



## Testimony

Before the Subcommittee on Health  
Care, Committee on Finance, U.S.  
Senate

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# MEDICAID ELIGIBILITY

## Accurate Beneficiary Enrollment Requires Improvements in Oversight, Data, and Collaboration

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Highlights of [GAO-20-147T](#), a testimony before the Subcommittee on Health Care, Committee on Finance, U.S. Senate

## Why GAO Did This Study

Medicaid, a joint federal-state health care program, is one of the nation's largest sources of funding for medical and other health-related services for tens of millions of low income and medically needy individuals. In fiscal year 2018, estimated federal and state expenditures for Medicaid were \$629 billion. The size and complexity of Medicaid make the program particularly vulnerable to improper payments—including payments made for people not eligible for Medicaid.

States have significant flexibility to design and implement their Medicaid programs based on their unique needs. These programs are administered at the state level, overseen at the federal level by CMS, and jointly funded by the states and federal government. The federal government matches most state expenditures for Medicaid services based on a statutory formula. Under the Patient Protection and Affordable Care Act, states have the option to expand their Medicaid programs to cover nearly all adults with incomes at or below 133 percent of the federal poverty level. States that choose to expand their programs receive a higher federal matching rate for the Medicaid expansion enrollees.

This testimony will cover improvements needed to ensure accurate eligibility determinations and focuses on (1) CMS's oversight of Medicaid eligibility and related expenditures; (2) CMS's efforts to improve Medicaid data; and (3) other opportunities to improve oversight and ensure appropriate enrollment. This testimony is generally based on GAO findings and recommendations on the Medicaid program issued from 2015 through 2018, and steps taken to address them through September 2019.

View [GAO-20-147T](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov).

October 30, 2019

## MEDICAID ELIGIBILITY

### Accurate Beneficiary Enrollment Requires Improvements in Oversight, Data, and Collaboration

#### What GAO Found

The Centers for Medicare & Medicaid Services (CMS) has taken steps to improve its oversight of the Medicaid program; however, GAO has identified areas where additional actions could improve program oversight and ensure that only eligible individuals are enrolled in the Medicaid program. These actions include closing gaps in oversight of eligibility determinations and related expenses, improving data, and furthering federal-state collaboration.

**Gaps in oversight of Medicaid eligibility determinations and related expenses.** Since 2014, CMS has not estimated improper payments due to erroneous eligibility determinations; it plans to report these estimates in November 2019. GAO found that for fiscal year 2017 Medicaid expansion enrollees accounted for nearly a quarter of all Medicaid enrollees and federal Medicaid expenditures. GAO's prior work has identified gaps in CMS oversight, which affects the federal match. An accurate determination of eligibility 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. GAO recommended that CMS conduct reviews of federal Medicaid eligibility determinations to ascertain their accuracy and institute corrective actions where necessary, and revise the sampling methodology for reviewing expenditures for the expansion population. CMS concurred with these recommendations, though has since indicated that it will not revise the sampling methodology. We continue to believe that additional steps are needed to fully implement these recommendations.

**Better Medicaid data.** Improvements in Medicaid data could aid program oversight to ensure that only eligible beneficiaries are enrolled. CMS officials acknowledged the need for improved data and cited the Transformed Medicaid Statistical Information System (T-MSIS) initiative as its primary effort—conducted jointly with states—to improve the collection of Medicaid expenditure and utilization data. According to CMS officials, aspects of T-MSIS are designed to broaden the scope and improve the quality of state-reported data, as well as the data's usefulness to states. GAO made a series of recommendations related to T-MSIS. CMS concurred with the recommendations, but some have not been fully implemented, including expediting the use of T-MSIS data for oversight, and outlining a plan and associated time frames for using the data for oversight.

