

Department of Health and Human Services
Office of Inspector General



Office of Audit Services

June 2026 | A-06-23-09006

**CMS Should Improve Its Policies
and Procedures for the Oversight of
States' Reported Medicaid
Expenditures to Better Protect the
Financial Integrity of the Medicaid
Program**



June 2026 | A-06-23-09006

CMS Should Improve Its Policies and Procedures for the Oversight of States' Reported Medicaid Expenditures to Better Protect the Financial Integrity of the Medicaid Program

Why OIG Did This Audit

- Within 30 days after the end of each quarter, States report to [CMS](#) their Medicaid expenditures and the associated Federal share on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64).
- CMS is responsible for reviewing the CMS-64 to verify that the expenditures reported are consistent with Medicaid requirements and Federal matching funds are properly allocated.
- Our audit determined whether CMS followed its policies and procedures related to its oversight of Medicaid State expenditures reported on the CMS-64 and whether the policies and procedures were sufficient to protect the financial integrity of the Medicaid program.

What OIG Found

- CMS did not consistently follow its policies and procedures related to the oversight of Medicaid State expenditures reported on the CMS-64. Specifically, CMS's quarterly review work papers for five selected States that we reviewed were not always clear, accurate, or consistent enough to validate that its analysts thoroughly completed all procedures outlined in its Review Guide.
- CMS's policies and procedures related to deferred expenditures did not adhere to the timely resolution timelines set forth in Federal regulations, resulting in deferred payments remaining unresolved for years.
- CMS's policies and procedures related to tracking of disallowed expenditures need improvement to allow for more accessible and accurate reporting of disallowed payment information.

What OIG Recommends

We made four recommendations to CMS, including that it develop and implement additional training for analysts assigned to review CMS-64s and modify and revise certain policies and procedures related to its oversight of States' CMS-64s. The full recommendations are in the body of the report.

CMS concurred with all four recommendations.

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Audit.....	1
Objectives.....	1
Background	1
Medicaid Program	1
CMS’s Quarterly Review Process	2
CMS’s Deferred Payment Process.....	3
CMS’s Disallowed Payment Process	4
How We Conducted This Audit.....	5
FINDINGS	5
CMS’s Quarterly Review Work Papers Were Not Always Clear, Accurate, or Consistent	6
CMS’s Policies and Procedures Related to Deferred Payments Did Not Adhere to the Resolution Timelines Set Forth in Federal Regulations.....	7
CMS’s Policies and Procedures Related to Disallowed Expenditures Need Improvement	8
RECOMMENDATIONS.....	9
CMS COMMENTS	9
APPENDICES	
A: Audit Scope and Methodology.....	10
B: Related Office of Inspector General Reports Issued in Federal Fiscal Year 2024 and Associated Recommended Recoveries.....	12
C: CMS Comments.....	13

INTRODUCTION

WHY WE DID THIS AUDIT

Within 30 days after the end of each quarter, States report to the Centers for Medicare & Medicaid Services (CMS) their Medicaid expenditures and the associated Federal share on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64). The amounts that States report must represent actual expenditures. CMS is responsible for reviewing each State's CMS-64 to verify that the expenditures reported are consistent with Medicaid requirements and Federal matching funds are properly allocated.

Due to the variation in States' Medicaid programs and an increasing number of different Federal matching rates, CMS's review of reported expenditures has become increasingly complex. Additionally, in Federal fiscal year (FY) 2024, the Office of Inspector General (OIG) found more than \$764.7 million in Federal Medicaid reimbursement for overpayments and incorrectly claimed expenditures not identified by CMS.¹ Because of the increasing complexities in the Medicaid program, and large overpayments identified in past OIG audits, we performed this audit of CMS's oversight of Medicaid State expenditures.

OBJECTIVES

Our objectives were to determine whether CMS followed its policies and procedures in the oversight of Medicaid State expenditures reported on the CMS-64 and whether the policies and procedures were sufficient to protect the financial integrity of the Medicaid program.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program according to a CMS-approved State plan. Each State has considerable flexibility in designing and operating its Medicaid program but must comply with applicable Federal requirements.

