United States Government Accountability Office

Testimony

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MEDICAID

Opportunities for Improving Program Oversight

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> **This testimony was revised on April 12, 2018 to correct the addressees on pages 1 and 16.**

MEDICAID

Opportunities for Improving Program Oversight

GAO Highlights

Why GAO Did This Study

Medicaid, a joint federal-state health care program, is a significant component of federal and state budgets, with total estimated outlays of $596 billion in fiscal year 2017. The program's size and diversity make it particularly vulnerable to improper payments. In fiscal year 2017, improper payments were an estimated $37 billion of federal Medicaid expenditures, an increase from an estimated $29.1 billion in fiscal year 2015.

The partnership between the federal government and states is a central tenet of the Medicaid program. Medicaid allows significant flexibility for states to design and implement their programs based on their unique needs. These programs are administered at the state level and overseen at the federal level by CMS. The resulting variability of state Medicaid programs complicates federal efforts to oversee program payments and beneficiaries' access to services.

This testimony focuses on the need for (1) better data, (2) improved oversight, and (3) greater federal-state collaboration to safeguard Medicaid program integrity. This testimony is based on GAO reports issued between May 2015 and January 2018 on the Medicaid program.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) has taken steps to improve Medicaid program integrity and reduce improper payments; however, GAO has identified areas where additional, or continued, action could help strengthen program integrity and ensure beneficiaries' access to services. These actions include improving data quality, oversight, and federal-state collaboration.

Need for better data. As GAO has previously reported, a fundamental challenge to the oversight of the Medicaid program is the lack of complete, accurate, and timely data. This challenge has hindered CMS's ability to ensure the appropriate use of federal and state dollars for beneficiary care. Without reliable data, CMS is unable to effectively monitor who is providing services, or the type of services provided. CMS has taken steps to develop reliable Medicaid data, most notably with the Transformed Medicaid Statistical Information System, which will collect more information on beneficiaries. This system could improve CMS's ability to identify improper payments and help ensure beneficiaries' access to services, but additional work is needed. In December 2017, GAO made two recommendations to CMS to improve the completeness and comparability of the data from this system and CMS's plans for oversight. The agency concurred with the recommendations, but has not yet implemented them.

Need for stronger oversight. GAO has previously identified areas where stronger CMS oversight will help the agency better manage program risks, and improve beneficiaries' access to needed health care services.

- **Manage program risks.** From May 2015 to December 2017, GAO made 11 recommendations that could help CMS better assess the risk of fraud, as well as ensure that only eligible providers—particularly those in managed care—and beneficiaries are enrolled and participating in the Medicaid program. The agency generally concurred with these recommendations, but has not yet implemented them.

- **Access to services.** From August 2017 to January 2018 GAO made eight recommendations aimed at ensuring that beneficiaries with a limited ability to care for themselves—such as those with disabilities, complex health needs, or infants with neonatal abstinence syndrome—have access to necessary services. The agency concurred with the recommendations, but has not yet implemented them.

Need for greater federal-state collaboration. GAO has previously reported that collaborative activities between the federal government and the states—such as sharing promising program integrity practices—are important to improving oversight of the Medicaid program. Recent examples of such activities include a national Medicaid training program for state officials and partnerships to combat Medicaid fraud. However, in March 2017, GAO also found that barriers—such as communication problems between CMS contractors and state officials—have limited the use of collaborative audits, which have the potential to identify substantial overpayments to providers. GAO recommended that CMS identify opportunities to address these barriers. CMS agreed with the recommendations, but has not yet implemented them.

United States Government Accountability Office

Chairmen Meadows and Palmer, Ranking Members Connolly and Raskin, and Members of the Subcommittees:

I am pleased to be here today to discuss oversight efforts intended to prevent improper payments in the Medicaid program.[1] This federal-state program is one of the nation's largest sources of funding for medical and other health-related services, covering acute health care, long-term care, and other services for over 73 million low income and medically needy individuals in fiscal year 2017. In that same year, estimated federal and state Medicaid expenditures were $596 billion. The size and complexity of Medicaid make the program particularly vulnerable to improper payments—including payments made for people not eligible for Medicaid or made for services not actually provided. Due to concerns about the adequacy of fiscal oversight, Medicaid has been on our list of high-risk programs since 2003.[2]

Despite efforts to reduce improper payments in the Medicaid program by the Centers for Medicare & Medicaid Services (CMS), which oversees the program, overall improper payments continue to increase—rising to about $37 billion in fiscal year 2017 compared with $29.1 billion in fiscal year 2015. The Medicaid program alone accounted for 26.1 percent of the fiscal year 2017 government-wide improper payment estimate. It is critical to take appropriate measures to reduce improper payments, as dollars wasted detract from our ability to ensure that the individuals who rely on the Medicaid program—including children, and individuals who are elderly or disabled—are provided adequate care.

The partnership between the federal government and states is a central tenet of the Medicaid program. Within broad federal requirements, states have significant flexibility to design and implement their programs based

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[1]An 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.

