



## Testimony

Before the Subcommittee on Health,  
Committee on Energy and Commerce,  
House of Representatives

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# MEDICAID

## Additional Federal Controls Needed to Improve Accuracy of Eligibility Determinations and for Coordination with Exchanges

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

I am pleased to be here today to discuss our recent reports that are being released today examining issues related to federal oversight of Medicaid eligibility determinations and coordination between Medicaid and the exchanges.<sup>1</sup>

Beginning in 2014, the Patient Protection and Affordable Care Act (PPACA) provided millions of low-income Americans new options for obtaining health insurance coverage—through the Medicaid program or by purchasing private health insurance through an exchange.<sup>2</sup>

- As one of the largest sources of health care coverage in the nation, Medicaid covered about 72 million individuals in fiscal year 2013. Under PPACA, states could choose to expand coverage to eligible individuals whose incomes are at or below 133 percent of the federal poverty level (FPL).<sup>3</sup> Both states and the federal government share in the financing of Medicaid, with increased federal matching funds available for enrollees covered under the expansion beginning in January 2014. To receive the increased matching funds, states must provide data on Medicaid enrollment and expenditures to the Centers

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<sup>1</sup>GAO, *Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds*, [GAO-16-53](#) (Washington, D.C.: October 16, 2015) and GAO, *Medicaid and Insurance Exchanges: Additional Federal Controls Needed to Minimize Potential for Gaps and Duplication in Coverage*, [GAO-16-73](#) (Washington, D.C.: October 9, 2015).

<sup>2</sup>Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010). For the purposes of this testimony, references to PPACA include the amendments made by HCERA.

<sup>3</sup>For the purposes of this testimony, we consider the District of Columbia a state. Medicaid is a joint federal-state program that finances health insurance coverage for certain categories of low-income and medically needy individuals. PPACA provides for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases this income level to 138 percent of the FPL.

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for Medicare & Medicaid Services (CMS), which oversees Medicaid.<sup>4</sup> As of September 2015, 30 states had expanded their Medicaid programs.<sup>5</sup>

- PPACA required the establishment of health insurance exchanges—that is, marketplaces where eligible individuals may compare and select among private health plans—in all states and provided for federal subsidies to assist qualifying low-income individuals in paying for exchange coverage.<sup>6</sup> States may elect to establish and operate an exchange, known as a state-based exchange, or allow CMS—which is responsible for overseeing the exchanges—to do so within the state, known as a federally facilitated exchange (FFE).<sup>7</sup> As of March 2015, CMS operated an FFE in 34 states, and 17 states were approved to operate state-based exchanges.<sup>8</sup>

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<sup>4</sup>CMS is an agency within the Department of Health and Human Services (HHS). The federal government matches most state expenditures for Medicaid services on the basis of a statutory formula based in part on a state's per capita income. Federal law specifies that this federal match may range from 50 to 83 percent. Under PPACA, increased federal matching rates are available for individuals who were not eligible for Medicaid under historic eligibility rules but receive coverage through (1) a state option to expand Medicaid under PPACA, or (2) a state's qualifying expansion of coverage prior to PPACA's enactment.

<sup>5</sup>An additional state, Montana, took steps to expand its Medicaid program, with the expansion pending federal approval. See Kaiser Family Foundation State Health Facts, "Status of State Action on the Medicaid Expansion Decision," updated September 1, 2015, accessed October 14, 2015, <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

<sup>6</sup>CMS commonly refers to the exchanges as marketplaces. Where we discuss exchanges in this testimony, we are referring only to the individual exchanges, rather than the small business exchanges also required under PPACA. We refer to health plans purchased through the exchanges as exchange coverage and enrollment in exchange coverage with federal subsidies as subsidized exchange coverage. Federal subsidies for exchange coverage include premium tax credits, which are available to eligible individuals with incomes between 100 and 400 percent of the FPL and who do not have access to minimum essential coverage, including most Medicaid coverage. In addition, subsidies may include cost-sharing reductions for eligible individuals with incomes between 100 and 250 percent of the FPL. Medicaid plans that provide less than full benefits do not constitute minimum essential coverage and therefore do not preclude individuals from being eligible for subsidized exchange coverage.

<sup>7</sup>In this testimony, we refer to states with federally facilitated exchanges as FFE states.

