DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY - 2 2006

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

FROM: Daniel R. Levinson
Inspector General

SUBJECT: Resolution of Audit Findings on States' Beneficiary Eligibility Determinations for Medicaid and the State Children's Health Insurance Program (A-07-06-03073)

Attached is a copy of our final report on the Centers for Medicare & Medicaid Services (CMS) resolution of Office of Management and Budget (OMB) Circular A-133 audit findings on States' beneficiary eligibility determinations for Medicaid and the State Children's Health Insurance Program (SCHIP).

OMB Circular A-133 states that each Federal awarding agency is responsible for issuing a management decision on audit findings that relate to its Federal awards. A management decision is the evaluation of the audit findings and the proposed corrective action plan and the issuance of a written decision on what corrective action is necessary. CMS is the Federal awarding agency for grants under Medicaid and SCHIP. According to the Department of Health and Human Services (HHS) "Grants Administration Manual," section 1-105-30(B)(1), action officials must resolve audit findings within 6 months of the end of the month of issuance or release of the audit report by the HHS Office of Inspector General.

Our objective was to determine, as of November 1, 2005, whether CMS had resolved OMB Circular A-133 audit findings for fiscal years (FYs) 2002 through 2004 on States' Medicaid and SCHIP beneficiary eligibility determinations.

CMS had not resolved all Circular A-133 audit findings on States' Medicaid and SCHIP beneficiary eligibility determinations. As of November 1, 2005, CMS had not resolved eligibility findings in 11 of the 22 FY 2002 audit reports submitted for resolution or in 25 of the 28 FY 2003 audit reports. Furthermore, CMS had not resolved the eligibility findings in the 25 FY 2004 audit reports.[1] Based on the prior years' results, we are concerned that CMS will not resolve eligibility findings in the FY 2004 audit reports in a timely manner.

The Medicaid and SCHIP eligibility findings were so significant, i.e., material, that they caused some auditors to issue Circular A-133 reports with qualified opinions for six States for both

[1] As of the end of our fieldwork (November 1, 2005), the 6-month timeframe for resolving Circular A-133 audit findings had not expired for the FY 2004 audits.

FYs 2002 and 2003 and for seven States for FY 2004. In addition, auditors disclaimed their opinions on Medicaid eligibility for Georgia's FYs 2003 and 2004 reports and for Washington's FY 2004 report.

CMS had not resolved all audit findings because it did not follow departmental policies and procedures. As a result, CMS did not have reasonable assurance that States had corrected deficiencies in determining Medicaid and SCHIP beneficiary eligibility.

We recommend that CMS (1) resolve the backlog of unresolved A-133 audit findings and (2) resolve A-133 audit findings on Medicaid and SCHIP beneficiary eligibility determinations within 6 months of receiving the audit reports, as required by departmental policies and procedures.

CMS agreed with our recommendations but stated that "the overall tone of the findings . . . misrepresents the actions taken, the degree of responsiveness, and the level of commitment by CMS in resolving A-133 audit findings." CMS stated that we had not provided sufficient information to determine (1) whether the findings cited in our report were still outstanding or (2) which Circular A-133 reports were issued with qualified opinions. CMS asserted that in a number of cases, it had resolved outstanding findings but had not properly recorded resolution because of procedural issues. CMS also stated that it had initiated a review of its audit resolution process to ensure consistent and timely actions and adherence to the process.

We did provide CMS with sufficient documentation to determine whether audit findings were still outstanding and which Circular A-133 reports were issued with qualified opinions. In addition, CMS acknowledged in its response that it had not submitted audit resolution documents. The "Grants Administration Manual" states that audit resolution documents must be submitted to resolve findings. Therefore, we continue to believe that our report accurately reflects the number of Circular A-133 audit reports with eligibility findings that CMS had not resolved as of November 1, 2005. Finally, we commend CMS for any substantive actions taken to improve its audit resolution process.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at george.reeb@oig.hhs.gov. Please refer to report number A-07-06-03073 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

RESOLUTION OF AUDIT FINDINGS ON STATES' BENEFICIARY ELIGIBILITY DETERMINATIONS FOR MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Daniel R. Levinson
Inspector General

May 2006
A-07-06-03073

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Office of Management and Budget (OMB) Circular A-133 requires non-Federal entities that expend $300,000 ($500,000 for fiscal years (FYs) that ended after December 31, 2003) or more in Federal awards in a year to have periodic single audits. Single audits are audits of all Federal awards given to an entity.

