



October 2020

MEDICAID PROGRAM INTEGRITY

Action Needed to Ensure CMS Completes Financial Management Reviews in a Timely Manner

GAO Highlights

Highlights of [GAO-21-17](#), a report to congressional requesters

Why GAO Did This Study

Over the last two decades, Medicaid—a joint, federal-state health care financing program for low-income and medically needy individuals—more than tripled in expenditures and doubled in enrollment. CMS estimates the program will continue to grow, exceeding \$1 trillion in expenditures and 81 million enrollees in 2028. The size and growth of Medicaid present oversight challenges. CMS is responsible for assuring that states' Medicaid expenditures comply with federal requirements, and FMRs are one of its financial oversight tools. CMS generally directs its regional offices to conduct one focused FMR each year on an area of high risk within their regions, typically within one state.

GAO was asked to examine CMS's use of FMRs. In this report, GAO examines the extent to which CMS has used FMRs to oversee state Medicaid programs. GAO reviewed CMS documentation on FMR findings and their status, and resources assigned to FMRs and other financial review functions. GAO also interviewed CMS officials from all 10 regional offices and the central office, and assessed CMS's FMR policies and procedures against federal internal control standards.

What GAO Recommends

CMS should develop and implement time frames to ensure the timely completion of FMRs. The Department of Health and Human Services concurred with our recommendation.

View [GAO-21-17](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

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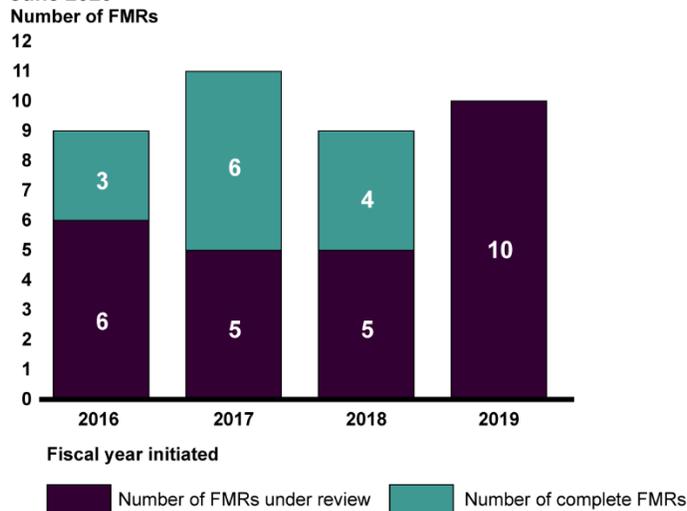
What GAO Found

Since fiscal year 2016, the Centers for Medicare & Medicaid Services (CMS) has initiated 49 financial management reviews (FMR) to examine state Medicaid agencies' compliance with a variety of federal policies. These 49 FMRs frequently found one or more instances of states' non-compliance.

- CMS identified instances of non-compliance that had a financial impact totaling about \$358 million.
- CMS identified internal control weaknesses and directed states to make changes to their Medicaid policies.

However, FMRs have not always examined topics or states that reflect the areas of highest expenditures. In 2018, GAO recommended that CMS improve its targeting of oversight resources. CMS agreed with this recommendation, but has not yet implemented it. In addition, CMS guidance generally expects draft FMR reports to be completed in the year they began. However, two-thirds of FMRs (26 of 39) initiated in fiscal years 2016 to 2019 were still under review in June 2020, which can delay state actions to address program vulnerabilities. CMS officials said that at least five states would not take actions—such as returning federal funds for unallowable expenditures—until they received a complete report.

Status of Financial Management Reviews (FMR) Initiated in Fiscal Years 2016 to 2019, as of June 2020



Source: GAO review of data from the Centers for Medicare & Medicaid Services. | GAO-21-17

CMS officials cited competing priorities, decreased staff, and the agency's review process—which involves multiple steps and levels of review—as factors affecting their use of FMRs for oversight. CMS took steps during the course of GAO's review to complete FMRs that had been under review for several years. The agency has not established time frames for the completion of individual review steps or for its overall review of FMR reports. Developing and implementing such time frames would provide a tool to help monitor CMS's progress in completing FMRs and ensure prompt action on FMR findings.

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Abbreviations

| | |
|----------|--|
| CMS | Centers for Medicare & Medicaid Services |
| COVID-19 | Coronavirus Disease 2019 |
| FMR | financial management review |
| FTE | full-time equivalent |
| HHS | Department of Health and Human Services |
| HHS-OIG | Department of Health and Human Services Office of Inspector General |

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October 14, 2020

Congressional Requesters

Over the last two decades, Medicaid—a joint, federal-state program that finances health care coverage for low-income and medically needy individuals—more than tripled in terms of expenditures and doubled in terms of enrollment. The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid, estimates that the Medicaid program will exceed \$1 trillion in expenditures and 81.5 million enrollees in 2028.¹

The size and growth of the Medicaid program underscore the importance of strong financial oversight to ensure states spend federal funds appropriately and that program enrollees have access to covered services. In exercising its oversight function, CMS conducts several activities, one of which is financial management reviews (FMR). FMRs can provide an in-depth look at state expenditures in areas where CMS believes federal dollars are at risk, and have the potential to help the agency identify large amounts of unallowable expenditures.

FMRs and other oversight efforts can lead to a variety of actions, including CMS directing states to reduce federal expenditures or return federal funds for unallowable expenditures, or to strengthen certain Medicaid policies and procedures to address internal control weaknesses. For example, in August 2018, we found that from fiscal years 2014 through 2017, CMS resolved errors that reduced federal expenditures by over \$5.1 billion. However, we also found CMS did not effectively target its oversight efforts to program areas or states of greatest risk, which raised concerns about federal oversight of Medicaid expenditures.² Our

¹Medicaid expenditures and enrollment grew from \$169 billion and 31.4 million enrollees in 1998 to over \$597 billion and 72.8 million enrollees in 2018. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, *National Health Expenditure Data, Expenditures, Enrollment, and per Enrollee Estimates of Health Insurance*, (Baltimore, Md.: Nov. 27, 2019), accessed August 5, 2020, <https://www.cms.gov/files/zip/nhe-tables.zip>; and S.P. Keehan, G.A.Cuckler, J.A.Poisal, A.M.Sisko, S.D. Smith, A.J. Madison, K.E. Rennie, J.A. Fiore, J.C. Hardesty, “National Health Expenditure Projections, 2019–28: Expected Rebound In Prices Drives Rising Spending Growth,” *Health Affairs*, vol. 39, no.4 (2020): pp. 704-714.

²See GAO, *Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures*, [GAO-18-564](#) (Washington, D.C.: Aug. 6, 2018).

prior work also noted that CMS had cancelled a number of planned FMRs and delayed the completion of others.

You asked us to examine CMS's use of Medicaid FMRs. This report examines the extent to which CMS has used FMRs to oversee states' Medicaid programs.

To examine the extent to which CMS has used FMRs to oversee states' Medicaid programs, we reviewed CMS's policies and procedures, documentation on the 49 FMRs CMS initiated in fiscal years 2016 through 2020, and CMS resources assigned to FMRs and other financial review functions. We also reviewed documentation for eight FMRs that CMS initiated in fiscal years 2012 through 2014, but had not completed at the time our study began. In addition, we interviewed officials from CMS's 10 regional offices, which had primary responsibility for conducting the FMRs we examined, and from CMS's central office, which oversaw regional office efforts. In November 2019, CMS announced a plan to reorganize its regional office structure.³ According to CMS officials, the reorganization did not affect FMRs that began prior to fiscal year 2020, including the FMRs we examined. Therefore, throughout the report, we refer to the 10 regional offices.

In evaluating this information, we compared CMS's policies and procedures against the Standards for Internal Control in the Federal Government.⁴ We determined that the control activities and monitoring components of internal controls were significant to our objective, along with the underlying principles that management design control activities to achieve its objectives and respond to risks, and that management remediate identified control deficiencies on a timely basis. We assessed CMS's documentation and information from agency interviews to determine whether CMS responded to known risks in a timely manner.

