



October 2019

# MEDICAID DEMONSTRATIONS

## Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements

Accessible Version

# GAO Highlights

Highlights of [GAO-20-149](#), a report to congressional requesters

## Why GAO Did This Study

Section 1115 demonstrations are a significant component of Medicaid spending and affect the care of millions of low-income and medically needy individuals. In 2018, CMS announced a new policy allowing states to test work requirements under demonstrations and soon after began approving such demonstrations. Implementing work requirements can involve various administrative activities, not all of which are eligible for federal funds.

GAO was asked to examine the administrative costs of demonstrations with work requirements. Among other things, this report examines (1) states' estimates of costs of administering work requirements in selected states, and (2) CMS's oversight of these costs. GAO examined the costs of administering work requirements in the first five states with approved demonstrations. GAO also reviewed documentation for these states' demonstrations, and interviewed state and federal Medicaid officials. Additionally, GAO assessed CMS's policies and procedures against federal internal control standards.

## What GAO Recommends

GAO makes three recommendations, including that CMS (1) require states to submit projections of administrative costs with demonstration proposals, and (2) assess risks of providing federal funds that are not allowable to administer work requirements and improve oversight procedures, as warranted. CMS did not concur with the recommendations and stated that its procedures are sufficient given the level of risk. GAO maintains that the recommendations are warranted as discussed in this report.

View [GAO-20-149](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov).

October 2019

# MEDICAID DEMONSTRATIONS

## Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements

## What GAO Found

Medicaid demonstrations enable states to test new approaches to provide Medicaid coverage and services. Since January 2018, the Centers for Medicare & Medicaid Services (CMS) has approved nine states' demonstrations that require beneficiaries to work or participate in other activities, such as training, in order to maintain Medicaid eligibility. The first five states that received CMS approval for work requirements reported a range of administrative activities to implement these requirements.

These five states provided GAO with estimates of their demonstrations' administrative costs, which varied, ranging from under \$10 million to over \$250 million. Factors such as differences in changes to information technology systems and numbers of beneficiaries subject to the requirements may have contributed to the variation. The estimates do not include all costs, such as ongoing costs states expect to incur throughout the demonstration.

**Selected States' Estimates of Administrative Costs to Implement Work Requirements in Approved Medicaid Demonstrations and Federal Share of those Costs**

State	Number of beneficiaries subject to requirements	Estimated costs (dollars in millions)	Estimated federal share (percentage)
Kentucky	620,000	271.6	87
Wisconsin	150,000	69.4	55
Indiana	420,000	35.1	86
Arkansas	115,000	26.1	83
New Hampshire	50,000	6.1	79

Source: GAO analysis of data reported by selected states and selected state documents. | GAO-20-149

Notes: Estimates of beneficiaries subject to work requirements include those who may be eligible for an exemption. Estimates of costs do not include all costs, and in Kentucky and Wisconsin include some costs not specific to work requirements. Estimates generally cover from 1 to 3 years of costs.

GAO found weaknesses in CMS's oversight of the administrative costs of demonstrations with work requirements.

- **No consideration of administrative costs during approval.** GAO found that CMS does not require states to provide projections of administrative costs when requesting demonstration approval. Thus, the cost of administering demonstrations, including those with work requirements, is not transparent to the public or included in CMS's assessments of whether a demonstration is budget neutral—that is, that federal spending will be no higher under the demonstration than it would have been without it.
- **Current procedures may be insufficient to ensure that costs are allowable and matched at the correct rate.** GAO found that three of the five states received CMS approval for federal funds—in one case, tens of millions of dollars—for administrative costs that did not appear allowable or at higher matching rates than appeared appropriate per CMS guidance. The agency has not assessed the sufficiency of its procedures for overseeing administrative costs since it began approving demonstrations with work requirements.

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**Abbreviations**

CMS	Centers for Medicare & Medicaid Services
FMAP	Federal Medical Assistance Percentage
HHS	Department of Health and Human Services
IT	information technology
MCO	managed care organization
PPACA	Patient Protection and Affordable Care Act
SNAP	Supplemental Nutritional Assistance Program
TANF	Temporary Assistance to Needy Families

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October 1, 2019

The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Frank Pallone, Jr.  
Chairman  
Committee on Energy and Commerce  
House of Representatives

Medicaid section 1115 demonstrations—which allow states to test and evaluate new approaches for delivering health care services under the federal-state Medicaid program—have become a significant feature of the program.<sup>1</sup> Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain federal Medicaid requirements and approve new types of expenditures that would not otherwise be eligible for federal Medicaid funds for experimental, pilot, or demonstration projects that, in the Secretary’s judgment, are likely to promote Medicaid objectives.<sup>2</sup> As of November 2018, over three-quarters of states operated at least part of their Medicaid program under a section 1115 demonstration; in fiscal year 2017, federal spending for demonstrations was about \$145 billion, or over one-third of federal Medicaid program expenditures.

The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), oversees Medicaid section 1115 demonstrations (referred to hereafter as demonstrations) and has approved states’ use of demonstrations for a variety of purposes. For example, under demonstrations, states have extended coverage to populations, offered services not otherwise eligible for Medicaid, and increased beneficiary premiums and cost-sharing above statutory limits.

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<sup>1</sup>Medicaid is a joint, federal-state program that finances health care coverage for low-income and medically needy individuals. The program is a significant component of federal and state budgets. It covered an estimated 75 million individuals at an estimated cost of \$629 billion in fiscal year 2018, including about \$393 billion in federal spending and \$236 billion in state spending, according to estimates from the Centers for Medicare & Medicaid Services’ Office of the Actuary.

<sup>2</sup>42 U.S.C. § 1315(a).

In January 2018, CMS issued guidance announcing a new opportunity for states to use demonstrations to require certain beneficiaries to work or participate in community engagement activities, such as vocational training or volunteer activities, as a condition of Medicaid eligibility.<sup>3</sup> CMS gave states flexibility in designing the work requirements within certain parameters. Medicaid beneficiaries not meeting these work requirements can face suspension or termination of coverage if they do not meet—and do not appropriately report having met—the number of hours of activity required. CMS approved the first demonstration testing work requirements in Kentucky in January 2018 and has since approved such requirements in eight other state demonstrations, with seven more state demonstration applications pending as of May 2019. While work requirements have long been a feature of programs such as Temporary Assistance to Needy Families (TANF), CMS has not previously approved work requirements in state Medicaid programs. As of August 2019, there is ongoing litigation challenging CMS’s approvals of such requirements in three states that had implemented, or were preparing to implement, work requirements: Arkansas, Kentucky, and New Hampshire.<sup>4</sup>

Implementing work requirements—like other changes in Medicaid—can increase Medicaid administrative costs, as states may need to change eligibility and enrollment systems and conduct additional beneficiary outreach, monitoring, and evaluation.<sup>5</sup> In general, the federal government

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<sup>3</sup>According to CMS’s guidance, work requirements are to be targeted to non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability. The guidance indicates that states will be required to provide exemptions for beneficiaries based on medical frailty, disability, and other reasons. See CMS, *State Medicaid Director Letter; Re: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries*, SMD: 18-002 (Baltimore, Md.: Jan. 11, 2018).

CMS and states have used various terms to refer to these requirements including “work requirements,” “community engagement requirements,” and “work and community engagement requirements.” We use the term “work requirements” in this report consistent with how similar requirements are referenced by other federal programs, including the Supplemental Nutritional Assistance Program (SNAP) and Temporary Assistance to Needy Families (TANF).

<sup>4</sup>The U.S. District Court for the District of Columbia vacated CMS’s approvals of the Arkansas and Kentucky demonstrations with work requirements in March 2019 and CMS’s approval of New Hampshire’s demonstration in July 2019. *Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019); *Stewart v. Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019); *Philbrick v. Azar*, No. 19-773 (JEB) (D.D.C. July 29, 2019). As of August 2019, CMS was appealing the decisions vacating demonstrations in Arkansas and Kentucky.

<sup>5</sup>In fiscal year 2018, Medicaid administrative expenditures were estimated to be \$28.8 billion or about 4.6 percent of total Medicaid expenditures, according to CMS’s Office of the Actuary.

provides 50 percent of the funds for administrative costs, but pays for up to 90 percent of certain costs, including those for information technology (IT) system changes. CMS is responsible for overseeing Medicaid administrative spending and ensuring that federal matching funds are only provided for costs that are allowable under Medicaid rules. Stakeholders have raised concerns that work requirements will increase administrative costs.

Given the number of states opting to test work requirements, you asked us to examine the administrative costs of demonstrations with work requirements and CMS oversight of those expenditures. This report examines

1. characteristics of work requirements in states with approved demonstrations and pending applications;
2. selected states' estimates of the administrative costs to implement demonstrations with work requirements; and
3. CMS's oversight of the administrative costs of demonstrations with work requirements.

To examine the characteristics of work requirements in states that have received approval and those with pending demonstration applications, we reviewed demonstration documentation from CMS. Specifically, we reviewed approval documents for the nine states that had received CMS approval as of May 2019.<sup>6</sup> As part of our review, we identified the extent of variation across states in the beneficiary groups subject to the work requirements, including the age and eligibility groups; the hours of work required and frequency of required reporting; and the consequences for non-compliance, including both the nature of the consequence—suspension or termination of coverage—and when it would take effect.<sup>7</sup> We also identified the extent of any variation in the populations states exempted from the work requirements and the types of activities that met the requirements. For the seven states with demonstration applications to

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<sup>6</sup>The nine states that received approval included Arizona, Arkansas, Indiana, Kentucky, Michigan, New Hampshire, Ohio, Utah, and Wisconsin. A tenth state, Maine, received CMS approval for work requirements, but the state subsequently terminated the demonstration. As such, we did not include Maine in our review.

<sup>7</sup>Medicaid eligibility groups include low-income individuals who meet financial and categorical requirements, such as adults, pregnant women, parents and children, individuals who are aged, and individuals with disabilities.

implement work requirements that were pending as of May 2019, we reviewed application documents for these same characteristics.

To examine selected states' estimates of the administrative costs of demonstrations with work requirements, we reviewed state data and documentation for the five selected states that had received approval as of November 2018. These states—Arkansas, Indiana, Kentucky, New Hampshire, and Wisconsin—had the most time to implement work requirements or make significant preparations to do so during the time that we conducted our review.<sup>8</sup> Using a data collection instrument provided to the selected states, we collected available estimates of the administrative costs for implementing and administering work requirements over the course of the demonstration approval periods (3 to 5 years), including the states' estimates of federal and non-federal costs.<sup>9</sup> We also requested available information on the amounts of expenditures for implementing and administering work requirements incurred from the date the state submitted its application through the end of calendar year 2018.<sup>10</sup> We asked the selected states to break those expenditures out according to several types of administrative activities, such as implementation and operation of IT systems, beneficiary outreach, and staff training, as well as by expected federal and non-federal amounts.

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<sup>8</sup>As noted earlier, the U.S. District Court for the District of Columbia vacated approvals for Arkansas and Kentucky in March 2019 and the approval for New Hampshire in July 2019. We included these states in the scope of our review because they had completed implementation activities prior to the approvals being vacated. Arkansas received approval of its demonstration in March 2018, implemented work requirements on June 1, 2018, and administered the requirements for 9 months before the relevant approval was vacated. Kentucky received approval for its demonstration in January 2018 and initially prepared to implement work requirements on July 1, 2018. That approval was vacated on June 29, 2018. Kentucky received a new approval for work requirements in November 2018 and began preparing for implementation in April 2019 before that approval was vacated on March 27, 2019. New Hampshire received approvals for its demonstration in May and November 2018, and implemented the demonstration in March 2019 before its approval was vacated 4 months later.

<sup>9</sup>States finance the non-federal share of Medicaid costs in large part through state general funds and depend on other sources of funds, such as taxes on health care providers and funds from local governments, to finance the remainder.

<sup>10</sup>States sometimes began IT system development activities while their applications were under review. According to CMS, states can receive federal approval and funds for related expenditures prior to the approval of the demonstration to the extent CMS determines they are reasonable and align with required business processes. See, CMS, *Medicaid and CHIP Frequently Asked Questions (FAQs) Advanced Planning Documents (APD) for System Development Associated with 1115 Demonstrations* (Baltimore, Md.: June 13, 2019). Selected states submitted applications between August 2016 and July 2018.



Where states could not provide expenditure amounts for a given type of activity, we asked them to affirm whether expenditures were incurred for that activity. We also reviewed related state documentation detailing the use of these funds, including descriptions of changes to IT systems and agreements state Medicaid agencies entered into with managed care organizations (MCO) or other state agencies to carry out administrative tasks related to work requirements.<sup>11</sup> In addition, we interviewed Medicaid officials in the five selected states and asked them about the administrative activities they had undertaken or planned to take to implement work requirements, expected ongoing annual costs, and factors that affected implementation costs. We used our reviews of state documentation and interviews with officials to identify any inconsistencies or limitations in the data reported by the states. Based on these steps, we found the data were sufficiently reliable for the purpose of our reporting objectives.