The Federal Government pays its share of a State's Medicaid expenditures based on the Federal Medical Assistance Percentage (FMAP), which varies depending on the State's relative per capita income. Within 30 days after the end of each quarter, States report expenditures and the associated Federal share on the CMS-64. The CMS-64 is a summary of a State's actual expenditures derived from source documents, including invoices, payment vouchers,

¹ Appendix B includes a list of related OIG reports and associated recommended Federal reimbursement.

governmental funds transfers, expenditure certifications, cost reports and settlements, and eligibility records. The CMS-64 shows the disposition of Medicaid grant funds for the quarter being reported and any prior period adjustments. It also accounts for any overpayments, underpayments, refunds received by the State Medicaid agency, and income earned on grant funds (42 CFR § 430.30). In addition, CMS's *State Medicaid Manual* § 2500(A)(1) states that reported amounts on the CMS-64 and attachments "must be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed."

The Social Security Act (the Act) gives the Secretary of the Department of Health and Human Services (HHS) fiscal oversight of States' Medicaid funding amounts, including the authority to increase or decrease this amount due to any prior quarter underpayment or overpayment, respectively.² Federal regulations address CMS's oversight of States' Medicaid programs, including determining the award amount by analyzing a State's estimated expenditures for the requested quarter, and making adjustments for prior quarter differences between the State's estimated and actual expenditures, and for other reasons such as deferrals or disallowances.³

CMS's Quarterly Review Process

In 2023, CMS employed 76 analysts across 2 regional branches (East and West) to perform quarterly reviews of CMS-64s to ensure that States' expenditures claimed for Federal reimbursement under the Medicaid program were programmatically reasonable, allowable, and allocable in accordance with existing Federal laws, regulations, and policy guidance. The analysts had 60 days after receiving a State's CMS-64 to complete their review.

CMS's *Financial Review Guide* (Review Guide) includes detailed steps for analysts to follow when reviewing CMS-64s.⁴ The Review Guide is intended to ensure that all States' CMS-64s are reviewed in a consistent manner. The analysts who review the CMS-64s and supporting documentation are responsible for determining such things as whether reported expenditures are complete and appropriate, mathematically correct, properly supported by State accounting records, and allowable in accordance with existing Federal laws, regulations, and the approved State plan. Analysts also determine whether States claimed reported expenditures at appropriate FMAPs.

During our audit period, the Review Guide included numerous detailed steps designed to aid the analysts in their reviews of medical assistance expenditures and administrative costs as well as in reporting their conclusions and recommendations and following up on prior quarters' conclusions and recommendations. The Review Guide specifies how frequently each step must be performed during a given year. Additionally, an analyst can expand or curtail certain review

² Section 1903(d) of the Act.

³ 42 CFR § 430.30.

⁴ The Review Guide, issued and updated in January 2022, was in effect during our audit period.

steps depending on the complexity of a State's Medicaid program and issues identified during the review process.⁵

Analysts use work papers to document and support their decisions during the quarterly review and to form the basis for the Financial Management Decision Report (decision report). Work papers include documents, information, and papers the analyst prepared or collected, and are used to control and structure the review process and develop conclusions. Analysts should prepare work papers in a manner that ensures continuity of the review effort and permits others to pick up the review at any point without significant loss of time and effort.

CMS's Deferred Payment Process

CMS's deferred payment process is outlined in its Standard Operating Procedures (SOP). According to its SOP, if an analyst determines that a State did not meet all of the criteria for claiming Federal funds for an expenditure, the analyst will work with the State to resolve any discrepancies during the review process (e.g., obtaining missing or incomplete documentation). If the discrepancies cannot be resolved within the required 60-day review timeframe, CMS may opt to defer (or withhold) payment of Federal funds for the expenditure. If this occurs:

- Within 75 days of a State certifying its CMS-64, CMS notifies the State with a written notice of deferral that (1) identifies the type and amount of the deferred payment and specifies the reason for deferral and (2) requests the State to make available all the documents and materials that are necessary to determine the allowability of the payment. The State is responsible for establishing the allowability of a deferred payment.⁶
- The State then has 60 days (or 120 days if it requests an extension) after receipt of the notice of deferral to provide CMS with all available requested documents and materials. CMS's policies and procedures also include an option for the State to request extensions beyond the 120 days.
- If CMS finds that a State's documents and materials are not readily reviewable or that additional information is needed, it notifies the State within 30 days of receipt that the State must submit all necessary documents and materials within 15 days. If the State does not respond within the 15 days, CMS's policies and procedures state that the payment can be immediately disallowed.

