



Testimony
Before the Subcommittee on Oversight
and Investigations, Energy and
Commerce Committee, House of
Representatives

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MEDICARE AND MEDICAID

Additional Actions Needed to Enhance Program Integrity and Save Billions

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

GAO Highlights

Highlights of [GAO-24-107487](#), a testimony before the Subcommittee on Oversight and Investigations, Energy and Commerce Committee, House of Representatives

Why GAO Did This Study

In 2023, the Medicare program spent an estimated \$1.0 trillion to provide health care services for approximately 66 million elderly and disabled individuals. This involved processing over a billion transactions. Medicaid is a joint federal-state program that finances health care for low-income and medically needy individuals. It is the second largest health care program by expenditures, with an estimated \$849 billion in federal and state spending for services provided to about 90 million individuals in 2023.

Medicare and Medicaid are complex and large programs. They represented 26 percent of federal program spending in fiscal year 2023. The programs are susceptible to improper payments, as well as potential mismanagement and fraud, waste, and abuse. As a result, GAO added Medicare to its High-Risk list in 1990 and Medicaid in 2003.

This testimony focuses on examples of steps taken by CMS to reduce improper payments in Medicare and Medicaid, as well as actions still needed by CMS and Congress. It draws on GAO's reports issued and recommendations made from 2008 through 2024 on the Medicare and Medicaid programs and known steps CMS has taken to address these recommendations as of March 2024.

What GAO Recommends

CMS has implemented dozens of GAO recommendations to improve Medicare and Medicaid. As of March 2024, over 100 recommendations to CMS remain unimplemented, including 15 related to improper payments.

View [GAO-24-107487](#). For more information, contact Jessica Farb at (202) 512-7114 or farbj@gao.gov.

April 16, 2024

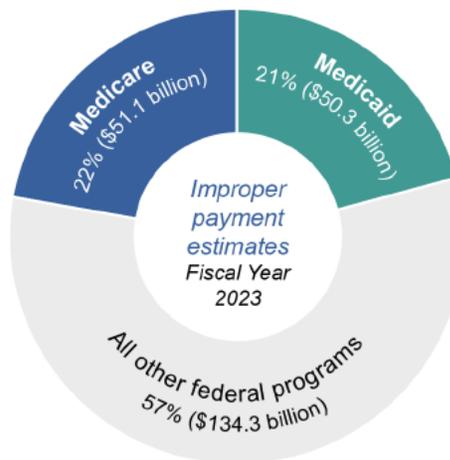
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What GAO Found

The Department of Health and Human Services (HHS) estimated a combined total of over \$100 billion in improper payments in the Medicare and Medicaid programs in fiscal year 2023. This represents 43 percent of the government-wide total of estimated improper payments that agencies reported for that year.

Improper Payments Estimates for Fiscal Year 2023



Improper payment

Any payment that should not have been made or that was made in an incorrect amount, including overpayments and underpayments.

Source: GAO analysis of Office of Management and Budget Payment Accuracy data. | GAO-24-107487

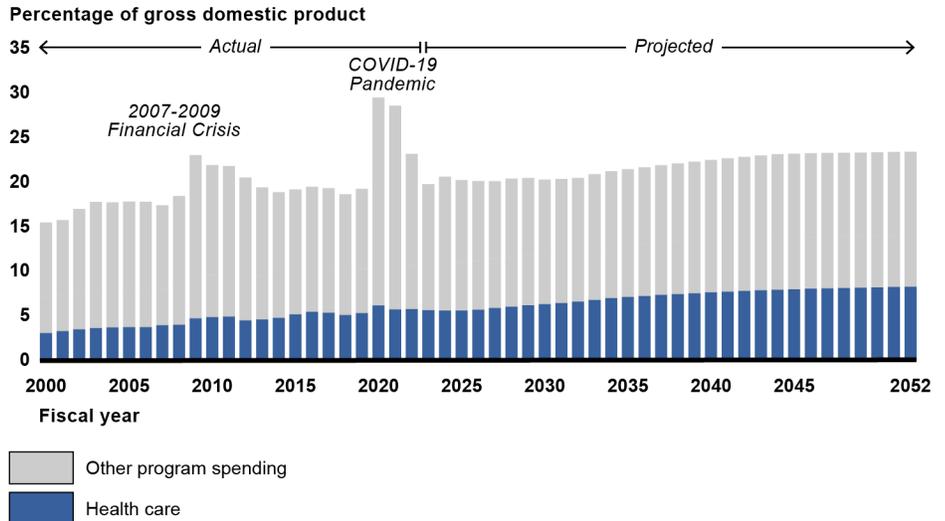
Note: Estimates also include payments whose propriety cannot be determined due to lacking or insufficient documentation.

The Centers for Medicare & Medicaid Services (CMS), within HHS, has taken several steps in response to GAO recommendations to help reduce improper payments in Medicare and Medicaid. These actions have resulted in billions of dollars in federal savings. For example:

- **Improved fraud prevention in Medicare.** CMS implemented capabilities that automatically stopped payments of certain improper and non-payable claims. These improvements generated an estimated almost \$2 billion in savings over a 5-year period.
- **Improved Medicaid managed care oversight.** CMS worked with states and audit contractors to improve oversight. This included an exponential increase in investigations of managed care providers, from 16 in 2016 through 2018 to 893 in 2019 through 2021. Preliminary results indicate that the audits are identifying overpayments.

In the current fiscal environment, addressing improper payments and providing sufficient oversight of program spending, more generally, is particularly important. Federal spending for Medicare and Medicaid has grown by almost 80 percent over the past decade and growth in these and other health programs is projected to continue.

Health Care and Other Government Program Spending, Actual and Projected



Source: Congressional Budget Office data and GAO simulation. | GAO-24-107487

CMS and congressional action on GAO recommendations related to Medicare and Medicaid has resulted in over \$200 billion in financial benefits since 2006. Action on recommendations that remain unimplemented would further enhance program integrity and save billions of dollars in Medicare and Medicaid spending.

- **Provider screening and enrollment.** GAO recommended CMS expand its review of states' implementation of provider screening and enrollment requirements in Medicaid, and monitor progress when states are not fully compliant. For Medicare, GAO recommended that CMS implement a risk-based plan for revalidating enrollment for Medicare providers after pauses during the COVID-19 pandemic.
- **Prepayment claim reviews in Medicare.** GAO recommended that CMS seek legislative authority to allow Recovery Auditors to conduct prepayment claim reviews, which are generally more cost effective than postpayment reviews in preventing improper payments.
- **Equalizing certain Medicare payments.** GAO recommended that Congress take action to address that Medicare pays more for certain services based on where they are provided. Congress has taken some actions. For example, this committee proposed and the House passed legislation to equalize payments for certain drug administration services. Taking additional steps to equalize payments has been estimated to save Medicare \$141 billion over 10 years.
- **Telehealth.** In response to the COVID-19 pandemic, HHS temporarily waived certain Medicare restrictions on telehealth and use increased dramatically. We recommended CMS comprehensively assess the quality of telehealth services in Medicare, which is needed to ensure those services are medically necessary, among other things.
- **Medicaid demonstrations.** In response to GAO recommendations, CMS has made changes to its policies for ensuring that demonstrations do not increase federal spending, reducing federal liabilities by over \$120 billion. Additional action by CMS and Congress could result in further savings.
- **State auditors.** State auditors play an important role in Medicaid oversight and have identified improper payments and other deficiencies through their reviews. GAO recommended that CMS use trends in state auditor findings to inform its Medicaid oversight and share information on the status of actions to address findings with state auditors.



