



April 2020

MEDICAID

State Views on Program Administration Challenges

Why GAO Did This Study

Medicaid—a joint federal-state health care financing program—is administered at the state level and overseen at the federal level by CMS. Since 2003, GAO has designated Medicaid as a high-risk program due to concerns related to adequacy of fiscal oversight, among other concerns. The Medicaid program has evolved considerably in areas such as eligibility, service delivery, and payment methods. Given these and other changes to Medicaid over time, stakeholders have questions about the impact of the range and complexity of federal Medicaid policies on states' ability to efficiently administer their programs.

GAO was asked to assess a range of federal Medicaid policies. This report describes (1) states' perspectives on any challenges related to federal Medicaid policies, including laws, regulations, and procedures; and (2) considerations for any related federal action to address the identified challenges.

GAO interviewed Medicaid officials from 50 states and the District of Columbia to obtain information on challenges related to Medicaid program areas, Medicaid waiver processes, and Medicaid reporting requirements. GAO also obtained input from CMS officials on state-identified challenges, reviewed CMS documents and prior GAO work, and reviewed publications from organizations representing Medicaid providers and beneficiaries.

The Department of Health and Human Services provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View [GAO-20-407](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

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What GAO Found

In interviews with GAO, a majority of Medicaid officials from the 50 states and the District of Columbia (hereafter, states) identified federal Medicaid policies—including laws, regulations, and procedures—in four program areas that posed a significant or moderate challenge to effective program administration. Of note:

- **Coverage exclusions and care coordination.** Officials from 47 states identified challenges with a policy that generally excludes Medicaid coverage for residents of institutions for mental diseases. State officials cited this coverage exclusion as a barrier to their ability to use Medicaid funds to provide a full continuum of care to beneficiaries with complex health care needs, including mental health or substance use treatment needs.
- **Covered benefits and eligibility.** Officials from 39 states identified challenges related to the requirement for coverage of outpatient prescription drugs, noting that newer drugs are often higher cost and may not yet have an established clinical benefit.
- **Medicare and Medicaid alignment.** Officials from 42 states identified challenges related to integrating care for beneficiaries eligible for both Medicare and Medicaid, due in part to differences between the programs.
- **Payment methods.** Officials from 27 states identified challenges with the requirement to pay federally qualified health centers and rural health clinics based on historic costs, citing higher payments than for other providers.

State officials also reported challenges with the processes for obtaining federal approval to waive certain statutory Medicaid requirements, citing lengthy delays and insufficient guidance. Finally, state officials identified challenges with some federal reporting requirements, including concerns about whether certain reported data are useful for program oversight.

The Centers for Medicare & Medicaid Services (CMS) recognizes many of the challenges identified by state officials and has taken steps to address some of them. Based on its prior work and the perspectives of others, GAO identified broader considerations for any potential federal actions to address these challenges, including tradeoffs and considerations related to the following:

- **Targeting oversight to critical areas.** GAO, state officials, and others noted the importance of targeting federal oversight to ensure beneficiary access and quality of care. In addition, GAO's prior work identified the need to target oversight to reduce improper payments and manage other program risks.
- **Leveraging Medicaid data.** Accurate and complete data on key measures—such as beneficiary access, service use, and related costs—are critical for informing any potential change to Medicaid policies.
- **Balancing federal oversight with state flexibility.** Balancing states' ongoing efforts to waive statutory requirements with an appropriate level of oversight is another consideration. GAO's prior work has identified multiple instances where improved oversight of such efforts was warranted.

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Abbreviations

| | |
|--------|---|
| CMS | Centers for Medicare & Medicaid Services |
| FMAP | Federal Medical Assistance Percentage |
| FQHC | federally qualified health center |
| HCBS | home- and community-based services |
| HHS | Department of Health and Human Services |
| IMD | institution for mental diseases |
| LTSS | long term services and supports |
| MACPAC | Medicaid and CHIP Payment and Access Commission |
| MCO | managed care organization |
| PPACA | Patient Protection and Affordable Care Act |
| RHC | rural health clinic |
| SSA | Social Security Act |
| SUD | substance use disorder |
| T-MSIS | Transformed Medicaid Statistical Information System |

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April 30, 2020

The Honorable Greg Walden
Republican Leader
Committee on Energy and Commerce
House of Representatives

The Honorable Michael C. Burgess, M.D.
Republican Leader
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Brett Guthrie
House of Representatives

Medicaid, a joint federal-state health care financing program, plays an important role in providing health care coverage for low-income and medically needy individuals. In fiscal year 2018, Medicaid covered an estimated 75 million beneficiaries with expenditures totaling approximately \$629 billion. Both the federal government and the states administer the program, including sharing responsibility for ensuring its fiscal integrity and that beneficiaries have access to quality care. Medicaid allows significant flexibility for states to design and implement their programs within broad federal requirements. For example, states can request waivers of certain federal requirements to target certain populations or to test new or innovative approaches for managing the health care needs of beneficiaries. The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid, monitors states' compliance with relevant requirements.

The Medicaid program has evolved considerably over time. For example, states have changed how they deliver and pay for services to Medicaid beneficiaries by increasingly contracting with managed care plans. States have also changed how they deliver long-term care services, moving from providing care predominantly in institutions—such as nursing homes—to providing more services in beneficiaries' homes or in other community-based settings. In addition, Medicaid eligibility has historically been limited to certain categories of low-income individuals, such as children, parents, pregnant women, and individuals who have disabilities or who are aged 65 and older. Beginning in 2014, the Patient Protection and

Affordable Care Act (PPACA) permitted states to expand their Medicaid programs beyond these categories to cover certain low-income adults; since then, more than half of the states have expanded their Medicaid programs.¹ Other factors—such as the aging of the population, the growth of high-cost prescription drugs, and the emergence of an opioid public health crisis—are posing challenges for the Medicaid program. Since 2003, we have designated Medicaid as a high-risk program, in part, because of concerns about the adequacy of fiscal oversight.²

Given these changes to Medicaid over time, stakeholders have questions regarding the impact of the range and complexity of federal Medicaid laws, regulations, or procedures—hereafter referred to as federal Medicaid policies—on states’ ability to efficiently administer their programs.

You asked us to obtain state Medicaid officials’ and stakeholders’ views on opportunities to improve the efficiency and effectiveness of the Medicaid program with respect to a range of federal Medicaid policies. This report describes

1. state perspectives on any challenges related to federal Medicaid policies, and
2. considerations for any federal action to address the identified challenges.

To describe state perspectives on any challenges related to federal Medicaid policies, we conducted semi-structured interviews with Medicaid officials from all 50 states and the District of Columbia.³ To determine the Medicaid policies to discuss with state officials, we reviewed our prior

¹Under PPACA, states may opt to expand their Medicaid programs to cover non-elderly, non-pregnant adults who are not eligible for Medicare, and whose income does not exceed 133 percent of the federal poverty level. Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). PPACA provided for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases income eligibility from 133 percent to 138 percent of the federal poverty level. PPACA also permitted an early expansion option, whereby states could expand eligibility for this population, or a subset of this population, starting on April 1, 2010.

²See GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, [GAO-19-157SP](#) (Washington, D.C.: Mar. 6, 2019).

³In this report, “state” refers to the 50 states and the District of Columbia.

Medicaid reports, as well as publications from the Medicaid and CHIP Payment and Access Commission (MACPAC) and others, and interviewed representatives from six national associations representing a variety of states' interests.⁴ We also reviewed CMS's compilation of current and pending section 1115 demonstrations, as of September 2018, and examples of current section 1915 waivers, as of November 2018.⁵ Based on this background research, we identified federal Medicaid policies that we grouped into three broad categories: (1) program areas, such as coverage and eligibility; (2) waiver and demonstration processes; and (3) reporting requirements. For the program areas category, we asked state officials to identify the extent to which, if at all, each policy posed a challenge for effective program administration, and to describe the nature of challenges of greatest concern.⁶ For the second category, we asked state officials whether they had experienced any challenges related to section 1115 demonstration and section 1915 waiver review processes, and to identify factors contributing to the challenges. For the third category, we asked state officials to identify any federal Medicaid reporting requirements that they considered to be overly burdensome.⁷ We also asked state officials to offer suggestions for addressing the challenges they identified. We did not independently assess the merits, costs, or other effects of state-suggested strategies.

⁴These organizations were the National Association of Medicaid Directors, National Governors Association, ADvancing States, National Association of State Directors of Developmental Disabilities Services, National Association of State Mental Health Program Directors, and the National Conference of State Legislatures.

⁵Under section 1115 of the Social Security Act (SSA), the Secretary of HHS may waive certain federal Medicaid requirements and approve expenditures that would not otherwise be eligible for federal Medicaid funds for certain experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to promote Medicaid objectives. Under section 1915(c) of the SSA, the Secretary of HHS may waive requirements that states offering home- and community-based services offer comparable benefits statewide and to all eligible beneficiaries, and that they use a single standard for eligibility. Section 1915(b) provides states with the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewideness, and freedom of choice.

⁶Specifically, we asked state officials to provide their perspectives on whether the policies posed a significant challenge, moderate challenge, minor challenge, or were not at all a challenge for effective program administration.

⁷We defined overly burdensome reporting requirements as Medicaid reporting requirements established by Congress or CMS that the states viewed as being too costly, vague, complicated, paperwork-heavy, unnecessary, or duplicative.

