiscal year 2017, expenditures for managed care were \$280 billion, representing almost half of total program expenditures, compared with 42 percent in fiscal year 2015. (See fig. 3.)

⁶CMS has also been developing and testing a variety of value-based payment models, under which physicians and other providers are paid and responsible for the care of a beneficiary for a long period and accountable for the quality and efficiency of the care provided. Examples of these models include accountable care organizations—groups of physicians and other health care providers who voluntarily work together to provide coordinated care—and bundled payment models, which provide a “bundled” payment intended to cover the multiple services beneficiaries receive during an episode of care for certain health conditions, such as hip replacements, congestive heart failure, and pregnancy.

Figure 3: Growth in Comprehensive Risk-Based Managed Care as a Share of Total Medicaid Expenditures, Fiscal Years 2005 through 2017



Source: GAO analysis of Centers for Medicare & Medicaid Services expenditures data. | GAO-18-598T

Note: States may have different types of managed care arrangements in Medicaid; managed care expenditures in this figure include expenditures for comprehensive, risk-based managed care—the most common type of managed care arrangement.

Accessible Data for Figure 3: Growth in Comprehensive Risk-Based Managed Care as a Share of Total Medicaid Expenditures, Fiscal Years 2005 through 2017

Fiscal year	Managed Care Expenditures	Non-Managed Care Expenditures
2005	40	259
2006	45	253
2007	53	262
2008	61	273
2009	69	290
2010	79	303
2011	91	315
2012	108	299
2013	129	302

Fiscal year	Managed Care Expenditures	Non-Managed Care Expenditures
2014	169	300
2015	220	302
2016	255	294
2017	280	289

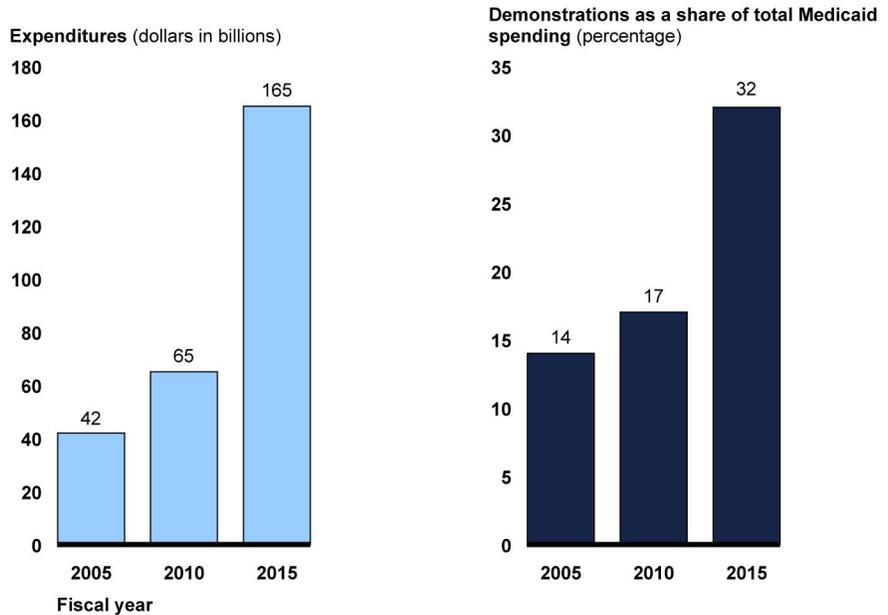
States also have the flexibility to innovate outside of many of Medicaid's otherwise applicable requirements through Medicaid demonstrations approved under section 1115 of the Social Security Act.⁷ These demonstrations allow states to test new approaches to coverage and to improve quality and access, or generate savings or efficiencies. For example, under demonstrations, states have

- extended coverage to certain populations,
- provided services not otherwise eligible for federal matching funds, and
- made incentive payments to providers for delivery system improvements.

As of November 2016, nearly three-quarters of states have CMS-approved demonstrations. In fiscal year 2015, total spending under demonstrations represented a third of all Medicaid spending nationwide. (See fig. 4.)

⁷Under section 1115 of the Social Security Act, the Secretary of Health and Human Services may waive certain Medicaid requirements and approve new types of expenditures that would not otherwise be eligible for federal Medicaid matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to promote Medicaid objectives. See 42 U.S.C. § 1315(a). The Secretary has delegated the approval and administration of Medicaid section 1115 demonstrations to CMS, which requires that such demonstrations be budget neutral to the federal government; that is, the federal government should spend no more for Medicaid under a state's demonstration than it would have spent without the demonstration. There are other types of waivers that states can apply for and use, including those approved under section 1915(c) of the Social Security Act, which authorizes the Secretary of Health and Human Services to waive requirements that states providing home and community based services would otherwise need to meet in the absence of the waiver.

Figure 4: Total Expenditures under Medicaid Section 1115 Demonstrations, Fiscal Years 2005, 2010, and 2015



Source: GAO analysis of Centers for Medicare & Medicaid Services demonstration expenditures data. | GAO-18-598T

Accessible Data for Figure 4: Total Expenditures under Medicaid Section 1115 Demonstrations, Fiscal Years 2005, 2010, and 2015 (1 of 2)

Fiscal year	Medicaid Demonstration Expenditures
2005	42
2010	65
2015	165

Accessible Data for Figure 4: Total Expenditures under Medicaid Section 1115 Demonstrations, Fiscal Years 2005, 2010, and 2015 (2 of 2)

Fiscal year	Percentage of
2005	14
2010	17
2015	32

In addition to other types of improper payments, Medicaid presents opportunities for fraud, because of the size, expenditures, and complexities of the program—including the variation in states’ design and implementation. Medicaid Fraud Control Units (MFCU)—state entities responsible for investigating and prosecuting Medicaid fraud—have

reported on Medicaid fraud convictions and recovered monies, in their annual reports.⁸ For example, over the past 5 years, MFCUs have reported an average of 1,072 yearly Medicaid fraud convictions. They also reported about \$680 million in recoveries related to fraud in fiscal year 2017—almost double the recoveries from fiscal year 2016.⁹

Three Broad Areas of Risk Threaten the Fiscal Integrity of Medicaid

Our prior work has identified three broad areas of risk to the fiscal integrity of Medicaid: improper payment rates, state use of supplemental payments, and oversight of demonstration programs.

