



SEP 25 2006

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Inspector General

SUBJECT: Ernst & Young Final Report: "Review of the Centers for Medicare & Medicaid Services' Medicaid Financial Management Oversight"

Attached is a final report by contractors Ernst & Young (E&Y) regarding financial management of the Medicaid program. Under a contract with the Office of Inspector General, E&Y conducted this review to provide recommendations for improving the financial management of the Medicaid program.

To accomplish the objectives, E&Y reviewed the current Centers for Medicare & Medicaid Services management structure, examined prior studies and audits, compared the financial management structures and activities of Medicare to those of Medicaid, held discussions with various stakeholders, and analyzed the issues identified through these activities. The E&Y report contains a series of findings, conclusions, and recommendations.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Judy Holtz, Acting Director of External Affairs, at (202) 619-0260 or through e-mail at [Judy.Holtz@oig.hhs.gov]. To facilitate identification, please refer to the report title in all correspondence.

Attachment

cc: Barry Clendenin
Office of Management and Budget

Christine Jones
Office of the Assistant Secretary for Resources and Technology

REVIEW OF

the Centers for Medicare & Medicaid Services'
Medicaid Financial Management Oversight

To the Inspector General of the
Department of Health and Human Services and
the Administrator of the Centers for Medicare & Medicaid Services

In connection with our audits of the Health Programs within the Centers for Medicare & Medicaid Services' (CMS) for the years ended September 30, 2005 and 2004, we were engaged by the Office of Inspector General to perform certain additional procedures to assess the financial management activities of the Health Programs. The purpose of these procedures was to review CMS' current financial management oversight of the Medicaid program in regard to its organization and administration and provide recommendations for improving future oversight functions and/or processes that would strengthen the financial management of the Medicaid program.

We conducted our procedures in accordance with the performance audit requirements of generally accepted *Government Auditing Standards*. Our procedures involved the following: (1) reviewing the current management structure, (2) examining prior studies and audits, (3) comparing Medicare to Medicaid, (4) holding discussions with various stakeholders, and (5) analyzing issues or lack of corrective action identified through the above mentioned activities, to the extent possible, which may or may not be linked to deficiencies in CMS' organization and administration of Medicaid financial management.

This report contains various findings, conclusions, and recommendations for the improvement of the internal control structure of Medicaid financial management and oversight activities.

We would be pleased to discuss the contents of the report or to respond to any questions at your convenience.

Ernst + Young LLP

August 30, 2006
Washington, DC

Centers for Medicare & Medicaid Services
Medicaid Financial Management
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RESULTS IN BRIEF

As early as the 1990s, the Government Accountability Office (GAO) and other auditors have identified weaknesses in the administration and oversight of Medicaid activities. The Medicaid program, administered by Centers for Medicare & Medicaid Services (CMS), in partnership with State Medicaid offices,¹ is a complex program that has expanded since 1998 by more than 86% or to \$182 billion in net Federal costs in fiscal year 2005. Over the past five years, CMS has received additional funding and undertaken a series of initiatives to enhance and focus its financial management and oversight of the Medicaid program. Many of these initiatives are a result of legislative directives allowing for more resources and changes in program policies. Although many of these directives were not fully implemented at the time of our review, which took place principally from January through May 2005, progress has been identified. Continued focus and development of strategies by senior level executives will be required to ensure that appropriate actions are completed.

The weaknesses identified in our review of prior reports consisted largely of (1) organizational structure limitations that impact CMS headquarter and regional office oversight, (2) insufficient program integrity programs, including an estimate of improper payments, (3) insufficient follow-up of eligibility determination deficiencies cited in single audit² reports, and (4) need for clear cut guidelines for approving and reviewing waivers and state plan amendments. We have obtained information on the status of recommendations made in the prior audits and studies we reviewed. These recommendations address ways CMS could define lines of authority or restructure its organization, the need to continue to develop strategies in implementing new directives and allocating resources, and the continued need to improve internal control over certain aspects of administration and oversight within the Medicaid program.

CMS' organizational structure creates challenges in effectively administering and overseeing Medicaid activities. We noted two areas—regional office resources and the lack of a separate, dedicated Chief Financial Officer (CFO) within the Office of Centers for Medicaid and State Operations (CMSO)—where discussions with certain CMS personnel indicated concern that the organizational structure for Medicaid activities was not designed appropriately or lines of authority are unclear. CMS's 10 regional offices are the Federal government's frontline for overseeing state Medicaid financial operations and expenditures. Because Medicaid is a state administered program the personnel in the regional offices act as liaisons between CMSO and states regarding Medicaid financial activities. The accountability of these personnel to the CMSO merits further focus. Resource allocation decisions made within the regional offices can weaken CMS' ability to ensure appropriate oversight of the Medicaid activities. Further,

1 For purposes of this report, States represent states, territories and the District of Columbia Medicaid Program offices.

2 OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations* was issued pursuant to the Single Audit Act of 1984 and the Single Audit Act Amendments of 1996. Under the Act, annually, each state's Medicaid program is required to be audited. The Circular was established to provide reasonable assurance that Federal financial assistance programs are managed in accordance with applicable laws and regulations. These audits are conducted by independent public accountants or state auditors. The results of these audits are provided to the state and CMS. In addition to assessing whether CMS oversight should be changed based on the findings, the CMS is responsible for following up with the state to ensure that the state takes appropriate action to correct deficiencies identified from the audit.

although the Medicaid program is one of the Federal Government's largest programs—soon to reach \$200 billion in Federal outlays, a separate, dedicated CFO or an independent executive to oversee financial activities has not been created. Currently, financial management oversight is primarily taking place within the CMSO with bookkeeping responsibilities and certain program integrity activities taking place within the CMS Office of Financial Management (OFM). Our discussions found varying opinions as to whether Medicaid needed a CFO. Stakeholders' views noted potential benefits of perceived increased independence and transparency into decision making while raising concerns about the specialized expertise needed to effectively implement a separate CFO function and possible diffusion of accountability.

Our review also noted that a primary tool that CMS utilizes in testing the states' quality control systems over determination of eligibility and verifying compliance with program laws and regulations is the states' single audits. During FY 2005, we noted during our audit of the Medicaid program that over 10% of the states received disclaimed opinions or qualified reports by independent auditors on compliance with Medicaid program requirements—the majority of these disclaimed opinions or qualifications were a result of noncompliance with eligibility requirements. There is limited follow-up on corrective action plans surrounding the single audits by both the states and CMS. It was unclear how, if at all, single audit findings or disclaimed opinions had been considered in the CMS Medicaid program oversight. Our discussions indicated that CMS should expand its role in its oversight of the states' assessment of eligibility. Because statutory eligibility determination was assigned to the states, the stakeholders believed that CMS' role should be in overseeing the implementation of quality control systems at the states to reduce errors in eligibility determination. Subsequent to our fieldwork, CMS noted that increased focus on resolution of external audits was being implemented.

Recent initiatives to provide an additional 100 personnel focused on Medicaid financial management, and just enacted legislation to add a further 100 personnel and additional financial resources focused on program integrity, are significant steps that can dramatically enhance the role the Federal government plays in managing the Federal and state partnership for Medicaid. Factors for CMS to consider as it develops its plans to deploy resources include placing additional focus on how such resources are deployed and utilized, efforts to provide transparency in how state plan amendments, waivers, and routine Federal oversight activities are conducted with visibility into outcomes across states to the extent practical, and/or potentially introducing financial management oversight through a CFO organization independent of program administration activities.

During June 2006, the GAO issued its report, *MEDICAID FINANCIAL MANAGEMENT: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts* (GAO-06-705) which discusses the status of Medicaid financial management oversight and the actions CMS has taken to address certain concerns identified in its previous reports. GAO's review was performed under different timeframes, and actions taken subsequent to the end of fieldwork may not be included in this report.

BACKGROUND

The Medicaid program, established in 1965, by Title XIX of the Social Security Act, provides grants to states for health and long-term care coverage to low income Americans including children, the elderly, and the disabled. Medicaid is the largest source of funding for medical and health-related services for people with limited income. During FY 2005, the average enrollment for the Medicaid program was 44.7 million Americans at a net cost of approximately \$182.2 billion.

CMS is the Federal agency responsible for administration and oversight of the Medicaid program and is responsible for ensuring that State Medicaid programs meet all Federal requirements. Staff members in CMS’ central office in Baltimore, Maryland and in 10 regional offices across the country are responsible for the financial oversight of the Medicaid program. Both the Office of Financial Management (OFM) and the CMSO play a role in this oversight and administration of Medicaid activities, as do many other entities as discussed below.

Entity	Responsibility
Centers for Medicaid and State Operations (CMSO)	<ul style="list-style-type: none"> • Processes and recommends approval of waivers and state plan amendments. • Develops, interprets, and applies specific laws, regulations, and policies that directly govern the financial operation and management of the Medicaid program. • Acts as the focal point for all agency interactions with states. • Develops national Medicaid policies and procedures that support and assure effective program administration. • Develops in consultation with the states, and tests new methods to improve the Medicaid programs through best practices. • Monitors program integrity efforts and activities performed by states.
Centers for Medicare & Medicaid Services (CMS) Regional Offices	<ul style="list-style-type: none"> • Acts as a liaison between CSMO and states. • Reviews the state budget and expenditure submissions and preparation of the regional decision report based on the submissions from the states. • Supports CSMO on program integrity efforts.
Centers for Medicare & Medicaid Services Office of Financial Management (CMS OFM)	<ul style="list-style-type: none"> • Records disbursement and accrual based financial activity related to Medicaid to financial systems. • Oversees the Medicaid Payment Error Rate Measurement Programs process (PERM). • Performs financial reconciliation and financial analyses processes of Medicaid activities. • Responsible for all CMS disbursements including the issuance of state Medicaid grants.
Department of Health and Human Services (DHHS) Office of Inspector General (OIG)	<ul style="list-style-type: none"> • Oversees annual CFO financial audit of Medicaid activities. • Performs program and financial audits. • Tracks open recommendations. • Tracks single audit reporting from states.