[2]See 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).

on their unique needs, resulting in 56 distinct Medicaid programs.[3] These programs are administered at the state level and overseen at the federal level by CMS, an agency within the Department of Health and Human Services (HHS). The resulting variability of state Medicaid programs complicates federal efforts to oversee program payments and beneficiaries' access to services.

My testimony today will focus on three actions important to improving oversight of the Medicaid program:

1. addressing data challenges that limit CMS's ability to ensure the appropriate use of federal Medicaid dollars;

2. strengthening federal oversight to address program risks that can help reduce improper payments, as well as ensure appropriate care for beneficiaries; and

3. improving federal-state collaboration to strengthen program oversight.

My remarks are based on our large body of work examining the Medicaid program, specifically our reports issued and recommendations made from May 2015 to January 2018. (See app. I for selected recommendations and a list of related GAO reports at the end of this statement.) Those reports provide further details on our scope and methodology. 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

Under Medicaid's federal-state partnership, 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

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[3]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.

made appropriately. (See fig. 1 for a diagram of the federal-state Medicaid partnership framework.) Financing Medicaid is also a fixture of the federal and 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 1: Federal-State Medicaid Partnership Framework**
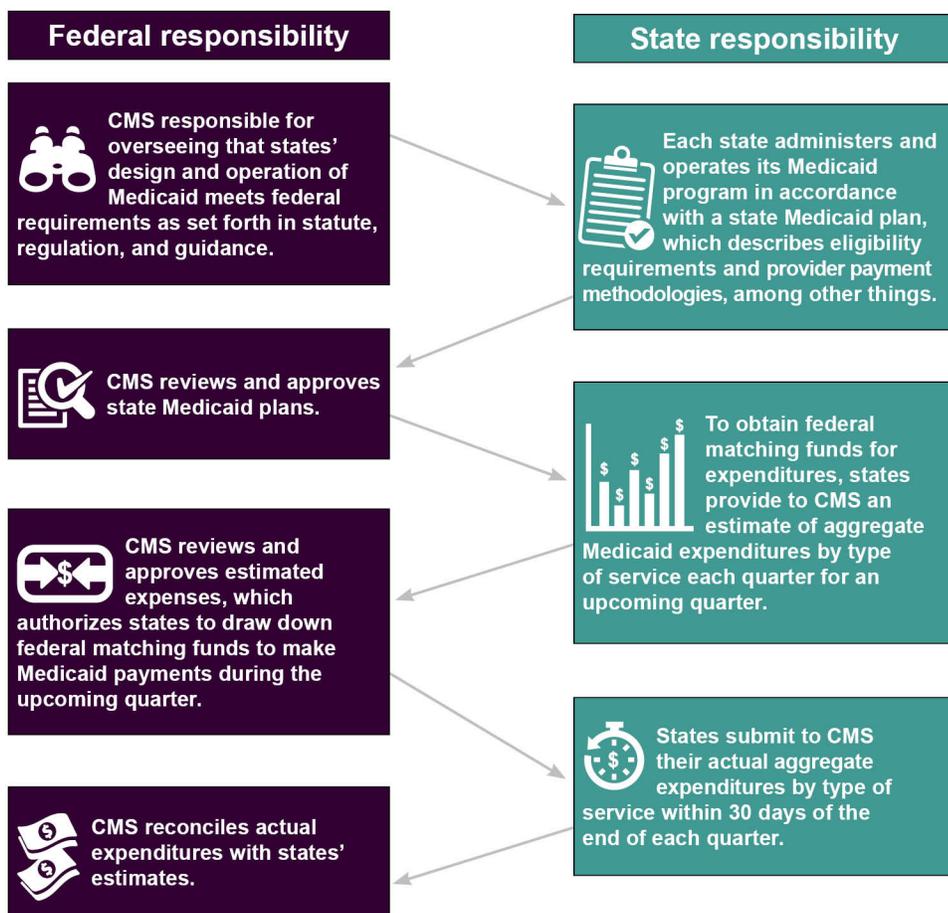
Source: GAO. | GAO-18-444T

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 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 demonstration to CMS for review. CMS will specify the special terms and conditions that encompass the requirements for an approved demonstration.

Medicaid Covers a Wide Variety of Services for Low-Income and Medically Needy Populations

Medicaid provides coverage to a diverse group of beneficiaries, including certain categories of children, parents and other non-elderly adults, pregnant women, and individuals who are disabled or aged 65 and older. The health care needs and costs of these populations vary. For example, in fiscal year 2013—which are the most recent reliable data—children and adults constituted the majority—75 percent—of enrollees; however, the bulk of Medicaid expenditures—66 percent—were for aged and disabled enrollees. (See fig. 2.)