Chairman Griffith, Ranking Member Castor, and Members of the Subcommittee:

Thank you for the opportunity today to discuss improper payments in the Medicare and Medicaid programs.¹ Medicare and Medicaid are large and complex programs that are susceptible to improper payments, as well as potential mismanagement and fraud, waste, and abuse. As a result of these program integrity risks, we added Medicare to our High-Risk list in 1990 and Medicaid in 2003.² Similarly, as of fiscal year 2024, the Office of Management and Budget designated all parts of Medicare, as well as Medicaid, “high-priority” programs due to the programs’ estimated improper payments.³ Since adding Medicare and Medicaid to our High-Risk list, we have made hundreds of recommendations to CMS related to our High Risk areas. Implementing our recommendations has resulted in over \$200 billion in financial benefits, including cost savings, since 2006.

In fiscal year 2023, Medicare and Medicaid grew to account for over 26 percent of federal spending overall, 6.1 percent of the nation’s economy.⁴ Further, the programs accounted for an estimated 43 percent of government-wide improper payments.⁵ We and others expect spending

¹An improper payment is defined by law as 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 good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. 31 U.S.C. § 3351(4). Executive agency estimates of improper payments also treat as improper any payments whose propriety cannot be determined due to lacking or insufficient documentation. 31 U.S.C. § 3352(c)(2).

²We provided an update on these high-risk areas in April 2023. See GAO, *High-Risk Series: Efforts Made to Achieve Progress Need to Be Maintained and Expanded to Fully Address All Areas*, [GAO-23-106203](#) (Washington, D.C.: Apr. 20, 2023).

³The Office of Management and Budget designates as high priority programs with annual reported estimated monetary loss from improper payments in excess of \$100 million in a given fiscal year.

⁴See Congressional Budget Office, *The Budget and Economic Outlook: 2024 to 2034* (Washington, D.C.: Feb. 7, 2024).

⁵Medicare accounted for 22 percent of the government-wide total of estimated improper payments that agencies reported in 2023, while Medicaid accounted for 21 percent. See GAO, *Improper Payments: Information on Agencies’ Fiscal Year 2023 Estimates*, [GAO-24-106927](#) (Washington, D.C.: Mar. 26, 2024).

for the Medicare and Medicaid programs will continue to grow.⁶ For example, the Congressional Budget Office projects that Medicare spending will double by 2034.⁷

In 2023, the Medicare program spent an estimated \$1.0 trillion to provide health care services for approximately 66 million elderly and disabled individuals. The Medicare program is complex, with more than 1.4 million providers, more than 20 different payment systems, and over one billion payment claims annually. Spending is expected to increase significantly over the next decade as the U.S. population ages and more individuals receive Medicare benefits.

After Medicare, the Medicaid program is the second largest health care program by expenditures, with an estimated total of \$849 billion in spending, including \$578 billion in federal spending and \$271 billion in state spending in fiscal year 2023. Medicaid finances health care for low-income and medically needy individuals. The program provided coverage for about 90 million individuals in 2023. 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 on their unique needs, resulting in 56 distinct Medicaid programs.⁸ The resulting variability of state Medicaid programs complicates federal efforts to oversee program payments and beneficiaries' access to services.

The Centers for Medicare & Medicaid Services (CMS) is the Department of Health and Human Services (HHS) agency responsible for overseeing the Medicare and Medicaid programs at the federal level.⁹ It is critical that CMS and states leverage available resources to reduce improper payments. Dollars wasted detract from the programs' ability to ensure that the individuals who rely on Medicare and Medicaid—including low-income

⁶See GAO, *The Nation's Fiscal Health: Road Map Needed to Address Projected Unsustainable Debt Levels*, [GAO-24-106987](#) (Washington, D.C.: Feb. 15, 2024).

⁷See Congressional Budget Office, *The Budget and Economic Outlook*, 18.

⁸In addition to the 50 states and the District of Columbia, five territories of the United States participate in the Medicaid program: American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands.

⁹Under 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.

children and individuals who are elderly or disabled—are provided adequate care.

Given the current fiscal environment, addressing improper payments in the Medicare and Medicaid programs—and providing sufficient oversight of program spending, more generally—is particularly important. Our most recent report on the nation’s fiscal health noted that the federal government faces an unsustainable long-term fiscal path. It also highlighted the importance of strengthening program integrity, including reducing improper payments, as a step to help to reduce the deficit.¹⁰ Our report also identified the need to review fiscal policies for the Medicare program. Ensuring Medicare payment integrity is also important to the longevity of the Medicare program given that the Medicare Hospital Insurance Trust Fund is projected to be depleted in 2031.¹¹

My testimony today will cover

1. trends in improper payment rates in Medicare and Medicaid;
2. examples of CMS efforts to reduce improper payments in Medicare and Medicaid, and relevant GAO recommendations the agency has not yet implemented; and
3. examples of GAO recommendations to CMS and Congress to improve oversight of Medicare and Medicaid spending.

My remarks are based on our large body of work examining the Medicare and Medicaid programs. This includes reports issued and recommendations made from 2008 through 2024, and known steps HHS, CMS, and Congress have taken to address these recommendations through March 2024. Those reports provide further details on our scope and methodology. (See a list of related GAO reports at the end of this statement.)

Since 2008, we have made over 200 recommendations to CMS related to our High-Risk areas, including Medicare and Medicaid program integrity. As of March 2024, 111 of these recommendations were open. This

¹⁰See [GAO-24-106987](#).

¹¹By 2031, the Medicare program’s revenue would only be sufficient to pay 89 percent of certain inpatient and related benefits, also known as Medicare Part A. See The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: Mar. 31, 2023).

includes 15 recommendations related to improper payments in the Medicare and Medicaid programs.

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

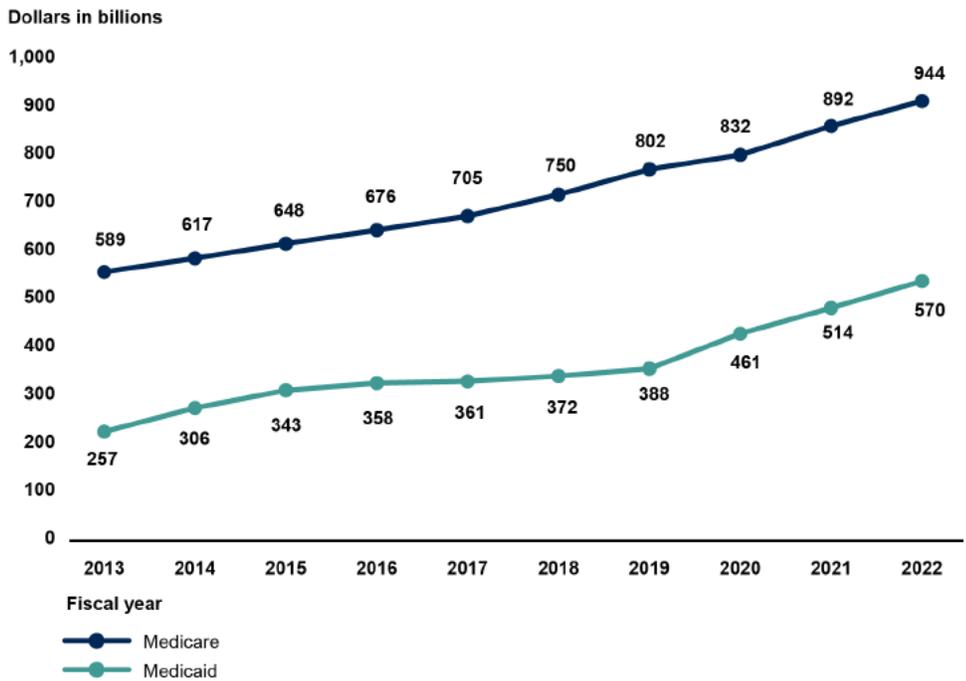
Medicare and Medicaid are among the fastest-growing programs and contribute to the federal deficit.¹² Of note, federal spending for Medicare and Medicaid has grown by almost 80 percent between 2013 and 2022.¹³ (See fig. 1.) We have projected that federal spending on health care—primarily through the Medicare and Medicaid programs—will further increase by 47 percent as a share of gross domestic product between 2023 and 2052.¹⁴

¹²According to the Congressional Budget Office, federal costs per beneficiary for Medicare and Medicaid continue to rise faster than gross domestic product per person, placing upward pressure on mandatory spending. Without commensurate revenue increases or policy changes, this trend will drive larger budget deficits. See Congressional Budget Office, *The Budget and Economic Outlook*.