³On November 25, 2019, CMS published a Federal Register notice, which outlined a plan to reorganize the agency's 10 regional offices into two branches, an East Branch and a West Branch. See 84 Fed. Reg. 64,899 (Nov. 25, 2019).

⁴See GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

We conducted this performance audit from September 2019 to October 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CMS and states generally share in the financing of Medicaid payments according to a formula established in law.⁵ In order to receive federal matching funds, states report quarterly expenditures on the CMS-64. These quarterly reports capture a state's aggregate Medicaid expenditures—amounts not linked to individual enrollees or services—for each type of service and population covered. If CMS identifies errors or unallowable expenditures, the agency can require states to reduce reported expenditures or return federal funds.⁶ CMS reviewers have 50 days to review each state's quarterly expenditures to assess whether reported expenditures are consistent with requirements.

To supplement their quarterly reviews, CMS regularly conducts FMRs, which allow CMS to examine complex issues in greater depth. In a June 2006 report, we highlighted how FMRs helped identify billions of dollars in unallowable expenditures outside of those detected by the quarterly reviews, as well as deficiencies in states' financial management practices.⁷ Through FMRs, CMS can examine individual claims for services from providers, and determine whether the state is following their

⁵The federal government matches state spending for most services using a statutory formula—the Federal Medical Assistance Percentage—under which the federal government pays a share of Medicaid expenditures based on each state's per capita income relative to the national average. Higher federal matching rates may apply for certain types of enrollees, services, or administrative costs. For example, states receive a higher federal matching rate for individuals covered under certain eligibility expansions.

⁶CMS and states generally resolve unallowable expenditures in the following ways: (1) a state submits an adjustment to reduce reported expenditures; or (2) CMS defers federal matching funds to a state if additional information is needed to determine whether a particular expenditure is allowable. If a state does not provide additional documentation or correct reporting, CMS may issue a disallowance to recover federal funds.

⁷See GAO, *Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts*, [GAO-06-705](#) (Washington, D.C.: June 22, 2006).

approved Medicaid state plans.⁸ FMRs also provide state and federal staff with valuable feedback on policy issues and programmatic vulnerabilities.

Our August 2018 report examining CMS's oversight of state-reported expenditures, including FMRs, also highlighted the role of FMRs in identifying unallowable expenditures.⁹ However, we found that CMS often cancelled FMRs, including 17 FMRs during fiscal years 2014 through 2018, or delayed their completion due to staffing shortages and other competing priorities. We recommended that CMS complete a comprehensive, national risk assessment to assure that resources directed toward CMS oversight of states' Medicaid expenditures are adequate, and allocated based on areas of highest risk. CMS agreed with this recommendation. While CMS has taken some steps to assess risk and staff capacity, the agency has not implemented this recommendation as of June 2020.¹⁰

FMR Processes

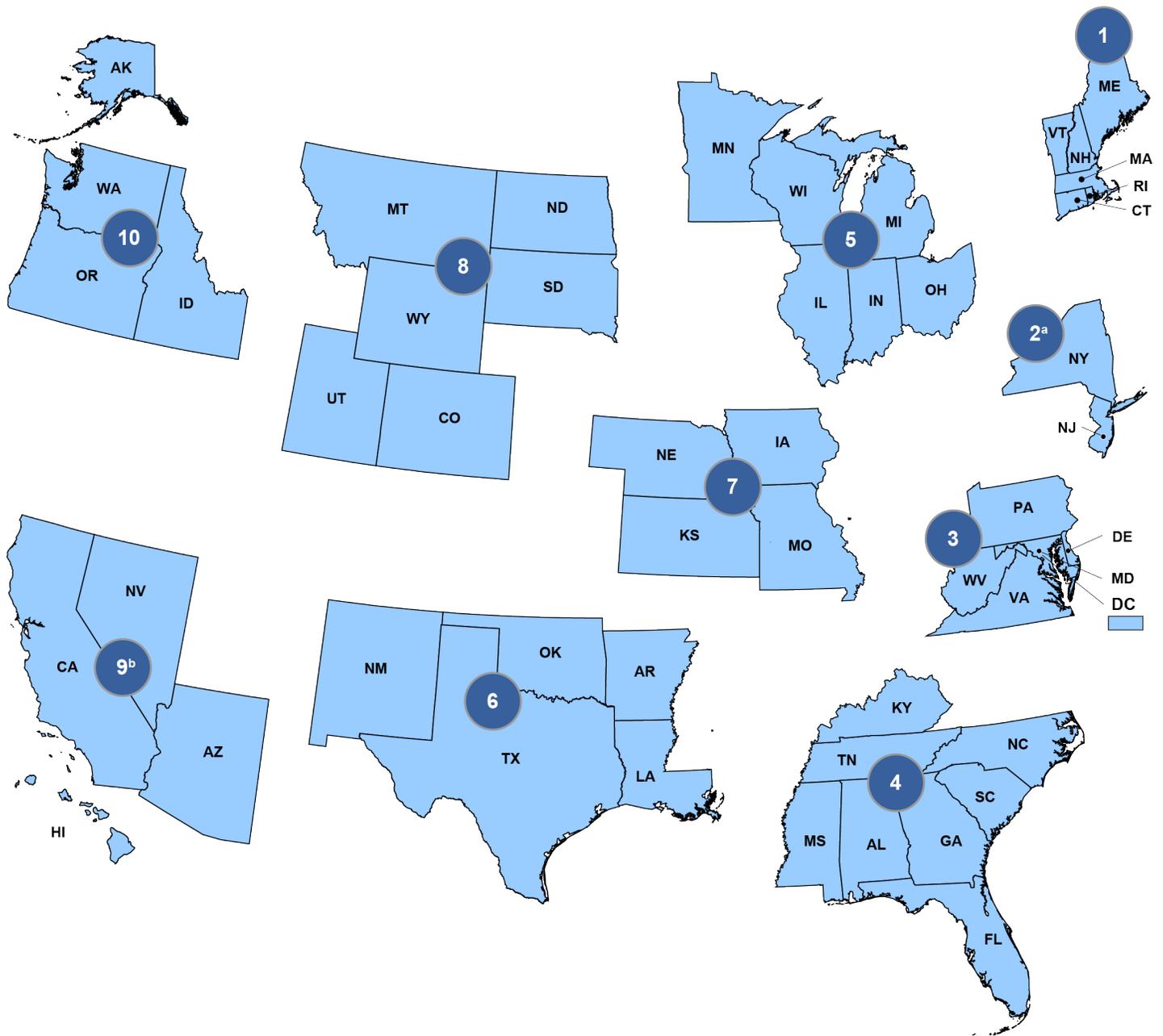
Prior to its November 2019 reorganization, CMS directed its 10 regional offices to conduct FMRs each year focused on states' compliance with a specific Medicaid program area, typically in one state in each respective region. (See fig.1.)

⁸State Medicaid plans describe how a state will administer its Medicaid program and are subject to CMS approval.

⁹See [GAO-18-564](#).

¹⁰As of October 2019, CMS had taken steps to address this recommendation by developing a tool to assess risk and staff capacity. When complete, this tool could allow the agency to identify opportunities to increase resources and determine the appropriate allocation of staff by state. However, CMS officials told us that with the November 2019 reorganization, they suspended further efforts to develop this assessment tool. Instead, CMS officials said they are further evaluating how to allocate resources best in its new organizational framework, which they consider an ongoing process.

Figure 1: Jurisdiction of CMS Regional Offices Prior to November 2019



Source: GAO review of documentation from the Centers for Medicare & Medicaid Services (CMS); Map Resources (map). | GAO-21-17

Note: On November 25, 2019, CMS published a Federal Register notice, which outlined a plan to reorganize the agency's 10 regional offices into two branches, an East Branch and a West Branch. See 84 Fed. Reg. 64,899 (Nov. 25, 2019).

^aRegional office 2 also oversaw Puerto Rico and the U.S. Virgin Islands.

^bRegional office 9 also oversaw American Samoa, Guam, and the Northern Mariana Islands.

Each year, CMS central office sent a letter directing each of the agency's regional offices to submit three or more FMR proposals. These proposals outlined plans to explore specific Medicaid program areas within one or more states in their respective regions. FMR proposals largely consisted of issues the regional offices identified through the quarterly expenditure reviews, news stories, or reports by HHS's Office of Inspector General (HHS-OIG). In selecting an FMR proposal, CMS central office considered several factors, including the topic and the amount of federal funds at risk, as well as states' program expenditures and the frequency of recent FMRs across states.¹¹

After CMS's central office selected FMR proposals, the regional offices conducted their reviews and submitted preliminary findings to the central office for approval.¹² CMS's central office typically approved the FMR findings before the regional office shared them with the state under review. FMR findings generally fell into two categories:

1. findings of non-compliance with a financial impact, for which CMS directed states to return federal Medicaid funds; and
2. findings that identify internal control weakness with no financial impact, for which CMS directed states to make changes to their Medicaid policies.

Once informed of the report findings—including while the FMR report was still under review—states could take corrective actions, although they were not required to do so.

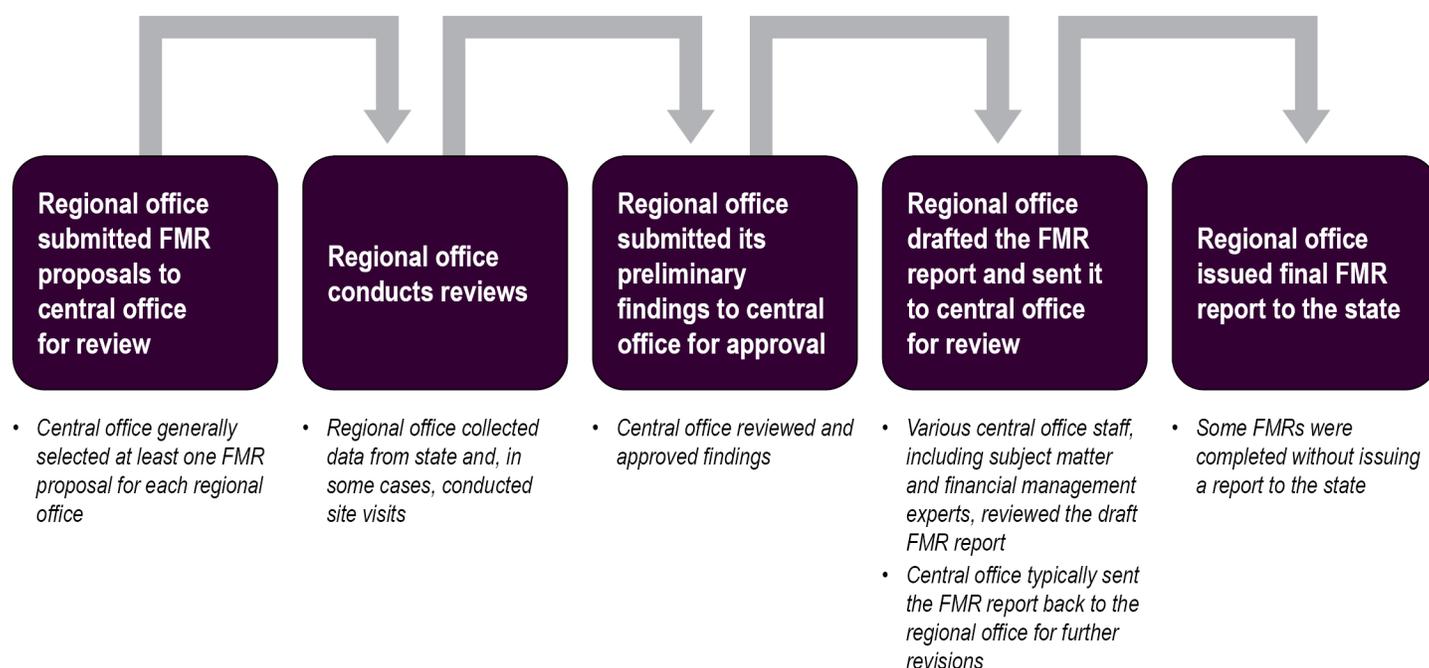
With its findings approved, regional offices drafted the FMR report and sent it to central office for additional review, including reviews by subject matter and financial management experts. Based on these reviews, CMS central office sent the FMR report back to the regional office for further

¹¹To address potential compliance issues outlined in FMR proposals not selected, CMS regional officials said they might resubmit proposals the following year, or monitor the issues at a high-level through quarterly reviews if time allows.

¹²CMS guidance directed regional offices to submit draft FMR reports by the end of the fiscal year in which they began. CMS officials told us that FMRs might also include observations, which they described as issues identified during the FMR that require state attention, but do not rise to the level of a finding.

revisions. CMS’s Financial Management Group was ultimately responsible for approving the draft report and advancing it to the Director of the Center for Medicaid and CHIP Services for final approval.¹³ CMS then typically issued the FMR report to the state under review.¹⁴ (See fig. 2.)

Figure 2: CMS’s Process for Medicaid Financial Management Reviews (FMR) Initiated Prior to November 2019



Source: GAO review of documentation from the Centers for Medicare & Medicaid Services (CMS). | GAO-21-17

Note: On November 25, 2019, CMS published a Federal Register notice, which outlined a plan to reorganize the agency’s 10 regional offices into two branches, an East Branch and a West Branch. See 84 Fed. Reg. 64,899 (Nov. 25, 2019). As of July 2020, CMS had not fully determined how it would conduct future FMRs in light of its reorganization.

CMS guidance directed regional offices to submit draft FMR reports by the end of the fiscal year in which they started.

¹³CMS officials indicated that for FMRs initiated in the future, the agency plans to involve subject matter and financial management experts earlier in the FMR review process. Specifically, these experts would be involved as FMR findings and reports are drafted, and before they are sent to the Financial Management Group and the Center for Medicaid and CHIP Services’ Director for review and approval.

¹⁴For example, CMS did not always issue FMR reports that did not include findings.

As of July 2020, CMS had not fully determined how it would conduct future FMRs in light of its reorganization, which regrouped states into two branches (East and West), in place of its 10 regional office structure. (See app. I) According to CMS officials, the agency expects to continue to initiate about 10 FMRs each year, but has not determined how it will allocate resources for FMRs across its new structure.

CMS Use of Financial Management Reviews to Oversee State Medicaid Programs Has Been Limited

CMS initiated 49 FMRs between fiscal years 2016 and 2020, which frequently included findings of states' non-compliance with certain Medicaid policies that had a financial impact or uncovered an internal control weakness. However, CMS's use of FMRs for program oversight has been limited. Agency officials cited competing priorities, decreased staff, and its internal report review process as factors affecting their use of FMRs.

CMS Has Used Financial Management Reviews to Examine Aspects of Medicaid Programs in Some States

In fiscal years 2016 through 2020, CMS initiated 49 FMRs to review state Medicaid agencies' compliance with a variety of federal Medicaid policies. However, CMS has not always used FMRs to examine program areas or states that reflect the areas of highest program risk as measured by overall spending, underscoring the need for CMS to implement our 2018 recommendation that it assess its oversight of Medicaid expenditures to determine if resources are adequate and allocated accordingly.¹⁵

Program Areas Examined

The FMRs initiated during this period examined a broad range of Medicaid program areas that, according to CMS officials, targeted about \$20 billion in federal funds at risk of not meeting program requirements.¹⁶ FMRs most frequently focused on eligibility expansions and state financing arrangements. Less frequently, FMRs examined Medicaid managed care, administrative financial oversight, and a broad range of

¹⁵See [GAO-18-564](#). As of June 2020, CMS had not implemented this recommendation.

¹⁶In estimating the amount of federal funds at risk, CMS calculates the total federal funds associated with each program area examined in the FMR. However, the amount of federal funds determined to be unallowable is typically a portion of this estimate or may be nothing at all.

areas including emergency services for undocumented individuals and home and community-based services.¹⁷ (See table 1.)

Table 1: Medicaid Financial Management Reviews (FMR) Program Areas and Federal Funds at Risk, Fiscal Years 2016 through 2020

| Medicaid program area | Number of FMRs | Federal funds at risk (dollars in billions) ^a |
|---|----------------|--|
| Eligibility expansion | 10 | 12.56 |
| State financing arrangements | 8 | 2.37 |
| Managed care ^b | 5 | 2.57 |
| Administrative financial oversight ^c | 5 | 0.36 |
| All other areas ^d | 21 | 1.89 |
| Total | 49 | 19.74^e |

Source: GAO review of documentation from the Centers for Medicare & Medicaid Services (CMS). | GAO-21-17

Notes:

^aIn estimating the amount of federal funds at risk, CMS calculates the total federal funds associated with each program area examined in the FMR. However, the amount of federal funds determined to be unallowable is typically a portion of this estimate or may be nothing at all.

^bCMS did not identify the federal funds at risk for one FMR examining managed care.

^cAdministrative financial oversight includes payments for eligibility and enrollment systems, school based administrative claims, and provider administrative fees.

^dOther program areas included home health services, personal care services, and mental health services, among others.

^eDue to rounding, numbers do not sum to total.

As noted in our prior work, the areas in which CMS chooses to conduct FMRs do not always reflect areas of highest program risk as measured by overall spending. For example, of the nearly \$20 billion in federal funds at risk,

- CMS initiated five reviews of managed care, totaling \$2.6 billion, yet managed care represents 45 percent of total Medicaid program spending, which was nearly \$600 billion in fiscal year 2018; and

¹⁷CMS officials said they continue to look for additional opportunities to use FMRs to examine issues related to Medicaid managed care. Such efforts would align with our prior recommendation that CMS increase its oversight of Medicaid managed care payments. See GAO, *Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks*, [GAO-18-528](#) (Washington, D.C.: July 26, 2018).

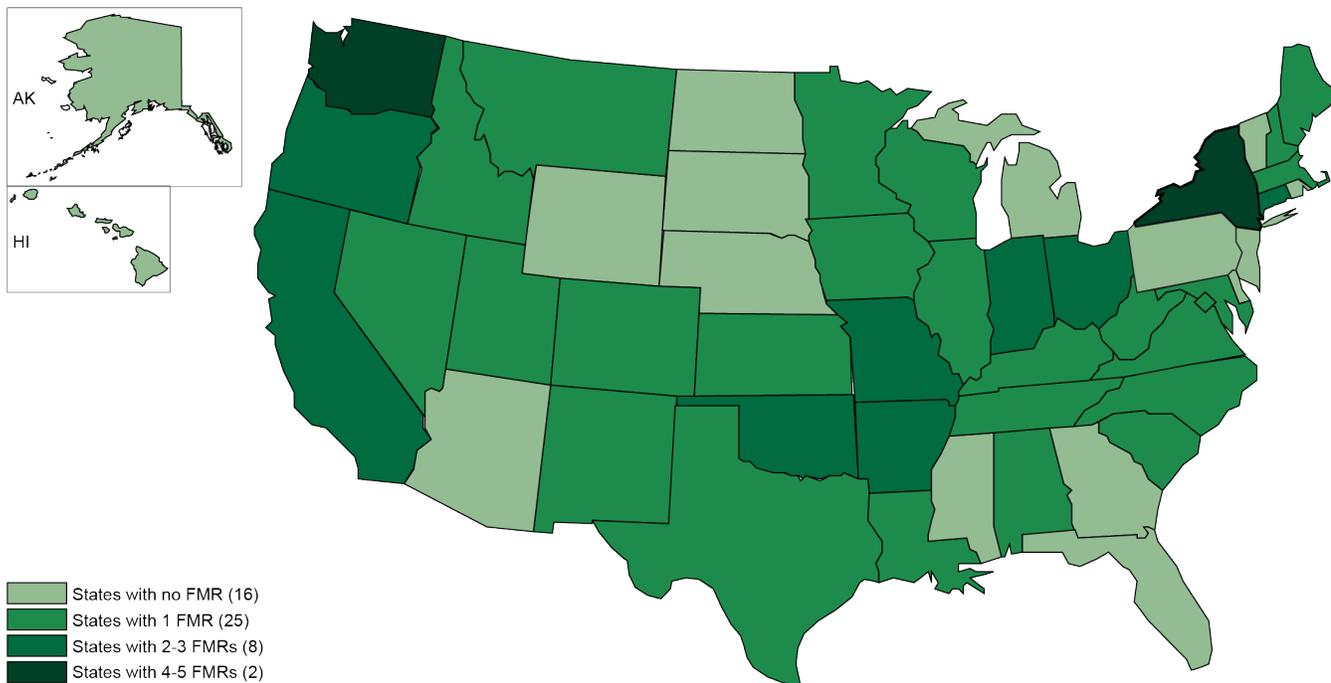
- CMS initiated 10 reviews of eligibility expansions, totaling \$12.6 billion, yet such expansions accounted for approximately 13 percent of Medicaid program spending in fiscal year 2018.

For additional information about FMRs initiated during this period, see appendix II.

States Examined

The extent to which CMS conducted FMRs across all states varied. For example, from fiscal years 2016 through 2020, CMS conducted one FMR in 25 states; two to three FMRs in eight states; four to five FMRs in two states, and no FMRs in 16 states.¹⁸ (See fig. 3.)

Figure 3: Number of Financial Management Reviews (FMR) in States, Fiscal Years 2016 through 2020



Source: GAO review of documentation from the Centers for Medicare & Medicaid Services (CMS). | GAO-21-17

Note: CMS also did not conduct an FMR in any of the five U.S. territories, each of which has a Medicaid program: American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

¹⁸CMS also did not conduct an FMR in any of the five U.S. territories with Medicaid programs: American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

FMR Findings

CMS officials said they typically select states for FMRs that have high expenditures due to the greater amount of federal dollars at risk. However, the 49 FMRs that CMS initiated over the 5-year period did not examine six of the 20 states with the highest Medicaid expenditures for services in 2018—Arizona, Florida, Georgia, Michigan, New Jersey, and Pennsylvania. Together, these six states represented 18 percent (\$106.9 billion) of federal Medicaid expenditures for services in fiscal year 2018. CMS officials told us that the most recent FMR in each of these states was as follows: Arizona and New Jersey, 2008; Florida and Pennsylvania, 2012; and Georgia and Michigan, 2013.

Beyond program expenditures, CMS officials said that other considerations affect their decisions regarding state selection for FMRs. For example, CMS officials said they might select a state with known compliance issues over one with higher expenditures in a given region.

FMRs initiated in fiscal years 2016 through 2020 frequently included findings that identified states’ non-compliance with certain federal Medicaid policies. In some cases, the FMR finding identified instances of non-compliance that had a financial impact, for which CMS directed states to return federal Medicaid funds. In other cases, the FMR finding identified internal control weaknesses with no financial impact, for which CMS directed states to make changes to their Medicaid policies.¹⁹ An individual FMR could include both types of findings or no findings. In some instances, states took steps to address the findings while the FMR report was still under review. (See table 2.)

Table 2: Number of CMS Medicaid Financial Management Reviews (FMR) by Finding Type, Fiscal Years 2016 through 2020

| FMR finding type | Number of FMRs |
|--|-----------------|
| Findings with financial impact and internal control weaknesses | 16 |
| Findings with financial impact only | 7 |
| Findings with internal control weaknesses only | 5 |
| No findings | 7 |
| FMRs that are underway, and have not yet identified findings | 14 ^a |
| Total FMRs | 49 |

Source: GAO review of documentation from the Centers for Medicare & Medicaid Services (CMS). | GAO-21-17

¹⁹Ten of the 49 FMRs began in fiscal year 2020. Therefore, findings from these FMRs were not available at the time we conducted our work.

¹⁹Ten of the 14 FMRs began in fiscal year 2020. CMS originally expected regional offices to submit draft reports for these FMRs to central office by September 30, 2020. However, due to the Coronavirus Disease 2019 (COVID-19), CMS officials told us that they suspended work on FMRs initiated in 2019 and 2020 in March 2020 so that staff could work on COVID-19 related activities. CMS officials said they expected to restart work on these FMRs in August 2020 and that regional offices should submit draft reports for FMRs initiated in 2020 by March 31, 2021.

Findings of non-compliance with financial impact. For 23 of the 49 FMRs, CMS found compliance issues with a financial impact totaling at least \$358 million.²⁰ As of June 2020, CMS had recovered about \$209 million (58 percent) of this total. CMS had not yet recovered the remaining amount for a variety of reasons, including that states disagreed with the findings or states wanted to receive the final FMR report before returning federal funds.²¹ A state that disagrees with FMR findings may provide CMS with additional data and documentation, or in the event of a disallowance, request a reconsideration or submit an appeal to HHS's Departmental Appeals Board. The following are examples of FMRs that resulted in CMS recovering federal funds.

- An FMR initiated in fiscal year 2016 examined New York's outpatient hospital reimbursement for mental health services and found unallowable expenditures, which resulted in CMS's recovery of \$126 million in federal funds.
- An FMR initiated in 2018 examined Alabama's use of certified public expenditures: certifications made by public entities, such as public hospitals, about funds spent on Medicaid services that are eligible for federal matching funds.²² CMS found that Alabama did not follow the hospital reimbursement methodology outlined in its Medicaid state plan and recovered \$30.8 million in federal funds.
- An FMR initiated in fiscal year 2016 examined claims data for Ohio's Medicaid expansion population. The FMR found that the state

²⁰For three of these 23 FMRs, CMS is awaiting state data and supporting documentation to calculate the amount of federal funds for recovery.

²¹As of June 2020, 17 of these 23 FMRs remained under review by CMS. For FMRs under review, the amount of federal funds identified for recovery can be subject to revision.

²²CMS initiated this FMR in response to an HHS-OIG recommendation directing the Alabama Medicaid program to work with CMS to determine whether the calculation of such expenditures in fiscal year 2010 was consistent with the state Medicaid plan. See Department of Health and Human Services, Office of Inspector General, *Alabama Did Not Comply With Federal and State Requirements for Claiming Medicaid Certified Public Expenditures for Federal Fiscal Year 2010*, July 2016 (A-06-15-00004).

incorrectly categorized certain enrollees as part of the expansion population and received a higher matching rate for them. This finding resulted in CMS's recovery of \$6.7 million in federal funds.²³

Findings of internal control weaknesses with no financial impact.

For 21 of the 49 FMRs, CMS found internal control weaknesses with no financial impact, and directed states to make changes, including strengthening internal controls, improving financial reporting, and implementing claim edits.

- An FMR initiated in fiscal year 2017 examined Arkansas' home health services expenditures, finding instances where an inpatient facility improperly provided these services. The FMR also found that payments for certain supplies exceeded the maximum amount allowed and claims did not always include sufficient detail to support payments. As a result, CMS directed the state to take corrective actions, including providing proper oversight and training to providers to ensure that home health services claims include the correct documentation.²⁴
- An FMR initiated in fiscal year 2016 examined Oklahoma's psychiatric residential treatment facilities and found that some facilities did not have the appropriate license.²⁵ As a result, CMS worked with the state to resolve the licensing issues.

In addition to the recovery of federal funds and improved program operations in certain states, CMS officials said that FMR findings have led to changes in agency policies. For example, CMS officials told us they modified supplemental payment reporting steps for the CMS-64, and

²³The state repaid these federal funds, although the FMR remains under review by CMS. This FMR includes two additional findings with financial impact, which could result in the recovery of an additional \$15.3 million in federal funds.

²⁴CMS officials said that Arkansas is awaiting the final report before it will take any action to address these findings.

²⁵CMS also recovered \$1.4 million in federal funds for this FMR. The state provided CMS with comments on the draft FMR report, and as of June 2020, the report was still under review by CMS.

issued a State Medicaid Director Letter addressing appropriate funding sources for the state share of supplemental payments.²⁶

Several Factors Contribute to CMS's Limited Use of FMRs for Program Oversight

Most of the 49 FMRs initiated in fiscal years 2016 through 2020 were still under review by CMS in June 2020, in some cases delaying important action by states to address vulnerabilities. While CMS does not expect regional offices to submit draft reports for the 10 FMRs initiated in fiscal year 2020 until March 31, 2021, two-thirds of the FMRs (26 of 39) initiated in the preceding 4 years were still under CMS review and were not complete.²⁷ (See fig. 4.) Of the 13 completed FMRs, CMS completed nine during the course of our review.²⁸

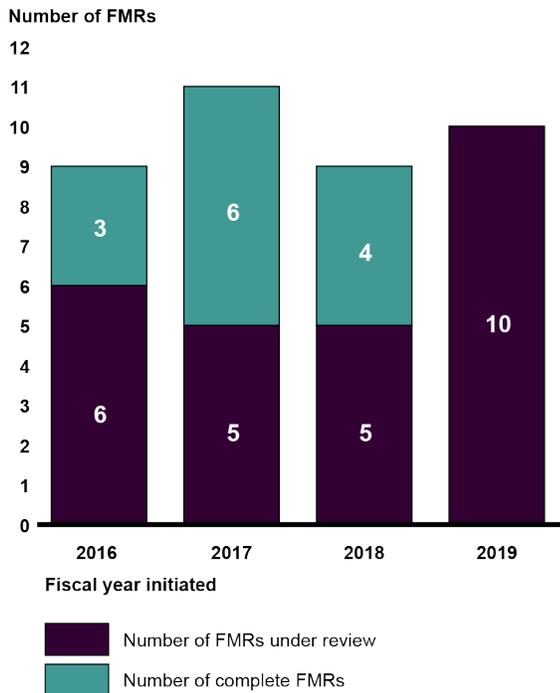
²⁶Centers for Medicare & Medicaid Services, *State Medicaid Director Letter, Accountability #2: Financing and Donations* (Baltimore, Md.: May 9, 2014), accessed June 19, 2020, <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/SMD-14-004.pdf>.

States finance their share of Medicaid program spending in a variety of ways, including state funds, such as state general funds appropriated to the state Medicaid program, and funds collected through taxes levied on health care providers.

²⁷Per agency guidance, CMS regional offices were to submit draft FMR reports to central office by the end of the fiscal year in which they began. However, due to the Coronavirus Disease 2019 (COVID-19), CMS officials told us that in March 2020, they suspended work on FMRs initiated in 2019 and 2020 so that staff could work on COVID-19 related activities. CMS officials said they expected to restart work on these FMRs in August 2020.

²⁸During the course of our review, CMS also completed three FMRs initiated in fiscal year 2012, one FMR from fiscal year 2013, and two FMRs from fiscal year 2014.

Figure 4: Status of Financial Management Reviews (FMR) Initiated in Fiscal Years 2016 through 2019, as of June 2020



Source: GAO review of data from the Centers for Medicare & Medicaid Services. | GAO-21-17

Notes: Per agency guidance, the Centers for Medicare & Medicaid Services (CMS) regional offices are to submit draft FMR reports to central office by the end of the fiscal year in which they began. However, due to the Coronavirus Disease 2019 (COVID-19), CMS officials told us that they suspended work on FMRs initiated in 2019 and 2020 in March 2020 so that staff could work on COVID-19 related activities. CMS officials said they expected to restart work on these FMRs in August 2020.

CMS generally expected its 10 regional offices to conduct one FMR each year. However, CMS waived the FMR requirement in one regional office in fiscal year 2016 and in four regional offices in fiscal year 2018. Additionally, in fiscal years 2017 and 2018, one regional office conducted more than one FMR.

While several states returned federal funds determined to be unallowable or addressed other FMR findings while the report was under review by CMS, other states did not. For example, according to CMS officials, at least five states with an FMR during this period were waiting for CMS to complete the relevant report before taking corrective actions, including returning federal funds. Specifically, as noted above, Arkansas will not return \$8.7 million in federal funds or take other actions to address vulnerabilities identified in its provision of home health services until it receives a complete report from CMS, according to agency officials. In

other cases, FMRs have been under review for multiple years, often for no clear reason.

CMS officials cited competing financial oversight priorities, decreased staffing levels, and its internal FMR report review process as contributing to limitations in their use of FMRs for program oversight.²⁹

Competing financial oversight priorities. CMS officials acknowledged that, due to competing priorities, FMRs can be a lower priority than other Medicaid financial oversight activities. For example, officials said that the CMS-64 quarterly reviews are a higher priority, because they are required, complex, time-consuming, and CMS has 50 days to complete them. CMS officials told us that staff work on FMRs in between their other responsibilities, and estimated that these individuals typically spend about 10 to 30 percent of their time working on FMRs.

In some cases, CMS waived the requirement that regional offices conduct one FMR each year due to competing priorities on staff time. CMS waived the requirement for FMRs in four regional offices in fiscal year 2018, and in one regional office in fiscal year 2016.³⁰ We previously reported that CMS waived the requirement for FMRs in all 10 regional offices in fiscal year 2015 so that the offices could instead examine Medicaid expansion population expenditures.³¹

Decreased staffing levels. CMS officials said that a decline in agency resources for financial management activities, including FMRs, has affected their ability to complete FMR reports in a timely manner. This decline in resources limits CMS's ability to use these financial management activities for program oversight. The number of regional office full-time equivalent (FTE) employees with responsibility for these activities has decreased steadily in recent years—22 percent since fiscal year 2013. (See table 3.)

²⁹Beyond these reasons, it is less clear why CMS still considered other FMRs to be under review. For example, for an FMR initiated in fiscal year 2012 examining Louisiana's supplemental payments to hospitals, CMS officials told us the state immediately addressed the finding and returned the unallowable federal funds, though CMS did not determine that this FMR was complete until March 2020.

³⁰For fiscal year 2018, one regional office conducted multiple FMRs.

³¹See [GAO-18-564](#).

Table 3: Number of CMS Financial Management Staff across All Regional Offices, Fiscal Years 2013 through 2020

| Fiscal year | Number of full-time equivalent employees |
|-------------|--|
| 2013 | 156 |
| 2014 | 154.5 |
| 2015 | 147.5 |
| 2016 | 138 |
| 2017 | 134 |
| 2018 | 125 |
| 2019 | 122.5 |
| 2020 | 121.5 |

Source: Data from the Centers for Medicare & Medicaid Services (CMS). | GAO-21-17

The change in the number of FTEs across regional offices varied widely. For example, while the Atlanta regional office experienced a decrease of 11 FTEs over this period, the Seattle regional office experienced an increase of one FTE.³² The confluence of decreased staffing levels and competing priorities creates oversight challenges. It also underscores the need for CMS to implement our 2018 recommendation that it conduct a national risk assessment of its oversight of Medicaid expenditures.

Internal report review process. CMS officials also cited its internal review process as contributing to delays in completing FMR reports. As noted, CMS central office staff told us they generally followed a multi-step review process to ensure that FMR reports submitted by regional offices were accurate and consistent with applicable laws, regulations, and national policy. This process typically included multiple levels of review and involved significant back and forth between central and regional offices, often spanning years. In one case, 6 years passed from the time the regional office first sent its draft report to central office and CMS completed the FMR.

A 2012 internal regional office assessment of the FMR report review process also identified delays associated with CMS's review process for FMRs. This assessment included several recommendations aimed at limiting the review process to 6 months, including a recommendation that

³²CMS officials told us that they have requested additional funding to replace financial management staff lost to attrition through their normal, internal CMS budget process, but have not yet received such funding.

central office “review and provide comments on draft FMR reports within 30 days” and that “this timeline should be enforced by central office.”

Despite these recommendations, CMS has yet to establish time frames for the completion of individual review steps or for its overall review of FMR reports, which is inconsistent with federal internal control standards related to monitoring and control activities. These standards state that management should remediate identified internal control deficiencies in a timely manner and design control activities to achieve objectives and respond to risks.³³ Developing and implementing such time frames would provide a tool to help monitor CMS’s progress in completing FMRs and ensure prompt action on FMR findings.

Conclusions

FMRs provide CMS with the opportunity to examine complex issues in greater depth and can lead to the identification and recovery of large amounts of unallowable federal expenditures or vulnerabilities in states’ Medicaid programs. However, our prior and current work identified limitations in CMS’s use of FMRs. In particular, in August 2018, we recommended that CMS conduct a national risk assessment of its oversight of Medicaid expenditures to determine if resources are adequate and allocated accordingly. We maintain that CMS should implement this recommendation to target resources to states and program areas with the highest risk, as measured by overall expenditures.

For this report, we found that CMS has not established time frames for completing its review of FMR reports. As a result, FMRs frequently remain under review at CMS’s central office for multiple years, often for no clear reason. CMS took steps during the course of our review to complete many FMRs that had been under review for several years. Nonetheless, the absence of explicit time frames for its internal review of FMR reports suggest that prolonged reviews are likely to recur in the future, delaying both the recovery of federal funds and important feedback to states on their Medicaid programs’ vulnerabilities.

Recommendation for Executive Action

We are making the following recommendation to CMS:

³³See [GAO-14-704G](#).

The Administrator of CMS should develop and implement time frames to ensure that the agency completes FMRs in a timely manner.
(Recommendation 1)

Agency Comments

We provided a draft of this report to HHS for review. In its comments, reproduced in appendix III, HHS concurred with our recommendation and described steps it was taking to improve the timeliness of FMR reporting. HHS also provided technical comments, which we incorporated as appropriate.

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

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.



Carolyn L. Yocom
Director, Health Care

List of Requesters

The Honorable Michael B. Enzi
Chairman
Committee on the Budget
United States Senate

The Honorable Tom Cotton
United States Senate

The Honorable Cory Gardner
United States Senate

The Honorable Charles E. Grassley
United States Senate

The Honorable Ron Johnson
United States Senate

The Honorable John Kennedy
United States Senate

The Honorable David Perdue
United States Senate

The Honorable Patrick J. Toomey
United States Senate

Appendix I: CMS Financial Management Group Branches as of November 2019

In November 2019, the Centers for Medicare & Medicaid Services (CMS) announced a reorganization that included changes to its Financial Management Group, which is responsible for quarterly reviews and financial management reviews, among other financial oversight activities. Under the reorganization, CMS regrouped states into two branches (East and West), in place of its 10 regional office structure. (See table 4.)

Table 4: CMS Financial Management Group Branches, November 2019

| Branch | States overseen |
|-------------|---|
| East Branch | A Connecticut, Massachusetts, Maine, New Hampshire, New York, Rhode Island, Vermont |
| | B District of Columbia, Delaware, Maryland, New Jersey, Pennsylvania, Virginia, West Virginia |
| | C Alabama, American Samoa, Florida, Georgia, Guam, Kentucky, Mississippi, North Carolina, Northern Mariana Islands, Puerto Rico, South Carolina, Tennessee, U.S. Virgin Islands |
| West Branch | A Arkansas, Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin |
| | B Iowa, Kansas, Louisiana, Missouri, Nebraska, New Mexico, Oklahoma, Texas |
| | C California, Hawaii, North Dakota, Nevada, South Dakota, Wyoming |
| | D Alaska, Arizona, Colorado, Idaho, Montana, Oregon, Utah, Washington |

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) documentation. | GAO-21-17

Note: On November 25, 2019, CMS published a Federal Register notice, which outlined its plan to reorganize the agency's 10 regional offices into two branches, an East Branch and a West Branch. See 84 Fed. Reg. 64,899 (Nov. 25, 2019).

Appendix II: Information on Medicaid Financial Management Reviews (FMR) Initiated in Fiscal Years 2016 through 2020

Table 5: Medicaid Financial Management Reviews (FMR) Initiated in Fiscal Years 2016-2020

| State ^a | Fiscal year | Program area | Estimated federal funds at risk (dollars in millions) ^b | Complete FMRs | FMR findings ^c | | Recovery of federal funds (dollars in millions) | |
|----------------------|-------------|---|--|---------------|---------------------------|----------------------------------|---|----------------------------------|
| | | | | | Financial impact | No financial impact ^d | Total amount identified | Amount recovered as of June 2020 |
| Alabama | 2018 | Hospitals' Certified Public Expenditures | 162.5 | ✓ | ✓ | — | 30.8 | 30.8 |
| Arkansas | 2019 | Medicaid Expansion Group Expenditure Reporting | 1,350.5 | — | ✓ | ✓ | 11.1 ^e | 0 |
| | 2017 | Home Health Services | 51.0 | — | ✓ | ✓ | 8.7 ^e | 0 |
| California | 2020 | Medi-Cal Enrollee Claims Not Eligible for Federal Match | Unknown | ▲ | — | — | — | — |
| | 2019 | Community First Choice Waiver | 285.9 | — | ✓ | ✓ | △ | — |
| | 2016 | Outpatient Supplemental Payments | 154.0 | — | — | ✓ | — | — |
| Colorado | 2017 | Intermediate Care Facilities for Individuals with Intellectual Disabilities Payments | 22.5 | — | ✓ | ✓ | 0.2 ^e | 0 |
| Connecticut | 2019 | Hospital User Fees and Taxes | 636.9 | — | — | ✓ | — | — |
| | 2016 | Public Psychiatric Residential Treatment Facilities | 41.3 | — | ✓ | — | 8.5 ^e | 0 |
| District of Columbia | 2020 | Medicaid Expansion Group Expenditure Reporting | 417.3 | ▲ | — | — | — | — |
| Idaho | 2018 | Skilled Professional Medical Personnel | 1.1 | — | ✓ | ✓ | 0.1 | 0.1 |
| Illinois | 2018 | Reclassifications from CHIP to Medicaid of First Year Medical Expenditures for Infants Born to Women Receiving Emergency Medical Services Under Title XIX | -81.9 | ▲ | — | — | — | — |
| Indiana | 2019 | Nursing Facility Funding Arrangements for the Upper Payment Limit | 669.1 | ▲ | — | — | — | — |
| | 2017 | Medicaid Expansion Group Expenditure Reporting | 1,800.0 | ✓ | — | — | — | — |
| Iowa | 2020 | Intellectual Disabilities Section 1915(c) Home and Community Based Services Waiver | 79.0 | ▲ | — | — | — | — |
| Kansas | 2017 | Managed Care Provider Payments | Unknown | ✓ | — | — | — | — |

Appendix II: Information on Medicaid Financial Management Reviews (FMR) Initiated in Fiscal Years 2016 through 2020

| State ^a | Fiscal year | Program area | Estimated federal funds at risk (dollars in millions) ^b | FMR findings ^c | | | Recovery of federal funds (dollars in millions) | |
|--------------------|-------------|--|--|---------------------------|------------------|----------------------------------|---|----------------------------------|
| | | | | Complete FMRs | Financial impact | No financial impact ^d | Total amount identified | Amount recovered as of June 2020 |
| Kentucky | 2017 | Medicaid Expansion Group Expenditure Reporting | 600.0 | — | — | — | — | — |
| Louisiana | 2020 | Multi State Review of Emergency Services for Undocumented Aliens | 66.3 ^f | ▲ | — | — | — | — |
| Maine | 2017 | Medicare Part B Premium Buy-Ins | 69.0 | — | ✓ | ✓ | △ | — |
| Maryland | 2016 | Medicaid Expansion Group Expenditure Reporting | 450.0 | — | ✓ | ✓ | 33.2 ^e | 0 |
| Massachusetts | 2018 | Claimed Managed Care Program Expenditures | 2,500.0 | — | ✓ | ✓ | 0.1 | 0.1 |
| Minnesota | 2020 | Medicaid Expansion Group Expenditure Reporting | 1,710.4 | ▲ | — | — | — | — |
| Missouri | 2019 | Section 1115 Waiver: Gateway to Better Health | 18.9 | — | ✓ | ✓ | 0.04 | 0.04 |
| | 2016 | School District Administrative Claiming | 12.8 | — | — | ✓ | — | — |
| Montana | 2020 | Medicaid Reimbursement for Dental Services | 88.9 | ▲ | — | — | — | — |
| New Hampshire | 2020 | Supplemental Payments for County-Owned Nursing Facility Services | 34.5 | ▲ | — | — | — | — |
| Nevada | 2017 | Eligibility and Enrollment—Maintenance and Operations and Eligibility Determinations | 57.0 | ✓ | — | — | — | — |
| New Mexico | 2020 | Multi State Review of Emergency Services for Undocumented Aliens | 66.3 ^f | ▲ | — | — | — | — |
| New York | 2020 | Medicaid Expansion Group Expenditure Reporting | 2,500.0 | ▲ | — | — | — | — |
| | 2019 | Hospital Supplemental Payments | 437.5 | ▲ | — | — | — | — |
| | 2018 | Eligibility and Enrollment Enhanced Match, State Enrollment Center | 40.2 | ✓ | — | — | — | — |
| | 2017 | Comprehensive Psychiatric Emergency Program Rates | 64.0 | ✓ | — | ✓ | — | — |
| | 2016 | Outpatient Hospital Reimbursement for Mental Health Services | 260.0 | ✓ | ✓ | — | 126.0 | 126.0 |

Appendix II: Information on Medicaid Financial Management Reviews (FMR) Initiated in Fiscal Years 2016 through 2020

| State ^a | Fiscal year | Program area | Estimated federal funds at risk (dollars in millions) ^b | FMR findings ^c | | | Recovery of federal funds (dollars in millions) | |
|--------------------|-------------|---|--|---------------------------|------------------|----------------------------------|---|----------------------------------|
| | | | | Complete FMRs | Financial impact | No financial impact ^d | Total amount identified | Amount recovered as of June 2020 |
| North Carolina | 2016 | Health Homes Data and Expenditure Reporting | 89.0 | ✓ | ✓ | ✓ | 30.6 | 0 |
| Ohio | 2018 | Medicaid Managed Care Risk Mitigation Adjustment | 8.8 | — | ✓ | — | 0.04 ^e | 0 |
| | 2016 | Medicaid Expansion Group Expenditure Reporting | 100.0 | — | ✓ | ✓ | 22.0 ^e | 6.7 |
| Oklahoma | 2018 | Health Home Services | 42.0 | — | ✓ | ✓ | 18.2 ^e | 0 |
| | 2016 | Psychiatric Residential Treatment Facilities | 48.0 | — | ✓ | ✓ | 1.4 | 1.4 |
| Oregon | 2018 | Medical Loss Ratio Risk Mitigation for 1115 Waiver | 60.0 | ✓ | ✓ | — | 29.6 | 29.6 |
| | 2017 | School Based Services Expenditures | 1.1 | — | ✓ | ✓ | 0.1 | 0.1 |
| South Carolina | 2020 | Nursing Facility Supplemental Payments | 16.5 | ▲ | — | — | — | — |
| Tennessee | 2019 | Nursing Facility Tax | 254.1 | — | — | — | — | — |
| Texas | 2020 | Multi State Review of Emergency Services for Undocumented Aliens | 66.3 ^f | ▲ | — | — | — | — |
| Utah | 2019 | Provider Administrative Fees | 250.0 | — | ✓ | ✓ | 5.6 ^e | 0 |
| Virginia | 2019 | Home and Community Based Services, Personal Care Services | 438.3 | — | ✓ | ✓ | 17.5 ^e | 0 |
| Washington | 2020 | 1915(K) Community First Choice Waiver | 250.6 | ▲ | — | — | — | — |
| | 2019 | Emergency Services for Undocumented Aliens | 55.0 | ▲ | — | — | — | — |
| | 2017 | Managed Care Drug Rebates Reporting for Family Planning and Breast/Cervical Cancer Services | 3.0 | ✓ | ✓ | — | 4.4 | 4.4 |
| | 2016 | Medicaid Expansion Group Expenditure Reporting | 3,000.0 | ✓ | — | — | — | — |
| West Virginia | 2017 | Medicaid Expansion Group Expenditure Reporting | 628.2 | ✓ | — | ✓ | — ^g | — |

Appendix II: Information on Medicaid Financial Management Reviews (FMR) Initiated in Fiscal Years 2016 through 2020

| State ^a | Fiscal year | Program area | Estimated federal funds at risk (dollars in millions) ^b | Complete FMRs | FMR findings ^c | | Recovery of federal funds (dollars in millions) | |
|--------------------|-----------------------|--|--|---------------|---------------------------|----------------------------------|---|----------------------------------|
| | | | | | Financial impact | No financial impact ^d | Total amount identified | Amount recovered as of June 2020 |
| Wisconsin | 2018 | Cost Settlements, 1915i Community Recovery Services | 0.1 | ✓ | ✓ | — | 9.6 | 9.6 |
| Total | 49^a | | 19,743.4 | 13 | 23 | 21 | 357.8 | 208.8 |

Legend:

✓ = yes

— = not applicable

▲ = FMR still in process, and it is unknown whether the FMR will identify findings. For the 10 FMRs initiated in fiscal year 2020, the Centers for Medicare & Medicaid Services (CMS) originally expected regional offices to submit draft reports to central office by September 30, 2020. However, due to the Coronavirus Disease 2019 (COVID-19), CMS officials told us that they suspended work on FMRs initiated in fiscal years 2019 and 2020 in March 2020 so that staff could work on COVID-19 related activities. CMS officials said they expected to restart work on these FMRs in August 2020, and that regional offices should submit draft reports for FMRs initiated in fiscal year 2020 by March 31, 2021.

△ = FMR includes a finding with a financial impact; however, the amount of federal funds eligible for recovery has not been calculated.

Source: GAO review of documentation from CMS. | GAO-21-17

Notes:

^aCMS initiated 49 FMRs from 2016 through 2020, and, in some cases, a single FMR examined multiple states. CMS did not conduct an FMR in 16 states during this period: Alaska, Arizona, Delaware, Florida, Georgia, Hawaii, Michigan, Mississippi, Nebraska, New Jersey, North Dakota, Pennsylvania, Rhode Island, South Dakota, Vermont, and Wyoming. CMS also did not conduct an FMR in any of the five U.S. territories, each of which has a Medicaid program: American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

^bIn estimating the amount of federal funds at risk, CMS calculates the total federal funds associated with each topic examined in the FMR.

^cAn individual FMR can include both types of findings or no findings. CMS reviews and approves FMR findings before drafting FMR reports.

^dThis category includes FMR findings of internal control weaknesses with no financial impact, such as findings requiring a state to improve financial reporting and to implement claim edits.

^eThe FMR is still under review by CMS; therefore, the amount of federal funds identified as eligible for recovery can be subject to revision.

^fCMS's estimated federal funds at risk of \$66.3 million includes funds for all three states examined in this FMR (Louisiana, New Mexico, and Texas).

^gThe FMR did not identify any amounts for recovery, but did identify \$4.9 million in drug rebates that were available to the state.

Appendix III: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

September 25, 2020

Carolyn L. Yocom
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "**MEDICAID PROGRAM INTEGRITY: Action Needed to Ensure CMS Completes Financial Management Reviews in a Timely Manner**" (Job code 103807/GAO-21-17).

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

Sincerely,

Sarah C. Arbes -S
Digitally signed by
Sarah C. Arbes -S
Date: 2020.09.28
14:39:18 -04'00'

Sarah C. Arbes
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MEDICAID PROGRAM INTEGRITY: ACTION NEEDED TO ENSURE CMS COMPLETES FINANCIAL MANAGEMENT REVIEWS IN A TIMELY MANNER (GAO-21-17)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report. HHS takes seriously its responsibilities to protect taxpayer funds by conducting thorough oversight of Medicaid expenditures claimed by states.

Because Medicaid is jointly funded by states and the Federal Government, and is administered by states within Federal guidelines, both HHS and states have key roles as stewards of the program. As such, HHS conducts multiple activities to oversee Medicaid expenditures and verify that Federal financial participation matches states' actual expenditures. For example, on a quarterly basis, states must submit to HHS their Medicaid expenditures and include supporting documentation such as invoices, cost reports, and eligibility records. HHS then reviews these expenditures and works with states to resolve any questionable expenditures to ensure that the appropriate amounts are spent and that higher matching rates are reported correctly. HHS also verifies that states are reporting waiver expenditures as required, and that supplemental payments do not exceed the annual cap under the state's Medicaid plan or waiver. To supplement the quarterly expenditure reviews, HHS asks regionally-based financial management staff to conduct targeted Financial Management Reviews (FMR) which allow for a more intensive review of state expenditures and can also include an analysis of the funding source and appropriateness of a payment.

As the GAO notes, HHS has experienced a decline in resources available for Medicaid financial management activities in recent years and as a result has chosen to prioritize oversight activities with required regulatory deadlines, such as quarterly expenditure reviews. Although FMRs are an important piece of HHS' Medicaid oversight strategy, HHS has the discretion to waive the requirement for the FMR in a given year at the request of financial management staff. Despite these resource limitations, HHS has recovered \$209 million in federal financial participation based on findings from FMRs since 2016. These findings have also provided HHS with the information necessary to require states to strengthen internal controls, improve financial reporting, and implement claim edits to ensure the accuracy and allowability of claim payments to Medicaid and CHIP providers.

To improve efficiency, alignment, and coordination of Medicaid and CHIP policy and operational activities throughout the regional locations, CMS announced a structural reorganization in November 2019 in order to create a more integrated structure. This reorganization also allows for a tighter coordination between financial policy and operations to prioritize efforts across the portfolio of Medicaid and CHIP activities. HHS intends to leverage the efficiencies gained through this reorganization to effectively target its oversight of state Medicaid programs to program areas or states that present the greatest risk and has already begun pursuing a strategy to enhance the timeliness of FMRs.

Recommendation

The Administrator of CMS should develop and implement timeframes to ensure that the agency completes FMRs in a timely manner.

**Appendix III: 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 PROGRAM INTEGRITY: ACTION NEEDED TO
ENSURE CMS COMPLETES FINANCIAL MANAGEMENT REVIEWS IN A TIMELY
MANNER (GAO-21-17)**

HHS Response

HHS concurs with the GAO's recommendation. HHS has already begun pursuing a strategy to enhance the timeliness of FMRs and, as part of that, will develop and implement timeframes to ensure that the agency completes FMRs in a timely manner. HHS will continue to leverage opportunities for efficiency, alignment, and coordination of Medicaid oversight that were gained through the recent reorganization.

Appendix IV: GAO Contacts and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact named above, Susan Anthony (Assistant Director), Dawn Nelson and Laura Tabellion (Analysts-in-Charge), Drew Long, Vikki Porter, and Jennifer Whitworth made key contributions to this report.

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