Figure 2: Medicaid Enrollment and Expenditures by Eligibility Group, Fiscal Year 2013
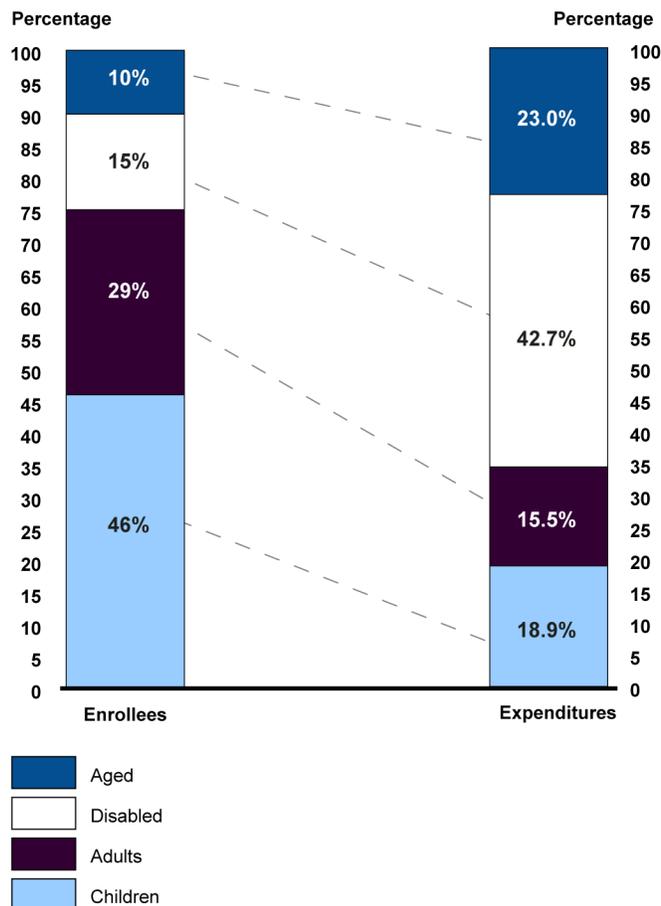
Source: GAO analysis of Medicaid and CHIP Payment and Access Commission (MACPAC) data. | GAO-18-444T

Note: Enrollees include individuals in 50 states and the District of Columbia who were enrolled in Medicaid during fiscal year 2013. Expenditures include both federal and state funds for 48 states and the District of Columbia, but exclude spending for administration. Payments from the Centers for Medicare & Medicaid Services to cover the costs of providing care to uninsured patients at

disproportionate share hospital are also excluded. Due to anomalies in the expenditure data, MACPAC excluded Rhode Island and Vermont from the expenditure data.

The program covers a comprehensive set of services, including physician, and inpatient and outpatient hospital care; and is also a particularly significant source of health care coverage and financing for certain services. For example, Medicaid is the nation's primary payer of long-term services and supports, including nursing home care and home- and community-based services, which allow individuals to live more independently and age in their homes. Medicaid is also the nation's largest source of funding for behavioral health services, including treatment related to mental health and substance use conditions.

States also have flexibility in determining how their Medicaid benefits are delivered. Many states deliver all or some services through contracted managed care organizations. For example, states may contract with managed care organizations to provide a specific set of Medicaid-covered services to beneficiaries and pay them a set amount per beneficiary per month; pay health care providers for each service they provide on a fee-for-service basis; or rely on a combination of both delivery systems. Managed care continues to be a growing component of the Medicaid program. In fiscal year 2017, expenditures for managed care represented almost 50 percent of total federal program expenditures, compared with 38 percent in fiscal year 2014.

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.[4] Demonstrations allow states to test new approaches to providing 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 Medicaid, and

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[4]Under 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.

- made payments to providers to incentivize delivery system improvements.

As we have previously reported, nearly three-quarters of states had CMS approved demonstrations as of November 2016. In fiscal year 2015, federal spending under demonstrations represented a third of all Medicaid spending nationwide.

CMS Must Address Data Challenges, Which Hamper Its Oversight of Medicaid

Our previous body of work has shown that underlying data challenges in the Medicaid program have persistently hindered CMS's ability to ensure the appropriate use of federal and state dollars for beneficiary care. CMS oversight relies in large part on state-reported data on multiple aspects of the Medicaid program, including expenditures and utilization of program services. We and others have reported that insufficiencies in these data have affected CMS's ability to ensure proper payments and beneficiaries' access to care. Specifically, we have previously raised concerns about the usefulness of state-reported Medicaid data, because of issues with completeness, accuracy, and timeliness. Examples of these data issues include the following:

- **Expenditure data.** CMS relies on a dataset known as the CMS-64, which is used to collect state-reported data on aggregate expenditures. These data are used to reimburse states for the federal share of program spending. In our prior work, we concluded that available Medicaid expenditure data do not provide CMS with sufficient information to consistently ensure that Medicaid payments are proper.[5] For example, we found in 2015 that CMS does not collect accurate state data on Medicaid enrollment by eligibility type in the CMS-64, thus complicating the agency's ability to identify erroneous expenditures due to incorrect eligibility determinations.[6]

- **Utilization data.** In our prior work, we concluded that utilization data in the Medicaid Statistical Information System—which states used to provide beneficiary-based data on eligibility and covered health care services, among other things—were incomplete and reported late. These types of data are important to both CMS and the states for

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[5]See GAO, *Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvement*, GAO-17-173 (Washington, D.C.: Jan. 6, 2017).

