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MEDICAID FINANCIAL MANAGEMENT

Better Oversight of State Claims for Federal Reimbursement Needed

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the results of our review of Medicaid financial management by the Centers for Medicare and Medicaid Services (CMS). My testimony today summarizes our report to the Subcommittee, published in February of this year,¹ which discusses the need to improve federal oversight of state Medicaid financial activities.

As you know, the federal government and the states share responsibility for the fiscal integrity and financial management of the jointly funded Medicaid program. In fiscal year 2000, the Medicaid program served about 33.4 million low-income families as well as certain elderly, blind, and disabled persons at a cost of \$119 billion to the federal government and \$88 billion to the states for program payments and administrative expenses.

States are the first line of defense in safeguarding Medicaid funds through their responsibilities for making proper payments to providers, recovering misspent funds, and accurately reporting costs for federal reimbursement. At the federal level, CMS is responsible for overseeing state financial activities and ensuring the propriety of expenditures reported by the states for federal reimbursement.

Audits of state Medicaid finances conducted annually in accordance with the Single Audit Act, as amended, have identified millions of dollars of questionable or unallowable costs incurred by state Medicaid agencies. In addition, annual financial statement audits required under the Chief Financial Officers Act of 1990, as expanded by the Government Management Reform Act of 1994, have identified many internal control weaknesses in CMS oversight of state Medicaid operations.

In light of these findings, you asked that we review the adequacy of CMS's financial oversight process for Medicaid. We assessed whether (1) CMS has an adequate oversight process to help ensure proper Medicaid expenditures, (2) CMS adequately evaluates and monitors its oversight process, making adjustments as necessary, and (3) the current CMS

¹U.S. General Accounting Office, *Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed*, [GAO-02-300](#) (Washington D.C.: Feb. 28, 2002).

organizational structure for financial management is conducive to directing its oversight process and sustaining future improvements.

To evaluate financial oversight and monitoring at CMS, along with the control activities used to help ensure the propriety of Medicaid expenditures, we performed work at CMS headquarters and regional offices, surveyed regional financial management staff and reviewed CMS manuals and other documentation and audit reports. To determine whether CMS's organizational structure for financial management is conducive to effectively directing its oversight process and sustaining future improvements, we interviewed directors, managers responsible for financial management at headquarters, and managers in five regions. We compared information we gathered about organizational structure, communications, and improvement initiatives with the Comptroller General's *Standards for Internal Control in the Federal Government*². We performed our work from October 2000 through September 2001 in accordance with generally accepted government auditing standards.

As discussed in our February 2002 report, we found that CMS has financial oversight weaknesses that leave the Medicaid program vulnerable to improper payments. The Comptroller General's *Standards for Internal Control in the Federal Government* requires that agency managers perform risk assessments, act to mitigate identified risks, and then monitor the effectiveness of those actions. In addition, the standards provide that agencies should ensure that the organizational structure is designed so that authority and responsibility for internal controls are clear. CMS oversight had weaknesses in each of these four areas, which I will discuss in turn.

CMS Had Not Implemented a Risk-Based Approach in Reviewing Expenditures

Our review found that CMS had only recently begun to assess areas at greatest risk for improper payments. As a result, controls were not in place that focused on the highest risk areas and resources had not yet been deployed to areas of greatest risk. The Comptroller General's *Standards for Internal Control in the Federal Government* requires that agency managers perform risk assessments and then act to mitigate identified risks that could impede achievement of agency objectives.

²U.S. General Accounting Office, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington D.C.: Nov. 1999).

Since 1998, financial auditors responsible for the annual financial statement audit of Medicaid expenditures have noted that CMS failed to institute an oversight process that effectively reduced the risk of inappropriate Medicaid claims and payments.³ Financial auditors identified internal control weaknesses that increased the risk of improper payments, including a significant reduction in the level of detailed analysis performed by regional financial analysts in reviewing state Medicaid expenses; minimal review of state Medicaid financial information systems; and lack of a methodology for estimating the range of Medicaid improper payments on a national level. The auditors recommended that CMS implement a risk-based approach for overseeing state internal control processes and reviewing Medicaid expenditures.

Regarding the auditor's findings and recommendations, CMS officials attributed most of the weaknesses in its oversight to reductions in staff at the same time Medicaid expenditures and oversight responsibilities increased. CMS data show a 32 percent drop in regional financial management staff from 95 full-time equivalent positions in FY 1992 to approximately 65 in FY 2000. At the same time, federal Medicaid expenditures increased 74 percent from \$69 billion to \$120 billion.⁴ On average, each of the 64 regional financial analysts is now responsible for reviewing almost \$1.9 billion in federal Medicaid expenditures each fiscal year as compared to an average of about \$0.7 billion a decade ago.

In light of these conditions, CMS managers acknowledged that they needed to revise their oversight approach and in April 2001, began to develop a risk-based approach for determining how best to deploy CMS resources in reviewing Medicaid expenditures.

This new assessment effort required each regional office to provide data on the states and territories in its jurisdiction based on regional analyst experience and knowledge. For each type of Medicaid service and administrative expense, the Medicaid risk analysis estimates the likelihood and significance of risk based on dollars expended annually and measures risk based on factors such as unclear payment policies; state payments involving county and local government; and federal audit results. The risk

³In some instances, these findings were included in the management letters that accompanied the audited financial statements for fiscal years 2000, 1999, and 1998.

⁴The \$120 billion in expenditures in 2000 is equal to \$97.8 billion in 1992 dollars when adjusted for inflation.

analysis provides a score for each state that is intended to specify the areas of greatest risk for improper payments.

Medicaid financial managers also tabulated a national risk score for each type of Medicaid service and administrative expense using the state risk scores. However, at the time of our review, CMS had not taken steps to use the risk analysis in deploying its regional financial oversight resources. Medicaid financial managers in headquarters and the regional offices plan to develop work plans that will allocate resources based on the risks identified from the analysis. CMS expects to implement these work plans in reviewing the state's quarterly expenditure reports for fiscal year 2003.

In evaluating the Medicaid risk analysis, we considered strategies that leading organizations used in successfully implementing risk management processes. Our executive guide, *Strategies to Manage Improper Payments*⁵ included two risk assessment strategies that are particularly applicable to CMS. These are that management should

- use information developed from risk assessments to form the basis from which it determines the nature of any corrective actions, and to provide baseline data for measuring progress in reducing payment inaccuracies and other errors; and
- reassess risks regularly to evaluate the effect of changing conditions, both internal and external, on program operations.

While the Medicaid risk analysis is a good start, we identified several improvements that should be made to the assessment before it is used to deploy resources. First, the analysis does not sufficiently take into account state financial oversight activities in assessing the risks for improper payments in each state. Several states have implemented techniques such as (1) prepayment edits and reviews to help prevent improper payments, (2) screening procedures to prevent dishonest providers from entering the Medicaid program, (3) postpayment reviews to detect inappropriate payments after the fact, and (4) payment accuracy studies to measure the extent of improper payments. CMS did not ask the regional financial analysts to consider whether states use these techniques, which have identified millions of dollars in overpayments. While regional financial

⁵U.S. General Accounting Office, *Strategies to Manage Improper Payments: Learning From Public and Private Sector Organizations*, [GAO-02-69G](#) (Washington D.C.: Oct. 1, 2001).

analysts may know about many activities like these through their oversight responsibilities, without collecting and documenting this information, CMS does not have a complete picture of the risk for improper payments in each state; nor will it have comprehensive information to determine the appropriate level of federal oversight that should be applied.

A second deficiency we found in the Medicaid risk analysis is that it did not specifically integrate information about state anti-fraud and -abuse efforts in assessing risks for each state. Regional financial analysts were instructed to consider the last time the regional office or HHS/OIG conducted a review or audit as one of the factors in determining the likelihood and significance of risk in each state. However, the analysts were not specifically instructed to consider results from reviews of state anti-fraud and -abuse efforts recently conducted by the CMS Medicaid Alliance for Program Safeguards, which has performed structured reviews in 16 states and plans to continue the reviews until all states are covered. CMS could gain valuable information for more accurately assessing the level of risk for improper payments in these 16 states as well as the appropriate level of federal oversight required.

Third, we found that the Medicaid risk analysis did not include mechanisms to ensure that such analysis would be an ongoing part of financial oversight. As identified risks are addressed and control activities are changed, agency managers should have methods in place to revisit their analysis to determine where risks have decreased and new ones have emerged. Medicaid financial managers had not determined how they would accomplish this.

Finally, the Medicaid risk analysis would be strengthened if states were systematically estimating the level of improper payments in their programs. CMS management has recognized this and has begun efforts to develop an approach for estimating improper Medicaid payments. In September 2001, nine states responded to a CMS solicitation to participate in pilot studies to develop payment accuracy measurement methodologies. The objective is to assess whether it is feasible to develop a single methodology for the diverse state Medicaid programs and to explore whether the range of improper Medicaid payments can be estimated nationally. Each of the nine states involved is developing a different measurement methodology. CMS managers expect the states to complete the pilots during fiscal year 2003, after which time CMS will select several of the state methodologies as test cases for fiscal year 2004. It is important that CMS continues to emphasize development of these payment accuracy reviews on a state-by-state basis and ultimately on a national level, since

this is a key baseline measure for managing improper payments in the Medicaid program.

Control Activities Were Not Effectively Implemented

Our review also found that while CMS had certain control activities in place to oversee Medicaid programs, it was not effectively implementing them, and therefore not mitigating identified risks. Control activities are an integral part of an organization's efforts to address risks that lead to fraud and abuse. Given the current level of resources and the size and complexity of the Medicaid program, CMS needs a different approach that incorporates new oversight techniques and strategies as well as the results of the risk assessment discussed previously.

In 1994, CMS began changing its oversight approach in an attempt to address resource challenges and growth in Medicaid expenditures. At that time, regional offices shifted from emphasizing detailed review of Medicaid expenditure data to increasing the level of technical assistance provided to states. Auditors of CMS financial statements found that as a result of this shift, regional offices were not providing appropriate review and oversight of state Medicaid programs, thus increasing the risk that errors and misappropriation could occur and go undetected. In our review, we found that the weaknesses identified by the auditors were still present.

In August 2001, we surveyed regional financial analysts to obtain their perspectives on the design and implementation of the Medicaid financial oversight process, covering the period from October 1, 1999, through the date of the survey. In comments to the survey, some regional analysts indicated that they were inundated with responsibility for multiple control activities and unable to perform them effectively. We asked the analysts to rate each of the control activities that they perform. The activity rated most important by 89 percent of those surveyed was quarterly expenditure reviews performed on-site at state Medicaid agencies. However, when asked about the adequacy with which they performed on-site expenditure reviews, almost 36 percent rated their performance "inadequate" or "marginal." In discussions, many financial analysts attributed deficiencies in expenditure reviews to inadequate staff resources, the low priority placed on financial management oversight, lack of training, and conflicting priorities.

Survey respondents also rated two other activities as important in overseeing the propriety of Medicaid activities—these were activities to (1) defer and disallow⁶ Medicaid expenditures and (2) perform focused financial management reviews. While more than 75 percent of analysts rated these activities as highly important, data provided by CMS indicate, however, that the amount of Medicaid expenditures disallowed by regional analysts has declined. For example, from 1990 to 1993, analysts disallowed on average \$239⁷ million in expenditures annually. However, for fiscal years 1997 through 2000, analysts disallowed on average \$43 million annually, which represents an 82 percent decline. During the same period, Medicaid expenditures went from an average of \$58 billion annually to \$106 billion annually—an increase of 83 percent.⁸

Similarly, focused financial management reviews declined. These reviews generally involve selecting a sample of paid claims related to certain types of Medicaid services provided. The reviews have been useful in identifying unallowable costs outside of those detected by reviewing quarterly expenditure reports. According to CMS managers, in fiscal year 1992, analysts performed about 90 in-depth reviews of specific Medicaid issues that identified approximately \$216 million in unallowable Medicaid costs. In fiscal year 2000, analysts only performed 8 focused financial management reviews but these 8 reviews resulted in almost \$45 million in disallowed costs—an average of about \$5.6 million per review. As demonstrated, this control activity is effective in detecting unallowable Medicaid costs; however, it must be consistently performed for cost savings to be realized.

CMS is taking actions to improve oversight by beginning a comprehensive assessment of its Medicaid oversight activities. However, agency managers are concerned that their ability to address identified risks effectively may be hindered without additional oversight resources. In the interim, CMS plans to use the current oversight process (i.e., quarterly expenditure

⁶A deferral is an action taken to withhold funds from the states until additional clarification or documentation is received from the states regarding Medicaid costs claimed. A disallowance is a determination by CMS that a claim or portion of a claim by a state for federal funds is unallowable.

⁷The calculation of this amount does not include \$1.15 billion in disallowances of Medicaid amounts for Disproportionate Share Hospital (DSH) claims in FY '92 that resulted from a change in the legislation related to DSH. Including this amount would increase the average disallowance to \$527 million for FY '90 – '93.

⁸Expenditure and disallowance data provided by CMS.

reviews and technical assistance) for targeting those Medicaid issues that the new risk analysis identifies.

In assessing what steps CMS could take to more efficiently and effectively carry out its responsibilities to help ensure the propriety of Medicaid finances, we considered strategies that other organizations have used in successfully addressing risks that lead to fraud, error, or improper payments. As discussed in our executive guide on *Strategies to Manage Improper Payments*, key strategies include

- selecting appropriate control activities based on an analysis of the specific risks facing the organization, taking into consideration the nature of the organization and the environment in which it operates.
- performing a cost-benefit analysis of potential control activities before implementation to ensure the cost of the activities is not greater than the benefit.
- contracting activities out to firms that specialize in specific areas like neural networking, where in-house expertise is not available.

Our executive guide points out that many organizations have implemented control techniques including data mining, data sharing, and neural networking to address identified risk areas and help ensure that program objectives are met.

- Data mining is a technique in which relationships among data are analyzed to discover new patterns, associations, or sequences. Using data mining software, the Illinois Department of Public Aid, in partnership with the Office of Inspector General at the Department of Health and Human Services, identified 232 hospital transfers that may have been miscoded as discharges, creating a potential overpayment of \$1.7 million.
- Data sharing allows entities to compare information from different sources to help ensure that Medicaid expenditures are appropriate. Last year we reported on a data sharing project called the Public Assistance Reporting Information System (PARIS) that has identified millions of dollars in costs savings for states.⁹ PARIS helps states share information on public assistance programs, in order to identify individuals who may be receiving benefits in more than one state simultaneously. Using the PARIS data match for the first time in 1997, Maryland identified numerous

⁹U.S. General Accounting Office, *Public Assistance: PARIS Project Can Help States Reduce Improper Benefit Payments*, [GAO-01-935](#) (Washington, D.C.: Sept. 6, 2001)

individuals who no longer lived in the state but for whom the state was continuing to pay a Medicaid managed care organization. The match identified \$7.3 million in savings for the Medicaid program.

- Neural networking is a technique used to extract and analyze data. A neural network is intended to simulate the way a brain processes information, learns, and remembers. This technique can help identify fraud schemes by analyzing utilization trends, patterns, and complex interrelationships in the data. In 1997, the Texas legislature mandated the use of neural networks in the Medicaid program. In fiscal year 2000, using neural networking, the Texas' Medicaid Fraud and Abuse Detection System recovered \$3.4 million.

These techniques, which have been shown to achieve significant savings by identifying and detecting improper payments, could help CMS better utilize its limited resources in applying effective oversight of Medicaid finances at the federal level.

Some state Medicaid agencies have already implemented data mining, data sharing, and neural networking techniques to help ensure Medicaid program integrity. State auditors and HHS/OIG staff have also had success using these techniques in overseeing state Medicaid programs. However, resources devoted to protecting Medicaid program integrity and the use of these techniques varies significantly state by state. When designing its Medicaid financial oversight control activities, CMS should take into consideration the use of data mining, data sharing, and neural networking as well as other control activities performed at the state level. In states where these techniques are not being used, CMS should consider using these tools in its oversight process.

Monitoring Activities Were Limited in Scope and Effectiveness

The Comptroller General's Standards for Internal Control in the Federal Government requires that agency managers implement monitoring activities to continuously assess the effectiveness of control activities put in place to address identified risks. Our review found that CMS had few mechanisms in place to continuously monitor the effectiveness of its oversight. Managers had not established performance standards for financial oversight activities, particularly their expenditure review activity. Limited data were collected to assess regional financial analyst performance in overseeing state Medicaid programs. Without effective monitoring, CMS did not have the information needed to help assure the propriety of Medicaid expenditures.

A CMS official told us that steps would be taken within the next year to begin monitoring the effectiveness of the Medicaid financial oversight process. Medicaid financial managers plan to reinstitute a performance reporting process that was in place prior to 1993. While this is a good step, the previous process lacked several elements necessary for effective internal control monitoring. For example, the performance reporting process did not establish agency-specific goals and measures for evaluating regional performance in reducing payment errors and inaccuracies. In addition, there were no formal criteria or standard estimation methodologies for regions to use in measuring the amount of unallowable costs that the states avoided because of technical assistance provided before payment. As discussed in our executive guide, *Strategies to Manage Improper Payments*, establishing such goals and measures is key to tracking the success of improvement initiatives.

In addition, the CMS audit resolution procedures did not collect sufficient information on the status of audit findings or ensure their timely resolution, as required by federal internal control standards. We found that audit resolution and monitoring activities performed by CMS and its regional offices were limited. Audit resolution activities were also inconsistently performed across the regions.

Within CMS, three units share responsibility for audit resolution activities related to the Medicaid program. In accordance with the HHS *Grants Administration Manual*,¹⁰ regional financial analysts are responsible for working with auditors to resolve findings, ensure questioned costs are recovered, verify that corrective actions have been taken, and document the status of audit resolution in quarterly reports. The Division of Audit Liaison (DAL) is responsible for maintaining a tracking system for each audit report and related findings, monitoring the timeliness and adequacy of audit resolution activities, distributing all audit clearance documents, and preparing monthly reports on the status of audit resolution and collection activities. The Division of Financial Management (DFM), the headquarters unit responsible for Medicaid financial management, has one headquarters staff person responsible for coordinating and interacting with DAL and regional analysts to ensure that Medicaid related findings

¹⁰The *Grants Administration Manual*, issued by HHS, provides guidance on implementing HHS policies on the administration of HHS grants. Chapter 1-105 of the manual addresses the resolution of audit findings.

are resolved. We found that many of these responsibilities were not being effectively carried out or were carried out inconsistently.

For instance, in discussions with regional financial analysts, we found that they spend very little time resolving state single audit findings due to competing oversight responsibilities. As a result, these findings are not always resolved, and related questioned costs are not promptly recovered. We found unrecovered questioned costs totaling \$24 million that were identified in audit reports that had been issued for years prior to fiscal year 1999. In addition, we found that as of September 30, 2001, regional analysts had not determined whether actions had been taken to resolve 85 Medicaid findings included in state single audit reports for fiscal year 1999. Lack of timely follow-up on financial management and internal control issues increases the risk that corrective actions may not have been taken, and that erroneous or improper payments are continuing to be made.

We also found that the regional financial analysts inconsistently followed procedures for monitoring, tracking, and reporting on the resolution of single audit and HHS/OIG audit findings. For example, 3 of the 10 regions had not prepared quarterly status reports that are intended to provide information on corrective actions that states have taken to resolve audit findings.

Further, pertinent information was not identified, documented, and distributed among those responsible for audit resolution. The internal control standard related to information and communication provides that pertinent information be identified, recorded, and distributed to the appropriate areas in sufficient detail, and at the appropriate time to enable the entity to carry out its duties and responsibilities efficiently and effectively. In our review, we found that the monthly DAL report intended to provide a complete list of all audits with unresolved Medicaid findings did not meet this standard. We analyzed a list provided by the HHS/OIG that included 23 Medicaid related reports issued by the HHS/OIG and state auditors in fiscal year 2001. We found four reports from the HHS/OIG list that were not included in DAL monthly reports related to the second, third, and fourth quarters of that year. This information is critical and must be distributed to the regions to ensure that they are acting to resolve all Medicaid related findings.

We also found that the regions did not document information critical to tracking unresolved audits in their regional quarterly status reports. The regions reported which audits had been resolved but not the status of those still under review. This makes it difficult to track audit status.

Organizational Structure Impedes Effective Oversight

The current organizational structure of CMS compounds the weaknesses I have highlighted today. This organizational structure has created challenges to effective oversight because of unclear lines of authority and responsibility between the regions and headquarters. Although the 10 regional offices are the CMS front line in overseeing state financial management and Medicaid expenditures, there are no reporting relationships to DFM, the headquarters unit responsible for Medicaid financial management.

For example, a working group headed by the director of DFM updated guidance for expenditure reviews in September 2000 in response to concerns raised by auditors about the inconsistency in expenditure reviews across regions. While the guide strongly encouraged regional analysts to perform all procedures, it did not mandate that they do so. Headquarters financial managers do not have direct authority to enforce such a directive and regional managers have discretion in how resources are utilized. Similarly, the guide allowed regional branch managers the discretion to review regional analyst's expenditure review workpapers for compliance with the guide or simply to obtain written or verbal assurance from the analyst that the procedures were performed. By allowing supervisors to satisfy their review responsibilities merely with verbal assurance, CMS minimized the effectiveness of this basic control. During our site reviews, we found evidence that supervisory reviews were not conducted.

The CMS organizational structure also hindered efforts to evaluate and monitor regional office performance. At the time of our review, there were few formal requirements for regions to report to headquarters and CMS did not collect, analyze, or evaluate consistent information on the quality of regional financial oversight for Medicaid across the country. Previous efforts to monitor performance were discontinued because regional staff resources were not available to collect and submit the data to headquarters managers. Headquarters managers, in turn, did not have the authority to require regions to collect such data. As a result, Medicaid financial managers in headquarters were not in a position to provide formal feedback to region financial management staff to improve their performance and therefore have not been in a position to assess the effectiveness of Medicaid oversight activities.

The current organizational structure also poses challenges to implementing corrective actions aimed at addressing oversight weaknesses and improving accountability. Over the past 2 years, headquarters financial managers have taken steps to develop and

implement improvements to the financial oversight process. Medicaid staff are currently

- developing risk analysis to identify expenditures of greatest risk;
- working with states to develop methodologies for estimating Medicaid improper payments;
- developing work plans that guide efforts to allocate financial oversight staff and travel resources based on the risk analysis; and
- developing performance-reporting mechanisms.

Medicaid staff have also recently

- formed a financial management strategy workgroup of headquarters and regional financial management staff to review the entire Medicaid financial oversight process and determine the proper structure for an adequate oversight process;
- updated its expenditure and budget review guides; and
- gathered information on how regional financial analyst staff time is allocated between oversight responsibilities.

Headquarters DFM managers recognize that regional office commitment is critical to successfully implementing and sustaining its improvement initiatives. The current structural relationship could diminish the chances of such success. Headquarters managers expressed concern that despite recent efforts to develop risk analysis and implement work plans that allocate resources based on identified risks, regional managers will still have the authority to decide how oversight resources are utilized. Given the multiple oversight activities that regional financial analysts are responsible for, headquarters managers have no assurance that review areas included in the work plans will be given priority in each region. Headquarters managers may experience similar difficulties in reestablishing performance reporting. According to one senior Medicaid manager, some regions have already petitioned headquarters managers not to use data on the amount of expenditures deferred and disallowed in gauging performance.

During our review, we asked regional financial analysts about several recent improvement initiatives to gauge their knowledge and participation in the initiatives. Several analysts we spoke with did not think the risk assessment effort was useful because they felt that they already knew the risks within the states that they were responsible for and did not need a formal assessment to tell them that. In our survey, we asked regional financial analysts to rate the importance of the risk assessment, staff time

allocation effort, and review guide updates to overall financial oversight. Approximately half of the survey respondents thought the initiatives were of marginal or little importance. During pretests of our survey, several analysts said they did not understand the purpose of the initiatives because no one had communicated to them how the information was going to be used.

In discussions with headquarters managers, they acknowledged that a written plan or strategy that describes the initiatives and the responsibility for implementing them was still being drafted. Such a plan or strategy could be very useful in soliciting regional analyst support. More importantly, headquarters managers acknowledged that performance accountability mechanisms for the regions are needed to implement improvements successfully. CMS is currently planning some changes that may improve mechanisms to hold CMS financial managers, including regional managers and administrators, accountable for critical tasks. CMS has developed a restructuring and management plan that seeks to add specific responsibilities tied to agency goals into senior managers' performance agreements. CMS has not determined how Medicaid financial management oversight responsibilities that can be evaluated will be included in the plan. This information is key to establishing a sound internal control environment for Medicaid finances throughout CMS.

As you can see, this structural relationship has created challenges in (1) establishing and enforcing minimum standards for performing financial oversight activities, (2) routinely evaluating the regional office oversight, and (3) implementing efforts to improve financial oversight. As a result, CMS lacks a consistent approach to monitor and improve performance among the units that share responsibility for financial management and ingrain a sound internal control environment for Medicaid finances throughout CMS.

In closing, Mr. Chairman, I want to emphasize that while CMS is acting to improve its financial oversight of the Medicaid program, the increasing size and complexity of the program, coupled with diminishing oversight resources, requires a new approach to address these challenges. Developing baseline information on Medicaid issues at greatest risk for improper payments and measuring improvements in program management against that baseline is key to achieving effective financial oversight. Determining the level of state activities in place to monitor and control Medicaid finances is also critical to determining the extent and type of control techniques as well as the amount of resources CMS must apply at

the federal level to oversee the program adequately. Establishing clear lines of authority and performance standards for CMS oversight would also provide for a more efficient, effective, and accountable Medicaid program. Our report includes recommendations in each of these areas. CMS's ability to make the kind of changes that we are recommending will require top-level management commitment, a comprehensive financial oversight strategy that is clearly communicated to all those responsible for program oversight, and clear expectations for implementation of the changes.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the subcommittee may have.

Contact and Acknowledgments

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