⁵ Per the Review Guide, the analyst should use professional judgment, in conjunction with management direction, in determining the scope of the review, and the analyst must document and justify such decisions. Inadequate staff resources or insufficient time, without other compelling reasons, are not acceptable justifications to curtail a step.

⁶ 42 CFR § 430.40(b).

- Finally, CMS has 90 days after receiving all necessary documents and materials to determine the allowability of a deferred payment. If CMS cannot complete this review within 90 days, CMS pays the claim, subject to a later determination of allowability.⁷ Payment of a deferred claim does not preclude a subsequent disallowance based on the results of an audit or financial review.⁸

CMS's Disallowed Payment Process

CMS's *Medicaid Program Cycle Memorandum* (Cycle Memo) documents its key control activities and processes as they relate to financial reporting for the Medicaid program. The Cycle Memo details CMS's disallowed payment process. CMS utilizes this process when it determines that a payment, or a portion of a payment, is not allowable or when a State cannot adequately support a previously deferred payment. CMS processes disallowed payments in the same manner, regardless of whether CMS or another party (e.g. OIG) identifies them. Specifically:

- CMS logs the proposed and issued disallowances into an Excel spreadsheet titled the "Disallowances Reconsideration Tracking Report" (Tracking Report), which is manually updated by certain CMS staff and protected against unauthorized access. Staff responsible for managing the Tracking Report request information on the status of disallowed payments from CMS branch managers and incorporate that information into the Tracking Report. In addition, CMS officials told us that multiple departments within CMS are responsible for tracking the status of disallowed payments.
- When CMS determines that a payment is unallowable, it promptly⁹ sends the State a disallowance letter that includes, among other things, the period in which the State claimed the payment, the payment amount, findings of fact on which the disallowance determination was based, a request that the State make an appropriate adjustment in a subsequent expenditure report, and appeals rights.¹⁰
- Once a disallowance is issued, the State has 60 days to request reconsideration and provide additional information or supporting documentation. If the State requests reconsideration, CMS then has 60 days to analyze the additional information and determine whether to allow the payment or uphold the disallowance. If CMS upholds

⁷ Most deadlines outlined in CMS's deferred payment process mirror those included in 42 CFR § 430.40(c).

⁸ 42 CFR § 430.40(d).

⁹ CMS interpreted "promptly" from Federal regulations to mean there is no time limit on when CMS must issue the disallowance letter.

¹⁰ 42 CFR § 430.42(a).

the disallowance, the State may appeal the disallowance to the Departmental Appeal Board (DAB).¹¹

HOW WE CONDUCTED THIS AUDIT

Our audit covered CMS's oversight of States' CMS-64s for the quarter ended March 31, 2023 (audit period). We reviewed CMS's policies and procedures related to its oversight of States' CMS-64s to determine whether they were appropriate and consistent with Medicaid requirements and program objectives. We also selected a nonstatistical sample of five States and assessed CMS's detailed workpapers and decision reports supporting CMS's reviews of the sampled States' CMS-64s to determine whether analysts thoroughly and consistently followed CMS's Review Guide steps. Finally, we analyzed CMS's lists of unresolved deferrals and issued disallowances to determine whether CMS was pursuing their resolution within the timelines set forth in Federal regulations.

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

The Appendix contains the details of our audit scope and methodology.

FINDINGS

CMS did not consistently follow its policies and procedures related to the oversight of Medicaid State expenditures reported on the CMS-64. For all five States that we reviewed, CMS's review work papers were not always clear, accurate, or consistent enough to validate that its analysts thoroughly completed all Review Guide steps.

Additionally, some CMS policies and procedures were not sufficient to protect the financial integrity of the Medicaid program. Specifically:

- CMS's policies and procedures related to deferred expenditures did not adhere to the resolution timelines set forth in Federal regulations.
- Deferred payments remained unresolved for several months or years, including some that had been unresolved since 2014.

¹¹ The DAB provides impartial, independent reviews of disputed decisions in a wide range of HHS programs under more than 60 statutory provisions. The DAB generally issues the final decision for HHS.

- CMS's policies and procedures related to tracking disallowed expenditures needed improvement to allow for more accessible and accurate reporting of disallowed payment information.