OMB Circular A-133 states that each Federal awarding agency is responsible for issuing a management decision on audit findings that relate to its Federal awards. A management decision is the evaluation of the audit findings and the proposed corrective action plan and the issuance of a written decision on what corrective action is necessary. The Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), is the Federal awarding agency for grants under Medicaid and the State Children's Health Insurance Program (SCHIP).

According to the HHS "Grants Administration Manual," section 1-105-30(B)(1), action officials must resolve audit findings within 6 months of the end of the month of issuance or release of the audit report by the HHS Office of Inspector General. Resolution is normally deemed to occur when:

- a final decision on the amount of any monetary recovery has been reached;
- a satisfactory plan of action, including time schedules, to correct all deficiencies has been established; and
- the report has been cleared from the HHS tracking system by submission and acceptance of an audit clearance document(s).

OBJECTIVE

Our objective was to determine, as of November 1, 2005, whether CMS had resolved OMB Circular A-133 audit findings for FYs 2002 through 2004 on States' Medicaid and SCHIP beneficiary eligibility determinations.

SUMMARY OF FINDINGS

CMS had not resolved all OMB Circular A-133 audit findings on States' Medicaid and SCHIP beneficiary eligibility determinations. As of November 1, 2005, CMS had not resolved eligibility findings in 11 of the 22 FY 2002 audit reports submitted for resolution or in 25 of the 28 FY 2003 audit reports. Furthermore, CMS had not resolved

the eligibility findings in the 25 FY 2004 audit reports.[1] Based on the prior years' results, we are concerned that CMS will not resolve eligibility findings in the FY 2004 audit reports in a timely manner.

The Medicaid and SCHIP eligibility findings were so significant, i.e., material, that they caused some auditors to issue Circular A-133 reports with qualified opinions for six States for both FYs 2002 and 2003 and for seven States for FY 2004. In addition, auditors disclaimed their opinions on Medicaid eligibility for Georgia's FYs 2003 and 2004 reports and for Washington's FY 2004 report.

CMS had not resolved all audit findings because it did not follow departmental policies and procedures. Because CMS had not resolved the audit findings, it did not have reasonable assurance that States had corrected deficiencies in determining Medicaid and SCHIP beneficiary eligibility.

RECOMMENDATIONS

We recommend that CMS:

- resolve the backlog of unresolved A-133 audit findings and

- resolve A-133 audit findings on Medicaid and SCHIP beneficiary eligibility determinations within 6 months of receiving the audit reports, as required by departmental policies and procedures.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

CMS agreed with our recommendations but stated that "the overall tone of the findings . . . misrepresents the actions taken, the degree of responsiveness, and the level of commitment by CMS in resolving A-133 audit findings." CMS stated that we had not provided sufficient information to determine (1) whether the findings cited in our report were still outstanding or (2) which Circular A-133 reports were issued with qualified opinions. CMS asserted that in a number of cases, it had resolved outstanding findings but had not properly recorded resolution because of procedural issues. CMS also stated that it had initiated a review of its audit resolution process to ensure consistent and timely actions and adherence to the process.

CMS's comments are included in their entirety as Appendix B.

[1]As of the end of our fieldwork (November 1, 2005), the 6-month timeframe for resolving Circular A-133 audit findings had not expired for the FY 2004 audits. Additional Medicaid and SCHIP eligibility audit findings (two for FY 2003 and three for FY 2004) were submitted to the HHS Office of Audit Resolution and Cost Policy (OARCP). OARCP coordinates when necessary with other affected Federal agencies to establish a uniform Federal position on actions to be taken and, because HHS has cognizance for all States, negotiates resolution on behalf of those agencies.

OFFICE OF INSPECTOR GENERAL RESPONSE

We did provide CMS with sufficient documentation to determine whether audit findings were still outstanding and which Circular A-133 reports were issued with qualified opinions. In addition, CMS acknowledged in its response that it had not submitted audit resolution documents. The "Grants Administration Manual" states that audit resolution documents must be submitted to resolve findings. Therefore, we continue to believe that our report accurately reflects the number of Circular A-133 audit reports with eligibility findings that CMS had not resolved as of November 1, 2005. Finally, we commend CMS for any substantive actions taken to improve its audit resolution process.

