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MEDICAID INTEGRITY

Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud, Waste, and Abuse

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Highlights

Highlights of GAO-06-578T, a testimony before the Subcommittee on Federal Financial Management, Government Information, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate

Why GAO Did This Study

Today's hearing concerns fraud, waste, and abuse control in Medicaid, a program that provides health care coverage for over 56 million eligible low-income people and is jointly financed by the federal government and the states. In fiscal year 2004, Medicaid had benefit payments of $287 billion, with a federal share of about $168 billion.

The states are primarily responsible for ensuring appropriate Medicaid payments through provider enrollment screening, claims review, overpayment recovery, and case referral to law enforcement. At the federal level, the Centers for Medicare & Medicaid Services (CMS) is responsible for supporting and overseeing state fraud, waste, and abuse control activities.

The Subcommittee requested information on how CMS and the states can better serve taxpayers and beneficiaries by reducing Medicaid fraud. This statement will focus on existing concerns about CMS's efforts to help states prevent and detect fraud, waste, and abuse; how provisions in recent legislation providing for a Medicaid Integrity Program will help CMS expand its current efforts; and challenges CMS needs to address as it implements new Medicaid Integrity Program efforts.

www.gao.gov/cgi-bin/getrpt?GAO-06-578T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600 or aronovitzl@gao.gov.

What GAO Found

As GAO testified in 2005, there has been a wide disparity between the level of staff and financial resources that CMS has expended to support and oversee state activities to control fraud and abuse and the amount of federal dollars at risk in Medicaid benefit payments. In fiscal year 2005, CMS dedicated an estimated 8.1 full-time equivalent employees to support states in their anti-fraud-and-abuse operations. In contrast, the federal government spent over $168 billion for Medicaid benefits in fiscal year 2004. Further, resource shortages severely limited two efforts that had shown potential to help states prevent and detect fraud, waste, and abuse. In addition to devoting limited staff and financial resources, CMS lacked a strategic plan to direct its anti-fraud-and-abuse efforts.

Enacted in February 2006, the Deficit Reduction Act of 2005 (DRA) provided for creation of the Medicaid Integrity Program and includes specific appropriations that CMS can use to fund activities to support anti-fraud-and-abuse efforts. It also included provisions that will address the agency's staffing and planning limitations related to Medicaid program integrity. For example, the law requires CMS to add 100 employees to work with states in support and oversight of their Medicaid program integrity efforts and to develop a comprehensive plan to explain how the agency will address Medicaid fraud, waste, and abuse. In addition, the DRA provided funds to expand a program that is designed to identify program vulnerabilities in Medicaid and Medicare—the federal health insurance program for the elderly and some disabled people—by examining billing and payment abnormalities in both programs.

In implementing the DRA provisions related to the Medicaid Integrity Program, CMS has a unique opportunity to strengthen its leadership of state and federal efforts to control fraud, waste, and abuse in the Medicaid program. The most immediate challenge will be to develop its comprehensive plan that will provide strategic direction for CMS, the states, and law enforcement partners.