¹³This is based on nominal spending figures. In real terms, federal spending has grown by approximately 45 percent over this time period.

¹⁴See [GAO-24-106987](#). These projections focus on spending for mandatory health care programs, such as Medicare and Medicaid.

Figure 1: Federal Spending in the Medicare and Medicaid Programs, 2013—2022



Source: Centers for Medicare & Medicaid Services National Health Expenditure Accounts data. | GAO-24-107487

Notes: This figure includes spending in nominal dollars. Adjusted for inflation, Medicare spending was about \$759 billion in 2013 and \$987 billion in 2022; federal Medicaid spending was about \$331 billion in 2013 and \$596 billion in 2022. GAO used the fiscal year 2023 gross domestic product price index to adjust for inflation.

Medicare and Medicaid pay for services through different mechanisms, including fee-for-service, in which individual health care providers are paid for each service delivered.¹⁵ Medicare and Medicaid increasingly provide coverage through managed care. Private managed care plans receive a periodic payment per beneficiary to provide a specific set of covered services to beneficiaries, also known as capitation payments. In 2021, 43 percent of Medicare beneficiaries and over 70 percent of Medicaid enrollees received coverage through managed care. Managed care represented 45 percent of Medicare spending and 58 percent of Medicaid spending in 2022.

¹⁵Under the Medicare program, fee-for-service is also known as Original Medicare and covers Parts A and B. Managed care is also known as Medicare Part C, or Medicare Advantage. Medicare Part D is a federal prescription drug benefit program for Medicare beneficiaries.

Improper payments are a significant risk to the Medicare and Medicaid programs. Improper payments generally include payments that are either made in an incorrect amount (overpayments and underpayments) or those that should not be made at all.¹⁶ In March 2020, the Payment Integrity Information Act of 2019 was enacted. The legislation and implementing guidance requires executive branch agencies to, among other things, (1) review periodically all programs and activities above \$10 million in annual outlays, and identify those that may be susceptible to significant improper payments (commonly referred to as a risk assessment); (2) develop improper payment estimates for those programs and activities that the agency risk assessments, the Office of Management and Budget, or statutes identify as being susceptible to significant improper payments; (3) analyze the root causes of improper payments and developing corrective actions to reduce them; and (4) report on the results of addressing the foregoing requirements.¹⁷

CMS estimates the rate of improper payments to better understand the causes and extent of program risks, develop strategies to protect program integrity, and measure progress toward reducing improper payments. CMS estimates improper payments in both Medicare and Medicaid.

- **Medicare improper payment calculations.** CMS annually computes improper payments for three components within Medicare: fee-for-service; Medicare Advantage; and Medicare Part D prescription drug coverage.¹⁸ (See table 1.) The fee-for-service estimate is developed under its own methodology through the Comprehensive Error Rate Testing program, which audits a random sample of claims to determine whether they met coverage, coding, and billing rules. For Medicare Advantage, CMS conducts audits of the beneficiary diagnoses that have been submitted by managed care plans and used to adjust payments based on clinical risks. Estimates for Medicare Part D prescription drug coverage are based on a random

¹⁶Improper payments can also include payments made in the correct amount that lack sufficient documentation.

¹⁷31 U.S.C. § 3352 and OMB Circular A-123 Appendix C, Requirements for Payment Integrity Improvement, OMB Memorandum M-21-19 (2021). Under PIIA, improper payments are considered “significant” if in the preceding fiscal year they may have exceeded either (1) 1.5 percent of program outlays and \$10 million or (2) \$100 million (regardless of the improper payment rate).

¹⁸For the purposes of measuring improper payments, CMS treats the three components of Medicare as three separate programs.

sample of prescription transactions to ensure the supporting documentation is sufficient per program rules.

Table 1: Estimated Improper Payment Amounts and Rates for the Medicare Program, Fiscal Years 2018—2023
Amounts in billions (and rates)

	2018		2019		2020		2021		2022		2023	
Medicare fee-for-service	\$31.6	(8.1)	\$28.9	(7.3)	\$25.7	(6.3)	\$25.0	(6.3)	\$31.5	(7.5)	\$31.2	(7.4)
Medicare Advantage	\$15.6	— ^a	\$16.7	— ^a	\$16.3	— ^a	\$23.2	— ^a	\$13.9	(5.4)	\$16.6	(6.0)
Prescription drug benefit (Part D)	\$1.3	— ^b	\$0.6	— ^b	\$0.9	— ^b	\$1.4	— ^b	\$1.4	— ^b	\$3.4	(3.7)
Total	\$48.5	n/a	\$46.2	n/a	\$42.9	n/a	\$49.6	n/a	\$46.8	n/a	\$51.1	n/a

Source: Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-107487

Note: These reflect point-in-time estimates of improper payments as originally reported by HHS and CMS for each fiscal year.

^aAccording to CMS, the agency refined its Medicare Advantage improper payment rate methodology for fiscal year 2022, and, as a result, those data should not be compared with prior years.

^bAccording to CMS, the agency refined its prescription drug benefit improper payment rate methodology for fiscal year 2023 and, as a result, those data should not be compared with prior years.

- Medicaid improper payment calculation.** CMS annually computes Medicaid improper payments as a weighted average of states' improper payment estimates for three component parts: fee-for-service, managed care, and beneficiary eligibility determinations. (See table 2.) The improper payment estimate for each component is developed under its own methodology within CMS's Payment Error Rate Measurement program, with each having different improper payment estimates and oversight concerns. The estimate of Medicaid fee-for-service improper payments includes a review of selected medical claims, while the managed care improper payment estimate calculated by CMS is focused on the monthly capitated payments that states make to plans. According to HHS, reviewing medical records associated with provider payments does not have a direct link to the established capitated payment sampled and, thus, is not included in the managed care component.¹⁹ As a result, the managed care estimate does not include erroneous payments Medicaid managed

¹⁹Capitation payments in Medicaid are based on, for example, eligibility group and age. In contrast, capitation payments in Medicare Advantage are adjusted for clinical risk based on beneficiaries' diagnoses. As such, CMS's estimate of improper payments for Medicare Advantage includes audits of the beneficiary diagnoses that have been submitted by managed care plans.

care plans make to their providers.²⁰ CMS conducts the Payment Error Rate Measurement across all states on a 17-state, 3-year rotation cycle, and computes an annual rolling average of improper payment rates from the 3 years of data.

Table 2: Estimated Improper Payment Amounts and Rates for the Medicaid Program, Fiscal Years 2018—2023
Amounts in billions (and rates)

	2018		2019		2020		2021		2022		2023	
Fee-for-service	n/a ^a	(14.3)	\$27.2	(16.3)	\$30.4	(16.8)	\$27.6	(13.9)	\$21.8	(10.4)	\$16.4	(6.9)
Eligibility	n/a ^a	(3.1)	\$32.2	(8.4)	\$60.5	(14.9)	\$75.7	(16.6)	\$61.3	(11.9)	\$34.9	(6.0)
Managed care	n/a ^a	(0.2)	\$0.3	(0.1)	\$0.1	(0.1)	\$0.1	(0.0)	\$0.1	(0.0)	\$0.0	(0.0)

Source: Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-107487

Notes: These reflect point-in-time estimates of improper payments as originally reported by HHS and CMS for each fiscal year. Amounts reflect the federal share of estimated improper payments and do not include the nonfederal share. Estimates for the eligibility component may not be comparable across years due to methodological changes. CMS calculates a separate estimate for total amounts. Estimates were as follows: \$57.4 billion in 2019, \$86.5 billion in 2020, \$98.7 billion in 2021, \$80.6 billion in 2022, and \$50.3 billion in 2023.