To examine CMS's oversight of the administrative costs of demonstrations with work requirements, we reviewed documentation of policies and procedures for approving, monitoring, and evaluating demonstrations. This included the policies and procedures applied to all demonstrations, as well as those applied to demonstrations with work requirements.<sup>12</sup> We also reviewed policies and procedures for approving federal funds for changes to Medicaid IT systems. In addition, for our five selected states, we reviewed state demonstration applications and interviewed state Medicaid officials about information the states provided to CMS during the approval process about projected administrative costs.

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<sup>11</sup>Descriptions of changes to IT systems included proposals submitted by states to CMS for approval of federal funds at higher federal matching rates available for certain system development, and maintenance and operations costs, or for updates to previous approvals, correspondence between the state and CMS on those proposals, and approval documents.

<sup>12</sup>With regard to policies and procedures with general application, we reviewed regulations detailing state requirements and CMS procedures for transparency of demonstration approvals and outcomes. 42 C.F.R. pt. 431 subpt. G. We also reviewed CMS's policy for ensuring that demonstrations are budget neutral. CMS, *State Medicaid Director Letter; Re: Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects*, SMD: 18-009 (Baltimore, Md.: Aug. 22, 2018). For policies and procedures specific to work and community engagement requirements, we reviewed guidance to states, issued in January 2018, on applying for approval of work requirements, as well as subsequent guidance, issued in March 2019, on monitoring and evaluation of demonstrations with work requirements. CMS, SMD: 18-002; and CMS, *1115 Demonstration State Monitoring & Evaluation Resources*, accessed March 14, 2019, <https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/evaluation-designs-and-reports/index.html>.

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We also reviewed state documents detailing plans for obtaining and using federal funds for the administrative costs associated with work requirements and related CMS approval documents. We compared states' plans with CMS policy on allowable administrative activities—those eligible for federal Medicaid matching funds—and the appropriate federal matching rates for those activities. We also interviewed CMS officials about the extent to which CMS considers administrative costs when approving demonstrations, how CMS oversees the administrative costs of demonstrations through the approval of IT funds and other processes, and how CMS ensures that states receive appropriate federal matching rates for allowable administrative costs under Medicaid rules. Finally, we assessed CMS's policies and procedures against federal standards for internal controls related to risk assessment.<sup>13</sup>

We conducted this performance audit from August 2018 to September 2019 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.

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## Background

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### Medicaid Section 1115 Demonstrations

As of November 2018, 43 states operated at least part of their Medicaid programs under demonstrations. State demonstrations can vary in size and scope, and many demonstrations are comprehensive in nature, affecting multiple aspects of states' Medicaid programs. In fiscal year 2017, federal spending on demonstrations accounted for more than one-third of total federal Medicaid spending and in eight states accounted for 75 percent or more of Medicaid expenditures.

CMS typically approves demonstrations for an initial 5-year period that can be extended in 3- to 5-year increments with CMS approval. Some

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<sup>13</sup>See GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). Internal control is a process affected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

states have operated portions of their Medicaid programs under a demonstration for decades. Each demonstration is governed by special terms and conditions, which reflect the agreement reached between CMS and the state, and describe the authorities granted to the state. For example, the special terms and conditions may define what demonstration funds can be spent on—including which populations and services—as well as specify reporting requirements, such as monitoring or evaluation reports states must submit to CMS.

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## Work Requirements

In January 2018, CMS announced a new policy to support states interested in using demonstrations to make participation in work or community engagement a requirement to maintain Medicaid eligibility or coverage.<sup>14</sup> CMS's guidance indicates that states have flexibility in designing demonstrations that test work requirements, but it also describes parameters around the populations that could be subject to work requirements and other expectations. CMS guidance addresses several areas, including the following:

- **Populations.** Work requirements should apply to working-age, non-pregnant adult beneficiaries who qualify for Medicaid on a basis other than a disability.
- **Exemptions and qualifying activities.** States must create exemptions for individuals who are medically frail or have acute medical conditions. States must also take steps to ensure eligible individuals with opioid addiction and other substance use disorders have access to coverage and treatment services and provide reasonable modifications for them, such as counting time spent in medical treatment toward work requirements. The guidance indicates that states can allow a range of qualifying activities that satisfy work requirements, such as job training, education programs, and community service. The guidance also encourages states to consider aligning Medicaid work requirements with work requirements in other federal assistance programs operating in their states.<sup>15</sup>

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<sup>14</sup>See CMS, SMD: 18-002.

<sup>15</sup>For example, SNAP includes work requirements that certain adult participants must comply with as a condition of eligibility for benefits. However, certain participants are exempt from SNAP work requirements, such as those who are physically unfit for employment or those participating in a drug addiction or alcohol treatment and rehabilitation program.

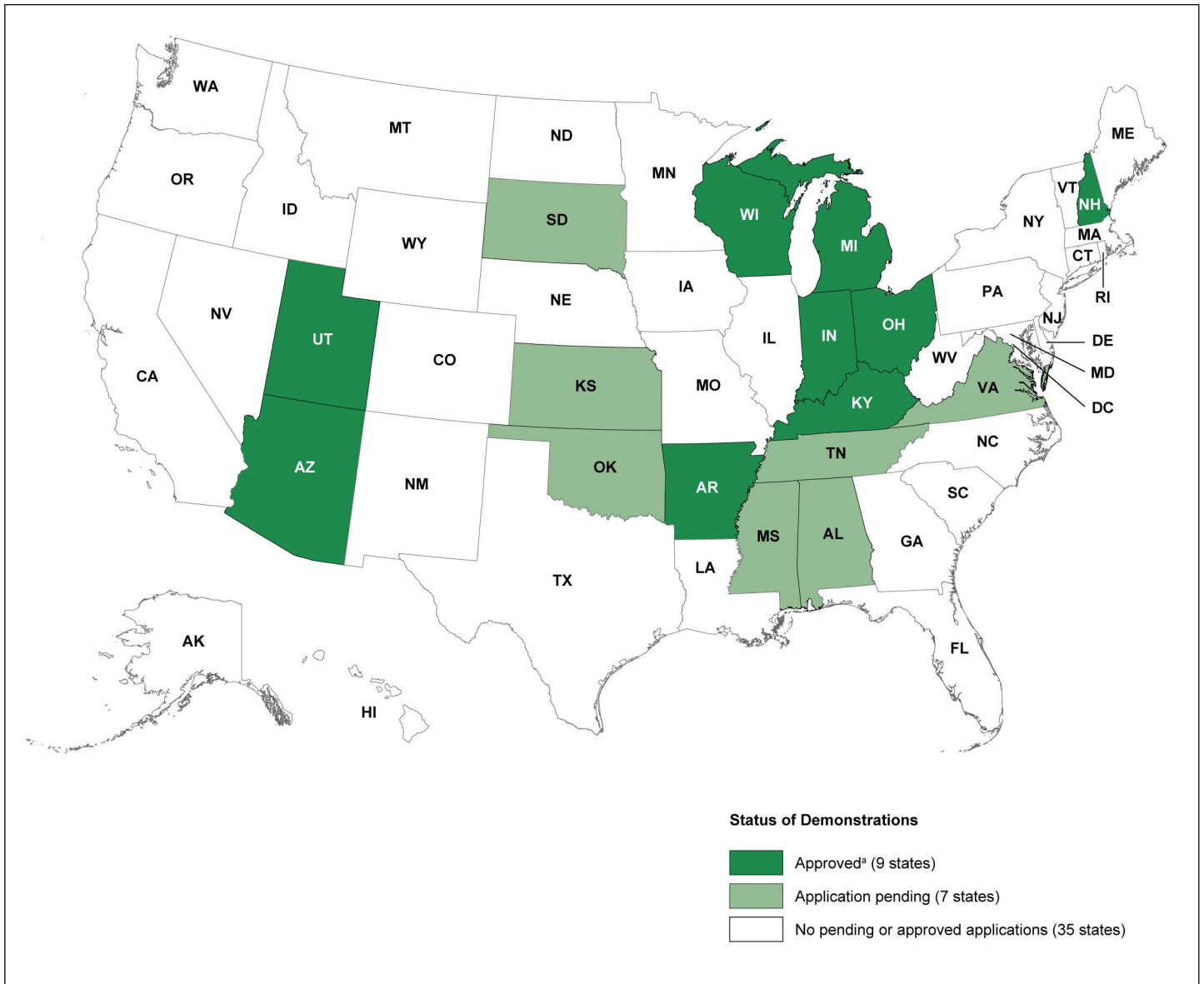
- 
- **Beneficiary supports.** States are expected to describe their strategies to assist beneficiaries in meeting work requirements and to link them to additional resources for job training, child care assistance, transportation, or other work supports. However, CMS's guidance specifies that states are not authorized to use Medicaid funds to finance these beneficiary supports.

About one-third of states have either received CMS approval or submitted applications to CMS to test work requirements in their demonstrations. Nine states have had work requirements approved as part of new demonstrations or extensions of or amendments to existing demonstrations as of May 2019.<sup>16</sup> Also as of May 2019, seven more states had submitted demonstration applications with work requirements, which were pending CMS approval. (See fig. 1.)

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<sup>16</sup>CMS also approved a demonstration for Maine to institute work requirements in December 2018, with implementation scheduled for July 2019. However, in January 2019, Maine communicated to CMS that the state would not be implementing the demonstration.

**Figure 1: States with Approved or Pending 1115 Demonstrations with Work Requirements, as of May 2019**

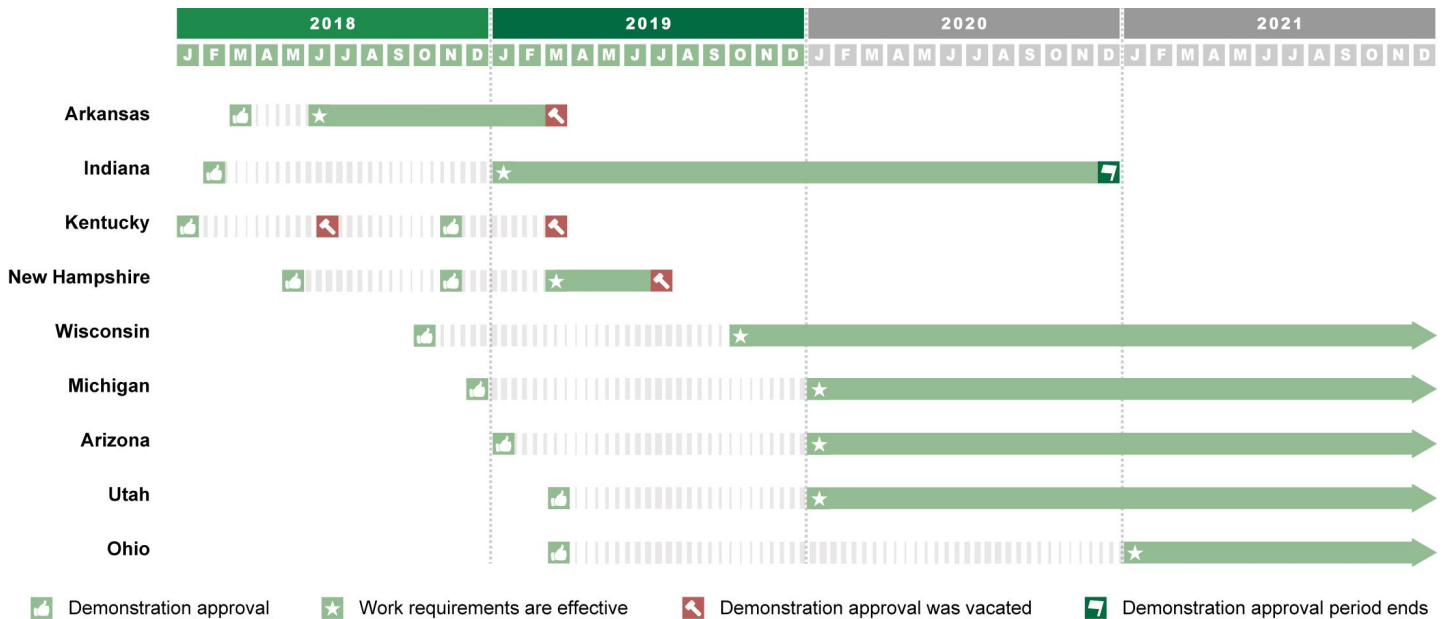


Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) documentation (data); Map Resources (map). | GAO-20-149

<sup>a</sup>A federal district court vacated CMS's approvals of demonstrations in Arkansas and Kentucky in March 2019, and in New Hampshire in July 2019; as of August 2019, CMS was appealing the decisions vacating demonstrations in Arkansas and Kentucky. CMS approved a demonstration for Maine to institute work requirements in December 2018. However, in January 2019, Maine communicated to CMS that the state would not be implementing the demonstration, and, as a result, we listed Maine as having no pending or approved application.

