United States Government Accountability Office

Report to Congressional Requesters

September 2023

MEDICAID PROGRAM INTEGRITY

Opportunities Exist for CMS to Strengthen Use of State Auditor Findings and Collaboration

GAO-23-105881

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GAO Highlights

Highlights of GAO-23-105881, a report to congressional requesters

Why GAO Did This Study

The size and growth of Medicaid present challenges for both the federal government and states, which share program oversight responsibilities. GAO has identified gaps in CMS's Medicaid oversight. GAO has also reported that CMS could use the work of state auditors, who are independent from their states' Medicaid programs, to help address those gaps.

GAO was asked to examine CMS and state auditor coordination. This report describes state auditors' Medicaid findings and the challenges they face auditing Medicaid. It also examines CMS's use of state auditors' findings and collaboration with auditors. GAO analyzed data on Medicaid single audit findings for fiscal years 2019 through 2021, which was the most recent data available. GAO also reviewed CMS documents and state auditor reports. In addition, GAO interviewed CMS officials and state auditors from seven selected states.

What GAO Recommends

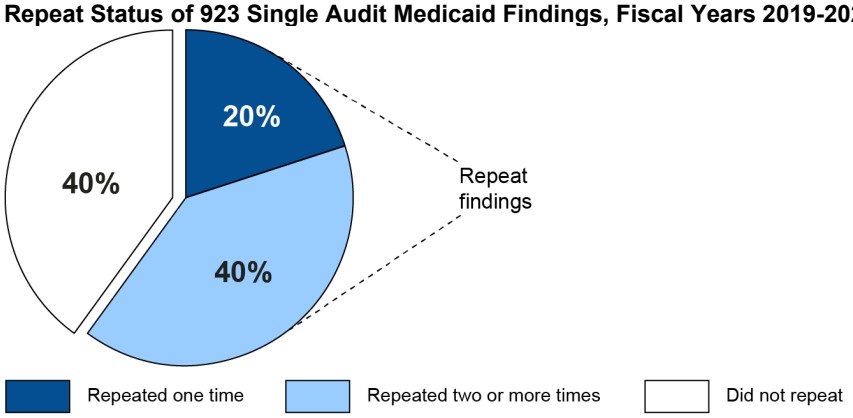
GAO is making two recommendations to CMS. CMS should (1) use analysis of trends in state auditor findings to inform its oversight; and (2) strengthen its collaboration with state auditors; for example, by sharing information on those trends and the status of actions to address audit findings, and continuing to identify Compliance Supplement updates. The agency said it believes it has already implemented the first recommendation and suggested removing it. GAO maintains that the recommendation is still valid because CMS has not yet used its analysis of trends to inform its oversight. The agency concurred with the second recommendation.

View GAO-23-105881. For more information, contact Michelle B. Rosenberg at (202) 512-7114 or rosenbergm@gao.gov.

What GAO Found

State auditors play an important role in Medicaid oversight, such as conducting states' annual single audits: audits required of entities that expend $750,000 or more in federal funding in a fiscal year. From fiscal years 2019 through 2021, state auditors identified an average of over 300 Medicaid audit findings a year, including overpayments for services provided to beneficiaries and payments to providers not enrolled in Medicaid. The Centers for Medicare & Medicaid Services (CMS) monitors states' progress toward resolving these findings. GAO found nearly 60 percent of Medicaid single audit findings were repeated from the prior year, indicating incomplete or ineffective corrective actions.

Repeat Status of 923 Single Audit Medicaid Findings, Fiscal Years 2019-2021



Source: GAO analysis of Federal Audit Clearinghouse data. | GAO-23-105881

State auditors faced challenges conducting Medicaid audits. For example, auditors from four selected states told GAO they faced resource challenges, such as a lack of training. Auditors from all selected states described challenges obtaining information from CMS or their state Medicaid agency necessary to conduct audits, such as information on program risks. CMS and other federal agencies have recently begun to address some of these challenges.

CMS has also used state auditor findings to inform some of its oversight activities, such as to identify states or topics for review. In January 2021, CMS started analyzing single audit findings to identify national trends. CMS also restarted efforts to collaborate with state auditors, which had paused due to the COVID-19 pandemic. Efforts include working together to identify updates to the Compliance Supplement, which serves as a guide for conducting the single audit.

These recent efforts are promising and consistent with CMS's pledge to collaborate with state auditors to improve Medicaid. However, CMS has an opportunity to strengthen these efforts. For example, CMS has not used its new analysis of national trends to inform its oversight, or shared results with state auditors. Enhanced collaboration with state auditors, such as continuing to work together each year to identify potential Compliance Supplement updates and sharing information on audit trends and CMS's activities to follow up on findings, could help target oversight to areas of greatest risk for noncompliance and improper payments, and fill gaps in program oversight.

Contents

Abbreviations

CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
OIG	Office of the Inspector General
NASACT	National Association of State Auditors, Comptrollers, and Treasurers
OMB	Office of Management and Budget
PERM	Payment Error Rate Measurement

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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September 21, 2023

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate

The Honorable James Comer
Chairman
Committee on Oversight and Accountability
House of Representatives

Medicaid—a joint, federal-state program that finances health care coverage for low-income and medically needy individuals—has grown substantially. In fiscal year 2022, Medicaid served an estimated 82 million beneficiaries at an estimated cost of $516 billion to the federal government. Medicaid's size and growth present challenges for both the federal government and states, which share responsibility for overseeing the program. For example, Medicaid improper payments—payments that should not have been made, that were made in incorrect amounts, or that have insufficient documentation—have generally grown in recent years and pose a significant threat to the integrity of the program.[1] In fiscal year 2022, Medicaid improper payments were estimated to total nearly $81 billion, representing over 15 percent of all Medicaid payments.[2] Due to these and other challenges, we have identified Medicaid as a high-risk program since 2003.

[1]An improper payment is statutorily defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. See 31 U.S.C. § 3351(4). Additionally, when an executive agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation, this payment must also be included in the improper payment estimate. 31 U.S.C. § 3352(c)(2).

[2]The estimated Medicaid improper payment rate decreased in fiscal year 2022. In fiscal year 2021, the improper payment rate was 21.7 percent. The Department of Health and Human Services (HHS) stated that the 2021 and 2022 rates reflect certain flexibilities afforded to states during the COVID-19 public health emergency, including postponed eligibility determinations and reduced provider enrollment requirements. See Department of Health and Human Services, *Agency Financial Report, Fiscal Year 2022* (Washington, D.C.: Nov. 14, 2022).

The partnership between states and the federal government is a central tenet of Medicaid, and both have responsibilities for safeguarding the program. State Medicaid agencies administer their own state Medicaid programs and have discretion to establish the parameters of their programs within broad federal guidelines, including determining eligibility, and enrolling individuals and providers. States also have the primary responsibility for ensuring the integrity of their Medicaid programs, such as preventing, identifying, and correcting improper payments. For its part, the Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), is responsible for overseeing the program and states' compliance with Medicaid requirements. CMS's oversight includes several activities aimed at strengthening the program's integrity, including estimating the extent of improper payments and reviewing states' Medicaid expenditures in areas that are at risk for improper payments or other program integrity issues.

State auditors—state entities independent of the Medicaid agency—also play an important role in Medicaid oversight. State auditors perform audits of their state's government operations or programs and produce audit reports and program evaluations, including audits of a state's Medicaid program. For example, state auditors may conduct or work with a contractor to conduct their state's single audits, which are audits that assess, among other things, whether the state has complied with requirements for use of federal funding for Medicaid and other state programs. Single audits are required annually by law when states and other entities expend $750,000 or more in a fiscal year in federal awards, and they are critical for helping ensure that federal funds are safeguarded and used effectively.[3] All states' Medicaid programs undergo a single audit. Additionally, some state auditors conduct standalone Medicaid audits. These standalone audits, which are distinct from single audits, may include performance reviews or examinations of payments made to Medicaid providers.

We have identified gaps in CMS's activities to oversee Medicaid, and we have reported that CMS could use the work of state auditors to help address those gaps. For example, in August 2018, we identified

[3]The Single Audit Act is codified at 31 U.S.C. §§ 7501-06, and implementing Office of Management and Budget (OMB) guidance is reprinted in 2 C.F.R. part 200, subpart F. Under these authorities, non-federal entities, such as states, that receive federal awards must undergo a single audit (or, in limited circumstances, a program-specific audit) of these awards annually (unless a specific exception applies) when their federal award expenditures meet or exceed $750,000. A "single audit" is an audit of the entity's financial statements and awards for the fiscal year. *See* 31 U.S.C. § 7502; 2 C.F.R. § 200.501 (2022).

weaknesses in federal oversight of Medicaid expenditures. Specifically, we reported that CMS did not effectively target its oversight of Medicaid expenditures to program areas or states of greatest risk for errors and that some expenditure analyses were not conducted consistently and took years to complete.[4]

Further, in March 2019, we reported that CMS may not have the information it needs to effectively address program risks and direct program integrity efforts. We also reported that CMS could use the work of state auditors as a source to identify program risks and address some gaps in oversight.[5] In addition, we have testified that state auditors are uniquely qualified to partner with CMS to improve Medicaid program integrity, and that CMS could improve Medicaid program integrity by providing state auditors with a substantive and ongoing role in auditing state Medicaid programs.[6]

You asked us to review ways CMS and state auditors could coordinate to improve Medicaid program integrity and address improper payments. This report

1. provides information on state auditors' Medicaid findings;
2. describes challenges state auditors have faced auditing Medicaid and federal actions to address them; and
3. examines CMS's use of state auditors' Medicaid findings and collaboration with auditors.

To provide information on state auditors' Medicaid findings, we analyzed data on Medicaid single audit findings and reviewed state auditor reports. We obtained data on single audit findings for all 50 states and the District of Columbia from the Federal Audit Clearinghouse—a repository of single audit reports and a database of information about their findings. Using data from the clearinghouse, we identified findings associated with the

[4]See GAO, *Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures,* GAO-18-564 (Washington, D.C.: Aug. 6, 2018). We made three recommendations to CMS, one of which was implemented by the agency as of January 2023.