<sup>8</sup>States with state-based exchanges may use the FFE information technology systems for eligibility and enrollment functions. In 2014, two states with state-based exchanges used the FFE information technology systems for eligibility and enrollment, while in 2015 three states with state-based exchanges did so.

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Many low-income individuals experience income volatility and are therefore likely to transition between Medicaid and subsidized exchange coverage. PPACA required the creation of a coordinated eligibility and enrollment process for Medicaid and the exchanges to streamline the eligibility determination process and to ensure that individuals are (1) enrolled in the coverage for which they are eligible, and (2) transferred to the appropriate form of coverage if their eligibility changes. Streamlining eligibility determinations necessitated the adoption of new policies and information technology systems by the states, and can require significant coordination between states and the federal government. Previous research has estimated that 6.9 million, or 7 percent, of individuals who receive either Medicaid or exchange subsidies will experience a change in eligibility from one to the other each year.<sup>9</sup> Given the complexity of designing coordinated policies and systems to facilitate Medicaid and exchange eligibility and enrollment, challenges could arise during the transition process. In particular, individuals may experience gaps in coverage, which can lead to individuals forgoing necessary care, or become simultaneously enrolled in both Medicaid and subsidized exchange coverage (referred to as duplicate coverage), which is generally not permitted under federal law.<sup>10</sup> Careful CMS oversight is crucial to ensure that determinations of Medicaid eligibility are appropriate, and that the risk of coverage gaps and duplicate coverage is minimized for individuals transitioning between the coverage types.

My statement draws from two reports that are being released today and will focus on:

1. CMS oversight of state enrollment of beneficiaries, and reporting of expenditures; and
2. the extent to which CMS and states had policies and procedures to minimize the potential for coverage gaps and duplicate coverage when individuals transition between Medicaid and exchange coverage.

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<sup>9</sup>See M. Buettgens, A. Nichols, and S. Dorn. *Churning Under the ACA and State Policy Options for Mitigation*, (Washington, D.C.: Urban Institute and Robert Wood Johnson Foundation, June 2012).

<sup>10</sup>Individuals enrolled in subsidized exchange coverage who are found to be eligible for Medicaid are permitted to be enrolled in both types of coverage through the end of the month of the eligibility determination. See 26 U.S.C. § 36B(c)(2)(A)-(B); 26 C.F.R. § 1.36B-2(c)(iv).

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To examine CMS oversight of state enrollment of beneficiaries and reporting of expenditures, we examined relevant federal laws and regulations, federal internal control standards,<sup>11</sup> CMS guidance and oversight tools, and interviewed CMS officials.<sup>12</sup> To examine the extent to which the federal government and states had policies and procedures that minimize the potential for coverage gaps and duplicate coverage, we reviewed relevant federal regulations and guidance, FFE documentation, and federal internal control standards, and interviewed CMS officials. We also collected information from eight states selected, among other factors, to include four FFE states.<sup>13</sup> The work upon which this statement is based was conducted in accordance with generally accepted government auditing standards.

In brief, while CMS has taken some actions, we found gaps in its oversight of Medicaid enrollment resulting from the PPACA expansion. CMS is missing opportunities that per federal internal control standards would better ensure the accuracy of eligibility determinations in all states, and also ensure that Medicaid expenditures for different eligibility groups are appropriately matched with federal funds. In regard to coordination between Medicaid and the exchanges, CMS implemented several policies and procedures, and has additional controls planned that represent positive steps toward minimizing the potential for coverage gaps and duplicate coverage in FFE states. However, as per federal internal control standards, those plans do not sufficiently address the risks. These gaps are further described below.

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## Oversight of Medicaid Enrollment

CMS has implemented interim measures to review the accuracy of state eligibility determinations and examine states' expenditures for different eligibility groups, for which states may receive up to three different federal matching rates. However, we found that CMS has excluded from review federal Medicaid eligibility determinations in the states that have delegated authority to the federal government to make Medicaid eligibility

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<sup>11</sup>Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives. See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

<sup>12</sup>For additional information on our methodology, see [GAO-16-53](#).

<sup>13</sup>For additional information on our methodology, see [GAO-16-73](#).