Estimated Improper Payments Exceed 10 Percent, and Do Not Fully Account for All Program Risks

CMS annually computes the national Medicaid improper payment estimate as a weighted average of states' improper payment estimates for three component parts—fee-for-service, beneficiary eligibility determinations, and managed care. The improper payment estimate for each component is developed under its own methodology.¹⁰ The national rate in fiscal year 2017 was 10.1 percent, or \$36.7 billion. Since 2016, Medicaid has exceeded the 10 percent criterion set in statute. As such, the program was not fully compliant with the Improper Payments Elimination and Recovery Act of 2010.¹¹

⁸Nearly all states have MFCUs responsible for investigating and prosecuting Medicaid fraud. MFCUs are funded jointly by the federal government and the states, and HHS-OIG provides oversight.

⁹See Department of Health and Human Services, Office of Inspector General, *Medicaid Fraud Control Units Fiscal Year 2017 Annual Report*, OEI-09-18-00180 (Washington, D.C.: March 2018).

¹⁰CMS has not calculated the beneficiary eligibility determinations component estimate since 2014 and has held constant this component of the national rate at 3.1 percent. Beginning in the 2019 reporting year, the agency plans to resume improper payment estimates for eligibility determinations.

¹¹When an agency is determined to not be in compliance with one or more of the Improper Payments Elimination and Recovery Act criteria by its Inspector General, it must submit a plan to Congress describing the actions it will take to come into compliance.

In May 2018, we reported that the Medicaid managed care component of the improper payment estimate does not fully account for all program risks in managed care.¹² We identified 10 federal and state audits and investigations (out of 27 focused on Medicaid managed care) that cited about \$68 million in overpayments and unallowable managed care organization costs that were not accounted for by the managed care improper payment estimate. Another of these investigations resulted in a \$137.5 million settlement to resolve allegations of false claims.¹³ We further noted that the full extent of overpayments and unallowable costs is unknown, because the 27 audits and investigations we reviewed were conducted over more than 5 years and involved a small fraction of the more than 270 managed care organizations operating nationwide as of September 2017.

Some examples of the state audits that identified overpayments and unallowable costs include the following:

- The Washington State Auditor’s Office found that two managed care organizations made \$17.5 million in overpayments to providers in 2010, which may have increased the state’s 2013 capitation rates.¹⁴
- The Texas State Auditor’s Office found that one managed care organization reported \$3.8 million in unallowable costs for advertising, company events, gifts, and stock options, along with \$34 million in other questionable costs in 2015.¹⁵

¹²States may have different types of managed care arrangements in Medicaid; our findings apply to comprehensive, risk-based managed care, the most common type of managed care arrangement. See GAO, *Medicaid: CMS Should Take Steps to Mitigate Program Risks in Managed Care*, [GAO-18-291](#) (Washington, D.C.: May 7, 2018).

¹³See [GAO-18-291](#).

¹⁴Washington State Auditor, *Performance Audit: Health Care Authority’s Oversight of the Medicaid Managed Care Program*, Audit No. 1011450 (April 14, 2014).

¹⁵Texas State Auditor, *An Audit Report on HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization*, Report No. 17-025 (Austin, Tex.: February 2017).

- The New York State Comptroller found that two managed care organizations paid over \$6.6 million to excluded and deceased providers from 2011 through 2014.¹⁶

To the extent that such overpayments and unallowable costs are unidentified and not removed from the cost data used to set managed care payment rates, they may allow inflated future payments and minimize the appearance of program risks in Medicaid managed care. This potential understatement of the program risks in managed care also may curtail investigations into the appropriateness of managed care spending. The continued growth of Medicaid managed care makes ensuring the accuracy of managed care improper payment estimates increasingly important.

In May 2018, we acknowledged that although CMS has increased its focus on and worked with states to improve oversight of Medicaid managed care; its efforts—for example, updated regulations and audits of managed care providers—did not ensure the identification and reporting of overpayments and unallowable costs.¹⁷ In May 2016, CMS updated its regulations for managed care programs, including that states arrange an independent audit of the data submitted by MCOs, at least once every 3 years. We found that although this requirement has the potential to enhance state oversight of managed care; CMS was reviewing the rule for possible revision of its requirements.¹⁸ We also noted that another effort to address program risks in managed care—the use of CMS program integrity contractors to audit providers that are paid by managed care organizations—has been limited. To address the program risks that are not measured as a part of CMS’s methodology to estimate improper payments, in May 2018 we recommended that CMS take steps to mitigate such risks, which could include revising its methodology or

¹⁶New York State Office of the State Comptroller, *Medicaid Managed Care Organization Fraud and Abuse Detection*, Report 2014-S-51 (Albany, N.Y.: July 15, 2016). HHS-OIG has the authority to exclude providers from federal health care programs, and maintains a list of all currently excluded providers called the List of Excluded Individuals/Entities. No payment may be made from any federal health care program for any items or services furnished, ordered, or prescribed by an excluded provider.

¹⁷[GAO-18-291](#).

¹⁸CMS indicated it will issue a Notice of Proposed Rulemaking in 2018 to streamline Medicaid managed care regulations and reduce burden. See Department of Health and Human Services, Medicaid and CHIP Managed Care, *Spring 2018 Unified Agenda of Federal Regulatory and Deregulatory Actions*, (CMS-2480-P), RIN 0938-AT40, accessed in May 14, 2018, <http://www.reginfo.gov>.

focusing additional audit resources on managed care. HHS concurred with this recommendation.¹⁹

Our prior work on Medicaid has also identified other program risks associated with provider enrollment and beneficiary eligibility that may contribute to improper payments. In table 1 below, we identify some examples of the previous recommendations we have made to address these types of program risks, and what, if any, steps CMS has taken in response to our recommendations.