[6]See 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).

Medicaid program oversight and evaluation. We noted that without better data, CMS may not be able to identify patterns that indicate inappropriate provider billing, or ensure that beneficiaries have access to covered services.

As we have previously reported, the lack of complete and timely data has limited CMS's oversight. Without reliable data, CMS is unable to effectively monitor who is providing services, or the type, amount, and dates of such services. For example, in January 2017, we found that the most recent Medicaid personal care services data were from 2012, and only 35 states had finished reporting for that year.[7] Further, 15 percent of claims lacked provider identification numbers, over 400 different procedure codes were used to identify the services, and the quantity and time periods varied widely. Without better data, we concluded that CMS is unable to effectively monitor who is providing personal care services or the type, amount, and dates of services.

Additionally, our prior work has found that the lack of complete and reliable data on services delivered in Medicaid managed care—known as encounter data—presents a significant oversight challenge for CMS given that over three-quarters of Medicaid beneficiaries were enrolled in managed care in 2014.[8] In July 2015, HHS's Office of Inspector General reported that states were not complying with federal requirements regarding the submission of Medicaid encounter data in the Medicaid Statistical Information System. Specifically, it determined that 11 states did not report encounter data for all managed care plans operating in their states in fiscal year 2011, as required.[9]

As part of its efforts to address longstanding data concerns, CMS has taken steps toward developing a reliable national repository for Medicaid data, most notably the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS will collect more information on enrollees than

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[7]See 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). Personal care services provide assistance to beneficiaries of all ages who have limited ability to care for themselves, because of physical, developmental, or intellectual disabilities. Personal care services assist beneficiaries with activities of daily living such as bathing, dressing, and toileting.

[8]See GAO, *Medicaid: Service Utilization Patterns for Beneficiaries in Managed Care*, GAO-15-481 (Washington, D.C.: May 29, 2015).

[9]See HHS-OIG, *Not All States Reported Medicaid Managed Care Encounter Data as Required*, OEI-07-13-00120 (Washington, D.C.: July 2015).

the Medicaid Statistical Information System—such as their citizenship, immigration, and disability status—as well as expanded diagnosis and procedure codes associated with their treatments. States will report data more frequently than they did for the Medicaid Statistical Information System and T-MSIS also includes approximately 2,800 automated quality checks, which should improve the timeliness and quality of data that states report. By providing more standardized data on various aspects of Medicaid—such as spending or utilization rates—states could be better positioned to compare their programs with other states, thereby improving their ability to identify and correct program inefficiencies.

Implementing the T-MSIS initiative has been a significant, multi-year effort. CMS has worked closely with states and has reached a point where nearly all states are reporting T-MSIS data. 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. While recognizing the progress that has been made, we recently noted that more work needs to be done before CMS or states can use these data for program oversight. Some examples of this work include the following:

- **Incomplete data.** CMS has made progress in the number of states reporting T-MSIS data. As we previously reported, from October 2016 to November 2017, the number of states reporting T-MSIS information increased from 18 to 49.[10] (See fig. 3.) However, the data being reported were not always complete. None of the six selected states in the sample we reviewed were reporting complete T-MSIS data as of August 2017.[11] State officials said that certain unreported elements were contingent on federal or state actions, while others were not applicable to their state's Medicaid program. However, we found that states did not always document the reasons for missing data, such as whether they planned to report data elements in the future or when they would report complete data.

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

[11]See GAO-18-70.

Figure 3: States' Transformed Medicaid Statistical Information System (T-MSIS) Reporting Status, as of November 2017

Legend:
- State was reporting T-MSIS data as of October 2016 **(18 states)**
- State began reporting T-MSIS data between October 2016 and November 2017 **(31 states)**
- State not reporting T-MSIS data **(2 states)**

Sources: GAO summary of Centers for Medicare & Medicaid Services information; Map Resources (map). | GAO-18-444T

- **Comparability of data.** Officials in selected states noted that a national repository of T-MSIS data could allow them to compare their Medicaid program data—such as spending or utilization rates—to other states, which could potentially improve their oversight.[12]

[12] See GAO-18-70.

However, these same state officials expressed concerns that states did not convert their data to the T-MSIS format in the same ways. These inconsistencies could make cross-state comparisons difficult.

- **Plans for using data for oversight.** Although CMS has taken steps to begin using T-MSIS data, CMS officials acknowledged in August 2017 that they had yet to outline how best to use T-MSIS data for program monitoring, oversight, and management, because they were still largely focused on working with the remaining states to begin reporting T-MSIS data, analyzing the quality and usability of the T-MSIS data, and preparing the data for research purposes.[13] In December 2017, we recommended that CMS articulate a specific plan and associated time frames for using T-MSIS data for oversight. We concluded that absent a specific plan and time frames, CMS's ability to use these data to oversee the program, including ensuring proper payments and beneficiaries' access to services, is limited. The agency concurred with the recommendation, but has not yet implemented it.