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INTRODUCTION

BACKGROUND

Office of Management and Budget Circular A-133 Audits

Office of Management and Budget (OMB) Circular A-133 sets forth standards for obtaining consistency and uniformity among Federal agencies for the audit of non-Federal entities expending Federal awards. OMB Circular A-133 requires periodic single audits for non-Federal entities that expend $300,000 ($500,000 for fiscal years (FYs) that ended after December 31, 2003) or more in Federal awards in a year.[1] Single audits are audits of all Federal awards to an entity. While State auditors conduct the majority of Circular A-133 audits of State governments, certified public accounting firms conduct some audits under contracts with certain States.

OMB Circular A-133, subpart C, section 300, requires that Federal award recipients:

- maintain internal controls for Federal programs;
- comply with laws, regulations, and the provisions of contracts or grant agreements;
- prepare appropriate financial statements, including the schedule of expenditures of Federal awards;
- ensure that the required single audits are performed and submitted to the Federal Audit Clearinghouse in conformance with the circular;[2] and
- follow up and take corrective actions on audit findings.

OMB Circular A-133 also states that the Federal awarding agency is responsible for issuing a management decision, within 6 months after formal receipt of the report, for findings that relate to its Federal awards. A management decision is the evaluation by the Federal awarding agency or passthrough entity of the audit findings and the proposed corrective action plan and the issuance of a written decision on what corrective action is necessary. OMB Circular A-133, subpart D, section 405(a), states:

> The management decision shall clearly state whether or not the audit finding is sustained, the reasons for the decision, and the expected auditee action to repay

[1]Some State and local governments that are required by constitution or statute, in effect on January 1, 1987, to be audited less frequently than annually are permitted to undergo audits biennially. Nonprofit organizations also are allowed to have biennial audits under certain conditions.

[2]The Federal Audit Clearinghouse operates on behalf of OMB to disseminate Circular A-133 audit findings to Federal agencies.

disallowed costs, make financial adjustments, or take other action. If the auditee has not completed corrective action, a timetable for follow-up should be given.

As the Federal awarding agency for grants under Medicaid and the State Children's Health Insurance Program (SCHIP), the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), is responsible for issuing management decisions on the Medicaid and SCHIP eligibility findings in the Circular A-133 reports within 6 months after formal receipt of the reports. The CMS Regional Administrators are responsible for issuing the management decisions.

Departmental Policies and Procedures

The HHS "Grants Administration Manual," section 1-105, sets forth departmental policies and procedures for resolving findings on grants, contracts, and cooperative agreements and for controlling the audit resolution process. According to section 1-105-30(B)(1) of the manual, action officials must resolve audit findings within 6 months of the end of the month of issuance or release of the audit report by the HHS Office of Inspector General (OIG). Resolution is normally deemed to occur when:

- a final decision on the amount of any monetary recovery has been reached;
- a satisfactory plan of action, including time schedules, to correct all deficiencies has been established; and
- the report has been cleared from the HHS tracking system by submission and acceptance of an audit clearance document(s).

National External Audit Review Center

The HHS, OIG, National External Audit Review Center (NEAR), reviews the Circular A-133 reports for compliance with Federal regulations and requirements of the Single Audit Act and for conformance with professional standards. NEAR transmits each Circular A-133 audit report to the CMS Audit Liaison Office, located in the CMS central office, and to the appropriate CMS regional office. The CMS regional office issues a management decision to the State based on the Circular A-133 report and an audit clearance document to the OIG audit resolution group after resolving the audit findings.

Medicaid Eligibility Quality Control Program

Enacted in 1965, Medicaid is a joint Federal and State entitlement program that provides health and long term care for certain individuals and families with low incomes and limited resources. Pursuant to section 1902(a)(4) of the Social Security Act (the Act), CMS established the Medicaid Eligibility Quality Control (MEQC) program to monitor States' Medicaid eligibility determinations and redeterminations. From 1978 through 1993, the MEQC program required States to sample and conduct detailed eligibility case

reviews and develop error rates. CMS reviewed the cases again and was authorized to impose sanctions if States exceeded a specified error rate.

Beginning in 1994, CMS offered States the option of continuing under the original MEQC program or participating in MEQC pilot projects. States may operate under a pilot project for up to a year and must reapply for new pilot projects annually. Additionally, States may apply for a section 1115 waiver project that may last for longer than a year with CMS approval. States are required to report the results of any pilot or waiver projects within specified time periods.

States that operate under the traditional MEQC program are still required to report Medicaid eligibility error rates. However, States under pilot or waiver projects are not required to determine or report those error rates. CMS does not accumulate the error results into a national error rate report on Medicaid eligibility.

For FY 2004, 34 States and other governmental entities operated under pilot projects, 10 operated under section 1115 waiver projects, and 9 operated under the traditional MEQC program.[3]

State Children's Health Insurance Program

SCHIP is a joint Federal and State program that provides uninsured low-income children with health care coverage. Pursuant to 42 CFR § 457.750(a), States are required to assess their SCHIPs and report the results to CMS by January 1 following the end of each fiscal year. States are not required to conduct reviews of SCHIP eligibility determinations. However, pursuant to 42 CFR § 457.750(b), States must report on SCHIP progress, successes and failures in the program's design and implementation, and budgets and expenditures for the program.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine, as of November 1, 2005, whether CMS had resolved OMB Circular A-133 audit findings for FYs 2002 through 2004 on States' Medicaid and SCHIP beneficiary eligibility determinations.

Scope

For FYs 2002 through 2004, we examined the Circular A-133 audit reports transmitted to CMS that contained Medicaid and SCHIP beneficiary eligibility audit findings. Our review covered the 50 States, New York City, Puerto Rico, and the District of Columbia.

[3]Includes all 50 States, New York City, Puerto Rico, and the District of Columbia.

For findings that CMS had resolved as of November 1, 2005, we did not determine how long the findings remained open before they were resolved.

Our objective did not require an understanding or assessment of CMS's overall internal control structure. Our review was limited to controls over CMS's resolution process for Medicaid and SCHIP beneficiary eligibility findings and was not intended to be a full-scale internal control assessment of CMS's operations.

We performed fieldwork from July through October 2005.

Methodology

To accomplish our objective, we:

- reviewed OMB Circular A-133 and other applicable Federal criteria, including Titles XIX and XXI of the Act (which govern, respectively, Medicaid and SCHIP), Federal regulations, the HHS "Grants Administration Manual," and the CMS "State Medicaid Manual";

- reviewed OMB Circular A-133 reports;

- interviewed CMS staff and reviewed documentation provided by CMS officials; and

- reviewed CMS policies and procedures for resolving Medicaid and SCHIP beneficiary eligibility findings contained in Circular A-133 reports.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

CMS had not resolved all Circular A-133 audit findings on States' Medicaid and SCHIP beneficiary eligibility determinations. As of November 1, 2005, CMS had not resolved eligibility findings in 11 of the 22 FY 2002 audit reports submitted for resolution or in 25 of the 28 FY 2003 audit reports. Furthermore, CMS had not resolved the eligibility findings in the 25 FY 2004 audit reports.[4] Based on the prior years' results, we are concerned that CMS will not resolve eligibility findings in the FY 2004 audit reports in a timely manner. (See Appendix A for the status of audit resolution, by State, for FYs 2002 through 2004.)

[4]As of the end of our fieldwork, the 6-month timeframe for resolving Circular A-133 audit findings had not expired for the FY 2004 audits. Additional Medicaid and SCHIP eligibility audit findings (two for FY 2003 and three for FY 2004) were submitted to the HHS Office of Audit Resolution and Cost Policy (OARCP). OARCP coordinates when necessary with other affected Federal agencies to establish a uniform Federal position on actions to be taken and, because HHS has cognizance for all States, negotiates resolution on behalf of those agencies.

CMS had not resolved all audit findings because it did not follow departmental policies and procedures. As a result, CMS did not have reasonable assurance that States had corrected deficiencies in determining Medicaid and SCHIP beneficiary eligibility.

CIRCULAR A-133 AND GRANTS ADMINISTRATION MANUAL

OMB Circular A-133, section 405(d), states: "The entity responsible for making the management decision shall do so within six months of receipt of the audit report. Corrective action should be initiated within six months after receipt of the audit report and proceed as rapidly as possible."

According to the HHS "Grants Administration Manual," section 1-105-30(B)(1), action officials must resolve audit findings within 6 months of the end of the month of issuance or release of the audit report by the HHS OIG.

AUDIT FINDINGS NOT RESOLVED

CMS had not resolved all Circular A-133 audit findings on States' Medicaid and SCHIP beneficiary eligibility determinations. As of November 1, 2005, CMS had not resolved eligibility findings in 11 of the 22 FY 2002 audit reports submitted for resolution or in 25 of the 28 FY 2003 audit reports. Furthermore, CMS had not resolved the eligibility findings in the 25 FY 2004 audit reports. In fact, CMS had not resolved any Circular A-133 audit findings for Tennessee since FY 2000. Based on the prior years' results, we are concerned that CMS will not resolve eligibility findings in States' FY 2004 audit reports in a timely manner.

DEPARTMENTAL POLICIES AND PROCEDURES NOT FOLLOWED

CMS had not resolved all audit findings because it did not follow departmental policies and procedures.

LACK OF REASONABLE ASSURANCE THAT STATES CORRECTED DEFICIENCIES

Because CMS had not resolved all audit findings, it did not have reasonable assurance that States had corrected deficiencies in determining Medicaid and SCHIP beneficiary eligibility. The findings in the FYs 2002 through 2004 Circular A-133 reports indicate that many States did not comply with Medicaid and SCHIP beneficiary eligibility requirements. Furthermore, the findings increased in frequency over those years.

Auditors reported eligibility findings in 44 percent of the Circular A-133 reports for FY 2002, 59 percent of the reports for FY 2003, and 61 percent of the reports for FY 2004. Additionally, 73 percent of all States' Circular A-133 reports had eligibility findings in at least 1 of the 3 FYs. Eligibility findings included payments made for incarcerated or deceased individuals, illegal immigrants, and other ineligible recipients.

In addition, auditors found that States had not (1) included all required documentation in case files, (2) corrected recurring eligibility determination errors in a timely manner, and/or (3) annually redetermined Medicaid and SCHIP eligibility.

The Medicaid and SCHIP eligibility findings were so significant, i.e., material, that they caused some auditors to issue Circular A-133 reports with qualified opinions for six States for both FYs 2002 and 2003 and for seven States for FY 2004.[5] In addition, auditors disclaimed their opinions on Medicaid eligibility for Georgia's FYs 2003 and 2004 reports and for Washington's FY 2004 report.[6]

RECOMMENDATIONS

We recommend that CMS:

- resolve the backlog of unresolved A-133 audit findings and

- resolve audit findings on Medicaid and SCHIP beneficiary eligibility determinations within 6 months of receiving the audit reports, as required by departmental policies and procedures.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS "agree[d] with the overall objective of the OIG report, which is for CMS to resolve OMB Circular A-133 audit findings in a substantive and timely manner." However, CMS believed that "the overall tone of the findings . . . misrepresents the actions taken, the degree of responsiveness, and the level of commitment by CMS in resolving A-133 audit findings."

CMS also agreed with our recommendations and noted that it was (1) nearing completion of a comprehensive restructuring of the entire CMS audit resolution process as it pertains to all OIG audits and (2) training staff responsible for resolving Circular A-133 audits on new procedures and reassigning control responsibility for those audits. CMS noted that its Kansas City regional office was working with the other regional offices "to address and resolve all outstanding A-133 audits . . . by early February [2006]."

CMS's comments are included in their entirety as Appendix B.

[5]A qualified opinion is an auditor's opinion that, except for the effects of the matter to which the qualification relates, the auditee complied with the laws, regulations, and provisions of the Federal program.

[6]A disclaimer of opinion is a statement in which the auditor does not express an opinion because the auditor could not determine whether the auditee complied with the laws, regulations, and provisions of the Federal program.

Audit Findings Not Resolved

Centers for Medicare & Medicaid Services Comments

CMS stated that "Other than a reference to numbers of outstanding unresolved findings, this report did not include the specific reports and associated findings. In that regard, we were not able . . . to ascertain if these findings were actually still outstanding."

In addition, CMS stated that ". . . we are reviewing and addressing a listing of outstanding findings provided separately by OIG. In that review process, we have noted that in a number of cases the findings for particular reports were resolved; however, because of procedural issues, the resolution was not recorded properly."

Office of Inspector General Response

We disagree that the draft report did not include the specific reports and associated findings. Appendix A clearly identified the Circular A-133 reports with unresolved findings. In addition, NEAR reviews Circular A-133 reports and submits coded audit findings to the appropriate CMS Regional Administrator and the CMS Audit Liaison Office for resolution. Therefore, the findings should have been available at both the regional and central office levels. Furthermore, in November 2005, we provided CMS with a detailed list of the Circular A-133 audit reports with unresolved findings that we proposed to include in our draft report. CMS reviewed the list and provided documentation that caused us to adjust the findings in our draft report before its release. On December 30, 2005, we also supplied CMS audit resolution staff with Attachment A to each of the FYs 2002 through 2004 audit reports.[7] Those attachments documented the unresolved findings of all Circular A-133 audit reports cited in our draft report.

Although CMS may have addressed the findings in a number of the reports cited in our draft report, the agency did not submit audit resolution documents as required by departmental policy. The "Grants Administration Manual" clearly states that audit resolution documents must be submitted to resolve findings. Therefore, we continue to believe that our report accurately reflects the number of Circular A-133 audit reports with eligibility findings that CMS had not resolved as of November 1, 2005. After we issued our draft report, on January 25, 2006, CMS provided a spreadsheet showing that it had resolved the eligibility findings in 6 of the 11 FY 2002 audit reports, 12 of the 25 FY 2003 audit reports, and 6 of the 25 FY 2004 audit reports.

[7]NEAR includes an Attachment A to each Circular A-133 audit report that it forwards to CMS. Attachment A provides coded report findings and recommendations and identifies the agency or agencies responsible for resolution.

Qualified and Disclaimed Opinions

Centers for Medicare & Medicaid Services Comments

CMS stated that the draft report did not separately identify the 13 audits with qualified opinions. With respect to the two audits with disclaimers of opinion, CMS said that ". . . our Atlanta RO [regional office] indicates that the Georgia FY 2003 audit does not contain any eligibility findings. . . . They also indicate that the FY 2004 Georgia audit has not been received yet." CMS added that the regional office was reviewing Washington's FY 2004 audit and the State's submitted corrective action plans.

Office of Inspector General Response

We agree that our draft report did not specifically address which States received qualified opinions. However, before issuing the draft report, we provided CMS audit resolution staff with the detailed Circular A-133 report findings, which clearly disclosed the States that received qualified opinions.

Georgia's FY 2003 audit included an eligibility finding. Specifically, the State auditor incorporated finding FA-419-03-01 in its disclaimer of opinion, and page D-63 of the report indicated that the auditor disclaimed on eligibility as well as other issues.

In addition, we sent multiple copies of Georgia's FY 2004 audit report to CMS. NEAR transmitted the report to the CMS Regional Administrator in Atlanta and the CMS Audit Liaison Office in the CMS central office on November 4, 2005. Additionally, our December 30, 2005, submission to CMS audit resolution staff included Attachment A to Georgia's FY 2004 audit report. Furthermore, NEAR later sent an additional copy of Georgia's FY 2004 audit report to CMS, and CMS certified receipt of the report on January 17, 2006.

Audit Resolution

Centers for Medicare & Medicaid Services Comments

CMS stated that it had "initiated a review of the audit resolution process, the goal of which is to ensure consistent and timely actions and adherence to the process."

Office of Inspector General Response

We note that although CMS questioned our audit findings, it initiated a review of its audit resolution process and agreed with our recommendations. We commend CMS for any substantive actions taken to reduce the backlog of unresolved audit findings and to ensure that its audit resolution process complies with departmental policies and procedures.

APPENDIXES

CIRCULAR A-133 ELIGIBILITY FINDINGS AND RESOLUTION FOR FISCAL YEARS 2002 THROUGH 2004

	2002		2003		2004	
	Submitted to CMS[1]	Resolved by CMS	Submitted to CMS	Resolved by CMS	Submitted to CMS	Resolved by CMS[2]
Alabama			x	x	x	
Alaska	x		x			
Arizona						
Arkansas	x	x	x		x	
California			x		x	
Colorado	x	x	x	x	x	
Connecticut	x	x	x		N/A	
Delaware	x	x	x		x	
District of Columbia					N/A	
Florida	x	x	x			
Georgia			x		x	
Hawaii	x	x	x		N/A	
Idaho	x		x		x	
Illinois						
Indiana			x		x	
Iowa						
Kansas						
Kentucky					x	
Louisiana						
Maine	x	x	x		x	
Maryland	x		x		x	
Massachusetts	x					
Michigan	N/A[3]		N/A		N/A	

[1]CMS is the Centers for Medicare & Medicaid Services.

[2]As of the end of our fieldwork, the 6-month timeframe for resolving Circular A-133 audit findings had not expired for the fiscal year (FY) 2004 audits.

[3]"N/A" refers to States that did not submit Circular A-133 reports for FY 2002, 2003, or 2004. Three States did not submit reports for FY 2002, two States did not submit reports for FY 2003, and seven States had not submitted reports for FY 2004 as of the end of our fieldwork.

	2002		2003		2004	
	Submitted to CMS[1]	**Resolved by CMS**	**Submitted to CMS**	**Resolved by CMS**	**Submitted to CMS**	**Resolved by CMS[2]**
Minnesota	x				x	
Mississippi						
Missouri	x	x			x	
Montana	N/A				N/A	
Nebraska						
Nevada						
New Hampshire	x		x			
New Jersey			x		N/A	
New Mexico	x		x			
New York			x		x	
New York City	x		x		x	
North Carolina			x		x	
North Dakota						
Ohio			x		x	
Oklahoma					x	
Oregon					x	
Pennsylvania	x	x				
Puerto Rico	N/A		N/A		N/A	
Rhode Island	x		x		x	
South Carolina			x			
South Dakota						
Tennessee	x		x		x	
Texas						
Utah			x		x	
Vermont	x				x	
Virginia	x	x	x	x		
Washington	x	x	x		x	
West Virginia						
Wisconsin			x		x	
Wyoming						
Total (53 Entities)	**22**	**11**	**28**	**3**	**25**	**0**

2002: Of 50 Circular A-133 audit reports, 22 (44 percent) had Medicaid or SCHIP beneficiary eligibility findings. Of the 22 reports with findings submitted to CMS, 11 had been resolved.

2003: Of 51 Circular A-133 audit reports, 30 (59 percent) had Medicaid or SCHIP beneficiary eligibility findings, 28 were submitted to CMS for resolution, and 2 were submitted to the Office of Audit Resolution and Cost Policy (OARCP). CMS had resolved the eligibility findings in 3 of the 28 reports.

2004: Of 46 Circular A-133 audit reports, 28 (61 percent) had Medicaid or SCHIP beneficiary eligibility findings, 25 were submitted to CMS for resolution, and 3 were submitted to OARCP. None of the 25 audit reports with findings submitted to CMS had been resolved.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

JAN 31 2006

TO: Daniel R. Levinson
Inspector General
Office of Inspector General

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

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OFFICE OF INSPECTOR GENERAL

SUBJECT: Office of Inspector General (OIG) Draft Report: "Resolution of Audit Findings on States' Beneficiary Eligibility Determinations for Medicaid and the State Children's Health Insurance Program" (A-07-06-03073)

Thank you for the opportunity to review and comment on the above OIG Draft Report. The OIG report on the Centers for Medicare & Medicaid Services' (CMS) implementation of Office of Management and Budget (OMB) Circular A-133 cites CMS for failure to resolve the audits within 6 months of receipt of the report as prescribed in Departmental guidelines. Resolution of an audit is accomplished with the submission and acceptance on an audit clearance document which then results in clearance from the Department of Health and Human Services tracking system. We note that as a result of an earlier review of the audit clearance and resolution procedures, we initiated and are nearing completion with respect to a comprehensive restructuring of the entire CMS audit resolution process as it pertains to all OIG audits. We expect that project will be completed by March 2006. In addition to updating the audit resolution procedures and manuals, staff responsible for resolving the A-133 audits will be trained on the new procedures and the control responsibility for assuring compliance with Departmental guidelines will be restructured and reassigned. Furthermore, as part of this initiative our Kansas City Regional Office is working with all our Regional Offices (ROs) nationally and the OIG to address and resolve all outstanding A-133 audits on an individual basis; we expect that activity to be completed by early February.

We agree with the overall objective of the OIG report, which is for CMS to resolve OMB Circular A-133 audit findings in a substantive and timely manner. However, we believe the overall tone of the findings articulated in this OIG report misrepresents the actions taken, the degree of responsiveness, and the level of commitment by CMS in resolving A-133 audit findings. In particular, we note that CMS had initiated, prior to the release of the draft report, an in-depth review of its audit resolution procedures. This review disclosed that CMS had taken actions on most of the A-133 audits included in the Report, but that audit clearance documents had not been submitted and/or accepted in all cases.

Finally, we have designated our Region VII as the lead in working with our other ROs and the OIG on ensuring the timely resolution of all A-133 audits. They will work with the OIG Region

VII staff to confirm actual status of the audits cited in the report and immediately begin resolution procedures for any that remain outstanding.