**Further federal-state collaboration needed for oversight and appropriate enrollment.** GAO has previously reported that collaborative activities between the federal government and the states are important to improving oversight of the Medicaid program. CMS has ongoing efforts to engage state agencies and others through a national Medicaid training program for state officials and partnerships to combat Medicaid fraud. Recently, steps were taken to better enable state auditors to audit states' eligibility determinations to ensure beneficiaries qualify for the Medicaid program and are enrolled in the correct eligibility group. GAO has previously suggested that CMS could leverage the unique qualifications of state auditors and help improve program integrity by further providing state auditors with a substantive and ongoing role in auditing state Medicaid programs.

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Chairman Toomey, Ranking Member Stabenow, and Members of the Subcommittee:

I am pleased to be here today to discuss the importance of ensuring that only eligible individuals are enrolled in the Medicaid program. This federal-state program is one of the nation's largest sources of funding for medical and other health-related services for over 75 million low-income and medically needy individuals. In fiscal year 2018, estimated federal and state Medicaid expenditures for Medicaid were \$629 billion. The size and complexity of Medicaid make the program particularly vulnerable to improper payments—including payments made for people not eligible for Medicaid. In fiscal year 2018, the national Medicaid improper payment estimate was approximately \$36 billion—nearly 10 percent of federal Medicaid expenditures. Due to concerns about the adequacy of fiscal oversight, Medicaid has been on our list of high-risk programs since 2003.<sup>1</sup>

The Medicaid program is a partnership between the federal government and the states, 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).<sup>2</sup> Within broad federal requirements, states have significant flexibility to design and implement their programs based on their unique needs, resulting in over 50 distinct state Medicaid programs.<sup>3</sup> These programs are administered at the state level and overseen at the federal level by the Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS).

The Patient Protection and Affordable Care Act (PPACA) gave states the option to expand their Medicaid programs by covering nearly all adults with incomes at or below 133 percent of the federal poverty level (FPL)

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<sup>1</sup>GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, [GAO-19-157SP](#) (Washington, D.C.: Mar. 6, 2019).

<sup>2</sup>The 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.

<sup>3</sup>Medicaid programs are administered by the 50 states, the District of Columbia, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

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beginning January 1, 2014.<sup>4</sup> States choosing to expand their programs receive a higher federal matching rate for these Medicaid expansion enrollees.<sup>5</sup> PPACA also includes a new approach to assessing individuals' financial eligibility for Medicaid.

My testimony today will cover improvements needed to ensure accurate beneficiary enrollment and will focus on:

1. CMS oversight of Medicaid eligibility and related expenditures;
2. CMS's efforts to improve Medicaid data; and
3. other opportunities to improve Medicaid oversight and ensure appropriate enrollment.

My remarks are based on our large body of work examining the Medicaid program, specifically our reports issued and recommendations made from 2015 through 2018, and steps HHS and CMS have taken to address these recommendations through September 2019. Those reports provide further details on our scope and methodology. (See app. I for selected recommendations and a list of related GAO reports at the end of this statement.) For further context, my remarks reference the most recently available data from CMS on Medicaid beneficiary enrollment and expenditures, including enrollment and expenditures for Medicaid expansion enrollees in fiscal year 2017, information reported by state auditors, and the Office of Management and Budget's (OMB) 2019 Compliance Supplement. 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

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<sup>4</sup>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). For purposes of this report, references to PPACA include the amendments made by HCERA. PPACA also permitted an early expansion option, whereby states could expand eligibility for this population, or a subset of this population, starting on April 1, 2010.

<sup>5</sup>In this testimony, Medicaid expansion enrollees refer to (1) 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; and (2) 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.

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believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

The federal government and states share responsibility for the financing and administration of the Medicaid program. With regard to financing, Medicaid is funded jointly by the federal government and states, with FMAP rates ranging from a statutory minimum of 50 percent to a statutory maximum of 83 percent. Under PPACA, expenditures for Medicaid expansion enrollees are matched at 90 percent for fiscal year 2020.