While recognizing the progress that has been made, more work needs to be done before CMS or states can use the T-MSIS data for program oversight. It remains unclear when all states will report complete and comparable T-MSIS data, and how CMS and states will use them to improve oversight. In December 2017, we recommended CMS take additional steps to expedite the use of T-MSIS for program oversight, and the agency concurred with our recommendation, but has not yet implemented it. Further delays in T-MSIS's use limit the agency's ability to reverse the trend of rising improper payments in the Medicaid program, underscoring the need for CMS to take additional steps to expedite the use of these data.

CMS Needs to Strengthen Oversight to Address Program Risks and Ensure Access to Care

CMS has taken steps to improve Medicaid program integrity and reduce improper payments. However, our work has identified several key areas where CMS should strengthen program oversight to address program risks that can result in improper payments, and ensure beneficiaries' access to needed health care services.

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[13]See GAO-18-70.

CMS Must Strengthen Oversight to Manage Program Risks

In federal programs, it is necessary to identify program risks in order to design and implement strategies to mitigate these risks. For Medicaid, our work has identified program risks associated with provider enrollment and beneficiary eligibility. Developing strategies to address these risks and monitor progress will improve CMS's ability to oversee the significant amount of funds expended in the Medicaid program and reduce improper payments. Below, we identify several examples of the recommendations we have made to address program risks, and what, if any, steps CMS has taken in response to our recommendations. (See table 1.)

Table 1: Examples of Actions Recommended by GAO to Address Medicaid Program Risks

Program risks	GAO findings and recommendations	Status and GAO response
Managing fraud risks	In December 2017, we assessed the Centers for Medicare & Medicaid Services' (CMS) antifraud efforts and found, among other things, that while the agency has shown commitment to combating fraud and has taken steps to identify fraud risks, it has not conducted a fraud risk assessment for Medicaid or developed a risk-based antifraud strategy.[a]	CMS concurred with these findings and our recommendations for the agency to conduct a fraud risk assessment and to develop a risk-based antifraud strategy for Medicaid, but has not yet implemented them. We will monitor CMS's actions.
Ensuring that only eligible providers are enrolled in Medicaid	In April 2016, based on two states and 16 health plans, we identified challenges to screening providers in Medicaid managed care for eligibility, partially due to fragmented information.[b] In turn, we made four recommendations aimed at assessing the databases used to screen providers, improved collaboration and coordination with other federal agencies on sharing databases and establishing a common identifier across databases, and providing guidance to state Medicaid agencies.	CMS has addressed two of the four recommendations. One remaining recommendation directs CMS to determine whether any of the databases used by states and health plans to screen providers should be added to the list of the databases identified by CMS for screening purposes. To implement the recommendation, CMS will need to determine whether the remaining databases it has studied should be added to its list and take the appropriate action. For the other remaining recommendation, CMS needs to explore the use of a common identifier for screening Medicaid managed care providers across databases. We will continue to monitor CMS's actions.
Ensuring that only eligible beneficiaries are enrolled in Medicaid	In October 2015, we identified gaps in CMS's efforts to ensure that only eligible individuals are enrolled into Medicaid, and that Medicaid expenditures for enrollees—particularly those eligible as a result of the Patient Protection and Affordable Care Act expansion—are matched appropriately by the federal government.[c]	In response to the Act, 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. We will continue to monitor this effort to determine if the agency is ascertaining the accuracy of federal eligibility determinations and taking corrective action where necessary.

Source: GAO | GAO-18-444T

Note: See appendix I for a more complete description of these recommendations and their accompanying reports.

[a]See 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).

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

[c]See 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.

CMS Should Improve Oversight to Ensure Access to and Provision of Necessary Services

Our prior work has shown that oversight is needed to ensure that Medicaid's low-income and medically needy population is able to access necessary health care services. This is particularly important for individuals with disabilities and complex health needs. Beneficiaries who have limited ability to care for themselves rely on long-term services and supports, including nursing home care and home- and community-based services. Others with opioid use disorders often rely on Medicaid to receive necessary behavioral health treatment. Oversight to ensure access and the quality of these services is particularly critical given that Medicaid is the largest payer of services for both of these groups. Below, we identify several examples of our concerns about access to and provision of Medicaid services, the recommendations we have made, and what steps, if any, CMS has taken in response to our recommendations. (See table 2.)