CMS'S QUARTERLY REVIEW WORK PAPERS WERE NOT ALWAYS CLEAR, ACCURATE, OR CONSISTENT

The Government Accountability Office's (GAO's) *Standards for Internal Control in the Federal Government* (known as the Green Book),¹² section 4.05, states that management recruits, develops, and retains competent personnel to achieve the entity's objectives and considers training to enable individuals to develop competencies appropriate for key roles, reinforce standards of conduct, and tailor training based on the needs of the role. Further, section 4.02 states that competence requires relevant knowledge, skills, and abilities, which are gained largely from professional experience, training, and certifications.

The Green Book, section 10.03, identifies effective management of an entity's workforce, its human capital, as essential, to achieving results and an important part of internal control. Further, the Green Book requires that management continually assess the knowledge, skills, and ability needs of the entity so that the entity can obtain a workforce that meets those needs to achieve organizational goals. Training should be aimed at developing and retaining employee knowledge, skills, and abilities to meet changing organizational needs. In addition, management should design control activities so that all transactions are completely and accurately recorded. Finally, Section 13.05 states that quality information is appropriate, current, complete, accurate, accessible, and provided on a timely basis.

CMS's Review Guide provides for a uniform and comprehensive review of the CMS-64 and is intended to ensure that States are reviewed in a consistent manner. Work papers should be adequately planned to support review objectives and prepared to (1) reflect the progress of the review, (2) ensure continuity of the effort, and (3) permit others to pick up the review at any point in time without significant loss of time and effort.

For the five States that we reviewed, CMS's quarterly review work papers were not always clear, accurate, or consistent enough for us to validate that all CMS review procedures were thoroughly completed. We identified considerable inconsistencies in the level of detail provided in the work papers, depending on which State was being reviewed and the analyst who prepared the work papers. Some work papers did not contain any quarter-specific information (e.g., dollar amounts) or a detailed description of steps taken to determine the accuracy and reliability of the information reported on a CMS-64.

Additionally, some work papers contained analyst notes from previous quarters. CMS officials confirmed that the notes were incorrectly carried over from prior quarters and should have been updated. It appeared that information in the work papers could have been copied and

¹² The 2014 version of the Green Book was in effect during our audit period.

past from prior quarters, which could indicate that every review step may not be thoroughly performed each quarter.

CMS has not updated its training manual for analysts that review CMS-64s since 2015 and, instead, relies on on-the-job training of new analysts and monthly staff meetings to provide updates. The lack of uniform training contributed to a lack of clarity, accuracy, and consistency in the review work papers from one analyst to another.

CMS'S POLICIES AND PROCEDURES RELATED TO DEFERRED PAYMENTS DID NOT ADHERE TO THE RESOLUTION TIMELINES SET FORTH IN FEDERAL REGULATIONS

Federal regulations state that within 60 days (or 120 days if the State requests an extension) after receipt of the notice of deferral, the State must make available, in readily reviewable form, all requested documents and materials except any that it identifies as not being available. If CMS finds that the materials are not readily reviewable or that additional information is needed, CMS must promptly notify the State that it has 15 days to submit all necessary materials and information. If the State does not provide the necessary materials within 15 days, CMS should disallow the claim.¹³

CMS's policies and procedures related to deferral resolution did not follow the deferral timelines set forth in Federal regulations. Specifically, CMS's policies and procedures:

- allowed for States to extend the deadline for providing CMS with requested documents and materials well beyond the 120-day limit
- did not require CMS to disallow a claim when a State missed the 15-day limit on providing additional necessary materials

As a result, CMS's deferred payments remained unresolved beyond the timeframes allowed in Federal regulations. As of January 1, 2023, there were 144 unresolved deferred payments issued by CMS, totaling almost \$1.5 billion. During the audit period, CMS resolved four deferred payments and issued five new deferred payments. As of March 31, 2023, there were 145 unresolved deferred payments, totaling over \$1.6 billion associated with 20 unresolved issues. Of these 145 unresolved deferred payments, 118 were related to unresolved issues that began in FY 2020 or earlier.