Table 1: Examples of GAO Recommendations to Address Medicaid Program Risks Associated with Managed Care, Provider Enrollment, and Beneficiary Eligibility Determinations

Program risks	GAO recommendations	Recommendation status
Addressing key risks, such as the extent of overpayments and unallowable costs, that are not measured in the managed care component of the Centers for Medicare & Medicaid Services' (CMS) improper payment estimate	One recommendation aimed at mitigating identified risks, such as revising the methodology to calculate the managed care component or focusing additional audit resources on managed care. ^a	CMS concurred with our recommendation, and indicated that it will review regulatory authority and audit resources to determine the best way to account for Medicaid program risks that are not accounted for in the managed care component.
Ensuring that only eligible providers are enrolled in Medicaid	Four recommendations aimed at assessing the databases used to screen providers, improve collaboration and coordination with other federal agencies on sharing databases and establishing a common identifier across databases, and providing guidance to state Medicaid agencies. ^b	CMS has addressed two of the four recommendations. To implement one remaining recommendation, CMS will need to determine whether the remaining databases (used by states and health plans to screen providers) that it has studied should be added to the agency's list of the databases used for screening purposes. For the other remaining recommendation, CMS needs to explore the use of a common identifier for screening providers across databases.
Ensuring that only eligible beneficiaries are enrolled in Medicaid	Two recommendations that CMS review federal determinations of Medicaid eligibility for accuracy, and take steps to increase assurance that expenditures for the different eligibility groups are correctly reported and appropriately matched. ^c	CMS established a more rigorous approach for verifying financial and nonfinancial information needed to determine Medicaid beneficiaries' eligibility. The agency stated that it would include reviews of federal eligibility determinations in states that have delegated that authority as a part of its review of states' eligibility determinations. The results of this effort will be reported in 2019.

Source: GAO | GAO-18-598T

^aSee GAO, *Medicaid: CMS Should Take Steps to Mitigate Program Risks in Managed Care*, [GAO-18-291](#) (Washington, D.C.: May 7, 2018).

^bSee GAO, *Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers*, [GAO-16-402](#) (Washington, D.C.: April 22, 2016).

^cSee GAO, *Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds*, [GAO-16-53](#) (Washington, D.C.: Oct. 16, 2015). Under the Patient Protection and Affordable Care Act, state Medicaid expenditures for certain Medicaid enrollees are subject to higher federal matching percentages.

¹⁹[GAO-18-291](#).

Lack of Transparency and Federal Oversight of States' Use of Supplemental Payments Increase Program Risk

Supplemental payments are payments made to providers—such as local government hospitals and other providers—that are in addition to the regular, claims-based payments made to providers for services they provided.²⁰ Like all Medicaid payments, supplemental payments are required to be economical and efficient.²¹

Supplemental payments have been growing and totaled more than \$48 billion in 2016. Our prior work has identified several concerns related to supplemental payments, including the need for more complete and accurate reporting, criteria for economical and efficient payments, and written guidance on the distribution of payments.²²

Complete and accurate reporting. Our prior work has identified increased use of provider taxes and transfers from local government providers to finance the states' share of supplemental payments, which, although allowed under federal law, effectively shift Medicaid costs from the states to the federal government. In particular, we previously reported in July 2014 that states' share of Medicaid supplemental payments financed with funds from providers and local governments increased the federal share from 57 percent in state fiscal year 2008 to 70 percent in state fiscal year 2012.²³ The full extent of this shift in states' financing

²⁰Two types of supplemental payments exist in Medicaid: (1) disproportionate share hospital (DSH) payments, which states are required to make to hospitals serving low-income and Medicaid patients to offset those providers' uncompensated care costs; and (2) non-DSH supplemental payments that states may, but are not required, to make to hospitals and other providers that, for example, serve high-cost Medicaid beneficiaries. Unless otherwise noted, our findings apply to both types of supplemental payments.

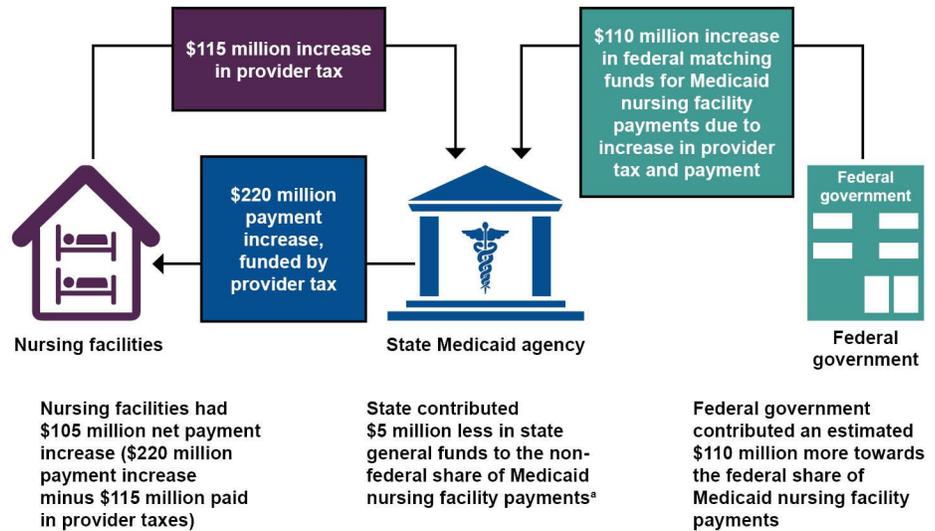
²¹Payments must also be sufficient to assure quality of care and to enlist enough providers so that care and services are available to Medicaid beneficiaries at least to the extent available to the general population in the geographic area. 42 U.S.C. § 1396a(a)(30)(A).

²²See, for example, GAO, *Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments*, [GAO-16-108](#) (Washington, D.C.: Feb. 5, 2016); and *Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy*, [GAO-15-322](#) (Washington, D.C.: April 10, 2015).

²³See GAO, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection [Reissued on March 13, 2015]*, [GAO-14-627](#) (Washington, D.C.: July 29, 2014).

structure was unknown, because CMS had not ensured that states report complete and accurate data on the sources of funds they use to finance their share of Medicaid payments, and CMS's efforts had fallen short of obtaining complete data.²⁴ (See table 2 below for our recommendation and actions CMS has taken.) For example, in July 2014, we reported that in one state, a \$220 million payment increase for nursing facilities resulted in an estimated \$110 million increase in federal matching funds to the state, and a net payment increase to the facilities of \$105 million.²⁵ (See fig. 5.)

Figure 5: Example of How One State's Use of Non-State Sources to Fund Medicaid Payments to Nursing Facilities Shifted Medicaid Costs to the Federal Government in State Fiscal Year 2015



Source: GAO. | GAO-18-598T

Criteria for economical and efficient payments. Our prior work has demonstrated that CMS lacks the criteria, data, and review processes to

²⁴Federal law requires that no less than 40 percent of the state's share of Medicaid payments be state funds—which can include state general funds, health care provider taxes imposed by the state, and intra-agency funds from non-Medicaid state agencies—but up to 60 percent may be financed by local governments and local government providers. We have reported that, absent complete and accurate data, CMS cannot ensure that states' use of local funding sources does not exceed the 60 percent. See [GAO-14-627](#).

²⁵See [GAO-14-627](#).

ensure that one type of supplemental payments—non-DSH supplemental payments—are economical and efficient.²⁶ For example, in April 2015, we identified public hospitals in one state that received such supplemental and regular Medicaid payments that, when combined, were hundreds of millions in excess of the hospitals' total Medicaid costs and tens of millions in excess of their total operating costs—unbeknownst to CMS.²⁷ Accordingly, we concluded that CMS's criteria and review processes did not ensure that it can identify excessive payments and determine if supplemental payments are economical and efficient. (See table 2 below for our recommendations and actions CMS has taken.)

Written guidance on the distribution of payments. According to CMS policy, Medicaid payments, including supplemental payments, should be linked to the provision of Medicaid services and not contingent on the provision of local funds. However, in February 2016 we reported that CMS did not have written guidance that clarifies this policy. In February 2016, we found examples of hospitals with large uncompensated costs associated with serving the low-income and Medicaid population that received relatively little in supplemental payments, while other hospitals with relatively low uncompensated care costs—but that were able to contribute a large amount of funds for the state's Medicaid share—received large supplemental payments relative to those costs, raising questions as to whether CMS policies are being followed.²⁸ (See table 2 for our recommendation and actions CMS has taken.)

²⁶Non-DSH supplemental payments that states may, but are not required to, make to hospitals and other providers that, for example, serve high-cost Medicaid beneficiaries.

²⁷See [GAO-15-322](#).

²⁸See [GAO-16-108](#).

Table 2: Examples of GAO Recommendations to Address Medicaid Program Risks Associated with Supplemental Payments

Program risks	GAO recommendations	Recommendation status
Complete and accurate reporting	One recommendation aimed at the Centers for Medicare & Medicaid Services (CMS) taking steps to ensure states report accurate and complete information on all sources of funds they use to finance their share of Medicaid spending. ^a	CMS did not concur with GAO's recommendation, although the agency stated that it will examine efforts to improve data collection for oversight.
Criteria for economical and efficient payments	Two recommendations called for CMS to (1) develop a policy that establishes criteria for defining when payments made to individual providers are economical and efficient, and (2) subsequently develop a process for identifying and reviewing payments to individual providers in order to determine whether they meet the criteria. ^b	CMS told us in April 2018 that it is developing a proposed rule on supplemental payment financing and oversight that may address these recommendations, although it does not have a time frame for its release.
Written guidance on the distribution of payments	One recommendation aimed at CMS issuing written guidance for states clarifying its policy of the distribution of supplemental payments. ^c	CMS told us in April 2018 that it is developing a proposed rule on supplemental payment financing and oversight that may address this recommendation, although it does not have a time frame for its release.

Source: GAO | GAO-18-598T

^aSee GAO, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, [Reissued on March 13, 2015], [GAO-14-627](#) (Washington, D.C.: July 29, 2014).

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

^cSee GAO, *Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments*, [GAO-16-108](#) (Washington, D.C.: Feb. 5, 2016).

Recognizing that Congress could help address some of the program risks associated with supplemental payments, in November 2012, we suggested that Congress consider requiring CMS to

- improve state reporting of supplemental payments, including requiring annual reporting of facility-specific payment amounts;
- clarify permissible methods for calculating these supplemental payments; and
- implement annual independent certified audits to verify state compliance with methods for calculating supplemental payments.²⁹

Subsequent to our work highlighting the need for complete and accurate reporting, in January 2017 a bill was introduced in the House of

²⁹See GAO, *Medicaid: More Transparency of and Accountability for Supplemental Payments are Needed*, [GAO-13-48](#) (Washington, D.C.: Nov. 26, 2012).

Representatives that, if enacted, would require annual state reporting of non-DSH supplemental payments made to individual facilities, require CMS to issue guidance to states that identifies permissible methods for calculating non-DSH supplemental payments to providers, and establish requirements for such annual independent audits.³⁰ Another bill was introduced in October 2017 that would require states to submit annual reports that identify the sources and amount of funds used to finance the state share of Medicaid payments.³¹ As of May 2018, no action had been taken on either proposed bill.

Absent Better Oversight, Demonstrations May Increase Federal Fiscal Liability

Demonstration programs, comprising about one-third of total Medicaid expenditures in fiscal year 2015, can be a powerful tool for states and CMS to test new approaches to providing coverage and delivering services that could reduce costs and improve outcomes. However, our prior work has identified several concerns related to demonstrations, including the need for ensuring that (1) demonstrations meet the policy requirements of budget neutrality—that is, they must not increase federal costs—and (2) evaluations are used to determine whether demonstrations are having their intended effects.³²

Budget neutrality of Medicaid demonstrations. Demonstration spending limits, by HHS policy, should not exceed spending that would have occurred in the absence of a demonstration. In multiple reports examining more than a dozen demonstrations between 2002 and 2017, we have identified a number of questionable methods and assumptions that HHS has permitted states to use when estimating costs. We found that federal spending on Medicaid demonstrations could be reduced by

³⁰The Improving Oversight and Accountability in Medicaid Non-DSH Supplemental Payments Act was introduced on January 13, 2017 and referred to the House Committee on Energy and Commerce. See H.R. 541, 115th Cong. § 2 (2017).

³¹The Medicaid Requiring Expenditures for Public Objectives to be Reflective of Total Spending Act (Medicaid REPORTS Act) was introduced on October 12, 2017 and referred to in the House Energy and Commerce Committee Subcommittee on Health. See H.R. 4054, 115th Cong. § 2 (2017).

³²See, for example, GAO, *Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures*, [GAO-18-220](#) (Washington, D.C.: Jan 19, 2018); and *Medicaid Demonstrations: Federal Action Needed to Improve Oversight of Spending*, [GAO-17-312](#) (Washington, D.C.: April 3, 2017).

billions of dollars if HHS were required to improve the process for reviewing, approving, and making transparent the basis for spending limits approved for Medicaid demonstrations.³³ The following are some examples of what we have previously found:

- In August 2014, we reported that HHS had approved a spending limit for Arkansas’s demonstration—to test whether providing premium assistance to purchase private coverage through the health insurance exchange would improve access for newly eligible Medicaid beneficiaries—that was based, in part, on hypothetical, not actual, costs. Specifically, the spending limit was based on significantly higher payment amounts the state assumed it would have to make to providers if it expanded coverage under the traditional Medicaid program, and HHS did not request any data to support the state’s assumptions. We estimated that by allowing the state to use hypothetical costs, HHS approved a demonstration spending limit that was over \$775 million more than what it would have been if the limit was based on the state’s actual payment rates for services under the traditional Medicaid program.³⁴
- We also reported in August 2014 that HHS officials told us it granted Arkansas and 11 other states additional flexibility in their demonstrations in order to increase spending limits if costs proved higher than expected.³⁵ We concluded that granting this flexibility to the states to adjust the spending limit increased the fiscal risk to the federal government.
- More recently, in April 2017, we reported that two states used unspent federal funds from their previous demonstrations to expand the scope of subsequent demonstrations by \$8 billion and \$600 million,

³³See, for example, [GAO-17-312](#) and GAO, *Medicaid Demonstrations: HHS’s Approval Process for Arkansas’s Medicaid Expansion Waiver Raises Cost Concerns*, [GAO-14-689R](#) (Washington, D.C.: Aug. 8, 2014); *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency*, [GAO-13-384](#) (Washington, D.C.: June 25, 2013); *Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns*, [GAO-08-87](#) (Washington, D.C.: Jan. 31, 2008); and *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, [GAO-02-817](#) (Washington, D.C.: July 12, 2002).

³⁴See [GAO-14-689R](#).

³⁵In September 2014, the Chairman of the House Committee on Energy & Commerce and the Ranking Member of the Senate Committee on Finance sent a letter to CMS asking, among other things, how the agency planned to ensure that spending for those newly eligible under Arkansas’s demonstration would not cost the federal government more than it would have cost under traditional Medicaid.

respectively. We concluded that inflating the spending limits in this way inappropriately increased the federal government’s fiscal liability for Medicaid.³⁶

We have previously made recommendations to improve oversight of spending on demonstrations, and HHS recently took action that partially responds to one of these recommendations. (See table 3 for examples of the recommendations and actions HHS has taken.) Specifically, under a policy implemented in 2016, HHS restricted the amount of unspent funds states can accrue for each year of a demonstration, and has also reduced the amount of unspent funds that states can carry forward to new demonstrations. For 10 demonstrations it has recently approved, HHS estimated that the new policy has reduced total demonstration spending limits by \$109 billion for 2016 through 2018, the federal share of which is \$62.9 billion. These limits reduce the effect, but do not specifically address all, of the questionable methods and assumptions that we have identified regarding how HHS sets demonstration spending limits.

Table 3: Examples of GAO Recommendations to Address Medicaid Program Risks Associated with Spending on Medicaid Demonstrations

Program risks	GAO recommendations	Recommendation status
Methods for determining budget neutrality	One recommendation that the Department of Health and Human Services (HHS) better ensure that valid methods are used to demonstrate budget neutrality. ^a	HHS has taken some steps in recent years to improve allowable methods for ensuring budget neutrality, but still needs written guidance on methodologies for demonstrating budget neutrality.
Lack of criteria for determining spending limits	One recommendation that HHS update its written budget neutrality policy to reflect the actual criteria and processes used to develop and approve demonstration spending limits. ^b	HHS announced and began implementing policy changes in 2016 that address some, but not all of our concerns, which it formalized in 2017. The agency expects to release additional guidance later in 2018. Once HHS provides additional written guidance on its criteria and processes, we will be in a position to consider closing this recommendation.

Source: GAO | GAO-18-598T

^aSee GAO, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, [GAO-02-817](#) (Washington, D.C.: July 12, 2002).

^bSee GAO, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency*, [GAO-13-384](#) (Washington, D.C.: June 25, 2013).

³⁶See [GAO-17-312](#).

Evaluation of Medicaid demonstrations. In a January 2018 report, we questioned the usefulness of both state-led and federal evaluations of section 1115 demonstrations, particularly with regard to how these evaluation results may inform policy decisions.³⁷

- State-led evaluations. We identified significant limitations among selected state-led demonstration evaluations, including gaps in reported evaluation results for important parts of the demonstrations. (See table 4.) These gaps resulted, in part, from CMS requiring final, comprehensive evaluation reports after the expiration of the demonstrations rather than at the end of each 3- to 5-year demonstration cycle. In October 2017, CMS officials stated that the agency planned to require final reports at the end of each demonstration cycle for all demonstrations, although it had not established written procedures for implementing this new policy. We concluded in January 2018 that without written procedures for implementing such requirements, gaps in oversight could continue.³⁸

Table 4: Examples of Gaps in States' Evaluations of Medicaid Section 1115 Demonstrations GAO Identified

State	Example of gaps in evaluations
Arizona	The state was required to evaluate whether providing long-term services and supports under a managed care delivery model improved access and quality of care. The evaluation report lacked information on important measures of access and quality.
Arkansas	The state was required to evaluate the effects of using Medicaid funds to purchase private insurance for more than 200,000 beneficiaries. The evaluation did not address a key hypothesis that using private insurance would improve continuity of coverage for these beneficiaries, who were expected to have frequent changes in income that could lead to coverage gaps.
Massachusetts	The state was required to evaluate the effectiveness of its approach of providing up to \$690 million in incentive payments to seven hospitals to improve quality of care and reduce per capita costs. Evaluation reports submitted after 5 years provided no conclusions on the impact of the payments in these areas.

Source: GAO. | GAO-18-598T

- Federal evaluations. Evaluations of federal demonstrations led by CMS have also been limited due to data challenges and a lack of transparent reporting. For example, delays obtaining data directly from states, among other things, led CMS to considerably reduce the scope of a large, multi-state evaluation, which was initiated in 2014 to examine the impact of state demonstrations in four policy areas

³⁷See [GAO-18-220](#).

³⁸CMS also planned to allow states to conduct less rigorous evaluations for certain types of demonstrations, but had not established criteria defining under what conditions these limited evaluations would be allowed, when we issued our January 2018 report.

deemed to be federal priorities.³⁹ In our January 2018 report, we found that although CMS had made progress in obtaining needed data, CMS had no policy for making the results public. By not making these results public in a timely manner, we concluded that CMS was missing an opportunity to inform important federal and state policy discussions.

In light of our concerns about state-led and federal demonstration evaluations, in January 2018, we recommended that CMS (1) establish written procedures for requiring final evaluation reports at the end of each demonstration cycle, (2) issue criteria for when it will allow limited evaluations of demonstrations, and (3) establish a policy for publicly releasing findings from federal evaluations of demonstrations. HHS concurred with these recommendations.⁴⁰

Fundamental Actions Needed to Strengthen Oversight and Manage Program Risks

Across our body of work, we have made 83 recommendations to CMS and HHS and suggested 4 matters for congressional consideration to address a variety of concerns about the Medicaid program. The agencies generally agreed with our recommendations and have implemented 25 of these recommendations to date, and CMS still needs to take fundamental actions in three areas—having more timely, complete, and reliable data; conducting fraud risk assessments; and strengthening federal-state collaboration—to strengthen Medicaid oversight and better manage program risks.

More Complete, Timely, Reliable Data for Oversight

An overarching challenge for CMS oversight of the Medicaid program is the lack of accurate, complete, and timely data. Our work has demonstrated how insufficient data have affected CMS's ability to ensure

³⁹The policy areas are (1) delivery system reform incentive payment programs, which provide incentive payments to providers that engage in various improvement projects that align with state delivery system reform objectives; (2) premium assistance to purchase insurance coverage in the exchange under PPACA; (3) beneficiary engagement policies, such as requiring monthly contributions; and (4) use of managed care to deliver Medicaid long-term supports and services.

⁴⁰See [GAO-18-220](#).

proper payments, assess beneficiaries' access to services, and oversee states' financing strategies.

As part of its efforts to address longstanding data concerns, CMS has taken some steps toward developing a reliable national repository for Medicaid data, most notably the Transformed Medicaid Statistical Information System (T-MSIS). Through T-MSIS, CMS will collect detailed information on Medicaid beneficiaries—such as their citizenship, immigration, and disability status—as well as any expanded diagnosis and procedure codes associated with their treatments. States are to report data more frequently—and in a timelier manner—than they have previously, and T-MSIS includes approximately 2,800 automated quality checks.⁴¹ The T-MSIS initiative has the potential to improve CMS's ability to identify improper payments, help ensure beneficiaries' access to services, and improve program transparency, among other benefits.

As we reported in December 2017, implementing the T-MSIS initiative has been—and will continue to be—a multi-year effort. CMS has worked closely with states and has reached a point where nearly all states are reporting T-MSIS data. While recognizing the progress made, we noted that more work needs to be done before CMS or states can use these data for program oversight:

- All states need to report complete T-MSIS data. For our December 2017 report, we reviewed a sample of six states and found that none were reporting complete data.⁴²
- T-MSIS data should be formatted in a manner that allows for state data to be compared nationally. In December 2017, we reported that state officials had expressed concerns that states did not convert their data to the T-MSIS format in the same ways, which could limit cross-state comparisons.⁴³

⁴¹In particular, we found that the usefulness of CMS data on Medicaid is limited because of issues with completeness, accuracy, and timeliness. With regard to timeliness, we found that available data were reported up to 3 years late and were previously submitted on a quarterly basis. Under T-MSIS, data are to be reported monthly.

⁴²The six selected states were not reporting complete data as of August 2017. See GAO, *Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight*, [GAO-18-70](#) (Washington, D.C.: Dec. 8, 2017).

⁴³See [GAO-18-70](#).

In our December 2017 report, we recommended that CMS take steps to expedite the use of T-MSIS data, including efforts to (1) obtain complete information from all states; (2) identify and share information across states to improve data comparability; and (3) implement mechanisms by which states can collaborate on an ongoing basis to improve the completeness, comparability, and utility of T-MSIS data. We also recommended that CMS articulate a specific plan and associated time frames for using T-MSIS data for oversight.⁴⁴ The agency concurred with our recommendations, but has not yet implemented them.

Our prior work has also noted areas where other data improvements are critical to program oversight:

- In July 2014, we found that there was a need for data on supplemental payments that states make to individual hospitals and other providers. In particular, our findings and related recommendation from July 2014 indicate that CMS should develop a data collection strategy that ensures that states report accurate and complete data on all sources of funds used to finance the states' share of Medicaid payments.⁴⁵
- In January 2017, we found limitations in the data CMS collects to monitor the provision of, and spending on, personal care services—services that are at a high risk for improper payments, including fraud.⁴⁶ In particular, data on the provision of personal care services were often not timely, complete, or consistent. Data on states' spending on these services were also not accurate or complete. In January 2017, we recommended that CMS improve personal care services data by (1) establishing standard reporting guidance for key data, (2) ensuring linkage between data on the provision of services and reported expenditures, (3) ensuring state compliance with reporting requirements, and (4) developing plans to use data for

⁴⁴We concluded that absent a specific plan and time frames, CMS's ability to use these data to oversee the program, including ensuring proper payments, was limited. See [GAO-18-70](#).

⁴⁵Better data on supplemental payments could also help ensure that states comply with federal requirements regarding how much local governments may contribute to the state's share of Medicaid payments. See [GAO-14-627](#).

⁴⁶Personal care services are key components of long-term, in-home care, providing assistance with basic activities, such as bathing, dressing, and toileting, to millions of individuals seeking to retain their independence and to age in place.

oversight.⁴⁷ The agency concurred with two recommendations and neither agreed nor disagreed with the other two recommendations, and has not yet implemented any.

More Complete Fraud Risk Assessment and Better Fraud Targeting

In December 2017, we examined CMS's efforts managing fraud risks in Medicaid and compared it with our Fraud Risk Framework, which provides a comprehensive set of key components and leading practices that serve as a guide for agency managers to use when developing efforts to combat fraud in a strategic, risk-based way.⁴⁸ This framework describes leading practices in four components: commit, assess, design and implement, and evaluate and adapt. (See fig. 6.) The Fraud Reduction and Data Analytics Act of 2015, enacted in June 2016, requires the Office of Management and Budget (OMB) to establish guidelines incorporating the leading practices from our Fraud Risk Framework for federal agencies to create controls to identify and assess fraud risks, and design and implement antifraud control activities.⁴⁹ In July 2016, OMB published guidance, and among other things, this guidance affirms that managers should adhere to the leading practices identified in our Fraud Risk Framework.⁵⁰

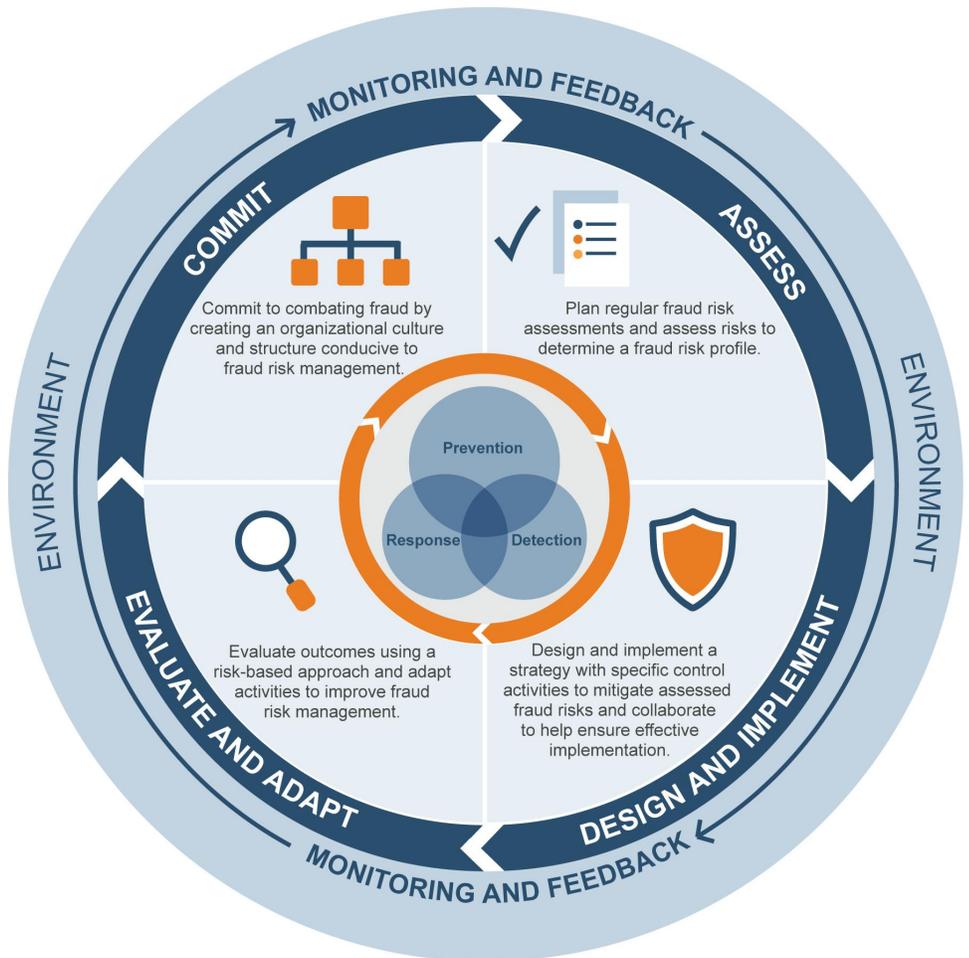
⁴⁷See GAO, *Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services*, [GAO-17-169](#) (Washington, D.C.: Jan. 12, 2017).

⁴⁸See GAO, *A Framework for Managing Fraud Risks in Federal Programs*, [GAO-15-593SP](#) (Washington, D.C.: July 28, 2015).

⁴⁹Pub. L. No. 114-186, § 3, 130 Stat. 546 (2016).

⁵⁰Office of Management and Budget, *Management's Responsibility for Enterprise Risk Management and Internal Control*, Circular No. A-123 (Washington, D.C.: July 15, 2016).

Figure 6: The Fraud Risk Management Framework



Source: GAO. | GAO-18-598T

In a December 2017 report, we found that CMS’s efforts partially aligned with our fraud risk framework. In particular, CMS had

- shown a commitment to combating fraud, in part, by establishing a dedicated entity—the Center for Program Integrity—to lead antifraud efforts, and offering and requiring antifraud training for stakeholder groups, such as providers, beneficiaries, and health-insurance plans; and
- taken steps to identify fraud risks, such as by designating specific provider types as high risk and developing associated control activities.

However, CMS had not conducted a fraud risk assessment for Medicaid, and had not designed and implemented a risk-based antifraud strategy.⁵¹ A fraud risk assessment allows managers to fully consider fraud risks to their programs, analyze their likelihood and impact, and prioritize risks. Managers can then design and implement a strategy with specific control activities to mitigate these fraud risks, as well as design and implement an appropriate evaluation. We concluded that through these actions, CMS could better ensure that it is addressing the full portfolio of risks and strategically targeting the most-significant fraud risks facing Medicaid. As a result, in December 2017 we made three recommendations to CMS, two of which were to conduct fraud risk assessments, and create an antifraud strategy for Medicaid, including an approach for evaluation.⁵² HHS concurred with our recommendations, but has not yet implemented them.

Greater Federal-State Collaboration to Strengthen Program Oversight

The federal government and the states play important roles in reducing improper payments and overseeing the Medicaid program, including overseeing spending on Medicaid supplemental payments and demonstrations. Our prior work shows that oversight of the Medicaid program could be further improved through leveraging and coordinating program integrity efforts with state agencies, state auditors, and other partners.

Collaborative audits with state agencies. As we have previously reported, CMS has made changes to its Medicaid program integrity efforts, including a shift to collaborative audits—in which CMS’s contractors and states work in partnership to audit Medicaid providers. In March 2017, we reported that collaborative audits had identified substantial potential overpayments to providers, but barriers—such as staff burden or problems communicating with contractors—had limited their use and prevented states from seeking audits or hindered the

⁵¹See GAO, *Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework*, [GAO-18-88](#) (Washington, D.C.: Dec. 5, 2017).

⁵²See [GAO-18-88](#).

success of audits.⁵³ We recommended that CMS address the barriers that limit state participation in collaborative audits, including their use in managed care delivery systems. CMS concurred with this recommendation and has taken steps to address them for a number of states, but has not yet made such changes accessible to a majority of states.

State auditors and federal partners. We have found that state auditors and the HHS-OIG offer additional oversight and information that can help identify program risks. To that end, we routinely coordinate our audit efforts with the state auditors and the HHS-OIG. For example, we have convened and facilitated meetings between CMS and state audit officials to discuss specific areas of concern in Medicaid and future opportunities for collaboration. The state auditors and CMS officials commented on the benefits of such coordination, with the state auditors noting that they can assist CMS's state program integrity reviews by identifying program risks.

State auditors also have conducted program integrity reviews to identify improper payments and deficiencies in the processes used to identify them. We believe that these reviews could provide insights into program weaknesses that CMS could learn from and potentially address nationally. Coordination also provides an opportunity for state auditors to learn methods for conducting program integrity reviews. The following are recent examples of reviews conducted:

- In 2017, the Oregon Secretary of State Audits Division found approximately 31,300 questionable payments to Coordinated Care Organizations (which receive capitated monthly payments for beneficiaries, similar to managed care organizations), based on a review of 15 months of data. In addition, the state auditor found that approximately 47,600 individuals enrolled in Oregon's Medicaid program were ineligible, equating to \$88 million in avoidable expenditures.⁵⁴
- Massachusetts' Medicaid Audit Unit's recent annual report (covering the time period from March 15, 2017, through March 14, 2018)

⁵³See GAO, *Medicaid Program Integrity: CMS Should Build on Current Oversight Efforts by Further Enhancing Collaboration with States*, [GAO-17-277](#) (Washington, D.C.: March 15, 2017).

⁵⁴State of Oregon, Secretary of State, Dennis Richardson and Oregon Audits Division Director, Kip Memmott, *Oregon Health Authority Should Improve Efforts to Detect and Prevent Improper Medicaid Payments* Report 2017- 25 (Salem, Ore.: November 2017).

reported that the state auditor identified more than \$211 million in unallowable, questionable, duplicative, unauthorized, or potentially fraudulent billing in the program.⁵⁵

- A 2017 report released by the Louisiana Legislative Auditor's Office stated that the office reviewed Medicaid eligibility files and claims data covering January 2011 through October 2016, and found \$1.4 million in questionable duplicate payments.⁵⁶
- In fiscal year 2017, the Mississippi Division of Medicaid reported that they recovered more than \$8.6 million through various audits of medical claims paid to health care providers. The division also referred seven cases to the state's attorney general's office, in which the division had identified \$3.1 million in improper billing.⁵⁷

At a May 2018 federal and state auditor coordination meeting that we participated in, the HHS-OIG provided examples of the financial impact of its work related to improper payments, including

- one review of managed care long term services and supports that identified \$717 million potential federal savings,
- three reviews of managed care payments made after beneficiaries' death that identified \$18.2 million in federal funds to be recovered, and
- two reviews of managed care payments made for beneficiaries with multiple Medicaid IDs that identified \$4.3 million in federal funds to be recovered.

Healthcare Fraud Prevention Partnership. The Healthcare Fraud Prevention Partnership (HFPP) is an important tool to help combat Medicaid fraud. In 2012, CMS created the HFPP to share information with public and private stakeholders, and to conduct studies related to health care fraud, waste, and abuse. According to CMS, as of October 2017, the HFPP included 89 public and private partners—including Medicare—and

⁵⁵Commonwealth of Massachusetts, Office of the State Auditor Suzanne M. Bump, *Office of the State Auditor—Annual Report Medicaid Audit Unit, March 15, 2017-March 14, 2018* (Boston, Mass.: March 15, 2018).

⁵⁶Louisiana Legislative Auditor, State of Louisiana, *Duplicate Payments for Medicaid Recipients with Multiple Identification Numbers* (Baton Rouge, La.: March 29, 2017).

⁵⁷Mississippi Division of Medicaid, *Medicaid Recovers \$8.6 Million in Fiscal Year 2017* (Jackson, Miss.), accessed May 29, 2018, <https://medicaid.ms.gov/medicaid-recovers-8-6-million-in-fiscal-year-2017/>.

Medicaid-related federal and state agencies, law enforcement agencies, private health insurance plans, and antifraud and other health care organizations. The HFPP has conducted studies that pool and analyze multiple payers' claims data to identify providers with patterns of suspect billing across private health insurance plans. In August 2017, we reported that the partnership participants separately told us the HFPP's studies helped them identify and take action against potentially fraudulent providers and payment vulnerabilities of which they might not otherwise have been aware, and fostered both formal and informal information sharing.⁵⁸

Chairman Johnson, Ranking Member McCaskill, and Members of the Committee, this concludes my prepared statement. I would be pleased to respond to any questions you may have.

GAO Contacts and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact Carolyn L. Yocom, who may be reached at 202-512-7114 or yocomc@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Leslie V. Gordon (Assistant Director), Deirdre Gleeson Brown (Analyst-in-Charge), Muriel Brown, Helen Desaulniers, Melissa Duong, Julianne Flowers, Sandra George, Giselle C. Hicks, Drew Long, Perry Parsons, Russell Voth, and Jennifer Whitworth.

⁵⁸See GAO, *Medicare: CMS Fraud Prevention System Uses Claims Analysis to Address Fraud*, [GAO-17-710](#) (Washington, D.C.: Aug. 30, 2017).

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