Table 2: Examples of Program Areas Requiring Action to Improve Access to and Provision of Medicaid Services

Program area	GAO recommendations	Status and GAO response
Oversight of access and quality in managed long-term services and supports	In August 2017, we recommended that the Centers for Medicare & Medicaid Services (CMS) take steps to better identify and obtain key information—namely, provider network adequacy; critical incidents that may cause abuse, neglect, or exploitation of beneficiaries, and appeals and grievances—which are necessary to oversee states' efforts to monitor beneficiary access to quality managed long-term services and supports.[a]	The agency stated that it will consider this recommendation as it conducts its review of managed care regulations to prioritize beneficiary outcomes and state priorities. The agency stated that it will continue to assist states through technical guidance and other means and is in the process of enhancing its capacity to measure and monitor care and quality for these services and others. We will continue to monitor CMS actions in this area.

Program area	GAO recommendations	Status and GAO response
Improving assessments of individuals' needs for home- and community-based services (HCBS)	In December 2017, we reported that CMS had not addressed risks associated with providers (individual or managed care plans) conducting beneficiary needs assessments.[b] When providers conduct such assessments, they can face potential conflicts that could lead to inappropriate levels of care for beneficiaries in HCBS programs.[c] Also, we found that CMS had not consistently required states to follow its 2013 guidance that managed care plans not be involved in assessments used to determine eligibility for HCBS. We recommended that CMS ensure that all HCBS programs have requirements for states to address providers' potential for conflicts of interest in conducting assessments.	CMS agreed with our recommendations, but has not yet implemented them. We will continue to monitor CMS's actions.
Assessing the expansion of medication-assisted treatment (MAT) for opioid abuse[d]	In October 2017, we reviewed federal efforts to expand access to comprehensive substance use services, including MAT. According to CMS, states are using the flexibility of demonstrations to cover a full continuum of care for individuals with substance use disorders, including short-term residential treatment. The Department of Health and Human Services (HHS) has some needed information for evaluating its efforts to expand access to MAT, but more information is needed.[e] In particular, we recommended that the agency establish targets related to expanding access to MAT, and establish timeframes for this evaluation.	HHS concurred with both recommendations, but has not yet implemented them. We will continue to monitor HHS's actions.
Implementing HHS's strategy to address neonatal abstinence syndrome.	In October 2017, we reviewed HHS's published strategy for addressing neonatal abstinence syndrome—a withdrawal condition in newborns occurring from the prenatal use of opioids or other drugs—most of whom are covered under Medicaid. We found that HHS has yet to determine how and when the recommendations from its strategy will be implemented.[f] We recommended that HHS should expeditiously develop a plan—including priorities; roles and responsibilities of stakeholders; timeframes; and methods for assessing progress—for implementing the recommendations included in its strategy to address neonatal abstinence syndrome.	HHS concurred that it should expeditiously address neonatal abstinence syndrome, but noted implementation of the strategy is contingent on funding. We will continue to monitor HHS's actions.

Source: GAO | GAO-18-444T

[a]See GAO, *Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs*, GAO-17-632 (Washington, D.C.: Aug. 14, 2017).

[b]Needs assessments are a process to collect data on functional needs, health status, and other areas that are used to determine individuals' eligibility for HCBS, and to plan services, such as the amount of services needed. Effective needs assessments help states ensure appropriate access to, and manage utilization of, services and therefore costs.

[c]See GAO, *Medicaid: CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services*, GAO-18-103 (Washington, D.C.: Dec. 14, 2017).

Greater Federal-State Collaboration Is Needed to Strengthen Program Oversight

The federal government and the states play important roles in reducing improper payments in the Medicaid program. CMS is responsible for broad oversight of the program, while states have had primary responsibility for ensuring the integrity of the Medicaid program by preventing, identifying, and correcting improper payments. Collaborative activities—such as identifying and sharing promising program integrity practices—are important to improving Medicaid oversight and we have previously recommended that CMS take steps to collect and share promising program integrity practices.[14] As we have previously noted, because states are the first line of defense against Medicaid improper payments, CMS should also take steps to address barriers that limit effective collaborations. Some recent examples of collaborative activities that promote program integrity include the Medicaid Integrity Institute (MII), coordination meetings with state auditors, and partnerships to combat Medicaid fraud.

- **The Medicaid Integrity Institute.** In a 2017 report we noted that CMS established the MII, the first national Medicaid training program for state program integrity officials in 2007.[15] The MII offers substantive training and support in a structured learning environment at no cost to the states, with almost 3,800 attendees participating in on-site courses from fiscal years 2012 through 2015. One of the important benefits of the MII reported by state officials and course participants is the opportunity to meet with and learn from program integrity officials from across the country in formal and informal settings. In the classroom, participants learn from state officials who serve as faculty for the MII courses, and from each other through in-class discussions. While on-site at the MII, there are also informal opportunities for information sharing that can lead to further state-to-state collaboration.

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

[15]See GAO-17-277.