CMS officials stated that analysts try to work with States to resolve issues causing the deferred payments without escalating the issues to disallowances. However, several deferred payments were repeated for multiple quarters over many years without resolution. For example:

- CMS issued 53 deferred payments to 1 State for the same issue related to a Medicaid waiver from FY 2014 through FY 2020. The deferrals, totaling almost \$139 million,

¹³ 42 CFR § 430.40(c).

remained unresolved as of July 2024. According to CMS, it was still working with the State to get answers to questions related to the associated claims.

- As of July 2024, CMS was waiting for additional documentation from one State to determine whether to disallow over \$20 million in deferred payments for an unresolved issue from FY 2017.
- One unresolved issue was due to CMS waiting to approve a State’s Medicaid State plan amendment (SPA) from 2011.¹⁴ This resulted in two deferred payments—one in FY 2015 and one in FY 2016—totaling nearly \$32 million. As of July 2024, the SPA was still not approved; therefore, the issue remained unresolved.

CMS’S POLICIES AND PROCEDURES RELATED TO DISALLOWED EXPENDITURES NEED IMPROVEMENT

The Green Book, section 3.01, calls for management to establish an organizational structure, assign responsibility, and delegate authority to achieve the entity’s objectives. Section 10.03 states that among other things, management should design control activities over information processing, segregate key duties and responsibilities, and ensure transactions are promptly recorded to maintain their relevance and value to management in controlling operations and making decisions. In addition, management should design control activities so that all transactions are completely and accurately recorded. Additionally, the Green Book, section 13.01, states that management should use quality information to achieve the entity’s objectives. Finally, Section 13.05 states that quality information is appropriate, current, complete, accurate, accessible, and provided on a timely basis.

CMS’s policies and procedures for tracking issued disallowed payments need improvement to sufficiently protect the financial integrity of the Medicaid program. The Tracking Report, which is specified in CMS’s policies and procedures, did not contain current, complete, accurate, or timely information regarding the status of all disallowed payments. It took CMS several months and attempts to provide a detailed list of disallowances and their current status to OIG. CMS officials stated that retrieving complete information on disallowed payments would be difficult and require significant time and labor. As a result, we were unable to verify that CMS was properly tracking all unresolved disallowed payments.

CMS’s Cycle Memo states that staff in one division (the Division of Financial Policy) is responsible for maintaining and updating the Tracking Report. However, in practice, after CMS disallows a payment, staff within multiple CMS divisions are responsible for tracking the status of the disallowed payment, including whether the State requested reconsideration and provided additional information, or whether the State appealed the disallowance. Having

¹⁴ A Medicaid State Plan is an agreement between a State and the Federal Government describing how that State administers its Medicaid program. When a State plans to make a change to its Medicaid program policies or operational approach, it sends a SPA to CMS for review and approval.

multiple divisions track issued disallowed payments contributed to CMS's issues with accurately tracking these payments. Further, CMS's Cycle Memo did not describe the responsibilities of these departments for tracking disallowed payments.

Finally, updating the status of disallowed payments on a State-specific basis would fit well into CMS's quarterly CMS-64 reviews. However, CMS's Review Guide does not have a specific step that clearly requires analysts to determine the statuses of disallowed payments.

RECOMMENDATIONS

- We recommend that CMS develop and implement additional training for analysts to improve the clarity, accuracy, and consistency of their documentation for reviewing CMS-64s.
- We recommend that CMS revise its policies and procedures related to deferred payments to align the deferral resolution timelines with Federal regulations.
- We recommend that CMS modify its policies and procedures to specify which CMS departments are responsible for tracking and resolving disallowed payments.
- We recommend that CMS modify its Review Guide to include a step that requires analysts to determine the status of disallowed payments.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described actions it planned to take to address them. Specifically, CMS stated that it intends to develop and implement additional training for CMS-64 analysts and to revise its policies and procedures related to deferred payments to clarify the process under the current regulations. Additionally, CMS stated that it will update its policies and procedures to clarify the roles and responsibilities of the various entities involved with tracking and resolving disallowed payments and update its Review Guide to include a step related to the status of disallowed payments. CMS also provided technical comments, which we addressed as appropriate.

CMS comments, excluding the technical comments, are included as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed CMS's policies and procedures related to its oversight of States' CMS-64s and detailed work papers and decision reports supporting CMS's quarterly reviews of a nonstatistical sample of five States' CMS-64s for the quarter ending March 31, 2023. We also reviewed CMS's lists of unresolved deferrals and issued disallowances for all States as of March 31, 2023.