^aCMS did not publish improper payment estimates by program component for Medicaid for fiscal year 2018.

Relationship between Improper Payments and Fraud

While improper payments can include, for example, overpayments made in error, they also include those resulting from fraud. Accordingly, all fraudulent payments are considered improper, but not all improper payments are the result of fraud.²¹ Generally, fraud involves obtaining a thing of value through willful misrepresentation.

The improper payment estimation process agencies use is not designed to detect or measure the amount of fraud that may exist. Further, estimates of improper payments cannot be used to determine the extent of fraud in a particular program. Federal programs that report improper payment data do not consistently assess what proportion of those payments were the result of fraud, and existing data on fraud make it difficult to produce reliable government-wide estimates.

²⁰State Medicaid programs and managed care plans may engage in additional program integrity efforts, which could include comparing encounter data with a sample of provider medical records.

²¹See GAO, *Improper Payments and Fraud: How They Are Related but Different*, [GAO-24-106608](#) (Washington, D.C.: Dec. 7, 2023).

Fraud estimation provides agencies with opportunities to improve fraud risk management. For example, estimates can demonstrate the scope of the problem, improve oversight prioritization, and help determine the return on investment from fraud risk management activities. In furtherance of these goals, we will be issuing a report imminently that includes a first-of-its-kind governmentwide estimate of federal spending lost to fraud.

Legislation, guidance from the Office of Management and Budget, and standards for internal control in the federal government have increasingly focused on the need for program managers to strategically address improper payments and fraud. Understanding the relationships and distinctions between improper payments and fraud is important to more effectively target the associated root causes and mitigate the impacts of each.

To help federal program managers strategically manage their fraud risks, we published *A Framework for Managing Fraud Risks in Federal Programs* (Fraud Risk Framework) in July 2015.²² Federal agencies are required to follow the leading practices outlined in the Fraud Risk Framework.²³ The Fraud Risk Framework describes leading practices in four components: commit, assess, design and implement, and evaluate and adapt.

Trends in Medicare and Medicaid Improper Payment Rates

HHS estimated a combined total of over \$100 billion in improper payments in the Medicare and Medicaid programs in fiscal year 2023. The estimated rates of improper payments—in particular, 7.4 percent for Medicare fee-for-service and 6.9 percent for Medicaid fee-for-service—represent a decline from prior years. However, the recent reduction in the Medicaid improper payment rate was due, in part, to flexibilities granted to states during the COVID-19 public health emergency, which ended in May 2023.

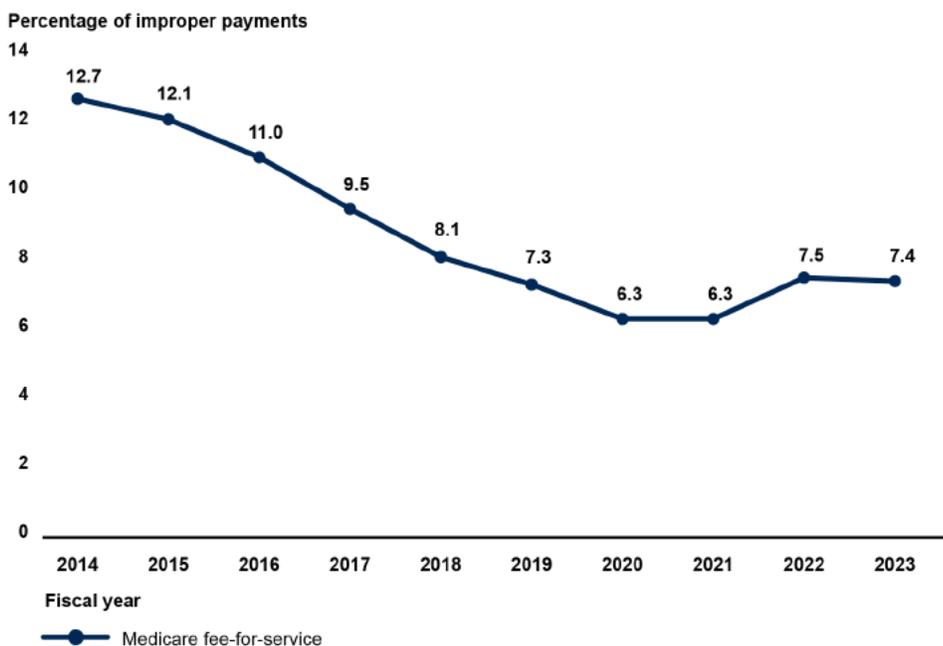
²²See GAO, *A Framework for Managing Fraud Risks in Federal Programs*, [GAO-15-593SP](#) (Washington, D.C.: July 28, 2015).

²³The Payment Integrity Information Act of 2019 requires the Office of Management and Budget (OMB) to maintain guidelines for agencies to establish financial and administrative controls to identify and assess fraud risks and that incorporate leading practices detailed in our Fraud Risk Framework. 31 U.S.C. § 3357(b). The Office of Management and Budget's *Management's Responsibility for Enterprise Risk Management and Internal Control* (OMB M-16-17) directs agencies to adhere to the Fraud Risk Framework's leading practices as part of their efforts to effectively design, implement, and operate an internal control system that addresses financial and nonfinancial fraud risks.

Medicare Improper Payment Rates

Across all three Medicare components—fee-for-service, Medicare Advantage, and Part D prescription drug coverage—CMS estimates show that total improper payments decreased 15 percent from fiscal year 2014 through fiscal year 2023. Those payments totaled almost \$60 billion in fiscal year 2014 and were about \$51 billion in fiscal year 2023. The estimated Medicare fee-for-service improper payment rate decreased over time, from 12.7 percent in 2014 to 7.4 percent in 2023. (See fig. 2.) As has been the case over the past decade, most Medicare improper payments were attributable to the program’s fee-for-service component, which comprised about \$31 billion in fiscal year 2023.

Figure 2: Estimated Medicare Fee-for-Service Improper Payment Rates, Fiscal Years 2014—2023



Source: Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-107487

As figure 2 shows, CMS has made considerable progress in reducing Medicare fee-for-service improper payment rates. CMS has cited updates to documentation requirements for home health agency services that took effect in 2015 as a key change in helping reduce the Medicare fee-for-service improper payment rate. Specifically, CMS began allowing additional types of documentation, such as provider notes, to support the medical necessity of home health services. This reduced instances of

payments being determined improper, according to CMS officials. HHS has also described steps the agency takes to mitigate improper payment risks, including system designs that detect anomalies and prevent payment for many erroneous claims. For example, automated claims edits can be put into place to deny payment for non-covered services or services submitted by ineligible providers.

The majority of fee-for-service improper payments in fiscal year 2023 were due to missing or insufficient documentation; for example, missing or insufficient documentation to support that skilled nursing facility services were necessary or that the facility met certification requirements. The next largest category was payment for medically unnecessary services. Services provided in a hospital that could have been provided in a lower-cost setting, such as a patient's home, and unrelated screening tests or therapies for which the patient had no symptoms or diagnoses are examples of medically unnecessary services in Medicare.

Data on trends in estimated improper payment rates from 2014 through 2023 are not depicted above for Medicare Advantage and Medicare Part D prescription drug coverage due to methodological changes in the estimates over time. In 2023, the estimated improper payment rate for Medicare Advantage was about 6 percent, or about \$16.6 billion in improper payments. For Medicare Part D prescription drug coverage, the improper payment rate for 2023 was about 3.7 percent, or about \$3.4 billion in improper payments.

Medicaid Improper Payment Rates

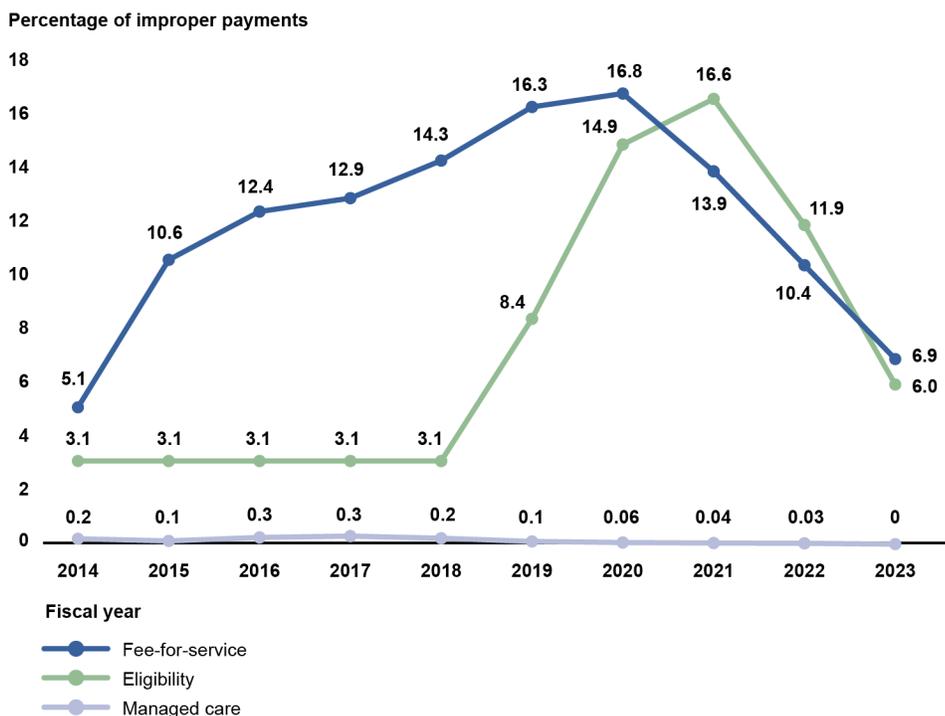
For fiscal year 2023, CMS estimated the national Medicaid improper payment rate to be 8.58 percent, or \$50.3 billion.²⁴ (See fig. 3.) This is a considerable decline from 2020 and 2021 when estimated improper payments reached an estimated \$86.5 billion and \$98.7 billion, respectively.²⁵ HHS attributes the decline in fiscal year 2023, in part, to flexibilities granted to states during the COVID-19 public health emergency. For example, states had the option to reduce requirements for provider enrollment and revalidation. States were also required to keep people continuously enrolled in Medicaid regardless of whether their

²⁴CMS calculates the improper payment rate across all states on a 17-state, 3-year rotation cycle and computes an annual rolling average of improper payment rates from the 3 years of data. In fiscal year 2023, the national rate included measurements from three fiscal years: 2021, 2022, and 2023.

²⁵This peak, in part, reflects CMS's resumption of measurement of the eligibility component of the rate, which had been frozen from fiscal years 2015 through 2018.

eligibility status changed.²⁶ Thus, payments that would have previously been determined to be improper—for example payments to a provider that had not had their enrollment revalidated—would not be improper under the relaxed requirements. With states beginning to resume standard processes for provider screening and enrollment and eligibility redeterminations in early 2023, the improper payment rate is likely to increase.

Figure 3: Estimated Medicaid Fee-for-Service, Managed Care, and Eligibility Improper Payment Rates, Fiscal Years 2014—2023



Source: Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) data. | GAO-24-107487

Notes: CMS conducts the Payment Error Rate Measurement across all states on a 17-state, 3-year rotation cycle and computes an annual rolling average of improper payment rates from the 3 years of data. Eligibility rates for fiscal years 2015-2018 were frozen at the 2014 level; rates beginning 2021 reflect new eligibility reviews for all states. Rates for fiscal years 2022 and 2023 used data from the time period when the COVID-19 public health emergency was under effect and certain requirements for provider screening and enrollment and eligibility redeterminations were suspended.

²⁶HHS also attributed the decline to improvements in state compliance with requirements. The department could not determine how much of the decline was due to flexibilities granted during the public health emergency versus improvements in state compliance.

Most Medicaid improper payments in fiscal year 2023 (82 percent) were associated with payments for services with missing or insufficient documentation, such as instances where states did not document beneficiary eligibility or the medical necessity of the claim.

As we have reported in prior work, Medicaid improper payment rates may be underestimated. CMS estimates managed care improper payment rates by reviewing the accuracy of capitation payments to managed care plans, but the rate does not account for all program risks. For example, federal and state audits of managed care plans identified overpayments and unallowable costs, such as services that were not medically necessary, or marketing costs that were not identified as part of CMS's improper payment review.

CMS neither conducts medical reviews of services provided to beneficiaries, nor reviews managed care plans' records or data in its review. To the extent that such payments and costs are not removed from the data used to set capitation rates, managed care plans can receive inflated payments. In May 2018, we recommended that CMS take steps to mitigate program risks that were not a part of the Medicaid managed care improper payment measurement, such as overpayments and unallowable costs. CMS agreed with our recommendation and has taken steps to focus additional audit resources on managed care, including by increasing the number of managed care related audits conducted.²⁷

CMS Actions Have Contributed to Declines in Improper Payments in Medicare, but Some Relevant GAO Recommendations Remain Open

CMS has taken a number of actions consistent with our recommendations that have contributed to the decline in estimated Medicare improper payments over the past decade, including the following:

- **Improved prepayment edits.** Prepayment edits are programmed into claims processing systems to compare claims data to Medicare requirements, which allow the agency to approve or deny claims or flag them for further review. CMS centralized the development of

²⁷See GAO, *Medicaid: CMS Should Take Steps to Mitigate Program Risks in Managed Care*, [GAO-18-291](#) (Washington, D.C.: May 7, 2018).

automated edits and created at least 90 edits to ensure Medicare only pays for covered services.²⁸

- **Improved fraud prevention.** In October 2012, we recommended that CMS define quantifiable benefits of its fraud prevention system and complete plans to integrate the system with claims processing.²⁹ In response, CMS defined actual amounts of claims payments denied and costs avoided, and implemented capabilities that automatically stopped payments of certain improper and non-payable claims. We estimated that these changes saved about \$1.77 billion over a 5-year period and continues to save millions annually. In addition, to address fraud risks, CMS developed risk assessment processes for all components of Medicare.³⁰
- **Extended enhanced prior authorization for high-cost items.** In response to our recommendation to evaluate and continue prior authorization efforts, CMS extended a demonstration program in eight states and the District of Columbia that required prior authorization for certain ambulance transports.³¹ We estimated that this extension saved about \$303 million over a 2-year period. As a result, CMS extended the demonstration nationwide in September 2020, which is likely to result in additional savings.

However, we have made a number of other recommendations to CMS that would also help address improper payment rates, but those recommendations have not yet been implemented. This adversely affects the agency's ability to address Medicare program risks, and it reduces the efficiency and effectiveness of existing agency efforts. The recommendations include the following examples:

²⁸For information on related recommendations, see GAO, *Medicare Program Integrity: Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment*, [GAO-13-102](#) (Washington, D.C.: Nov. 13, 2012).

²⁹See GAO, *Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness*, [GAO-13-104](#) (Washington, D.C.: Oct. 15, 2012).

³⁰The processes, for example, document vulnerabilities, risk levels, residual risks, and mitigation strategies and includes monitoring mitigation steps and regularly re-examining vulnerabilities based on risk and environmental factors. 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).

³¹See GAO, *Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending*, [GAO-18-341](#) (Washington, D.C.: Apr. 20, 2018).

Provider enrollment screening. During the COVID-19 public health emergency, CMS postponed provider enrollment revalidations for about 237,000 providers. Revalidations are intended to ensure providers continued to comply with Medicare requirements and ensure that beneficiaries receive services from legitimate providers. In December 2022, we recommended that CMS implement a plan for conducting provider enrollment revalidations, prioritizing moderate- and high-risk provider types.³² CMS agreed with this recommendation. As of February 2024, the agency reported increasing the capacity to perform revalidations, and we are in the process of confirming what actions the agency has taken to ensure providers are revalidated.

Recovering Medicare Advantage improper payments. In April 2016, we reported years long delays in completing audits of Medicare Advantage contracts and other challenges, contributing to an inability to recover identified overpayments from Medicare Advantage organizations.³³ We recommended that CMS take action to enhance the timeliness of the audits and improve the efficiency and effectiveness of reducing and recovering improper payments. HHS concurred with the recommendation.

As of February 2024, CMS had initiated automated reviews and was continuing to explore additional ways to enhance the timeliness of the risk adjustment data validation audit process, according to agency officials. Additionally, the agency's 2024 budget justification described additional steps to improve the timeliness of the audit process. Until CMS completes these steps, it will miss opportunities to recover improper payments.

³²We also reported that CMS waived fingerprint criminal background checks for high-risk providers during the COVID-19 public health emergency. Fingerprint-based criminal background checks are used to identify any criminal convictions for which the individual may or must be excluded from participation in Medicare. We recommended that CMS develop policies to postpone rather than waive fingerprint-based criminal background checks. In response to our recommendation, CMS issued regulations effective January 1, 2024, that authorize the agency to postpone rather than waive fingerprint-based criminal background checks for providers that were in a high-risk category at the time of initial enrollment. The agency is also taking steps to perform the fingerprint-based criminal background checks during its provider revalidations. See GAO, *Medicare: CMS Needs to Address Risks Posed by Provider Enrollment Waivers and Flexibilities*, [GAO-23-105494](#) (Washington, D.C.: Dec. 19, 2022).

³³See GAO, *Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments*, [GAO-16-76](#) (Washington, D.C.: Apr. 8, 2016).

Prepayment Claim Reviews. In April 2016, we recommended that CMS request legislative authority to allow Recovery Auditors to conduct prepayment claim reviews.³⁴ Prepayment reviews prevent improper payments from being made and are generally more cost-effective than postpayment reviews. Additionally, CMS conducted a demonstration from 2012 through 2014 that allowed the Recovery Auditors to conduct prepayment claim reviews, and the agency considered the demonstration a success. HHS did not concur with our recommendation and has not taken any action to request such legislative authority. According to HHS, CMS has other program integrity activities to prevent improper payments. We maintain that allowing Recovery Auditors to conduct prepayment claim reviews will help prevent improper payments.

Assessing documentation requirements. Medicare and Medicaid may require different documentation to support payment for similar services. This may result in differing improper payment rates, complicating CMS's efforts to identify and address program risks. In March 2019, we recommended that CMS take steps to routinely assess documentation requirements to ensure they are both necessary and effective.³⁵ HHS agreed with the recommendation. As of February 2024, CMS stated that the agency was reviewing and assessing how to best implement the recommendation.

In addition, we previously reported in our 2023 biennial High-Risk report, that in its 2022 Agency Financial Report, HHS included targets for further reducing Medicare improper payments and highlighted corrective actions to address root causes of payment errors. However, as we indicated in the report, the action plan does not identify clear metrics to assess progress, resources needed to implement corrective actions, or time frames for completing these actions.³⁶ We continue to discuss with HHS the need to address these concerns as part of our High-Risk work.

³⁴See GAO, *Medicare: Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data*, [GAO-16-394](#) (Washington, D.C.: Apr. 13, 2016).

³⁵See GAO, *Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments*, [GAO-19-277](#) (Washington, D.C.: Mar. 27, 2019).

³⁶See [GAO-23-106203](#).

CMS Has Taken Steps to Address Medicaid Improper Payments, but Relevant GAO Recommendations Remain Open

CMS has taken steps consistent with GAO recommendations aimed at addressing improper payments in the Medicaid program. CMS's steps include the following:

- **Managed care oversight.** In response to our recommendation that CMS remove impediments to collaborative audits, CMS worked with states and audit contractors to improve managed care oversight.³⁷ Audit contractors investigated 893 managed care providers between fiscal years 2019 and 2021, an exponential increase from the 16 investigations they conducted between fiscal years 2016 and 2018. Preliminary results provided by CMS in 2022 indicated that these audits have identified overpayments made by managed care plans to providers.
- **Assessment of program risks.** In 2021 and 2022, CMS developed Risk Assessment Frameworks for Medicaid that outlined its approach for fraud risk assessments to document vulnerabilities, including risk levels and mitigation strategies.³⁸ These actions were consistent with leading practices identified in GAO's Fraud Risk Framework.
- **Accuracy of provider enrollment.** Nearly one quarter, or \$17.8 billion, of Medicaid improper payments in 2020 were related to states' noncompliance with provider screening and enrollment requirements. In June 2021, CMS issued guidance outlining information states were to submit to demonstrate compliance with these requirements, which partially addressed our recommendation that CMS expand its review of states' implementation of those requirements.³⁹ However, CMS allowed states to waive these requirements during the COVID-19 public health emergency, and all states opted to do so.

We have also made a number of recommendations for CMS to address improper payment rates in Medicaid that remain unimplemented. Without taking these additional actions, CMS is missing opportunities to reduce

³⁷See GAO, *Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks*, [GAO-18-528](#) (Washington, D.C.: July 26, 2018).

³⁸For information on related recommendations, see [GAO-18-88](#). In March 2022, CMS also outlined plans to use the fraud risk framework to prioritize risk assessments for program areas such as nonemergency medical transportation. See GAO, *Medicaid: Efforts to Address Fraud in Nonemergency Medical Transportation*, [GAO-22-105447](#) (Washington, D.C.: Sept. 28, 2022).

³⁹See GAO, *Medicaid Providers: CMS Oversight Should Ensure State Implementation of Screening and Enrollment Requirements*, [GAO-20-8](#) (Washington, D.C.: Oct. 10, 2019).

improper payments and safeguard resources intended to provide care for Medicaid beneficiaries.

Recovering Medicaid improper payments. In June 2023, we recommended that CMS enhance the effectiveness of recovery audits, which involve postpayment reviews of claims for improper payments, by taking several actions including conducting a cost-effectiveness study to determine whether states should include payments to managed care organizations as part of the program.⁴⁰ CMS disagreed with this recommendation. According to CMS, it is important that states be able to tailor recovery audit programs to their specific needs and environment and that states have other ways to monitor improper payments in managed care. We maintain that our recommendation for a cost-effectiveness study is valid.

Collaboration with state auditors. State auditors play an important role in Medicaid oversight. In September 2023, we recommended that CMS leverage findings from and improve collaboration with state auditors. Specifically, CMS should use trends in state auditor findings to inform its oversight and share information on those trends and the status of actions to address findings with state auditors. Given their roles and responsibilities—which can include carrying out or overseeing their state’s single audits—state auditors are uniquely positioned to help CMS in its oversight of state Medicaid programs.⁴¹

Through their program integrity reviews, state auditors have identified improper payments in the Medicaid program and deficiencies in the processes used to identify them.⁴² For example:

- State auditors in Ohio found deficiencies in system controls and data accuracy that contributed to about \$119 million in improper payments

⁴⁰See GAO, *Medicaid: CMS Oversight and Guidance Could Improve Recovery Audit Contractor Program*, [GAO-23-106025](#) (Washington, D.C.: June 28, 2023).

⁴¹Single audits are required annually by law when states and other entities expend \$750,000 or more in a fiscal year in federal awards, and they are critical for helping ensure that federal funds are safeguarded and used effectively. A single audit is an audit of the entity’s financial statements and awards for the fiscal year. See 31 U.S.C. § 7502; 2 C.F.R. § 200.501 (2024).

⁴²See GAO, *Medicaid Program Integrity: Opportunities Exist for CMS to Strengthen Use of State Auditor Findings and Collaboration*, [GAO-23-105881](#) (Washington, D.C.: Sept. 21, 2023).

made to managed care plans over a 3-year period for individuals who were incarcerated, deceased, or had multiple identification numbers.

- In a 2020 audit, auditors in Wisconsin questioned over \$428,000 in payments made to providers who had been terminated from participation in the program.

Provider enrollment. As previously noted, our October 2019 report found there was noncompliance with provider screening and enrollment requirements. We recommended that CMS expand its review of states' implementation of provider screening and enrollment requirements and, for states not fully compliant with the requirements, annually monitor their implementation progress.⁴³ CMS agreed with our recommendations. As of December 2023, CMS described technical assistance to states to enhance compliance with requirements. CMS needs to assess all states' compliance with the requirements and assess annually areas of noncompliance to fully implement our recommendations.

In February 2023, states began resuming normal Medicaid operations that were suspended during the COVID-19 public health emergency, such as those related to beneficiary eligibility redeterminations and provider screening and enrollment. Those efforts were ongoing as of March 2024.

In January 2020, before the onset of the COVID-19 pandemic, we reported that state and federal audits across 21 states published between 2014 and 2018 identified weaknesses in states' Medicaid eligibility determinations, including that states did not complete redeterminations (10 states) or terminate coverage for ineligible individuals (nine states) in a timely manner.⁴⁴ And, as previously mentioned, our October 2019 report found substantial noncompliance with provider screening and enrollment requirements.⁴⁵ These preexisting challenges underscore the importance of CMS and states continuing to work together now that the public health emergency has ended to ensure that eligibility determinations and provider screening and enrollment processes are conducted in a manner that ensures Medicaid program integrity.

As CMS and states resume normal operations across both Medicaid and Medicare, it may help to consider actions that other agencies have taken

⁴³See [GAO-20-8](#).

⁴⁴See GAO, *Medicaid Eligibility: Accuracy of Determinations and Efforts to Recoup Federal Funds Due to Errors*, [GAO-20-157](#) (Washington, D.C.: Jan. 13, 2020).

⁴⁵See [GAO-20-8](#).

in efforts to reduce improper payments. In a 2023 report, we identified common features in federal programs that have successfully reduced improper payments.⁴⁶ The most common features in the eight federal agencies with reductions in estimated improper payment rates fell into two broad categories:

- establishing accountability and facilitating internal collaboration; and
- providing technology, tools, and training targeted to root causes.

For example, one agency established a cross-agency corrective action planning group to track all improper payments through root-cause categories in order to take appropriate action on known issues.⁴⁷

Agencies also provided training and technical assistance on topics such as addressing root causes and establishing corrective action plans. Considering these practices in Medicare and Medicaid more broadly could help CMS and states continue to make progress reducing improper payment rates, securing limited resources for the benefit of individuals who rely on these programs.

Implementing Other GAO Recommendations Could Help Improve Oversight of Medicare and Medicaid Program Spending

CMS's and Congress's actions in response to our recommendations have resulted in more accurate and efficient payments, as well as both financial and other benefits to Medicare and Medicaid and beneficiaries.

Specifically, since 2006, these efforts have resulted in more than \$200 billion in financial benefits, including cost savings, as well as over 300 other program improvements.

However, we have made several recommendations to Congress and CMS that, if implemented, could further improve the efficiency of Medicare spending or the agency's oversight of such spending.

Equalizing certain payments. In December 2015, we found that Medicare generally pays more for certain office visits that occur in hospital outpatient departments than those that occur in physician

⁴⁶See GAO, *Improper Payments: Programs Reporting Reductions Had Taken Corrective Actions That Shared Common Features*, [GAO-23-106585](#) (Washington, D.C.: June 30, 2023).

⁴⁷We have previously reported that developing corrective action plans that respond to identified root causes of improper payments is a critical component in government-wide efforts to reduce improper payments. See GAO, *Payment Integrity: Selected Agencies Should Improve Efforts to Evaluate Effectiveness of Corrective Actions to Reduce Improper Payments*, [GAO-20-336](#) (Washington, D.C.: Apr. 1, 2020).

offices.⁴⁸ In order to prevent increasing Medicare costs, we recommended that Congress direct HHS to equalize payment rates for those services. According to the Congressional Budget Office, this would save the Medicare program \$141 billion over 10 years. The Bipartisan Budget Act of 2015 partially addresses this recommendation by limiting certain providers from billing at the higher, outpatient rates.⁴⁹ However, this legislation excluded services furnished by off-campus outpatient departments; as of March 2024, this recommendation has not been fully implemented.⁵⁰ In order to fully implement our recommendation, payment should be equalized, regardless of whether it is considered on- or off-campus.

Payments to cover uncompensated care. Medicare pays hospitals to help cover the costs of care provided to uninsured and other low-income individuals—known as uncompensated care. In June 2016, we found that Medicare’s payments for uncompensated care were not well aligned with the costs that hospitals incur for such care, because, in part, such payments did not account for hospitals’ Medicaid payments that offset uncompensated care costs.⁵¹ We recommended that CMS account for any payments that hospitals have received to cover the costs of uncompensated care under the Medicaid program. This would help ensure that billions of dollars of Medicare uncompensated care payments are based on accurate costs and better target payments to hospitals. While HHS concurred with our recommendation, as of February 2024, the agency was reconsidering its position and had not taken action to

⁴⁸See GAO, *Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform*, [GAO-16-189](#) (Washington, D.C.: Dec. 18, 2015).

⁴⁹Pub. L. No. 114-74, § 603, 129 Stat. 584, 597-598 (2015). See also 21st Century Cures Act, Pub. L. No. 114-255, § 16001, 130 Stat. 1033, 1324 (2016) (excluding services furnished by certain mid-build providers).

⁵⁰This committee proposed and the House of Representatives passed the Lower Costs, More Transparency Act which would equalize payments for certain drug administration services at off-campus hospital outpatient departments if enacted, partially addressing GAO’s matter. H.R. 5378, 118th Cong. (2023).

⁵¹See GAO, *Hospital Uncompensated Care: Federal Action Needed to Better Align Payments with Costs*, [GAO-16-568](#) (Washington, D.C.: June 30, 2016).

implement it. We maintain that implementing our recommendation would better ensure payment accuracy and efficiency.⁵²

Medicare Advantage encounter data. CMS collects Medicare Advantage encounter data—claims-like data collected from Medicare Advantage plans. In June 2022, we reported that CMS was using these data in its methodology for adjusting payments to Medicare Advantage plans, which totaled \$350 billion in 2021.⁵³ In July 2014, we recommended that CMS do more to validate Medicare Advantage encounter data, including by performing statistical analyses and reviewing medical records.⁵⁴ HHS generally agreed with this recommendation, and CMS took some steps to implement it; for example, CMS conducted some analyses of completeness and accuracy for internal purposes. However, as of February 2024, CMS had not shared these analyses with us. Until CMS fully validates the completeness and accuracy of Medicare Advantage encounter data, the soundness of the adjustments to billions of dollars in payments to Medicare Advantage organizations remains unsubstantiated.

Medicare Advantage plan payment adjustments. CMS pays Medicare Advantage plans a predetermined amount per beneficiary that is adjusted for health status, based in part on coded diagnoses. In January 2012, we found that diagnostic coding differences existed between Medicare

⁵²Additionally, we have reported that state payments to Medicaid providers have resulted in surplus Medicaid payments, and may not align with patient volume or costs. Specifically, in February 2016, we reported that nine selected hospitals that received large supplemental payments received average surplus payments of about \$39 million, and used revenues to fund hospital operations, maintenance, and capital purchases, such as a helicopter. We also found that hospitals with relatively low uncompensated care costs received large supplemental payments relative to those costs. We made two recommendations to promote consistency in the distribution of supplemental payments, both of which remain unimplemented. See *Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments*, [GAO-16-108](#) (Washington, D.C.: Feb. 5, 2016).

⁵³See GAO, *Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight*, [GAO-22-106026](#) (Washington, D.C.: June 28, 2022).

⁵⁴See GAO, *Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Assess Data Quality before Use*, [GAO-14-571](#) (Washington, D.C.: July 31, 2014).

Advantage plans and Medicare fee-for-service equivalent to \$3.9 billion to \$5.8 billion in excess payments in 2010.⁵⁵

We recommended that CMS improve the accuracy of its diagnostic coding adjustments to Medicare Advantage plan payments. The agency neither agreed nor disagreed with our recommendation, but made changes that have the potential to improve the accuracy of the diagnostic coding adjustments. For example, CMS began excluding diagnosis codes used for its health status adjustment that were not consistently reported across fee-for-service and Medicare Advantage; this may decrease the size of the adjustment needed to account for diagnostic coding differences between Medicare Advantage plans and Medicare fee-for-service.

However, a modified methodology for calculating diagnostic coding differences that incorporates, for example, more recent data, and incorporates the effect of coding difference trends would better ensure an accurate adjustment in the future. Until CMS analyzes the sufficiency of its adjustments, the agency may be making billions of excess payments to Medicare Advantage plans. As of February 2024, this recommendation remains open.

Telehealth. In response to the COVID-19 pandemic, HHS temporarily waived certain Medicare restrictions on telehealth and use increased dramatically. Both Congress and CMS have taken actions to make certain waiver provisions permanent. While likely benefitting beneficiaries and providers, these program flexibilities also increase certain risks. In September 2022, we found that CMS had not comprehensively assessed the quality of telehealth services, and we recommended they do so.⁵⁶ In November 2022, CMS told us they disagreed with this recommendation and as of March 2024, had not taken action to implement it. We maintain the importance of comprehensively assessing the quality of telehealth services to ensure that services are medically necessary, equitable, and lead to improved health outcomes.

⁵⁵See GAO, *Medicare Advantage: CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices*, [GAO-12-51](#) (Washington, D.C.: Jan. 12, 2012).

⁵⁶See GAO, *Medicare Telehealth: Actions Needed to Strengthen Oversight and Help Providers Educate Patients on Privacy and Security Risks*, [GAO-22-104454](#) (Washington, D.C.: Sept. 26, 2022).

Similarly, additional actions by CMS in areas where we have made recommendations could further improve oversight of Medicaid program spending.

Supplemental payments. Supplemental payments—which totaled \$56.2 billion in 2022—are payments made to providers in addition to regular claims-based payments for specific services.⁵⁷ The Consolidated Appropriations Act, 2021, required additional state reporting on supplemental payments made to eligible providers as we had recommended in November 2012.⁵⁸ CMS subsequently issued guidance outlining the required elements of the reporting, and, according to CMS, states have begun reporting data.

However, this reporting does not include information on the sources of funds used to finance the nonfederal share, as we recommended in December 2020.⁵⁹ Without that information, CMS cannot adequately determine whether payments are (1) consistent with statutory requirements for economy and efficiency, and (2) financed with permissible sources of funds. Having this additional information would better position CMS to effectively oversee states' Medicaid programs and identify potentially impermissible financing and payment arrangements for additional review.

Demonstrations. Demonstrations—which made up about 52 percent of Medicaid spending in fiscal year 2019—allow states and CMS to test new coverage and service delivery options. However, our past work has identified concerns with CMS methods for ensuring that demonstrations

⁵⁷This included supplemental payments made to hospitals and nonhospital providers, such as mental health facilities, nursing homes, and physicians. See the Medicaid and CHIP Payment and Access Commission, “Exhibit 24. Medicaid Supplemental Payments to Hospital Providers by State,” accessed March 29, 2024, <https://www.macpac.gov/publication/medicaid-supplemental-payments-to-hospital-providers-by-state/>; and Medicaid and CHIP Payment and Access Commission, “Exhibit 25. Medicaid Supplemental Payments to Non-Hospital Providers by State,” accessed March 29, 2024, <https://www.macpac.gov/publication/medicaid-supplemental-payments-to-non-hospital-providers-by-state/>.

⁵⁸Pub. L. No. 116-260, div. CC, § 202, 134 Stat. 1182, 2977 (2020). See GAO, *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*, [GAO-13-48](#) (Washington, D.C.: Nov. 26, 2012).

⁵⁹CMS neither agreed nor disagreed with our recommendation but acknowledged the need for additional state Medicaid financing and payment data to oversee the Medicaid program. See GAO, *Medicaid: CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight*, [GAO-21-98](#) (Washington, D.C.: Dec. 7, 2020).

meet the requirement that demonstrations be budget neutral—that is, they must not increase federal costs. For example, in January 2008, we recommended that Congress consider establishing statutory requirements for HHS to more clearly outline the methods used to demonstrate budget neutrality.⁶⁰ In June 2013, we made a recommendation to CMS to ensure valid methods are used to set demonstration spending limits.⁶¹

Congress has not taken action to address our recommendation, but CMS has made some progress. In response to our recommendation, in 2016, CMS began implementing a series of policy changes to better ensure budget neutrality, which has resulted in significant reductions in federal liabilities. CMS's first change limited the amount of accrued unspent funds states could carry over from one demonstration period to the next. This reduced demonstration spending limits by an estimated \$210 billion from 2016 through 2020, of which the federal share was more than \$124 billion. In 2021, CMS began implementing additional changes to ensure that appropriate base data were being used to set demonstration spending limits at renewal. CMS estimated that these changes would further reduce spending limits by about \$106 billion in fiscal years 2023 through 2027, of which we estimate the federal share would be more than \$60 billion.⁶²

Not all problems related to budget neutrality for demonstrations that we identified were addressed by CMS's new policies. Congressional action to require HHS to improve the review process, and additional actions by CMS to ensure valid methods are used to set spending limits, could result in significant savings.

State directed payments. Using state directed payments, states can direct how managed care plans pay providers, including requiring payments in addition to negotiated base payments. Rapid growth in state directed payments reached at least \$38.5 billion in 2022, the sixth year of state use. In a December 2023 report we found that CMS has insufficient

⁶⁰See GAO, *Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns*, [GAO-08-87](#) (Washington, D.C.: Jan. 31, 2008).

⁶¹HHS initially disagreed with our 2013 recommendation on spending limits. As of February 2024, the recommendation remained partially addressed. See GAO, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency*, [GAO-13-384](#) (Washington, D.C.: June 25, 2013).

⁶²CMS's estimates for the effects on spending limits were limited to three states. According to CMS, the agency has applied the policy for other states.

fiscal guardrails for approving those payments and recommended that CMS enhance those guardrails.⁶³ In May 2023, CMS issued proposed rules, in part, to enhance fiscal oversight of state directed payments. To address our recommendation, any final rules would need to establish standards for determining whether proposed payments are reasonable and appropriate, and require states to submit data on actual spending when seeking to renew payments.

Chairman Griffith, Ranking Member Castor, and Members of the Subcommittee, this concludes my statement. I would be pleased to respond to questions.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact Jessica Farb at (202) 512-7114 or farbj@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made contributions to this testimony include Susan Barnidge and Shannon Legeer (Assistant Directors), Hannah Locke and Kate Nast Jones (Analysts-in-Charge), Drew Long, and Ethiene Salgado-Rodriguez. Other contributors included Dean Campbell, Kevin Dong, Gabrielle Fagan, Dan Flavin, Laura Tabellion, Matt Valenta, and Jennifer Whitworth.

⁶³See GAO, *Medicaid Managed Care: Rapid Spending Growth in State Directed Payments Needs Enhanced Oversight and Transparency*, [GAO-24-106202](#) (Washington, D.C.: Dec. 14, 2023).

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The Nation's Fiscal Health: Road Map Needed to Address Projected Unsustainable Debt Levels. [GAO-24-106987](#). Washington, D.C.: February 15, 2024.

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