Program administrative responsibilities are shared between states and the federal government. State administrative responsibilities include, among other things, determining eligibility, enrolling beneficiaries, and adjudicating claims. With regard to eligibility, 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,
- accurately assigning enrollees to the appropriate eligibility group, and
- promptly disenrolling individuals who are not eligible.<sup>6</sup>

PPACA requires 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.<sup>7</sup> In addition, states have had to make changes to reflect new sources of documentation and income used for verification. In certain circumstances, states may delegate responsibility to the federal government to make eligibility determinations.

At the federal level, CMS is responsible for overseeing states' design and operation of their Medicaid programs and ensuring that federal funds are

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<sup>6</sup>Factors that states verify include, among others, citizenship, immigration status, age (date of birth), Social Security number, income, residency, and household composition.

<sup>7</sup>For 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).

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appropriately spent. CMS oversees state enrollment of beneficiaries and reporting of expenditures. For example:

- CMS reviews and approves states' Medicaid eligibility verification plans, which rely primarily on information available through data sources—including federal data sources such as the Social Security Administration and the Internal Revenue Services, or state data sources such as state tax records or unemployment information—rather than paper documentation from families.
- CMS has various review processes in place to ensure that expenditures reported by states are supported and consistent with Medicaid requirements. The agency also has processes to check whether the correct federal matching rates were applied only to expenditures receiving a higher than standard federal matching rate, which can include certain types of services and populations.
- CMS estimates Medicaid improper payments, including improper payments due to erroneous beneficiary eligibility determinations. Although CMS has not calculated the improper payments related to beneficiary eligibility determinations since 2014, it plans to begin reporting this estimate in November 2019.

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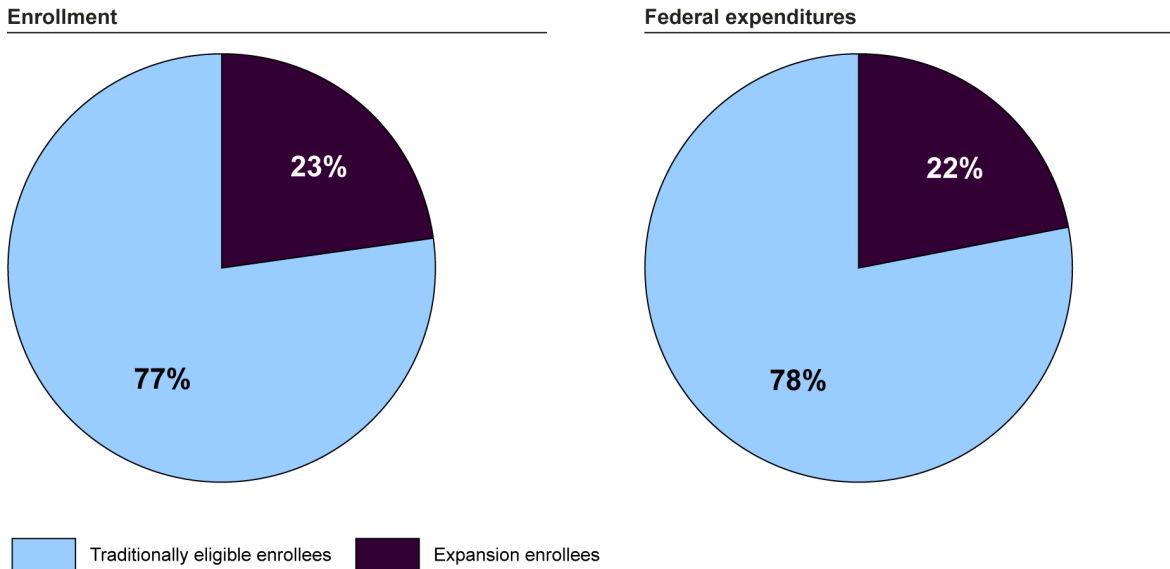
## CMS Oversight of Medicaid Eligibility Determinations and Related Expenditures Has Gaps

Our previous work has identified gaps in CMS oversight of Medicaid eligibility determinations, which affect the federal matching rate. An accurate determination of eligibility 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. The implications of inaccurate eligibility determinations can be significant, especially given the growth in enrollment and spending of the expansion population, which represented nearly one quarter of program enrollment and federal expenditures in fiscal year 2017.<sup>8</sup> (See fig. 1.)