Entity	Responsibility
Department of Health and Human Services Division of Payment Management (DPM)	<ul style="list-style-type: none"> • Provides grant payments to the states and cash management services for CMS. • Oversees the states' quarterly reporting of fund draws and available obligations.
State Medicaid Offices	<ul style="list-style-type: none"> • Administers the Medicaid program to local beneficiaries. • Determines eligibility of participants (frequently at the local government). • Pays the providers for Medicaid services. • Ensures proper payment and recovery of funds paid for unallowable claims. • Responsible for investigating and ensuring prosecution of Medicaid fraud. • In some cases, voluntarily obtains SAS 70³ reports on controls on Medicaid financial management systems.
State Auditors and Independent Public Accountants	<ul style="list-style-type: none"> • Performs/oversees state single audits. • Performs state audits and reviews.

Medicaid is financed through a partnership between the Federal government and states. States are required to submit to CMS a comprehensive written plan that describes the nature and scope of its program. If the state plan meets Federal requirements, the Federal government matches state expenditures on Medicaid based on a statutorily defined formula called the Federal Matching Assistance Percentage (FMAP). This matching rate varies by state and is currently between 50 and 77 percent. These payments are processed by the DHHS Division of Payment Management (DPM). There is no limit or cap to the amount of state expenditures the Federal government will match, except with respect to the disproportionate share programs and payments to territories. The process states use to fund their share can include provider taxes and other mechanisms that have been assessed in some cases as abusive.

At the Federal level, the CMSO in conjunction with the regional offices and the OFM have responsibilities in the oversight of the Medicaid program. The CMSO is responsible for approving state Medicaid plans, working with the states on program integrity exclusive of the PERM, awarding grants, and budgeting. Many management oversight activities for Medicaid are taking place within CMSO with the Director of CMSO functioning as the Medicaid CFO. Currently, the CMS CFO, located in OFM, also functions as a CFO for Medicare. The OFM is responsible for the issuance of the cash disbursements for the grants that have been awarded by CMSO, oversight of the PERM, and the performance of financial reconciliations and analyses. The ROs are responsible for overseeing state financial management and internal controls,

³ CMS, and in some cases the states are contracting with Independent Public Accountants to perform a Statement of Auditing Standards No. 70, *Reports on the Processing of Transactions by Service Organizations* (SAS 70) reports. These reports provide for a service organization's description of its controls that may be relevant to a client's internal control, on whether such controls had been placed in operation as of a specific date on whether they are suitably designed to achieve specified control objectives and on whether the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the related control objectives were achieved during the period specified.

ensuring the reasonableness of budgets reported to estimate Federal funding requirements, and ensuring the propriety of expenditures reported for Federal matching.

Key activities performed in CMS ROs include reviewing state budget estimates and expenditure reports, preparing decision reports that document approvals for Federal reimbursements and reimbursement deferral actions, providing technical assistance to the states, and serving as a liaison to the state and audit entities. The CMS Regional Administrators report to the CMS Administrator. CMSO relies on regional decision reports to help determine state grant awards. The OFM is responsible for all CMS disbursements including the issuance of disbursements for state Medicaid grants. Reviews of the Medicaid expenditure reports are the primary oversight control activities performed by regional financial analysts. These reviews are used to determine if Medicaid expenditures are complete, properly supported by the state's accounting records, claimed at appropriate Federal matching rates, and allowable in accordance with existing Federal laws. Regional analysts are expected to obtain knowledge about each state's financial management and internal control to aid in assessing the expenditures reported for Federal reimbursement. Although the regional financial analysts maintain an integral role as they are responsible for performing frontline activities to oversee state financial management activities, personnel do not report to CMSO, but instead to the CMS Regional Administrators, who report to the CMS Administrator.

In accordance with Federal guidelines, each state has latitude to design their individual Medicaid programs with respect to administrative structure, eligibility, services and payment. Each state is also responsible for establishing an adequate internal control to ensure that the Medicaid program is managed effectively and efficiently within the Federal requirements. Quarterly, states submit various Federal reporting forms through the Medicaid Budget and Expenditure system (MBES) that provide regional analysts with the budget and expenditure data to execute their financial management and oversight responsibilities.

Annually, each state's Medicaid program is required to be audited under Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. The Circular was established to provide reasonable assurance that Federal financial assistance programs are managed in accordance with applicable laws and regulations. These audits are conducted by independent public accountants or state auditors. The results of these audits are provided to the state and CMS. The CMS is responsible for following up with the state to ensure that the state takes appropriate action to correct deficiencies identified from the audit.

In FY 2004, CMS was provided funding to hire 100 additional full time equivalent (FTE) "funding specialists" to support its oversight of Medicaid activities. Specifically, CMS tasked the funding specialists to monitor state budget-making processes, examine quarterly funding requests and work with states to ensure that the administration of Medicaid activities within the state meet Federal requirements. These individuals, although mostly located in the states and regions, report directly to CMSO. During FY 2005, the new FTEs were sent to extensive training to understand their new job requirements. In FY 2006, an additional 100 FTEs, and additional funding, were provided by the Deficit Reduction Act (DRA) to support Medicaid program integrity activities. These resources are in the process of being deployed. Finally, in FY 2006, the Payment Error Rate Measurement Program (PERM) is being implemented. Under

the PERM, Medicaid has 3 components – a fee-for-service error rate, an eligibility error rate, and a managed care error rate. A national contractor will calculate the Medicaid fee-for-service and managed care error rates for each state once every 3 years or 17 states each year. The states will conduct an eligibility review once every 3 years and submit the results to CMS for calculation of the states eligibility error rate. The PERM is to be published as an interim final rule at the end of August 2006.

OBJECTIVES, SCOPE AND METHODOLOGIES

The purpose of this project was to review CMS's current financial management oversight of the Medicaid program in regard to its organization and administration and provide recommendations for improving future oversight functions and/or processes that would strengthen the financial management of the Medicaid program. We accomplished this project by performing the following: (1) reviewing the current management structure, (2) examining prior studies and audits, (3) comparing Medicare to Medicaid, (4) holding discussions with various stakeholders, and (5) analyzing issues or lack of corrective action identified through the above mentioned activities, to the extent possible, which may or may not be linked to deficiencies in CMS' organization and administration of Medicaid financial management. For the purpose of defining the scope of this project, we considered GAO's definition of Medicaid financial activities. GAO's February 2002 report, *Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed*, defines Medicaid financial activities as follows:

“The internal control structure and financial oversight process that CMS has designed for Medicaid includes activities for:

- approving and awarding grants to make funds available to the States for the efficient operation of the Medicaid program;
- overseeing State financial management and internal control processes;
- ensuring the reasonableness of budgets reported to estimate Federal funding requirements;
- ensuring the propriety of expenditures reported for Federal matching funds.”

During our assessment we did not consider processes within the states or processes related to identifying funding mechanisms, except insofar as they related to understanding the need for Federal oversight resources, as they were excluded from the scope of this engagement. We did, however, consider additional program controls that are currently under development such as the Medicaid and State Children's Health Insurance Program (SCHIP) PERM; Medicare/Medicaid data matches; automated reporting systems and recently added Federal resources devoted to Medicaid financial management and program integration.

Specific tasks included:

- To develop and document a thorough description of CMS' current financial management oversight activities of the Medicaid program, we worked with the management of CMS and other selected oversight entities to obtain an understanding of the processes and gain

concurrence from management as to the accuracy of our documentation. Specific steps performed included:

- We met with personnel from the CMSO, OFM, OIG, two regional offices including New York and Pennsylvania, and two funding specialists from Washington, D.C. and Maryland and obtained an understanding of the Medicaid process. Additionally, we met with individuals from the states of Maryland and New York Medicaid office to obtain an overview of state Medicaid activities.
- We reviewed prior year audit work papers and met with personnel involved in fraud and abuse activities, MMIS, MSIS, and the PERM.
- We obtained and reviewed CMS' manuals and training guides related to Medicaid activities.
- We reviewed a complete list of all Medicaid budget, expenditure, and accounting reports that states are required to submit based on related legislation, regulation, State Medicaid Manual instruction, or CMS directive. We reviewed the State Medicaid Manuals to compile a list of reports submitted by the states.
- We received a list of the total Federal dollars spent on financial management, Health Care Fraud and Abuse (HCFAC), Medicaid Fraud Control Units, Federal match of state and local administration, PERM project, etc., for the most current reporting period.
- We obtained and reviewed a complete listing of all Federal electronic databases and information technology (IT) systems that are used in the financial management and program integrity of the Medicaid program.
- We obtained a detailed organizational chart of all central and regional offices' divisions/groups/defined teams working in CMS that have a significant role in Medicaid financial management and program integrity. This organizational chart identified the lines of reporting between the central office and the regional offices with respect to financial management and program integrity.
- Based on information received, we prepared a thorough description of all current and upcoming Medicaid financial management activities, including process flowcharts of a typical Medicaid claim transaction, including the reporting process, the information systems and databases used, documents, and CMS personnel involvement.
- We obtained documentation and made certain comparisons between the Medicare and Medicaid financial management and oversight processes.
- We performed a literature search of GAO and OIG reports and other selected sources to aid in identifying issues regarding vulnerabilities of the Medicaid program and related such information, as appropriate, to potential gaps in oversight structures. We met with CMS personnel to discuss the status of corrective actions and determined which issues still existed.
- Under the initial task order, we were requested to facilitate a one-day meeting with CMS management, OIG and other selected stakeholders to validate the oversight structures identified and aid in validating gaps identified in prior phases of the work and in identifying gaps and/or potential areas for improvement based on input from the attendees. Our task order was subsequently amended on September 15, 2005 to cancel the one-day meeting and instead hold separate discussions with Federal senior management

personnel responsible for various activities of Medicaid financial management that were made available to us from CMS/CMSO, CMS/OFM, ASRT (formerly ASBTF), OMB, GAO and OIG (hereafter referred to as stakeholders). The discussions primarily addressed the following questions.