To describe considerations for any federal action to address the identified challenges, we reviewed pertinent laws and regulations, as well as our prior reports and recommendations pertaining to policies identified as challenging. A list of related products is included at the end of this report. We also reviewed information reported by state Medicaid officials in the interviews noted above, obtained input from CMS officials on state challenges, and reviewed CMS guidance and documentation. Finally, we reviewed the websites of 85 national organizations with Medicaid-related experience, including provider associations, beneficiary advocates, and public policy organizations (hereafter, stakeholders) to review their relevant publications or policy positions related to the challenges identified by states.⁸ The considerations we identified are not exhaustive, but highlight the need to account for varying perspectives on any potential changes to federal Medicaid policy.

We conducted this performance audit from June 2018 to April 2020 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

Medicaid Program Design

Medicaid allows significant flexibility for states to design and implement their programs. Each state is required to have a Medicaid state plan—reviewed and approved by CMS—that describes how the state will administer its Medicaid program within broad federal guidelines. In establishing these plans, states have some discretion in setting Medicaid eligibility standards and provider payment rates; determining the amount, scope, and duration of covered benefits, and how these benefits are

⁸We identified these 85 national organizations by reviewing the published list of commenters on a recent CMS Notice of Proposed Rulemaking related to Medicaid: *Medicaid and Children's Health Insurance Plan (CHIP) Managed Care* 83 Fed. Reg. 57,264 (Nov. 14, 2018). We then reviewed the websites of these organizations to identify publicly available Medicaid-related policy publications.

delivered; and developing their own administrative structures.⁹ (See table 1.)

Table 1: Examples of State Flexibilities in Medicaid Program Design

| Eligibility | Services | Payment |
|--|---|--|
| <p>Subject to federal requirements, states determine covered populations.</p> <ul style="list-style-type: none"> States are required to cover certain categories of low-income individuals, such as pregnant women, parents and children, and individuals who are age 65 and over or who have disabilities. States can opt to expand Medicaid to cover certain childless adults with incomes at or below 133 percent of the federal poverty level. | <p>Subject to federal requirements, states determine the amount, scope, and duration of covered services.</p> <ul style="list-style-type: none"> States must cover a wide array of mandatory services, which include inpatient hospital services, physician services, and nursing facility services. States may cover additional optional services, such as prescription drugs. States may require certain beneficiaries to share in the cost of coverage, provided the total amount of premiums and cost sharing incurred does not exceed certain thresholds. | <p>Subject to federal requirements, states establish provider payment systems and rates.</p> <ul style="list-style-type: none"> States may pay providers for each service on a fee-for-service basis. States may pay managed care organizations based on a predetermined, per beneficiary, per month basis. States may use alternative payment methods, such as performance based payments for providers that achieve specified quality goals, or bundled payments for episodes of care, to incentivize improved care quality. States generally must pay federally qualified health centers and rural health clinics under a prospective payment system that pays each facility a fixed, per-visit rate based on its historical costs. |

Source: GAO analysis of federal laws and regulations. | GAO-20-407

As a program for low-income and medically needy populations, Medicaid covers a range of services that may be important for individuals with complex needs, such as behavioral health services, long term services and supports (LTSS), and services for individuals who are eligible for both Medicare and Medicaid. Specifically:

- Medicaid is the nation’s largest payer for behavioral health services, which refer to treatment for mental health conditions and substance use disorder (SUD), such as opioid use disorder. Treatment includes an array of options ranging from less to more intensive, and may include prevention services, screening and assessment, outpatient treatment, inpatient treatment, and emergency services.

⁹For example, states may pay health care providers for each service they provide on a fee-for-service basis; contract with managed care organizations (MCO) to provide a specific set of Medicaid-covered services to beneficiaries; or rely on a combination of both delivery systems. The percentage of beneficiaries served through MCOs has grown and represented nearly 70 percent of all Medicaid beneficiaries in 2017.

-
- Medicaid is also the nation’s largest payer for LTSS, which comprise a broad range of health care, personal care, and supportive services to help individuals who have a limited ability to care for themselves. For example, LTSS can help individuals perform routine daily activities, such as eating, dressing, bathing, and making meals. LTSS includes services in institutional settings, such as nursing facilities, and services delivered outside of institutional settings, known as home- and community-based services (HCBS). National Medicaid spending for HCBS as a percentage of LTSS spending surpassed the percentage spent on institutional care in fiscal year 2013 and has continued to grow since that time.¹⁰
 - Medicaid beneficiaries who are age 65 and over or who have disabilities may be enrolled in Medicare as well and are referred to as dual-eligible beneficiaries.¹¹ For these individuals, Medicaid supplements Medicare coverage by providing assistance with Medicare premiums and cost sharing, as well as by covering services not included in Medicare, such as LTSS. For services covered under both programs, Medicare must pay for services before Medicaid. With few exceptions, Medicaid is considered the payer of last resort, meaning that when beneficiaries have another source of health care coverage—such as Medicare or private health insurance provided through an employer—that source, to the extent of its liability, should generally pay for services before Medicaid. This concept is referred to as “third party liability.”

Despite the breadth of services often covered by Medicaid, certain services are explicitly excluded from coverage. For example, since its inception in 1965, Medicaid has excluded coverage of services provided to most residents of institutions for mental diseases (IMD)—generally, facilities larger than 16 beds that primarily provide inpatient, residential, or other services to persons with behavioral health conditions, including

¹⁰See GAO, *Medicaid Home- and Community-Based Services: Selected States’ Program Structures and Challenges Providing Services*, [GAO-18-628](#) (Washington, D.C.: Aug. 30, 2018). The percentage of HCBS spending as a percentage of LTSS spending varied widely by state.

¹¹Medicare is the federally financed health insurance program for persons 65 years of age or over, certain individuals with disabilities, and individuals with end-stage renal disease.

serious mental illness and SUD.¹² This exclusion is in place, in part, to ensure that states maintain primary responsibility for paying for psychiatric institutional care and do not shift these costs to the federal government.¹³ Additionally, Medicaid generally excludes coverage of services provided to inmates of public institutions during their period of incarceration.¹⁴ Medicaid also only covers room and board in certain inpatient facility types and generally does not cover other social services, known as social determinants of health, such as housing costs in community-based settings.¹⁵

Medicaid expenditures are financed by both the federal government and the states. The rate at which the federal government matches state expenditures—the Federal Medical Assistance Percentage (FMAP)—varies by state, as well as for certain types of beneficiaries, services, or administrative costs.¹⁶ For example, the federal government pays a different portion of Medicaid expenditures for traditionally eligible beneficiaries than for those qualifying under a PPACA expansion. Program oversight efforts are also shared by the federal government and the states, and are aimed, in part, at ensuring that funds are used appropriately and that beneficiaries have access to covered benefits. To facilitate oversight efforts, states must submit a variety of federally

¹²An IMD is a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. 42 U.S.C. § 1396d(i). The exclusion applies to any services provided to a Medicaid IMD resident regardless of whether services are provided inside or outside of the IMD. Exceptions include services provided to individuals age 65 and older residing in an IMD and inpatient psychiatric services for individuals under age 21.

¹³Historically, financing of inpatient psychiatric treatment was a state and local responsibility. See Medicaid and CHIP Payment and Access Commission, *Report to Congress on Oversight of Institutions for Mental Diseases* (Washington, D.C.: December 2019).

¹⁴Public institutions include facilities such as prisons or jails. CMS regulations generally define “an inmate of a public institution” as an individual living in an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control, with certain exceptions. 42 C.F.R. § 435.1010 (2019). Inpatient services provided to Medicaid-eligible inmates who are admitted to hospitals or other qualifying facilities for at least 24 hours are eligible for Medicaid funds.

¹⁵Room and board is covered in specified settings, including nursing facilities, inpatient hospitals, and psychiatric facilities for individuals under age 21.

¹⁶The federal government pays a higher portion of Medicaid expenditures in states with low per capita incomes relative to the national average.

required reports on multiple aspects of the Medicaid program, such as expenditures, service utilization, or performance measures related to approved waivers.

Medicaid Waivers and Demonstrations

Under sections 1915 and 1115 of the Social Security Act, CMS can waive certain federal Medicaid requirements upon a state's request. Such waivers have become a significant feature of the Medicaid program, with all states operating aspects of their programs under one or more approved waivers or demonstrations.¹⁷ For example, section 1915 waivers provide states flexibilities to implement managed care and provide HCBS, such as waiving the requirement to offer the same services statewide or to provide beneficiaries with services that are comparable in terms of their amount, duration, and scope. Section 1115 demonstrations may offer broader flexibilities and be used for a broader range of program purposes. For example, under section 1115 demonstrations, states have extended coverage to populations not otherwise eligible for Medicaid, offered services not otherwise covered by Medicaid, and increased beneficiary premiums and cost-sharing above statutory limits. (See table 2.)

¹⁷We have reported that spending on demonstrations has increased significantly since 2005, and accounted for one-third of total federal Medicaid spending in 2015. See GAO, *Medicaid Demonstrations: Federal Action Needed to Improve Oversight of Spending*, [GAO-17-312](#) (Washington, D.C.: Apr. 3, 2017).

