



August 2018

MEDICAID

CMS Needs to Better Target Risks to Improve Oversight of Expenditures

GAO Highlights

Highlights of [GAO-18-564](#), a report to congressional requesters

Why GAO Did This Study

Medicaid has grown by over 50 percent over the last decade, with about \$370 billion in federal spending in fiscal year 2017. CMS is responsible for assuring that expenditures—reported quarterly by states—are consistent with Medicaid requirements and matched with the correct amount of federal funds. CMS’s review of reported expenditures has become increasingly complex due to variation in states’ Medicaid programs and an increasing number of different matching rates.

GAO was asked to examine CMS’s oversight of state-reported Medicaid expenditures. In this report, GAO examined how CMS assures that (1) expenditures are supported and consistent with requirements; and (2) the correct federal matching rates were applied to expenditures subject to a higher match. GAO also examined the financial impact of resolved errors. GAO reviewed documentation for the most recently completed quarterly reviews by 3 of CMS’s 10 regional offices for six states that varied by Medicaid program expenditures and design. GAO also reviewed policies, procedures, and data on resolved errors; and interviewed CMS and state officials. GAO assessed CMS’s oversight processes against federal standards for internal control.

What GAO Recommends

GAO is making three recommendations, including that CMS improve its risk-based targeting of oversight efforts and resources, and clarify related internal guidance. The Department of Health and Human Services concurred with these recommendations.

View [GAO-18-564](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or YocomC@gao.gov.

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CMS Needs to Better Target Risks to Improve Oversight of Expenditures

What GAO Found

The Centers for Medicare & Medicaid Services (CMS), which oversees Medicaid, has various review processes in place to assure that expenditures reported by states are supported and consistent with Medicaid requirements. The agency also has processes to review that the correct federal matching rates were applied to expenditures receiving a higher than standard federal matching rate, which can include certain types of services and populations. These processes collectively have had a considerable federal financial benefit, with CMS resolving errors that reduced federal spending by over \$5.1 billion in fiscal years 2014 through 2017.

However, GAO identified weaknesses in how CMS targets its resources to address risks when reviewing whether expenditures are supported and consistent with requirements.

- CMS devotes similar levels of staff resources to review expenditures despite differing levels of risk across states. For example, the number of staff reviewing California’s expenditures—which represent 15 percent of federal Medicaid spending—is similar to the number reviewing Arkansas’ expenditures, which represents 1 percent of federal Medicaid spending.
- CMS cancelled in-depth financial management reviews in 17 out of 51 instances over the last 5 years. These reviews target expenditures considered by CMS to be at risk of not meeting program requirements.

CMS told GAO that resource constraints contributed to both weaknesses. However, the agency has not completed a comprehensive assessment of risk to (1) determine whether oversight resources are adequate and (2) focus on the most significant areas of risk. Absent such an assessment, CMS is missing an opportunity to identify errors in reported expenditures that could result in substantial savings to the Medicaid program.

GAO also found limitations in CMS’s processes for reviewing expenditures that receive a higher federal matching rate.

- Internal guidance for examining variances in these expenditures was unclear, and not all reviewers in the three CMS regional offices GAO reviewed were investigating significant variances in quarter-to-quarter expenditures.
- Review procedures for expenditures for individuals newly eligible for Medicaid under the Patient Protection and Affordable Care Act were not tailored to different risk levels among states. For example, in its reviews of a sample of claims for this population, CMS reviewed claims for the same number of enrollees—30—in California as for Arkansas, even though California had 10 times the number of newly eligible enrollees as Arkansas.

Without clear internal guidance and better targeting of risks in its review procedures for expenditures receiving higher matching rates, CMS may overpay states.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
FMAP	Federal Medical Assistance Percentage
FMR	Financial Management Review
HHS	Department of Health and Human Services
IHS	Indian Health Service
PPACA	Patient Protection and Affordable Care Act

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August 6, 2018

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

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

The Honorable Michael C. Burgess
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Fred Upton
House of Representatives

Over the last decade, Medicaid—a joint, federal-state program that finances health care coverage for low-income and medically needy populations—has increased by over 50 percent, both in terms of enrollment and cost. In fiscal year 2017, Medicaid covered an estimated 73.5 million individuals at an estimated cost of \$596 billion, including about \$369 billion in federal spending.¹ Federal projections indicate that those costs will continue to grow.²

The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid, is responsible for providing federal funds on the basis of state estimates of expenditures. CMS subsequently reconciles states' actual expenditures against those estimates. Thus, a key part of CMS's oversight responsibility is to review state-reported expenditures to assure

¹Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, *2016 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2017).

²See, CMS, *2016 Actuarial Report on the Financial Outlook for Medicaid*.

that they are supported and consistent with Medicaid requirements.³ Each quarter, states report their expenditures to CMS through its CMS-64 form. CMS regional offices are responsible for reviewing these reported expenditures and working with states to resolve any questionable expenditures. If CMS identifies errors—which can include (1) errors in the amounts reported or (2) reported expenditures that are not allowable—the agency can require states to reduce reported expenditures or return federal funds. Because Medicaid requirements include higher than standard federal matching rates for certain types of services and for certain populations of enrollees, part of CMS’s review process is to assure that expenditures are being matched at the correct rate.⁴ For example, states receive higher matching rates for services provided in Indian Health Service (IHS) facilities and for family planning services. They also receive higher matching rates for individuals newly eligible under the Patient Protection and Affordable Care Act (PPACA), referred to in this report as Medicaid expansion enrollees.⁵

While there is a common reporting form, state expenditure reporting varies depending upon the populations and services states cover and how they deliver and finance care. These variations reflect the diversity of the design of states’ Medicaid programs; however, the task of reviewing reported expenditures has grown increasingly complex due to this variation, and is further complicated by the growing number of different

³This includes assessing whether expenditures are consistent with regulatory requirements, agency guidance, and program provisions established in state Medicaid plans (which describe how the state will administer its Medicaid program and are subject to CMS approval), and other agreements between the state and CMS, among other things.

⁴In general, the amount of federal funds that states receive for Medicaid services is determined by a standard formula—the Federal Medical Assistance Percentage (FMAP), which results in a specific federal matching rate for each state. However, there are a number of exceptions and different federal matching rates can apply for certain types of beneficiaries, services, or administrative costs.

⁵Under PPACA, states may opt to expand their Medicaid programs by covering nearly all adults with incomes at or below 133 percent of the federal poverty level beginning January 1, 2014. See Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010). For purposes of this report, references to PPACA include the amendments made by HCERA. PPACA also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases this income level to 138 percent of the federal poverty level. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), (e)(14)(I). In 2016, states received a 100 percent federal match for their medical expenditures for the enrollees included in our study. See 42 U.S.C. § 1396d(y).

federal matching rates for expenditures. When reporting errors or inappropriate expenditures go undetected, it can result in overpayment by the federal government.

Given the significance of federal Medicaid expenditures and past concerns about the challenges CMS has faced in ensuring that expenditures are being matched at the correct rate, you asked us to examine CMS oversight of state-reported expenditures. This report examines the following:

1. CMS's policies and procedures for assuring that state-reported Medicaid expenditures are supported and consistent with Medicaid requirements.
2. How CMS assures that correct federal matching rates are applied to expenditures subject to a higher than standard matching rate.
3. The financial impact of CMS's efforts to resolve errors in reported expenditures.

To examine CMS's policies and procedures for assuring that state-reported Medicaid expenditures are supported and consistent with Medicaid requirements, we reviewed CMS's internal guidance to regional offices on conducting quarterly reviews of reported expenditures. We also reviewed CMS's guidance to states on reporting expenditures, including the reporting forms. To examine how CMS's regional offices implemented this guidance, we selected 3 of 10 regional offices to achieve geographic variation. We selected regional offices 3, 6, and 9, which cover states in the East, South, and West of the United States. Within our three regional offices, we selected six states to review CMS's oversight: Arkansas, California, Maryland, Nevada, Pennsylvania, and Texas. We selected these states to achieve variation in program expenditures, enrollment, and program features, including whether they expanded Medicaid eligibility under PPACA. Together these six states account for approximately 30 percent of total federal Medicaid expenditures in fiscal year 2015. We visited our selected regional offices to conduct a walkthrough of their review of expenditures for our selected states for the most recently completed quarter at the time we planned our site visits, generally the first quarter of fiscal year 2017.⁶

⁶We selected first quarter fiscal year 2017 because it was the most recently completed quarterly review at the time we selected our states. For California, the most recently completed quarterly review was for the fourth quarter of fiscal year 2015.

We obtained and examined copies of reviewers' documentation of the steps taken to complete their quarterly reviews in the six selected states, including the completed review guides, summary memos, and correspondence with state officials. We also reviewed CMS's internal guidance for conducting financial management reviews, and obtained and examined documentation of reviews conducted from 2014 through 2017 (the first 4 years of expansion under PPACA), and resources assigned to review functions. In reviewing documentation of the quarterly reviews and the financial management reviews, we determined whether current procedures were resulting in reviewers identifying errors, but did not assess the magnitude of the errors identified. We interviewed officials from CMS's central office and our three selected regional offices about their review policies, processes, and resources. We also interviewed Medicaid officials from our six selected states about their experiences submitting data and undergoing CMS's review processes. In evaluating this information, we compared policies and procedures against the Standards for Internal Control in the Federal Government.⁷

To examine how CMS assures that correct matching rates are applied to expenditures, we reviewed CMS policies and procedures for reviewing expenditures subject to a higher than standard federal matching rate, including the quarterly review guide. In addition, we examined the extent to which these were consistently applied by reviewing the quarterly review documentation for our three selected regional offices. Specifically, we examined how they reviewed expenditure reporting for four types of expenditures for which states receive a higher federal matching rate: IHS, services for certain women with breast or cervical cancer, family planning, and Medicaid expansion.⁸ We selected these four expenditure types because they cover a variety of services and populations, and under CMS's quarterly review guidance, they are subject to specific review procedures. We also tested CMS's reviews by completing our own reviews of reported expenditures in the six states. Specifically, we

⁷GAO, *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.