States with approved work requirements were in various stages of implementation as of August 2019, and three states faced legal challenges to implementation. The requirements were in effect in Arkansas for 9 months before a federal district court vacated the approval in March 2019.<sup>17</sup> Work requirements became effective in Indiana in January 2019 and will be enforced beginning in January 2020. CMS’s approval of work requirements in Kentucky was vacated in March 2019—several days before the work requirements were set to become effective on April 1, 2019.<sup>18</sup> As of August 2019, CMS was appealing the court decisions vacating demonstration approvals in Arkansas and Kentucky. Other states’ requirements are approved to take effect in fiscal years 2020 and 2021. (See fig. 2.)

**Figure 2: Approval and Effective Dates for States with Approved Work Requirements, as of August 2019**



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) documentation. | GAO-20-149

<sup>17</sup>Gresham v. Azar, 363 F. Supp. 3d 165 (D.D.C. 2019).

<sup>18</sup>CMS’s initial approval of Kentucky’s demonstration in January 2018 was vacated by the U.S. District Court for the District of Columbia in June 2018. Stewart v. Azar, 313 F. Supp. 3d 237 (D.D.C. 2018). CMS reapproved Kentucky’s demonstration on November 20, 2018. The U.S. District Court for the District of Columbia vacated this approval on March 27, 2019. Stewart v. Azar, 366 F. Supp. 3d 125 (D.D.C. 2019).

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Notes: Kentucky was first approved to implement work requirements in January 2018; this approval was vacated by the U.S. District Court for the District of Columbia in June 2018. CMS reapproved Kentucky's demonstration in November 2018. New Hampshire was first approved in May 2018 to implement work requirements, and, in November 2018, CMS approved an extension of the state's demonstration, including its work requirements. Under the terms of the approvals, states have discretion to delay effective dates for work requirements.

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## Federal Funding for Administrative Costs to Implement Work Requirements

Implementing work requirements, as with other types of beneficiary requirements, can involve an array of administrative activities by states, including developing or adapting eligibility and enrollment systems, educating beneficiaries, and training staff. In general, CMS provides federal funds for 50 percent (referred to as a 50 percent matching rate) of state Medicaid administrative costs. These funds are for activities considered necessary for the proper and efficient administration of a state's Medicaid program, including those parts operated under demonstrations.<sup>19</sup> CMS provides higher matching rates for certain administrative costs, including those related to IT systems. For example, expenditures to design, develop, and install Medicaid eligibility and enrollment systems are matched at 90 percent, and maintenance and operations of these systems are matched at 75 percent.<sup>20</sup>

States may also receive federal funds for administrative activities delegated to MCOs. The amount of federal Medicaid funds states receive for payments to MCOs that bear financial risk for Medicaid expenditures is determined annually by a statutory formula based on the state's per capita income, known as the Federal Medical Assistance Percentage (FMAP).<sup>21</sup> The FMAP sets a specific federal matching rate for each state that, for fiscal year 2019, ranges from 50 percent to 76 percent. There are exceptions to this rate for certain populations, providers, and services. For example, states that chose to expand Medicaid under the Patient

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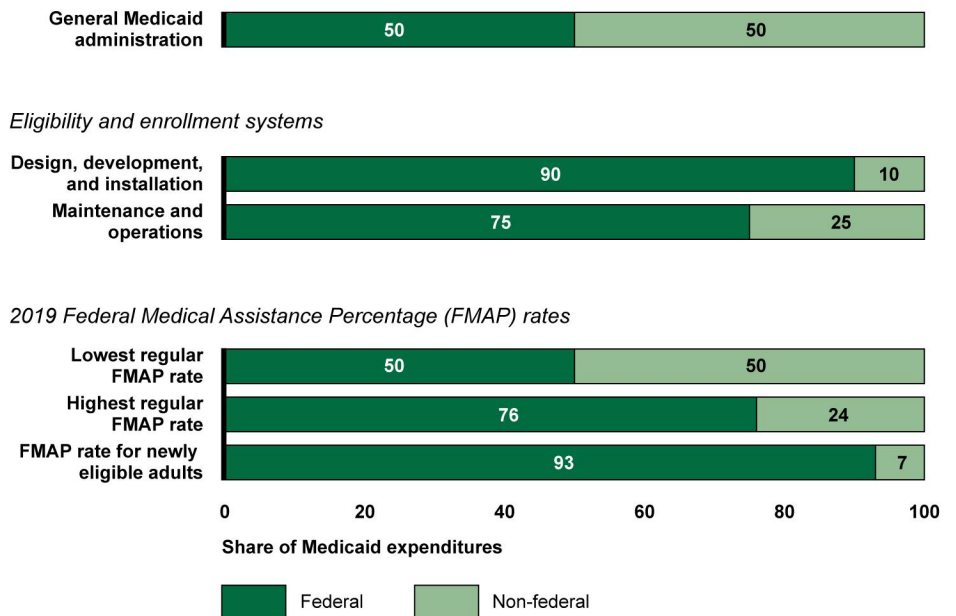
<sup>19</sup>42 U.S.C. § 1396b(a)(7).

<sup>20</sup>42 U.S.C. § 1396b(a)(3)(A)(i), (a)(3)(B).

<sup>21</sup>42 U.S.C. § 1396d(b). The FMAP applies broadly to Medicaid expenditures, including expenditures for most Medicaid services.

Protection and Affordable Care Act (PPACA) receive a higher FMAP for newly eligible adults, equal to 93 percent in 2019.<sup>22</sup> (See fig. 3.)

**Figure 3: Federal and Non-Federal Shares for Selected Types of Medicaid Expenditures, Fiscal Year 2019**



Source: GAO analysis of Centers for Medicare & Medicaid Services documentation. | GAO-20-149

**Data table for Figure 3: Federal and Non-Federal Shares for Selected Types of Medicaid Expenditures, Fiscal Year 2019**

	Federal share of Medicaid expenditures	Non-federal share of Medicaid expenditures
<b>General Medicaid administration</b>	50	50
<b>Eligibility and enrollment systems</b>		
Design, development, and installation	90	10
Maintenance and operations	75	25
<b>2019 Federal Medical Assistance Percentage (FMAP) rates</b>		
Lowest regular FMAP rate	50	50
Highest regular FMAP rate	76	24
FMAP rate for newly eligible adults	93	7

<sup>22</sup>Newly eligible adults under PPACA include nonelderly, nonpregnant adults who are not eligible for Medicare, and whose income does not exceed 138 percent of the federal poverty level. The FMAP for newly eligible adults will decrease to 90 percent in 2020.



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Notes: The FMAP is a statutory formula that determines the federal government's share for most Medicaid expenditures based on each state's per capita income relative to the national average. In 2019, the federal share ranged from 50 percent to 76 percent. Newly eligible adults refer to individuals eligible because their state chose to expand Medicaid under the Patient Protection and Affordable Care Act. Under the act, costs for these individuals are matched at a higher rate than the regular FMAP rates.

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## CMS Oversight of Administrative Costs

CMS has several different related processes under which the agency oversees Medicaid administrative costs, including those for demonstrations.

- **Demonstration approval, monitoring, and evaluation.** States seeking demonstration approvals must meet transparency requirements established by CMS. For example, states must include certain information about the expected changes in expenditures under the demonstration in public notices seeking comment at the state level and in the application to CMS, which is posted for public comment at the federal level. In addition, CMS policy requires that demonstrations be budget neutral—that is, that the federal government should spend no more under a demonstration than it would have without the demonstration. Prior to approval, states are required to submit an analysis of their projected costs with and without the demonstration. CMS uses this information to determine budget neutrality and set spending limits for demonstrations. During the demonstration, CMS is responsible for monitoring the state's compliance with the terms and conditions of the demonstration, including those related to how Medicaid funds can be spent and the demonstration spending limit. States must also evaluate their demonstrations to assess the effects of the policies being tested, which could include impacts on cost.
- **Review and approval of federal matching funds for IT projects.** To request higher federal matching rates for changes to Medicaid IT systems, including eligibility and enrollment systems, states must submit planning documents to CMS for review and approval. States' plans must include sufficient information to evaluate the state's goals, procurement approach, and cost allocations within a specified budget. States may request funds for system development related to a proposed demonstration before the demonstration is approved. Funding can be approved and expended under the approved plan while the demonstration application is being reviewed.<sup>23</sup> States submit

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<sup>23</sup>CMS's process recognizes that for timely implementation, some system design, development, and installation may need to occur prior to demonstration approval.

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updates to planning documents annually for CMS review, which can include requested changes to the approved budget.

- **Quarterly expenditure reviews.** In order to receive federal matching funds, states report their Medicaid expenditures quarterly to CMS, including those made under demonstrations. Expenditures associated with demonstrations, including administrative expenditures, are reported separately from other expenditures. CMS is responsible for ensuring that expenditures reported by states are supported and allowable, meaning that the state actually made and recorded the expenditure and that the expenditure is consistent with Medicaid requirements. With regard to consistency, this includes comparing reported expenditures to various approval documents. For example, CMS is responsible for comparing reported demonstration expenditures against the special terms and conditions that authorize payment for specified services or populations and establish spending limits. CMS is also responsible for reviewing states' reported expenditures against budgets in states' planning documents to ensure that states do not exceed approved amounts.

A list of GAO reports related to these CMS oversight processes is included at the end of this report.

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## States' Work Requirements Varied in Terms of Target Population, Required Activities, and Consequences of Non-Compliance

States took different approaches to designing work requirements under their Medicaid demonstrations. These requirements varied in terms of the beneficiary groups subject to the requirements; the required activities, such as frequency of required reporting; and the consequences beneficiaries face if they do not meet requirements.

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### Beneficiaries Subject to Work Requirements and Required Activities

In the nine states with approved work requirements as of May 2019, we found differences in the age and eligibility groups subject to work requirements, and, to a lesser extent, the number of hours of work required and frequency of required reporting to the state. For example:

- **Age and eligibility groups subject to work requirements.** Four of these states received approval to apply the requirements to adults under the age of 50, similar to how certain work requirements are applied under the Supplemental Nutrition Assistance Program (SNAP).<sup>24</sup> Among the other five states, approved work requirements apply to adults up to the age of 59 (Indiana and Utah), 62 (Michigan), and 64 (Kentucky and New Hampshire). States generally planned to apply the requirements to adults newly eligible under PPACA or a previous coverage expansion, but some states received approval to apply the requirements to additional eligibility groups, such as parents and caretakers of dependents.<sup>25</sup>
- **Number of hours of work required and frequency of required reporting.** Under approved demonstrations in seven states, Medicaid beneficiaries must complete 80 hours of work or other qualifying activities per month to comply with work requirements. Five states' approved demonstrations require beneficiaries to report each month on their hours of work or other qualifying activities, using methods approved by the state, such as online or over the phone. (See table 1.)

We saw similar variation under the seven state applications that were pending as of May 2019.<sup>26</sup>

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<sup>24</sup>Generally, SNAP recipients ages 18 through 49 who are not physically or mentally unfit for employment, are in a household not responsible for a dependent child, and do not meet other exemptions must work or participate in a work program 20 hours or more per week or otherwise earn the value of their SNAP benefits. In addition, SNAP recipients ages 16 through 59 must generally comply with general work requirements that typically include registering for work and may include additional required activities.

<sup>25</sup>Prior to PPACA, states could expand coverage to populations not traditionally eligible for Medicaid—such as childless adults—using state funds or through a section 1115 demonstration.

<sup>26</sup>States' pending applications varied in terms of the age groups subject to the requirements with maximum ages ranging from 50 years to 65 years. In terms of eligibility groups, six of the seven states had not expanded Medicaid to those newly eligible under PPACA. Thus, those states' applications focused the work requirements on other eligibility groups, such as parents and caretakers of dependents. All seven states were seeking approval to require beneficiaries to complete 80 hours per month (or 20 hours per week) of work or other qualifying activities, and one state planned to require childless adults to participate 30 hours per week.

**Table 1: Beneficiary Groups Subject to and Characteristics of Medicaid Work Requirements in States that Received Approval for Such Requirements, as of May 2019**

State	Beneficiary groups subject to the work requirements			Beneficiary reporting requirements	
	Maximum age	Newly eligible adults <sup>a</sup>	Other eligibility groups <sup>b</sup>	Number of hours required monthly	Frequency of required reporting to state
Arizona	49	Yes	NA	80	Monthly
Arkansas	49	Yes	NA	80	Monthly
Indiana	59	Yes	Yes	80	Annually
Kentucky	64	Yes	Yes	80	Monthly
Michigan	62	Yes	NA	80	Monthly
New Hampshire	64	Yes	NA	100	Monthly
Ohio	49	Yes	NA	80	Annually
Utah	59	<sup>c</sup>	Yes	<sup>d</sup>	Annually
Wisconsin	49	<sup>c</sup>	NA	80	<sup>e</sup>

Legend:  
 ✓ = yes  
 NA = not applicable

Source: Centers for Medicare & Medicaid Services (CMS) documentation. | GAO-20-149

Note: The U.S. District Court for the District of Columbia vacated CMS's approvals of demonstrations in Arkansas and Kentucky in March 2019, and in New Hampshire in July 2019. *Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019); *Stewart v. Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019); *Philbrick v. Azar*, No. 19-773 (JEB) (D.D.C. July 29, 2019).

<sup>a</sup>The Patient Protection and Affordable Care Act (PPACA) permitted states to expand Medicaid coverage to nonelderly, non-pregnant adults who are not eligible for Medicare and whose income does not exceed 138 percent of the federal poverty level.

<sup>b</sup>This includes such groups as parents and caretakers of dependents.

<sup>c</sup>Utah and Wisconsin expanded coverage to adults with incomes at or below 100 percent—rather than 138 percent—of the federal poverty level and gained approval to subject those beneficiaries to work requirements.

<sup>d</sup>Utah requires beneficiaries to work 30 hours per week or complete a set of qualifying activities.

<sup>e</sup>Wisconsin's approval to implement work requirements does not specify the frequency of required reporting.

All nine states with approved work requirements as of May 2019 exempted several categories of beneficiaries and counted a variety of activities as meeting the work requirements. For example, all nine states exempted from the work requirements people with disabilities, pregnant women, and those with certain health conditions, such as a serious mental illness.<sup>27</sup> In addition, depending on the state, other groups were

<sup>27</sup>CMS guidance requires states to exempt certain populations, such as individuals determined to be medically frail and individuals classified as “disabled” for Medicaid eligibility purposes, and to make reasonable modifications for others.

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also exempted, such as beneficiaries who are homeless, survivors of domestic violence, and those enrolled in substance use treatment programs. States also counted activities other than work as meeting the work requirements, such as job training, volunteering, and caregiving for non-dependents. In addition to work requirements, eight of the nine states received approval under their demonstrations to implement other beneficiary requirements, such as requiring beneficiaries to have expenditure accounts.<sup>28</sup> (See app. I for more information on these other beneficiary requirements.)

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## Beneficiary Consequences for Non-Compliance

The consequences Medicaid beneficiaries faced for non-compliance and the timing of the consequences varied across the nine states with approved work requirements. The consequences for non-compliance included coverage suspension and termination.<sup>29</sup> For example, Arizona received approval to suspend beneficiaries' coverage after 1 month of non-compliance. In contrast, Wisconsin will not take action until a beneficiary has been out of compliance for 4 years, at which time coverage will be terminated. Three states (Arkansas, Michigan, and Wisconsin) imposed or planned to impose a non-eligibility period after terminating a beneficiary's enrollment.<sup>30</sup> For example, under Arkansas' demonstration, after 3 months of non-compliance, the beneficiary was not eligible to re-enroll until the next plan year, which began in January of each year. Thus, beneficiaries could be locked out of coverage for up to 9 months. (See table 2.) For states with pending applications, suspension or termination of coverage takes effect after 2 or 3 months of non-compliance.

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<sup>28</sup>Beneficiary expenditure accounts are similar to health savings accounts where funds are used to pay for health care expenses.

<sup>29</sup>Under a suspension, beneficiaries remain enrolled, but coverage is suspended until they come into compliance with the work requirements or a specified period of time has elapsed. Under termination, enrollment in the Medicaid program is terminated for individuals and they must reapply to regain coverage. In some states, coverage may first be suspended and subsequently terminated if beneficiaries do not come into compliance by their annual eligibility redetermination.

<sup>30</sup>States with a non-eligibility period restrict an individual from reenrolling in the program following a coverage termination due to noncompliance with the work requirements for a set period of time or until certain conditions are met.

**Table 2: Beneficiary Consequences for Non-Compliance with Medicaid Work Requirements in States with Approved Requirements, as of May 2019**

State	Number of months of non-compliance before consequence	Type of consequence <sup>a</sup>	Non-eligibility period <sup>b</sup>
Arizona	1	Suspension	NA
Arkansas	3 in a calendar year	Termination	0 to 9 months
Indiana	4 in a calendar year	Suspension then termination	NA
Kentucky	2 in a row	Suspension then termination	NA
Michigan	3 in 12 months	Termination	At least 1 month
New Hampshire	2 in a row	Suspension then termination	NA
Ohio	2 (60 days)	Termination	NA
Utah	3 in 12 months	Termination	NA
Wisconsin	48	Termination	6 months

Legend:  
NA = not applicable

Source: Centers for Medicare & Medicaid Services (CMS) documentation. | GAO-20-149

Note: The U.S. District Court for the District of Columbia vacated CMS’s approvals of demonstrations in Arkansas and Kentucky in March 2019, and in New Hampshire in July 2019. *Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019); *Stewart v. Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019); *Philbrick v. Azar*, No. 19-773 (JEB) (D.D.C. July 29, 2019).

<sup>a</sup>Under a suspension, beneficiaries remain enrolled, but coverage is suspended until they come into compliance with the work requirements or a specified period of time has elapsed. Under termination, enrollment in the Medicaid program is terminated for individuals and they must reapply to regain coverage. In some states, coverage may first be suspended and subsequently terminated if beneficiaries do not come into compliance by their annual eligibility redetermination.

<sup>b</sup>States with a non-eligibility period restrict an individual from reenrolling in the program following a coverage termination due to noncompliance with the work requirements for a set period of time or until certain conditions are met.

For states that suspend coverage for beneficiaries, there are different conditions for coming into compliance and lifting the suspension. For example:

- Arizona received approval to automatically reactivate an individual’s eligibility at the end of each 2-month suspension period.
- In other states, such as Indiana, beneficiaries must notify the state that they have completed 80 hours of work or other qualifying activities in a calendar month, after which the state will reactivate eligibility beginning the following month. (See text box.)

**Indiana’s Suspension Process for Non-Compliance with Medicaid Work Requirements**

At the end of each year, the state reviews beneficiaries’ activities related to work requirements. Beneficiaries must meet the required monthly hours 8 out of 12 months of the year to avoid a suspension of Medicaid coverage.

If coverage is suspended for not meeting work requirements, the suspension will start January 1 and could last up to 12 months. During a suspension, beneficiaries will not be able to access Medicaid coverage to receive health care.

Beneficiaries with suspended Medicaid coverage can reactivate coverage if they become

- pregnant;
- medically frail; or
- employed, enrolled in school, or engaged in volunteering.

Beneficiaries must contact the state to reactivate coverage.

Source: GAO summary of Indiana’s “Gateway to Work suspension process” website, accessed June 24, 2019, <https://www.in.gov/fssa/hip/2593.htm>. | GAO-20-149.

To prevent suspension from taking effect, two states (Kentucky and New Hampshire) require beneficiaries to make up required work hours that were not completed in order to maintain compliance with work requirements. For example, in Kentucky, if the beneficiary worked 60 hours in October (20 hours less than the required 80), the beneficiary must work 100 hours in November to avoid suspension of coverage in December.<sup>31</sup>

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## Available Estimates of Costs to Implement Work Requirements Varied among Selected States, with the Majority of Costs Expected to Be Financed by Federal Dollars

Available estimates of the costs to implement Medicaid work requirements varied considerably among the five selected states, and these estimates did not account for all costs. These states estimated that federal funding would cover the majority of these costs, particularly costs to modify IT systems.

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<sup>31</sup>Kentucky’s vacated approval also allowed beneficiaries to avoid suspension or have their coverage reactivated if they become suspended if they complete a state-approved health or financial literacy course—an option that could be used once in a 12-month period.

## Selected States' Estimates of Administrative Costs Associated with Work Requirements Ranged from Millions to Hundreds of Millions of Dollars

Selected states (Arkansas, Indiana, Kentucky, New Hampshire, and Wisconsin) reported estimates of the costs to implement work requirements that ranged from under \$10 million in New Hampshire to over \$250 million in Kentucky.<sup>32</sup> These estimates—compiled by states and reported to us—did not include all planned costs. The estimates were based on information the states had readily available, such as the costs of contracted activities for IT systems and beneficiary outreach, and primarily reflect up-front costs. Four selected states (Arkansas, Indiana, Kentucky, and New Hampshire) had begun implementing work requirements and making expenditures by the end of 2018. Together, these states reported to us having spent more than \$129 million in total for implementation activities from the time the states submitted their demonstration applications through the end of 2018.<sup>33</sup> (See table 3.)

**Table 3: Selected States' Estimates of Administrative Costs and of Initial Expenditures for Implementing Medicaid Work Requirements**

State	Estimated costs (dollars in millions)	Description of estimates of administrative costs and of initial expenditures
Kentucky	271.6	<ul style="list-style-type: none"> <li>• Estimate includes \$220.9 million in information technology (IT) costs for the Medicaid demonstration as a whole, including work requirements, for fiscal years 2019 and 2020, and \$50.7 million in payments for managed care organizations' cost to administer work and other beneficiary requirements for the period of July 2018 through June 2020.</li> <li>• Estimate does not include expected costs for evaluating work requirements.</li> </ul> <p><b>Expenditures from application date (August 2016) through 2018:</b> more than \$99.5 million.<sup>a</sup></p>

<sup>32</sup>We collected information from the five states that received approval for demonstrations with work requirements as of November 2018, which had the most time to implement work requirements or make significant preparations to do so during the time that we conducted our review. Kentucky's and Wisconsin's estimates include some costs not specific to work requirements.

<sup>33</sup>As with estimated costs, states' expenditure amounts represented available information and did not include all expenditures associated with implementing Medicaid work requirements.



State	Estimated costs (dollars in millions)	Description of estimates of administrative costs and of initial expenditures
Wisconsin	69.4	<ul style="list-style-type: none"> <li>Estimate includes \$57.3 million for beneficiary outreach, evaluation, and other services from July 2019 through June 2021, and \$12.1 million in fiscal year 2019 for IT systems changes for the Medicaid demonstration as a whole.</li> </ul> <p><b>Expenditures from application date (January 2018) through 2018:</b> None.<sup>b</sup></p>
Indiana	35.1	<ul style="list-style-type: none"> <li>Estimate includes \$14.4 million for IT systems for fiscal years 2018 through 2021, and \$20.7 million for managed care organizations' activities in 2019.</li> <li>Estimate does not include expected costs for evaluation.</li> </ul> <p><b>Expenditures from application date (July 2017) through 2018:</b> more than \$800,000.<sup>c</sup></p>
Arkansas	26.1	<ul style="list-style-type: none"> <li>Estimate includes contracts in place from July 2017 through June 2019 for IT systems, beneficiary outreach, and other activities, such as data analysis.</li> <li>Estimate does not include expected costs for beneficiary notices and increased payments to qualified health plans.</li> </ul> <p><b>Expenditures from application date (June 2017) through 2018:</b> more than \$24.1 million.<sup>d</sup></p>
New Hampshire	6.1	<ul style="list-style-type: none"> <li>Estimate includes \$4.5 million for IT system and other contracts in place from July 2018 through June 2019, and \$1.6 million for evaluation activities from 2019 through 2025.</li> <li>Estimate does not include all expected costs, such as increased payments to managed care organizations.</li> </ul> <p><b>Expenditures from application date (October 2017) through 2018:</b> more than \$4.4 million.<sup>e</sup></p>

Source: GAO analysis of data reported by selected states and selected state documents. | GAO-20-149

Notes: States used standardized data collection instruments to report to GAO their estimated costs and expenditures to implement work requirements approved under Medicaid section 1115 demonstrations.

<sup>a</sup>Kentucky's expenditures include costs associated with the demonstration as a whole, such as project management and training costs. These costs do not include payments to managed care organizations.

<sup>b</sup>Wisconsin had not begun to implement work requirements by the end of 2018 and so had not made associated expenditures.

<sup>c</sup>Indiana did not include expenditures they could not separately identify, such as expenditures associated with beneficiary outreach, staff training, demonstration evaluation, and other activities.

<sup>d</sup>Arkansas did not include expenditures they could not separately identify, such as expenditures associated with notices, staff training, qualified health plans' activities to educate beneficiaries, and other activities. Arkansas included all expenditures for one contract that expired in March 2019.

<sup>e</sup>New Hampshire did not include expenditures they could not separately identify, such as certain beneficiary outreach expenditures.

Several factors may have contributed to the variation in the selected states' estimated costs of administering work requirements, including planned IT system changes and the number of Medicaid beneficiaries subject to the work requirements.

**IT system changes.** Selected states planned distinct approaches to modify their IT systems in order to administer work requirements. For example:

- Indiana, which implemented work requirements by expanding on an existing work referral program, planned to leverage existing IT systems, making modifications expected to result in IT costs of \$14.4 million over 4 years.
- In contrast, Kentucky planned to develop new IT system capabilities to communicate, track, and verify information related to work requirements. Kentucky received approval to spend \$220.9 million in fiscal years 2019 and 2020 to do that and make changes needed to implement other beneficiary requirements in its demonstration.

**Number of beneficiaries subject to requirements.** The estimated cost of some activities to administer work requirements depended on the number of Medicaid beneficiaries subject to work requirements, which varied across selected states. For example:

- Kentucky estimated 620,000 beneficiaries would be subject to work requirements—including those who may qualify for exemptions—and estimated costs of \$15 million for fiscal years 2019 and 2020 to conduct beneficiary education, outreach, and customer service.
- In contrast, Arkansas had fewer beneficiaries subject to work requirements (about 115,000 in February 2019, with about 100,000 of those eligible for exemptions) and estimated fewer outreach costs. The state estimated \$2.9 million in costs from July 2018 through June 2019 to conduct education and outreach.<sup>34</sup>

As noted earlier, states' available estimates did not include all expected Medicaid costs. For example, four of the five selected states planned to use MCOs or other health plans to help administer work requirements, but two of these four did not have estimates of the associated costs. Indiana and Kentucky estimated additional payments to MCOs—\$20.7 million in Indiana to administer work requirements in 2019 and \$50.7 million in Kentucky to administer its demonstration from July 2018 through June 2020. In contrast, officials in New Hampshire told us that no estimates were available. In Arkansas, where beneficiaries receive premium support to purchase coverage from qualified health plans on the state's health insurance exchange, plans were instructed to include the costs of administering work requirements in the premiums, according to Arkansas officials. State officials and representatives from a qualified

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<sup>34</sup>Other selected states' estimates of the number of beneficiaries potentially subject to the requirements (including those who may qualify for exemptions) were as follows: 420,000 in Indiana; 50,000 in New Hampshire; and 150,000 in Wisconsin, although this included beneficiaries aged 50 and up who are not subject to work requirements.

health plan we spoke with could not provide the amount that the state's premium assistance costs increased as a result.

States' estimates also did not include all ongoing costs that they expect to incur after the up-front costs and initial expenditures related to implementation of the work requirements. States had limited information about ongoing costs, but we collected some examples. For instance, New Hampshire provided estimated costs of \$1.6 million to design and implement the evaluation of its demonstration, which all states are required to perform. In addition, officials or documents in each selected state acknowledged new staffing costs that may be ongoing, such as Indiana's costs for five full-time employees to assist beneficiaries with suspended coverage to meet requirements or obtain exemptions.<sup>35</sup>

Finally, states reported that administering Medicaid work requirements will increase certain non-Medicaid costs—costs that are not funded by federal Medicaid, but are borne by other federal and state agencies, stakeholders, or individuals. For instance, New Hampshire officials planned to use approximately \$200,000 to \$300,000 in non-Medicaid funds for six positions performing case management for workforce development. Similarly, in July 2017, Indiana estimated that providing beneficiaries with job skills training, job search assistance, and other services would cost \$90 per month per beneficiary, although state officials said these costs were uncertain after learning they were not eligible for federal Medicaid funds. In addition, beneficiaries and entities other than states, such as community organizations, may incur costs related to the administration of work requirements that are not included in states' estimates.<sup>36</sup>

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<sup>35</sup>Another example of new staffing costs that may be ongoing is Kentucky's estimate of MCOs' annual costs of \$5.4 million for 270 caseworkers to help identify beneficiaries with certain medical frailties. These beneficiaries receive 12-month exemptions from work requirements, mandatory cost sharing, and healthy behavior incentives.

<sup>36</sup>For example, according to representatives of a stakeholder organization we interviewed, churches, libraries, and homeless services organizations in Arkansas have dedicated resources to help beneficiaries comply with work requirements, and beneficiaries spent time and resources for transportation costs and cellular phone minutes to comply with work requirements. In addition, we spoke with representatives of a qualified health plan in Arkansas that serves Medicaid beneficiaries who said that administering work requirements would increase non-Medicaid members' premiums.

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## Selected States Estimated the Federal Government Would Pay the Majority of Administrative Costs Associated with Work Requirements

All five selected states expected to receive federal funds for the majority of estimated costs and expenditures (described previously) for implementing work requirements.<sup>37</sup> For example, the four selected states that provided data on expenditures to administer work requirements through 2018 (Arkansas, Indiana, Kentucky, and New Hampshire) expected the portion of those expenditures paid by the federal government to range from 82 percent in Indiana to 90 percent in New Hampshire and Kentucky.<sup>38</sup> These effective matching rates exceed the 50 percent matching rate for general administrative costs, largely due to higher matching rates of 75 and 90 percent of applicable IT costs. For example, Kentucky received approval to spend \$192.6 million in federal funds for its \$220.9 million in expected IT costs over 2 years to implement work requirements and other beneficiary requirements, an effective match rate of 87 percent.

In addition to higher federal matching rates for IT costs, the selected states receive federal funds for the majority of MCO capitation payments, which the states planned to increase to pay MCOs' costs to administer work requirements.<sup>39</sup> Each of the three states that planned to use MCOs to administer work requirements planned to increase capitation payments in order to do so. For example, Indiana planned to increase capitation payments to MCOs by approximately 1 percent (or \$20.7 million in 2019) to pay for a variety of ongoing activities to administer work requirements, including requiring MCOs to help beneficiaries report compliance, reporting beneficiaries who qualify for exemptions, and helping the state verify the accuracy of beneficiary reporting, according to state officials. The federal government pays at least 90 percent of capitation payments to MCOs to provide covered services to beneficiaries who are newly eligible under PPACA, the primary population subject to work

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<sup>37</sup>States reported that the federal share of estimated costs would be as follows: Arkansas, 83 percent; Indiana, 86 percent; Kentucky, 87 percent; New Hampshire, 79 percent; and Wisconsin, 55 percent.

<sup>38</sup>The federal share of expenditures reported by Arkansas was 86 percent.

<sup>39</sup>Capitation payments provide MCOs a set payment per beneficiary to provide a specific set of Medicaid-covered services to Medicaid beneficiaries.

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requirements among the five selected states.<sup>40</sup> Indiana and Kentucky also received approval to apply work requirements to other populations, and capitation payments for these other populations receive federal matching rates of 66 percent in Indiana and 72 percent in Kentucky in fiscal year 2019.

States' approaches to implementing work requirements can affect the federal matching funds they receive. For example, Arkansas officials told us that the state decided to collect information on beneficiary compliance through an on-line portal—the initial cost of which received an effective federal matching rate of 87 percent, according to Arkansas. Officials told us that the state avoided having beneficiaries report compliance to staff—costs of which receive a 75 percent matching rate.<sup>41</sup> However, after approximately 17,000 beneficiaries lost coverage due to non-compliance with work requirements, Arkansas revised its procedures to allow beneficiaries to report compliance to state staff over the phone.

Three of the five selected states sought to leverage other programs funded by the federal government to help implement work requirements or provide beneficiary supports, such as employment services. Kentucky officials reported piloting elements of Medicaid work requirements using its SNAP Employment and Training program. Similarly, Arkansas officials sought a waiver to be able to use TANF funds to provide employment services to individuals without children in order to serve Medicaid beneficiaries subject to work requirements.<sup>42</sup> New Hampshire also used TANF funds to provide employment services to Medicaid beneficiaries who were also enrolled in TANF.

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<sup>40</sup>Specifically, states will receive a 93 percent federal matching rate for medical assistance costs for newly eligible beneficiaries in fiscal year 2019, and 90 percent thereafter. States receive this federal matching rate for the non-benefit portion of MCO capitation payments if states transfer the financial risk associated Medicaid beneficiaries to the MCO. In addition, Arkansas receives this federal matching rate for premiums to qualified health plans for these beneficiaries.

<sup>41</sup>Costs for developing the IT systems may be eligible for a 90 percent federal match rate and 75 percent match rate for ongoing maintenance and operation, including staffing costs.

<sup>42</sup>As of June 2019, information on the status of this waiver application was not available from the Arkansas officials we spoke with.

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## Weaknesses Exist in CMS's Oversight of Administrative Costs of Demonstrations with Work Requirements

CMS does not consider administrative costs when approving any demonstrations—including those with work requirements—though these costs can be significant. The agency has recently taken steps to obtain more information about demonstration administrative costs. However, we identified various weaknesses in CMS's oversight of administrative costs that could result in states receiving federal funds for costs to administer work requirements that are not allowable.

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### CMS's Approval Process Does Not Take into Account How a Demonstration Will Affect Administrative Costs

CMS's demonstration approval process does not take into account the extent to which demonstrations, including those establishing work requirements, will increase a state's administrative costs. CMS policy does not require states to provide projections of administrative costs in their demonstration applications or include administrative costs in their demonstration cost projections used by CMS to assess budget neutrality. CMS officials explained that in the past demonstrations had generally not led to increases in administrative costs, and as such, the agency had not seen a need to separately consider these costs.

However, the officials told us and have acknowledged in approval letters for demonstrations with work requirements, that demonstrations may increase administrative costs. Kentucky provides an example of this, reporting to us estimated administrative costs of approximately \$270 million—including about \$200 million in federal funds—to implement the demonstration over 2 years. However, neither Kentucky nor the other four selected states provided estimates of their administrative costs in their applications to CMS, and CMS officials confirmed that no additional information on administrative costs was provided by the states while their demonstration applications were being reviewed.

By not considering administrative costs in its demonstration approval process, CMS's actions are counter to two key objectives of the demonstration approval process: transparency and budget neutrality.

- **Transparency.** CMS's transparency requirements are aimed at ensuring that demonstration proposals provide sufficient information to ensure meaningful public input. However, CMS officials told us that they do not require the information states provide on the expected changes in demonstration expenditures in their applications to account for administrative costs. This information would likely have been of interest in our selected states, because public commenters in each state expressed concerns about the potential administrative costs of these demonstrations. In prior work, we reported on weaknesses in CMS's policies for ensuring transparency in demonstration approvals.<sup>43</sup>
- **Budget neutrality.** The aim of CMS's budget neutrality policy is to limit federal fiscal liability resulting from demonstrations, and CMS is responsible for determining that a demonstration will not increase federal Medicaid expenditures above what they would have been without the demonstration. However, CMS does not consider administrative costs when assessing budget neutrality. For three of our five selected states, the demonstration special terms and conditions specify that administrative costs will not be counted against the budget neutrality limit.

Even though demonstrations' administrative costs can be significant, CMS officials said the agency has no plans to revise its approval process—either to (1) require states to provide information on expected administrative costs to CMS or the public, or to (2) account for these costs when the agency assesses whether a demonstration is budget neutral. CMS officials explained that the agency needs more experience with policies that require administrative changes under a demonstration before making any revisions to its processes. Without requiring states to submit projections of administrative costs in their demonstration applications, and by not considering the implications of these costs for federal spending, CMS puts its goals of transparency and budget neutrality at risk. This is inconsistent with federal internal control

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<sup>43</sup>In 2019, we reported that CMS's approach to ensuring public transparency had weaknesses when states proposed making major changes to their demonstrations through amendments or major changes to pending applications. For example, we found that enrollment information was not disclosed when Arkansas and New Hampshire each sought to amend their demonstrations to add a work requirement. We made recommendations, with which CMS concurred, for the agency to develop policies to improve transparency when states propose major changes. See GAO, *Medicaid Demonstrations: Approvals of Major Changes Need Increased Transparency*, [GAO-19-315](#) (Washington, D.C.: Apr. 17, 2019).

standards that call for agencies to identify, analyze, and respond to risks related to achieving program objectives.<sup>44</sup>

### CMS Has Taken Steps to Collect New Information on Administrative Costs, yet Risks May Remain of CMS Providing Federal Funds for Work Requirement Costs that Are Not Allowable

CMS recently implemented procedures that may provide additional information on demonstrations' administrative costs. These included implementing new procedures to identify costs specific to demonstrations when approving federal matching funds for states' planned IT costs and issuing guidance on monitoring and evaluating demonstrations. However, it is unclear whether these efforts will result in data that improve CMS's oversight. (See table 4.)

**Table 4: CMS Initiatives that May Provide the Agency with Information on Demonstration Administrative Costs**

CMS initiative	Description and limitations
New procedures for IT funding approvals	<p><b>Description:</b> CMS officials told us that in 2018 the agency began requiring states to identify funding amounts specific to demonstrations in their information technology (IT) funding requests.</p> <p><b>Limitations:</b></p> <ul style="list-style-type: none"> <li>• CMS has not consistently applied this requirement. For example, Arkansas did not identify in its IT funding request the amounts specific to its demonstration, which the state reported to us exceeded \$20 million; however, in February 2019 CMS approved the request without this information.</li> <li>• How states decide which IT costs are associated with their demonstrations is unclear. CMS officials said that states work with CMS analysts on their requests, but otherwise the agency had not provided guidance to states on how to break out these costs.</li> </ul>
New monitoring guidance	<p><b>Description:</b> In March 2019, CMS issued guidance recommending that states implementing work requirements and other changes to eligibility and coverage annually report on trends in their demonstrations' administrative costs, including explaining increases or decreases in costs of greater than 2 percent.</p> <p><b>Limitation:</b> Annual reporting is recommended, but not required.</p>
New evaluation guidance	<p><b>Description:</b> In March 2019, CMS issued guidance directing states implementing work requirements and other changes to eligibility and coverage to evaluate the effects of the policy on the sustainability of the Medicaid program, which includes determining demonstration startup and ongoing administrative costs.</p> <p><b>Limitation:</b> Evaluation findings for demonstrations with work requirements will not be available for several years, with the first evaluation report due in Indiana in June 2022.</p>

Source: GAO analysis of information from the Centers for Medicare & Medicaid Services (CMS). | GAO-20-149

<sup>44</sup>See [GAO-14-704G](#).



In addition to these new initiatives, states' quarterly expenditure reports provide CMS with some information on their demonstration administrative costs, but this information also has limitations. States are required to separately track and report administrative expenditures attributable to their demonstrations in their quarterly expenditure reports. However, CMS officials told us that states typically use the same resources, such as staff, to administer their demonstrations and their regular Medicaid program, which can affect the demonstration costs states report. We found that about a quarter of states with demonstration expenditures in fiscal year 2017 reported no administrative expenditures related to their demonstrations. CMS officials acknowledged that the data states submit in their quarterly expenditure reports may not provide a meaningful measure of states' demonstration-related administrative costs.<sup>45</sup>

CMS's recently implemented procedures may provide more information on the amounts states are spending on demonstration administrative costs, but they do not address weaknesses we found in CMS's oversight of administrative costs. In four of the five selected states, we identified examples of states requesting federal matching funds for costs to administer work requirements that do not appear to be allowable, or at higher matching rates than appropriate under CMS guidance. In some cases, states received CMS approval for planned administrative costs while in others it was unclear whether CMS would have identified the issues through their oversight procedures. Areas of risk included funds for planned IT costs, funds for beneficiary supports, and funds provided under managed care contracts.

**Federal funds for planned IT costs that may not be allowable or eligible for higher matching rates.** Three of our five selected states requested and received funding approval for planned IT costs to

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<sup>45</sup>In the past, we reported on CMS's oversight of demonstration spending and found that states were not always complying with reporting requirements for demonstration expenditures, and CMS was not consistently enforcing these requirements. For example, CMS did not consistently require selected states to report the information needed to assess compliance with demonstration spending limits. We recommended that CMS develop standard operating procedures for sufficient reporting requirements and to require consistent monitoring. HHS agreed with this recommendation and in 2018 reported that the agency had developed draft guidance, including a standard reporting tool for states, to better ensure consistent reporting of the elements needed to assess compliance with demonstration spending limits. See GAO, *Medicaid Demonstrations: Federal Action Needed to Improve Oversight of Spending*, [GAO-17-312](#) (Washington, D.C.: Apr. 3, 2017).

implement their demonstrations that did not appear to be allowable or at higher matching rates than appropriate under CMS guidance.<sup>46</sup>

- Kentucky and Indiana requested and received funding approval for planned IT costs that do not appear to be allowable under CMS guidance.<sup>47</sup> Kentucky requested and received CMS approval for funds (at the 90 percent federal matching rate) for a contract that included activities to assist Medicaid beneficiaries obtain employment. (See text box.) However, CMS's 2018 guidance states that Medicaid funding is not available to finance beneficiary supports, such as job training or other employment services.<sup>48</sup> CMS officials said that the agency did not review the contract and approved the request based on Kentucky's assertion that these costs were specific to technology. Indiana received approval to receive IT funds to develop a website that provides beneficiaries access to information and tools to seek, acquire, and retain employment, costs that also appear related to beneficiary supports.<sup>49</sup>

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<sup>46</sup>An evaluation of whether states received federal funds under these approvals and the extent to which the underlying costs complied with relevant statutes and regulations regarding allowable federal expenditures and appropriate matching rates was outside the scope of our review. We are referring these matters to the HHS Office of Inspector General for review and any action deemed appropriate.

<sup>47</sup>To request federal funds for state planned IT activities, states prepare and submit advance planning documents to CMS. Advance planning documents include preliminary cost estimates for the activities that states plan to undertake. According to CMS officials, the amounts approved in states' advance planning documents serve as a limit on the amounts states can ultimately spend on IT costs.

<sup>48</sup>In its guidance, CMS indicates that states will be required, as part of their demonstration applications, to describe strategies to assist beneficiaries in meeting work requirements and to link beneficiaries to additional resources, such as job training or other employment services, which are broadly described as beneficiary supports. The guidance clarifies that, despite that expectation, CMS will not provide authority to use Medicaid funds to finance those services. See CMS, SMD: 18-002.

<sup>49</sup>In June 2019, CMS officials told us that the agency's view is that the costs in Indiana as well as Kentucky were allowable on the basis that the activities enabled systems development. We are including CMS's position in our referral to the HHS Office of Inspector General.

**Kentucky Received Approval of Information Technology Funding for Activities Aimed at Helping Beneficiaries Obtain Employment**

In 2018, in an update to its information technology budget request, Kentucky included costs for a contract with the state’s Department of Workforce Services to assist Medicaid beneficiaries in developing skills needed to obtain and retain employment. The contracted services included activities such as

- assessing beneficiaries’ eligibility for non-Medicaid programs,
- providing services to beneficiaries at career assistance centers, and
- making referrals to other agencies and programs.

Kentucky budgeted \$21 million for this contract at a 90 percent federal matching rate (\$18.9 million in federal funds) for fiscal year 2019 and another \$21 million at a 75 percent matching rate (\$15.8 million in federal funds) for fiscal year 2020. CMS approved Kentucky’s budget request without reviewing the contract.

Source: GAO analysis of documentation from the Centers for Medicare & Medicaid Services (CMS) and Kentucky Department for Medicaid Services. | GAO-20-149.

- Indiana and New Hampshire received funding approval for federal IT funds at the 90 percent matching rate for costs that do not appear eligible for that rate. In 2018, CMS approved Indiana’s request for a 90 percent match rate to pay \$500,000 in consulting fees to develop work requirement policies, despite CMS guidance indicating that policy research and development activities should be matched at 50 percent.<sup>50</sup> New Hampshire requested and received CMS approval in 2018 for federal funds at a 90 percent matching rate for \$180,000 in costs to educate beneficiaries about work requirements, including costs to place outreach calls through an existing contracted call

<sup>50</sup>CMS’s guidance related to funding for IT systems details activities eligible for enhanced matching rates and also includes a list of activities that are to receive a 50 percent match rate. That list includes the costs for policy research and development. See CMS, State Medicaid Director Letter, *Re: Mechanized Claims Processing and Information Retrieval Systems-Enhanced Funding*, SMD: 16-004 (Baltimore, Md.: Mar. 31, 2016).

In June 2019, CMS officials told us that it is the agency’s view that the 90 percent match rate approved was appropriate because Indiana’s policy development activities affected IT systems development. We are including CMS’s position in our referral to the HHS Office of Inspector General.

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center.<sup>51</sup> CMS guidance indicates that these costs should receive funding at a lower matching rate.<sup>52</sup>

**Federal funds for beneficiary supports that are not allowable.**

Wisconsin requested and planned to seek federal funds for beneficiary support costs that are not allowable until our work identified the issue for CMS. Wisconsin officials told us that it was their understanding during the planning phase of the demonstration that administrative costs incurred by state programs providing such services were eligible for federal matching funds. State officials said that CMS officials told them on multiple occasions that the state could receive a 50 percent federal match for these costs. Based on this, the state requested budget authority from its legislature for \$51.2 million for employment and training services, of which it anticipated \$23.1 million would come from federal Medicaid funds. CMS officials told us that such costs are not eligible for federal matching funds and maintained that the agency's guidance—which indicates that beneficiary support costs are not eligible for federal

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<sup>51</sup>The state's contract with the vendor administering the call center describes over 50,000 calls to be conducted in four phases: an initial outreach call to those subject to the requirement (i.e., mandatory population) who are not in another work program, a second call to the frail population urging them to apply for an exemption, a call to the mandatory population to remind them to report hours, and a call to non-compliant members "urging" them to take steps to prevent suspension.

<sup>52</sup>According to CMS guidance, call center activities related to general beneficiary education, among other topics, can receive a 50 percent federal matching rate, and call center activities related to the receipt of data required for eligibility determination or on-going case maintenance can receive a 75 percent match. See CMS, SMD: 16-004.

In June 2019, CMS officials told us that the 90 percent matching rate approved for the New Hampshire request was appropriate because the state was developing and testing call center functionality, which is a development cost. We are including CMS's position in our referral to the HHS Office of Inspector General.

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matching funds—was clear.<sup>53</sup> In response to our inquiries, the agency contacted the state in April 2019 and clarified this with officials.<sup>54</sup>

**Federal funds for costs to administer work requirements provided through managed care contracts, which may not be allowable.** As noted earlier, three of the five selected states (Indiana, Kentucky, and New Hampshire) required or planned to require MCOs to perform a number of activities to implement work requirements.<sup>55</sup> These activities included, for example, providing information on options to satisfy work requirements, assisting beneficiaries with reporting compliance with work requirements, and providing referrals to state work requirement resources. To fund these activities, officials in these states said that they plan to increase their capitation payments. States will receive at least a 90 percent federal matching rate for most of these payments, because the payments are largely for beneficiaries who are newly eligible under PPACA. It is unclear, however, whether including these activities in capitation payments is allowable. CMS regulations provide that states may only include administrative costs that are related to the provision of covered health care services in their MCO capitation payments.<sup>56</sup> In addition, CMS guidance notes that implementing work requirements will not change the types of expenditures that are allowable. We provided CMS with specific examples of activities states delegated or planned to delegate to MCOs and asked if these types of activities met CMS's

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<sup>53</sup>See CMS, SMD: 18-002.

<sup>54</sup>CMS officials also noted that Wisconsin's reported administrative expenditures would be subject to CMS review and the state would only receive federal matching funds for allowable expenditures. However, in past work, we found that CMS was not sufficiently targeting risk in its oversight of Medicaid expenditures, potentially allowing errors—including for expenditures that are not allowable—to go undetected. We recommended that CMS improve its risk-based targeting of oversight efforts and resources. CMS agreed with this recommendation and planned to complete a national risk assessment and identify opportunities to increase resources and determine the appropriate allocation of staff. See GAO, *Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures*, [GAO-18-564](#) (Washington, D.C.: Aug. 6, 2018).

<sup>55</sup>In addition, Arkansas is relying on qualified health plans to perform activities to administer work requirements in its demonstration. For example, according to officials from one qualified health plan, the plan sent 270,000 letters to beneficiaries at a cost of \$25,000 and issued \$30 rewards cards to 600 beneficiaries for attesting to meeting work requirements for three consecutive months.

<sup>56</sup>42 C.F.R. § 438.3(c)(1)(ii) (2018)

criteria to be included under capitation payments.<sup>57</sup> CMS officials told us that federal review of the related managed care contracts in Indiana and New Hampshire had not been completed as of June 2019 and could not make a definitive statement.<sup>58</sup>

While CMS guidance requires states to carry out a range of activities to implement work requirements—some of which are not eligible for federal Medicaid funds—agency officials told us that CMS has not updated any procedures for the various reviewers of these costs. Further, CMS has not completed a risk assessment to determine whether current procedures for overseeing administrative costs are sufficient, and agency officials told us that there were no plans to do so.<sup>59</sup> According to federal internal control standards, agencies should identify, analyze, and respond to risks related to achieving program objectives (in this case, ensuring that administrative expenditures under demonstrations are allowable and matched at the correct rate).<sup>60</sup> Without identifying, assessing, and addressing the risks posed by demonstrations that may increase administrative costs, CMS may be providing federal funds for costs that are not allowed or at inappropriately high matching rates.

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<sup>57</sup>States are required to submit managed care contracts and capitation rates to CMS for review and approval.

<sup>58</sup>Although CMS officials could not comment on specific examples, in general, they said certain types of MCO activities could be allowable, such as training customer service staff about work requirements. With regard to MCOs helping beneficiaries report compliance with work requirements, CMS officials cited 42 C.F.R. § 438.608(a)(3), which requires MCOs to promptly notify the state when it receives information about a beneficiary's circumstances that may affect eligibility, such as a change in residence or death. In July 2019, CMS approved Kentucky's contracts with MCOs for the period July 2018 through June 2019 and related capitation rates for July 2018 through March 2019. These rates included a \$17 million overall increase for MCOs' costs to administer the demonstration. According to officials, CMS approved this rate increase for MCOs' costs to prepare to meet new requirements under the demonstration and to notify beneficiaries of new requirements. Officials said that CMS's approval did not address the use of federal funds for other MCO activities to administer work requirements that were outlined in the contract, such as referring beneficiaries to resources related to work requirements, so it remains unclear whether capitation payments for those costs are allowable.

<sup>59</sup>CMS officials said that the agency had no plans to conduct a risk assessment of its oversight procedures until it gained more experience with work requirement policies to determine if any mid-course correction is needed.

<sup>60</sup>See [GAO-14-704G](#).

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## Conclusions

A third of states have sought approval to implement work requirements in their Medicaid programs. CMS has acknowledged that demonstrations, including those with work requirements, may increase Medicaid administrative costs—and therefore overall Medicaid spending. Yet, CMS is not factoring these costs into its approval decisions, which is counter to the agency’s goals of transparency and budget neutrality. Further, the agency has not taken steps to assess and respond to risks of federal funds being spent for administrative costs that are not allowable or matched at rates higher than what is appropriate, risks we found in four of the five demonstrations we reviewed. While administrative costs are a relatively small portion of states’ Medicaid spending, the weaknesses in CMS’s oversight of these costs could take on increased importance as more states seek and receive approval to implement work requirements.

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## Recommendation for Executive Action

We are making the following three recommendations to CMS:

The Administrator of CMS should require states to submit and make public projections of administrative costs when seeking approval of demonstrations, including those with work requirements and all other demonstrations. (Recommendation 1)

The Administrator of CMS should account for the administrative costs of demonstrations, including those with work requirements and all other demonstrations, when assessing whether demonstrations are budget neutral. (Recommendation 2)

The Administrator of CMS should assess the risks of providing federal funds for costs to administer work requirements that are not allowable and should respond to risks by improving oversight procedures, as warranted. This assessment should consider risks related to costs for information systems, beneficiary supports, and managed care. (Recommendation 3)

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## Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comments and its comments are reproduced in appendix II. HHS also provided us with technical comments, which we incorporated in the report as appropriate. HHS did not concur with our recommendations. In general, HHS commented that it expects administrative costs to represent a relatively small proportion of total Medicaid spending and that its current approach to overseeing administrative costs—including those incurred under Medicaid demonstrations—is appropriate given the level of financial risk. HHS commented that administrative costs were approximately 5 percent of Medicaid expenditures. While these cost may represent a relatively small share of total spending, CMS projected them to be \$18 billion in federal funds in fiscal year 2019—and this does not include all administrative spending. In particular, it does not include amounts paid to MCOs for administrative costs, which are likely considerable given that managed care payments now represent about half of all Medicaid spending. Further, demonstrations may represent a heightened financial risk given our finding that they can result in additional administrative costs that would not otherwise occur.

Regarding our first recommendation to require states to submit and make public projections of administrative costs, HHS commented that its experience suggests that demonstration administrative costs will be a relatively small portion of total costs and therefore HHS believes making information about these costs available would provide stakeholders little to no value. As noted, Medicaid is a significant component of federal and state budgets. In each of the five states we reviewed, public commenters expressed concerns about the potential administrative costs of Medicaid demonstrations with work requirements, suggesting stakeholders would value information about these costs. We maintain that requiring states to make public information about administrative costs would help to ensure that demonstration proposals provide sufficient information to ensure meaningful public input.

Regarding our second recommendation to account for administrative costs when assessing whether demonstrations are budget neutral, HHS again commented that its experience suggests that demonstration administrative costs will be a relatively small portion of total costs and that it believed that its current approach is appropriate for the level of financial risk. However, we found that demonstration administrative costs could be significant and HHS's current policy of not considering these costs in its



assessments of budget neutrality could increase federal fiscal liability. For example, in Kentucky, we found estimated administrative costs for implementing the demonstration exceeded \$270 million over about 2 years. We maintain that including administrative costs in its assessments will help HHS ensure that demonstrations are budget neutral.

Regarding our third recommendation to assess and respond to risks of providing federal funds for costs to administer work requirements that are not allowable, HHS commented that (1) all states' requests for federal Medicaid funding are subject to the same federal regulations and requirements; (2) the expenditures reported by states to GAO had not been reviewed against federal requirements or certified by states to be accurate and permissible; and (3) HHS believes its existing approach is appropriate for the low level of risk that administrative expenditures represent. Our findings indicate that CMS's oversight procedures—which are designed to prevent state spending on costs that do not meet federal requirements—have vulnerabilities, particularly given the types of administrative activities associated with work requirements. Four of the five states we reviewed were planning to seek federal funds for costs (1) that did not appear allowable, or (2) at higher matching rates than appear appropriate, and three states succeeded in gaining CMS approval to do so. We agree with HHS that CMS may also identify inappropriate expenditures during its reviews of state-reported expenditures. However, our past work has identified weaknesses in that review process.<sup>61</sup> In 2018, we reported that CMS officials indicated that resource constraints have limited the agency's ability to target risk during such reviews, potentially allowing errors to go undetected. Finally, the basis for HHS's conclusion that its current approach is appropriate for the risks posed by these administrative expenditures is unclear. As we note in our report, CMS officials told us that they had not assessed whether current procedures sufficiently address risks posed by administrative costs for work requirements and had no plans to do so. We maintain that assessing these risks of providing federal funds for costs that are not allowable and improving oversight, as warranted, would help HHS to ensure the integrity of the Medicaid program.

As agreed with your offices, 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

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<sup>61</sup>See [GAO-18-564](#).

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Secretary of Health and Human Services, the appropriate congressional committees, and other interested parties. In addition, this report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7144 or [yocomc@gao.gov](mailto:yocomc@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix III.



Carolyn L. Yocom  
Director, Health Care

# Appendix I: Other Beneficiary Requirements in States with Approved Medicaid Work Requirements

Eight of the nine states that received approval for work requirements, as of May 2019, also received approval under their demonstrations for other beneficiary requirements, such as requiring beneficiaries to have expenditure accounts.<sup>1</sup> Some of these beneficiary requirements preceded work requirements, while others were newly introduced with the work requirements. For example, Kentucky was developing and implementing work requirements at the same time as other beneficiary requirements, such as the requirement for beneficiaries to have two expenditure accounts and make premium payments. (See table 5.)

**Table 5: Other Beneficiary Requirements in States with Approved Medicaid Work Requirements, as of May 2019**

State	Premium payments	Beneficiary expenditure accounts <sup>a</sup>	Reductions to retroactive eligibility <sup>b</sup>	Non-eligibility periods for non-compliance <sup>c</sup>	Healthy behavior incentives <sup>d</sup>
Arizona	Yes	Yes	Yes	NA	Yes
Arkansas	Yes	NA	Yes	Yes	NA
Indiana	Yes	Yes	Yes	Yes	Yes
Kentucky	Yes	Yes	Yes	Yes	Yes
Michigan	Yes	Yes	NA	Yes	Yes
New Hampshire	NA	NA	Yes	NA	NA
Ohio	NA	NA	NA	NA	NA
Utah	Yes	NA	Yes	NA	NA
Wisconsin	Yes	NA	NA	Yes	Yes

<sup>1</sup>Beneficiary expenditure accounts are similar to health savings accounts where funds are used to pay for health care expenses. Healthy behavior incentives can be direct financial incentives (e.g., reduced or increased cost-sharing requirements) or additional health care coverage for services that encourage beneficiaries to use certain health services, such as primary care; participate in certain activities, such as consuming a healthy diet or increasing physical activity; or cease unhealthy activities, such as smoking.

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**Appendix I: Other Beneficiary Requirements in  
States with Approved Medicaid Work  
Requirements**

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Legend:

✓ = yes

NA = not applicable

Source: Centers for Medicare & Medicaid Services (CMS) documentation. | GAO-20-149

Note: The U.S. District Court for the District of Columbia vacated CMS's approvals of demonstrations in Arkansas and Kentucky in March 2019, and in New Hampshire in July 2019. *Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019); *Stewart v. Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019); *Philbrick v. Azar*, No. 19-773 (JEB) (D.D.C. July 29, 2019).

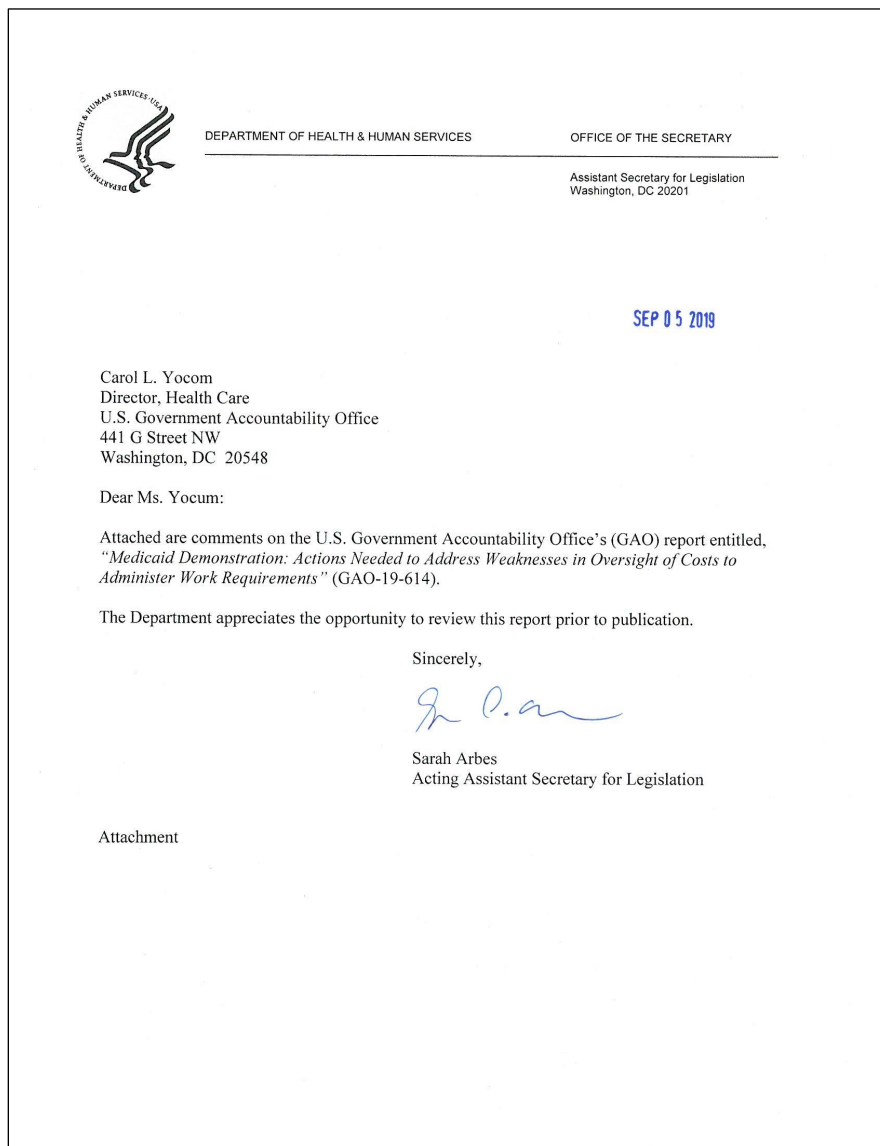
<sup>a</sup>Beneficiary expenditure accounts are similar to health savings accounts where funds are used to pay for health care expenses. In some states, beneficiary premium payments are credited to these accounts.

<sup>b</sup>Unless waived under section 1115(a), states are required to provide Medicaid coverage to enrollees beginning 3 months prior to the month of their Medicaid application if the individual would have been eligible during this time.

<sup>c</sup>A non-eligibility period is the length of time a beneficiary is restricted from reenrolling in the program following a coverage termination due to noncompliance with certain beneficiary requirements.

<sup>d</sup>Healthy behavior incentives can be direct financial incentives (e.g., reduced or increased cost-sharing requirements) or additional health care coverage for services that encourage beneficiaries to use certain health services, such as primary care; participate in certain activities, such as consuming a healthy diet or increasing physical activity; or cease unhealthy activities, such as smoking.

# Appendix II: Comments from the Department of Health and Human Services



**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES  
ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED –  
MEDICAID DEMONSTRATION ADMINISTRATIVE COSTS (GAO 19-614)**

The U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report on the administrative costs of Medicaid section 1115 demonstrations implementing community engagement activities, with a specific focus on work requirements, and HHS' oversight of these costs.

The GAO concluded, based on a limited review, that HHS has weaknesses in its overall oversight of administrative costs under section 1115 demonstrations. The GAO examined five states approved to implement demonstrations that included community engagement requirements, and reviewed each state's application, HHS approval documents, and HHS policy and procedures for monitoring and evaluation. The GAO also used a survey instrument to collect data from these states about their current and projected administrative costs. The GAO did not assess the state data it collected against federal certification requirements for permissible administrative costs or actual payment to states from HHS. Therefore, the GAO was not able to determine the administrative costs states would actually incur as a result of community engagement activities. The GAO also was not able to determine whether any of the costs highlighted in its report were unallowable.

HHS believes that its current approach for review and oversight of state administrative costs is appropriate for the level of financial risk to the federal government. Administrative costs represent a small share of total federal Medicaid outlays under the Medicaid program, at approximately five percent, and that percentage has been stable or declining over time. The HHS Office of the Actuary presents estimates of administrative costs in several *Actuarial Reports on the Financial Outlook for Medicaid* that show these costs represented approximately 5 percent of program expenditures in 2011, 4.5 percent in 2016, and most recently, 4.6 percent in 2019. Specifically, in the *2017 Actuarial Report on the Financial Outlook for Medicaid*, the HHS Office of the Actuary further projected those administrative expenditures, as a percentage of total Medicaid outlays, would decline to an estimated 3.7 percent by 2026.<sup>1</sup>

Further, in the January 2018 State Medicaid Director Letter signaling HHS' willingness to consider state proposals for community engagement requirements, HHS clearly explained that its new approach to these proposals did not change the types of services that are eligible for federal matching funds. Federal financial participation (FFP) for expenditures on allowable services, and FFP for expenditures that are necessary for the proper and efficient administration of the state's Medicaid program must be in accordance with statute, and this expectation was reinforced in HHS discussions with individual states. Accordingly, federal outlays for state administrative expenditures incurred under this demonstration opportunity will be subject to the same federal oversight processes for permissible payments applied across a state's Medicaid program.

HHS monitors administrative costs through separate tracking and reporting of actual recorded administrative expenditures that are certified for accuracy by state officials and are reviewed through HHS' quarterly expenditure claims review process. Through this process, HHS is able to

<sup>1</sup> The HHS Office of the Actuary reports on the *Financial Outlook for Medicaid* are available on CMS.gov at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.html>.

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES  
ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED –  
MEDICAID DEMONSTRATION ADMINISTRATIVE COSTS (GAO 19-614)**

identify, and address with states, any concerns with the states' reported certified administrative expenditures. Furthermore, HHS reviews states' Advance Planning Documents for demonstration-related IT system design, development, and implementation to ensure projected costs align with federal requirements.

HHS also reviews states' demonstration-related managed care organization (MCO) contracts and rates to ensure all payments are allowable for FFP and works to bring states into compliance if any costs are not allowable for FFP. Upon receiving GAO's preliminary findings related to MCO payments, HHS immediately undertook an expedited review of the applicable contracts and rates. The contract reviews are still underway; however, a preliminary assessment showed that most, if not all, of the activities in the contracts in these states appear to fit in the appropriate categories of MCO administrative activities. Should CMS determine that any aspect of the MCO contracts or rates in these three states was inappropriate; CMS will take appropriate action, where legally warranted.

In summary, HHS believes that its current approaches to reviewing and overseeing state administrative costs, including oversight of section 1115 demonstration administrative costs, appropriately safeguard against the federal government's exposure to excessive expenditures, and that these approaches represent a prudent level of federal effort given the low level of risk that administrative expenditures represent as a small and stable percentage of total federal Medicaid outlays.

The GAO's recommendations and HHS' responses to each recommendation are below. HHS also has technical comments on the draft report that it will provide separately.

**GAO Recommendation**

The Administrator of CMS should require states to submit and make public projections of administrative costs when seeking approval of demonstrations, including those with work requirements and all other demonstrations.

**HHS Response**

HHS does not concur with this recommendation.

HHS experience with administrative costs under the Medicaid program suggests that we can expect administrative costs over the life of a demonstration to be a relatively small portion of the total cost. Therefore, we believe making this information available as a part of the transparency requirements would add little to no value to informing stakeholders about the potential critical impacts of a state's section 1115 demonstration application.

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES  
ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED –  
MEDICAID DEMONSTRATION ADMINISTRATIVE COSTS (GAO 19-614)**

**GAO Recommendation**

The Administrator of CMS should account for the administrative costs of demonstrations, including those with work requirements and all other demonstrations, when assessing whether demonstrations are budget neutral.

**HHS Response**

HHS does not concur with this recommendation.

HHS experience with administrative costs under the Medicaid program suggests that we can expect administrative costs over the life of a demonstration to be a relatively small portion of the total cost. Federal regulations governing all state Medicaid programs, including those operated under section 1115 authority require state officials to submit actual recorded expenditures, and state officials certify to the accuracy of the expenditure data provided to HHS. HHS believes that our current approach to accounting for state administrative costs is appropriate for the level of financial risk to the federal government.

**GAO Recommendation**

The Administrator of CMS should assess the risks of providing federal funds for costs to administer work requirements that are not allowable and should respond to risks by improving oversight procedures, as warranted. This assessment should consider risk related for information systems, beneficiary supports, and managed care.

**HHS Response**

HHS does not concur with this recommendation.

State requests for federal funding for any Medicaid expenditure incurred, including under section 1115 community engagement demonstrations, are subject to the same federal regulations and certification requirements for permissible Medicaid program costs. As explained above, the administrative costs the GAO collected from states with community engagement demonstrations were not assessed against HHS' federal certification requirements or our other oversight policies and procedures. Our oversight of administrative costs for community engagement demonstrations is no different and no less stringent than for any other state Medicaid administrative expenditure. HHS believes that its current approach to reviewing and overseeing state administrative costs is appropriate for the level of financial risk to the federal government, given the low level of risk that administrative expenditures represent as a small and stable percentage of total federal Medicaid outlays.



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## Text of Appendix II: Comments from the Department of Health and Human Services

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Page 1

Carol L. Yocom Director, Health Care

U.S. Government Accountability Office

441 G Street NW

Washington, DC 20548

Dear Ms. Yocum:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled , "Medicaid Demonstration: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements" (GAO-19-614).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Sarah Arbes

Acting Assistant Secretary for Legislation

Attachment

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Page 2

### GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED- MEDICAID DEMONSTRATION ADMINISTRATIVE COSTS (GAO 19-614)

The U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report on the administrative costs of Medicaid section 1115 demonstrations implementing community engagement

activities, with a specific focus on work requirements, and HHS' oversight of these costs.

The GAO concluded, based on a limited review, that HHS has weaknesses in its overall oversight of administrative costs under section 1115 demonstrations. The GAO examined five states approved to implement demonstrations that included community engagement requirements, and reviewed each state's application, HHS approval documents, and HHS policy and procedures for monitoring and evaluation. The GAO also used a survey instrument to collect data from these states about their current and projected administrative costs. The GAO did not assess the state data it collected against federal certification requirements for permissible administrative costs or actual payment to states from HHS. Therefore, the GAO was not able to determine the administrative costs states would actually incur as a result of community engagement activities. The GAO also was not able to determine whether any of the costs highlighted in its report were unallowable.

HHS believes that its current approach for review and oversight of state administrative costs is appropriate for the level of financial risk to the federal government. Administrative costs represent a small share of total federal Medicaid outlays under the Medicaid program, at approximately five percent, and that percentage has been stable or declining over time. The HHS Office of the Actuary presents estimates of administrative costs in several Actuarial Reports on the Financial Outlook for Medicaid that show these costs represented approximately 5 percent of program expenditures in 2011, 4.5 percent in 2016, and most recently, 4.6 percent in 2019. Specifically, in the 2017 Actuarial Report on the Financial Outlook for Medicaid, the HHS Office of the Actuary further projected those administrative expenditures, as a percentage of total Medicaid outlays, would decline to an estimated 3.7 percent by 2026.<sup>1</sup>

Further, in the January 2018 State Medicaid Director Letter signaling HHS' willingness to consider state proposals for community engagement requirements, HHS clearly explained that its new approach to these proposals did not change the types of services that are eligible for federal matching funds. Federal financial participation (FFP) for expenditures on allowable services, and FFP for expenditures that are necessary for the proper and efficient administration of the state's Medicaid program must be in accordance with statute, and this expectation was reinforced in HHS discussions with individual states. Accordingly, federal outlays for state administrative expenditures incurred under this demonstration opportunity will be

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<sup>1</sup> The HHS Office of the Actuary reports on the Financial Outlook for Medicaid are available on CMS.gov at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.html>

subject to the same federal oversight processes for permissible payments applied across a state's Medicaid program.

HHS monitors administrative costs through separate tracking and reporting of actual recorded administrative expenditures that are certified for accuracy by state officials and are reviewed through HHS' quarterly expenditure claims review process. Through this process, HHS is able to

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### Page 3

identify, and address with states, any concerns with the states' reported certified administrative expenditures. Furthermore, HHS reviews states' Advance Planning Documents for demonstration-related IT system design, development, and implementation to ensure projected costs align with federal requirements.

HHS also reviews states' demonstration-related managed care organization (MCO) contracts and rates to ensure all payments are allowable for FFP and works to bring states into compliance if any costs are not allowable for FFP. Upon receiving GAO's preliminary findings related to MCO payments, HHS immediately undertook an expedited review of the applicable contracts and rates. The contract reviews are still underway; however, a preliminary assessment showed that most, if not all, of the activities in the contracts in these states appear to fit in the appropriate categories of MCO administrative activities. Should CMS determine that any aspect of the MCO contracts or rates in these three states was inappropriate; CMS will take appropriate action, where legally warranted.

In summary, HHS believes that its current approaches to reviewing and overseeing state administrative costs, including oversight of section 1115 demonstration administrative costs, appropriately safeguard against the federal government's exposure to excessive expenditures, and that these approaches represent a prudent level of federal effort given the low level of risk that administrative expenditures represent as a small and stable percentage of total federal Medicaid outlays.

The GAO's recommendations and HHS' responses to each recommendation are below. HHS also has technical comments on the draft report that it will provide separately.

#### GAO Recommendation

The Administrator of CMS should require states to submit and make public projections of administrative costs when seeking approval of demonstrations, including those with work requirements and all other demonstrations.

HHS Response

HHS does not concur with this recommendation.

HHS experience with administrative costs under the Medicaid program suggests that we can expect administrative costs over the life of a demonstration to be a relatively small portion of the total cost. Therefore, we believe making this information available as a part of the transparency requirements would add little to no value to informing stakeholders about the potential critical impacts of a state's section 1115 demonstration application.

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GAO Recommendation

The Administrator of CMS should account for the administrative costs of demonstrations, including those with work requirements and all other demonstrations, when assessing whether demonstrations are budget neutral.

HHS Response

HHS does not concur with this recommendation.

HHS experience with administrative costs under the Medicaid program suggests that we can expect administrative costs over the life of a demonstration to be a relatively small portion of the total cost. Federal regulations governing all state Medicaid programs, including those operated under section 1115 authority require state officials to submit actual recorded expenditures, and state officials certify to the accuracy of the expenditure data provided to HHS. HHS believes that our current approach to accounting for state administrative costs is appropriate for the level of financial risk to the federal government.

GAO Recommendation

The Administrator of CMS should assess the risks of providing federal funds for costs to administer work requirements that are not allowable and should respond to risks by improving oversight procedures, as warranted. This assessment should consider risk related for information systems, beneficiary supports, and managed care.

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HHS Response

HHS does not concur with this recommendation.

State requests for federal funding for any Medicaid expenditure incurred, including under section 1115 community engagement demonstrations, are subject to the same federal regulations and certification requirements for permissible Medicaid program costs. As explained above, the administrative costs the GAO collected from states with community engagement demonstrations were not assessed against HHS' federal certification requirements or our other oversight policies and procedures. Our oversight of administrative costs for community engagement demonstrations is no different and no less stringent than for any other state Medicaid administrative expenditure. HHS believes that its current approach to reviewing and overseeing state administrative costs is appropriate for the level of financial risk to the federal government, given the low level of risk that administrative expenditures represent as a small and stable percentage of total federal Medicaid outlays.

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# Appendix III: GAO Contact and Staff Acknowledgments

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## GAO Contact

Carolyn L. Yocom, (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Susan Barnidge (Assistant Director), Russell Voth (Analyst in Charge), Linda McIver, and Matt Nattinger made key contributions to this report. Also contributing were Giselle Hicks, Drew Long, Ethiene Salgado-Rodriguez, and Emily Wilson Schwark.

## Related GAO Reports

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

*Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures.* [GAO-18-564](#). Washington, D.C.: August 6, 2018.

*Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures.* [GAO-18-220](#). Washington, D.C.: January 19, 2018.

*Medicaid Demonstrations: Federal Action Needed to Improve Oversight of Spending.* [GAO-17-312](#). Washington, D.C.: April 3, 2017.

*Medicaid: Federal Funds Aid Eligibility IT System Changes, but Implementation Challenges Persist.* [GAO-15-169](#). Washington, D.C.: December 12, 2014.

*Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency.* [GAO-13-384](#). Washington, D.C.: June 25, 2013.

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

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