Table 2: Types of Medicaid Waiver and Demonstration Authorities

| Authority | Description | Examples of uses | Duration of approval and renewal period | Examples of key oversight requirements |
|-----------|---|---|---|--|
| 1915(b) | Allows states to waive comparability and statewideness requirements, and implement a managed care or specialty physician care arrangement that may restrict beneficiary choice of providers, use cost savings to provide additional services to beneficiaries, and restrict provider participation. | <ul style="list-style-type: none"> Require all beneficiaries to enroll in managed care. Implement managed care for home- and community-based services (HCBS) in conjunction with 1915(c) authority. | 2 or 5 years ^a | States demonstrate the implemented arrangement is cost-effective, efficient, and consistent with Medicaid principles. |
| 1915(c) | Allows states to establish HCBS programs and to waive the following requirements: <ul style="list-style-type: none"> Provision of benefits on a statewide basis. Provision of comparable benefits to all beneficiaries. Income and resource rules applicable in the community. | <ul style="list-style-type: none"> Target HCBS programs to limited geographic areas. Tailor services to meet needs of a particular group. Establish program enrollment caps. | Initial approval: 3 or 5 years ^a Renewal: 5 years | States must demonstrate cost-neutrality relative to providing services in institutions, establish provider standards, and ensure services are targeted to individual beneficiaries' needs. |
| 1115 | Allows states to obtain federal matching funds for experimental, pilot, or demonstration projects that are considered likely to promote Medicaid objectives. | <ul style="list-style-type: none"> Cover certain excluded services, such as substance use treatment in institutions for mental diseases. Implement alternative payment methods. | Initial approval: 5 years Renewal: generally 3 or 5 years, or up to 10 years | States must demonstrate budget neutrality relative to what program spending would otherwise be and meet terms and conditions for the demonstration. |

Source: GAO analysis of federal laws and regulations and Centers for Medicare & Medicaid Services. | GAO-20-407

^aAn approval period may extend for 5 years if the waiver includes dually eligible individuals.

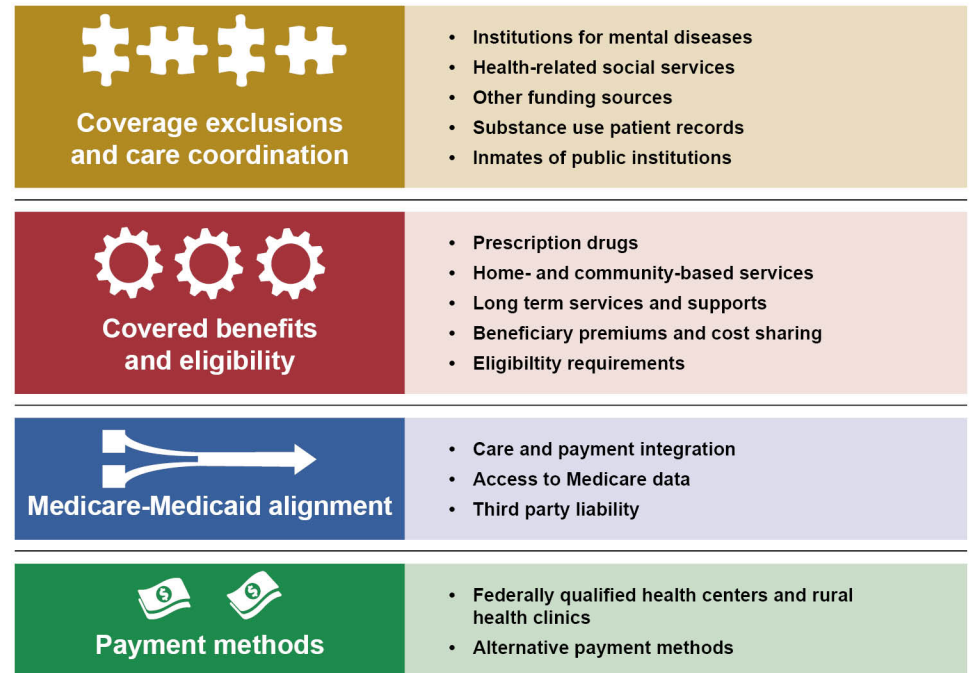
State Officials Identified Various Federal Policies as Challenges to Medicaid Program Administration

State officials identified challenges that some federal Medicaid policies may pose for the effective administration of their Medicaid programs. These include policies related to (1) four key program areas, (2) Medicaid waiver and demonstration review processes, and (3) Medicaid reporting requirements. State officials also provided some suggested strategies for addressing the identified challenges.

Four Key Medicaid Program Areas

Medicaid officials in a majority of states identified significant or moderate challenges with federal Medicaid policies that we categorized into four key program areas: (1) coverage exclusions and care coordination, (2) covered benefits and eligibility, (3) Medicaid and Medicare alignment, and (4) payment methods. (See fig. 1.) Other policies we discussed with state officials were less frequently identified as posing significant or moderate challenges for effective program administration. Instead, a majority of states viewed these areas as either a minor challenge or not at all a challenge. For example, officials from 39 states viewed federal policy options for the provision of telehealth services as a minor challenge or not at all a challenge, and officials from 37 states viewed the provision of mandatory services similarly. (See app. I for a summary of states' perspectives on additional federal policies.)

Figure 1. Key Medicaid Program Areas Identified by State Medicaid Officials as Posing Challenges for Effective Program Administration



Source: GAO analysis of information from interviews with Medicaid officials from 50 states and the District of Columbia. | GAO-20-407

Coverage Exclusions and Care Coordination



Coverage exclusions and care coordination

- One key federal policy challenge was the institution for mental diseases (IMD) coverage exclusion. An IMD is a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.
- Medicaid officials in 47 states identified the IMD exclusion as a significant or moderate challenge for effective program administration.

Source: GAO analysis of information from interviews with Medicaid officials from 50 states and the District of Columbia. | GAO-20-407

Medicaid officials from nearly all states identified federal Medicaid policies that posed challenges related to coverage exclusions and care coordination. For example, policies that exclude coverage for IMD and health-related social services were identified by officials in 47 states and 44 states, respectively, as posing a significant or moderate challenge for effective program administration. While acknowledging the historical reasons for such coverage exclusions, state officials cited them as a barrier to their ability to use Medicaid funds to provide a full continuum of care to beneficiaries with complex health care needs, including mental health or SUD treatment needs. State officials acknowledged opportunities to obtain Medicaid coverage for some of these services through use of managed care or section 1115 demonstrations, but frequently noted concerns about limits on the days of coverage allowed and the administrative burden associated with these options.¹⁸ In addition, officials from 41 states cited a federal law related to sharing medical records for patients with SUD as a significant or moderate challenge. According to officials, the law, which is not limited to Medicaid providers, can limit information-sharing, such as medication or treatment history, among providers, and officials suggested updating the requirement to align with patient record privacy provisions enacted under the Health Insurance Portability and Accountability Act of 1996. (See table 3.)

¹⁸In August 2017, we reported that CMS has changed policies over time to allow states to finance care for adult Medicaid beneficiaries in IMD facilities through managed care and under section 1115 demonstrations. Additionally, we found that states had created facilities with 16 or fewer beds specifically to obtain Medicaid funding without triggering the IMD exclusion. See GAO, *Medicaid: States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies*, [GAO-17-652](#) (Washington, D.C.: Aug. 9, 2017).

Table 3: Examples of State Challenges and Suggested Strategies Related to Federal Policies Affecting Coverage Exclusions and Care Coordination

| Federal policy description and examples of challenges identified by state officials, including suggested strategies for addressing the challenges | | Number of states | | | |
|---|--|-----------------------|--------------------|-----------------|------------------------|
| | | Significant challenge | Moderate challenge | Minor challenge | Not at all a challenge |
| Institution for mental diseases (IMD) | <p>Description: Medicaid generally excludes federal payments for services provided to beneficiaries age 21-64 residing in IMDs, which are generally facilities with more than 16 beds that primarily provide services to persons with mental health and other needs^a Under certain conditions, managed care organizations can provide services in an IMD for up to 15 days per month.</p> <p>Reported challenges: State officials noted that the exclusion limits their ability to use Medicaid funds to provide beneficiaries with a full continuum of treatment. It also may divert beneficiaries to more expensive hospital settings or set incentives for care based on facility size rather than quality or cost effectiveness. State officials also noted that the 15-day monthly limit for managed care coverage is administratively burdensome.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> • Update the statute to allow Medicaid payment for services for IMD residents. • Increase the bed limit or remove residential substance use treatment facilities from the IMD definition. • Increase the 15 day limit for managed care coverage. • Base coverage limits on medical necessity rather than the number of days. | 34 | 13 | 3 | 1 |
| Health-related social services | <p>Description: Medicaid does not generally pay for social services, such as community-based housing.</p> <p>Reported challenges: State officials cited the lack of financing for social services, particularly housing, as a challenge to their efforts to lower costs and improve health outcomes for Medicaid beneficiaries. It can also result in individuals accessing hospitals or other higher-cost institutional settings.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> • Authorize federal Medicaid funds for health-related social services in limited circumstances, such as for beneficiaries in need of long term services and supports or residential treatment. • Authorize coverage of such services in cases where it would be cost effective to do so. | 30 | 14 | 7 | 0 |

| Federal policy description and examples of challenges identified by state officials, including suggested strategies for addressing the challenges | | Number of states | | | |
|---|---|-----------------------|--------------------|-----------------|------------------------|
| | | Significant challenge | Moderate challenge | Minor challenge | Not at all a challenge |
| Substance use patient records | <p>Description: Health care providers generally must obtain prior written consent to disclose to other providers or entities information that would identify the patient as having or having had a substance use disorder (SUD).^b</p> <p>Reported challenges: State officials noted the requirement inhibits sharing of information—such as medication and treatment history—among care providers and health plans, and can pose a barrier to care coordination.</p> <p>State-suggested strategies: Amend the law to allow the sharing of patient health information relating to a SUD similar to what is allowed for other patient health information under the Health Insurance Portability and Accountability Act of 1996.</p> | 26 | 15 | 9 | 1 |
| Other funding sources | <p>Description: Medicaid funds must not be used for administrative costs of other federal programs, such as the Supplemental Nutrition Assistance Program, and administrative costs related to multiple programs must be allocated based on the relative benefit to the Medicaid program.</p> <p>Reported challenges: State officials cited limited or unclear authority to coordinate Medicaid funds with other funding as a barrier to providing beneficiaries with a coordinated package of services across programs.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> Enhance guidance on coordinating and integrating funding across programs. Reinstate federal policy allowing non-Medicaid programs to leverage Medicaid funding for shared information technology systems.^c | 20 | 21 | 10 | 0 |
| Inmates of public institutions | <p>Description: Inmates of a public institution who are held involuntarily, such as in a correctional facility, may be enrolled in Medicaid, but generally may not receive Medicaid covered services.</p> <p>Reported challenges: State officials cited challenges to ensuring care coordination, particularly for short-term incarceration and when a release date is not known, which can affect efforts to address substance use and other treatment needs among a population described as high risk.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> Repeal the statutory prohibition on such coverage. Provide coverage to inmates in certain circumstances—such as a transition period prior to release, short term incarceration, or for individuals receiving court-ordered treatment. | 18 | 16 | 15 | 2 |

Source: GAO analysis of information from interviews with Medicaid officials from 50 states and the District of Columbia. | GAO-20-407

Note: We did not evaluate the merits, costs, or other effects of implementing state suggested strategies, nor did we ask the Centers for Medicare & Medicaid Services to provide input on them.