- What are the primary differences between CMS's current financial management of the Medicaid and Medicare programs? What improvements could CMS realize by applying some aspects of the Medicare approach to Medicaid financial management?
- What previously published GAO, OIG and audit findings, conclusions and recommendations continue to present the greatest risk to Medicaid financial management, either because the recommendations have yet to be addressed or corrective action has not fully addressed the basis of the recommendation? What actions has CMS taken to date regarding these issues?
- What, if any, vulnerabilities exist related to CMS' current organizational structure of Medicaid financial management? How does dissemination of financial review responsibilities to regional offices affect CMS oversight? Are lines of reporting for financial specialists clear? Should CMS create a separate Medicaid CFO?
- What progress has CMS made to date toward creating and publishing PERM in the Medicaid program? Once the PERM implementation is completed, how will the resulting measures be used to improve Medicaid program integrity? What additional activities are needed to generate comparable data useful for program oversight?
- What financial management activities are currently in place at the Federal level regarding eligibility determinations? Are Federally mandated requirements regarding eligibility determinations at the state/local level sufficient? What additional activities could the Federal government take to improve eligibility controls (such as assisting program participants with best practices or increasing standardization of eligibility determinations)?
- Based on our discussions, we analyzed those problems identified by the stakeholders and linked them, as appropriate to potential gaps in CMS's organization and administration of Medicaid financial management.

We performed our principal fieldwork from January 2005 through May 2005, at the CMS central office in Baltimore, Maryland, DHHS headquarters, the two regional offices and the two states, mentioned above. Through March of 2006, we conducted the separate discussions referenced above to document Medicaid financial management and oversight activities and to gain a status of corrective actions identified in previous GAO and OIG reports and to gain their perspectives on areas for improvement and potential solutions.

During June 2006, the GAO issued its report, *MEDICAID FINANCIAL MANAGEMENT: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts* (GAO-06-705) which discusses the status of Medicaid financial management oversight and the actions CMS has taken to address certain concerns identified in its previous reports. GAO's review was performed under different timeframes, and actions taken subsequent to our end of fieldwork may not be included in this report.

COMPARISONS OF MEDICAID TO MEDICARE TO IDENTIFY DIFFERENCES IN PROGRAM OVERSIGHT

The CMS, one of the largest purchasers of health care, had outlays of more than \$484 billion during FY 2005. The majority of these outlays related to CMS' administering of the Medicare and Medicaid programs. The CMS is responsible for establishing policies for program eligibility and benefit coverage processes for over one billion Medicare claims annually, providing states with funds for Medicaid/SCHIP, and safeguarding funds from waste, fraud and abuse. As part of this engagement, we were asked to perform a comparison of the Medicare and Medicaid programs.

The Medicare program, established in 1965, was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people aged 65 and over. In 1972, the program was expanded to cover disabled and people with end-stage renal disease. The Medicare program processes over one billion fee-for-service claims a year incurring costs of over \$300 billion a year for approximately 42 million beneficiaries. In the past several years, with the implementation of the Medicare drug plans and other new programs, Medicare costs have continued to rise. Medicare contractors administer the day-to-day operations of the Medicare program by paying claims, auditing provider cost reports, and establishing and collecting overpayments. CMS is responsible for establishing an adequate internal control to ensure that the Medicare program is managed effectively and efficiently within the Federal requirements. It establishes nationwide coverage rules and disseminates these rules to the contractors. The administration and oversight of financial activities is primarily the responsibility of the CMS headquarters—the OFM—and the regional offices. Additionally, CMS uses independent certified public accountants to review Medicare contractor financial balances and financial systems in order to validate the adequacy and consistency of internal controls. On a monthly basis, Medicare contractors perform a reconciliation of their Form CMS 1522 Funds Expended Reports to their paid claims or system reports. In FY 2004, CMS initiated its implementation of the Healthcare Integrated General Ledger Accounting System (HIGLAS), its new program-wide financial management system, at the contractor locations.

The Medicaid program, on the other hand, is a health care program for low-income and disabled Americans, administered by CMS in partnership with the states. In FY 2005, there were approximately 44.7 million individuals participating in the Medicaid program incurring Federal costs of approximately \$182 billion. The CMS provides matching payments to the states and territories to cover the Medicaid program and related costs. State medical payments are matched according to a formula that uses as a starting point each state's per capita income. Under Federal legislation, states set eligibility, coverage, and payment standards. State governments have a great deal of flexibility to tailor their individual Medicaid programs to their individual circumstances and priorities. Accordingly, there is a wide variation in the services offered by the state. Each state is responsible for establishing an adequate internal control to ensure that the Medicaid program is managed effectively and efficiently within the Federal requirements. Quarterly, states submit various Federal reporting forms through the Medicaid Budget and Expenditure system (MBES) that provide regional analysts with budget and expenditure data to execute their financial management and oversight responsibilities. In addition, annually each state's Medicaid program is audited under OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. In general the results of these audits are provided

to the state and made available to the responsible Federal agencies which awarded the grants. In addition to administering a broad framework of the program under Federal legislation and regulations, CMS' primary roles in the Medicaid program are paying matching funds to the states and ensuring that the states conform to Federal requirements. Additionally, CMS is responsible for following up with the state to ensure that the state takes appropriate action to correct deficiencies identified from the single audits.

In our comparison of Medicaid to Medicare, we reviewed three components: the organizational structure, the program integrity activities, and the role of the intermediary versus the states. Primary differences for each component are as follows:

Organizational Structure—the organizational structures for the programs were similar in the sense that both utilize headquarters and regional office personnel to oversee the program. Differences noted are as follows:

- Although the organizational structure identifies the activities of a CFO for the Medicaid function as falling under the responsibilities of the Director of CMSO, significant financial activities are taking place in the ROs. The personnel in the ROs report to Regional Administrators, who further report to the CMS Administrator. Certain processing functions and the newly developed PERM responsibilities are taking place within the CMS CFO office located in the OFM. Beginning in September 2004, CMS hired 100 funding review specialists who report to CMSO even though they are nominally attached to a RO to assist in certain financial management activities. In the Medicare program financial activities are being reviewed by the CFO of CMS, and Regional offices are executing limited financial management related to disbursements.
- While regional office personnel are utilized in the oversight of financial activities in both the Medicare and Medicaid programs, because Medicaid is administered as a Federal/State partnership, there are less Federal FTEs supporting the financial management oversight function of the Medicaid process. In both cases, the regional personnel report to regional administrators instead of headquarters personnel responsible for administering the programs.
- Oversight of financial management activities in the Medicaid program is different due to the nature of the Medicaid program. CMS is responsible for administering Medicare's day-to-day operations and overseeing the contractors. Over the last 10 years, for Medicare, CMS has developed processes to periodically independently assess carriers and intermediary activities through use of SAS 70 audits. For Medicaid, regional office reviews of state submissions of budget and execution reports, and State single audit reports are the primary means of overseeing the Medicaid financial activities.
- From a payment perspective, while Medicaid pays its states through grants administered by the DHHS PDM, Medicare pays its contractors utilizing draws through commercial banking institutions.

Program Integrity Activities—As both the Medicaid and Medicare programs grow in costs and complexity, program integrity activities within CMS have become more critical in ensuring that the programs are administered effectively and efficiently. Up until the last several years, Federal resources applied to Medicaid program integrity activities were very limited as compared to

Medicare; however, both programs have implemented or expanded program integrity activities to identify potential deficiencies. Although the Medicare program integrity activities are more developed, additional resources are being provided to support the development of additional programs within Medicaid.

For Medicare, program integrity activities primarily take place under the authority of the OFM. The Medicare program includes a nationwide statistically derived sample of claims to project an annual error rate in the Comprehensive Error Rate Tracking program (CERT), and periodic reviews of controls at intermediaries (SAS 70s.)

Program integrity activities within the Medicaid program are more diverse in that these activities take place largely in the states, but are augmented to some extent, through CMS’ oversight. For example, the Medicare/Medicaid Data Match and the PERM, which is currently under development, are the responsibility of the OFM, state single audits are performed in the states, and the Medicaid Alliance for Program Safeguards (MAPS), and Medicaid Eligibility and Quality Control (MEQC) are performed within CMSO. The Focused Financial Management Reviews are performed at the ROs. To improve national consistency in the issuance and application of Medicaid reimbursement policies, the National Institutional Reimbursement Team (NIRT) and the National Non-Institutional Provider Team (NIPT) were recently developed within CMSO. The NIRT is responsible for reviewing all institutional State Plan Amendments (SPAs), providing technical assistance to the states, and developing Medicaid institutional reimbursement regulations and policy. NIPT functions similarly to the NIRT, but for non-institutional providers, namely physicians.

In the Deficit Reduction Act (DRA) of 2005, Congress has approved an additional 100 FTEs to increase its focus on Medicaid program integrity activities. In section 6035 of the DRA, Congress mandated CMS to enter contracts with “eligible entities” to perform some of the very functions that Medicare payment contractors have historically performed (prepayment reviews of claims, audits, identification and return of overpayments, provider outreach and the like). The following table presents a key comparison of major program integrity activities of the Medicare and Medicaid program:

		Medicare	Medicaid
Program Integrity Activities		<ul style="list-style-type: none"> • Comprehensive Error Rate Tracking (CERT) • Hospital Payment Monitoring Program (HPMP) • Audit Quality Review (AQR) • Medicare Program Integrity (MIP) • Medicare/Medicaid Match • SAS 70 IT Audits 	<ul style="list-style-type: none"> • Medicaid Alliance for Program Safeguards (MAPS) • Medicaid Eligibility and Quality Control (MEQC) • Payment Error Rate Measurement (PERM) under development • State single audits and desk reviews • Focused Financial Management Reviews • Medicare/Medicaid Match • Voluntary SAS 70 IT audits at certain states • State Plan Amendments (SPA) and waiver reviews

Role of the Carriers and Intermediaries Versus the States — For Medicare activities, CMS establishes and disseminates nationwide coverage rules to carriers and intermediaries which are intended to be uniformly implemented. Intermediaries provide local administration of the Medicare Program by processing Medicare benefit claims and issuing benefit checks to providers. The Medicare contractors provide technical assistance to providers and service beneficiaries' needs, and respond to inquiries. The providers are responsible for the services to the Medicare participants. The regional office employees mainly provide direct services to Medicare contractors, state agencies, health care providers, beneficiaries, and the general public.