⁸The Centers for Disease Control and Prevention provide breast and cervical cancer screening and diagnostic services to certain low-income and uninsured women. States can use Medicaid funds to cover treatment for women who are diagnosed with breast or cervical cancer through this program, and they receive a higher than standard federal match for these expenditures.

calculated the variance in expenditures from the quarter under review to the previous quarter, which is in line with CMS's review guidance. We also interviewed CMS officials, including officials in our selected regional offices about their review process. In evaluating the measures CMS has taken to assure that correct matching rates are applied to different expenditures, we compared policies and procedures against the Standards for Internal Control in the Federal Government.⁹

To examine the financial impact of errors resolved by CMS, we reviewed data on errors resolved in fiscal years 2014 through 2017, the four most recent years of available data.¹⁰ Specifically, we reviewed data on the magnitude of errors resolved through states reducing reported expenditures and on errors resolved by CMS issuing a disallowance, which requires a state to return federal funds. We also reviewed data on deferrals of federal funds (i.e., CMS defers payment until issues are resolved) as of the end of fiscal year 2017. We asked CMS officials responsible for overseeing data on errors to describe the reliability of the data, including any limitations. For the data on disallowances, deferrals, and errors resolved by states reducing reported expenditures, we reviewed relevant documentation; examined the data for obvious errors, such as missing values; and compared the results to other supporting documentation to ensure accuracy, when possible. We determined that all data were sufficiently reliable for the purposes of our reporting objectives. We also reviewed the documentation from the three selected regional offices' quarterly expenditure reviews for examples of errors resolved in our six selected states. Using the data on disallowances, and documentation from the quarterly expenditure reviews, we analyzed the range in types of errors and the range in the financial impact of errors resolved by CMS. We also interviewed CMS officials from the regional offices and CMS's central office about the errors resolved and their procedures for issuing deferrals and disallowances.

We conducted this performance audit from April 2017 to August 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

⁹ See [GAO-14-704G](#).

¹⁰ Errors resolved by CMS included expenditures that were identified through the quarterly review and through other types of review, such as financial management reviews. Examples of errors include expenditures that were unallowable, expenditures not supported by state documentation, and expenditures claimed under the incorrect federal match.

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

State Expenditure Reporting

In order to receive federal matching funds, states report expenditures quarterly to CMS on the CMS-64.¹¹ States are required to report their expenditures to CMS within 30 days of the end of each quarter, but may adjust their past reporting for up to 2 years after the expenditure was made, referred to as the 2-year filing limit. Adjustments can reflect resolved disputes or reclassifications of expenditures. Expenditures reported after the 2-year filing limit are generally not eligible for a federal match, with certain exceptions.¹²

The CMS-64 is a series of forms that capture expenditure data for different aspects of states' Medicaid programs, such as different types of services, populations, and different federal matching rates.¹³ (See table 1 for examples of the expenditure types captured by the CMS-64.) States report their expenditures quarterly on the CMS-64 at an aggregate level—such as a state's total expenditures for such categories of services as inpatient hospital services—and these reported expenditures are not linked to individual enrollees or services. States' reporting may vary depending on the features of their Medicaid program. Some examples of this variation include the following:

- States that expanded eligibility under PPACA would need to report expenditures not only by the type of services (e.g., inpatient hospital

¹¹Reported expenditures must represent actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed.

¹²The 2-year limit does not apply to any claim for any adjustment to prior year costs if they stem from HHS's Office of Inspector General or GAO audit findings, court-ordered retroactive payments, or where the state had good cause—as determined by HHS—to file late due to circumstances beyond the state's control.

¹³CMS has a specified list of 49 categories of service, many of which are broken out into further subcategories including specific provider types, services, and programs, such as Medicare.

services), but also by populations receiving different federal matching rates, such as expansion enrollees.

- States with waivers—that is, where the state received approval from HHS to waive certain Medicaid requirements in order to test and evaluate new approaches for delivering and financing care under a demonstration—would need to report those expenditures associated with these waivers on additional forms.¹⁴

Table 1: Examples of Expenditure Types Reported by States on the CMS-64 Form

Expenditure Type	Description
Inpatient hospital services	Payments to hospitals for inpatient services.
Supplemental payments to hospital	Payments made in addition to the payment for services on behalf of individual enrollees.
Managed care	Payments to managed care organizations, which are responsible for providing services to enrollees in return for a predetermined per person per month payment.
Waiver expenditures	Payments made for services delivered through and populations covered by Medicaid waivers; reporting requirements are specific to the terms and conditions of the waiver agreement.
Prior period adjustments	Adjustments made to previously reported expenditures; each adjustment must reflect the category of service being adjusted and the matching rate at the time the expenditure was originally incurred.
Medicaid expansion	Payments for services on behalf of Medicaid expansion enrollees by general categories of service.

Source: GAO review of documentation from the Centers for Medicare & Medicaid Services (CMS). | GAO-18-564

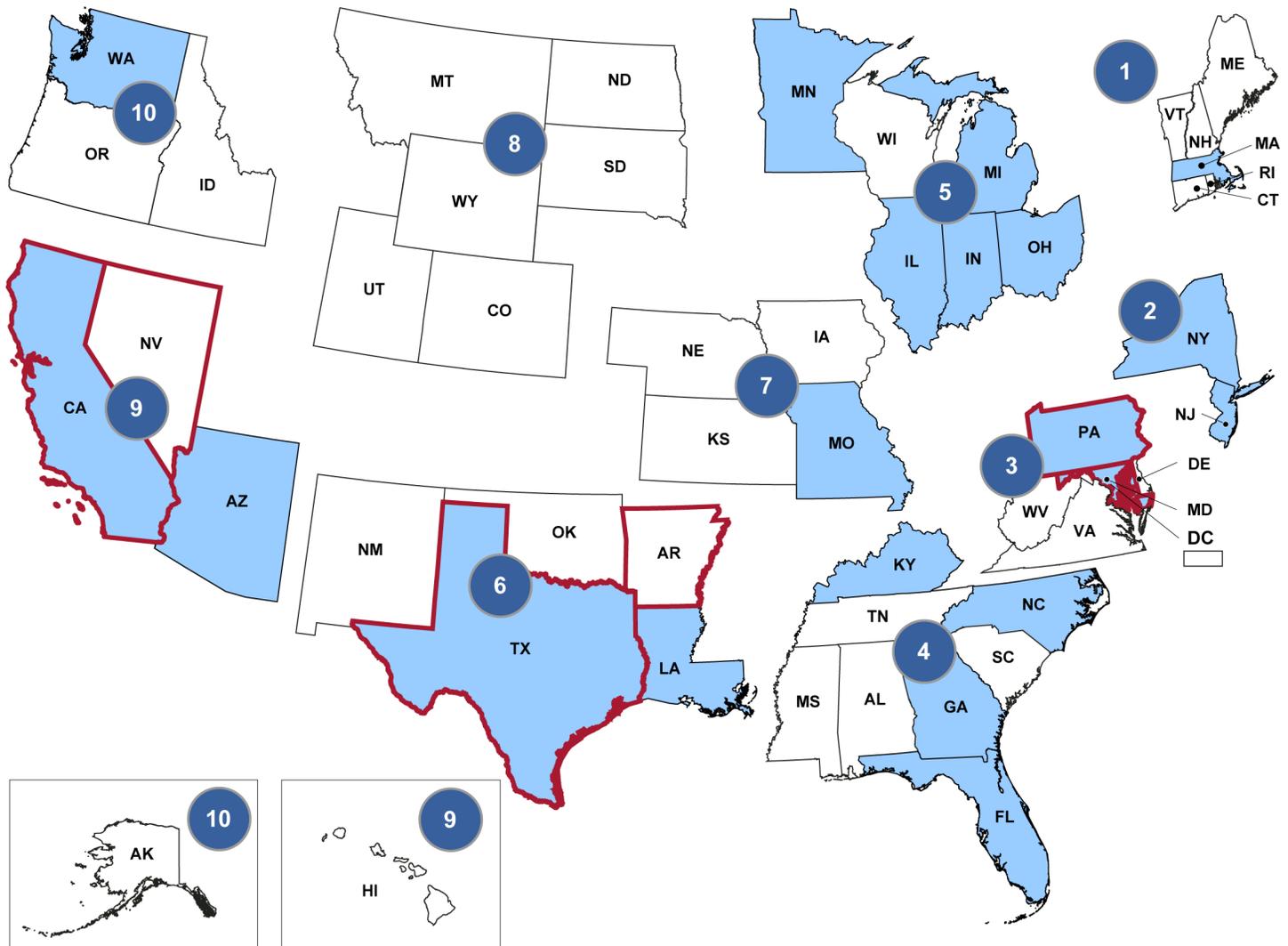
CMS Oversight of State Expenditure Reporting

CMS is responsible for assuring 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. CMS regional offices perform the ongoing oversight, with enhanced oversight procedures in the 20 states with the highest federal Medicaid expenditures.¹⁵ (See fig.1)

¹⁴States can apply for a variety of Medicaid waivers including waivers referred to as 1115 demonstrations. Under section 1115 of the Social Security Act, the Secretary of Health and Human Services may waive certain federal Medicaid requirements and approve new types of expenditures that would not otherwise be eligible for federal Medicaid matching funds for experimental, pilot, or demonstration projects that, in the Secretary’s judgment, are likely to promote Medicaid objectives. States must apply to HHS for approval for their Medicaid waivers, each requiring a separate approval process.