^aAn IMD is a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. 42 U.S.C. § 1396d(i).

^bThis requirement is commonly referred to as “Part 2” for the regulations in which it is codified (42 C.F.R. Part 2).

^cThe Office of Management and Budget Circular A-87 specifies that costs associated with building shared state-based information technology systems must be allocated across all benefitting programs in proportion to their use of the system. A policy known as the “A-87 Exception,” which was in effect from August 2011 through December 2018, provided an exception to this requirement and allowed states to integrate eligibility systems across human services programs without having to allocate the costs accordingly.

Covered Benefits and Eligibility



- One key federal policy challenge was the requirement to cover all outpatient prescription drugs approved by the Food and Drug Administration that are offered by manufacturers participating in the Medicaid Drug Rebate Program.
- Medicaid officials in 39 states identified this prescription drug coverage requirement as a significant or moderate challenge for effective program administration.

Source: GAO analysis of information from interviews with Medicaid officials from 50 states and the District of Columbia. | GAO-20-407

Medicaid officials from most states identified challenges related to federal Medicaid policies affecting covered benefits and beneficiary eligibility. For example, officials from 39 states identified moderate or significant challenges related to the requirement that they generally must cover all Food and Drug Administration-approved outpatient prescription drugs from manufacturers participating in the Medicaid Drug Rebate Program, which provides significant discounts to state Medicaid programs in the form of rebates for certain outpatient prescription drugs.¹⁹ State officials noted the importance of beneficiary access to prescription drugs, as well as the importance of the Medicaid Drug Rebate Program. However, officials provided examples of the challenges related to this coverage requirement, including that (1) newer drugs are often higher cost, and (2) certain higher cost drugs may not yet have an established clinical benefit or have a lower cost alternative that is available. State-suggested strategies to address this challenge included amending the requirement to allow states to cover fewer drugs or to delay coverage until clinical effectiveness is proven. Officials from 29 states also identified federal requirements for providing coverage for HCBS as posing significant or moderate challenges for program administration. Specifically, state officials described a hesitancy to cover HCBS under their state plan, citing cost concerns associated with the requirements for states that opt to do so to offer services to all eligible individuals. (See table 4.)

¹⁹All states have opted to cover outpatient drugs in their Medicaid program and therefore must cover all Food and Drug Administration approved drugs made by a manufacturer that has entered into a rebate agreement, outside of certain permitted exclusions or restrictions that are outlined in the law. See 42 U.S.C. § 1396r-8(d).

Table 4: Examples of State Challenges and Suggested Strategies Related to Federal Policies Affecting Covered Medicaid Benefits and Eligibility

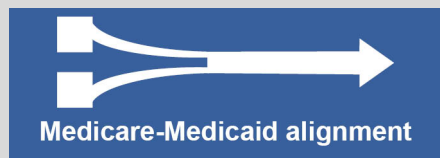
| Federal policy description and examples of challenges identified by state officials, including suggested strategies for addressing the challenges | Number of states | | | |
|---|-----------------------|--------------------|-----------------|------------------------|
| | Significant challenge | Moderate challenge | Minor challenge | Not at all a challenge |
| <p>Prescription drugs Description: States generally must cover all outpatient prescription drugs approved by the Food and Drug Administration that are offered by manufacturers participating in the Medicaid Drug Rebate Program.</p> <p>Reported challenges: State officials cited the higher cost of newer prescription drugs and cases where clinical effectiveness was not yet determined as complicating their efforts to control costs and manage care.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> Amend requirement to allow states to cover fewer drugs, delay coverage until clinical effectiveness is proven, or provide a grace period after a new drug is approved to establish utilization management strategies. Create a funding pool for high cost drugs to spread risks across payers. | 25 | 14 | 8 | 4 |
| <p>Beneficiary premiums and cost sharing Description: States cannot impose premium and cost sharing requirements on beneficiaries that, in the aggregate, exceed 5 percent of a family's monthly or quarterly household income.</p> <p>Reported challenges: State officials said that determining which individuals should be included in the household income calculation and the frequency of the calculation can be challenging, and said that data systems may not capture all relevant information.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> Simplify the calculation by establishing a standard dollar amount, setting individual versus household income limits, or by calculating the amount less frequently. | 21 | 9 | 12 | 9 |
| <p>Home- and community-based services (HCBS) Description: States that opt to cover HCBS services under state plan authority must allow enrollment of all eligible individuals.</p> <p>Reported challenges: State officials noted that the HCBS enrollment requirement affects cost control efforts and increases the use of waivers and demonstrations, where such enrollment can be capped.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> Allow states to limit HCBS enrollment through their state plans. | 10 | 19 | 9 | 12 |

| Federal policy description and examples of challenges identified by state officials, including suggested strategies for addressing the challenges | | Number of states | | | |
|---|---|-----------------------|--------------------|-----------------|------------------------|
| | | Significant challenge | Moderate challenge | Minor challenge | Not at all a challenge |
| Long term services and supports (LTSS) | <p>Description: States are limited in the extent to which they can tailor LTSS services to particular populations under state plan authority.</p> <p>Reported challenges: State officials said that limited ability to tailor LTSS to certain populations—for example, establishing different eligibility criteria for nursing facility services and HCBS, or differentiating services between urban and rural areas—leads to increased use of waivers and demonstrations, under which such efforts may be allowed.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> • Allow states more flexibility to target LTSS to certain beneficiaries under state plan authority. | 11 | 16 | 11 | 12 |
| Eligibility requirements | <p>Description: States must cover specified beneficiary groups such as children, pregnant women, and individuals with disabilities, whose financial and other eligibility requirements vary.</p> <p>Reported challenges: State officials cited differences in eligibility criteria across groups as administratively challenging and confusing to beneficiaries. Differences in eligibility requirements between Medicaid and other federal programs also limit integration.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> • Align eligibility criteria across Medicaid groups or other federal programs. | 13 | 13 | 17 | 8 |

Source: GAO analysis of information from interviews with Medicaid officials from 50 states and the District of Columbia. | GAO-20-407

Notes: For certain federal policies, total responses are less than 51, as not all states answered particular questions. For example, in some cases states declined to provide responses to federal policies that did not apply to their program. We did not evaluate the merits, costs, or other effects of implementing state-suggested strategies, nor did we ask the Centers for Medicare & Medicaid Services to provide input on them.

Medicare-Medicaid Alignment



- One key federal policy challenge was integration of care for beneficiaries that are dually eligible for both Medicare and Medicaid. These programs differ in areas such as covered services and administration.
- Medicaid officials in 42 states identified integration of care for dually eligible beneficiaries as a significant or moderate challenge for effective program administration.

Source: GAO analysis of information from interviews with Medicaid officials from 50 states and the District of Columbia. | GAO-20-407

State Medicaid officials also frequently identified federal policies that posed challenges pertaining to care provided to individuals eligible for both Medicare and Medicaid. Officials acknowledged CMS initiatives to address such challenges and the complexity of doing so. Nonetheless, officials from 42 states identified significant or moderate challenges related to integrating care across Medicare and Medicaid, due in part to fundamental differences between the programs. Officials from 32 states identified significant or moderate challenges with accessing Medicare data for dual-eligible beneficiaries, and officials from 29 states identified such challenges related to assuring that the appropriate program pays for coverage. State-suggested strategies to address these challenges included enhancing administrative alignment between the two programs. (See table 5.)