[5]See GAO, *Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments*, GAO-19-277 (Washington, D.C.: Mar. 27, 2019). We made four recommendations to CMS, two of which were implemented by the agency as of January 2023.

[6]See GAO, *Medicaid: CMS Has Taken Steps to Address Program Risks but Further Actions Needed to Strengthen Program Integrity*, GAO-18-687T (Washington, D.C.: Aug. 21, 2018).

Medicaid program for fiscal years 2019 through 2021, the most recent years available at the start of our review.[7] We analyzed the data to describe Medicaid single audit findings nationally, including the total number of findings each fiscal year, the percentage of findings that the auditor identified as a repeat of a finding from the previous year (known as a repeat finding), and the percentage of findings for which the auditor identified questioned costs, which may indicate potentially improper payments.[8] We assessed the reliability of the Federal Audit Clearinghouse's single audit data, such as by examining the data for missing information and interviewing federal officials. We determined that the data were sufficiently reliable for the purposes of our analyses. (See app. I for more information about our analysis of Federal Audit Clearinghouse data.)

In addition, we reviewed the statewide single audit reports and any publicly available standalone Medicaid audits on state auditors' websites to provide additional information about state auditor Medicaid findings. We reviewed reports and audits from a non-generalizable sample of seven states: Kentucky, Nevada, North Carolina, Ohio, Pennsylvania,

[7]We considered findings to be Medicaid findings if they included the Catalog of Federal Domestic Assistance Number 93.778—the number assigned to the Medical Assistance federal award. In 2021, the Assistance Listings replaced the Catalog of Federal Domestic Assistance. A single audit finding can be associated with multiple federal awards. For example, a finding can be associated with Medicaid and another federal award program, such as the Temporary Assistance for Needy Families program.

[8]OMB's single audit guidance requires the auditor to (1) identify whether the reported audit finding was a repeat finding and (2) report known questioned costs when either known or likely questioned costs are greater than $25,000, among other things. See 2 C.F.R. § 200.516 (2022). A questioned cost is a program cost that the auditor questions because the cost (1) resulted from a violation or possible violation of a provision of a statute, regulation, contract, grant, cooperative agreement, or other agreement or document governing the use of federal funds; (2) where the cost, at the time of the audit, is not supported by adequate documentation; or (3) where the cost incurred appears unreasonable and does not reflect the actions a prudent person would take in the circumstances. See 2 C.F.R. § 200.1 (2022).

Wisconsin, and Wyoming.[9] We selected these states to achieve variation across a range of criteria, including Medicaid expenditures in fiscal year 2020, whether the state auditor's office conducted standalone Medicaid audits, and whether the single audit was conducted by the state auditors' office or through a contract with a private accounting firm.[10]

To describe challenges state auditors have faced auditing Medicaid and federal actions to address them, we collected information from selected states, national organizations, and federal agencies. Specifically, we interviewed officials or collected written responses from

- state auditors and accounting firms contracted to conduct their single audits (if applicable) from our seven selected states;
- national stakeholder organizations: the National Association of State Auditors, Comptrollers, and Treasurers (NASACT), the American Institute of Certified Public Accountants, and the National Association of Medicaid Directors; and
- federal agencies; specifically, CMS, HHS, and HHS's Office of the Inspector General (OIG).

To identify examples of the challenges these officials described, we reviewed single and standalone Medicaid audit reports issued by state auditors from the 50 states and the District of Columbia from fiscal or calendar year 2019 through October 2022. We also reviewed federal documents related to conducting single audits, including the Medicaid portion of the Office of Management and Budget's (OMB) single audit

[9]Single audits must be conducted by an independent auditor in accordance with generally accepted government auditing standards. 31 U.S.C. § 7502(c). We identified single audit reports for fiscal years 2019 through 2021 by reviewing state auditor websites and the Federal Audit Clearinghouse. We identified state auditors that published standalone Medicaid audits between fiscal or calendar year 2019 and October 2022 by reviewing the state auditor websites for all 50 states plus the District of Columbia, as identified by the National Association of State Auditors, Comptrollers, and Treasurers (NASACT). NASACT is an organization whose membership is comprised of officials who have been elected or appointed to the offices of state auditor, state comptroller, or state treasurer in the 50 states, the District of Columbia, and the U.S. territories. See National Association of State Auditors, Comptrollers, and Treasurers, "Online Directory," accessed June 12, 2023, https://www.nasact.org/AF_MemberDirectory.asp. Some state auditor websites are searchable by the fiscal year a report was published while others are searchable by the calendar year.

[10]We included two states in our sample that contract with a private accounting firm to conduct single audits. We used a NASACT report to determine whether a state's single audit was conducted by the state's audit agency or a private firm. See NASACT, *Auditing in the States: A Summary, 2021 Edition* (Lexington, KY.: 2021).

Compliance Supplement, and agendas from HHS, CMS, and state auditor meetings on the Compliance Supplement.[11]

To examine CMS's use of state auditors' Medicaid findings and collaboration with the auditors, we reviewed single audit guidance issued by OMB, HHS regulations, and CMS documents, including agency procedures for following up and using single audit findings and standalone audits. Further, we reviewed CMS data on Medicaid single audit findings and documentation of how it monitored states' progress toward addressing these findings for a non-generalizable sample of 15 single audit findings from our seven selected states. We selected these findings to ensure variation on a range of criteria, including finding topics, the presence of associated questioned costs, and whether the auditor identified the finding as a repeat from the prior audit year. We assessed CMS's oversight of these 15 single audit findings against OMB guidance and agency procedures.

Additionally, we interviewed officials from CMS, HHS, and HHS-OIG to learn about CMS efforts to use state auditor findings for Medicaid oversight and collaborate with state auditors. We also interviewed or obtained written responses from officials from NASACT, as well as state auditors, accounting firms that conduct single audits, and state Medicaid officials from our selected states to obtain perspectives on auditors' interactions with CMS. We assessed these efforts within the context of CMS's Comprehensive Medicaid Integrity Plan for fiscal years 2019 through 2023 and federal internal control standards—specifically, the internal control principle regarding how agencies should identify, analyze, and respond to risks.[12]

We conducted this performance audit from March 2022 to September 2023 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to

[11]OMB annually issues the Compliance Supplement to guide auditors on what program compliance requirements should be tested for programs audited as part of the single audit. Auditors who conduct single audits generally follow implementing guidance in OMB's annual Compliance Supplement and agency guidance specific to their programs to determine whether the award recipient has complied with federal statutes, regulations, and award terms that may have a direct and material effect on each of the recipient's major programs.

[12]See Centers for Medicare & Medicaid Services, Comprehensive Medicaid Integrity Plan for Fiscal years 2019 – 2023 (Baltimore, Md.: June 2018); and GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Single Audits and Medicaid

States' annual single audits help to ensure that federal funds are safeguarded and used effectively. Some state auditors conduct single audits themselves, and other state auditors work with accounting firms that conduct these audits on behalf of the state.[13] All states' Medicaid programs annually undergo single audits; the Medicaid portion of the Compliance Supplement guides the performance of the audits. OMB annually updates and issues the Compliance Supplement with input from federal agencies, such as CMS. According to OMB, the Compliance Supplement identifies existing compliance requirements that should be tested in a single audit, because they could have both a direct and material effect on a program, such as Medicaid.

CMS is responsible for annually informing OMB about which compliance requirements should be subject to audit and included in the Medicaid section of the Compliance Supplement, including any updates or changes from the prior year.[14] CMS works with OMB to ensure that the Compliance Supplement directs auditors to focus their tests on the Medicaid compliance requirements most likely to cause improper payments, fraud, waste, or abuse; or generate audit findings for which CMS would take sanctions.

The Compliance Supplement requires auditors to determine tests for compliance with Medicaid program requirements within specified areas. For example, under the 2023 Compliance Supplement, auditors must determine tests for six specified types of compliance requirements subject

[13]According to NASACT, 16 states contracted out at least a portion of their single audit to accounting firms as of July 2022.

[14]We previously reported that such annual updates are necessary for many reasons, including ensuring that program requirements are current and that audits test compliance with requirements that are most at risk for improper payments. See GAO, *COVID-19: Current and Future Federal Preparedness Requires Fixes to Improve Health Data and Address Improper Payments*, GAO-22-105397 (Washington, D.C.: Apr. 27, 2022).

to audit.[15] Within the scope of what is outlined in the Compliance Supplement, auditors have discretion for how they design the tests. Auditees, such as state Medicaid agencies, must submit completed single audit reporting packages to the Federal Audit Clearinghouse.

For Medicaid, single audit findings represent deficiencies in each state's Medicaid program. Pursuant to the Single Audit Act and implementing OMB guidance, state Medicaid agencies must take steps, including corrective actions, to resolve these findings. In addition, the Single Audit Act and implementing OMB guidance require CMS to provide technical assistance and advice to auditors and to follow up on findings to ensure that state Medicaid agencies take timely and appropriate corrective actions to address findings identified through the single audits.[16] CMS's single audit follow-up responsibilities include the following:

- Issuing management decisions about each audit finding, which must include CMS's decision on whether the agency agreed with the audit finding, and whether the state is to make any financial adjustments or take other action to resolve the finding, among other things. These decisions must be issued within 6 months of the single audit being accepted by the Federal Audit Clearinghouse.[17]
- Monitoring state Medicaid agencies' progress toward implementing corrective actions.[18]
- Tracking single audit trends over time to examine the effectiveness of CMS's follow-up processes and whether single audits are improving states' compliance with Medicaid program rules.[19]

[15]For Medicaid, the six applicable types of compliance requirements are (1) activities allowed or unallowed; (2) allowable costs/cost principles; (3) eligibility; (4) matching level of effort, earmarking; (5) reporting; and (6) special tests and provisions. Within the special tests and provisions area, auditors are required to conduct multiple tests that are specified in the Compliance Supplement. These special tests and provisions may change from year-to-year due to updates made to the Compliance Supplement.

[16]See 31 U.S.C. § 7502(f)(1); 2 C.F.R. § 200.513(a)(3), (c)(3) (2022). According to HHS officials, CMS is responsible for following up on most Medicaid single audit findings. Some Medicaid single audit findings are cross-cutting findings that apply to more than one HHS agency. Further, HHS officials stated that the department is responsible for following up on the internal control deficiency for cross-cutting findings and CMS officials told us that CMS is responsible for recovering any Medicaid funds associated with the finding.