Finding 1

CMS had not resolved all OMB Circular A-133 audit findings on States' Medicaid and SCHIP beneficiary eligibility determinations. As of November 1, 2005, CMS had not resolved eligibility findings in 11 of the 22 fiscal year (FY) 2002 audit reports submitted for resolution or in 25 of the 28 FY 2003 audit reports. Furthermore, CMS had not resolved the eligibility findings for the 25 FY 2004 audit reports. Based on the prior years' results, we are concerned that CMS will not resolve eligibility findings in the FY 2004 audit reports in a timely manner.

CMS Response

Other than a reference to numbers of outstanding unresolved findings, this report did not include the specific reports and associated findings. In that regard, we were not able to verify the validity of these statements; that is, to ascertain if these findings were actually still outstanding. However, in independent actions, undertaken prior to the receipt of this report we are reviewing and addressing a listing of outstanding findings provided separately by OIG. In that review process, we have noted that in a number of cases the findings for particular reports were resolved; however, because of procedural issues, the resolution was not recorded properly. For example, in our review we note that CMS had taken actions on most of the identified outstanding A-133 audits, but that audit clearance documents had not been submitted and/or accepted in all cases.

Finding 2

The Medicaid and State Children's Health Insurance Program (SCHIP) eligibility findings were so significant, i.e., material, that they caused some auditors to issue Circular A-133 reports with qualified opinions for six States for both FYs 2002 and 2003 and for seven States for FY 2004. In addition, auditors disclaimed their opinions on Medicaid eligibility for Georgia's FYs 2003 and 2004 reports and for Washington's FY 2004 report.

CMS Response

As indicated in the CMS response to Finding 1, we note that the report did not separately identify the "six" and "seven" audits referenced in Finding 2. However, as an overall response, we reiterate that prior to the issuance of this report, CMS initiated actions on most of the A-133 audits referred to in the report. Specifically, the CMS Region VII is working with OIG Region VII staff to address and resolve all audits referenced in the report.

With respect to the two audits specifically mentioned in this finding, our Atlanta RO indicates that the Georgia FY 2003 audit does not contain any eligibility findings. They are currently preparing the audit clearance document on the systems and financial findings. They also indicate that the FY 2004 Georgia audit has not been received yet. Once the audit is received they will address any finding accordingly. The Washington 2004 A-133 Audit is currently under review

by our RO program and fiscal staff to see if the Corrective Action Plans (CAPs) submitted by the State are acceptable and if further action is needed including requesting Federal financial participation (FFP) to be returned by the State. They currently are reviewing approximately 24 CAPs. The OIG Clearance Document has been completed (27 pages), but will not be submitted until all CAPs have been reviewed and deemed acceptable. The State has returned $14.6 million in FFP so far for various findings. This review has taken a little longer due to the disclaimer by the State Auditor. Currently, the State Auditor and the State Medicaid Agency are cooperating so the situation that occurred in the State fiscal year (SFY) 2004 audit does not reoccur in the SFY 2005 audit. We believe that the ROs have been working diligently on clearing these audits.

Finding 3

CMS had not resolved all audit findings because it did not follow departmental policies and procedures. Because CMS had not resolved the audit findings, it did not have reasonable assurance that States had corrected deficiencies in determining Medicaid and SCHIP beneficiary eligibility.

CMS Response

Although the primary objective is to resolve any findings, we recognize that strong internal control mechanisms and consistent procedures are important for tracking such actions. In that regard, we have initiated a review of the audit resolution process, the goal of which is to ensure consistent and timely actions and adherence to the process.

OIG Recommendation 1

CMS should resolve the backlog of unresolved A-133 audit findings.

OIG Recommendation 2

CMS should resolve A-133 audit findings on Medicaid and SCHIP beneficiary eligibility determinations within 6 months of receiving the audit reports, as required by departmental policies and procedures.

CMS Response

We agree that any backlog of unresolved A-133 audit findings must be resolved timely; that is, within A-133 time standards. In that regard, as indicated previously, we are currently working with our ROs and the OIG to review and address all outstanding audit findings. Furthermore, we are also assessing the audit resolution and tracking process; the objective is to update and restructure the existing internal controls and tracking processes in order to ensure consistent adherence to these standards.

Technical Comment

Page 2, 3rd paragraph, last sentence: delete the "s" in the "FYs" so that the sentence reads, "… for Georgia's FY 2003 and 2004…"