Table 5: Examples of State Challenges and Suggested Strategies Related to Federal Policies Affecting Medicare and Medicaid Alignment

| Federal policy description and examples of challenges identified by state officials, including suggested strategies for addressing the challenges | Number of states | | | |
|--|-----------------------|--------------------|-----------------|------------------------|
| | Significant challenge | Moderate challenge | Minor challenge | Not at all a challenge |
| <p>Care and payment integration^a</p> <p>Description: The Centers for Medicare & Medicaid Services (CMS) has identified policy options for states to integrate administrative processes and payment across Medicare and Medicaid in an effort to provide a more seamless experience for dual-eligible beneficiaries.</p> <p>Reported challenges: State officials reported that program differences limit integration efforts, noting an inability to mandatorily enroll Medicaid beneficiaries in Medicare managed care plans. State officials also said that payment integration is complicated due to differences in covered services and limited opportunities to share savings across programs.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> • Create a new single program to serve dual-eligible beneficiaries. • Enhance administrative alignment between the programs, such as requiring dual-eligible beneficiaries to enroll in Medicare managed care plans. • Enhance opportunities for states to share savings with Medicare. • Continue CMS initiatives in this area. | 19 | 23 | 4 | 4 |
| <p>Access to Medicare data</p> <p>Description: CMS allows states to access and use Medicare data subject to certain requirements and data release policies.</p> <p>Reported challenges: State officials cited challenges that included sharing data with Medicaid managed care plans, such as claims data for care coordination purposes, and outdated data.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> • Provide further guidance on how Medicare data can be used. • Allow Medicaid managed care plans to access Medicare data. | 19 | 13 | 9 | 8 |
| <p>Third party liability</p> <p>Description: For dual-eligible beneficiaries, Medicare must pay for covered services before Medicaid.^b</p> <p>Reported challenges: State officials cited burden associated with identifying Medicare contacts to address issues that arise and potential delays in beneficiaries' access to services.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> • Identify Medicare partners for states to contact when issues arise. | 9 | 20 | 11 | 10 |

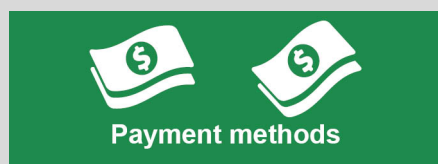
Source: GAO analysis of information from interviews with Medicaid officials from 50 states and the District of Columbia. | GAO-20-407

Notes: For certain federal policies, total responses are less than 51 as not all states answered particular questions. For example, in some cases states declined to provide responses to federal policies that did not apply to their program. We did not evaluate the merits, costs, or other effects of implementing state-suggested strategies, nor did we ask the Centers for Medicare & Medicaid Services to provide input on them.

^aDue to similarity in content, we have combined state responses for two of the policies we discussed with states: Medicare and Medicaid care integration and Medicare and Medicaid payment integration. The totals in the right column represent states' characterization of the level of challenge related to federal policies on Medicare and Medicaid care integration. States' characterization of the level of challenge related to Medicare and Medicaid payment integration policies were the following: significant (16 states), moderate (22 states), minor (six states), and not at all a challenge (five states).

^bUnder the concept of third party liability, Medicaid is typically considered the payer of last resort, meaning that when beneficiaries have another source of health care coverage—such as Medicare or private health insurance provided through an employer—that source, to the extent of its liability, should generally pay for services before Medicaid does.

Payment Methods



- One key federal policy challenge was the requirement to use prospective payment based on costs for federally qualified health centers (FQHCs) and rural health clinics (RHCs). Under the prospective payment system, each facility has a specific payment rate based on its historical costs, adjusted for inflation and changes in scope of services provided.
- Medicaid officials in 27 states identified payment methods for FQHCs and RHCs as a significant or moderate challenge for effective program administration.

Source: GAO analysis of information from interviews with Medicaid officials from 50 states and the District of Columbia. | GAO-20-407

A final area of concern for Medicaid officials from a majority of states included policies related to provider payment methods. For example, officials from 27 states identified challenges associated with the federal law that generally requires them to pay federally qualified health centers (FQHC) and rural health clinics (RHC) on the basis of a prospective payment system, under which each facility is generally paid a rate based on its historical costs.²⁰ State officials noted that such facilities play a substantial role in providing services to Medicaid beneficiaries. Examples of challenges that state officials cited related to this requirement included that these facilities can receive substantially higher payments than other providers for the same service, which can affect the states' ability to control program costs, particularly in states with a larger number of FQHC and RHC facilities. State-suggested strategies to address this challenge included eliminating the prospective payment requirement or limiting the number of such facilities in a state. Officials from 28 states also identified challenges related to their efforts to implement alternative payment methods that can incentivize the provision of quality care. (See table 6.)

²⁰In general, a non-profit or public health center may qualify as a FQHC if it receives a federal grant under Section 330 of the Public Health Service Act; meets the requirements to receive such a grant; or is an outpatient health facility operated by certain tribal or urban Indian organizations. A public, for-profit, or non-profit health center may qualify as a RHC if it is located in a rural area designated as a shortage area and meets other requirements. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established a prospective payment system for FQHCs and RHCs, which was intended to incentivize the facilities to operate more efficiently than under previous reimbursement policy.

Table 6: Examples of State Challenges and Suggested Strategies Related to Federal Medicaid Policies Affecting Payment Methods

| Federal policy description and examples of challenges identified by state officials, including suggested strategies for addressing the challenges | Number of states | | | |
|--|-----------------------|--------------------|-----------------|------------------------|
| | Significant challenge | Moderate challenge | Minor challenge | Not at all a challenge |
| <p>Federally qualified health centers (FQHC) and rural health clinics (RHC)</p> <p>Description: States generally must pay FQHCs and RHCs using a prospective payment system, under which each facility has a specific payment rate based on its historical costs, adjusted for inflation and changes in scope of services provided.</p> <p>Reported challenges: State officials noted cost pressures related to paying these facilities substantially more than other providers for the same services, and providers converting to FQHCs or RHCs to obtain these higher rates. State officials said the policy has been a barrier to their payment reform efforts.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> • Eliminate requirement that states pay these facilities on a prospective payment system basis. • Limit the number of such facilities in a state. • Revise the prospective payment system calculation methodology, such as to reflect more recent costs. | 14 | 13 | 14 | 9 |
| <p>Alternative payment methods</p> <p>Description: States can use alternative payment methods to promote high-quality and cost-efficient care, and allow providers to earn more for assuming additional risk.</p> <p>Reported challenges: State officials noted delayed guidance or lack of clarity over how they can use these payment methods for certain services, such as long term services and supports and prescription drugs. State officials also cited the need to use waiver authority to implement certain payment methods.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> • Provide additional federal guidance on how states may implement these payment methods. • Streamline authorities for states to use these methods. | 6 | 22 | 15 | 8 |

Source: GAO analysis of information from interviews with Medicaid officials from 50 states and the District of Columbia. | GAO-20-407

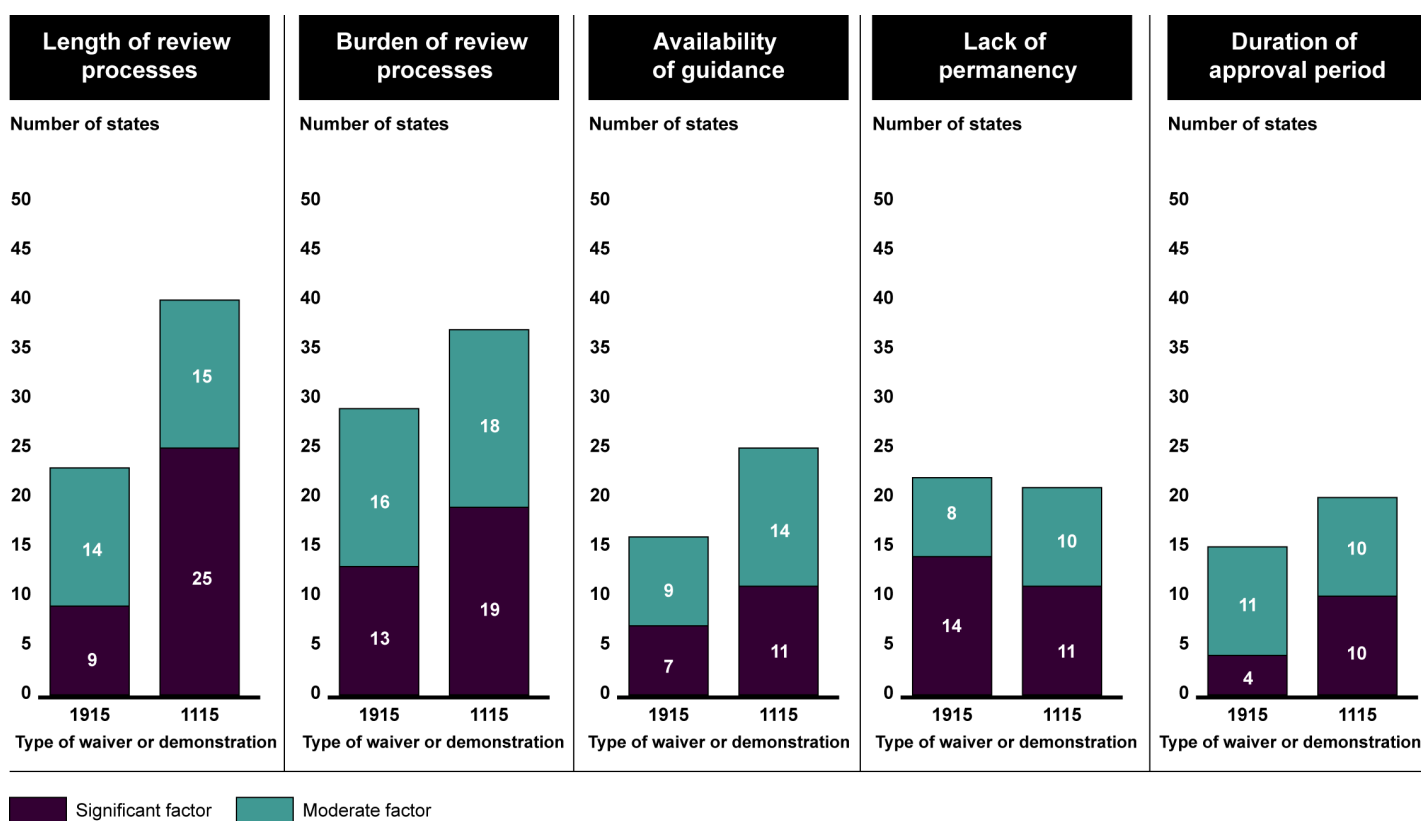
Notes: For certain federal policies, total responses are less than 51 as not all states answered particular questions. For example, in some cases, states declined to provide responses to federal policies that did not apply to their program. We did not evaluate the merits, costs, or other effects of implementing state-suggested strategies, nor did we ask the Centers for Medicare & Medicaid Services to provide input on them.

Review Processes for Medicaid Waivers and Demonstrations

Medicaid officials from 46 states reported experiencing challenges related to federal review processes for section 1915 waivers or section 1115 demonstrations. State officials commonly identified five factors as contributing to challenges, including the length of time of the review processes, the level of guidance available to the state during the request

for approval, and the level of burden associated with the processes. In general, state officials reported more challenges with section 1115 demonstration processes than with section 1915 waiver processes. (See fig. 2.)

Figure 2: Five Factors Commonly Identified by State Medicaid Officials as Posing Challenges to Section 1115 Demonstration and Section 1915 Waiver Review Processes



Source: GAO analysis of information from interviews with Medicaid officials from 50 states and the District of Columbia. | GAO-20-407

Notes: Under section 1915(c) of the Social Security Act (SSA), the Secretary of the Department of Health and Human Services (HHS) may waive requirements that states offering home- and community-based services offer comparable benefits statewide and to all eligible beneficiaries, and that they use a single income and resource standard to determine eligibility. Section 1915(b) of the SSA allows states to obtain waivers of statutory requirements for comparability, state wideness, and freedom of choice. Under section 1115 of the SSA, the Secretary of HHS may waive certain federal Medicaid requirements and approve expenditures that would not otherwise be eligible for federal Medicaid funds for certain experimental, pilot, or demonstration projects that, in the Secretary's judgement, are likely to promote Medicaid objectives.

State Medicaid officials generally acknowledged steps CMS has taken to address these challenges. Examples of such steps included CMS efforts to improve and standardize the review process for section 1915 waivers, and to reduce the length and burden of the review process for section 1115 demonstrations that have authorized coverage for Medicaid beneficiaries receiving SUD treatment services in IMDs.²¹ State officials also cited recent options to extend the duration of certain demonstrations to 10 years.²²

These steps notwithstanding, state officials described the ways in which the five factors still contribute to challenges with waiver and demonstration processes. Examples of ongoing challenges noted by state officials include the following:

- **Section 1915 waivers.** State officials noted that the complexity and length of application and renewal submissions require significant resources and are of unclear value, particularly for waivers with a long history of effectiveness and cost savings and without substantive redesign. Officials said that differences in the duration of various waiver types and the length of renewal processes add to the burden. State officials also noted concerns with the usability of the CMS waiver management system, such as lack of support for text editing functions, which poses inefficiencies for entering information into the system.
- **Section 1115 demonstrations.** State officials noted that CMS's review of these demonstrations can span multiple years; officials cited the lack of an explicit time limit for federal review. Officials said that this uncertainty complicates their planning, such as efforts to meet state appropriation timelines and program implementation dates. In addition, officials said that absent or conflicting CMS guidance on requirements for approval add to the length of time and associated burden of such processes. For example, after working with CMS for

²¹See Centers for Medicare & Medicaid Services, *Informational Bulletin*, "State Plan Amendment and 1915 Waiver Process Improvements to Improve Transparency and Efficiency and Reduce Burden" (Baltimore, Md.: Nov. 6, 2017); and Centers for Medicare & Medicaid Services, *Informational Bulletin*, "Update on State Plan Amendment and Section 1915 Waiver Process Improvements" (Baltimore, Md.: Aug. 16, 2018).

²²In 2017, CMS announced that in certain cases the agency may approve the extension of routine, successful, non-complex 1115 demonstrations for a period up to 10 years. See Centers for Medicare & Medicaid Services, *Informational Bulletin*, "Section 1115 Demonstration Process Improvements" (Baltimore, Md.: Nov. 6, 2017).

over a year on a demonstration submission, officials from one state said they were told that the submission was not allowable under 1115 authority and would need to be authorized under a separate waiver authority.

In light of these challenges, state officials suggested several potential strategies to address them, including the following:

- Provide permanent approval or longer duration of approval for long-standing waivers or demonstrations.
- Look for additional opportunities to streamline oversight of longstanding waivers and demonstrations. For example:
 - Target reviews for renewals to focus on specific changes to waivers or demonstrations rather than performing a comprehensive review.
 - For section 1915 waivers, allow states to provide outcome reports, with additional renewal information being reserved for cases where a concern was identified based on the outcome reports.
 - For section 1115 demonstrations, reduce or discontinue evaluation requirements after a set number of renewals.
- Share additional information with states regarding the scope of demonstration options and CMS expectations for approval and monitoring.
- Shorten section 1115 demonstration approval time frames by establishing a time limit for review, adding CMS staff, or by improving coordination and consistency within CMS.

More broadly, as an alternative to waivers and demonstrations, officials from 46 states reported that specific flexibilities available under section 1915 or section 1115 should be provided through state Medicaid plans. Examples of such flexibilities suggested by state officials included authority to

- require all populations—including dual-eligible beneficiaries, American Indians and Alaska Natives, and children with special health care needs—to enroll in managed care plans;
- limit enrollment for HCBS;

-
- more flexibly tailor services—including LTSS—to target populations or areas within a state;
 - extend Medicaid coverage to include services provided to individuals residing in IMDs; and
 - extend Medicaid to cover health-related social services, such as community-based housing.²³

Federal Medicaid Reporting Requirements

While generally acknowledging the importance of federal Medicaid reporting requirements, officials from nearly all states indicated that these requirements can be administratively challenging in some cases. Officials from 48 states reported that they viewed one or more federal Medicaid reporting requirements as overly burdensome.²⁴ State officials most frequently characterized these concerns as pertaining to a limited number of reporting requirements. State officials did not always name particular reporting requirements in discussing their concerns about burden; however, some of the specific reporting requirements officials cited included the following:

- The form CMS-64 quarterly expenditure report, which states use to report Medicaid expenditures to CMS for the purpose of determining federal funding.
- Certain reports related to section 1115 demonstrations and section 1915(c) waivers, such as the annual CMS-372(s) report, which states use to report financial and other information about 1915(c) waivers, including information used to demonstrate budget neutrality.

Officials from over half of the states highlighted a perceived lack of relevance or usefulness of some of the data states are required to report to CMS, expressed concerns about duplicative data requests, or cited uncertainty about how CMS uses the data. Questions raised by state officials included

- the need to report certain data separately, such as data on children’s screening services, when CMS could obtain these data directly from the Transformed Medicaid Statistical Information System (T-MSIS)—

²³In addition, officials from a number of states suggested that flexibilities that have been widely approved across states or have been approved on a long-standing basis should also be provided through state Medicaid plans.

²⁴We defined overly burdensome reporting requirements as Medicaid reporting requirements established by Congress or CMS that were viewed as being too costly, vague, complicated, paperwork-heavy, unnecessary, or duplicative.

CMS's system to collect detailed claims and eligibility data from all states; and

- the extent to which labor intensive quarterly reports, such as CMS-64 or 1115 demonstration reports, were reviewed within CMS or used for program oversight.

In addition, state officials expressed concerns about a lack of clear and consistent CMS guidance for a number of Medicaid reporting requirements, including requirements related to the CMS-64, T-MSIS, and section 1115 demonstration reports. State officials also cited as administratively challenging the need to use federal information systems, which can complicate state efforts to submit data for the CMS-64 report and can require extensive manual data entry, according to state officials. State officials also noted that certain quality measures—such as measures included in Adult and Child Core Sets—may require complex information that is not readily available in electronic health records or provider claims.²⁵

State Medicaid officials also described beneficial aspects associated with CMS's reporting requirements, such as the potential to utilize T-MSIS to make comparisons across states. State officials also noted that these reporting requirements require states to generate data, which the states can also use to assess their programs and facilitate data-driven decision making. Some states also suggested potential strategies to lessen challenges associated with certain reporting requirements. For example, state officials suggested that CMS could

- enhance communication and transparency on its review and use of reported information;
- review the scope and frequency of data required and concentrate on key program outcomes; and
- streamline reporting by leveraging available sources of information, such as T-MSIS.

²⁵The Adult Core Set and Child Core Set include standardized health care quality measures that state Medicaid programs voluntarily report.

Targeting Oversight and Leveraging Available Data Are among Considerations for Addressing State-Identified Challenges

CMS is taking steps to address some of the challenges state officials identified as affecting the administration of their Medicaid programs. Several federal policies that state officials commonly identified as challenging—such as certain coverage exclusions and policies affecting Medicare-Medicaid alignment—were also priority areas for federal action identified by CMS officials. For example, CMS officials agreed that Medicaid policies related to care and payment integration for dual-eligible beneficiaries and to the waiver and demonstration processes, among others, pose challenges for states.²⁶ CMS officials reported ongoing efforts in several of these areas. (See table 7.)