We assessed internal controls necessary to satisfy the audit objectives. We gained an understanding of and reviewed CMS's policies and procedures regarding its reviews of the CMS-64s, deferred claims, and disallowed claims.

We performed audit work from June 2023 through November 2025.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal laws, regulations, and guidance
- Met with CMS officials to gain an understanding of their oversight process for reviewing CMS-64s
- Reviewed CMS's policies and procedures related to its oversight of States' CMS-64s (e.g., the Review Guide, SOP and the Cycle Memo) to determine whether they were appropriate and consistent with Medicaid requirements and program objectives
- Compared CMS's prior and current policies and procedures for reviewing States' CMS-64s to determine how the CMS-64 oversight process has changed over time and to determine CMS's ability to adjust to changes in the Medicaid financial environment
- Compared CMS-64 oversight staffing levels from 2020 to 2023 to determine whether there were considerable changes in the staffing levels
- Selected a nonstatistical sample of 5 States based on Medicaid expenditures in FY 2022 (3 in the top 20; 2 outside the top 20) and CMS regional branch coverage (3 from the East, 2 from the West)
- Assessed CMS's detailed workpapers and decision reports supporting CMS's review of the 5 selected States' CMS-64s for the quarter ending March 31, 2023, to determine whether analysts thoroughly and consistently followed CMS's Review Guide steps

- Analyzed CMS’s lists of unresolved deferrals and issued disallowances for all States to determine whether CMS was pursuing their resolution within the timelines set forth in Federal regulations
- Discussed the results of our audit with CMS officials

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

**APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS ISSUED IN
FEDERAL FISCAL YEAR 2024 AND ASSOCIATED RECOMMENDED RECOVERIES**

Report Title	Report Number	Date Issued	Recommended Recovery
<i>South Carolina Did Not Always Invoice Rebates to Manufacturers for Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations</i>	<u>A-07-22-07010</u>	8/28/2024	\$12,204,259
<i>North Carolina Did Not Report and Return All Medicaid Overpayments for the State’s Medicaid Fraud Control Unit Cases</i>	<u>A-06-23-04004</u>	6/20/2024	20,134,402
<i>California Improperly Claimed \$52.7 Million in Federal Medicaid Reimbursement for Capitation Payments Made on Behalf of Noncitizens With Unsatisfactory Immigration Status</i>	<u>A-09-22-02004</u>	5/17/2024	52,652,689
<i>Colorado Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for Some Cases Identified by the State’s Program Integrity Section</i>	<u>A-07-19-02816</u>	5/14/2024	673,686
<i>New Mexico Should Refund Almost \$120 Million to the Federal Government for Medicaid Nursing Facility Level-of-Care Managed Care Capitated Payments</i>	<u>A-06-20-09001</u>	5/8/2024	119,118,308
<i>Alabama Claimed Federal Medicaid Reimbursement for Millions of Dollars in Targeted Case Management Services That Did Not Comply With Federal and State Requirements</i>	<u>A-07-22-03253</u>	4/1/2024	5,039,433
<i>Delaware Made Capitation Payments to Medicaid Managed Care Organizations After Enrollees’ Deaths</i>	<u>A-03-22-00205</u>	3/25/2024	3,484,904
<i>Pennsylvania Improperly Claimed \$551 Million in Medicaid Funds for Its School-Based Program</i>	<u>A-02-21-01011</u>	3/11/2024	551,436,272
Total			\$764,743,953

APPENDIX C: CMS COMMENTS




DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: March 24, 2026

TO: John D. Hagg
Acting Deputy Inspector General for Audit Services

FROM: Dr. Mehmet Oz 
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: CMS Should Improve Its Policies and Procedures for the Oversight of States' Reported Medicaid Expenditures to Better Protect the Financial Integrity of the Medicaid Program (A-06-23-09006)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to ensuring that Medicaid dollars are spent responsibly, transparently, and in support of the beneficiaries who depend on this program for their health. CMS takes seriously its responsibilities to protect taxpayer funds by conducting thorough oversight of the Medicaid expenditures claimed by states.