[17]See 31 U.S.C. § 7502(f)(1); 2 C.F.R. §§ 200.513(c)(3)(i), 200.521(a), (d) (2022).

[18]See 31 U.S.C. § 7502(f)(1); 2 C.F.R. § 200.513(c)(3)(ii) (2022).

[19]See 31 U.S.C. § 7502(f)(1); 2 C.F.R. § 200.513(c)(3)(iv) (2022).

CMS conducts various activities to manage these single audit responsibilities, including designating staff to follow-up on Medicaid single audit findings, developing internal procedures, and tracking findings using data systems.

- **Designating staff.** CMS created its Audit and Review Branch, which, according to agency officials, is responsible for following up on most of the single audit findings assigned to CMS. The remaining findings are handled by other CMS staff with expertise in the area related to the Medicaid finding.
- **Developing procedures.** CMS developed procedures to promote standardization and compliance with OMB guidance. For example, CMS developed procedures for communicating management decisions to state officials through letters—referred to as management decision letters. CMS also developed procedures for completing report clearance documents to report, track, and monitor the status of unresolved findings and states' progress toward implementing corrective actions.
- **Tracking audit findings.** CMS uses data systems to track single audits, including CMS's Audit Management System. This system provides CMS with the ability to manage and oversee their responsibilities to single audits, as well as other Medicaid audits, such as audits performed by GAO and HHS-OIG. Further, this system allows CMS to track audit information, such as findings and corrective actions, generate notifications when follow-up tasks are due, and generate reports for tracking progress.

HHS and HHS-OIG also have a role in developing single audit policy and audit oversight. For example, HHS is responsible for setting department-wide audit resolution policies, and it has developed procedures and best practices for its staff carrying out single audit follow-up activities. In April 2022, we identified gaps in HHS single audit policies and recommended that HHS develop policies and procedures to better enable it to provide input to OMB to annually update the Compliance Supplement. We noted that these policies and procedures should include steps to proactively involve external stakeholders, such as state auditors, when drafting potential updates to the Compliance Supplement before submitting them to OMB.[20] HHS-OIG, an independent office within HHS established under the Inspector General Act to protect the integrity of agency programs and operations, provides assistance, such as data analysis, to auditors

[20]HHS agreed with our recommendation, and as of April 2023, had begun taking steps to address it. See GAO-22-105397.

conducting single audits and conducts quality control reviews of completed single audits, according to HHS-OIG officials.

Standalone Medicaid Audits

In addition to conducting single audits, some state auditors conduct standalone audits of Medicaid programs and providers. These audits are done at the request of their state legislatures or for other reasons, such as at the discretion of the state auditor. Standalone audits can include performance audits that examine topics such as beneficiary eligibility and payments to providers. Our review of state auditors' websites found that 30 states conducted standalone audits of their Medicaid programs from 2019 through October 2022. According to CMS officials, CMS is not required to follow up on standalone Medicaid audit findings. However, state Medicaid agencies may need to take actions in response to standalone audits. For example, according to North Carolina Medicaid officials, the state Medicaid agency must address findings from standalone audits conducted by the office of the state auditor.

CMS's Medicaid Program Integrity Activities

CMS conducts a range of activities to assess and protect the integrity of the Medicaid program and prevent the likelihood of improper payments, including estimating improper payments through the Payment Error Rate Measurement (PERM) program, overseeing states' Medicaid expenditures by conducting quarterly and annual reviews, reviewing states' compliance with beneficiary eligibility requirements, and monitoring states' compliance with provider screening and enrollment requirements. Our prior work has identified gaps in some of these activities, and CMS has implemented some of our recommended actions to strengthen Medicaid oversight. For example:

- **PERM.** CMS uses the PERM to estimate Medicaid improper payments to help identify the causes and extent of program risks, and to help identify strategies to address them.[21] In 2019, we found that medical reviews, which contribute to CMS's fee-for-service improper payment estimates, may not provide the robust state-specific information needed to identify causes of improper payments and

[21]To help comply with requirements in the Improper Payments Information Act of 2002, CMS developed its PERM Program to measure improper payments in Medicaid and the Children's Health Insurance Plan. See Pub. L. No. 107-300, 116 Stat. 2350. The Payment Integrity Information Act of 2019, Pub. L. No. 116-117, 134 Stat. 113 (2020), which is codified at 31 U.S.C. §§ 3351-3358, repealed the Improper Payments Information Act and enacted similar requirements for improper payment estimation. CMS computes the national Medicaid improper payment rate as the weighted average of states' improper payment rate estimates using three key components of the Medicaid program: fee-for-service, managed care, and beneficiary eligibility.

address program risks.[22] Further, in 2018, we reported that the managed care component of the error rate was incomplete, because it did not account for all program risks. CMS implemented our recommendation to mitigate program risks by increasing its investment of audit resources on managed care, and revising audit guidance.[23]

- **Annual financial management reviews.** Each year, CMS conducts financial management reviews to provide an in-depth look at state expenditures in areas where CMS believes federal dollars are at risk, and have the potential to help the agency identify large amounts of unallowable expenditures. We previously reported that these reviews have not always examined topics or states that reflect the areas of highest expenditures and recommended that CMS develop and implement time frames to ensure the timely completion of financial management reviews.[24]
- **Provider screening and enrollment.** Payments to providers not enrolled in Medicaid or not screened in accordance with program requirements are a significant driver of improper payments. In 2019, we found that some states had not implemented certain provider screening and enrollment requirements, and CMS's oversight of

[22]Medical reviews are reviews of provider-submitted documentation to determine if services were medically necessary and complied with coverage policies. These reviews are used for estimating improper payments in Medicare and Medicaid. For example, CMS estimates Medicaid fee-for-service improper payments, in part, by conducting medical reviews. See GAO-19-277. We made four recommendations to CMS, including that CMS assess and ensure the effectiveness of Medicare and Medicaid documentation requirements. CMS concurred with three of these recommendation and, as of January 2023, CMS had implemented two of them. Further, CMS officials told us that the agency has released state-specific PERM improper payment rates since December 2021. According to CMS documentation, the PERM program was not designed to produce the same level of precision at the state level as it does at the national level. In addition, state-specific improper payment rates cannot be compared between states due to variation in states' Medicaid programs and the resulting methodological differences in estimating PERM rates, among other reasons.

[23]See GAO, *Medicaid: CMS Should Take Steps to Mitigate Program Risks in Managed Care*, GAO-18-291 (Washington, D.C.: May 7, 2018). We concluded that the PERM does not account for key program integrity risks in Medicaid managed care; specifically, unidentified overpayments and unallowable costs. We recommended that CMS take steps to mitigate the program risks, such as by revising the error rate methodology or focusing additional audit resources on managed care.

[24]See GAO-18-564; and GAO, *Medicaid Program Integrity: Action Needed to Ensure CMS Completes Financial Management Reviews in a Timely Manner*, GAO-21-17 (Washington, D.C.: Oct. 14, 2020). These two reports included a total of four recommendations to improve oversight of Medicaid expenditures. As of March 2023, CMS had implemented one of these recommendations, and had taken steps toward implementing two others.

states did not provide comprehensive and timely information on states' compliance with requirements.[25] In recent PERM reviews, CMS has cited improvements in states' compliance with provider screening and enrollment requirements.

Medicaid Findings Often Repeated from Prior Year

State auditors identified over 900 Medicaid single audit findings for fiscal years 2019 through 2021, many of which had also been identified in the prior year. Single and standalone Medicaid audit findings from selected states fell into seven topic areas, including Medicaid information technology and beneficiary eligibility.

State Auditors Have Identified Over 300 Medicaid Findings Each Year since 2019; More than Half Were Repeat Findings

Single Audit Findings Categories

Single audit findings are classified into three categories based on the auditor's judgment of the finding's significance and pervasiveness, in accordance with generally accepted government auditing standards. A finding may be classified into multiple categories.

Noncompliance is a failure to comply with federal statutes, regulations, or other program requirements.

Material weakness involves a severe deficiency in internal controls with a reasonable possibility that noncompliance will not be prevented, detected, or corrected in a timely way.

Significant deficiency also involves deficiency in internal controls related to noncompliance; it is less severe than material weakness but important enough to merit attention.

Source: GAO summary of Federal Regulations and American Institute of Certified Public Accountants Professional Standards. | GAO-23-105881

Our analysis of single audit data found that, nationwide, state auditors identified 923 Medicaid findings through single audits for fiscal years 2019, 2020, and 2021—an average of more than 300 findings per year. That equates to an average of about six Medicaid findings per state each year, although the actual number of findings each year varied across states. In 2020, for example, Michigan's single audit had 24 Medicaid findings, while three states' audits (Arizona, Hawaii, and South Dakota) had no Medicaid findings.

Each finding indicates a deficiency in a state's program, which state auditors classify into one or more categories based on their evaluation of the finding's significance and pervasiveness.

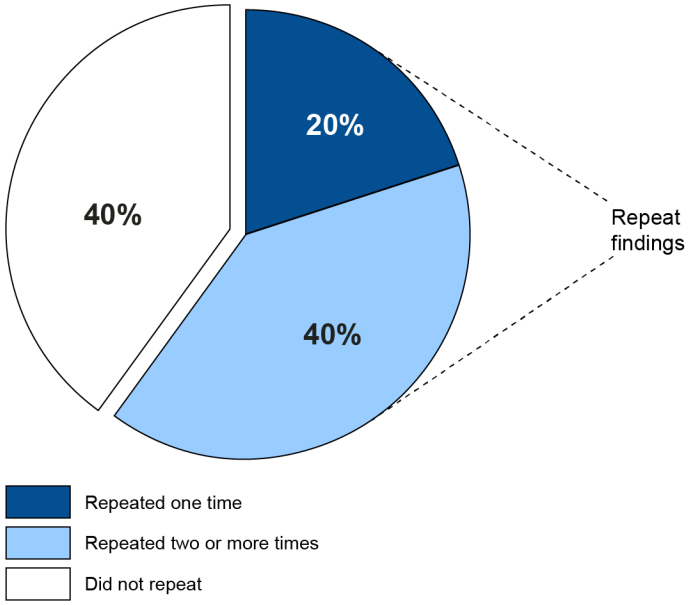
- State auditors determined that over two-thirds (69 percent) of Medicaid single audit findings from fiscal years 2019 through 2021 involved noncompliance with a law or other Medicaid program requirement. For example, Wisconsin state auditors classified a finding that providers received Medicaid payments for services after being terminated from the Medicaid program as noncompliance.
- State auditors determined that over one-third (36 percent) of Medicaid single audit findings from fiscal years 2019 through 2021 were material weaknesses, indicating a severe deficiency. For example, Ohio state auditors classified a finding as a material weakness when they found problems with the state's system for verifying income eligibility, and determined that these problems created an increased risk that ineligible people could receive Medicaid benefits.[26]

[25]See GAO, *Medicaid Providers: CMS Oversight Should Ensure State Implementation of Screening and Enrollment Requirements,* GAO-20-8 (Washington, D.C.: Oct. 10, 2019). As of April 2023, CMS had partially addressed one of the two recommendations in this report to improve oversight of states' implementation of the provider screening and enrollment requirements.

[26]The finding was also classified as a noncompliance.

In addition, 60 percent of Medicaid single audit findings from fiscal years 2019 through 2021 were repeat findings, indicating the state auditor determined they were the same or substantially similar to a finding from the previous year. Repeat findings could occur because a corrective action was not taken, was not completed, or was ineffective. About 20 percent of findings repeated once, while nearly 40 percent were repeated in two or more consecutive years.[27] (See fig. 1.) For example, auditors in North Carolina identified significant deficiency findings with questioned costs in fiscal years 2019, 2020, and 2021 resulting from medical coding or other documentation errors.

Figure 1: Repeat Status of 923 Single Audit Medicaid Findings, Fiscal Years 2019 through 2021



Source: GAO analysis of data from the Federal Audit Clearinghouse. | GAO-23-105881

Note: To determine the number of times each Medicaid finding from fiscal years 2019 through 2021 was marked as a repeat of a finding from the previous year, we analyzed single audit findings associated with the Medicaid program between fiscal years 2017 through 2021.

About 30 percent of Medicaid single audit findings included questioned costs, indicating a program cost was potentially improper. For example, in its fiscal year 2020 audit, auditors in Wisconsin questioned over $428,000

[27]To conduct this analysis, we analyzed single audit findings associated with the Medical Assistance program (Assistance Listing Number 93.778, previously referred to as a Catalog of Federal Domestic Assistance Number) between fiscal years 2017 through 2021 to determine the number of times each finding was marked as a repeat of a finding from the previous year.

in payments made with federal funds to providers who had been terminated from participation in the state's Medicaid program. Ohio's fiscal year 2019 audit included questioned costs of nearly $28,000 for payments made for services provided to individuals who were incorrectly determined to be eligible for the program.

Selected State Auditors' Findings Related to Medicaid Information Technology, Beneficiary Eligibility, and Other Topics

In fiscal years 2019 through 2021, single audits for our seven selected states produced 74 Medicaid findings—ranging from zero to eight findings per state. These findings fell into seven topic areas: information technology (19 findings), beneficiary eligibility (16 findings), improper payments (10 findings), managed care (10 findings), reporting (nine findings), provider screening and enrollment (four findings), and other (six findings).[28] Seventeen of the 74 findings from these states identified questioned costs, ranging from $40 due to errors in Medicaid billing and payment to $6.4 million made to a state-operated alcohol and drug abuse treatment center that was not eligible for the type of payment made. (See table 1.)

Table 1: Medicaid Single Audit Findings from Seven Selected States, Fiscal Years 2019 through 2021

Topic[a]	Number of findings	Finding example	Questioned costs
Information technology	19	Medicaid information technology systems, including those that processed claims, were not secure and produced inaccurate results, because of incomplete testing procedures, or they did not comply with federal and state regulations.	None
Beneficiary eligibility	16	State overpaid for services provided to individuals deemed eligible for Medicaid, but who were placed in an incorrect eligibility category or for whom the state did not have documentation to support the eligibility determination.	Nine findings identified questioned costs ranging from $290 to $1,122,338.
Improper payments	10	Providers continued to receive payments for services after they had been terminated from the Medicaid program.	Six findings identified questioned costs ranging from $40 to $6,429,812.
Managed care	10	Managed care organization audits of patient encounter and financial data were either not performed or were not posted on the state's website as required.	None
Reporting	9	The state Medicaid agency did not have adequate internal controls to ensure that Medicaid expenditure reports were accurate.	Two findings identified questioned costs ranging from $10,906 to less than $25,000.

[28]Some findings could be categorized under two topics. For example, a finding may fall into both the managed care and reporting topic. In these instances, we categorized the finding as a managed care finding. Similarly, we categorized any finding on beneficiary eligibility as a beneficiary eligibility finding.

Provider screening and enrollment	4	Errors found in provider screening records, such as no evidence that credentials were checked or no evidence that a background check was performed, as required by federal regulations to prohibit payments to ineligible providers.	None
Other	6	Insufficient control policies and procedures to monitor contractor performance to ensure completeness of drug rebate revenue received from drug manufacturers.	None

Source: GAO analysis of single audit reports. | GAO-23-105881

Note: Our selected states were Kentucky, Nevada, North Carolina, Ohio, Pennsylvania, Wisconsin, and Wyoming.

[a]Some findings could be categorized under two topics. For example, a finding may fall into both the managed care and reporting topic. In these instances, we categorized the finding as a managed care finding. Similarly, we categorized any finding on beneficiary eligibility as a beneficiary eligibility finding.

In addition to the single audits, state auditors in four of our selected states conducted standalone Medicaid audits from fiscal or calendar year 2019 through October 2022. These standalone Medicaid audits were either program audits, such as performance audits, or provider payment audits. Specifically, Nevada, North Carolina, and Ohio conducted standalone Medicaid program audits during this time period. Nevada conducted two such audits, Ohio conducted three, and North Carolina conducted four.[29] These standalone program audits included examinations of the state Medicaid program's performance on a range of topics, such as managed care, beneficiary eligibility, pharmacy services, and provider enrollment. For example, state auditors in Ohio conducted an audit examining payments made to managed care organizations and found deficiencies in system controls and data accuracy that contributed to about $118.5 million in improper payments over a 3-year period for incarcerated or deceased individuals, or individuals with multiple identification numbers.[30]

[29]State auditors in Nevada and North Carolina conducted standalone Medicaid performance audits, while state auditors in Ohio conducted what they refer to as public interest audits. Performance audits provide objective analysis, findings, and conclusions to assist management and those charged with governance and oversight to, among other things, improve program performance and operations, reduce costs, facilitate decision making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability. See GAO, *General Auditing Standards: 2018 Revision Technical Update April 2021 (Supersedes GAO-18-586G)*, GAO-21-368G (Washington, D.C.: Apr. 14, 2021). According to Ohio officials, public interest audits often accomplish the same underlying objectives as performance audits. However, these audits do not comply with all performance audit standards, which allows the auditor greater flexibility in, for example, determining the scope of the audit.

[30]See Ohio Auditor of State, Medicaid Contract Audit, *Ohio Department of Medicaid Improper Capitation Payments* (Columbus, Ohio: Dec. 28, 2021).

In addition to Medicaid program audits, state auditors from two of our selected states (Ohio and Pennsylvania)—conducted provider payment audits—audits of payments to individual Medicaid providers. These audits analyzed Medicaid claims to identify any improper payments that were made to the providers. State auditors in Ohio conducted 63 Medicaid provider audits, and Pennsylvania conducted 17 such audits. For example, state auditors in Pennsylvania identified $1,551 in improper payments made to a provider organization that serves adults with intellectual and developmental disabilities during a 1-year period.[31] (See table 2.)

Table 2: Standalone Medicaid Audits in Four Selected States

State	Number of audit reports issued	Topics covered
Nevada	• Two program audits	Services for persons with intellectual or developmental disabilities, and information security
North Carolina	• Four program audits	Provider enrollment, managed care contract oversight, managed care contract provisions, and managed care rate setting
Ohio	• Three program audits • 63 provider payment audits	Managed care payments, eligibility, pharmacy services and reimbursement under managed care, and provider payment reviews
Pennsylvania	• 17 provider payment audits	Provider payment reviews

Source: GAO summary of standalone Medicaid audit reports. | GAO-23-105881

Note: We identified state auditors' standalone Medicaid audits by reviewing states' websites for audits published from calendar or fiscal year 2019 through October 2022. Some state auditor websites are searchable by the fiscal year a report was published, while others are searchable by the calendar year.

CMS and Others Have Taken Steps to Address Some of the Challenges State Auditors Face

Auditors in all seven of our selected states, federal officials, and a stakeholder told us that state auditors face challenges, either with having sufficient resources—such as staff—or information to conduct Medicaid audits. CMS, HHS, and HHS-OIG have recently begun to address some of these challenges by taking steps to improve their collaboration with state auditors.

Resource challenges. Auditors from four of the selected states said they faced resource or capacity challenges when conducting Medicaid single audits. For example, auditors from four states told us they had trouble keeping up with Medicaid program changes due to challenges that included staff turnover and lack of training.

[31]See Commonwealth of Pennsylvania Department of the Auditor General, *Merakey Pennsylvania Costs reimbursed by the Pennsylvania Department of Human Services* (Harrisburg, Pa.: Oct. 8, 2020).

Federal officials and a stakeholder also described resource challenges state auditors have faced auditing Medicaid. For example, according to CMS officials, state auditors' offices have different structures and levels of resources, which can influence the types of audits they conduct and the areas of Medicaid they examine. State auditors in our selected states confirmed this variation. For example, the number of full-time state auditor staff who conduct Medicaid audits ranged from zero in one state to 30 in another. Furthermore, according to NASACT officials, state auditor staff generally have financial auditing expertise, but would benefit from training specific to Medicaid.

As a result of these challenges, state auditors from two of our selected states told us they relied on contractors to conduct their state's single audit. A third state auditor told us that they focused their resources on the single audit, and did not have the staff to conduct standalone Medicaid audits each year.