The Medicaid program is substantially less uniform. Within broad national guidelines set by the Federal government states administer the Medicaid and SCHIP programs. Each of the states establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. The states also prepare budget and expenditure reports quarterly and submit them to the regional office for review. Nationwide, there are 10 regional offices with the responsibilities of acting as a liaison between central office and the states, reviewing the budget and expenditure submissions from the states, and preparing the regional decision report based on the submissions from the states, and transmitting that decision to CMSO. The CMSO serves as the focal point for all agency interactions with states and local governments. The CMSO develops national Medicaid policies and procedures that support and assure effective state program administration. The states and CMSO develop and test new and innovative methods to improve the Medicaid programs through demonstrations and best practices.

We discussed our comparison of the two programs with the stakeholders. Most stakeholders indicated that because of fundamental differences in the programs, while the comparison of the Medicare program to the Medicaid program can be useful in identifying high level gaps (for example, lack of a PERM process) it was less useful in assessing how financial management activities are carried out. Our analysis supported the view that the Medicare financial management approach is not directly applicable to the Medicaid program because of the fundamental differences in the programs.

PROGRESS NOTED ON CORRECTIVE ACTIONS; HOWEVER FURTHER ENHANCEMENTS ARE NEEDED

Beginning in the mid 1990s, GAO, the OIG and other financial auditors have identified and reported on serious deficiencies in the financial management activities and oversight of the Medicaid programs. The weaknesses identified in our review consisted largely of (1) organizational structure limitations that impact CMS headquarter and regional office oversight, (2) insufficient program integrity programs including an estimate of improper payments, (3) insufficient follow-up of single audit report deficiencies particularly as they relate to eligibility determination, and (4) need for clear cut guidelines for approving and reviewing waivers and state plan amendments. Recommendations to address these weaknesses included ways CMS could define lines of authority or restructure its organization, the need to continue to develop strategies in implementing new directives and allocating resources, and the continued need to improve internal control over certain aspects of administration and oversight within the Medicaid programs. In the past several years, CMS has focused on resolving several of these issues

identified; however, more progress is needed to resolve many of the more complex issues. As part of this engagement, we have reviewed the status of corrective actions regarding Medicaid financial management. Appendix A discusses the issues and recommendations identified in prior reports and corrective actions taken.

Over the past several years, CMS has focused on making improvements to its Medicaid financial management processes. Many of these improvements are still underway and have taken significant resources and time to implement due to the complexity, the cost, the need for legislative approval, or limited personnel resources available to the Medicaid financial process. Steps taken include the following:

- Beginning in FY 2004, CMS was provided the authority to hire 100 FTE funding specialists to monitor state budget-making processes, examine quarterly funding requests and work with states to ensure that the administration of Medicaid activities within the state meet Federal requirements. Additionally, the funding specialists will participate in financial management reviews of specific financing arrangements at the states and participate in the development of findings related to those reviews. These funding specialists are independent of the financial analysts within the RO. As of April 2005, 95 of the 100 funding specialists had been hired with 10 located at CMSO headquarters and 85 located in the regional offices and states. All 95 employees have been sent to a formal two-week training to provide an understanding of CMSO policies and operations related to Medicaid reimbursement and state financing and will attend ongoing training to be updated on future changes. We visited two new funding specialists from the State of Maryland and the District of Columbia. At the time of our visits—between February 2005 and April 2005—the funding specialists were in the early stages of learning the position. At the time of our interview, it was too early to determine the effectiveness of the new funding specialists, what specific tasks they would perform or how they would be measured, but their presence was frequently identified as part of the overall solution in enhancing Medicaid financial management.
- CMS has instituted a financial management work planning process which was responsive to ensure prior organization structure concerns were addressed. Under the process each regional office proposes an annual workplan describing specific activities that it will perform and be held accountable for throughout the fiscal year. Each regional office workplan is reviewed and approved through the Regional Administrator and the CMSO. The process incorporates a resource assessment effort and risk assessment and analysis. CMS indicated that the goal in establishing the financial management workplan is to strengthen CMS' Medicaid financial oversight by establishing performance expectations, to track related actions and their results, and to improve communication among CMSO and the regions.
- Analysis of changes in quarterly budget and expenditure submissions is a major consideration in the regional office's recommendation to award a grant or validate expenditures and a step in the CMS Financial Review Guide. We noted in our FY 2004 internal control report that regional office documentation to support the analysis of state submissions was not adequate. Ongoing training has been provided for CMSO and regional office personnel to ensure up-to-date knowledge of CMSO financial management and oversight policies. The FY 2005 report on internal control noted

certain improvements in documentation related to the analysis of state submissions as compared to weaknesses identified during FY 2004.

- To address concerns about the need for additional program integrity issues, the DRA passed in early 2006 will provide 100 additional FTEs to support Medicaid activities and provide for additional funds in Medicaid integrity programs to improve the accuracy of payments in the Medicaid Program. The Act also appropriated an additional \$630 million over the next 10 years to carryout the Medicaid integrity program, as well as an additional \$125 million over five years.
- As more fully addressed below, CMS initiated its PERM program—a program whose methodologies were defined by CMS for consistent application by all states to calculate improper payment error rates. Under PERM, Medicaid has 3 components – a fee-a-for-service error rate, an eligibility error rate, and a managed care error rate. A national contractor will calculate the Medicaid fee-for-service and managed care error rates for each state once every 3 years or 17 states each year. The states will conduct an eligibility review once every 3 years and submit the results to CMS for calculation of the states eligibility error rate. The PERM is expected to be published as an interim final rule at the end of August 2006.
- In an effort to improve national consistency in the issuance and application of Medicaid reimbursement policy, CMS has developed the NIRT, who is responsible for reviewing all institutional reimbursement state plan amendments, providing technical assistance to the states, and developing Medicaid institutional reimbursement regulations and policy. As a result of this effort, CMS believes the team’s work will help ensure consistency in the application and review of Medicaid policies. A separate team—NIPT—has also been established for non-institutional providers, namely physicians.
- CMS has initiated plans in developing a new financial management system—HIGLAS—for the Medicaid and Medicare financial activities. Full implementation is expected by FY 2007.
- The FY 2005 CMS financial audit reported that although the methodology currently employed by CMS can produce a reasonable incurred-but-not-reported (IBNR) estimate for Medicaid financial reporting, the process is highly dependent on information provided by the various states. Errors, inconsistencies and varying interpretations at the state level can occur and significantly affect the CMS IBNR liability. CMS has developed a workgroup consisting of CMSO, the Office of the Actuary (OACT), and OFM to meet periodically to discuss the progress in developing a methodology to collect the necessary data to estimate an IBNR amount from claims data maintained internally.

Recent initiatives to provide an additional 100 personnel focused on Medicaid financial management, and just enacted legislation, to add a further 100 personnel and additional financial resources focused on program integrity are significant steps that can dramatically enhance the role the Federal government plays in managing the Federal and state partnership for Medicaid. Factors for CMS to consider as it develops its plans to deploy resources include placing additional focus on how such resources are deployed and utilized, efforts to provide transparency in how state plan amendments, waivers, and routine Federal oversight activities are conducted with visibility into outcomes across states to the extent practical, and/or potentially introducing

financial management oversight through a CFO organization independent of program administration activities.

Although progress has been made and is expected to be ongoing, emphasis is still needed in completing certain corrective actions and resolving other issues more fully described in the sections that follow. In its June 2006 report, GAO identified certain actions CMS had taken subsequent to our fieldwork to address many of these issues.

ORGANIZATIONAL STRUCTURE CREATES CHALLENGES

GAO's *Standards for Internal Control in the Federal Government* provides that an agency organizational structure is appropriate for the nature of its operations and designed so that authority and internal control responsibility is defined and well understood. CMS' organizational structure creates challenges in effectively administering and overseeing Medicaid activities. We noted two areas—regional office resources and the lack of a separate CFO for Medicaid—where stakeholders indicated concern that the organizational structure for Medicaid activities was not designed appropriately or lines of authority were unclear.

Regional Office Resources

As GAO reported in FY 2002, although CMS's 10 regional offices are the Federal government's frontline for overseeing state Medicaid financial operations and expenditures, there are no reporting lines to the headquarters unit responsible for Medicaid financial management (CMSO). Currently regional office personnel report to Regional Administrators. Each regional office proposes an annual workplan describing specific activities that it will perform and be held accountable for throughout the fiscal year. Each regional office workplan is reviewed and approved through the Regional Administrator and the CMSO. The process incorporates a resource assessment effort and risk assessment and analysis. CMS has noted that this plan cannot be changed without approval of the central office. However, one stakeholder indicated that because the operating budget for CMS is focused on the payment of Medicare claims, Medicaid resources are sometimes taken away or shared to perform Medicare responsibilities in the regional offices. This could happen each time the priorities change or there is a limitation of available resources. Another stakeholder indicated that lines of authority need to be drawn between the regional personnel performing key functions and the Headquarter division with authority over the program. Since ultimately the administration of Medicaid is a shared responsibility with the states, some stakeholders felt that CMS should consider realigning some of the regional personnel to report directly to the CMSO to ensure priorities within the Medicaid process are met. Approximately 65 funding specialists located in the regions are allotted to the Medicaid program. Beginning in September 2004, 100 funding review specialists were hired who report to CMSO. The impact of those 100 new specialists has yet to be seen at the end of our fieldwork.

Lack of Medicaid CFO

Although the Medicaid program exceeds costs of \$180 billion—one of the Federal Government's largest programs, a CFO or an independent executive to oversee financial activities has not been

created. Currently, financial management oversight is primarily taking place within the CMSO with the Director of CMSO also serving as the CFO. Bookkeeping responsibilities and certain program integrity activities are taking place within the OFM.

In February 2004, a study, *Medicaid's Federal-State Partnership: Alternatives for Improving Financial Integrity*, performed by the Henry J. Kaiser Family Foundation, suggested that a CFO be created for the Medicaid program. In the study, the foundation noted that Medicaid pursued funding without the standing and credibility of a dedicated CFO. It noted that the CMS CFO does not currently exercise authority over substantive financial matters affecting Medicaid; instead, those authorities reside in the director of CMSO—the same individual charged with achieving programmatic objectives and effective working relationships with the states. In its suggested possibilities for reform, the foundation stated that vesting financial oversight and authority in executive officers whose sole function is to create and enforce financial controls and accountability would aid in increasing accountability.

Our discussions identified varying opinions on whether a separate CFO should be appointed to oversee and create additional emphasis for Medicaid financial management activities. Of the four stakeholders who expressed a view on this issue, two stakeholders felt that a separate CFO was warranted. In discussing this point, some of the stakeholders linked this desire for a separate CFO to a concern that certain funding mechanisms may have been developed in consultation with CMS, and other potentially costly decisions were made without independent analysis of the ultimate cost of the changes. Accordingly, routine decision making may have a significant financial impact inadvertently. The Medicaid program, including reviews of SPAs, was noted as lacking transparency. SPAs are initially submitted by the states to the CMS ROs then reviewed at the CMSO through the NIRT and NIPT. SPAs are largely the process where state funding mechanisms are approved. While SPAs are generally not shared with OMB, demonstration projects, including assertions that such projects will be budget neutral, are shared with OMB. Transparency and visibility concerns were raised principally within the context of understanding how state plans, funding mechanisms and application of the regulatory framework compare across the states. They were focused on how processes to critically assess and monitor state plans, funding mechanisms and their implementation could vary by state and create perceived inequities or give rise to decisions with long term consequences not finally understood by all stakeholders. Tools such as creating a repository of all state plans, funding mechanisms and administrative decisions available in a searchable and comparative format were discussed. We understand that aspects of such a plan are under consideration by CMS, but not funded. Transparency for decisions made was one perceived possible benefit for a separate CFO organization. The stakeholders indicated that other formulations to provide such visibility may be possible.

Views of the four stakeholders presenting a position were as follows:

- One stakeholder felt that a separate CFO could create more visibility into the Medicaid program. The sense of this discussion; however, was to question whether, depending on how such a separate CFO function was created and staffed, there would be a substantive change in the decision making process and visibility into key decisions.
- Another stakeholder indicated they believe there should be a separate CFO for Medicaid activities. It would provide for a clearer segregation of duties between the program and

financial processes, demonstrate independent oversight of program activities by a separate financial team, and be in the best interest for the American tax dollars. Currently, they believe that having the duties of the CFO be subsumed into CMSO creates an appearance of little independence between both program and financial activities and may hinder transparency.

- According to a CMS stakeholder, one could argue that there is a need for separate Medicare and Medicaid CFOs. However, this stakeholder does not feel that this is a good idea due to the expertise within CMSO and the complexity of the program, and that if the duties of such a position were segregated; they should be resident within CMSO.
- CMSO indicated that it believes that the merits of having one person directly accountable to the legislators argue for no separate CFO. In regard to a segregation of duties between the CFO, Chief Operating Officer (COO), and program design and administration this CMSO stakeholder feels that because of the way Medicaid is designed these duties would be better suited within CMSO. Currently, because the administration of the program is within the states, it is the belief of CMSO that there are more than 50 financial managers and COOs. In addition, CMSO feels that it is critical due to the complexity of the program for one unit to have the global view of activities—both financial and program. For example, they expressed a view that believed that a divided structure would not have been able to restructure one state’s financing plan successfully because one person saw the whole picture thus enabling accountability within that state. Additionally, if more segregation of duties is created, CMSO feels that resources will be stretched and believes it is more efficient to have CMSO overseeing everything.

Our review of other operating components within DHHS generally identified a separate CFO from program responsibilities. Although many of the operating components utilized the DHHS Program Support Center to outsource accounting and bookkeeping responsibilities, the operating component maintained a separate CFO whose authority dealt with making financial and budgeting decisions. Such a model, segregating the duties of the CFO from the duties of the underwriter or the loan originator within other insurance and financial related businesses is generally the norm.

Concerns exist regarding the independence of the CFO activities and the need to enhance visibility into key decisions. There are differing views on whether or not and how an independent CFO would address these concerns effectively.

PAYMENT ERROR RATE MEASUREMENT DEVELOPMENT AND IMPLEMENTATION STILL IN PROCESS

The Federal government and states each have responsibilities for administering Medicaid programs and for ensuring that Medicaid funds are spent appropriately on covered services provided to eligible beneficiaries. CMS administers Medicaid at the Federal level and establishes policies related to preventing and detecting improper payments. Beginning in the mid-1990s, financial auditors reported that CMS needed to develop a process in estimating improper payments in the Medicaid/SCHIP programs to mirror similar reporting for the Medicare program. In FY 2002, Congress passed the Improper Payment Integrity Act (IPIA.)

One practical implication of the IPIA has been to require CMS to design a methodology and calculate an error rate for improper payments within the Medicaid/SCHIP programs. Although previous pilot programs were initiated through FY 2005, CMS has been unsuccessful in developing a national error rate for the Medicaid/SCHIP programs.

During FY 2006, CMS initiated its implementation of the PERM program—a program whose methodologies were defined by CMS for consistent application by all states. CMS would use HCFAC funds to reimburse the states for costs incurred. Under PERM, Medicaid has 3 components – a fee-a-for-service error rate, an eligibility error rate, and a managed care error rate. A national contractor will calculate the Medicaid fee-for-service and managed care error rates for each state once every 3 years or 17 states each year. The states will conduct an eligibility review once every 3 years and submit the results to CMS for calculation of the states eligibility error rate. The PERM is expected to be published as an interim final rule at the end of August 2006. The effectiveness of result of the first year of the program was not available to us at the end of fieldwork.

CMS is still determining how the results will be utilized once the program is fully implemented and what actions will be taken with the states to reduce calculated errors. Legislation—the DRA— has been passed to add 100 additional staff to support program integrity initiatives. How these FTEs will be utilized is still under discussion through a DRA workgroup of senior executives within CMS and DHHS.

Based on discussions certain concerns with the PERM program were raised. One stakeholder expressed a belief that, because the primary purpose of the PERM is to provide a tool for satisfying the requirements of the IPIA, and because of the methodologies being employed, the PERM may not be suitable for some other desirable program oversight purposes. For example, because the PERM will calculate an error rate for each state only every third year, the stakeholder believes it will be difficult for states to use PERM results to monitor the effectiveness of corrected actions. Further, the stakeholder believes the PERM is not designed to produce a national error rate that is comparable from year to year, a comparison that might be useful for CMS's oversight of Medicaid. More broadly the stakeholder believes that devoting state and Federal resources to the measurement of an error rate is likely to leave fewer resources available for addressing the underlying causes of the errors measured. However, other stakeholders indicated that the results from PERM would likely be used for some of the same purposes the previous stakeholder questioned.

When stakeholders were asked how the resulting measures would be used to improve Medicaid program integrity, most stakeholders indicated that trends could be developed to determine if progress was being made to reduce, prevent and detect improper payments. CMSO indicated that it would consider eventually using the error rate process to pursue with each state reimbursement for improper payments.

There will be a substantial investment of resources in developing error rate measures under PERM for compliance with IPIA. The ultimate focus of the program is still under development, as is the strategy to use the results of PERM on managing the program. Pending finalization of such plans and processes, the ultimate use of this information remains to be determined.

STATE OVERSIGHT AND SINGLE AUDIT PRIMARY TEST FOR ELIGIBILITY AND PROGRAM COMPLIANCE

Medicaid is a needs-based program that provides payment for certain medical services to low-income individuals and families. The costs and administration of the Medicaid program are shared by the Federal and state governments. Administration at the state level includes determining individuals' eligibility and benefit levels. Federal oversight responsibilities include monitoring states' performance using MEQCS. In determining eligibility, mistakes are sometimes made or inaccurate information provided, which results in overpayments of medical services provided to clients. Overpayments generally result when a (1) participating household or individual intentionally provides incorrect or insufficient information on which eligibility determinations are based, (2) participating household or individual unintentionally provides incorrect or insufficient information, or (3) state administering agency incorrectly determines eligibility or benefits or does not correctly act on client-reported information. Program administrators try to prevent overpayments by carefully determining an applicant's initial eligibility. However, errors are difficult to identify and when errors are made and identified, recovering overpayments is often very time consuming and difficult.

One of the primary tools in testing the states' quality control systems over determination of eligibility is the state's single audits. During FY 2005, 11 states received disclaimers or qualified reports by independent auditors on compliance with Medicaid program requirements, compliance findings in single auditors' reports requiring resolution, and various differences in processes, systems, and issues from state to state. The majority of these disclaimers or qualifications were a result of noncompliance with eligibility requirements.

We discussed with the stakeholders whether the CMS should expand its role in determining eligibility. Because responsibility for eligibility determination is statutorily assigned to the states, stakeholders generally believed that CMS' role should be in overseeing the implementation of quality control systems at the states to reduce errors in eligibility determination. Although CMS performs some follow up on findings identified in the single audits including comments related to eligibility determination, the majority of the stakeholders believed that more needed to be done. According to one stakeholder, there needs to be more funding directed to expanding the role of the Federal government when it comes to the oversight of the states regarding eligibility.

Our work suggests that further emphasis to follow up on single audit findings with a particular emphasis on eligibility is warranted. CMS noted efforts were underway subsequent to our fieldwork to resolve current outstanding A-133 audits and to ensure prompt and timely resolution of future audits.

RECOMMENDATIONS FOR EXECUTIVE ACTION

Recent initiatives to provide an additional 100 personnel focused on Medicaid financial management, and just enacted legislation, to add a further 100 personnel and additional financial resources focused on program integrity are significant steps that can dramatically enhance the role the Federal government plays in managing the Federal and state partnership for Medicaid.

Factors for CMS to consider as it develops its plans to deploy resources include placing additional focus on how such resources are deployed and utilized, efforts to provide transparency in how state plan amendments, waivers, and routine Federal oversight activities are conducted with visibility into outcomes across states to the extent practical, and/or potentially introducing financial management oversight through a CFO organization independent of program administration activities. To strengthen Medicaid internal controls and financial oversight processes that CMS has in place to ensure the effective processing of Medicaid activity, we recommend the following:

- Segregate, where practicable, the program activities associated with administering the Medicaid program from the financial management related aspects traditionally associated with the activities of CFOs. Because of the unique nature of the Medicaid program certain duties might continue to be within CMSO even though those duties are of a financial nature.
- To the extent possible, provide visibility into the program administration activities, including judgments regarding individual state operations, which can help ensure that decisions are made transparently and consistently across jurisdictions recognizing the unique nature of each local Medicaid program. Because routine judgments or interpretations may have long term funding consequences, a process to assess which decisions merit further visibility should be developed and implemented.
- Consider aligning the regional office personnel to headquarter program offices or consider developing a mechanism so that as priorities change a minimum number of FTEs are continuously focused on Medicaid financial administration and oversight activities. Such alignment change options range from fundamentally revisiting the regional structure to building on the existing annual region plans to designate particular personnel and provide for input regarding performance of the personnel assigned and resources devoted by program (CMSO) personnel.
- Continue to develop a process to monitor the responsibilities of the new 100 funding specialists and the results of their efforts. Additionally, consider reviewing periodically the distribution of the specialists to ensure proper allocation to locations that may need further emphasis to be responsive to risk. One input to this process may lie in the severity and nature of single audit findings.
- Continue to develop a comprehensive strategic plan through the work of the DRA workgroup in identifying the authority and responsibility and in the recruiting, training and placement of the new 100 FTEs that have been recently legislated within the DRA.
- Develop a strategy in enhancing internal control as it relates to assessing state quality control systems over eligibility determination, and following up on single audit issues.
- Continue to refine procedures to provide a mechanism for CMS central and regional offices to monitor states' activities, documenting the results, and enforce compliance and consistency with CMS financial management procedures.
- Continue to develop strategies in refining communication between the States, regional offices, and headquarters to ensure the various groups complement each other's efforts in

carrying out their authority in accomplishing the Medicaid Program goals. This is critical with limitations of available resources.

- Continue in the implementation of the PERM process to estimate improper payments for both the Medicaid and SCHIP- related payments. Additionally, develop a strategy on how the results of the PERM will be utilized in strengthening internal control and reducing improper payments.
- Continue to enhance its financial systems at the Federal and state level to ensure compliance with the Federal requirements.

AGENCY COMMENTS AND OUR EVALUATIONS

During August 2006, we received written comments from CMS on a draft of this report. The full text of CMS comments is located in Appendix B. In its written comments, CMS outlined a series of actions it has begun to take to address its Medicaid financial management challenges—many of which were implemented or in process of being implemented subsequent to our end of fieldwork for this report. These improvements included creation of the Medicaid Integrity Group (MIG) and the implementation of the Comprehensive Medicaid Integrity Plan, among others.

Additionally, CMS indicated they did not believe it was necessary to create another new and separate financial structure for Medicaid financial management activities, at a time when they continue to move forward rapidly on many unprecedented steps to strengthen Medicaid financial management. CMS further indicated that they believe that their limited resources should continue to be focused on improvements to the current oversight structure. Finally, CMS included certain technical comments that were considered and incorporated, as deemed appropriate, in the completion of this report.

Centers for Medicare & Medicaid Services Acronyms
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AQR	Audit Quality Review Program
CFO	Chief Financial Officer
COO	Chief Operating Officer
CMS	Centers for Medicare & Medicaid Services
CMSO	Centers for Medicaid and State Operations
DHHS	Department of Health and Human Services
DPM	Division of Payment Management
DRA	Deficit Reduction Act
FMAP	Federal Matching Assistance Percentage
FTE	Full-Time Equivalent
FY	Fiscal Year
GAO	Government Accountability Office
HCFAC	Health Care Fraud and Abuse
HIGLAS	Health Care Integrated General Ledger Accounting System
IPIA	Improper Payment Integrity Act of 2002
MAPS	Medicaid Alliance for Program Safeguards
MBES	Medicaid Budget and Expenditure System
MEQC	Medicaid Eligibility and Quality Control
MIP	Medicare Program Integrity
NIPT	National Non-Institutional Provider Team
NIRT	National Institutional Reimbursement Team
OACT	CMS Office of the Actuary
OFM	Office of Financial Management
OIG	Office of Inspector General
OMB	Office of Management and Budget
PERM	Payment Error Rate Measurement Program
RO	Regional Offices
SCHIP	State Children's Health Insurance Program
SPA	State Plan Amendments

**Centers for Medicare & Medicaid Services
Other Related Products**

- The Kaiser Commission on Medicaid and the Uninsured “Medicaid’s Federal-State Partnership: Alternatives for Improving Financial Integrity”, February 2004
- The Committee on Energy and Commerce Joe Barton, Chairman U.S. House of Representatives “Barton Seeks Medicaid Documents From Hospitals”, January 2005
- Ernst & Young’s Report on Internal Control, Report on Compliance with Laws and Regulations, December 1, 2004, and CMS’s response, November 19, 2004
- Ernst & Young’s FY 2005 Report on Internal Control, Report on Compliance with Laws and Regulations, October 28, 2005
- Letter from the Honorable Charles E. Grassley, Chairman, Committee on Finance, August 18, 2004, and CMS’s response, January 18, 2005
- Reducing Medicaid Fraud The Potential of the False Claims Act, June 2003
- The Kaiser Commission on Medicaid and the Uninsured “Upper Payment Limits: Reality and Illusion in Medicaid Financing”, February 2002
- Testimony of Dennis Smith, Director CMSO, Senate Subcommittee on Federal Financial Management, March 28, 2006

OIG Reports

- Adequacy of Washington State’s Medicaid Payments to Newport Community Hospital, Long-Term Care Unit (A-10-04-00001), March 2005
- Review of Colorado’s Accounts Receivable System for Medicaid Provider Overpayments (A-07-04-03049) July 2004
- Audit of Medicaid Family Care Administrative Costs Claimed for the Period October 1, 1999 through December 31, 2002 – Wisconsin Department of Health and Family Services Madison, Wisconsin (CIN A-05-03-00067), June 2004
- Testimony of Daniel R. Levinson, Inspector General, Senate Subcommittee on Federal Financial Management, March 28, 2006
- Review of Ohio’s Medicaid Disproportionate Share Hospital Payments (A-05-01-0058), June 2004

<p style="text-align: center;">Centers for Medicare & Medicaid Services Other Related Products</p>
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- Review of Alabama’s Medicaid Disproportionate Share Hospital Program (A-04-01-02006), June 2004
- Audit of California’s Medicaid Selective Provider Contracting Program, July 1, 1998 through June 30, 2002 (A-09-02-00082), May 2004
- Audit of Medicaid Provider Accounts Receivable Overpayments In Iowa (A-07-04-01002), March 2004
- Testimony of George M. Reeb, Assistant Inspector General for CMS, March 18, 2004
- Review of Medicaid Disproportionate Share Hospital Payment Limits for St. Vincent Charity Hospital and St. Luke’s Medical Center, Cleveland, Ohio (A-05-01-00087), March 2004
- Review of Medicaid Upper Payment Limit Requirements for Michigan (A-05-03-00065), January 2004
- Review of Federal Reimbursement for Health Care Coverage Under the State Children’s Health Insurance Program and Medicaid Program Wisconsin Department of Health and Family Services, Madison, Wisconsin (A-05-03-00092), October 2003
- Testimony of Michael F. Mangano, Principal Deputy Inspector General, June 13, 2002
- Medicaid Post Payment Safeguards (OEI-05-99-00072), July 2000
- Medicaid Claims Processing Safeguards (OEI-05-99-00071), July 2000
- Medicaid Proactive Safeguards (OEI-05-99-00070), July 2000

GAO Reports

- Head Start Comprehensive Approach to Identifying and Addressing Risks Could Help Prevent Grantee Financial Management Weaknesses (GAO-05-176), February 2005
- Medicaid Drug Rebate Program Inadequate Oversight Raises Concerns About Rebates Paid to States (GAO-05-102), February 2005
- High-Risk Series An Update (GAO-05-207), January 2005
- Medicaid Program Integrity State and Federal Efforts to Prevent and Detect Improper Payments (GAO-04-707), July 2004

**Centers for Medicare & Medicaid Services
Other Related Products**

- Medicaid Waivers DHHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns (GAO-04-480), June 2004
- Medicaid Intergovernmental Transfers Have Facilitated State Financing Schemes (GAO-04-574T), March 2004
- Federal Budget: Opportunities for Oversight and Improved Use of Taxpayer funds (GAO-03-1029T), July 16, 2003
- Medicaid and SCHIP: Recent DHHS Approvals of Demonstration Waiver Projects Raise Concerns (GAO-02-817), July 2002
- Medicaid Integrity: Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud and Abuse (GAO-06-578T), March 28, 2006
- Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed (GAO-02-706T), June 13, 2002
- Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed(GAO-02-300), February 2002
- Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes (GAO-02-147) October 2001
- Medicaid Improved Federal Oversight of State Financing Schemes Is Needed (GAO-04-228), February 2004
- SCHIP: DHHS Continues to Approve Waivers That Are Inconsistent with Program Goals (GAO-04-166R), January 2004
- Medicaid HCFA Reversed Its Position and Approved Additional State Financing Schemes (GAO-02-147), October 2001
- Medicaid State Efforts to Control Improper Payments Vary (GAO-01-662), June 2001
- Medicaid State Financing Schemes Again Drive Up Federal Payments (GAO/T-HEHS-00-193), September 2000
- Medicaid in Schools Improper Payments Demand Improvements in HCFA Oversight (GAO/HEHS/OSI-00-69), April 2000