As described in the OIG's report, the Form CMS-64 is a statement of the quarterly expenditures for which states claim federal matching funds under Title XIX of the Social Security Act (the Act). The amounts reported on the Form CMS-64 and its attachments must be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed. Claims developed through the use of sampling, projections, or other estimating techniques are considered estimates and are not allowable under any circumstances. On a quarterly basis, CMS reviews each state's Form CMS-64 submission to ensure that inappropriate amounts are not claimed. Conducting these quarterly reviews is resource dependent and prioritized based on areas of risk, and enhanced oversight procedures are performed for the 20 states with the highest federal Medicaid expenditures.

The Chief Financial Officer (CFO) Audit at CMS conducts an annual examination of the agency's financial statements and internal controls over financial reporting. Governed by the Chief Financial Officers Act of 1990, one of its goals is ensuring the accuracy of CMS financial reporting and the effectiveness of management systems used to oversee CMS's programs, including Medicaid. This includes a review of CMS's process relating to quarterly reviews of state submissions of Form CMS-64 expenditures, as well as related deferral actions and disallowance actions. The most recent fiscal year (FY) 2025 CFO audit was just completed

and there were no findings related to these activities, nor have there been any findings related to these activities since FY 2022.

CMS uses a comprehensive internal, risk-based review guide when conducting the quarterly Form CMS-64 reviews to ensure that the expenditure reports for all states are reviewed in a consistent manner that maximizes the efficiency of Agency oversight resources. As a result of these reviews, CMS prevents significant amounts of at-risk or unallowable Federal Financial Participation (FFP) from being paid to states, or recovers such amounts. The review guide is regularly updated to reflect programmatic changes and emerging risks. CMS also conducts periodic training to ensure that any review guide updates are thoroughly communicated to the CMS staff responsible for performing and managing the quarterly reviews. Further, CMS has standing internal monthly meetings attended by all CMS-64 review staff, along with relevant managers, in which best practices, emerging vulnerabilities, and new requirements are discussed in detail. In addition, CMS provides guidance and frequent technical assistance to states to assist them with their reporting and to ensure that they have the mechanisms and systems in place to track and report expenditures accurately.

CMS currently tracks state expenditures through the automated Medicaid and CHIP Budget and Expenditure System (MBES/CBES), the legacy system for budget and expenditures reporting. MBES/CBES is a web-based application system that allows states to report budgeted and actual expenditures for Medicaid by electronically submitting their Form CMS-64 directly to CMS. To modernize and streamline the current system and federal and state processes used in overseeing and monitoring Medicaid expenditures, CMS is incorporating the Form CMS-64 into the Medicaid & CHIP Financial (MACFin) System at the end of calendar year 2026. MACFin will increase accuracy, efficiency, and transparency while also decreasing administrative burden for state budget and expenditure reporting, CMS budget and expenditure review, and grant processes. For example, MACFin will add new reporting functionality, automation of current manual processes, and documentation upload and depository capabilities, with a focus on improving the overall user experience.

To supplement the quarterly Form CMS-64 expenditure reviews, CMS also conducts targeted Financial Management Reviews (FMRs), which are an in-depth review of a particular area of a state program to ensure it is operating in accordance with federal laws, rules, and regulations. The findings from FMRs have provided CMS with the information necessary to require states to strengthen internal controls, improve financial reporting, and implement claim edits to ensure the accuracy and allowability of claim payments to Medicaid and CHIP providers. FMRs can also result in the return of FFP to the federal government.

Recently, CMS has also been conducting more focused financial reviews as part of its quarterly Form CMS-64 reviews. For example, CMS is performing focused reviews in eight states to ensure any claims for FFP associated with individuals with an unsatisfactory immigration status are for emergency services, consistent with federal law. As of February 2026, these enhanced financial oversight efforts have resulted in over \$1.8 billion in FFP deferred or voluntarily returned, pending a final determination of allowability. As a result of these reviews, CMS is also working with states to update policies, internal controls, public assistance cost allocation plans,

and IT systems to ensure that states are claiming for Medicaid and administrative expenditures in accordance with federal law.

CMS is committed to working with states to improve the functioning and fiscal integrity of the Medicaid program. The OIG's recommendations and CMS's responses are below.

OIG Recommendation 1

We recommend that CMS develop and implement additional training for analysts to improve the clarity, accuracy, and consistency of their documentation for reviewing CMS-64s.