- **Coordination with state auditors.** Similarly, in another 2017 report we noted that CMS and selected state audit officials held meetings in November 2016 and May 2017 to discuss specific areas of concern in Medicaid and future collaboration.[16] We facilitated the November 2016 meeting, and participated in and presented prior audit results at the May 2017 meeting. These meetings served as a platform to discuss challenges with Medicaid oversight. For example, at the November 2016 meeting, state auditors discussed challenges they have had accessing data needed for Medicaid managed care oversight. Additionally, the state auditors and CMS officials discussed some of the benefits of coordination, with the state auditors noting that they can assist CMS's state program integrity reviews by identifying program weaknesses.

- **Partnerships to combat Medicaid fraud.** In 2012, CMS created the Healthcare Fraud Prevention Partnership (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 Medicaid-related federal and state agencies, law enforcement agencies, private health insurance plans, and antifraud and other health care organizations.[17] 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.[18]

- **Collaborative audits.** CMS oversees and supports states, in part, by hiring contractors to audit Medicaid providers and facilitating state practices to improve program integrity. In recent years, CMS made changes to its Medicaid program integrity efforts, including a shift to collaborative audits—in which CMS contractors and states work in partnership to audit Medicaid providers. In March 2017, we reported that collaborative audits have identified substantial potential

[16]See 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).

[17]See GAO-18-88.

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

overpayments to providers, but barriers—such as staff burden or problems communicating with contractors—have limited their use and prevented states from seeking audits or hindered the success of audits.[19] We recommended that CMS address the barriers that limit state participation in collaborative audits. 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.

Chairmen Meadows and Palmer, Ranking Members Connolly and Raskin, and Members of the Subcommittees, 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 me 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), Summar Corley (Analyst-in-Charge), Daniel Klabunde, Drew Long, Vikki Porter, and Jennifer Whitworth.

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[19]See GAO-17-277.

Appendix I: Selected GAO Recommendations to Improve the Oversight of the Medicaid Program

The following table lists selected recommendations we have made to the Department of Health and Human Services, the Centers for Medicare & Medicaid Services, and the Office of Management and Budget regarding oversight of the Medicaid program, as well as a matter for congressional consideration. These recommendations remain unimplemented, as of March 2018.

Table 3: Selected GAO Recommendations to Improve the Oversight of the Medicaid Program

GAO Report	Recommendation
Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed. GAO-18-179. January 5, 2018.	The Centers for Medicare & Medicaid Services (CMS) should: • provide guidance and clarify requirements regarding the monitoring and reporting of deficiencies that states using home and community-based services (HCBS) waivers are required to report on their annual reports; • establish standard Medicaid reporting requirements for all states to annually report key information on critical incidents, considering, at a minimum, the type of critical incidents involving Medicaid beneficiaries, and the type of residential facilities, including assisted living facilities, where critical incidents occurred; and • ensure that all states submit annual reports for HCBS waivers on time as required.
Medicaid: CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services. GAO-18-103. December 14, 2017.	CMS should: • ensure that all types of Medicaid HCBS programs have requirements for states to avoid or mitigate potential conflicts of interest on the part of entities that conduct needs assessments that are used to determine eligibility for HCBS and to develop HCBS plans of service. These requirements should address both service providers and managed care plans conducting such assessments.
Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework. GAO-18-88. December 5, 2017.	CMS should: • provide fraud-awareness training relevant to risks facing CMS programs and require new hires to undergo such training and all employees to undergo training on a recurring basis; • conduct fraud risk assessments for Medicare and Medicaid that include respective fraud risk profiles and plans for regularly updating the assessments and profiles; and • create, document, implement, and communicate an antifraud strategy that is aligned with and responsive to regularly assessed fraud risks. This strategy should include an approach for monitoring and evaluation.
Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight. GAO-18-70. December 8, 2017.	CMS should: • take additional steps to expedite the use of the Transformed Medicaid Information System (T-MSIS) 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; and • articulate a specific plan and associated time frames for using T-MSIS data for oversight.

GAO Report	Recommendation
Opioid Use Disorders: HHS Needs Measures to Assess the Effectiveness of Efforts to Expand Access to Medication-Assisted Treatment. GAO-18-44. October 31, 2017.	The Department of Health and Human Services (HHS) should: • establish performance measures with targets related to expanding access to medication assisted treatment (MAT) for opioid use disorders; and • establish timeframes in its evaluation approach that specify when its evaluation of efforts to expand access to MAT will be implemented and completed.
Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome. GAO-18-32. October 4, 2017.	HHS should: • develop a plan—which includes priorities, timeframes, clear roles and responsibilities, and methods for assessing progress—to effectively implement the recommendations related to neonatal abstinence syndrome identified in the *Protecting Our Infants Act: Final Strategy*.
Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs. GAO-17-632. August 14, 2017.	CMS should: • take steps to identify and obtain key information needed to oversee states' efforts to monitor beneficiary access to quality services, including, at a minimum, obtaining information specific to network adequacy, critical incidents, and appeals and grievances.
Medicaid Program Integrity: CMS Should Build on Current Oversight Efforts by Further Enhancing Collaboration with States. GAO-17-277. March 15, 2017.	CMS should: • identify opportunities to address barriers that limit states' participation in collaborative audits; • collaborate with states to develop a systematic approach to collect promising state program integrity practices; and • collaborate with states to create and implement a communication strategy for sharing promising program integrity practices with states in an efficient and timely manner.
Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services. GAO-17-169. January 12, 2017.	CMS should: • establish standard reporting guidance for personal care services collected through T-MSIS to ensure that key data reported by states, such as procedure codes, provider identification numbers, units of service, and dates of service, are complete and consistent; • better ensure, for all types of personal care services programs, that data on provision of personal care services and other HCBS collected through T-MSIS claims can be specifically linked to the expenditure lines on the CMS-64 that correspond with those particular types of HCBS services; • better ensure that personal care services data collected from states through T-MSIS and the Medicaid Budget and Expenditure System comply with CMS reporting requirements; and • develop plans for analyzing and using personal care services data for program management and oversight.
Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports. GAO-17-145. January 9, 2017.	CMS should: • require all states to collect and report on progress toward achieving managed long-term services and supports program goals, such as whether the program enhances the provision of community-based care; • establish criteria for what situations would warrant exceptions to the federal standards that the data used to set rates be no older than the three most recent and complete years; and • provide states with guidance that includes minimum standards for encounter data validation procedures.