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determinations through the FFE. As a result, we determined that this creates a gap in efforts to ensure that only eligible individuals are enrolled into Medicaid, and that state expenditures are appropriately matched by the federal government.

In addition, we found that CMS reviews of states' expenditures do not use information obtained from the reviews of state eligibility determination errors to better target its review of Medicaid expenditures for the different eligibility groups. An accurate determination of these different eligibility groups is critical to ensuring that only eligible individuals are enrolled, that they are enrolled in the correct eligibility group, and that states' expenditures are appropriately matched with federal funds for Medicaid enrollees. Consequently, we concluded that CMS cannot identify erroneous expenditures due to incorrect eligibility determinations, which also limits its ability to ensure that state expenditures are appropriately matched with federal funds.

To improve the effectiveness of its oversight determinations and increase assurances that states receive an appropriate amount of federal matching funds, we recommended that CMS (1) review federal determinations of Medicaid eligibility for accuracy, and (2) use the information obtained from state and federal eligibility reviews to inform the agency's review of expenditures for different eligibility groups in order to ensure that expenditures are reported correctly and appropriately matched. The agency generally concurred with our recommendations.

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## Coordination between Medicaid and Exchanges

CMS's policies and procedures do not sufficiently minimize the potential for coverage gaps and duplicate coverage in FFE states. We found that individuals transitioning from Medicaid to exchange coverage may experience coverage gaps, for example, if they lose Medicaid eligibility toward the end of a month. Individuals who experience coverage gaps may decide to forgo necessary care. In addition, we found that some individuals had duplicate coverage. While some amount of duplicate coverage is permissible under federal law—and may be expected during the transition from exchange to Medicaid coverage—we found that duplicate coverage was also occurring under other scenarios, such as when individuals do not end their subsidized exchange coverage after being determined eligible for Medicaid. Individuals may be held liable for repaying certain exchange subsidies received during the period of duplicate coverage. Further, the federal government could be paying twice—subsidizing exchange coverage and reimbursing states for Medicaid spending—for individuals enrolled in both types of coverage.

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While CMS has implemented policies and procedures that help minimize the potential for coverage gaps and duplicate coverage, we identified weaknesses in CMS's controls for FFE states based on federal internal control standards.<sup>14</sup> Specifically, we found that CMS's controls do not provide reasonable assurance that accounts—that is, electronic records—for individuals transitioning from Medicaid to exchange coverage in FFE states are transferred in near real time, putting individuals at greater risk of experiencing coverage gaps. In addition, we found weaknesses in CMS's controls for preventing, detecting, and resolving duplicate coverage in FFE states—for example, CMS had no specific plan for monitoring the effectiveness of planned periodic checks for duplicate coverage, making it difficult for the agency to provide reasonable assurance that its procedures are sufficient or whether additional steps are needed.

Our findings based on three states in 2014 also indicate that a relatively small proportion of Medicaid and exchange enrollees transitioned between the coverage types in 2014, and thus the incidence of coverage gaps and duplicate coverage could be limited. However, to the extent that transitions increase in the future—particularly if exchange enrollment continues to grow and if additional states expand Medicaid—improvements to CMS controls to minimize coverage gaps and duplicate coverage will be increasingly important.

To better minimize the risk of coverage gaps and duplicate coverage for individuals transitioning between Medicaid and the exchanges in FFE states, we recommended that CMS take three actions, including (1) routinely monitoring the timeliness of account transfers from states, (2) establishing a schedule for regular checks for duplicate coverage, and (3) developing a plan to monitor the effectiveness of the checks. The agency concurred with our recommendations and summarized planned steps to address these risks.

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<sup>14</sup>Consistent with federal internal control standards, in its responsibilities for administering and overseeing Medicaid and the exchanges, CMS should design and implement necessary policies and procedures to achieve agency objectives and assess program risk. These policies and procedures should include internal controls, such as conducting monitoring to assess performance over time, that provide reasonable assurance that an agency has effective and efficient operations, and that program participants are in compliance with applicable laws and regulations.

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

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## GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Carolyn L. Yocom, Director, Health Care at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Susan Barnidge, Assistant Director; Robert Copeland, Assistant Director; Priyanka Sethi Bansal; Corissa Kiyon; Drew Long; and Jessica L. Preston.



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