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<sup>8</sup>Our analysis of Medicaid expansion enrollment excludes totals reported by the U.S. territories of American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. Federal Medicaid expenditure totals exclude New York, which had a significant adjustment from the prior period in fiscal year 2017.

**Figure 1: Medicaid Enrollees and Federal Expenditures by Eligibility, Fiscal Year 2017**



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-20-147T

Notes: Figure excludes totals reported by the U.S. territories of American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. Federal expenditure totals exclude New York, which had a significant adjustment from the prior period in fiscal year 2017.

Enrollment data represent enrollment for the month of September 2017, the last month of fiscal year 2017.

Traditionally eligible enrollees are eligible under historic eligibility categories.

Expansion enrollees are (1) individuals whose coverage began after their state opted to expand Medicaid as authorized by the Patient Protection and Affordable Care Act (PPACA), and (2) individuals who were not traditionally eligible, but were covered 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.

In September 2016, we reported on our undercover testing for determining Medicaid eligibility and the vulnerabilities we found.<sup>9</sup> We found weaknesses that led to inaccurate eligibility determinations. For

<sup>9</sup>See GAO, *Patient Protection and Affordable Care Act: Final Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015*, GAO-16-792 (Washington, D.C.: Sept. 9, 2016). To do this testing, we submitted eight fictitious applications through federal marketplaces for two states and states' marketplaces in two states in 2015. All four states' Medicaid programs had expanded eligibility. Our testing also included attempts to obtain other subsidized health-plan coverage in addition to Medicaid.

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example, three of eight fictitious applications we submitted to federal and state marketplaces were approved for Medicaid, despite having identity information that did not match Social Security Administration records.<sup>10</sup> These results, while illustrative of the challenges of assuring accurate eligibility determinations, cannot be generalized.

With respect to CMS's reviews of eligibility determinations, in 2015, we also found that CMS did not review federal Medicaid eligibility determinations in the states that delegated such authority to the federal government.<sup>11</sup> Based on our findings, we made the following recommendations.

- CMS should use 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. In February 2019, we considered this recommendation implemented, as CMS confirmed that it was sharing information between its eligibility reviews and quarterly expenditure reviews regarding Medicaid expansion enrollees.<sup>12</sup>
- CMS should conduct reviews of federal Medicaid eligibility determinations to ascertain their accuracy and institute corrective action plans where necessary. CMS has taken some action to review federal eligibility determinations; however, until the review results are publicly reported, which CMS expects to occur in November 2019, this recommendation is not fully implemented. We will continue to monitor CMS's implementation of this recommendation.

In August 2018, we reported that improvements in oversight of state expenditures could help CMS ensure that individuals are enrolled in the

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<sup>10</sup>PPACA provides for the establishment of health insurance marketplaces to assist consumers in comparing and selecting among insurance plans offered by participating private insurers of health care coverage. Under PPACA, states may elect to operate their own health-care marketplaces, or they may rely on the federal Health Insurance Marketplace, known to the public as HealthCare.gov.

<sup>11</sup>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).

<sup>12</sup>States report data on their aggregate expenditures to CMS, which then uses that data to reimburse states for the federal share of program spending. CMS conducts quarterly expenditure reviews of this state-reported data. The CMS-64 is used to collect state-reported data on aggregate expenditures. These data are used to reimburse states for the federal share of program spending.