Information challenges. State auditors from all seven selected states said they had difficulty obtaining information necessary to conduct Medicaid single audits; namely, information specific to their state, nationwide Medicaid information, or both.

Auditors from six of the selected states told us they faced challenges obtaining information specific to their state's Medicaid program, with some auditors noting more than one challenge. For example:

- Auditors from three selected states expressed concerns that the data they receive from their state Medicaid agency or the agency's contractor were not sufficiently reliable to use in audits. For example, auditors from two of these states told us the eligibility data maintained by their state's Medicaid agency were unreliable for the purposes of the audit, and that working with the agency to obtain sufficiently reliable data that could be used for audits was difficult and time consuming.[32]
- Auditors from four selected states noted that the process of obtaining needed information or documentation from state Medicaid agencies can be difficult and slow. For example, three of these auditors noted challenges identifying and contacting Medicaid officials with relevant expertise due to turnover or fragmentation at state Medicaid agencies.

[32]We have reported on CMS's efforts to improve the quality and availability of Medicaid data as part of GAO's High Risk Series. See GAO, *High Risk Series: Efforts Made to Achieve Progress Need to be Maintained and Expanded to Fully Address all Areas,* GAO-23-106203 (Washington, D.C.: Apr. 20, 2023).

- Auditors in five of our selected states said they had difficulty obtaining data needed to conduct Medicaid audits. For example, an auditor from one state reported being unable to access data needed to conduct Medicaid audits from managed care organizations.[33] Another state auditor reported previously experiencing challenges accessing data from managed care organizations, but that the state Medicaid program's managed care contracts now include a provision providing the state auditor with access to data.[34]

Our review of state auditors' Medicaid audit reports also indicated that obtaining state-level information is a challenge. For example, a standalone Medicaid audit issued by the Iowa state auditor highlighted data challenges. In this instance, the auditor reported that the initial Medicaid data received were not usable for testing whether Medicaid payments to providers were allowable. Specifically, these data included duplicate claims and other irregularities. While the state Medicaid agency later provided usable data, the audit notes that the process of obtaining these data consumed nearly all resources the state auditor allotted for the review.[35]

HHS-OIG officials told us they have taken steps to help state auditors address data challenges. For example, in a recent training for state auditors, HHS-OIG encouraged state auditors to seek access to data through their state Medicaid agency, and then seek assistance from the Inspector General, as needed. Further, HHS-OIG has partnered with the state auditors to conduct audits and help them analyze data that is unavailable to them. For example, HHS-OIG partnered with the Massachusetts state auditor to access and analyze an alternate source of

[33]OMB's single audit guidance requires auditees to provide single auditors with access to supporting documentation and any other information the auditor needs to perform the single audit. See 2 C.F.R. § 200.508(d) (2022). This means that state Medicaid agencies must provide state auditors with access to any data managed care organizations provided to the Medicaid agency that is needed for the single audit.

[34]States may choose to include such a provision in their contracts with managed care organizations. For example, Ohio's managed care contracts include a provision requiring the plan to provide all data, documentation, information, and other records in the manner requested by the state auditor within 30 calendar days, unless an exception is granted by the Medicaid agency.

[35]See Office of Auditor of State, State of Iowa, *A Review Of Encounter Data from the Iowa Medicaid Enterprise within the Department Of Human Services for The Period April 1, 2016 through December 31, 2018* (Des Moines, Iowa: Jan. 9, 2020).

data on Medicaid hospice payments for individuals who were enrolled in both Medicare and Medicaid.[36]

Regarding challenges obtaining nationwide information needed for conducting Medicaid audits, auditors from all seven selected states told us they lacked information from CMS that could inform audit priorities and goals.

- Auditors from four states in our sample told us they lack information on program vulnerabilities and oversight issues across states, especially those that inform CMS's nationwide Medicaid priorities for single audits and other audits. The auditors told us this information would help them focus their single audits on areas of greatest risk. For example, one state auditor told us that proactive communication from CMS about audit trends across states would identify issues and areas of risk where the auditor may want to focus its audit priorities.
- Auditors from six selected states told us they lack clear or timely information on how to interpret the Compliance Supplement. For example, one state auditor noted the benefit of having more information on CMS expectations regarding the testing of certain Medicaid payments, such as hospital supplemental payments. Another auditor told us it is challenging to interpret recent updates to the Compliance Supplement.

Federal steps to share information with state auditors. To help address these issues or provide needed information, CMS, HHS, and HHS-OIG have taken recent steps to collaborate with state auditors, including re-initiating a working group to identify potential updates to the Compliance Supplement and partnering with NASACT to provide Medicaid training to state auditors.

- CMS officials told us that the Compliance Supplement Working Group was re-initiated in April 2022. The working group first began in 2019, but had been dormant since 2020 due to the COVID-19 pandemic. Working group participants include CMS, HHS, NASACT, and state auditors. According to NASACT officials, all states are welcome to participate in this working group, and according to CMS officials, auditors from eight or nine states have participated in this group. Since resuming in April 2022, the working group has been meeting approximately every month to discuss potential updates to the

[36]See Commonwealth of Massachusetts, Office of the State Auditor, *Office of Medicaid (MassHealth)—Payments for Hospice-Related Services for Dual-Eligible Members, For the period January 1, 2015 through July 31, 2019,* Audit No. 2020-1374-3M1 (Boston, Mass.: July 20, 2021).

Medicaid section of the Compliance Supplement and related issues, such as the timely resolution of single audit findings and challenges related to shared training between federal and state auditors. According to CMS officials, the group plans to continue meeting at least quarterly. Officials from NASACT and state auditors from two of our selected states told us the working group has been helpful, for example, for identifying potential updates to the Compliance Supplement and improving communication between auditors and CMS.[37]

- HHS-OIG partnered with NASACT to conduct a 3-day training for state auditors on Medicaid and auditing the program. This training was held in April 2023 and, according to NASACT officials, had over 300 participants representing 46 states. Topics discussed during this training included single audits, audit challenges regarding Medicaid managed care, Medicaid expenditure reporting, and Medicaid quality of care audits.

CMS Follows Up on Auditors' Medicaid Findings, but Has Not Yet Used or Shared Information on National Trends

CMS follows up on state auditors' Medicaid single audit findings, consistent with OMB guidance and agency procedures. CMS has also used state auditor findings to inform some of its oversight activities and has begun promising efforts to analyze single audit findings and to increase collaboration with state auditors. However, CMS has not yet used national audit trends to inform its oversight.

CMS Follows Up on State Auditors' Medicaid Single Audit Findings

CMS follows up on state auditors' Medicaid single audit findings—including by issuing management decision letters and monitoring states' progress addressing findings until they are resolved—consistent with OMB guidance and agency procedures.[38] Specifically, according to CMS documentation we reviewed and agency officials, during the time of our review, CMS reviewed single audit reports and states' corrective actions to resolve findings; tracked findings and states' progress toward implementing corrective actions; and consulted with state Medicaid agency officials and state auditors, as needed.

[37]CMS also reaches out to the American Institute of Certified Public Accountants to solicit input regarding annual changes to the Compliance Supplement from accounting firms that contract with states to conduct the single audit. Officials from the American Institute of Certified Public Accountants told us that CMS also briefs them on decisions made by the Compliance Supplement working group.

[38]Follow-up on standalone audit findings happens at the state-level, according to CMS officials.

CMS followed up on 807 Medicaid single audit findings for fiscal years 2019 through 2021, and generally issued management decision letters for findings within the required 6-month period, according to data from the agency.[39] Management decision letters include information on whether CMS agreed with the audit finding and actions the state needs to take to resolve the finding. Based on our review of CMS documentation for a sample of 15 Medicaid single audit findings from our selected states, we found that CMS issued management decision letters for all 15 findings and these letters generally were consistent with OMB guidance and CMS's procedures. For example, CMS issued management decision letters for 14 of our 15 findings within 6 months of the single audit being accepted by the Federal Audit Clearinghouse.[40] Further, all 15 letters stated whether CMS agreed with the findings and most included some information on state actions needed to resolve the findings, such as

- updating procedures and performance standards to improve the accuracy of a state's quarterly Medicaid expenditure reports, and providing copies of these documents to CMS;
- providing CMS with documents demonstrating steps taken to identify and recover payments made to providers that had been terminated from the state's program; and
- repaying federal funds, as appropriate, and making corresponding adjustments to the state's quarterly Medicaid expenditure report.

CMS also monitors states' progress toward implementing corrective actions to address single audit findings by completing documents known as report clearance documents each quarter. According to CMS guidance, CMS uses report clearance documents to report, track, and monitor the status of unresolved findings and states' progress toward implementing corrective actions to address them, including the repayment of the federal share of any questioned costs as appropriate. Among the 14 Medicaid findings from our sample that were unresolved at the time CMS issued the management decision letter, CMS completed quarterly report clearance documents for all findings until they were closed.

Throughout the follow-up process, CMS officials told us they consulted with state Medicaid officials and, when they determined it was necessary,

[39]The number of Medicaid single audit findings assigned to CMS differs from the total number of single audit findings reported to the Federal Audit Clearinghouse, because HHS, rather than CMS, handles follow-up for some Medicaid findings.

[40]For the letter that was not issued within the required 6-month period, CMS officials explained that the 2 month delay in issuing the letter was caused by the agency implementing new internal processes for issuing management decision letters.

with auditors to understand audit findings, corrective actions, and states' progress implementing corrective actions. Medicaid officials from all selected states and state auditors from some of these states confirmed that CMS followed up on single audit findings. Specifically:

- **State Medicaid officials.** Medicaid officials from our seven selected states confirmed that CMS officials contacted them at least quarterly or intermittently about their Medicaid single audit findings.
- **State auditors.** NASACT officials told us that CMS occasionally shared information with state auditors about follow-up on their single audit findings when the auditor raised a significant issue. Auditors from four of our selected states told us that CMS had not coordinated with them to follow up on their single audit findings. Auditors from the other three states told us that CMS had shared some information on audit follow-up with them, such as copies of management decision letters.

Among the 807 Medicaid findings that CMS followed-up on for fiscal years 2019 through 2021, 191 were associated with questioned costs, according to data from CMS. As of January 2023, CMS officials told us the agency recouped $52.6 million in federal funds associated with 70 of these findings.

CMS officials explained that the agency does not recoup questioned costs associated with all single audit findings. For example, one of the Medicaid findings in our sample estimated over $6 million in questioned costs for disproportionate share hospital payments to a facility that was not eligible for such payments.[41] The state corrected these payments by redistributing them, as appropriate, to eligible facilities. While the situation was corrected, the solution did not result in costs being recouped by CMS.

Further, CMS generally does not recoup funds associated with single audit findings on Medicaid beneficiary eligibility, because recoupments based on eligibility errors are authorized by law in limited

[41]Disproportionate share hospital payments are payments made to qualifying hospitals that serve a large number of Medicaid and uninsured individuals.

circumstances.[42] For example, CMS may disallow federal funds related to eligibility errors as part of the PERM process. In addition, CMS expects states to make adjustments to their quarterly Medicaid expenditure reports for eligibility-related improper payments identified under CMS's Medicaid Eligibility Quality Control program, which complements the PERM program by improving the accuracy of states' eligibility determinations.[43] According to CMS single audit documentation, outside of these circumstances, such as when responding to single audit findings, CMS will work with the state to address any internal control deficiency identified in the audit, but will not pursue recoupments associated with questioned costs.

CMS Considers State Auditor Findings to Inform Its Oversight, but Has Not Used National Trends

CMS officials told us that the agency considers single and standalone state audit findings, along with other sources, when identifying topics and states for targeted CMS oversight actions. These oversight actions include quarterly expenditure reviews, annual financial management reviews, and eligibility reviews.[44] CMS officials provided us with information on a few instances when state auditor findings resulted in additional reviews. First, the agency initiated a review of Louisiana's

[42]See 42 U.S.C. § 1396b(u); 42 C.F.R. Part 431, Subpart Q (2022). We previously reported that CMS officials recognize the benefits of using state and federal audits, such as single audits, as part of a broader strategy to improve program integrity and oversee states' eligibility determination processes. We also reported, however, that CMS officials told us they do not have the authority to recoup federal funds related to eligibility errors identified outside of the PERM process, such as through state single audits. Federal law enacted in 1982 requires CMS to reduce federal payments to a state Medicaid program if the program's error rate exceeds 3 percent. In enacting this requirement, Congress acknowledged that even with state good faith efforts to ensure full compliance, some payment errors will occur and provided for waiver of this reduction in limited circumstances. According to CMS officials, as a result, CMS lacks authority to recoup eligibility-related errors below this threshold. See GAO, *Medicaid Eligibility: Accuracy of Determinations and Efforts to Recoup Federal Funds Due to Errors,* GAO-20-157 (Washington, D.C.: Jan. 13, 2020).

[43]The Medicaid Eligibility Quality Control program is conducted by states during the 2 years between their PERM reviews. As part of the program, states are required to conduct a review of paid claims for services provided in the 3 months following the effective date of eligibility that was triggered by an erroneous determination. The payment review is undertaken to assess the financial implications of the eligibility determination error, and any federal share of identified overpayments are to be returned to CMS via an adjustment on state's expenditure report.

[44]CMS's activities to oversee Medicaid expenditures include conducting quarterly reviews of states' expenditure and conducting annual more in-depth financial management reviews that examine states' expenditures in areas where CMS believes federal dollars are at risk or have the potential to help the agency identify large amounts of unallowable expenditures. CMS examines states' compliance with beneficiary eligibility requirements through eligibility reviews.

eligibility determination processes based on the findings from two standalone audits published by the state auditor in 2018.[45] In addition, CMS officials told us that since 2019 the agency performed two financial management reviews of the state of Washington in response to single audit findings. One of these reviews examined expenditures for undocumented immigrants. The other review examined expenditures related to Washington's Community First Choice program, which provides long-term services and supports for certain medically needy individuals living outside of medical institutions. Using state auditor findings in these ways can help CMS target its reviews to states, services, or populations most at risk for improper payments or other program integrity issues.[46] Furthermore, it is consistent with CMS's Comprehensive Medicaid Program Integrity Plan and with CMS's internal guidance for identifying topics for its quarterly Medicaid expenditure reviews and annual financial management reviews.[47]

In addition, CMS officials told us the agency can use data it collects on Medicaid single audit findings to identify states or groups of states that may benefit from technical assistance. Agency officials provided a few examples of technical assistance CMS provided to officials in individual states. For example, CMS met with Alaska Medicaid officials in 2022 to discuss repeat single audit findings relating to the state's Medicaid claims for services provided to American Indians or Alaskan Natives.

CMS has also begun two additional efforts to use state auditor Medicaid findings. Specifically, it has employed a contractor to analyze single audit findings to identify national trends, and begun coordinating with HHS to develop single audit metrics.

[45]The Louisiana Legislative Auditor issued one audit that estimated the state made between $61.6 million and $85.5 million in overpayments for adults found to be ineligible for expanded Medicaid eligibility under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148), and a second audit that estimated the state improperly paid managed care organizations over $60,000 on behalf of five individuals ineligible for Medicaid. See Louisiana Legislative Auditor, *Medicaid Eligibility: Wage Verification Process of the Expansion Population* (Baton Rouge, La.: Nov. 8, 2018); and Louisiana Legislative Auditor, *Medicaid Eligibility: Modified Adjusted Gross Income Determination Process* (Baton Rouge, La.: Dec. 12, 2018). CMS reviewed these reports and concluded that estimated overpayments were likely inflated due to limitations in the audit methodology. See Centers for Medicare & Medicaid Services, *Louisiana Medicaid Eligibility Determinations for the Adult Expansion Population* (Baltimore, Md.: September 2020).

[46]See GAO-14-704G.

[47]See Centers for Medicare & Medicaid Services, *Comprehensive Medicaid Integrity Plan for Fiscal years 2019 – 2023* (Baltimore, Md.: June 2018).

- **Contract to analyze single audit findings.** According to CMS officials, in January 2021 a contractor started analyzing information that CMS tracks on Medicaid single audit findings. According to its statement of work, among other things, the contractor is responsible for reviewing audit findings to identify if they are highly concentrated in one policy area. As part of this process, CMS officials told us the contractor has produced monthly reports on single audit findings. Our review of one of these reports found that it includes information on the topic area for each finding, as well as whether a finding was a repeat finding or had questioned costs. According to CMS officials, these monthly reports have been helpful in providing information on repeat findings, topic areas that have the greatest number of findings, and underlying issues that lead to findings.
- **Single Audit Metrics.** CMS officials told us they are also coordinating with HHS regarding the development of department-wide single audit metrics. HHS officials told us they are considering 16 metrics to collect and track information on single audit trends, including whether audits were submitted on time and whether the awarding agency, such as CMS, issued management decision letters within the required 6-month window. As of May 2023, HHS has started collecting information and reporting on some of these metrics.

However, CMS is still determining how the agency will use these two efforts to inform its Medicaid oversight activities. CMS officials told us their contractor's analyses are the agency's first effort to analyze information on single audit findings to identify national trends. Further, these analyses are ongoing in order to continually monitor the status of findings and inform CMS of any trends or areas of high risk, and its contractor is still refining its analyses. While CMS officials told us they intend for the contractor's analyses to identify trends across single audit findings, the monthly report that CMS shared with us did not include such information, and CMS did not share any other results from the analyses that identified trends.

Agency officials told us that as of June 2023, CMS has not yet used these analyses of single audit findings to inform updates to the Compliance Supplement or other oversight activities, such as identifying Medicaid topic areas for further examination. According to CMS officials, while any trends resulting from state audits could be considered for quarterly Medicaid expenditure and annual financial management reviews, the agency is still determining how these analyses could be used for Medicaid oversight purposes in the future. Similarly, CMS officials told us that it will consider how it can use the information from HHS on single

audit metrics to improve its oversight of single audits, such as processes for following-up on single audit findings.

CMS has the opportunity to strengthen its Medicaid oversight activities by continuing to develop its analyses of Medicaid single audit findings and then using that information to inform its oversight.[48] For example, by continuing to analyze single audit findings to identify trends, including trends in repeat findings, CMS has the opportunity to focus its program integrity efforts to address identified issues and, thus, potentially reduce future repeat findings. In addition, by examining audit trends across states at least annually, CMS would be better positioned to identify best practices or approaches for addressing recurring and emerging audit trends. CMS could then work with state Medicaid agencies to efficiently resolve or prevent findings. For example, Medicaid officials from two of our selected states told us that obtaining information from CMS on national audit trends and best practices for addressing audit findings would be useful for addressing single audit findings.

Moreover, using information from an annual analysis of single audit trends to inform oversight could also help CMS address gaps in certain oversight activities. For example, we have previously identified limitations in the PERM program and challenges with CMS's efforts to identify state-specific information on the causes and extent of program risks, and to develop strategies to mitigate these risks.[49] Information on single audit trends could enable CMS to augment PERM results and provide CMS with additional insights on the prevalence and causes of improper payments.

Using information on single audit trends at least annually to inform and address gaps in oversight would be consistent with OMB guidance, which highlights the importance of tracking single audit trends in metrics over time. Further, it would be consistent with CMS's single audit procedures that state that CMS shall be aware of audit trends and make changes in response to deficiencies in operations or policies.[50] Federal agencies, like CMS, also have a general responsibility to identify and respond to risks

[48]Single audits are conducted each year.

[49]See GAO-19-277.

[50]See 2 C.F.R. § 200.513 (2022) and Centers for Medicare & Medicaid Services, *Single Audit Resolution Standard Operating Procedure,* Version Number: 1.0 (Baltimore, Md.: Feb. 12, 2022). Federal regulations cite two purposes for tracking single audit trends, both to examine the effectiveness of single audits in increasing states' compliance with program requirements, and to examine agency processes for following-up on audit findings.

that are related to achieving their programs' objectives, such as safeguarding Medicaid.[51] In addition, analyzing and using trends in single audit findings aligns with our prior finding that augmenting PERM results with information from other sources, including findings from state auditors, is one option to better ensure that corrective actions address program risks.[52]

CMS Efforts to Improve Collaboration are Ongoing

In its Comprehensive Medicaid Integrity Plan for fiscal years 2019 through 2023, CMS pledged to more closely collaborate with state auditors to improve fiscal accountability for Medicaid expenditures and to improve Medicaid program integrity. Our interviews with state auditors, NASACT, and CMS officials identified CMS efforts, including recent efforts, to collaborate with state auditors around single audits, including identifying updates for the Compliance Supplement, and providing technical assistance and trainings.

- **Identifying potential updates to the Compliance Supplement.** According to CMS officials, the agency had been working with state auditors since April 2022 to identify potential updates to the 2023 Compliance Supplement. Agendas for the Compliance Supplement Working Group meetings show that CMS has sought auditor feedback on a variety of Compliance Supplement topics, including proposed updates related to disproportionate share hospital payments, quarterly expenditure statements, and new audit tests. CMS has made changes to the Compliance Supplement based on these conversations. For example, CMS told us it made some updates to the Compliance Supplement related to overpayments under managed care contracts based on feedback from state auditors. Further, NASACT officials told us that this working group has been a forum for discussing auditors' concerns and identifying proposed updates to the Compliance Supplement, and has increased contact between CMS and the auditors.
- **Technical assistance.** CMS officials told us that they provide a CMS point of contact in the Compliance Supplement, encourage state auditors to come to them with questions throughout the audit cycle, and provide assistance to auditors in response to these questions. Agency officials told us that, on average, they receive about five inquiries per month from state auditors. CMS officials said the inquiries from states tend to be technical in nature, such as requests for clarification on a program requirement or on the Compliance

[51]See GAO-14-704G.

[52]See GAO-19-277.

Supplement. CMS officials also told us that in May 2023, state auditor officials from one state requested guidance on how to proceed with a single audit finding that the auditors identified repeatedly over several years, and believed that their Medicaid agency was not taking adequate actions to resolve. CMS officials met with these auditors to learn more about this issue, and indicated they will continue to coordinate with them.

- **Training.** CMS officials told us that the agency has provided training to state auditors. For example, agency officials told us CMS held a virtual training in November 2020 on a National Correct Coding Initiative special test and related auditing procedures that were added to the 2020 Compliance Supplement. CMS has also sought feedback on state auditors' training needs. Our review of agendas for some working group meetings between June 2022 and February 2023 showed that CMS obtained input from state auditors on topics for the NASACT training in April 2023, such as criteria and risks that can be used for determining Medicaid expenditure tests. The recent NASACT Medicaid training for state auditors included HHS-OIG presentations related to these topics.

While these efforts are consistent with CMS's pledge to collaborate with state auditors, continuing and expanding them would further strengthen Medicaid oversight. For example:

- The Compliance Supplement Working Group was active from 2019 until 2020 when CMS chose to pause the group due to the COVID-19 public health emergency, according to CMS officials. While this may have helped CMS focus its resources on responding to COVID-19, the pause in the working group affected state auditors who continued to have to conduct single state audits. For example, an auditor from one of our selected states expressed reluctance with participating in the reinitiated working group, because CMS's prior effort to collaborate on Compliance Supplement updates did not result in changes that reflected the auditors' feedback. Since it was reinitiated in April 2022, the working group has received positive responses from state auditors, and CMS plans on meeting with auditors at least quarterly. Continuing such collaborations to identify Compliance Supplement updates could improve single audit guidance.
- Since the Compliance Supplement Working Group meetings were reinitiated, CMS has obtained auditor feedback on topics for training. However, auditors from some selected states told us they faced challenges keeping up with Medicaid program changes, in part, due to a lack of training. Also, auditors from some selected states told us they lacked clear information on how to interpret the Compliance

Supplement, including sections that were recently updated. Continuing to have regular discussions between CMS and state auditors to address auditors' training needs could help ensure that auditors are effective in conducting reviews of their states' Medicaid programs.

- Auditors from all seven of our selected states told us that CMS had not shared information on single audit trends. Further, four of these auditors told us that nationwide information—such as audit trends, emerging issues, and areas of concerns—would help them conduct audits. For example, one state auditor told us that information on single audit trends and on the results from the PERM or other federal reviews would help them better focus their audit tests. Another state auditor told us that having information from CMS on audit objectives and key areas of risk in Medicaid would help them conduct their single audits. CMS officials told us they have considered sharing single audit data with state auditors; however, CMS's analysis is still under development. Once completed, sharing information about audit trends as part of its state auditor collaborations could help state auditors better conduct and design their annual Medicaid audits, and produce meaningful findings.
- Auditors from our selected states told us they had no or limited contact with CMS regarding CMS's actions in response to single audit findings. Specifically, auditors from three of our selected states told us they had no contact with CMS throughout the single audit process in the past 3 fiscal years, including any follow-up on findings. Auditors from the remaining four states told us they had limited insight into CMS's follow-up activities based on, for example, receiving copies of management decision letters. Further, NASACT officials told us that state auditors invest a significant amount of work and resources into conducting audits, and often make the same findings year after year. As a result, they said it is unclear to auditors if they are examining issues that are important to federal partners, including CMS. CMS officials told us that the agency was considering ways to make CMS's single audit follow-up more transparent, such as sharing management decision letters, and CMS was in the process of identifying what information would be helpful to state auditors. Increasing auditors' awareness of CMS's activities to follow up on single audit findings could help state auditors have a clear understanding of actions being taken to resolve findings, which is information that could be helpful given the frequency of repeat findings.

Continuing and expanding on collaborations between CMS and state auditors could also be beneficial for CMS. The agency could use

collaboration with state auditors, as well as meaningful findings from their audits, to help strengthen its program integrity efforts, including identification of ways to focus future CMS or state auditor reviews. Therefore, building on CMS's current efforts to collaborate with state auditors may provide CMS with the opportunity to better target areas of non-compliance with Medicaid program regulations and address the areas at greatest risk for fraud, waste, and abuse.

Conclusions

Medicaid's federal-state partnership means that both CMS and states, including state auditors, play an important role in ensuring the integrity of the program. State auditors are uniquely positioned to help CMS fill gaps in Medicaid oversight. In particular, these auditors' reviews of their states' Medicaid program—including their single audit findings—reveal deficiencies in key areas, such as states' compliance with beneficiary eligibility requirements, the accuracy of states' expenditure reports, and controls to prevent the likelihood of improper payments. While CMS follows up on Medicaid single audit findings to help ensure that deficiencies are corrected, nearly 60 percent of the Medicaid findings reported to the Federal Audit Clearinghouse were repeated from the previous year, indicating persistent problems.

CMS's efforts to begin analyzing single audit findings to identify national trends and improve collaborations with state auditors are promising, but these efforts are still in development. Continuing and strengthening CMS's current efforts would provide the agency with opportunities to improve Medicaid oversight and provide needed information and support to state auditors. Annually examining and using trends in state auditor findings would help CMS to identify and resolve deficiencies that could be important for individual states, as well as across the United States. In addition, continued and enhanced collaboration with state auditors—including working together to identify potential updates to the Compliance Supplement and training for state auditors, sharing information on national audit trends and program risks, and increasing auditors' awareness of CMS's single audit follow up activities—could help maximize the auditors' oversight of the Medicaid program. Further, such actions could help auditors better target their reviews to areas at risk for noncompliance with program regulations, as well as fraud, waste, and abuse. Ultimately, this could help to address gaps in some of CMS's program oversight activities and improve Medicaid program integrity.

Recommendations

We are making the following two recommendations to CMS:

The Administrator of CMS should annually examine state auditors' Medicaid findings to identify trends across states and use this information to inform oversight activities and audit processes. (Recommendation 1)

The Administrator of CMS should build on the agency's efforts to collaborate with state auditors on Medicaid oversight activities. These collaboration efforts should include continuing to identify potential updates to the Compliance Supplement, having regular discussions to address auditor training needs, annually sharing information on trends in audit findings and program risks, and increasing auditor awareness of actions taken to address single audit findings. (Recommendation 2)

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for review and comment. In its written comments, which are reproduced in appendix II, HHS suggested we remove one recommendation and concurred with our other recommendation. HHS also provided technical comments, which we incorporated as appropriate.

HHS stated that it appreciated the intent of our first recommendation to annually examine state auditors' Medicaid findings to identify trends across states and use this information to inform oversight activities and audit processes. However, HHS suggested that we remove this recommendation because it believes it had already implemented it through its contractor's analyses of single audit findings. As noted in the draft report, the contractor is still refining these analyses. In addition, CMS's monthly contractor report that we reviewed did not include an identification of national trends, and CMS did not share any other results from the contractor's analyses that identify trends across states, as we recommended. We revised the final report to clarify these points.

In addition, as we noted in our draft report, CMS is still determining how to use the contractor's analyses to inform Medicaid oversight activities. For example, CMS had not yet used the results of these analyses to inform Compliance Supplement updates or other oversight activities, such as identifying areas for further examination. As a result, the recommendation has not been fully implemented. As part of its comments, HHS reiterated its commitment to analyzing single state audit findings, identifying trends and key risk areas, and using them to inform Medicaid oversight. We are pleased that CMS is committed to this work and will monitor its actions to determine when it has fully implemented our recommendation.

HHS concurred with our second recommendation to build on the agency's efforts to collaborate with state auditors on Medicaid oversight activities. In its comments, HHS noted that it will share results from its contractor's analyses of single audit findings with state auditors when the analyses are complete and will explore ways to share information with state auditors about actions taken to address single audit findings.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, the Administrator of CMS, and other interested parties. In addition, the report is available at no charge on the GAO website at https://www.gao.gov.

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

Michelle B. Rosenberg
Director, Health Care

Appendix I: Analysis of Medicaid Single Audit Findings from the Federal Audit Clearinghouse

The Single Audit Act requires non-federal entities, including states and the District of Columbia, that receive federal awards to undergo a single audit (or, in limited circumstances, a program-specific audit) of those awards annually (unless a specific exception applies), when their federal award expenditures meet or exceed $750,000 in a fiscal year.[1] A single audit is an audit of an entity's financial statements and expenditures of federal awards that can identify the award recipient's deficiencies in (1) compliance with provisions of laws, regulations, contracts, or grant agreements; or (2) its financial management and internal control systems. All states' Medicaid programs have had a single audit.

The Census Bureau operates the Federal Audit Clearinghouse on behalf of the Office of Management and Budget (OMB).[2] The clearinghouse maintains a repository of completed single audit reports and a database of their findings, among other things.[3] Auditees annually submit single audit reporting packages to the clearinghouse, and such packages provide information on the nature of each audit finding, including the deficiency identified, the severity of the finding, whether the finding was repeated from the prior audit year, and any questioned costs, which may indicate potentially improper payments.

We obtained data from the clearinghouse for all 50 states and the District of Columbia for fiscal years 2019 through 2021, which was the most recently available data at the time of our review.[4] Using these data, we identified findings associated with the Medicaid program by identifying all findings that included the Medical Assistance program Catalog of Federal Domestic Assistance number (93.778) as an applicable federal award program.[5] We downloaded single audit data from the clearinghouse on December 1, 2022. As of this date, single state audit data from six states were missing from the clearinghouse for at least one year.

[1]31 U.S.C. § 7502; 2 C.F.R. § 200.501 (2022).

[2]OMB is responsible for developing government-wide single audit guidance. See 31 U.S.C. § 7505.

[3]The clearinghouse is available online. See Federal Audit Clearinghouse, Image Management System, accessed July 6, 2023, https://facdissem.census.gov/Main.aspx.

[4]Single audit data is identified by the fiscal year of each auditee.

[5]In 2021, the Assistance Listings replaced the Catalog of Federal Domestic Assistance.

A single audit finding can be associated with multiple federal awards; for example, a finding can be associated with Medicaid and other federal award program such as the Temporary Assistance for Needy Families program.

For those six states, we identified the missing findings and audit reports by downloading the applicable single state audit from the state auditor's website or by contacting the state auditor's office directly. Based on this information, we added a total of 15 missing findings to our dataset for the purpose of conducting further analysis of national single audit trends for Medicaid.

We analyzed the data to determine characteristics of Medicaid single audit findings in and across fiscal years 2019, 2020, and 2021, including

- the total number of findings each fiscal year for all 50 states and the District of Columbia, the total number for each state in each fiscal year, and the average number per state in each fiscal year;
- the number and percentage of findings that the auditor identified as a repeat finding from the previous year over the 3-year period, and the number and percentage of findings over the 3-year period that the auditor identified as a repeat finding in two or more consecutive single audits;[6]
- the number and percentage of findings for which the auditor identified questioned costs over the 3-year period; and
- the number and percentage of findings that were identified by the auditor as a material weakness, a significant deficiency, or a noncompliance over the 3-year period.

The results of our analysis reflect the data contained in the clearinghouse. We assessed the reliability of clearinghouse data by interviewing knowledgeable officials from OMB and the Department of Health and Human Services; spot checking a small number of selected findings to compare certain data elements, such as finding type in the clearinghouse to the corresponding data in the single audit reports; and examining the data for logical errors, missing values, and values outside of expected ranges. Our spot checks revealed a limited number of discrepancies between the information contained in the audit reports and the information in the clearinghouse. We did not examine the extent to which such discrepancies occurred across all records. Thus, we cannot generalize the error rate to the entire data set. Based on a comprehensive reliability test of the clearinghouse data, we determined that the data were sufficiently reliable for the purposes of analyzing these data to determine characteristics of Medicaid single audit findings.

[6]For the analysis of findings that repeated for 2 or more consecutive years, we analyzed single audit data for fiscal years 2017 through 2021. This analysis included findings that were in the Federal Audit Clearinghouse as of December 1, 2022.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

August 23, 2023

Michelle B. Rosenberg
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Rosenberg:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, **"MEDICAID PROGRAM INTEGRITY: Opportunities Exist for CMS to Strengthen Use of State Auditor Findings and Collaboration" (GAO-23-105881).**

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

Sincerely,

Melanie Anne Egorin

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID PROGRAM INTEGRITY: OPPORTUNITIES EXIST FOR CMS TO STRENGTHEN USE OF STATE AUDITOR FINDINGS AND COLLABORATION (GAO-23-105881)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report regarding HHS' coordination with state auditors.

The Medicaid program is a joint federal-state partnership, and states share oversight responsibility with the federal government. HHS has an extensive oversight program in place at the national level to detect and combat fraud, waste, and abuse in Medicaid. However, states have primary responsibility for ensuring the integrity of their Medicaid programs, and each conducts its own Medicaid oversight program. In addition to the state Medicaid agency's oversight work, each state has an independent state auditor, whose office conducts two types of audits related to Medicaid. First, the state auditor or its designated contractor conducts yearly "single audits," a term of art that describes federally required audits of entities that expend $750,000 or more in federal funding in a fiscal year. Second, the state auditor may conduct standalone Medicaid audits on other topics at the request of the state legislature or at the discretion of the state auditor.

HHS provides technical assistance and guidance to state auditors to assist with single audits, and regularly solicits their feedback. First, HHS maintains a Compliance Supplement which details program rules and requirements for each of the programs likely to be subject to single audits. In 2019, HHS began soliciting feedback on the Compliance Supplement from state auditors through the National Association of State Auditors, Comptrollers and Treasurers (NASACT). Since 2019, HHS has been convening a regular working group with state auditors as an open forum to discuss suggested changes or updates to the Compliance Supplement, and any other topics that the auditors would like to raise. HHS has relied on feedback from the auditors through comments received by NASACT for updates to the 2023 Compliance Supplement, and the current workgroup meeting discussions will inform the 2024 edition.

Second, state auditors regularly communicate with program staff when technical assistance is required for a single audit. State auditors have access to HHS staff who provide guidance on specific issues encountered during the audit or during audit planning.

When audits are complete, state auditors provide the audit and their findings to the Federal Audit Clearinghouse (FAC). Findings associated with HHS programs are assigned to HHS for review and follow-up. HHS is required by law to follow up on single audit findings. HHS uses the HHS Audit Tracking and Analysis System (ATAS) to track all single audit findings and assigns those related to CMS programs to CMS for further action. Within CMS, the findings are reviewed by the Office of Financial Management and assigned to the appropriate program within CMS for follow-up and resolution. The program office reviews the findings and issues a Management Decision Letter to the auditee, stating whether or not the audit findings are sustained, whether or not the corrective action plan (CAP) proposed to resolve the finding by the auditee is accepted, and the reasons for the decision. During this process, the appropriate office within HHS monitors the single audits for CAP implementation (either the Audit and Review Branch (ARB) for Medicaid recommendations, or the Center for Program Integrity, for Medicaid program integrity recommendations). HHS requires the states to provide CMS tangible evidence that policies and procedures have been implemented or improved. The appropriate program staff review these

documents provided by the states and determines if the documents provided are sufficient to close the finding. If needed, CMS requests additional evidence. Once CMS determines that the CAP is sufficient and fully implemented, the finding is closed.

HHS is not required to follow up on standalone audits, as these audit findings are directed at the state Medicaid agency for resolution. However, HHS conducts holistic risk assessments on topics of concern, and would consider standalone state auditor reports that are not single audits as part of these risk assessments. For example, HHS performs Medicaid program integrity reviews of states' oversight of high-risk areas. To determine the states and areas upon which to focus, HHS considers a variety of sources, including OIG/GAO reports, Payment Error Rate Measurement (PERM) improper payment rates, and past audits. State auditor reports, whether part of the single audit or not, are considered as one source of data for this purpose.

In addition to resolution of specific single audit findings, HHS may also take further action on issues raised by state auditors. For example, a financial management review (FMR) may be generated based on single audit findings. FMRs are targeted reviews examining a state's compliance with federal policies, and are performed on an annual basis. HHS may also target issues raised in single audits through increased scrutiny during quarterly reviews of states' reported Medicaid spending, as applicable, which may lead to states returning funds to the federal government or the state taking corrective actions, such as voluntary refund of Federal Financial Participation (FFP), or a change in processes.

HHS also recognizes the importance of state auditors' single state audit findings to monitoring trends in state Medicaid programs, which is an important part of our oversight work. To that end, HHS engaged a contractor in 2020 to analyze all single state audit findings to identify trends and key risk areas that can inform future updates to the Compliance Supplement and other CMS oversight work. This work is ongoing, and the results will be reviewed for future compliance oversight.

GAO's recommendations and HHS' responses are below.

GAO Recommendation 1
The Administrator of CMS should annually examine state auditors' Medicaid findings to identify trends across states and use this information to inform oversight activities and audit processes.

HHS Response
HHS appreciates the intent of this recommendation, and that GAO recognizes the importance of state auditors' Medicaid findings for oversight. HHS also believes that their work is a valuable part of Medicaid oversight, and, as described above, engaged a contractor prior to this audit to analyze single state audit findings to identify trends and key risk areas that can inform future updates to the Compliance Supplement and other CMS oversight work. Therefore, HHS continues to recommend that GAO remove this recommendation, because HHS believes it has already been implemented, and review of trends in findings will be an ongoing process.

GAO Recommendation 2
The Administrator of CMS should build on the agency's efforts to collaborate with state auditors on Medicaid oversight activities. These collaboration efforts should include continuing to identify potential updates to the Compliance Supplement, having regular discussions to address auditor training needs, annually sharing information on trends in audit findings and program risks, and increasing auditor awareness of actions taken to address single audit findings.

HHS Response

HHS concurs with this recommendation, and as stated above, HHS is already continuing to identify potential updates to the Compliance Supplement through the ongoing working group convened in 2019. These working group meetings include an open forum to discuss auditor training needs. In addition, as stated above, HHS has already engaged a contractor prior to this audit to analyze single state audit findings to identify trends and key risk areas. HHS will share these findings with state auditors when the analysis is completed. To increase auditor awareness of actions taken to address single audit findings, HHS will continue to explore the most efficient manner of sharing necessary information with the state auditors.

HHS thanks GAO for their efforts on this issue and looks forward to working with GAO on this and other issues in the future.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Michelle B. Rosenberg, (202) 512-7114 or rosenbergm@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Will Simerl (Assistant Director), Kristin Ekelund (Analyst-in-Charge), Drew Long, Sean Miskell, and Laura Tabellion make key contributions to this report. Also contributing were Francis Choi, Evan Eising, Minsoo Kim, Andrew Kurtzman, Ravi Sharma, Roxanna Sun, and Jennifer Whitworth.

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