GAO Report	Recommendation
Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvement. GAO-17-173. January 6, 2017.	CMS should: • take immediate steps to assess and improve the data available for Medicaid program oversight, including, but not limited to, 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.
Improper Payments: Strategy and Additional Actions Needed to Help Ensure Agencies Use the Do Not Pay Working System as Intended. GAO-17-15. October 14, 2016.	Congress should: • consider amending the Social Security Act to explicitly allow the Social Security Administration to share its full death file with Treasury for use through the Do Not Pay (DNP) working system. The Office of Management and Budget (OMB) should: • develop guidance that clarifies whether the use of DNP's payment integration functionality is required and—if required—the circumstances and process in which agencies may obtain an exemption from this requirement; • develop a strategy—and communicate its strategy through guidance—for how agencies should use the DNP working system to complement existing data matching processes and whether and how agencies should consider using the DNP working system to streamline existing data matching; • develop and implement monitoring mechanisms—such as goals, benchmarks, and performance measures—to evaluate agency use of the DNP working system; • develop a process for comparing agency reporting on the use of the DNP working system to available sources, such as OMB guidance and DNP working system adjudication reports; and • revise its guidance to clarify whether agencies should report on their uses of all of the functionalities of the DNP working system in their agency financial reports.
Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers. GAO-16-402. April 22, 2016.	CMS should: • consider which additional databases that states and Medicaid managed care plans use to screen providers could be helpful in improving the effectiveness of these efforts and determine whether any of these databases should be added to the list of databases identified by CMS for screening purposes; and • coordinate with other federal agencies, as necessary, to explore the use of an identifier that is relevant for the screening of Medicaid managed care plan providers and common across databases used to screen Medicaid managed care plan providers.
Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds. GAO-16-53. October 23, 2015.	CMS should: • conduct reviews of federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary; and • 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.
Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls. GAO-15-313. May 14, 2015.	CMS should: • provide guidance to states on the availability of automated information through Medicare's enrollment database—the Provider Enrollment, Chain and Ownership System—and full access to all pertinent system information, such as ownership information, to help screen Medicaid providers more efficiently and effectively.

Source: GAO. | GAO-18-444T

Related GAO Reports

Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed. GAO-18-179. Washington, D.C.: January 5, 2018.

Medicaid: CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home-and Community-Based Services. GAO-18-103. Washington, D.C.: December 14, 2017.

Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight. GAO-18-70. Washington, D.C.: December 8, 2017.

Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework. GAO-18-88. Washington, D.C.: December 5, 2017.

Opioid Use Disorders: HHS Needs Measures to Assess the Effectiveness of Efforts to Expand Access to Medication-Assisted Treatment. GAO-18-44. Washington, D.C.: October 31, 2017.

Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome. GAO-18-32. Washington, D.C.: October 4, 2017.

Medicare: CMS Fraud Prevention System Uses Claims Analysis to Address Fraud. GAO-17-710. Washington, D.C.: August 30, 2017.

Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs. GAO-17-632. Washington, D.C.: August 14, 2017.

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.

High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others. GAO-17-317. Washington, D.C.: February 15, 2017.

Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services. GAO-17-169. Washington, D.C.: January 12, 2017.

Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports. GAO-17-145. Washington, D.C.: January 9, 2017.

Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvement. GAO-17-173. Washington, D.C.: January 6, 2017.

Improper Payments: Strategy and Additional Actions Needed to Help Ensure Agencies Use the Do Not Pay Working System as Intended. GAO-17-15. Washington, D.C.: October 14, 2016.

Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers. GAO-16-402. Washington, D.C.: April 22, 2016.

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: Service Utilization Patterns for Beneficiaries in Managed Care. GAO-15-481. Washington, D.C.: May 29, 2015.

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