¹⁵In fiscal year 2016, the top 20 states represented over 75 percent of federal Medicaid expenditures, with federal expenditures ranging from approximately \$6 billion to over \$53 billion per state.

Figure 1: Jurisdiction of CMS Regions, Including States with Highest Expenditures, Fiscal Year 2017



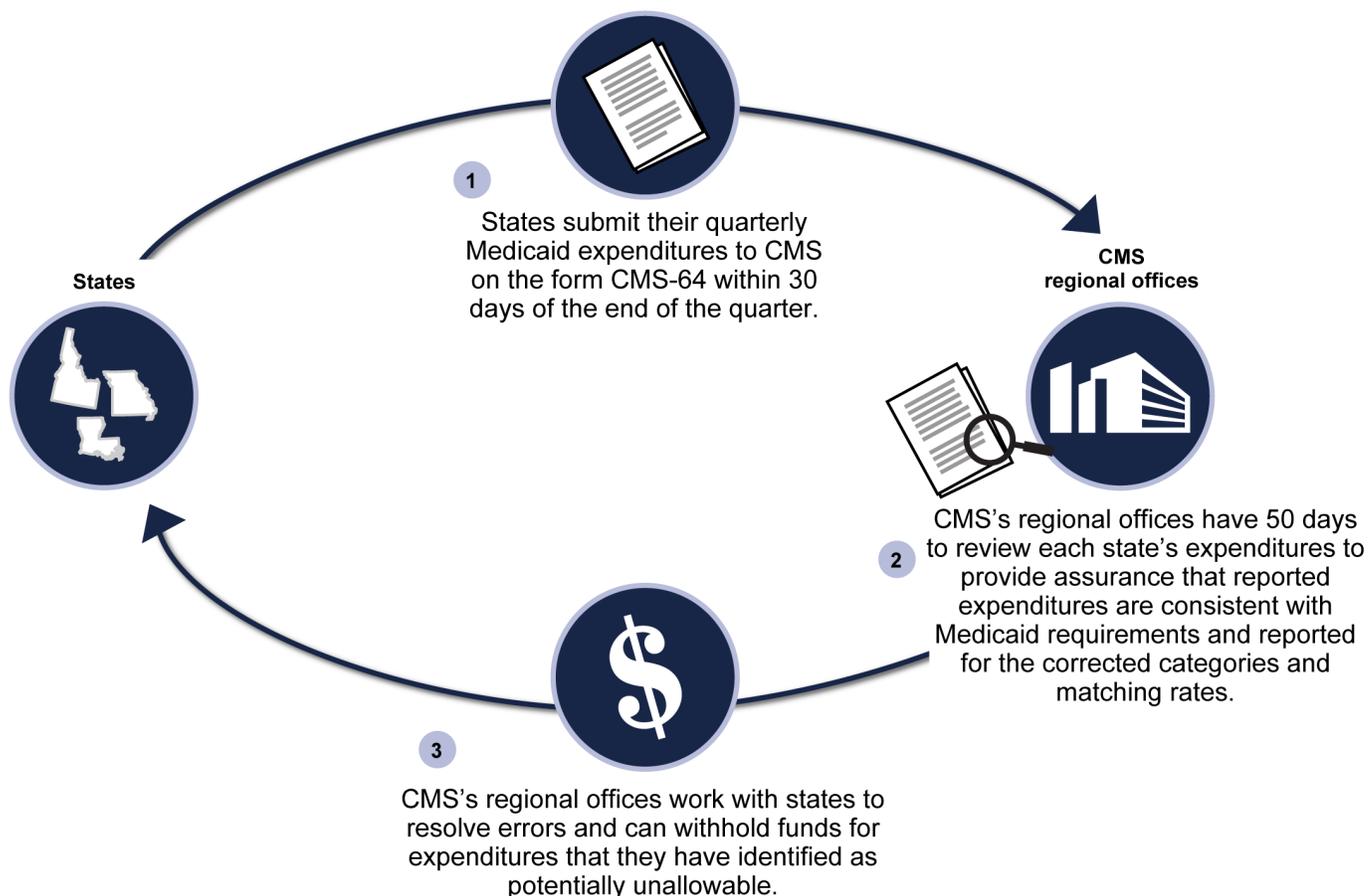
- States that do not rank in the top 20 by federal share of Medicaid expenditures in fiscal year 2017
- States that rank in the top 20 by federal share of Medicaid expenditures in fiscal year 2017
- States that were part of GAO's selected sample
- States that were not part of GAO's selected sample

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) documentation and expenditure data; Map Resources (map). | GAO-18-564

Notes: Regional office 2 also oversees Puerto Rico and the U.S. Virgin Islands, and regional office 9 oversees American Samoa, Guam, and the Northern Mariana Islands. Expenditures represented are for medical services and exclude administrative expenditures.

CMS is required to review the expenditures reported by states each quarter. (See fig. 2.) Regional office reviewers have 50 days to review the expenditures and compute the federal share of states' Medicaid expenditures.

Figure 2: CMS Quarterly Review Process



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) regulations and guidance. | GAO-18-564

As part of the quarterly review, regional office reviewers also check that expenditures receive the correct matching rate. In general, the amount of federal funds that states receive for Medicaid services is determined annually by a statutory formula—the Federal Medical Assistance Percentage (FMAP), which results in a specific federal matching rate for each state. However, there are a number of exceptions where higher federal matching rates can apply for certain types of beneficiaries, services, or administrative costs. See table 2 for examples of higher

matching rates that apply for expenditures for certain types of enrollees, services, or administrative costs.

Table 2: Examples of Higher Federal Matching Rates and Corresponding Federal Expenditures, Fiscal Year 2016

Type of expenditure	Federal Medical Assistance Percentage (FMAP) (percent)	Federal expenditures (dollars in millions)	Share of total federal Medicaid spending (percent)
Medicaid expansion population ^a	100 ^b	65,160	17.9
Indian Health Service	100	1,854	0.5
Family planning	90	1,550	0.4
Design and development of eligibility and enrollment systems	90	1,382	0.4
Breast or cervical cancer treatment	Enhanced FMAP ^c	459	0.1

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-564

^aThis includes expenditures for medical services provided to individuals who are newly eligible for Medicaid under the Patient Protection and Affordable Care Act (PPACA). See 42 U.S.C. § 1396d(y). Under PPACA, states also received an increased FMAP determined by formula for individuals who were not otherwise eligible for Medicaid but were covered by Medicaid under a demonstration or a program funded only by the state prior to the enactment of PPACA, ranging from 85 to 95 percent in 2016.

^bThis FMAP is scheduled to gradually diminish to 90 percent by 2020.

^cStates receive an increased match equivalent to their enhanced FMAP—the match for their Children’s Health Insurance Program—for their expenditures for treatment provided to certain women with breast or cervical cancer. Like the Medicaid FMAP, the enhanced FMAP varies by state.

When CMS identifies questionable expenditures or errors through its reviews, there are several ways that they can be resolved, as summarized below.

- **Deferral of federal funds.** CMS can defer federal matching funds if, during the quarterly review, the regional office reviewer needs additional information to determine whether a particular expenditure is allowable. The reviewer may recommend that CMS defer the expenditure until the state provides additional support or corrects the reporting.¹⁶
- **State reducing reported expenditures.** If the state agrees that the questionable expenditure is an error, the state can submit an adjusted report during the quarterly review or make an adjustment in a

¹⁶According to CMS guidance, deferrals are taken as temporary actions and, if states do not provide additional supporting documentation or correct reporting, the deferral may result in CMS taking a disallowance.

subsequent quarter.¹⁷ These adjustments prevent federal payments for those expenditures.

- **Disallowance of expenditure.** If CMS determines an expenditure is not allowable, CMS can issue a disallowance, and the state returns federal funds through reductions in future federal allocations. States may appeal disallowances.

CMS Has Processes in Place to Assure that State-Reported Medicaid Expenditures Are Supported and Allowable, but Weaknesses Limit Its Ability to Effectively Target Risk

CMS uses a variety of processes to assure that state-reported expenditures are supported during quarterly reviews and performs focused financial management reviews on expenditures considered at risk of not complying with Medicaid requirements. Although we found that CMS was identifying errors and compliance issues using both review methods, we also found weaknesses in how CMS targets its oversight resources to address risks.

¹⁷CMS refers to the savings from these reductions as averted funds at risk. In order to qualify as averted funds at risk, the funds must be federal expenditures, which had been claimed by the state and were credited back to CMS as a result of intervention by regional office officials. Specifically, the state must have agreed to make an adjustment for the entire amount in question, retracted the claim prior to the submission of the CMS-64, or made a prior period adjustment that was verified.

CMS Uses Quarterly Reviews, Supplemented with More Focused Reviews, to Assure that Reported Expenditures Are Supported and Allowable and Has Detected Errors in the Process

CMS uses quarterly reviews to assess whether expenditures are supported by the state's accounting systems; are in accordance with CMS approved methodologies, plans, and spending caps; and whether there are significant unexplained variances—changes in expenditures—from one quarter to the next (referred to as a variance analysis).¹⁸ CMS review procedures include validation measures that check to ensure that expenditures were reported within the 2-year limit, which is a check done on all types of expenditures. Another validation measure compares expenditures to various approval documents.¹⁹ For example, when a state has a waiver in place, expenditures are reviewed against waiver agreements that authorize payment for specified services or populations. Other examples include comparing supplemental payment expenditures to caps set for those expenditures. (See table 3.)

¹⁸According to state Medicaid officials, states enter the expenditures manually into the CMS-64. Manual entry increases the risk of entry errors such as mistyped amounts, and the quarterly review compares the information states have entered into the CMS-64 with their accounting records to verify amounts, among other things.