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correct Medicaid eligibility group.<sup>13</sup> CMS processes for reviewing expenditures reported by states and FMAP rates collectively have had a considerable federal financial benefit, with CMS resolving errors that reduced federal spending by over \$5.1 billion in fiscal years 2014 through 2017. However, we identified weaknesses in how CMS targets its resources to address risks when reviewing whether states' expenditures are supported and consistent with Medicaid requirements. For example:

- CMS devotes similar levels of staff resources to review expenditures despite differing levels of risk across states. For example, the number of staff reviewing California's expenditures—which represent 15 percent of federal Medicaid spending—is similar to the number reviewing Arkansas' expenditures, which represents 1 percent of federal Medicaid spending.
- Additionally, CMS reviews a sample of claims for expansion enrollees to examine Medicaid expansion expenditures, but the sample size does not account for previously identified risks in a state's program. Specifically, as we noted in a 2015 report, CMS's sampling review of expansion expenditures was not linked to or informed by reviews of eligibility determinations conducted by CMS, some of which identified high levels of eligibility determination errors.<sup>14</sup>

To address these weaknesses, we made three recommendations, including that the Administrator of CMS revise the sampling methodology for reviewing expenditures for the Medicaid expansion population to better target reviews to areas of high risk. CMS concurred with this recommendation, but in November 2018, CMS officials indicated that given the agency's resources, they believe the current sampling methodology is sufficient and have no plans to revise it. However, we continue to believe action is needed to better target areas of high risk and this recommendation remains unimplemented.

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<sup>13</sup>See GAO, *Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures*, [GAO-18-564](#) (Washington, D.C.: Aug. 6, 2018).

<sup>14</sup>See [GAO-18-564](#) and [GAO-16-53](#). We previously found that eight of the nine states we reviewed reported errors resulting in incorrect eligibility determinations. We recommended that CMS use information obtained from assessments of state eligibility determinations to inform its review of expenditures for different eligibility groups. In February 2019, CMS confirmed that the agency will continue to share information as it conducts eligibility determination reviews for estimating improper payments. This will allow CMS to continue using information on eligibility determination errors to better focus the expenditure reviews.

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Our examination of Medicaid eligibility determinations will continue as we have work underway that will describe

- how selected states decide the basis of eligibility for individuals who may qualify for Medicaid under more than one category of eligibility, such as a low-income individual with a disability;
- what is known about the accuracy of Medicaid eligibility determinations and selected states' processes to improve the accuracy of determinations; and
- CMS efforts to recoup funds related to eligibility errors.

We expect to complete this work early next year.

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## CMS Efforts to Improve Medicaid Data Could Benefit Program Oversight

Improvements in Medicaid data could benefit program oversight, including ensuring that only eligible beneficiaries are enrolled. CMS has acknowledged the need for improved Medicaid data and the Transformed Medicaid Statistical Information System (T-MSIS) initiative is the agency's primary effort—conducted jointly with states—to improve its collection of Medicaid expenditure and utilization data.<sup>15</sup> According to CMS officials, aspects of T-MSIS are designed to broaden the scope and improve the quality of state-reported data, as well as the data's usefulness for states. T-MSIS also includes automated quality checks that should improve the quality of data that states report. In addition,

- T-MSIS is designed to capture significantly more data from states than was previously reported. For example, T-MSIS will include a beneficiary eligibility file that will have expanded information on enrollees, such as their citizenship, immigration, and disability status; and expanded diagnosis and procedure codes associated with their treatments.
- T-MSIS also is intended to benefit states by reducing the number of reports CMS requires them to submit, and by improving program efficiency by allowing states to compare their data with other states' data in the national repository or with information in other CMS repositories, including Medicare data.

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<sup>15</sup>See GAO, *Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements*, [GAO-17-173](#) (Washington, D.C.: Jan. 6, 2017).