Table 7. Examples of Perspectives and Actions Taken by CMS Related to Federal Medicaid Policies State Officials Viewed as Challenging

| Federal policy challenge identified by state Medicaid officials | Centers for Medicare & Medicaid Services (CMS) perspectives | CMS reported actions |
|---|--|--|
| Institution for mental diseases (IMD): General statutory exclusion of coverage for services provided to beneficiaries aged 21 to 64 residing in IMDs. | CMS agreed that the exclusion poses challenges for states. CMS noted that the SUPPORT for Patients and Communities Act provides for greater flexibility for IMD coverage and that, under certain conditions, states can receive federal payments for IMD coverage through Medicaid managed care plans. | <ul style="list-style-type: none"> Released guidance in 2017 and 2018 describing opportunities for states to cover services for residents of IMDs through section 1115 demonstrations. Implemented a state plan option to provide services to individuals 21 to 64 years of age who are residents of certain IMDs with substance use disorders for up to 30 days per 12 month period for a 5-year period from October 1, 2019, through September 30, 2023.^a |
| Health-related social services: Medicaid does not generally pay for health-related social services, such as housing. | CMS agreed that social services not covered by Medicaid, particularly community-based housing, pose challenges for states. | <ul style="list-style-type: none"> Provided technical assistance to states regarding housing services that can be covered under waivers and demonstrations. |
| Medicare and Medicaid alignment: Program differences between Medicare and Medicaid limit care and payment integration. | CMS agreed that care and payment integration for dual-eligible beneficiaries poses challenges for states. CMS further acknowledged concerns associated with state investments resulting in federal savings. | <ul style="list-style-type: none"> Released guidance in 2018 and 2019 describing opportunities for states to improve integration across programs. Tested models for states to align the financing of these two programs and integrate services, including through a financial alignment initiative in 13 states.^b Created a State Data Resource Center to help simplify states' access to Medicare data. |

²⁶CMS identified another commonly reported state challenge—Medicaid prescription drug coverage requirements—as an area of agency priority for federal action, but did not report any actions in this area due to statutory restrictions. However, CMS officials acknowledged state concerns with coverage of prescription drugs.

| Federal policy challenge identified by state Medicaid officials | Centers for Medicare & Medicaid Services (CMS) perspectives | CMS reported actions |
|--|--|--|
| Waiver and demonstration review processes: Multiple factors—such as the length and burden of review processes—complicate state implementation. | CMS agreed that these processes pose challenges for states and noted actions taken to reduce burden and streamline processes. CMS also noted the need for legislation to make commonly approved waivers permanent and that legislative changes might need to include ways to monitor waivers and demonstrations to ensure beneficiary protections. | <ul style="list-style-type: none"> Streamlined processing of waivers and demonstrations. For example: <ul style="list-style-type: none"> reduced processing times for 1915 waivers; reduced requests for additional information and temporary extensions; approved 10-year extensions of 1115 demonstrations; and clarified guidance and provided resources for 1115 demonstrations, including a website on monitoring and evaluation resources and technical assistance webinars. |
| Federal Medicaid reporting requirements: Among other challenges, federal information systems can complicate efforts to submit data. | CMS recognized state challenges regarding reporting expenditures on the form CMS-64. | <ul style="list-style-type: none"> Engaged with states and other stakeholders on an updated reporting system that is under development, which includes efforts to modernize state expenditure reporting on the form CMS-64. |

Source: GAO analysis of information provided by CMS. | GAO-20-407.

^aSpecifically, the SUPPORT for Patients and Communities Act authorizes a state plan option to provide services to Medicaid beneficiaries aged 21 to 64 who have at least one substance use disorder diagnosis and reside in an eligible IMD from October 1, 2019, through September 30, 2023. Such services may be covered for a maximum of 30 days per 12 month period. Pub. L. No. 115-271, § 5052, 132 Stat. 3894, 3971 (2018).

^bThe Financial Alignment Initiative was authorized by the Patient Protection and Affordable Care Act to test ways to improve care for dually eligible beneficiaries and reduce program costs by aligning financing and coordinating care across Medicare and Medicaid. Pub. L. No. 111-148, § 3021, 124 Stat. 119, 389 (2010).

With common areas of concern between states and CMS providing a starting point, we also identified five interrelated considerations that apply broadly to any efforts to address the challenges identified by state Medicaid officials, including the officials’ suggested strategies for addressing the challenges. These considerations—which we identified based on our prior work, interviews with state officials, as well as CMS and stakeholder perspectives—highlight potential tradeoffs and the need to account for varying perspectives on any potential changes to federal Medicaid policy.²⁷

Targeting federal oversight to critical areas. Medicaid policy changes that may address state-identified challenges could have implications for

²⁷Since 2003, we have identified Medicaid as a high-risk program due to concerns such as the need for more accurate and complete data to effectively manage and oversee the program, the appropriate use of Medicaid dollars, and access to care. See [GAO-19-157SP](#).

program oversight. Oversight activities need to be conducted in a manner that ensures beneficiary access and quality of care, as well as the appropriate use of federal expenditures, including protecting against improper payments. Our prior work, state officials, and stakeholders highlighted the importance of federal oversight and the need to effectively target oversight. For example:

- In March 2020, we reported that HHS reported an increase in the total estimated improper payments for the Medicaid program in excess of \$21.1 billion for fiscal year 2019. HHS reported that most errors in beneficiary eligibility determinations were due to insufficient documentation; another significant cause for estimated Medicaid improper payments resulted from state noncompliance with provider screening and enrollment requirements.²⁸
- In July 2018, we recommended that CMS take steps to improve oversight of payment risks in Medicaid managed care, given states' rapidly increasing use of this delivery system.²⁹
- In August 2018, we recommended that CMS target its oversight efforts based on program risks, such as by allocating oversight resources more proportionately to program expenditures.³⁰

Leveraging program data. The extent to which quality data are adequate to inform policy decisions and support targeted oversight is another consideration. CMS officials noted that state-suggested strategies have not necessarily been fully evaluated. Accurate and complete data on key measures—such as measures of beneficiary access and use of services and the costs of providing such services—are critical for federal oversight, including ensuring proper payments, and for informing any evaluation of policies. For example, quality data could shed light on the cost effectiveness of extending Medicaid coverage to additional services, such as IMD and social services. We have previously

²⁸See GAO, *Payment Integrity: Federal Agencies' Estimates of FY 2019 Improper Payments*, [GAO-20-344](#) (Washington, D.C.: Mar. 2, 2020).

²⁹See GAO, *Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks*, [GAO-18-528](#) (Washington, D.C.: Jul. 26, 2018). This report included three recommendations related to CMS oversight of Medicaid managed care. As of March 2020, two of these recommendations had been implemented and one remained open.

³⁰See GAO, *Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures*, [GAO-18-564](#) (Washington, D.C.: Aug. 6, 2018). As of March 2020, this recommendation remained open.

reported that incomplete and inconsistent state data complicate program oversight, and that CMS needs to take additional steps to ensure data quality.³¹ While state officials viewed certain federal reporting as overly complex in terms of the number and scope of required reporting elements, states and several stakeholders also highlighted the benefits of standardized, quality data for program oversight and benchmarking across states, and that a targeted focus on key outcomes could inform both state and federal oversight efforts.

Balancing oversight and flexibility for waivers and demonstrations.

Balancing states' ongoing reliance on waivers and demonstrations with an appropriate level of oversight is another consideration. State officials identified several challenges related to waiver and demonstration review processes, and suggested that certain flexibilities could be provided through state plans. CMS and other stakeholders have also identified opportunities for streamlining these processes in cases viewed as posing limited risk. For example, MACPAC recommended extending the approval and renewal periods of certain waivers frequently used to establish managed care and allowing additional flexibility under state plan authority.³² While recognizing the inherent challenge in balancing federal oversight with state flexibility, our prior work has identified multiple instances where improved oversight of waivers and demonstrations was warranted. For example, we have issued reports regarding the importance of federal oversight of waivers and demonstrations for

- avoiding unintended outcomes, such as problems related to beneficiaries' quality of care;³³

³¹See GAO, *Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements* [GAO-17-173](#) (Washington, D.C.: Jan. 6, 2017). We have also found that data limitations affect CMS's ability to oversee quality of care for vulnerable populations, such as children who should receive a blood lead screening. For example, see GAO, *Medicaid: Additional CMS Data and Oversight Needed to Ensure Children Receive Recommended Screenings*, [GAO-19-481](#) (Washington, D.C.: Aug. 16, 2019).

³²See Medicaid and CHIP Payment and Access Commission, "Chapter 1: Streamlining Medicaid Managed Care Authority," *March 2018 Report to Congress on Medicaid and CHIP*, (Washington, D.C.: March 2018).

³³See GAO, *Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed*, [GAO-18-179](#) (Washington, D.C.: Jan. 5, 2018); and *Long Term Care: Federal Oversight of Growing Medicaid Home and Community Based Waivers Should be Strengthened*, [GAO-03-576](#) (Washington, D.C.: Jun. 20, 2003).

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- ensuring transparency in obtaining public input during the review and approval process;³⁴ and
 - requiring states to report the information needed to monitor aspects of their managed long term services and supports programs.³⁵

Based on these and other findings, we identified the need for more robust information on the effectiveness of demonstrations, as well as more consistent monitoring of spending, quality, and costs.³⁶

Clarifying CMS policy. Opportunities may exist where improved communication and collaboration between CMS and state Medicaid programs could address particular challenges in lieu of program or policy changes. For example, officials from several states noted that they are uncertain as to what can be authorized and what information CMS needs to approve states' section 1115 demonstrations, which the officials said has created inefficiencies in their efforts to transform their Medicaid programs. In addition, we previously recommended that CMS issue criteria for how it evaluates whether spending authorized under section 1115 demonstrations promotes Medicaid objectives.³⁷ Beyond waivers and demonstrations, state officials expressed interest in enhanced communication and coordination from CMS on federal policy updates and general program changes, such as when CMS identifies new areas of oversight. State officials also commented on the benefits of CMS facilitating efforts to address common problems faced across states.

Responding to change. Our prior work, state officials, and other stakeholders articulated the importance of adapting Medicaid policy and

³⁴See GAO, *Medicaid Demonstrations: Approvals of Major Changes Need Increased Transparency*, [GAO-19-315](#) (Washington, D.C.: Apr. 17, 2019).

³⁵See GAO, *Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in Long Term Services and Supports Programs*, [GAO-17-632](#) (Washington, D.C.: Aug. 14, 2017).