¹⁹CMS has a guide for reviewers conducting the quarterly reviews. It serves as a template for the review itself and contains instructions and procedures for conducting and documenting each step of the review.

Table 3: Examples of CMS Validation Procedures for Selected Types of Expenditures

Expenditure type	Validation measure used in quarterly review
Category of service	<p>The reviewer must verify that the amounts reported by service are supported by the state’s accounting records.</p> <p>The reviewer conducts a variance analysis, which compares current expenditures to previous quarter expenditures and investigates significant differences. The reviewer develops a threshold for significance based on professional judgment.</p>
Waiver expenditures ^a	<p>The reviewer must verify that the state is reporting the expenditures as required under the terms of the waiver agreement. If there have been changes to the waiver agreement, the reviewer must verify that reported expenditures are consistent with those changes.</p>
Prior period adjustments	<p>States may adjust claims filed in earlier quarters to reflect, for example, expenditures that were not claimed earlier or claimed on the wrong service line. The reviewer must determine whether</p> <ul style="list-style-type: none"> • adjustments were filed within the 2-year window, • reported at the correct matching rate, and • meet the requirements for an exception (if not submitted within 2 years of the quarter in which the expenditure was incurred).
Supplemental payments	<p>Supplemental payments are payments to providers that are in addition to the payment for service on behalf of individual enrollees. The reviewer must check that the payments do not exceed the annual cap under the CMS approved state Medicaid plan or waiver. Based on professional judgment the reviewer may test a sample of reported payments to ensure that they were claimed in accordance with approved methodologies.</p>

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) guidance. | GAO-18-564

^aStates may seek permission from CMS to provide services under waivers of traditional Medicaid requirements; for example, in order to provide services to a targeted population or to a limited number of beneficiaries. Waivers are developed and proposed by states and must be approved by CMS in order for states to receive federal matching funds for medical expenditures.

Our examination of the quarterly reviews indicated that the reviews involved significant coordination with other CMS staff and the state. In addition to reviewing state documentation, officials from two regional offices told us that they consult other regional office staff who oversee the approval of new expenditures to ensure that expenditures reflect approved program features. For example, officials in region 9 told us that in reviewing managed care expenditures, they consult with their colleagues who review the state’s payment methodologies for capitated payments.²⁰ In reviewing information technology development expenditures—which are subject to a higher federal matching rate—reviewers for all six selected states examined advanced planning documents, which requires coordination with staff who approve those

²⁰Capitated payments to Medicaid managed care organizations are typically made on a predetermined, per person per month basis. CMS is responsible for reviewing state payment rates for managed care organizations to ensure that they are reasonable and appropriate for the populations and services covered.

documents to ensure that the state was receiving the correct matching rates and staying within the approved amounts.²¹ With regard to coordination with states, we found that regional reviewers for all six reviews contacted states to follow-up on issues identified during the review. Officials also described being in regular contact with states to stay abreast of program, system, and staffing changes to inform their reviews. For example, according to regional officials, Arkansas experienced some significant and unexpected staffing challenges in 2016 that resulted in delays in the state reporting expenditures and returning federal overpayments, and the reviewer worked closely with state staff to track the state's progress.

We found evidence that reviewers identified errors during their quarterly reviews. In the six quarterly reviews we examined, regional offices identified errors in three of the six states.²² For example, region 3 reviewers found errors in Maryland's expenditure reporting—including claims for the wrong matching rate for two enrollees who were not eligible for PPACA's Medicaid expansion and reporting provider incentive payments on the wrong line—and worked with the state to correct those errors. Additionally, region 9 reviewers found errors in California's reporting of expenditures. For example, they found that the state reported waiver expenditures for the incorrect time period, which has implications for CMS's ability to monitor and enforce spending limits for the waiver. Reviewers worked with the state to correct those errors.

To supplement the quarterly reviews, CMS generally directs regional offices to conduct a focused financial management review (FMR) each year on an area of high risk within the region, typically within one state.²³ According to regional officials, CMS uses these reviews to investigate expenditures in greater depth and detail than is reasonable within the timeframes of a quarterly review. For example, reviewers can examine individual claims for services from providers or the methodologies developed for certain payment types. Regional reviewers also use these

²¹Advanced planning documents specify, among other things, CMS approval for the planned information technology activities, allocated funding, and timeframes.

²²We examined the documentation of the quarterly reviews conducted for the first quarter of fiscal year 2017 for Arkansas, Maryland, Nevada, Pennsylvania, and Texas, and the fourth quarter of fiscal year 2015 for California, which was the most recent quarter reviewed at the time of our work.

²³Risks can include new expenditure types or areas where the state has historically experienced challenges in reporting.

reviews to investigate errors that could not have been detected by the quarterly review. For example, regional office 6 officials told us that they uncovered inappropriate financing arrangements when they used an FMR to examine how Texas financed the state share of its supplemental payments to hospitals in one of its counties. To do so, the regional office reviewed payments from the state to the provider, project plans, and interviewed providers—steps that are not part of the quarterly review process. Rather, in the quarterly review, the reviewer only checks that state-reported payments are supported by state accounting records and are within applicable caps; thus, inappropriate financing of the state share would not have been detected through the quarterly review.

In fiscal years 2014 through 2017, CMS used FMRs to review various expenditures considered to be at risk for not complying with Medicaid requirements. Specifically, as outlined in annual work plans, regional offices planned to conduct 31 FMRs and estimated that the total amount of federal funds at risk in expenditure areas covered by their planned reviews was \$12 billion.²⁴ (See app. I.) Planned FMRs targeted a wide range of topics, with the reviews most frequently targeting expenditures for the Medicaid expansion population. (See table 4.)

Table 4: Areas of Focus of Planned Financial Management Reviews (FMR) and Associated Federal Funds at Risk, Fiscal Years 2014-2017

FMR areas	Number of proposed FMRs	Federal funds at risk (dollars in millions)
Medicaid expansion	6	6,578
Supplemental payments	2	2,500
Mental health	4	413
Information technology ^a	4	150
School-based administrative	2	14
Managed care	2	3 ^b
Other ^c	11	2,747

Source: GAO review of Centers for Medicare & Medicaid Services documentation | GAO-18-564

Note: Planned FMRs included 10 planned for fiscal year 2014, 10 for fiscal year 2016, and 11 in fiscal year 2017. CMS did not plan for any FMRs in 2015.

²⁴Within these areas, regional offices identified approximately \$4.9 billion, \$4.2 billion, and \$3.4 billion in federal funds at risk each year in 2014, 2016, and 2017, respectively. Regional offices did not conduct FMRs in 2015.

^aThese expenditures include payments for eligibility and enrollment systems, state Medicaid management information systems, and incentive payments to providers for health information technology.

^bOne region did not identify the federal funds at risk in its FMR focused on managed care.

^cOther topics included state financing, prescription drugs, and home health services, among others.

We found that CMS frequently identified compliance issues through FMRs. As of March 2018, CMS reported that reviewers had identified compliance issues with financial impact in 11 of the 31 planned FMRs, though most of those findings were still under review. More findings from the planned FMRs are likely as some of the reviews were still ongoing. We reviewed the draft results for 5 FMRs.²⁵ Among these, CMS found that four states were reporting expenditures that were not allowable. For example, as noted earlier, a 2014 FMR on supplemental payments in Texas revealed inappropriate funding arrangements, and CMS issued a disallowance for approximately \$27 million. In some cases, FMRs did not have apparent financial findings, but identified significant internal control weaknesses in the state and recommended specific corrective actions—such as better aligning eligibility and expenditures systems to better detect and correct irregularities—that would provide greater assurances that federal funds are appropriately spent.

Both the quarterly reviews and the FMRs occur in conjunction with other ongoing CMS financial oversight activities. For example in addition to reviewing expenditures, regional office reviewers assess how states estimate their costs, set payment rates for managed care and home and community based services, and allocate costs among different Medicaid administrative activities under their cost allocation plans. CMS officials told us that issues relating to state compliance with Medicaid requirements for expenditures could be identified during these other oversight activities and could inform follow-up during the quarterly reviews or be the subject of a FMR.²⁶ Officials also told us that since FMRs were instituted, the agency has built in more front-end procedures for preventing problems with the accuracy and allowability of reported

²⁵We reviewed FMRs conducted in California in 2014; Texas in 2014; Maryland in 2016; Arkansas in 2017; and Indiana in 2017.

²⁶In addition, officials in one regional office told us they coordinate with HHS's Office of Inspector General, which also conducts audits and reviews of Medicaid expenditures. These audits can involve testing state-reported Medicaid expenditures for compliance with Medicaid requirements.

expenditures. As examples, they cited their work on managed care rate reviews, among other things.

Weaknesses Limit CMS's Ability to Effectively Target Risk in Its Oversight of Expenditures

We identified two weaknesses in how CMS is allocating resources for overseeing state-reported expenditures that limited the agency's ability to target risk in its efforts to assure that these expenditures are supported and consistent with Medicaid requirements. First, we found that CMS has allocated similar staff resources to states with differing levels of risk. For example, the staff resources dedicated to reviewing California's expenditures—ranking first nationally in expenditures and constituting 15 percent of all federal Medicaid expenditures—are comparable to significantly smaller states in other regions, despite California's history of reporting challenges and its inability to provide electronic records, which requires on-site review.²⁷ (See fig. 3.) CMS has allocated 2.2 staff to review California's expenditures in contrast to one person to review Arkansas' expenditures, which constitute 1 percent of federal Medicaid expenditures, and Arkansas does not have a similar history of complex reporting challenges. We also found that California's reviewers have set a higher threshold for investigating variances in reported expenditures than in the five other selected states. Specifically, reviewers investigated variances in California of plus or minus 10 percent if the variances represented more than 2 percent of medical expenditures, or \$450 million in the quarter we reviewed. The state experienced an approximately 24 percent increase in its prescription drug expenditures—roughly \$200 million—during that quarter, but the variance was deemed not significant.²⁸ In contrast, for two of our five other selected states, we found that reviewers generally investigated variances of plus or minus 10 percent regardless of the dollar amount of the variance and in the remaining three states they had significantly lower dollar thresholds than used for California.

