



Testimony

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MEDICAID

Overview of Key Issues Facing the Program

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Chairman Pitts, Ranking Member Green, and Members of the Subcommittee:

We are pleased to be here today to discuss key issues facing the Medicaid program. The Medicaid program marks its 50th anniversary on July 30, 2015. Over the past half-century, Medicaid has grown to be one of the largest sources of health care coverage and financing for a diverse low-income and medically needy population. Medicaid is a significant component of federal and state budgets, with estimated outlays of \$508 billion in fiscal year 2014, of which \$304 billion was financed by the federal government and \$204 billion by the states.¹ Operating as an important health care safety net, Medicaid covered about 72 million individuals—roughly one-fifth of the U.S. population—during fiscal year 2013.² Medicaid is undergoing a period of transformative change, as enrollment is growing under the Patient Protection and Affordable Care Act (PPACA). In particular, PPACA permits states to expand their Medicaid programs by covering certain low-income adults not historically eligible for Medicaid coverage, and more than half of the states have done so.

Medicaid is designed as a federal-state partnership, and both the federal government and the states play important roles in ensuring that Medicaid is fiscally sustainable over time and effective in meeting the needs of the vulnerable populations it serves. Medicaid is financed jointly by the federal government and states, 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). By design, Medicaid allows significant flexibility for states to design and implement their programs. While state flexibility is a key element of the program, federal oversight is important to help ensure that funds are used appropriately and that enrollees can access quality care. However, significant challenges for oversight exist, given the size, growth,

¹Centers for Medicare & Medicaid Services, Office of the Actuary, *2013 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2014). As of June 30, 2015, the Centers for Medicare & Medicaid Services had not published data on final fiscal year 2014 expenditures.

²This figure represents the total number of individuals ever enrolled in the program in 2013. There were about 58 million individuals enrolled in the program at any one point in time. See Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (Washington, D.C.: March 2014).

and diversity of Medicaid, which we designated as a high-risk program in 2003 due to these factors and gaps in oversight we identified.

Over the years, we have reported on a number of challenges facing Medicaid, and made numerous recommendations regarding gaps in federal oversight of the program.³ Our statement today highlights key issues that face the Medicaid program, based on our work. To identify the key issues for this statement, we reviewed more than 70 reports on Medicaid that we issued from January 2005 through June 2015, including our most recent high risk update, which provides an overview of challenges facing Medicaid and areas needing improved federal oversight.⁴ From January 2015 to May 2015, we also obtained and reviewed information from CMS about the status of our prior recommendations, as well as current CMS efforts related to Medicaid.⁵ The issues we discuss are neither inclusive of all the issues facing Medicaid nor all the issues CMS faces in its oversight efforts. 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.

In summary, we found that the Medicaid program faces a range of key issues as it marks its 50th year. Attention to these key issues—access to care; transparency and oversight; program integrity; and federal financing—will be important to ensuring that the Medicaid program is both effective for the enrollees who rely on it and accountable to the taxpayers. Matters for congressional consideration and selected GAO recommendations that address these key issues are summarized in appendix I.

³See, for example, GAO, *High-Risk Series: An Update*, [GAO-15-290](#) (Washington, D.C.: Feb. 11, 2015).

⁴See the list of related GAO products at the end of this statement for selected reports about Medicaid.

⁵See Appendix I for selected prior GAO recommendations regarding Medicaid. GAO has made over 80 recommendations regarding Medicaid.

Access to care. Maintaining and improving access to care is critical to ensuring that the program is effective for the individuals who rely on it. National survey data have suggested that access to medical care reported by Medicaid enrollees is generally comparable to that of individuals with private health insurance—with few (less than 4 percent) reporting difficulty obtaining necessary medical care in 2008 and 2009—but that Medicaid enrollees do face particular challenges in accessing certain types of care, such as obtaining specialty care (like mental health care) or dental care.⁶ For example, our 2010 national survey of physicians found that specialty physicians were generally more willing to accept privately insured children as new patients than Medicaid-covered children, and that more physicians reported having difficulty referring Medicaid-covered children to specialty providers than reported having difficulty referring privately insured children.⁷ CMS has taken steps to help ensure enrollees' access to care, and we have recommended additional steps that could bolster those efforts. For example, in April 2011 we recommended CMS take steps to improve its data from states to help assess Medicaid enrollees' access to care.⁸ In particular, we recommended that CMS work with states to explore options for capturing information on children's receipt of services for which they were referred. The agency has issued guidance to states about how to report referrals for health care services, but has no plans to require states to report whether children receive services for which they are referred. We continue to believe this information is important for monitoring and ensuring children's access to care.

⁶See, for example, GAO, *Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance*, [GAO-14-40](#) (Washington, D.C.: Nov. 21, 2013); *Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care*, [GAO-13-15](#) (Washington, D.C.: Dec. 10, 2012); and *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*, [GAO-13-55](#) (Washington, D.C.: Nov. 15, 2012).

⁷See GAO, *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care*, [GAO-11-624](#) (Washington, D.C.: June 30, 2011).

⁸See GAO, *Medicaid and CHIP: Reports for Monitoring Children's Health Care Services Need Improvement*, [GAO-11-293R](#) (Washington, D.C.: April 5, 2011).

Transparency and oversight. Efforts to ensure fiscal accountability through increased transparency and improved oversight can help ensure the appropriate use of Medicaid funds. States are responsible for financing the non-federal share of their programs, and can use state general funds as well as other sources, such as taxes on health care providers and transfers of funds from local governments. However, we have found CMS lacks complete and reliable data about the sources of funds states use to finance the non-federal share of Medicaid, including data needed to monitor states' reliance on providers and local governments to finance the non-federal share, which can shift costs to the federal government. CMS also lacks complete data on program payments to providers, which hinders oversight. Accordingly, our work has pointed to the need for better data on states' funding sources and state payments to providers, as well as improved policy and oversight.⁹ In addition, we have highlighted the need for improvements in HHS's criteria, policy, and process for approving states' spending on demonstrations—state projects that may test new ways to deliver or pay for Medicaid benefits, which have grown over time to account for close to one-third of federal Medicaid spending in 2014.¹⁰ Although HHS policy requires demonstrations to be budget-neutral to the federal government, HHS has approved demonstration spending limits that we estimate were billions of dollars higher than what federal spending would have been if the states' existing Medicaid programs had continued. We found that HHS has allowed states to use questionable methods and assumptions for their spending estimates, without providing adequate documentation to support them. We have also found that HHS has not issued explicit criteria explaining how it determines that demonstration spending furthers Medicaid objectives, and that HHS's approval documents are not always clear as to what, precisely, approved expenditures are for and how they will promote

⁹See, for example, GAO, *Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy*, [GAO-15-322](#) (Washington, D.C.: April 10, 2015); *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, [GAO-14-627](#) (Washington, D.C.: July 29, 2014); and *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*, [GAO-13-48](#) (Washington, D.C.: Nov. 26, 2012).

¹⁰See, for example, GAO, *Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives*, [GAO-15-239](#) (Washington, D.C.: April 13, 2015); *Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns*, [GAO-14-689R](#) (Washington, D.C.: Aug. 8, 2014); and *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency*, [GAO-13-384](#) (Washington, D.C.: June 25, 2013).

these objectives.¹¹ As a result, the bases for HHS's decisions involving tens of billions of Medicaid dollars are not transparent.

Congress and HHS have taken important steps in recent years to improve transparency, oversight, and fiscal accountability, and we have recommended additional steps that would build on those efforts. For example, in July 2014, we recommended that CMS take steps to ensure that states report accurate and complete information on all sources of funds used to finance the nonfederal share of Medicaid, and offered suggestions for doing so. HHS disagreed, stating that its current efforts were adequate.¹² However, we continue to believe that improved data are needed to improve transparency and oversight. In addition, in April 2015, we recommended that CMS take steps to ensure that states report accurate and complete provider-specific payment data and develop a policy and process for reviewing payments to individual providers to determine whether they are economical and efficient, and HHS concurred with our recommendations.¹³ In November 2012, we suggested that, because CMS said legislation was required for the agency to take particular steps to improve oversight of certain high-risk Medicaid payments, Congress consider requiring CMS to improve reporting of these payments and subject them to independent audit.¹⁴ We also have made multiple recommendations aimed at improving HHS's demonstration approval process, such as by improving its review criteria and methods. In 2008, because HHS disagreed that our recommended changes were needed—maintaining that its process was sufficient—we suggested that Congress consider requiring the Secretary of HHS to take certain actions to improve the demonstration approval process, such as by better ensuring that valid methods are used to demonstrate budget neutrality, and documenting the basis for such approvals.¹⁵ In April 2015, we recommended that HHS ensure that its demonstration approvals document the criteria used to assess whether demonstrations are likely to

¹¹See [GAO-15-239](#).