**Centers for Medicare and Medicaid Services (CMS)
Chart of CMS' Findings and Corrective Actions
Appendix A**

Report Title, Number, Issuer	Significant Findings as Related to Medicaid Financial Management	Summary of Recommendations per Report	Corrective Action Taken or Planned by CMS
FY 2005 Report on Internal Control, Ernst & Young	The regional offices did not have the resources to conduct a thorough review of the budget and expenditure submissions from the states. In September 2000, CMSO issued financial review guides to assist the regional office analysts in examining budget and expenditure reports as well as to standardize the review procedures performed between analysts and regions.	Ernst & Young recommended that CMS continue to refine its procedures to provide a mechanism for CMS central and regional offices to monitor states' activities and enforce compliance with CMS financial management procedure by: 1. Providing specific guidance in the use and preparation of the Financial Review Guides to ensure that the regional offices consistently use the guide to document procedures performed during the quarterly expenditure and budgetary reviews and that any decision to expand or curtail the scope of the review or review procedures be documented; and 2. Developing a specific scope to be used to identify areas for review and that this scope, or any deviations from the scope, be documented within the trend analysis work paper(s) along with explanations.	1. CMSO will revise the regional office Review Guides for CMS-64, 37, 21, and 21b to include updated statutory and regulatory citations and to capture the steps that the regional offices should take in terms of their reviews of the aforementioned reports/forms. 2. The MBES/CBES systems will be programmed to require supervisory sign-off on regional office decisions, and 3. Upon completion of the regional office review guides, Central office staff will request copies of regional office work papers to perform 6 desk audits. Central office staff will travel to four of the regional offices to perform in-depth reviews.
FY 2005 Report on Internal Control, Ernst & Young	Insufficient Documentation/Lack of Grants Monitoring. During the review of single audits performed for recipients of Federal awards, untimely submission of audit reports and lack of evidence of follow-ups on audit findings were noted. Additionally, CMS does not sufficiently analyze or track resolution of findings at the States resulting from audits of internal controls in Medicaid and State Children's Health Insurance programs (SCHIP).	Ernst & Young recommended that DHHS and its Operating Divisions: 1. Coordinate with the Census Bureau, the centralized warehouse for Single Audit reports, to ensure the notification of the receipt of reports are received timely and information is accurate; 2. Develop or enhance procedures to ensure that DHHS grant recipients per the PMS system are reviewed/audited in accordance with A-133 and tracked in the current system available. PMS and the tracking systems should be reconciled based on common identifiers on an ongoing basis, and 3. Develop clear documentation to demonstrate follow-up on audit findings and disclaimers of opinion on Medicaid program compliance. Additionally, CMS does not sufficiently analyze or track resolution of findings at the States resulting from audits of internal controls in Medicaid and State Children's Health Insurance programs.	Corrective actions are currently being coordinated between the Office of Inspector General and the CMSO. Additionally, CMSO has hired 100 new funding specialists to work with the states to gain compliance with Medicaid requirements.

**Centers for Medicare and Medicaid Services (CMS)
Chart of CMS' Findings and Corrective Actions
Appendix A**

<p>Report Title, Number, Issuer</p> <p>FY 2005 Report on Internal Control, Ernst & Young</p>	<p>Significant Findings as Related to Medicaid Financial Management</p> <p>Ernst & Young found that although the methodology currently employed by CMS can produce a reasonable IBNR estimate for Medicaid, the process is highly dependent on information provided by the various states. Errors, inconsistencies and varying interpretations at the state level can occur and significantly affect the CMS IBNR liability. It should be noted that a 15-month time-lag exists from the date of the state IBNR information to the date of CMS' fiscal year-end calculation. Repeat Finding.</p>	<p>Summary of Recommendations per Report</p> <p>Ernst & Young recommended that CMS enlist OACT to help review the annual Medicaid IBNR calculation. Ernst & Young further recommended that formal analytical review procedures (i.e. documented and reviewed) be developed to prevent or detect clerical errors in the spread sheets and that CMS proactively obtain input from the states via the regional offices on trends, system changes, program changes, etc. associated with individual states. For SCHIP, Ernst & Young recommended that CMS identify a methodology for estimating an IBNR for SCHIP related expenditures.</p>	<p>Corrective Action Taken or Planned by CMS</p> <p>A workgroup consisting of CMSO, OACT, and OFM will meet periodically to discuss the progress in developing a methodology to collect the necessary data to estimate an IBNR amount from claims data maintained internally. To accomplish this objective, OACT and CMSO will work to:</p> <ol style="list-style-type: none"> 1. Create a medical statistical information system (MSIS) extract for three states for FY 2003 and FY 2004 containing data elements needed for analyzing claim lags. 2. Conduct exploratory analysis to determine feasibility of using MSIS data in evaluating state IBNR submissions. This will involve comparing estimates of IBNR at 9/30/02 with subsequent MSIS payments and developing claims lag factors from MSIS data and analyzing for reasonableness and consistency. 3. If exploratory analysis conducted in (2) is favorable, estimate resources needed to produce similar data and analysis for all states on an ongoing basis. 4. OACT will develop an implementation plan for ongoing use of MSIS in evaluating the state IBNR submissions. 5. OACT will review the data received from the Medicaid IBNR surveys for reasonableness, compare it to the MSIS extract described in (1) and make a determination as to the methodology for the calculation of the Medicaid IBNR estimate. 6. OACT will provide the final estimate for the Medicaid IBNR for inclusion into CMS' financial statements, and 7. CMSO/OFM/OACT will draft the policies and procedures for the calculation of the Medicaid IBNR.
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FY 2005 Report on Internal Control, Ernst & Young	CMS' financial management system (FMS) is not compliant with Federal Financial Management Improvement Act (FFMIA). Ernst & Young noted certain deficiencies with FMS that currently would not be considered a single integrated financial system such as the limited traceability between FMS, MBES, and FACS. Repeat Finding.	Ernst & Young recommended that CMS continue to enhance its financial systems to ensure compliance with FFMIA.	CMS is currently in the process of implementing a new integrated financial management system and updating its policies and procedures that may resolve CMS' system issues (i.e. MBES and integrated through HIGLAS by the end of FY 2006).
FY 2005 Report on Internal Control, Ernst & Young	CMS' FMS does not meet the criteria specified in the FFMIA. Specifically, CMS does not have an integrated financial management system, and CMS' FMS is unable to prepare financial statements and the Statement of Transactions as required. CMS' FMS does not provide the appropriate level of detail to support data analysis by the budget staff. Repeat Finding.	Ernst & Young recommended that CMS continue to enhance its financial systems to ensure compliance with FFMIA.	CMS is currently in the process of implementing a new integrated financial management system and updating its policies and procedures that may resolve CMS' system issues. (i.e., MBES and integrated through HIGLAS by the end of FY 2006).
FY 2005 Report on Internal Control, Ernst & Young	CMS is not fully compliant with the Improper Payment Information Act of 2002 (IPIA). Ernst & Young noted that the nationwide estimates of Health Programs' improper payments and rates were not reported in FY 2005. Repeat Finding.	Ernst & Young recommended that CMS continue to implement a process to estimate improper payments for both the Medicaid and SCHIP-related payments.	On October 5, 2005, an interim final rule was published in the Federal Register, which indicated that CMS will measure Medicaid and SCHIP managed care and eligibility error rates. The CMS expects to be fully compliant with IPIA by FY 2008. The CMS has established an eligibility workgroup to make recommendations on the best approach to conduct Medicaid and SCHIP eligibility reviews. The plan is to have recommendations from the workgroup in FY 2006 so that eligibility reviews can commence in FY 2007 for error rate reporting in FY 2008.
FY 2005 Report on Internal Control, Ernst & Young	There are inadequate formal written policies and procedures in place for access control. Additionally, certain weaknesses were identified during Ernst & Young's vulnerability and penetration testing. Repeat Finding.	Ernst & Young recommended that CMS update its policies and procedures.	CMS is currently in the process of implementing a new integrated financial management system and updating its policies and procedure that may resolve CMS' system issues.
FY 2005 Report on Internal Control, Ernst & Young	CMS lacks sufficient integration or reconciliation and tracking processes to ensure that obligation activity within the Payment Management System, which tracks draws for state grants, is consistent with obligation activity within CMS' general ledger.	Ernst & Young recommended that CMS work with Division of Payment Management (DPM) to reconcile the expenditures reported on the CMS 64 and the PMS 272.	The OIG is initiating a review of the obligations within DPM and differences that may exist with the operating division's financial systems. CMS is currently developing a corrective action plan to resolve this issue.

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<p>FY 2004 Report on Internal Control, Ernst & Young</p>	<p>Currently, the states use a CMS 64 to report accrued expenditures to CMS while the states submit a PMS 272 to report expenditures on a cash basis to the Payment Management System resulting in inconsistent expenditure activity within the two systems for the same grant.</p> <p>CMS does not have proper identification and resolution of financial reporting and management issues. As CMS Health Programs grow and consume additional resources, at the margin it can be anticipated that certain matters which might formerly be insignificant in relation to CMS and DHHS as a whole may loom larger.</p>	<p>Ernst & Young recommended that CMS develop a process for proper identification and resolution of financial reporting and management issues. As CMS Health Programs grow and consume additional resources, at the margin it can be anticipated that certain matters which might formerly be insignificant in relation to CMS and DHHS as a whole may loom larger.</p>	<p>CMS has implemented a policy of writing white papers on certain issues that may affect its financial statements.</p>
<ul style="list-style-type: none"> ● <i>Adequacy of Washington State's Medicaid Payments to Newport Community Hospital, Long-Term-Care Unit, (A-10-04-00007), OIG;</i> ● <i>Review of Alabama's Medicaid Disproportionate Share Hospital Payments (A-04-01-02006), OIG;</i> ● <i>Review of Ohio's Medicaid Disproportionate Share Hospital Payments, (A-05-01-00058), OIG;</i> ● <i>High Risk Series an Update, (GAO-05-207), GAO;</i> ● <i>Testimony of George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits to the House Committee on Energy and Commerce, March 18, 2004;</i> ● <i>Medicaid Intergovernmental Transfers Have Facilitated State Financing Schemes (GAO-04-574T), GAO</i> 	<p>There is no assurance that the Medicaid funds paid are actually used for the intended purposes. States have used varied financing schemes, sometimes involving intergovernmental transfers, or IGTs, to increase Federal Medicaid matching payments. Some states, for example, receive Federal matching funds on the basis of large Medicaid payments to certain providers, such as nursing homes operated by local governments, which exceed established Medicaid rates. The large payments are often temporary, since the states can require the local-government providers to return all or most of the money to the states. States can use these funds – which essentially make a round-trip from the states to providers and back to the states at their own discretion.</p>	<p>CMS must establish consistent, clear-cut guidelines about states' financing arrangements. There should be assurance that the funds paid are actually used for the intended purposes. There should be a clear trail of responsibility within the State as to who is accountable for proper expenditure of Medicaid funds. The State Medicaid agency must ensure that quality and timely healthcare services are being delivered to properly eligible beneficiaries.</p>	<p>The CMS will not approve new SPA proposals until states have fully explained how they finance their Medicaid programs and until such time that states have agreed to terminate any such financing schemes. The CMS is working with states to terminate such practices, which many states have agreed to stop as of the end of their 2005 state fiscal year. As of September 30, 2005, 26 states have terminated 62 such financing practices effective with the end of their state fiscal year 2005.</p>