²⁷As we previously reported, California's reporting of the state's Medicaid waiver expenditures had not aligned with the requirements of the waiver agreement from 2010-2015, leaving CMS unable to assess whether the state was in compliance with the spending limits for the waiver during this period. See GAO, *Medicaid Demonstrations: Federal Action Needed to Improve Oversight of Spending*, [GAO-17-312](#) (Washington, D.C.: April 3, 2017).

²⁸According to CMS, this variance was not investigated because the regional office was aware of delays in the state's reporting of prescription drug expenditures that accounted for some of the variance.

Figure 3: Challenges in Reviewing California’s Reported Medicaid Expenditures

As of May 2018, California was not submitting supporting documents for reported expenditures electronically. Reviewers for the Centers for Medicare & Medicaid Services (CMS) reviewed piles of summary level supporting documents each quarter (as seen below) and had to be on-site at state offices in Sacramento in a room full of hard copy documents when further investigation was required. These challenges are in addition to reporting delays, which CMS officials told us resulted from a fragmented program that processes expenditures through four different information systems, and a high volume of prior period adjustments each quarter (over 3,000 pages of them in the quarter we reviewed).



Summary level supporting documentation examined by region 9 officials in reviewing California’s expenditures for the fourth quarter, fiscal year 2015.

Source: GAO. | GAO-18-564

Second, CMS reported cancelling the FMR requirement for regional offices in 17 out of 51 instances in the last 5 years when faced with resource constraints. In some cases, CMS excused individual regional offices from conducting planned FMRs due to staff shortage as the agency did for regions 3 and 7 in 2014; region 8 in 2016; and regions 3, 7, 8, and 9 in 2018. In 2015, according to CMS officials, all 10 regions were excused from conducting an FMR, because the regional offices needed their staff to focus on implementing new procedures for validating expenditures for the Medicaid expansion population. In addition to cancelling FMRs, CMS was delayed in finalizing FMRs. Among the eight FMRs that were conducted in fiscal year 2014,

- three have been issued as final reports,
- CMS decided no report was needed on a fourth, and

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- the four remaining FMRs from 2014 were still under review as of March 2018, delaying important feedback to states on their vulnerabilities.²⁹

According to CMS officials, resource constraints have contributed to both of these weaknesses. Our analysis of staffing data indicated that, from fiscal years 2014 to 2018, the number of full time equivalent staff dedicated to financial oversight activities declined by approximately 19 percent across all 10 regions.³⁰ These staff are responsible not only for completing the quarterly reviews and FMRs, but also other financial oversight activities, including resolving audit findings and other on-going oversight activities noted previously.³¹ During this period, federal Medicaid expenditures are estimated to have increased by approximately 31 percent, and the reporting of expenditures has grown more complex.³² In addition to the decline in dedicated staff, officials told us they faced challenges in filling vacancies either because of hiring restrictions or challenges in recruiting qualified candidates.³³ Officials described instances where regional offices shared resources with other offices to address critical gaps in resources. For example region 9 was able to obtain part-time assistance from a region 6 reviewer to help review California's expenditures. However, CMS officials told us that they had not permanently reallocated resources between regional offices, because all regional offices are under-resourced given their various oversight responsibilities as of May 2018. With regard to cancelling FMRs, CMS officials noted that other oversight responsibilities, including the quarterly

²⁹In 2006, we reported that the value of the FMRs lay in not just identifying disallowances but also in providing feedback on policy issues and programmatic vulnerabilities and in elevating these to the attention of both state and federal staff. 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).

³⁰In fiscal year 2014, CMS allocated 154.5 full time equivalent staff to financial management oversight. This allocation declined to 125 staff in fiscal year 2018.

³¹According to CMS officials, regional office financial management oversight staff are responsible for follow-up work associated with audits conducted by HHS's Office of Inspector General.

³²Both state and regional office officials told us that the length of states' quarterly reports has grown over the last 5 years, increasing from several hundred pages to over a 1,000 pages. Officials said that this included new lines of reporting that require additional time to complete and review. A number of factors drove this change, including additional reporting on the Medicaid expansion and increased implementation of Medicaid waivers.

³³According to CMS officials, the regional offices have been under a partial hiring freeze since 2014.

reviews, are required under statute or regulation and thus have a higher priority than FMRs.

Compounding its resource allocation challenges, CMS has not conducted a comprehensive, national assessment of risk to determine whether resources for financial oversight activities are (1) adequate and (2) allocated—both across regional offices and oversight tools—to focus on the greatest areas of risk. Agency officials told us that they have not conducted a formal risk assessment, because they are assessing risk on an on-going basis, allocating resources within each region accordingly and sharing resources across regions to the extent possible. However, this approach does not make clear whether the level of resources dedicated to financial oversight nationally is adequate given the risk.

Federal internal control standards for risk assessment require agencies to identify and analyze risks related to achieving the defined objectives (i.e., assuring that state-reported expenditures are in accordance with Medicaid rules), and respond to risks based on the significance of the risk. Without completing a comprehensive, national assessment of risk and determining whether staff resources dedicated to financial oversight are adequate and allocated commensurate with risk, CMS is missing an opportunity to improve its ability to identify errors in reported expenditures that could result in hundreds of millions of dollars in potential savings to the Medicaid program.

Vulnerabilities Exist in CMS's Review of Expenditures for Which States Receive Higher Federal Matching Rates

CMS reviewers in the selected regional offices we reviewed did not consistently perform variance analyses—which compare changes in expenditures from the quarter under review to the previous quarter—of higher matched expenditures during quarterly reviews. Further, the sampling procedures used to examine Medicaid expansion expenditures did not account for varying risks across states.

CMS Did Not Consistently Conduct Variance Analyses When Reviewing Certain Types of Expenditures that Receive Higher Federal Matching Rates

CMS has multiple procedures in place to review expenditures that receive a higher federal matching rate. As with other expenditures, reviewers are required to complete a variance analysis, comparing reported expenditures in the quarter under review to those reported in the prior quarter and investigating variances above a certain threshold. However, we found that our three selected regional offices were not consistently conducting these analyses across several different types of expenditures with higher matching rates.

While CMS's internal guidance required that regional offices conduct variance analyses on expenditures with higher matching rates, we found that for the quarter we investigated (generally the 1st quarter of fiscal year 2017), our selected regional offices did not consistently do so for three types of expenditures that we reviewed: IHS, family planning, and certain women with breast or cervical cancer. Two of the three regional offices (regions 3 and 9) did not conduct or did not document these required variance analyses, and the remaining regional office (region 6) conducted the analyses but deviated from standard procedures outlined in CMS guidance, as summarized below.

- CMS region 3. Reviewers did not conduct variance analyses for either Maryland or Pennsylvania. Regional office staff with whom we spoke said that as part of the quarterly review they conduct the standard variance analysis on category of service lines of the CMS-64. Expenditures for IHS, family planning and services for certain women with breast or cervical cancer are not separately identified at that level. Although CMS reviewers said they thought the standard analysis was sufficient, net changes within a broad service category may obscure major changes within these higher matched expenditures. For example, examining changes in total inpatient hospital expenditures would not necessarily reveal a significant variance limited to inpatient expenditures in IHS facilities that receive a higher federal match.
- CMS region 9. Reviewers told us that they examined higher matched expenditures for California; however, no variance analyses of IHS, family planning, or breast or cervical cancer services were included in the work papers provided to us. In addition, they told us that they do not conduct a variance analysis on IHS, family planning, and services for certain women with breast or cervical cancer for Nevada, noting that expenditures in these areas tend to be quite small.
- CMS region 6. Reviewers conducted a variance analysis of these higher matched expenditures for Arkansas and Texas and provided

us documentation; however, the documentation showed some deviation from the required steps specified in CMS’s guidance. For example, for Texas, spending on two of the three categories was beyond the threshold for significance, but the reviewer did not document any follow-up with the state.

Although expenditures for IHS, family planning, and certain women with breast or cervical cancer constituted a small share of total federal spending on Medicaid services—roughly 1 percent—combined spending on these categories was approximately \$1 billion in the first quarter of fiscal year 2017. Our analysis indicated that variances in spending for these three services ranged widely across our six states, and in four of the states, some of their expenditures were above the thresholds for significance. (See fig. 4.) For example, in regional office 3, Maryland experienced a significant variance in its family planning expenditures—an increase of approximately \$8 million dollars or 7,700 percent from the previous quarter—but there was no indication in the documentation provided that the regional office identified or investigated that variance.

Table 5: Variances for Certain Higher-Match Expenditure Types in Selected States that Were Not Investigated by CMS, First Quarter, Fiscal Year 2017

Regional office	State	Threshold of significance ^a	Expenditure type	Variance		Significant but not investigated
				Percentage	Amount (dollars)	
3	Maryland	10 percent variance and over \$200,000	Indian Health Services	0	0	
			Family planning	7,708	8,277,623	✓
			Breast or cervical cancer treatment ^b	17	137,110	
	Pennsylvania	10 percent variance and over \$250,000	Indian Health Services	0	0	
			Family planning	-0.1	-17,276	
			Breast or cervical cancer treatment ^b	-11	-665,469	✓
6	Arkansas	10 percent variance	Indian Health Services	288	223,816	✓
			Family planning	6	111,133	
			Breast or cervical cancer treatment ^b	0	0	
	Texas	10 percent variance	Indian Health Services	-45	-6,650	✓
			Family planning	-14	-1,991,944	✓
			Breast or cervical cancer treatment ^b	-1	-261,243	

Regional office	State	Threshold of significance ^a	Expenditure type	Variance		Significant but not investigated
				Percentage	Amount (dollars)	
9	California	10 percent variance and 2 percent of Medicaid payments	Indian Health Services	-21	-3,264,514	
			Family planning	-3	-3,690,457	
			Breast or cervical cancer treatment ^b	38	5,587,226	
	Nevada	5 percent variance and 5 percent of Medicaid payments	Indian Health Services	-27	-1,472,367	
			Family planning	10	300,156	
			Breast or cervical cancer treatment ^b	-11	-71,178	

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data and documentation. | GAO-18-564

Notes: Columns not checked as “significant but not investigated,” reflect, in all cases, variances that were deemed not significant. Expenditures represented are for medical services and exclude administrative expenditures.

^aThresholds of significance were provided by CMS reviewers in each region and are based on the reviewers’ professional judgement.

^bStates receive a higher than standard federal matching rate for Medicaid expenditures for treatment provided to certain low-income and uninsured women who are diagnosed with breast or cervical cancer.

Similar to the variance analyses for other higher matched expenditure types, we found that the selected regional offices did not consistently conduct variance analyses on expenditures reported for the Medicaid expansion population. First, although five of our six states opted to expand Medicaid under PPACA, two of the five states (Maryland and Pennsylvania) were not subjected to a variance analysis for their expansion populations, a segment that accounted for nearly \$7 billion in Medicaid expenditures in fiscal year 2016.³⁴ Among the remaining three states, CMS regional office staff conducted a variance analysis, but in two of them, the reviewers did not document whether they investigated significant variances, leaving it unclear whether this required step was taken. Specifically, for two of the three remaining states—Arkansas and Nevada—reviewers did not document which variances were deemed significant or that any such variances were discussed with state officials.

The guidance specified in CMS’s quarterly review guide is not always clear or consistent. For example:

³⁴Texas has not expanded Medicaid under PPACA and therefore did not have any expansion expenditures.

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- For IHS, family planning, and certain women with breast or cervical cancer, the guidance is explicit that the analysis is required, but the automated variance report used by reviewers for the step does not include these expenditures.
 - For Medicaid expansion expenditures, the review guide is not explicit about whether a variance analysis is required, but CMS has an automated variance report available for these expenditures, which suggests that such an analysis was expected.
 - The guidance suggests that a variance analysis should be conducted for expansion enrollees; however, it does not specify whether the analysis should be conducted in conjunction with—or take the place of—more in-depth examinations.

According to federal internal controls standards for information and communication, agencies should communicate the information necessary for staff to achieve the agency's objectives.³⁵ CMS's guidance on conducting variance analyses for types of expenditures with higher federal matching rates has not been sufficiently clear to assure that such analyses are being consistently conducted. By not consistently conducting such checks, errors may be going undetected and CMS may be providing federal funds at a higher matching rate than is allowable.

The Sampling Procedures Used to Examine Medicaid Expansion Expenditures Did Not Account for Varying Risks across States

CMS has additional procedures in place to review service expenditures reported for the Medicaid expansion population, a category of expenditures that received a 95 percent federal match in 2017. Specifically, in addition to a variance analysis, CMS guidance specifies that each regional office reviewer is to review claims for a sample. The guide directs the reviewer to obtain a full list of all expansion enrollees from the state and to select 30 to 40 for further review. Next, the reviewer is to obtain supporting documentation from the state listing the eligibility factors for the sampled enrollees, such as age, pregnancy status, Medicare enrollment, and income. The reviewer is to select a single claim for each enrollee and verify that the corresponding expenditures were reported under the correct federal matching rate category—i.e., that the sample claim for each individual was accounted for in the relevant section of the CMS-64. The review guide specifies that the sample review be conducted each quarter unless the state has had four consecutive

³⁵See [GAO-14-704G](#).

quarters with three or fewer errors, in which case, the sampling must be performed only annually.³⁶

We found that regional offices were identifying errors in their sampling reviews. For example, region 3 reviewers found that Pennsylvania had incorrectly categorized an individual in the sample as a Medicaid expansion enrollee, with the selected expenditures initially reported as eligible for the higher matching rate. According to CMS central office officials, the sampling methodology has helped identify systemic issues with state expenditure systems in some states and resulted in corrections, adjustments, and in one case, a disallowance. Under current procedures, among our five selected states that expanded Medicaid under PPACA, all five were determined to have had four consecutive clean quarters according to agency officials; that is, the state had three or fewer errors in each quarter.³⁷ Nationally, all but one of the 33 states that have implemented Medicaid expansion under PPACA had four consecutive clean quarters as of March 2018, according to CMS officials.

We found, however, that CMS's procedures for sampling reviews had a key weakness in that they did not account for varying risks across states, as illustrated in the following examples.

- We found that sample size does not account for significant differences in program size. For example, both California and Arkansas have expanded Medicaid under PPACA, and regional office staff told us they reviewed claims for 30 expansion enrollees in each of the two states, despite the fact that California has over 10 times as many expansion enrollees as Arkansas.³⁸ Region 9 officials told us that for

³⁶If a state has four to six errors, CMS is to defer an extrapolated share of Medicaid expansion expenditures and the state must develop a corrective action plan. Similarly, if a state has seven or more errors, the state must develop a corrective action plan, but CMS may defer the entire Medicaid expansion expenditure.

³⁷A recent report on California's eligibility determination procedures by HHS's Office of Inspector General revealed that, based on a sample of 150 enrollees, an estimated 450,000 Medicaid expansion enrollees may not have been eligible for coverage. The sample consisted of new enrollees who signed up between October 1, 2014 and March 31, 2015. See Department of Health and Human Services, Office of Inspector General, *California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements*, A-09-16-02023 (Washington, D.C.: February 2018).

³⁸In fiscal year 2016, Arkansas reported 321,000 expansion enrollees. In the same period, California reported 3,673,900 expansion enrollees.

California they had initially sampled 100 enrollees during the first quarter they were required to conduct this analysis, but the review was time consuming given staff resources, and they were advised by CMS's central office to limit their sample to 30 individuals. CMS officials told us that the sampling procedures are resource intensive and that the sample size they decided upon was what they thought they had the resources to complete.

- Additionally, the sample size does not account for previously identified risks in a state's program. Specifically, as we noted in a 2015 report, CMS's sampling review of expansion expenditures was not linked to or informed by reviews of eligibility determinations conducted by CMS, some of which identified high levels of eligibility determination errors.³⁹ According to CMS officials, the expenditure review is primarily intended to ensure that states are correctly assigning expenditures for the expanded eligibility groups as initially determined, not whether the eligibility determination is correct.

Federal standards for internal control related to risk assessment require that agencies identify, analyze, and respond to risks.⁴⁰ However, because CMS's sampling methodology does not account for risk factors like program size and high levels of eligibility determination errors, the agency's review of expansion population expenditures may be missing opportunities to detect systemic issues with improperly matched expenditures.

Quarterly variance analyses and sampling of Medicaid expansion enrollees can be supplemented by financial management reviews. For fiscal year 2016, CMS recommended regional offices conduct FMRs on expenditure claims for expansion enrollees. As of March 2018, however, regional offices had completed an FMR on Medicaid expansion expenditures in only one state, with no findings, and were in the process of completing FMRs for five other states. According to CMS officials, no additional reviews in this area were planned for fiscal year 2018.

³⁹See GAO, *Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds*, [GAO-16-53](#) (Washington, D.C.: Oct. 16, 2015). We previously found that eight of the nine states we reviewed reported errors resulting in incorrect eligibility determinations. We recommended that CMS use information obtained from assessments of state eligibility determinations to inform its review of expenditures for different eligibility groups. As of April 2017, CMS reported that the agency was establishing a process to have the reviews interact with one another.

⁴⁰[GAO-14-704G](#).

CMS Resolved over \$5.1 Billion in Expenditure Errors in Fiscal Years 2014 through 2017

Financial Impact of Expenditure Reviews Compared with Program Integrity Recoveries

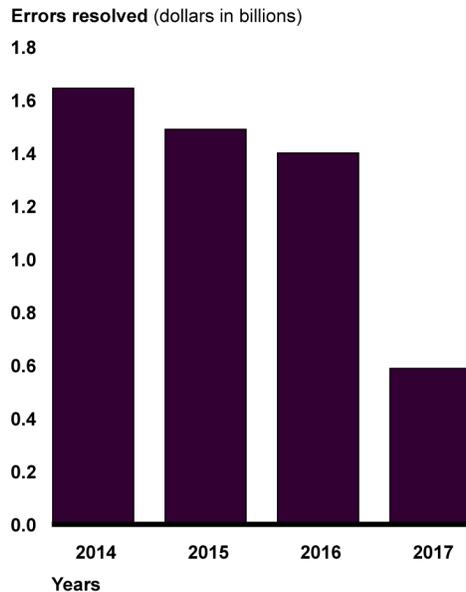
The impact of CMS's expenditure review activities is greater than the impact from other program integrity efforts. For example, in fiscal year 2015, CMS resolved errors through expenditure reviews that saved over \$1.4 billion in federal funds. In the same year, CMS reported that efforts by states and the federal government to identify improper payments to providers—for example, services that were billed by a provider but were not received by a beneficiary—resulted in recoveries that totaled \$852.9 million, in both state and federal funds.

Source: GAO analysis | GAO-18-564

In fiscal years 2014 through 2017, CMS's regional offices resolved expenditure errors that reduced federal spending by over \$5.1 billion, with at least \$1 billion in errors resolved in each of three of those four years. Errors were resolved through states agreeing to reduce their reported expenditures, which prevented federal payments to the state for those expenditures; and through CMS issuing disallowances, under which states are required to return federal funds.⁴¹ Although CMS resolved over \$1 billion in expenditure errors in each year of fiscal years 2014 through 2016, CMS resolved less than \$600 million in fiscal year 2017. CMS officials explained that this change likely reflects delays in clearance of disallowances due to the transition between presidential administrations. (See fig. 3.) In addition to these resolved errors, as of the end of 2017, CMS had \$4.47 billion in outstanding deferrals of federal funds, where CMS was delaying federal funds until additional information was provided. Expenditures flagged for deferrals may or may not represent errors.

⁴¹It is likely that regional offices resolved more than \$5.1 billion during this period, because regional offices do not consistently report amounts resolved through states reducing reported expenditures to CMS central office. One regional office—which oversees 2 states in the top 20 for spending—told us they track these amounts but do not report them to CMS. CMS officials also told us that from 2014 through 2017, regional offices were not always documenting the financial impact of errors that were resolved by states reducing reported expenditures due to resource and time constraints. Officials told us that they have directed the regional offices to document these expenditures and submit them to CMS central office going forward.

Figure 4: Federal Financial Impact of Errors Resolved by CMS, Fiscal Years 2014-2017



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-18-564

Note: These numbers reflect the federal savings from errors resolved by states reducing reported expenditures and through disallowances. The amounts may understate the total amount of errors resolved, because CMS regional offices did not consistently report the amounts of errors resolved through states reducing reported expenditures to CMS central office.

CMS Methods for Resolving Errors and Addressing Questionable Expenditures

- Reach agreement with the state to reduce its reported expenditures by the amount in error (either in the quarter under review or the next quarter).
- Issue a disallowance, which requires the state to return federal funds for expenditures that are not allowable.
- Defer federal funds if CMS needs additional information as to whether an expenditure is allowable.

Source: GAO analysis | GAO-18-564

All 10 CMS regional offices resolved errors from fiscal years 2014 through 2017, though the magnitude varied across regions. (See table 5.) Among the 10 regional offices, 9 reported that they had resolved errors through states agreeing to reduce reported expenditures. Additionally, 9 regional offices issued a total of 49 disallowances across 16 states, with the majority of the disallowances occurring in regional offices 2 and 3. Finally, all 10 regional offices had taken deferrals for questionable expenditures, with 22 states having outstanding “active” deferrals that had not been resolved as of the fourth quarter of fiscal year 2017, which ranged in amount from \$178 to \$444 million. CMS officials told us that the range of resolved errors and deferred funds across regional offices may reflect differences in the proportion of high-expenditure states. For example, regional office 4 oversees four states ranking in the top 20 in terms of Medicaid expenditures, while regional office 8 does not oversee any top-20 states. The variation may also reflect large actions taken in specific states. For example, the majority of the disallowed funds in regional office 2 from fiscal years 2014 to 2017 were due to a single disallowance of \$1.26 billion in one state.

Table 6: Resolved Errors from Fiscal Years 2014 through 2017 and Outstanding Deferrals as of Fiscal Year 2017, By CMS Regional Office

Regional office	States within region ^a	Resolved expenditure errors, fiscal years 2014-2017		Outstanding deferred funds, as of quarter 4, fiscal year 2017 (dollars in millions) ^b
		Reductions in reported expenditures (dollars in millions)	Disallowed amounts (dollars in millions)	
1	CT, ME, MA, NH, RI, VT	0.2	62.8	45.4
2	NY, NJ	600.0	1,729.7	321.4
3	DE, DC, MD, PA, VA, WV	116.2	328.2	225.1
4	AL, FL, GA, KY, MS, NC, SC, TN	1,205.1	211.1	5.1
5	IL, IN, MI, MN, OH, WI	51.9	144.8	2.0
6	AR, LA, NM, OK, TX	Not Reported	233.5	333.6
7	IA, KS, MO, NE	21.1	13.0	3.5
8	CO, MT, ND, SD, UT, WY	118.6	2.1	163.6
9	AZ, CA, HI, NV	263.3	15.8	3,373.1
10	AK, ID, OR, WA	1.7	0.0	0.6
Total		2,378.1	2,741.1	4,473.5

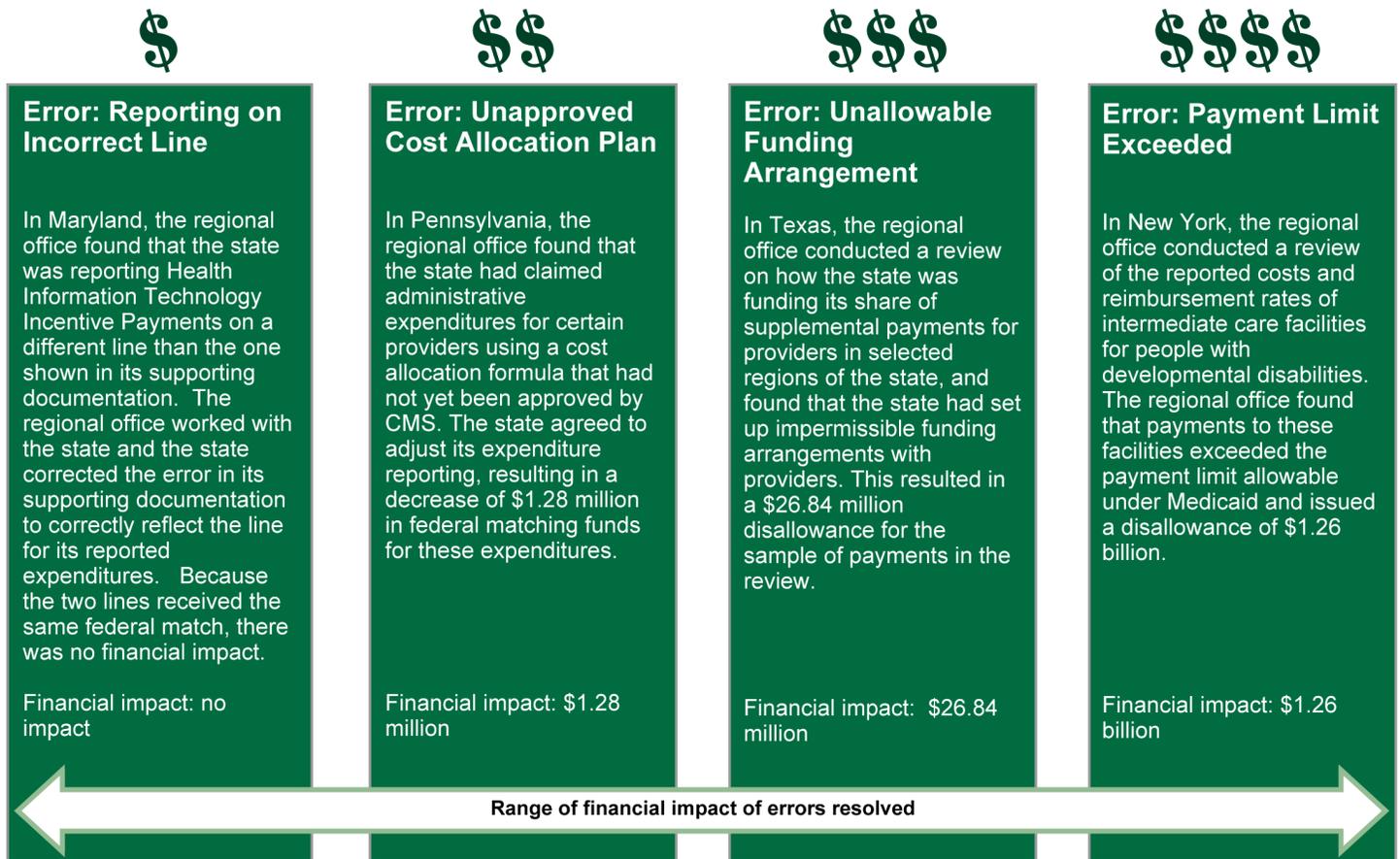
Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-18-564

^aRegional office 2 also oversees Puerto Rico and the U.S. Virgin Islands, and regional office 9 oversees American Samoa, Guam, and the Northern Mariana Islands.

^bActive deferrals of federal funds that had not been resolved as of the fourth quarter of 2017.

The financial significance of individual errors resolved by CMS’s regional offices varied significantly. We found that regional offices resolved errors that ranged from reporting errors that had no federal financial impact—such as expenditures that were allowable, but were reported on the incorrect line—to hundreds of millions of dollars in expenditures that were found to be unallowable under Medicaid requirements. Over the fiscal years we reviewed, more than half of the disallowances CMS issued were less than \$15 million; however, in four states CMS issued disallowances of over \$100 million, including a disallowance of over \$1 billion in New York. (See fig. 5.)

Figure 5: Examples of Errors Resolved in Selected States from Fiscal Year 2014 through Fiscal Year 2016



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) documentation and data. | GAO-18-564

In some cases, actions taken by CMS to resolve errors were the culmination of years of work. For example, over several years the California Medicaid program reported a large volume of expenditures for which it did not yet have sufficient supporting documentation. The regional office officials told us that the state reported these expenditures in order to comply with the 2-year filing limit, and had reported these as “placeholder claims,” with the intention of providing additional support at a later time. Over the course of at least 6 years, CMS deferred hundreds of millions of dollars in federal funds related to these placeholder claims. Of the active deferrals as of the end of fiscal year 2017, most of the total amount of deferred funds was taken for expenditures in California, which represented \$3.4 billion of the \$4.5 billion in total active deferrals. According to CMS officials, in 2015, CMS prohibited California from

reporting additional placeholder claims. Region 9 officials told us that they continue to work with the state to clear the deferrals related to this issue. They were able to resolve 9 related deferrals in fiscal year 2017; however, another over 60 deferrals were still unresolved.

Conclusions

The growth of federal Medicaid expenditures, estimated at about \$370 billion in fiscal year 2017, makes it critically important to assure expenditures are consistent with Medicaid requirements. CMS has a variety of processes in place to review state-reported expenditures, and those reviews have resulted in CMS resolving errors that have saved the federal government a considerable amount of money; over \$5 billion in the last 4 years. However, the increasing complexity of expenditure reporting is occurring as resources to review these expenditures are decreasing, hindering CMS's ability to target risk and potentially allowing for hundreds of millions of federal dollars in errors to go undetected. In the absence of a comprehensive risk assessment, which CMS has not conducted, CMS may be missing opportunities to better target resources to higher risk expenditures and increase the savings from these oversight activities.

The variety of different matching rates has contributed to the increased complexity of CMS's expenditure reviews. Although CMS has review procedures in place to assure that the correct matching rate is applied for services and populations receiving a higher federal matching rate, unclear guidance has contributed to inconsistency in the extent to which these reviews are conducted. In addition, we found weaknesses in the sampling methodology CMS requires its regional offices to use to help ensure that expenditures for Medicaid expansion enrollees—expenditures that receive a higher matching rate and that represented almost 20 percent of total federal Medicaid spending in 2016—are consistent with Medicaid requirements. In particular, the methodology does not account for risk factors like program size or vulnerabilities in state eligibility-determination processes and systems. As a result of the inconsistency in reviews and a sampling methodology that does not consider program risk, errors may be going undetected, resulting in CMS providing federal funds at higher federal matching rates than is allowable. In addition, CMS could be missing opportunities to identify any systemic issues that may contribute to such errors.

Recommendations

We are making the following three recommendations to CMS:

1. The Administrator of CMS should complete a comprehensive, national risk assessment and take steps, as needed, to assure that resources to oversee expenditures reported by states are adequate and allocated based on areas of highest risk. (Recommendation 1)
2. The Administrator of CMS should clarify in internal guidance when a variance analysis on expenditures with higher match rates is required. (Recommendation 2)
3. The Administrator of CMS should revise the sampling methodology for reviewing expenditures for the Medicaid expansion population to better target reviews to areas of high risk. (Recommendation 3)

Agency Comments

We provided a draft of this report to HHS for review and comment. HHS concurred with all three recommendations, noting that it takes seriously its responsibilities to protect taxpayer funds by conducting thorough oversight of states' claims for federal Medicaid expenditures. Regarding our first recommendation—that CMS complete a comprehensive, national risk assessment and take steps to assure that resources are adequate and allocated based on risk—HHS noted that CMS will complete such an assessment, and, based on this review, will determine the appropriate allocation of resources based on expenditures, program risk, and historical financial issues. CMS will also identify opportunities to increase resources. Regarding our second recommendation—clarifying internal guidance on when a variance analysis on higher matched expenditures is required—HHS noted that CMS will issue such internal guidance. Regarding our third recommendation—that CMS revise the sampling methodology for reviewing expenditures for the Medicaid expansion population to better target reviews to areas of high risk—HHS noted CMS is considering ways to revise its methodology.

HHS's comments are reproduced in appendix II.

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 Secretary of Health and Human Services, appropriate congressional committees, and other interested parties. The correspondence is also 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 III.



Carolyn L. Yocom
Director, Health Care

Appendix I: CMS Financial Management Review (FMR) Topics and Estimated Amounts at Risk, Fiscal Years 2014 through 2017

Regional office	Fiscal year ^a	State	Topic	Estimated amount at risk ^b (dollars in millions)
1	2014	NH	Medicaid Management Information System transition assistance payments to providers	14
	2016	CT	Public psychiatric residential treatment facilities	41
	2017	ME	Medicare Part B premium buy-ins	69
2	2014	VI	Accuracy of federal claiming	125
	2016	NY	Outpatient hospital reimbursement for mental health services	260
	2017	NY	Review of comprehensive psychiatric emergency program rates	64
3	2014 ^c	VA	1915c waiver	302
	2016	MD	Medicaid expansion expenditures	450
	2017	WV	Medicaid expansion expenditures	628
4	2014	TN	Provider taxes implemented to avoid program reductions	869
	2016	NC	Health homes data and expenditures reporting	89
	2017	KY	Medicaid expansion expenditures	600
5	2014	MN	Provider incentive payments for health information technology	27
	2016	OH	Medicaid expansion expenditures	100
	2017	IN	Medicaid expansion expenditures	1,800
6	2014	TX	1115 demonstration provider incentive payments	2,300
	2016	OK	Public psychiatric residential treatment facilities	48
	2017	AR	Home health services	51
7	2014 ^c	MO	Prescription drug expenditures	637
	2016	MO	School district administrative claiming	13
	2017	KS	Managed care organizations' provider payments	Unknown
8	2014	UT	Provider incentive payments for health information technology	52
	2016 ^d	n/a	n/a	n/a
	2017	CO	Intermediate care facilities	23
9	2014	CA	Federally qualified health center reimbursement payments	565
	2016	CA	Outpatient supplemental payments	154
	2017	NV	Eligibility and enrollment maintenance and operations	57
10	2014	AK	Personal case services	18
	2016	WA	Medicaid expansion expenditures	3,000
	2017	OR	School based services expenditures	1
	2017	WA	Managed care organizations' reporting of drug rebates	3

Source: GAO summary of Centers for Medicare & Medicaid (CMS) documentation. | GAO-18-564

**Appendix I: CMS Financial Management
Review (FMR) Topics and Estimated Amounts
at Risk, Fiscal Years 2014 through 2017**

^aCMS canceled the requirement for an FMR in 2015.

^bAmount of risk refers to a regional office's assessment of the federal funds associated with the topics that are at risk if a state's reporting is not consistent with Medicaid requirements in these areas.

^cCMS cancelled these 2014 FMRs due to a staffing shortage.

^dRegion 8 was excused from the requirement to conduct an FMR in 2016 due to staffing constraints.

Appendix II: 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

JUL 18 2018

Carolyn Yocom
Director, Health Care Team
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: CMS Needs to Better Target Risks to Improve Oversight of Expenditures*" (GAO-18-564).

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

Sincerely,

A handwritten signature in black ink, appearing to read "Matt D. Bassett".

Matthew D. Bassett
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: CMS NEEDS TO BETTER TARGET RISKS TO IMPROVE OVERSIGHT OF EXPENDITURES (GAO-18-564)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report on Medicaid expenditures. 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, and work together closely to carry out these responsibilities. 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. To assist states in their reporting, HHS provides guidance and training to make sure that states have mechanisms and systems to track and report expenditures accurately.

In addition, HHS regional offices perform enhanced oversight procedures in the 20 states with the highest federal Medicaid expenditures. Enhanced oversight procedures include verifying that the amounts reported are supported by the state's accounting records, and conducting variance analyses which compare current expenditures to previous quarter expenditures and investigating significant differences. 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 reviews, HHS asks each regional office to conduct targeted annual financial management reviews which allow for a more intensive review of state expenditures and include an analysis of the funding source and appropriateness of a payment.

As GAO notes, HHS has multiple procedures in place to recoup Medicaid funds when necessary. HHS can defer federal matching funds during the quarterly review if additional information is needed to determine whether a particular expenditure is allowable. If a state agrees that the questionable expenditure is an error, the state can submit an adjusted report or make an adjustment in the subsequent quarter. HHS also has the authority to issue a disallowance, requiring the state to return federal funds through reductions in future federal allocations.

As a result of these oversight processes, HHS worked with states to resolve \$2.1 billion and recover an additional \$647 million from states, totaling \$2.7 billion in questionable costs in fiscal year 2017. Furthermore, an estimated \$457 million in questionable reimbursement was averted due to preventive interaction between HHS and states to promote proper state Medicaid financing¹.

GAO's recommendations and HHS' responses are below.

Recommendation

¹ <https://oversight.house.gov/wp-content/uploads/2018/04/Hill-CMS-Statement-Medicaid-IP-4-12.pdf>

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: CMS NEEDS TO BETTER TARGET RISKS TO IMPROVE OVERSIGHT OF EXPENDITURES (GAO-18-564)

The Administrator of CMS should complete a comprehensive, national risk assessment and take steps as needed to assure that resources to oversee expenditures reported by states are adequate and allocated based on areas of highest risk.

HHS Response

HHS concurs with this recommendation. CMS will complete a comprehensive national review to assess the risk of Medicaid expenditures reported by states and allocate resources based on risk. Based on this review, CMS will identify opportunities to increase resources and review the current allocation of financial staff to determine the appropriate allocation by state based on expenditures, program risk, and historical financial issues.

Recommendation

The Administrator of CMS should clarify in internal guidance when a variance analysis on expenditures with higher match rates is required.

HHS Response

HHS concurs with this recommendation. CMS will issue internal guidance clarifying when a variance analysis on expenditures with higher match rates is required.

Recommendation

The Administrator of CMS should revise the sampling methodology for reviewing expenditures for the Medicaid expansion population to better target reviews to areas of high risk.

HHS Response

HHS concurs with this recommendation. CMS is considering ways to revise the sampling methodology for reviewing expenditures for the Medicaid expansion population.

Appendix III: GAO Contact 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 Barnidge (Assistant Director), Jasleen Modi (Analyst-in-Charge), Caroline Hale, Perry Parsons, and Sierra Gaffney made key contributions to this report. Also contributing were Giselle Hicks, Drew Long, and Jennifer Whitworth.

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