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With the continued implementation of T-MSIS, CMS has taken an important step toward developing a reliable national repository for Medicaid data. While recognizing CMS's progress, we have made several recommendations aimed at improving the quality and usefulness of T-MSIS data. For example, we recommended in 2017 that CMS refine its T-MSIS data priority areas to identify those that are critical for reducing improper payments and expedite efforts to assess and ensure their quality.<sup>16</sup> CMS has implemented this recommendation, yet other recommendations that CMS concurred with related to T-MSIS have not been fully implemented, including outlining a specific plan and associated time frames for using T-MSIS data for oversight.<sup>17</sup>

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## Further Collaboration with Stakeholders Could Improve Program Oversight and Better Ensure Appropriate Enrollment

We have previously reported 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.<sup>18</sup> CMS has engaged state agencies and other partners to promote program integrity through the Medicaid Integrity Institute, a national training program for states, and other partnerships to combat Medicaid fraud. These efforts have created more opportunities for program integrity professionals to collaborate, share best practices, and ultimately increase the effectiveness of their oversight activities.

We have also testified that state auditors are uniquely positioned to help CMS in its oversight of state Medicaid programs, because of their roles and responsibilities—which can include carrying out or overseeing their

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<sup>16</sup>[GAO-17-173](#).

<sup>17</sup>See GAO, *Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight*, [GAO-18-70](#) (Washington, D.C.: Dec. 8, 2017).

<sup>18</sup>See GAO, *Medicaid: Opportunities for Improving Program Oversight*, [GAO-18-444T](#) (Washington, D.C.: Apr. 12, 2018); *Medicaid: Actions Needed to Mitigate Billions in Improper Payments and Program Integrity Risks*, [GAO-18-598T](#) (Washington, D.C.: June 27, 2018); and *Medicaid: CMS Has Taken Steps to Address Program Risks but Further Actions Needed to Strengthen Program Integrity*, [GAO-18-687T](#) (Washington, D.C.: Aug. 21, 2018).

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state's single audits.<sup>19</sup> Through their program integrity reviews, state auditors have identified improper payments in the Medicaid program and deficiencies in the processes used to identify them. For example, state auditors have found that in some cases their state Medicaid agencies' eligibility determinations did not identify or address beneficiaries' changes in circumstances, and in other cases relied on incorrect or incomplete income or asset information.

- A 2018 audit of New Jersey's Medicaid program found the state was not identifying and disenrolling some deceased individuals.<sup>20</sup> When state auditors conducted a data match to a Social Security number verification service, they found managed care payments of \$510,834 and fee-for-service claims of \$217,913 for 41 individuals after their reported date of death. Auditors recommended that the eligibility system be reconciled with a Social Security number validation service on a periodic basis to better identify deceased individuals.
- In 2017, state auditors in North Carolina found that most of the 10 sample county departments of social services did not consistently provide adequate oversight or controls for the eligibility determination of new applications and re-certifications.<sup>21</sup> For new applications, the auditors showed accuracy error rates ranging from 1 percent to nearly 19 percent; for redeterminations of eligibility, accuracy error rates ranged from 1 percent to 23 percent.

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<sup>19</sup>See [GAO-18-687T](#). Organizations based in the United States with expenditures of federal funding of \$500,000 or more (\$750,000 or more for fiscal years beginning on or after December 26, 2014) within the organization's fiscal year are required to send an audit report to the OMB, in accordance with the Single Audit Act, as amended, and OMB implementing regulations. See 31 U.S.C. §§ 7501-7507; 2 C.F.R., pt. 200, subpt. F (2017) (as added by 78 Fed. Reg. 78590, 78608 (Dec. 26, 2013)). A single audit consists of (1) an audit and opinions on the fair presentation of the financial statements and the schedule of expenditures of federal awards; (2) gaining an understanding of and testing internal control over financial reporting, and the entity's compliance with laws, regulations, and contract or grant provisions that have a direct and material effect on certain federal programs (i.e., the program requirements); and (3) an audit and an opinion on compliance with applicable program requirements for certain federal programs.

<sup>20</sup>New Jersey Legislature Office Of Legislative Services, Office of the State Auditor, *Department of Human Services, Division of Medicaid Assistance and Health Services NJ FamilyCare Eligibility Determinations, July 1, 2014 to July 30, 2017* (Trenton, N.J.: Sept. 25, 2018).

<sup>21</sup>State of North Carolina, Office of the State Auditor, *North Carolina Medicaid Program, Recipient Eligibility Determination* (Raleigh, N.C.: January 2017).

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- Based on information from an independent verification service, state auditors in New York found, during a 9-month period in 2014, that 354 Medicaid enrollees were actually deceased, and that the state made \$325,030 in Medicaid payments for a subset of these individuals.<sup>22</sup> Auditors noted that the state’s eligibility system did not have a standard process to periodically verify the life status of all enrollees and end coverage for deceased individuals.

In April 2019, the Comptroller General and representatives from the National State Auditors Association sent a letter to CMS requesting changes to the Compliance Supplement to leverage state auditors’ ability to examine key areas of Medicaid, including improvements in the oversight of Medicaid eligibility processes. The Compliance Supplement—which is issued by the OMB based on agency input and direction—is used by state auditors during their annual audit of state entities that administer federal financial assistance programs, including Medicaid.

In June 2019, OMB issued the 2019 Compliance Supplement, which included changes related to overseeing testing of eligibility determinations that GAO and the state auditors had proposed.<sup>23</sup> Specifically, the supplement now permits state auditors to test eligibility determinations to ensure that beneficiaries qualify for the Medicaid program and are in the appropriate enrollment category. The supplement also notes a requirement for states to coordinate with other state and federal insurance affordability programs, including the federally facilitated exchanges.

These changes to the Compliance Supplement will better enable state auditors to audit states’ eligibility determinations to ensure beneficiaries qualify for the Medicaid program and are enrolled in the correct eligibility group. Such eligibility determinations will supplement CMS’s eligibility determination reviews and may yield insights into program weaknesses that CMS could learn from and potentially address nationally. We continue to believe that CMS could help improve program integrity by

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<sup>22</sup>New York State Office of the State Comptroller, Division of State Government Accountability, *Appropriateness of the Medicaid Eligibility Determined by the New York State of Health System*, Report 2014-S-4 (Albany, N.Y.: Oct. 28, 2015).

<sup>23</sup>2 C.F.R. pt. 200, subpt F, app. XI (2019).

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further providing state auditors with a substantive and ongoing role in auditing their state Medicaid programs.

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

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## GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact me at (202) 512-7114 or [yocomc@gao.gov](mailto: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), Kristin Ekelund (Analyst-in-Charge), Michael Erhardt, Arushi Kumar, and Drew Long. Also contributing were Susan Anthony, Vikki Porter, and Emily Wilson.

# Appendix I: Selected GAO Recommendations to Strengthen Oversight of Medicaid Beneficiary Enrollment

**Table 1: Status of Selected GAO Recommendations to Strengthen CMS’s Oversight of Medicaid Beneficiary Enrollment, through September 2019**

GAO recommendation	Status of recommendation; actions needed to implement recommendations
<b>Improving oversight of Medicaid eligibility determinations and related expenditures</b>	
Issue guidance to states to better identify beneficiaries who are deceased. (GAO-15-313) <sup>a</sup>	Recommendation implemented; no action needed.
Conduct reviews of federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary. (GAO-16-53) <sup>b</sup>	Not fully implemented. Conduct a systematic review of eligibility determinations reached by federally facilitated exchanges, and implement any corrective actions. The Department of Health and Human Services indicated that it will include results of eligibility determinations for two states where there were federal eligibility determinations when it begins reporting improper payment estimates due to erroneous eligibility determinations in November 2019. It is too early to assess whether this will be sufficient for identifying and correcting errors and associated payments.
Use the information obtained from state and federal eligibility reviews to inform the Centers for Medicare & Medicaid Services’ (CMS) review of expenditures for different eligibility groups in order to ensure that expenditures are reported correctly and matched appropriately. (GAO-16-53) <sup>b</sup>	Recommendation implemented; no action needed.
Complete a comprehensive, national risk assessment and take steps, as needed, to assure that resources to oversee expenditures reported by states are adequate and allocated based on areas of highest risk. (GAO-18-564) <sup>c</sup>	Not fully implemented. Conduct a national risk assessment to determine whether resources for financial oversight activities are adequate and allocated—both across the CMS’s regional offices and oversight tools—to focus on the greatest areas of risk, and take steps to reallocate staff and resources, as appropriate.
Clarify in internal guidance when a variance analysis on expenditures with higher match rates is required. (GAO-18-564) <sup>c</sup>	Not fully implemented. Update internal guidance on conducting variance analyses for expenditures with higher federal matching rates to assure that analyses are consistently conducted.
Revise the sampling methodology for reviewing expenditures for the Medicaid expansion population to better target reviews to areas of high risk. (GAO-18-564) <sup>c</sup>	Not implemented. Update CMS’s sampling methodology for reviewing expenditures to account for risk factors like program size and high levels of eligibility determination errors. <sup>d</sup>
<b>Improving Medicaid data to benefit program oversight</b>	
Take immediate steps to assess and improve the data available for Medicaid program oversight, including, but not limited to, the Transformed Medicaid Statistical Information System (T-MSIS). Such steps could include (1) refining the overall data priority areas in T-MSIS to better identify those variables that are most critical for reducing improper payments, and (2) expediting efforts to assess and ensure the quality of these T-MSIS data. (GAO-17-173) <sup>e</sup>	Recommendation implemented; no action needed.

**Appendix I: Selected GAO Recommendations  
to Strengthen Oversight of Medicaid  
Beneficiary Enrollment**

GAO recommendation	Status of recommendation; actions needed to implement recommendations
<p>Take additional steps to expedite the use of data for program oversight. Such steps should include, but are not limited to, efforts to (1) obtain complete information from all states on unreported T-MSIS data elements and their plans to report applicable data elements; (2) identify and share information across states on known T-MSIS data limitations to improve data comparability; and (3) implement mechanisms, such as the Learning Collaborative, by which states can collaborate on an ongoing basis to improve the completeness, comparability, and utility of T-MSIS data. (<a href="#">GAO-18-70</a>)<sup>f</sup></p>	<p>Not fully implemented.</p> <p>Continue taking steps to make T-MSIS data usable for Medicaid program oversight, such as (1) obtaining information on the completeness and comparability of T-MSIS data, (2) notifying states of their compliance status and obtaining corrective action plans, and (3) establishing mechanisms for ongoing feedback and collaboration across states.</p>
<p>Articulate a specific plan and associated time frames for using T-MSIS data for oversight. (<a href="#">GAO-18-70</a>)<sup>f</sup></p>	<p>Not fully implemented.</p> <p>Outline a specific plan and associate time frames for using T-MSIS data for oversight.</p>

Source: GAO | GAO-20-147T.

<sup>a</sup>GAO, Medicaid: Additional Actions Needed to Help Improve Provide and Beneficiary Fraud Controls, [GAO-15-313](#) (Washington, D.C.: May 14, 2015).

<sup>b</sup>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).

<sup>c</sup>GAO, Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures, [GAO-18-564](#) (Washington, D.C.: Aug. 6, 2018).

<sup>d</sup>According to agency officials, CMS believes its sampling methodology is sufficient and has no plans to revise it. The agency noted that the current methodology requires a minimum sample size, but gives reviewers the flexibility to expand the size of the sample if warranted by risk and as resources permit. We continue to believe that the current methodology does not sufficiently target areas of high risk.

<sup>e</sup>GAO, Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements, [GAO-17-173](#) (Washington, D.C.: Jan. 6, 2017).

<sup>f</sup>GAO, Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight, [GAO-18-70](#) (Washington, D.C.: Dec. 8, 2017).



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Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds. [GAO-16-53](#). Washington, D.C.: October 16, 2015.

Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls. [GAO-15-313](#). Washington, D.C.: May 14, 2015.

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