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MEDICAID FRAUD AND ABUSE

CMS's Commitment to Helping States Safeguard Program Dollars Is Limited

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Highlights

Highlights of GAO-05-855T, a testimony before the Committee on Finance, U.S. Senate

Why GAO Did This Study

Today's hearing addresses fraud and abuse control in Medicaid, a program that provides health care coverage for eligible low-income individuals and is jointly financed by the federal government and the states. In fiscal year 2003, Medicaid covered nearly 54 million people and the program's benefit payments totaled roughly $261 billion, of which the federal share was about $153 billion.

States are primarily responsible for ensuring appropriate payments to Medicaid providers through provider enrollment screening, claims review, overpayment recoveries, and case referrals. At the federal level, the Centers for Medicare & Medicaid Services (CMS) is responsible for supporting and overseeing state fraud and abuse control activities. Last year, GAO reported that CMS had initiatives to assist states, but the dollar and staff resources allocated to oversight suggested that CMS's level of effort was disproportionately small relative to the risk of federal financial loss.

Concerned about the stewardship of federal Medicaid funds, this Committee has raised questions about CMS's commitment to Medicaid fraud and abuse control. This statement focuses on (1) the level of resources CMS currently applies to helping states prevent and detect fraud and abuse in the Medicaid program and (2) the implications of this level of support for CMS fraud and abuse control activities.

www.gao.gov/cgi-bin/getrpt?GAO-05-855T.

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.

What GAO Found

Since GAO reported last year, the resources CMS expends to support and oversee states' Medicaid fraud and abuse control activities remain out of balance with the amount of federal dollars spent annually to provide Medicaid benefits. In fiscal year 2005, CMS's total staff resources allocated to these activities was about 8.1 full-time equivalent (FTE) staffing units—approximately 3.6 FTEs at headquarters and 4.5 FTEs in the regional offices. Among CMS's 10 regional offices—each of which oversees states whose Medicaid outlays include billions of federal dollars—7 offices each have a fraction of an FTE and the rest each have less than 2 FTEs allocated to Medicaid fraud and abuse control efforts. Moreover, the placement of the Medicaid fraud and abuse control staff at headquarters—apart from the agency's office responsible for other antifraud and abuse activities—as well as a lack of specified goals for Medicaid fraud and abuse control raise questions about the agency's level of commitment to improve states' activities in this area.

CMS's support and oversight initiatives include a pilot project for states to enhance claims scrutiny activities by coordinating with the Medicare program. Despite the project's positive results in several states, less than one-fifth of the states currently participate in the project and resource constraints may require CMS to scale back these efforts instead of expanding them to additional states that are seeking to participate. Similarly, CMS's support activities—such as conducting national conferences, regional workshops, and training—have been terminated altogether. The frequency of CMS's on-site reviews of states' fraud and abuse control activities—about seven to eight visits a year—has not changed since GAO reported on this last year. This means that federal oversight of a state's Medicaid program safeguards will not occur, at best, more than once every 7 years.

Relatively few and questionably aligned resources and an absence of strategic planning underscore the limited commitment CMS has made to strengthening states' ability to curb fraud and abuse. Despite the millions of dollars CMS receives annually from a statutorily established fund for fraud and abuse control, the agency has not allocated these resources to sufficiently fund initiatives that can help states increase the effectiveness of their Medicaid fraud and abuse control efforts. Developing a strategic plan for Medicaid fraud and abuse control activities would give CMS a basis for providing resources that reflect the financial risk to the federal government.

In discussing the facts in this statement with a CMS Medicaid official, he stated that the agency does not view antifraud and abuse initiatives as separate from financial oversight, an area that has received substantial resources in recent years. While we agree that financial management is important to program integrity, we believe that an increased commitment to helping states fight fraud and abuse is warranted.