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<ul style="list-style-type: none"> ● <i>Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments</i>, (GAO-04-707), GAO ● <i>Medicaid Improved Federal Oversight of State Financing Schemes Is Needed</i>, (GAO-04-228), GAO 	<p>CMS has a problem with Medicaid fraud and its limited oversight is insufficient to protect the integrity of the program.</p>	<p>The management oversight structure should be adequate to ensure that Medicaid funds are paid only for health care services and products that are appropriate and necessary.</p>	<p>CMS has hired 100 additional FTEs to support CMSO in the oversight of the state's budget and expenditure processes. Additionally, CMS has initiated its implementation of the new PERM process that is expected to calculate an improper payment rate for each state once every three years.</p>
<ul style="list-style-type: none"> ● <i>Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed</i> (GAO/AIMD 02-300), GAO 	<p>Better oversight of state claims for Federal reimbursement is needed.</p>	<p>Risk Assessment - GAO recommended that the CMS Administrator revise current risk assessment efforts in order to more effectively and efficiently target oversight resources towards areas most vulnerable to improper payments by:</p> <ul style="list-style-type: none"> ● collecting, summarizing, and incorporating profiles of state financial oversight activities, that include information on state prepayment edits, provider screening procedures, postpayment detection efforts, and payment accuracy studies; ● incorporating information from reviews of state initiatives to prevent Medicaid fraud and abuse; ● developing and instituting feedback mechanisms to make risk assessment a continuous process and to measure whether risks have changed as a result of corrective actions taken to address them; and ● completing efforts to develop an approach to payment accuracy reviews at the state and national levels. 	<p>CMS has hired 100 additional FTEs to support CMSO in the oversight of the state's budget and expenditure processes. Additionally, CMS has begun its implementation of the new PERM process that is expected to calculate an improper payment rate for each state.</p> <p>During FY 2002, CMS instituted a Financial Management work planning process. Under the process each regional office proposes an annual workplan describing specific activities which it will perform and be held accountable for throughout the fiscal year. Each regional office workplan is reviewed and approved through the Regional Administrator and the CMSO. The process incorporates a resource assessment effort and risk assessment and analysis. CMS indicated that the goal in establishing the FM workplan is to strengthen CMS' Medicaid financial oversight by establishing performance expectations, track related actions and their results, and improve communication among CMSO and the regions. Finally, through the DRA act, Medicaid will be hiring 100 additional FTE's to support program integrity initiatives.</p>
<ul style="list-style-type: none"> ● <i>Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed</i> (GAO/AIMD 02-300), GAO 	<p>Better oversight of state claims for Federal reimbursement is needed.</p>	<p>Financial Oversight Control Activities---GAO recommended that the CMS administrator restructure oversight control activities by</p> <ul style="list-style-type: none"> ● increasing in-depth oversight of areas of higher risk as identified from the risk assessment efforts and applying fewer resources to lower risk areas; ● incorporating advanced control techniques, such as data mining, data sharing, and 	<p>CMS has hired 100 additional FTEs to support CMSO in the oversight of the state's budget and expenditure processes. Training has been provided to ensure regional office personnel and the new FTE's understand CMSO policies.</p>

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<ul style="list-style-type: none"> • <i>Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed</i> (GAO/AIMD 02-300), GAO 	<p>Better oversight of state claims for Federal reimbursement is needed.</p>	<p>neural networking, where practical to detect potential improper payments; and</p> <ul style="list-style-type: none"> • using comprehensive Medicaid payment data that states must provide in the legislatively mandated national MSIS database. 	<p>CMS has hired 100 additional FTEs to support CMSO in the oversight of the state's budget and expenditure processes. Additionally, CMS has begun its implementation of the new PERM process that is expected to calculate an improper payment rate for each state.</p>
<ul style="list-style-type: none"> • <i>"Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed"</i> (GAO/AIMD 02-300), GAO 	<p>Better oversight of state claims for Federal reimbursement is needed.</p>	<p>Monitoring Performance--GAO recommended that the CMS Administrator develop mechanisms to routinely monitor, measure, and evaluate the quality and effectiveness of financial oversight, including audit resolution, by</p> <ul style="list-style-type: none"> • collecting, analyzing, and comparing trend information on the results of oversight control activities particularly deferral and disallowance determinations, focused financial reviews, and technical assistance; • using the information collected above to assess overall quality of financial management oversight; • identifying standard reporting formats that can be used consistently across regions for tracking open audit findings and reporting on the status of corrective actions; and • revising audit tracking reports to ensure that all audits with Medicaid related findings are identified and promptly reported to the regions for timely resolution. 	<p>During FY 2002, CMS instituted a Financial Management work planning process. Under the process each regional office proposes an annual workplan describing specific activities that it will perform and be held accountable for throughout the fiscal year. Each regional office workplan is reviewed and approved through the Regional Administrator and the CMSO. The process incorporates a resource assessment effort and risk assessment and analysis. CMS indicated that the goal in establishing the financial management workplan is to strengthen CMS' Medicaid financial oversight by establishing performance expectations, track related actions and their results, and improve communication among CMSO and the regions. Finally, through the DRA act, Medicaid will be hiring 100 additional FTEs to support program integrity initiatives.</p>

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		<ul style="list-style-type: none"> developing a written plan and strategy, that clearly defines and communicates the goals of Medicaid financial oversight and responsibilities for implementing and sustaining improvements. 	<p>indicated that the goal in establishing the financial management workplan is to strengthen CMS' Medicaid financial oversight by establishing performance expectations, track related actions and their results, and improve communication among CMSO and the regions. Finally, CMS has implemented a performance program whereby 20 top goals are developed for Medicaid and distributed in the performance plans of its executives down to the lower staff.</p>



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

AUG 24 2006

DATE:

TO: Daniel R. Levinson
Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

A handwritten signature in black ink, appearing to read "Mark McClellan", written over the printed name of the sender.

SUBJECT: The Office of Inspector General (OIG) Draft Report: "Centers for Medicare & Medicaid Services Medicaid Financial Management Oversight Activities" (OEI-06-04-00480)

Thank you for the opportunity to review and comment on the OIG draft report. The report reviewed the Centers for Medicare & Medicaid Services' (CMS) current financial management oversight of the Medicaid program. We highlight our overall comments about the report and also provide technical comments on specific items in the report.

The CMS has been strongly engaged in many new and expanded efforts to improve financial oversight over the last few years. These activities were highlighted in an extensive GAO Report, *MEDICAID FINANCIAL MANAGEMENT: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts* (GAO-06-705), that was released in June but not referenced in your report. Several of the recommendations for executive action noted in your report are already being addressed by CMS and are documented in the referenced GAO report. These specifically include the following:

1. Improved efforts to oversee State claims for Federal reimbursement;
2. Improved efforts to identify payment errors;
3. Enhanced ability to address high-risk State funding practices that increase Federal costs through the hiring of approximately 100 funding specialists and providing them with specific work plan goals
4. Creation of a new unit that centralized responsibility for approving State plan amendments (SPAs) related to reimbursement;
5. Continuation of identifying billions of dollars in questionable Federal reimbursement through focused financial reviews and OIG audits;
6. Created goals to reduce inappropriate Federal reimbursement;

7. Enhancing internal tracking processes related to results of its financial management activities;
8. Requiring accountability of financial managers;
9. Measuring payment errors under the Improper Payments Information Act.
10. Creation of the Medicaid Integrity Group and initial implementation of the Comprehensive Medicaid Integrity Plan.

Particularly in light of these steps, we do not believe that the report has shown any specific examples or actions where Medicaid program, financial, or oversight activities have been compromised because both the program and financial management activities are both located within the Center for Medicaid and State Operations (CMSO) and not in a separate organizational structure. While the report repeatedly states that this type of structure would provide increased visibility, transparency, and consistency, it does not provide any examples of areas where this is the case and what is meant by these terms, nor does it recognize all of the existing financial review and oversight of the program outside of CMS. In fact, in recent years, the Medicaid program has been one of the most thoroughly reviewed Federal programs, by the U.S. Government Accountability Office (GAO), OIG, CFO auditors, Congress, and outside interests. In addition, the Department of Health and Human Services and the Office of Management and Budget (OMB) review significant program and policy decisions on an ongoing basis, through a separate organizational structures. Such reviews and oversight have provided much more extensive national visibility and transparency to every significant program and financial decision than could be provided by adding another organizational layer within CMS.

Therefore, we do not believe it is necessary to create another entirely new and separate financial structure for Medicaid financial management activities, at a time when we continue to move forward rapidly on many unprecedented steps to strengthen Medicaid financial management. Instead, we believe our limited resources should continue to be focused on improvements to the current oversight structure as indicated above and documented in the GAO report.