³⁶For example, see GAO, *Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements* [GAO-20-149](#) (Washington, D.C.: Oct. 1, 2019); *Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures*, [GAO-18-220](#) (Washington, D.C.: Jan. 19, 2018); and [GAO-17-312](#).

³⁷See GAO, *Medicaid Demonstrations: Approval Criteria and Documentation Needed to Show How Spending Furthers Medicaid Objectives*, [GAO-15-239](#) (Washington, D.C.: Apr. 13, 2015). As of March 2020, this recommendation remained open.

practices to reflect broader changes or trends, such as unexpected economic events or changes in the type and amount of health care beneficiaries need. For example:

- Our work on economic downturns identified a need to provide states timely temporary Medicaid assistance during a national economic downturn.³⁸
- State officials and stakeholders noted that the national opioid crisis has highlighted the need to address coverage for Medicaid beneficiaries with SUD.³⁹

However, there are varying perspectives on how to respond to such changes. For example, state officials suggested extending Medicaid coverage to historically excluded services, as successful treatment for beneficiaries with SUD may involve stays in IMDs and include health-related social services, such as housing. Other stakeholders highlighted the need to be mindful of the historic reasons for excluding such services from coverage and considering additional opportunities to provide services to beneficiaries suffering from SUD and other conditions.

Agency Comments

We provided a draft of this report to HHS for review. HHS provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last

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

³⁹See also GAO, *Opioid Use Disorder: Barriers to Medicaid Beneficiaries' Access to Treatment Medications*, [GAO-20-233](#) (Washington, D.C.: Jan. 24, 2020); and *Medicaid: Opioid Use Disorder Services for Pregnant and Postpartum Women, and Children*, [GAO-20-40](#) (Washington, D.C.: Oct. 24, 2019).

page of this report. GAO staff who made key contributions to this report are listed in appendix II.



Carolyn L. Yocom
Director, Health Care

Appendix I: State Perspectives on Additional Federal Medicaid Policies

We conducted interviews with Medicaid officials from 50 states and the District of Columbia regarding challenges related to federal Medicaid policies. Table 8 summarizes responses related to policies that officials from fewer than half of the states identified as posing a moderate or significant challenge to their efforts to administer their Medicaid program.

Table 8: Examples of State Challenges and Suggested Strategies Related to Other Federal Medicaid Policies

| Federal policy description and examples of challenges identified by state officials, including suggested strategies for addressing the challenges | Number of states | | | |
|--|-----------------------|--------------------|-----------------|------------------------|
| | Significant challenge | Moderate challenge | Minor challenge | Not at all a challenge |
| <p>State payments to Medicare</p> <p>Description: For dual-eligible beneficiaries, state Medicaid programs partially finance Medicare prescription drug costs and certain other costs, including Medicare premiums, deductibles, and copayments.</p> <p>Reported challenges: State officials cited Medicaid payments for these Medicare costs as a large and growing portion of their budgets. State officials said that the prescription drug payment is tied to historic spending data, which penalizes states that have tried to control such costs in the intervening years. In years where Medicare Part B premiums rise, many Medicare beneficiaries are protected by a hold-harmless provision that prevents their Medicare premiums from increasing more than their Social Security benefit payments. This protection does not apply to dual-eligible beneficiaries, however, and state officials said they therefore absorb a disproportionate share of costs in these years.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> Remove the requirement for Medicaid programs to pay the federal government for drug-related costs for dual-eligible beneficiaries and to make Medicare cost-sharing payments on behalf of dual-eligible beneficiaries. Revisit the Medicaid role in absorbing Medicare Part B premium increases in years in which Medicare premium increases exceed increases in Social Security benefit payments. Revise states' Medicare prescription drug payment amounts to consider states' cost control efforts, or require Medicare to cover cost increases | 13 | 11 | 19 | 7 |
| <p>Prescription drugs</p> <p>Description: Subject to federal requirements, states may use policies such as prior authorization and clinical criteria to manage utilization of prescription drugs.</p> <p>Reported challenges: State officials described challenges managing opioid utilization without creating barriers to access to care.</p> | 8 | 17 | 13 | 13 |

**Appendix I: State Perspectives on Additional
Federal Medicaid Policies**

| Federal policy description and examples of challenges identified by state officials, including suggested strategies for addressing the challenges | Number of states | | | |
|---|-----------------------|--------------------|-----------------|------------------------|
| | Significant challenge | Moderate challenge | Minor challenge | Not at all a challenge |
| <p>Premium assistance^a Description: States may use Medicaid funds to purchase private employer-sponsored or individual health insurance plans for beneficiaries instead of enrolling them in the Medicaid program if doing so is cost effective. States must ensure that such coverage meets all Medicaid requirements, including services covered and cost sharing protections.</p> <p>Reported challenges: State officials noted that requirements related to supplementing such coverage to meet Medicaid requirements and determining its cost effectiveness are complex and burdensome.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> Discontinue or simplify requirements to supplement coverage. Simplify the cost effectiveness determination. | 8 | 15 | 16 | 12 |
| <p>Managed care enrollment Description: States are generally not allowed to require certain populations—dual-eligible beneficiaries, American Indians and Alaska Natives, and children with special health care needs—to enroll in managed care unless they do so under waiver authority.</p> <p>Reported challenges: State officials noted excluding certain populations from managed care complicates oversight of care. Officials also said that it leads to use of waivers or demonstrations to implement managed care.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> Allow states to require all populations to enroll in managed care through their state plans. | 7 | 8 | 14 | 21 |
| <p>Comparability of benefits Description: States generally must offer comparable benefits across Medicaid beneficiaries in a group and across geographic regions, and use comparable eligibility standards.</p> <p>Reported challenges: State officials said that such requirements pose barriers to piloting services, providing additional benefits to serve people with more complex medical issues, or addressing regional variation in service needs.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> Allow states to more flexibly target services to particular populations or areas of a state. Allow states to provide tiered benefit packages, such as a basic package that is available to all beneficiaries and additional benefit levels that are available for populations with specific or more complex needs. | 6 | 16 | 18 | 11 |

Appendix I: State Perspectives on Additional Federal Medicaid Policies

| Federal policy description and examples of challenges identified by state officials, including suggested strategies for addressing the challenges | Number of states | | | |
|--|-----------------------|--------------------|-----------------|------------------------|
| | Significant challenge | Moderate challenge | Minor challenge | Not at all a challenge |
| <p>Federal Medical Assistance Percentage (FMAP)</p> <p>Description: Different FMAPs can apply to certain types of beneficiaries, services, or administrative costs.</p> <p>Reported challenges: State officials noted that different FMAPs across eligibility groups, services, or administrative functions create complexity and are administratively challenging to implement.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> • Establish a single, blended FMAP rate. • Provide more guidance for how states determine which FMAP rate applies for different eligibility categories. | 6 | 12 | 20 | 13 |
| <p>Mandatory services</p> <p>Description: Federal law requires states to cover specified mandatory services, while other services can be offered by states on an optional basis.^b</p> <p>Reported challenges: State officials said that the distinction between mandatory and optional services is outdated and is biased toward institutional services. State officials noted that some key services, such as prescription drugs or home- and community-based services, are not mandatory. States noted challenges related to mandatory non-emergency medical transportation and Early and Periodic Screening, Diagnostic and Treatment services, including demonstrating compliance with access requirements.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> • Update mandatory and optional services or consider a different approach, such as benchmark services. • Provide guidance on how states need to document access to non-emergency medical transportation and Early and Periodic Screening, Diagnostic, and Treatment services. | 2 | 12 | 17 | 20 |
| <p>Telehealth services</p> <p>Description: Telehealth refers to use of technology and interactive telecommunication to deliver health services. Medicaid does not define telehealth as a distinct service, and states have flexibility in how they define and use it.</p> <p>Reported challenges: State officials cited the need for more information about the use of these services, and noted that Medicare telehealth policies are more restrictive than Medicaid, which limits use for dual-eligible beneficiaries.</p> <p>State-suggested strategies:</p> <ul style="list-style-type: none"> • Provide additional guidance on telehealth strategies. | 1 | 10 | 16 | 23 |

Source: GAO analysis of information from interviews with Medicaid officials from 50 states and the District of Columbia. | GAO-20-407

Notes: We did not evaluate the merits, costs, or other effects of implementing state suggested strategies, nor did we ask the Centers for Medicare & Medicaid Services to provide input on them. For certain federal policies, total responses are less than 51 as not all states answered particular

**Appendix I: State Perspectives on Additional
Federal Medicaid Policies**

questions For example, in some cases states declined to provide responses to federal policies that did not apply to their program

^aWe asked states about challenges related to use of premium assistance or integrating Medicaid coverage with other products, such as private insurance available through health insurance exchanges established under the Patient Protection and Affordable Care Act.

^bMandatory services include inpatient hospital services, outpatient hospital services, Early and Periodic Screening, Diagnostic, and Treatment Services, nursing facility services, home health services, physician services, rural health clinic services, federally qualified health center services, laboratory services and X-ray services, family planning services, nurse midwife services, certified pediatric and family nurse practitioner services, certain freestanding birth center services, transportation to medical care, and tobacco cessation counseling for pregnant women.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Susan Anthony (Assistant Director), Emily Beller Holland (Analyst-in-Charge), Colson Campbell, Drew Long, Alexandre Massey, Vikki Porter, and Emily Wilson Schwark made key contributions to this report.

Related GAO Products

Payment Integrity: Federal Agencies' Estimates of FY 2019 Improper Payments. [GAO-20-344](#). Washington, D.C.: March 2, 2020.

Opioid Use Disorder: Barriers to Medicaid Beneficiaries' Access to Treatment Medications. [GAO-20-233](#). Washington, D.C.: January 24, 2020.

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