¹²See [GAO-14-627](#).

¹³See [GAO-15-322](#).

¹⁴See [GAO-13-48](#).

¹⁵See GAO, *Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns*, [GAO-08-87](#) (Washington, D.C.: Jan. 31, 2008).

promote Medicaid objectives, and HHS concurred with this recommendation.¹⁶

Program integrity. Improving program integrity can help ensure the most appropriate use of Medicaid funds. The program’s size and diversity make it particularly vulnerable to improper payments, including payments made for treatments or services that were not covered by the program, that were not medically necessary, or that were never provided. Improper payments are a significant cost to Medicaid—totaling an estimated \$17.5 billion in fiscal year 2014, according to HHS. An effective federal-state partnership is key to ensuring the most appropriate use of funds by (1) identifying and preventing improper payments in both fee-for-service and managed care, (2) setting appropriate payment rates for managed care organizations, and (3) ensuring only eligible individuals and providers participate in Medicaid.¹⁷ CMS has taken steps to improve program integrity, and we have recommended other steps that would bolster those efforts. In May 2014, for example, we recommended CMS take steps to improve oversight of growing Medicaid managed care expenditures.¹⁸ CMS has taken some steps, but the lack of a comprehensive program integrity strategy for managed care leaves a growing portion of Medicaid funds at risk. We believe that further actions, in particular requiring states to conduct audits of payments to and by managed care organizations, and updating guidance on Medicaid managed care program integrity practices, are crucial to improving program integrity.

Federal financing. Medicaid’s federal-state partnership could be improved through a revised federal financing approach that better addresses variations in states’ financing needs. The federal government shares in the costs of state Medicaid payments using the Federal Medical

¹⁶See [GAO-15-239](#).

¹⁷See, for example, GAO, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*, [GAO-15-313](#) (Washington, D.C.: May 14, 2015); *Medicaid Information Technology: CMS Supports Use of Program Integrity Systems but Should Require States to Determine Effectiveness*, [GAO-15-207](#) (Washington, D.C.: Jan. 30, 2015); *Medicaid: Additional Federal Action Needed to Further Improper Third-Party Liability Efforts*, [GAO-15-208](#) (Washington, D.C.: Jan. 28, 2015); and *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, [GAO-14-341](#) (Washington, D.C.: May 19, 2014).

¹⁸See [GAO-14-341](#).

Assistance Percentage (FMAP), which is determined annually by a statutory formula based in part on each state's per capita income. States with lower per capita incomes receive higher matching rates. Automatically providing increased federal financial assistance to states affected by national economic downturns, in a timely and targeted way—through temporary changes to the federal funding formula—could help provide assistance that is more responsive to states' particular economic conditions than past federal assistance when Congress acted to temporarily increase support to states by increasing the share of Medicaid expenditures paid by the federal government.¹⁹ We suggested in November 2011 that Congress could consider enacting a federal funding formula that provides such automatic, targeted and timely assistance.²⁰ In addition, we have described revisions to the current federal funding formula that could more equitably allocate Medicaid funds to states by better accounting for their ability to fund Medicaid.²¹ These improvements could better align federal funding with each state's resources, demand for services, and costs; better facilitate state budget planning; and provide states with greater fiscal stability during times of economic stress.

In conclusion, our previous work highlights the range of challenges facing the Medicaid program as it approaches its 50th anniversary. Addressing these challenges is critical to ensuring continued access to care for tens of millions of Americans and the fiscal sustainability of the program. In the coming weeks, we will issue a report that discusses these challenges—and recommendations we made in prior work to address them—in greater detail. The report will also describe the Medicaid program's ongoing transformation, as federal and state governments implement PPACA changes, prepare for the aging of the population, and adopt new technologies. These challenges and the transformation of the Medicaid program increase the importance of federal oversight and we stand ready to assist Congress in carrying out this oversight.

¹⁹See, for example, GAO, *Medicaid: Prototype Formula Would Provide Automatic, Targeted Assistance to States during Economic Downturns*, [GAO-12-38](#) (Washington, D.C.: Nov. 10, 2011); and *Medicaid: Improving Responsiveness of Federal Assistance to States during Economic Downturns*, [GAO-11-395](#) (Washington, D.C.: March 31, 2011).

²⁰See [GAO-12-38](#).

²¹See GAO, *Medicaid: Alternative Measures Could Be Used to Allocate Funding More Equitably*, [GAO-13-434](#) (Washington, D.C.: May 10, 2013).

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee, this concludes our prepared statement. We would be pleased to respond to any questions that you might have at this time.

GAO Contacts and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Katherine M. Iritani at (202) 512-7114 or iritanik@gao.gov or Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony include Robert Copeland, Assistant Director; Kristen Joan Anderson; Robin Burke; Drew Long; Jasleen Modi; and Jessica Morris.

Appendix I: Matters for Congressional Consideration and Selected Medicaid-Related Recommendations, as of June 2015

The following table lists prior Medicaid-related matters for congressional consideration GAO has suggested.

Table 1: Matters for Congressional Consideration

GAO Report	Matters for Congressional Consideration
Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed. GAO-13-48 , November 26, 2012	Congress should consider requiring the Centers for Medicare & Medicaid Services (CMS) to <ol style="list-style-type: none"> 1. improve state reporting of non-disproportionate share hospital (DSH) supplemental payments, including requiring annual reporting of payments made to individual facilities and other information that the agency determines is necessary to oversee non-DSH supplemental payments; 2. clarify permissible methods for calculating non-DSH supplemental payments; and 3. require states to submit an annual independent certified audit verifying state compliance with permissible methods for calculating non-DSH supplemental payments.
Medicaid: Prototype Formula Would Provide Automatic, Targeted Assistance to States during Economic Downturns. GAO-12-38 , November 10, 2011	Congress could consider enacting a Federal Medical Assistance Percentage (FMAP) formula that is targeted for variable state Medicaid needs and provides automatic, timely, and temporary increased FMAP assistance in response to national economic downturns.
Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns. GAO-08-87 , January 31, 2008	Congress may wish to consider requiring increased attention to fiscal responsibility in the approval of Section 1115 Medicaid demonstrations by requiring the Department of Health and Human Services (HHS) to improve the demonstration review process through steps such as clarifying criteria for reviewing and approving states' proposed spending limits; better ensuring that valid methods are used to demonstrate budget neutrality; and documenting and making public material explaining the basis for any approvals.

Source: GAO. | GAO-15-746T

The following table lists selected Medicaid-related recommendations GAO has made to the Department of Health and Human Services that the agency has either not taken or has not completed steps to implement the recommendation.

Table 2: Selected Medicaid-Related Recommendations, as of June 2015

GAO Report	Recommendation
Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls. GAO-15-313 , May 14, 2015	The Centers for Medicare & Medicaid Services (CMS) should <ol style="list-style-type: none"> 1. issue guidance to states to better identify beneficiaries who are deceased; and 2. provide guidance to states on the availability of automated information through Medicare’s enrollment database—the Provider Enrollment, Chain, and Ownership System (PECOS)—and full access to all pertinent PECOS information, such as ownership information, to help screen Medicaid providers more efficiently and effectively.
Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives. GAO-15-239 , April 13, 2015	The Department of Health and Human Services (HHS) should <ol style="list-style-type: none"> 1. issue criteria for assessing whether section 1115 expenditure authorities are likely to promote Medicaid objectives; 2. ensure the application of these criteria is documented in all HHS’s approvals of section 1115 demonstrations, including those approving new or extending or modifying existing expenditure authorities, to inform internal and external stakeholders—including states, the public, and Congress—of the basis for the agency’s determinations that approved expenditure authorities are likely to promote Medicaid objectives; 3. take steps to ensure that Medicaid demonstration approval documentation consistently provides assurances—such as through claiming protocols or the application template—that states will avoid duplicative spending by offsetting as appropriate all other federal revenues received when claiming federal Medicaid matching funds.
Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy. GAO-15-322 , April 10, 2015	CMS should <ol style="list-style-type: none"> 1. take steps to ensure that states report accurate provider specific payment data that include accurate unique national provider identifiers; 2. develop a policy establishing criteria for when such payments at the provider level are economical and efficient; and 3. once criteria are developed, develop a process for identifying and reviewing payments to individual providers in order to determine whether they are economical and efficient.
Medicaid Information Technology: CMS Supports Use of Program Integrity Systems but Should Require States to Determine Effectiveness. GAO-15-207 , January 30, 2015	HHS should direct CMS to require states to measure quantifiable benefits, such as cost reductions or avoidance, achieved as a result of operating information systems to help prevent and detect improper payments.
Medicaid: Additional Federal Action Needed to Further Improper Third-Party Liability Efforts. GAO-15-208 , January 28, 2015	HHS should direct CMS to <ol style="list-style-type: none"> 1. routinely monitor and share across all states information regarding key third-party liability efforts and challenges; and 2. provide guidance to states on their oversight of third-party liability efforts conducted by Medicaid managed care plans.

**Appendix I: Matters for Congressional
Consideration and Selected Medicaid-Related
Recommendations, as of June 2015**

GAO Report	Recommendation
Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection. GAO-14-627 , July 29, 2014	CMS should develop a data collection strategy that ensures that states report accurate and complete data on all sources of funds used to finance the nonfederal share of Medicaid payments.
Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures. GAO-14-341 , May 19, 2014	CMS should <ol style="list-style-type: none"> 1. hold states accountable for Medicaid managed care program integrity by requiring states to conduct audits of payments to and by managed care organizations; and 2. update CMS's Medicaid managed care guidance on program integrity practices and effective handling of managed care organization recoveries.
Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency. GAO-13-384 , June 25, 2013	HHS should update the agency's written budget neutrality policy to reflect actual criteria and processes used to develop and approve demonstration spending limits, and ensure the policy is readily available to state Medicaid directors and others.
Medicaid and CHIP: Reports for Monitoring Children's Health Care Services Need Improvement. GAO-11-293R , April 5, 2011	CMS should work with states to identify additional improvements that could be made to the CMS 416 annual reports, including options for reporting on the receipt of services separately for children in managed care and fee-for-service delivery models, while minimizing reporting burden, and for capturing information on the CMS 416 relating to children's receipt of treatment services for which they are referred.

Source: GAO. | GAO-15-746T

Related GAO Products

The following are selected GAO products pertinent to the key issues discussed in this statement. Other products may be found at GAO's website at www.gao.gov.

Access to Care

Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance. [GAO-14-40](#). Washington, D.C.: November 21, 2013.

Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care. [GAO-13-15](#). Washington, D.C.: December 10, 2012.

Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance. [GAO-13-55](#). Washington, D.C.: November 15, 2012.

Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care. [GAO-11-624](#). Washington, D.C.: June 30, 2011.

Medicaid and CHIP: Reports for Monitoring Children's Health Care Services Need Improvement. [GAO-11-293R](#). Washington, D.C.: April 5, 2011.

Oral Health: Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns. [GAO-11-96](#). Washington, D.C.: November 30, 2010.

Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain. [GAO-09-723](#). Washington, D.C.: September 30, 2009.

Transparency and Oversight

Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives. [GAO-15-239](#). Washington, D.C.: April 13, 2015.

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

Medicaid Financing: Questionnaire Data on States' Methods for Financing Medicaid Payments from 2008 through 2012. [GAO-15-227SP](#). Washington, D.C.: March 13, 2015, an e-supplement to [GAO-14-627](#).

Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns. [GAO-14-689R](#). Washington, D.C.: August 8, 2014.

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

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

Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed. [GAO-13-48](#). Washington, D.C.: November 26, 2012.

Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments. [GAO-08-614](#). Washington, D.C.: May 30, 2008.

Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns. [GAO-08-87](#). Washington, D.C.: January 31, 2008.

Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency. [GAO-07-214](#). Washington, D.C.: March 30, 2007.

Program Integrity

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

Medicaid Information Technology: CMS Supports Use of Program Integrity Systems but Should Require States to Determine Effectiveness. [GAO-15-207](#). Washington, D.C.: January 30, 2015.

Medicaid: Additional Federal Action Needed to Further Improve Third-Party Liability Efforts. [GAO-15-208](#). Washington, D.C.: January 28, 2015.

Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures. [GAO-14-341](#). Washington, D.C.: May 19, 2014.

Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use. [GAO-11-475](#). Washington, D.C.: June 30, 2011.

Federal Financing

Medicaid: Alternative Measures Could Be Used to Allocate Funding More Equitably. [GAO-13-434](#). Washington, D.C.: May 10, 2013.

Medicaid: Prototype Formula Would Provide Automatic, Targeted Assistance to States during Economic Downturns. [GAO-12-38](#). Washington, D.C.: November 10, 2011.

Medicaid: Improving Responsiveness of Federal Assistance to States during Economic Downturns. [GAO-11-395](#). Washington, D.C.: March 31, 2011.

Other GAO Products

High-Risk Series: An Update. [GAO-15-290](#). Washington, D.C.: February 11, 2015.

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