CMS Response

CMS concurs with this recommendation. CMS intends to develop and implement additional training for analysts that review the Form CMS-64. As noted above, CMS already uses a comprehensive internal review guide that is regularly updated to reflect programmatic changes and assessments of risk. CMS also conducts periodic training for the CMS staff responsible for performing the quarterly reviews.

OIG Recommendation 2

We recommend that CMS revise its policies and procedures related to deferred payments to align the deferral resolution timelines with Federal regulations.

CMS Response

CMS concurs with this recommendation. CMS intends to revise its policies and procedures related to deferred payments to clarify the process under the current regulations. In certain circumstances, CMS and the state have mutually agreed to provide the federal government additional time to hold the deferred FFP while CMS obtains more information from the state necessary for determining the allowability of the state's claimed expenditures. This is in service of preventing payment of unallowable FFP to states and unnecessary administrative burden.

OIG Recommendation 3

We recommend that CMS modify its policies and procedures to specify which CMS departments are responsible for tracking and resolving disallowed payments.

CMS Response

CMS concurs with this recommendation. CMS will update its policies and procedures to make clear the roles and responsibilities of the various entities involved with tracking and resolving disallowed payments.

CMS affirms that it actively tracks all appealed disallowances and maintains relevant documentation, however, CMS does not agree with the OIG's finding that having multiple entities

involved in tracking disallowances is the cause of delays in resolving them. In fact, the involvement of multiple entities allows for effective and efficient oversight, review, and resolution, rather than contributing to any delays. In addition, it is important to distinguish delays caused by internal CMS issues from those due to established statutory administrative appeals processes, such as those included in section 1116 of the Social Security Act.

OIG Recommendation 4

We recommend that CMS modify its Review Guide to include a step that requires analysts to determine the status of disallowed payments.

CMS Response

CMS concurs with this recommendation. CMS will update the Form CMS-64 review guide to include a step related to the status of disallowed payments.

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.



TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

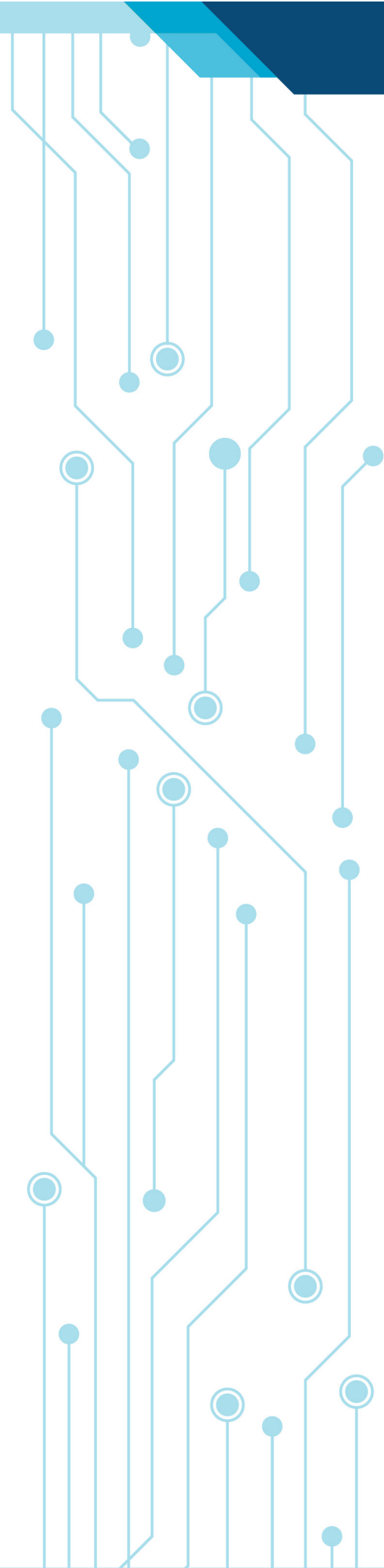
Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. [Learn more about complaints OIG investigates.](#)

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of [whistleblowing](#) or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.



Stay In Touch

Follow HHS-OIG for up to date news and publications.



OIGatHHS



HHS Office of Inspector General

[Subscribe To Our Newsletter](#)

[OIG.HHS.GOV](https://oig.hhs.gov)

Contact Us

For specific contact information, please [visit us online](#).

U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov