United States Government Accountability Office

Report to Congressional Requesters

July 2018

MEDICAID MANAGED CARE

Improvements Needed to Better Oversee Payment Risks

Accessible Version

GAO-18-528

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GAO Highlights

Highlights of GAO-18-528, a report to congressional requesters

Why GAO Did This Study

Federal spending on services paid for under Medicaid managed care was $171 billion in 2017, almost half of the total federal Medicaid expenditures for that year. Federal and state program integrity efforts have largely focused on Medicaid fee-for-service delivery where the state pays providers directly, rather than managed care, where it pays MCOs. As a result, less is known about the types of payment risks under managed care.

GAO was asked to examine payment risks in Medicaid managed care. In this report, GAO (1) identified payment risks; (2) identified any challenges to state oversight and strategies to address them; and (3) assessed CMS efforts to help states address payment risks and oversight challenges. To do this work, GAO reviewed findings on managed care payment risks and oversight challenges from federal and state audits and other sources. GAO also interviewed 49 state program integrity stakeholders in 10 states selected based on size, the percent of population in managed care, and geography. Stakeholders included the state Medicaid managed care office, state Medicaid program integrity unit, state auditor, Medicaid Fraud Control Unit, and an MCO.

What GAO Recommends

GAO recommends that CMS (1) expedite issuing planned guidance on Medicaid managed care program integrity, (2) address impediments to managed care audits, and (3) ensure states account for overpayments in setting future MCO payment rates. The Department of Health and Human Services concurred with these recommendations.

View GAO-18-528. For more information, contact Carolyn L.Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

Under Medicaid managed care, managed care organizations (MCO) receive a periodic payment per beneficiary in order to provide health care services. Managed care has the potential to help states reduce Medicaid program costs and better manage the use of health care services. However, managed care payments also have the potential to create program integrity risks. GAO identified six types of payment risks associated with managed care, including four related to payments that state Medicaid agencies make to MCOs, and two related to payments that MCOs make to providers. Of the six payment risks GAO identified, state stakeholders responsible for ensuring Medicaid program integrity more often cited the following two as having a higher level of risk:

(1) incorrect fee-for-service payments from MCOs, where the MCO paid providers for improper claims, such as claims for services not provided; and

(2) inaccurate state payments to MCOs resulting from using data that are not accurate or including costs that should be excluded in setting payment rates.

GAO also identified multiple challenges to program integrity oversight for managed care programs. Stakeholders most frequently cited challenges related to (1) appropriate allocation of resources, (2) quality of the data and technology used, and (3) adequacy of state policies and practices. Some stakeholders offered strategies to address these challenges, including collaborating with other entities to identify problem providers and fraud schemes, as well as having effective data systems to better manage risks.

The Centers for Medicare & Medicaid Services (CMS), which oversees Medicaid, has initiated efforts to assist states with program integrity oversight for managed care. However, some of these efforts have been delayed, and there are also gaps in oversight.

- CMS's planned Medicaid managed care guidance to states has been delayed due to the agency's internal review of the regulations; as of May 2018, no issuance date had been set for the guidance.
- CMS established a new approach for conducting managed care audits beginning in 2016. However, only a few audits have been conducted, with none initiated in the past 2 years. In part, this is due to certain impediments identified by states, such as the lack of some provisions in MCO contracts.
- CMS has updated standards for its periodic reviews of the state capitation rates set for MCOs. However, overpayments to providers by MCOs are not consistently accounted for in determining future state payments to MCOs, which can result in states' payments to MCOs being too high.

Lack of guidance and gaps in program integrity oversight are inconsistent with federal internal control standards, as well as with CMS's goals to (1) improve states' oversight of managed care; (2) use audits to investigate fraud, waste, and abuse of providers paid by MCOs; and (3) hold MCOs financially accountable. Without taking action to address these issues, CMS is missing an opportunity to develop more robust program integrity safeguards that will help mitigate payment risks in Medicaid managed care.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
HHS-OIG	Department of Health and Human Services' Office of Inspector General
MCO	managed care organization
MFCU	Medicaid Fraud Control Unit
UPIC	Unified Program Integrity Contractor

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July 26, 2018

The Honorable Claire McCaskill
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Thomas R. Carper
Ranking Member
Permanent Subcommittee on Investigations
Committee on Homeland Security and Governmental Affairs
United States Senate

Federal spending on services delivered and paid for under Medicaid managed care totaled $171 billion in 2017, almost half of the total $364 billion in federal Medicaid expenditures for that year.[1] Under Medicaid managed care, states pay a set periodic amount per beneficiary to managed care organizations (MCO) for each enrolled beneficiary, and MCOs pay health care providers for the services delivered to enrollees.[2] Used effectively, managed care may help states reduce Medicaid program costs and better manage utilization of health care services.

The Centers for Medicare & Medicaid Services (CMS)—an agency within the Department of Health and Human Services (HHS)—and the states have implemented program integrity policies and processes in an effort to address payment risks in Medicaid, such as those related to fraud, waste, and abuse. However, these program integrity efforts have remained largely focused on fee-for-service arrangements, where states pay health care providers directly for services rendered. Payments for these services provided under fee-for-service arrangements are audited by multiple entities and reviewed for incorrect or fraudulent patterns at the federal

[1]Medicaid is a joint federal-state program that finances health care coverage for low-income and medically needy individuals.

[2]States may have different types of managed care arrangements in Medicaid, such as primary care case management, prepaid ambulatory health plans, or comprehensive managed care, some of which have a limited benefit package or do not assume financial risk for services provided. In this report, we are referring to comprehensive, risk-based managed care provided through MCOs, which is the most common managed care arrangement. An MCO contracts with a state to provide comprehensive health care services through its network of providers, is responsible for ensuring access to Medicaid services, and is at financial risk for the cost of providing these services.

and state levels. In contrast, under managed care, states do not pay providers directly, but rather pay MCOs, which are responsible for providing services through their provider networks; MCOs are responsible for overseeing the appropriateness of the payments they make to providers. Less is known about the types of Medicaid payment risks and the program integrity process and challenges under managed care. We recently reported on certain payment risks in Medicaid managed care that are not adequately accounted for in determining the scope of Medicaid improper payments to MCOs.[3] This lack of knowledge is of particular concern, given the recent rapid growth in enrollment in Medicaid managed care. Between 2013 and 2016 (the most recent year for which data are available), Medicaid enrollment in comprehensive, risk-based managed care increased by 56 percent, or from 35.0 million beneficiaries to 54.6 million beneficiaries.

You asked us to identify payment risks and oversight challenges associated with Medicaid managed care. In this report, we

1. identify any potential payment risks that exist in Medicaid managed care;
2. identify any potential oversight challenges associated with identified payment risks, and the strategies states use to address them; and
3. assess CMS's efforts to assist states in addressing these payment risks and associated oversight challenges.

To address the first two objectives, we first reviewed reports resulting from federal and state audits and investigations, regarding payment risks and improper payments in Medicaid managed care and managed care in general. Through a literature search and outreach to state auditing organizations, we identified and reviewed audit reports of Medicaid managed care programs—such as those issued by HHS's Office of Inspector General (HHS-OIG) and state audit agencies—as well as

[3]See GAO, *Medicaid: CMS Needs to Better Measure Program Risks in Managed Care*, GAO-18-291 (Washington, D.C.: May 7, 2018). In this report, we recommended that CMS measure certain program risks that are not accounted for in its current oversight of Medicaid managed care. In addition, in another report, we found that CMS has not conducted a risk assessment for Medicaid or Medicare related to fraud in these programs. See GAO, *Medicare and Medicaid: CMS Needs to Fully Align its Antifraud Efforts with the Fraud Risk Framework*, GAO-18-88 (Washington, D.C.: Dec. 5, 2017). We recommended that CMS take steps to assess risks and create strategies to address them. CMS agreed with the recommendations in both of these reports.

investigations involving payments to MCOs and MCO providers. We also reviewed our prior work and reports related to Medicaid program integrity. Based on this review, we identified different types of payment risks, as well as reported challenges to program integrity oversight of these risks. We next interviewed officials from a non-generalizable sample of 10 states regarding their views about the level of risk of each type of payment risk; the extent they experienced the challenges to oversight; and whether they had used any oversight strategies to address Medicaid managed care payment risks. We selected states that had a significant share of their Medicaid populations enrolled in MCOs, and to provide a mix of population sizes and geographic locations.[4] Within each state, we conducted structured interviews with a total of 49 stakeholders from the following five entities that have oversight responsibilities related to Medicaid program integrity: (1) the state Medicaid managed care office; (2) the state Medicaid program integrity unit; (3) the state auditor; (4) the state Medicaid Fraud Control Unit (MFCU); and (5) an MCO.[5]

To assess CMS's efforts to assist states in addressing these payment risks and associated oversight challenges, we reviewed CMS's managed care regulations and guidance; current program integrity plan; and documents relating to training, technical assistance, monitoring and oversight.[6] We conducted interviews with CMS officials and CMS audit contractors regarding their roles, responsibilities, and oversight activities. Additionally, we reviewed our prior work related to program integrity risks in Medicaid managed care and identified applicable federal internal control standards—specifically those related to communicating guidance and to conducting effective monitoring—that we could use to assess CMS's efforts.[7]

[4]Selected states included California, Florida, Georgia, Hawaii, Massachusetts, Michigan, Nevada, Oregon, Tennessee, and Wisconsin. These states accounted for 34 percent of total federal and state Medicaid managed care expenditures in all states in fiscal year 2017.

[5]MCOs were identified by calculating the median enrollment of plans operating in each state in 2014 and selecting the plan with the median enrollment or next highest level of enrollment.

[6]See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Comprehensive Medicaid Integrity Plan, Fiscal Years 2014-2018.*

[7]See GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

We conducted this performance audit from October 2016 to July 2018 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.

Background

Medicaid is jointly financed by the federal government and the states, with the federal government reimbursing states for a share of their expenditures for Medicaid covered services provided to eligible beneficiaries. The federal share of spending is based on a statutory formula that determines a federal matching rate for each state.[8]

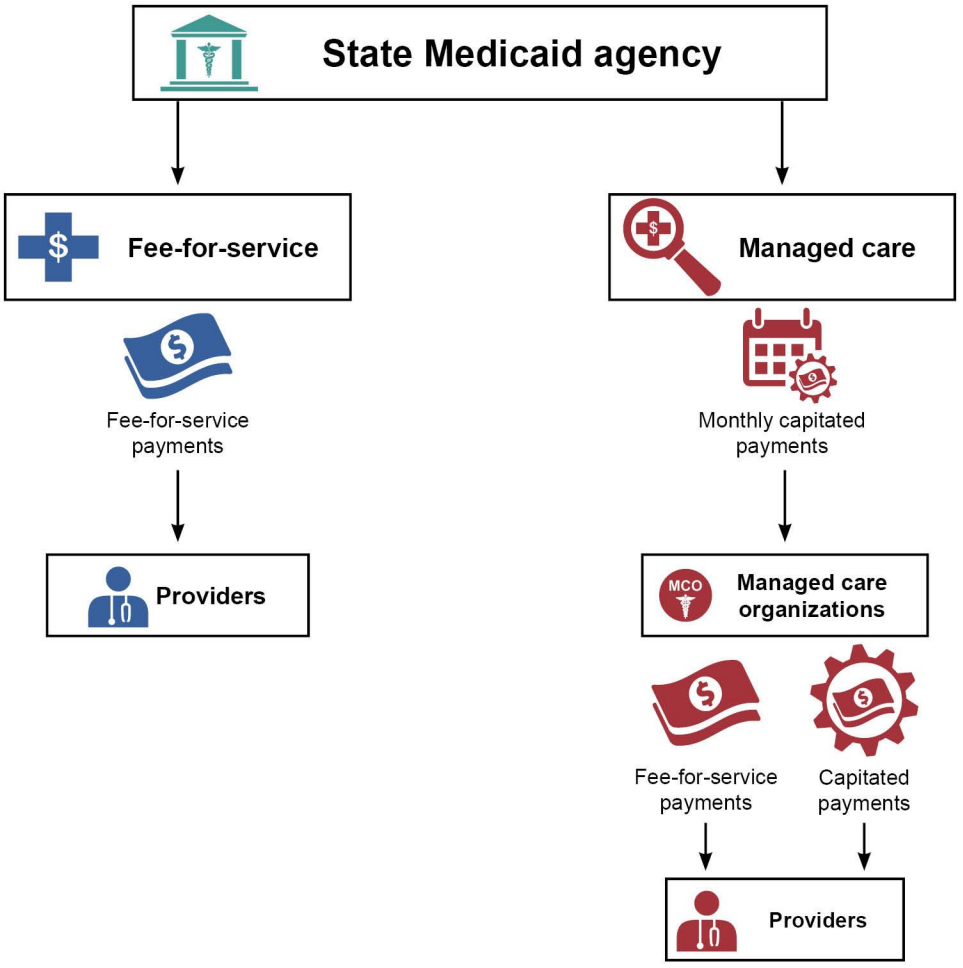
Medicaid Service Delivery Models

States may provide Medicaid services under either or both a fee-for-service model and a managed care model. Under a fee-for-service delivery model, states make payments directly to providers for services provided, and the federal government reimburses the state its share of spending based on these payments. Under a managed care service delivery model, states pay MCOs a capitation payment, which is a fixed periodic payment per beneficiary enrolled in an MCO—typically, per member per month. The federal government reimburses its share of spending based on the capitation payments states made to the MCO. In return for the capitated payment, each MCO is responsible for arranging for and paying providers' claims for all covered services provided to Medicaid beneficiaries. For example, MCOs may pay providers on a fee-for-service basis or with a monthly capitation payment per beneficiary, or through some other payment approach in which the provider assumes some risk for providing covered services. In either case, MCOs are required to report to the states information on services utilized by

[8]The federal government matches most state Medicaid expenditures for services on the basis of the Federal Medical Assistance Percentage formula, which, using per capita income, determines each state's federal matching rate. The federal medical assistance percentage for a state can range from 50 percent to 83 percent; in fiscal year 2017, the federal share of Medicaid service expenditures was about 62 percent.

Medicaid beneficiaries—information typically referred to as encounter data. Figure 1 illustrates these models.

Figure 1: Medicaid Fee-for-Service and Managed Care Delivery Models



Source: GAO. | GAO-18-528

Notes:

States may have different types of managed care arrangements in their Medicaid programs, some of which have a limited benefit package or do not assume financial risk for services provided. In this report, we are referring to comprehensive, risk-based managed care provided through MCOs, which is the most common managed care arrangement.

Managed care organizations may also pay providers through other payment approaches in which the provider assumes some risk for covered services.

State and MCO Program Integrity Responsibilities

Program integrity refers to the proper management and function of the Medicaid program to ensure that quality and efficient care is being provided, while Medicaid payments are used appropriately and with minimal waste. Program integrity efforts encompass a variety of administrative, review, and law enforcement strategies.

State stakeholders—Medicaid managed care offices, state Medicaid program integrity units, Medicaid Fraud Control Units (MFCUs), and in many cases state auditors—and MCO stakeholders—MCOs that contract with states to deliver Medicaid services—play important roles in the oversight of managed care payment risks and have a variety of program integrity responsibilities. A stakeholder's program integrity responsibilities can be specialized—such as for MFCUs, which focus on fraudulent behavior—or varied—such as for state Medicaid managed care offices and MCOs, which are responsible for monitoring fraud and other issues, such as compliance with quality standards or ensuring MCOs meet contract requirements. (See table 1.)

Table 1: Examples of Program Integrity Oversight Responsibilities of State-Level Stakeholders in Medicaid Managed Care

State-level stakeholder	Examples of program integrity oversight responsibilities
State Medicaid managed care offices	State Medicaid managed care offices are responsible for reviewing MCO quality standard reports, and monitoring MCO compliance with contract requirements, such as those related to network adequacy, reporting overpayments to, or fraud by, providers, and reporting ineligible or deceased individuals.
State program integrity units	State program integrity units may have responsibility for program integrity for services delivered under both managed care and fee-for-service. These units are responsible for developing policies to prevent Medicaid improper payments, identify improper payments the Medicaid agency has made, and recover improper payments. They also may be responsible for ensuring that providers that engage in fraudulent or abuse activities do not enroll in the program and are reported as terminated providers.
Medicaid Fraud Control Units (MFCU)	MFCUs are responsible for investigating and prosecuting Medicaid fraud. MFCUs are generally located in state Attorney General offices. State program integrity units refer potential fraud cases to MFCUs for further investigation and legal action.
State auditors	State auditors are responsible for assessing financial management and accountability in state government agencies and programs. The extent to which state audit offices conduct audits of a state Medicaid program—and audits particularly of Medicaid managed care—can vary by state.
Managed care organizations (MCO)	MCOs are responsible for developing policies and implementing procedures to prevent incorrect payments to providers, monitoring providers to ensure they are complying with program requirements, reporting overpayments made to providers, reporting ineligible or deceased individuals, and reporting providers engaged in fraudulent activity.

Source: GAO analysis of information from state auditors, the Medicaid and CHIP Payment and Access Commission, and the National Association of State Medicaid Fraud Control Units. I GAO-18-528

Note: States vary in the organizational structure of their Medicaid program. For example, in some states the program integrity unit may be within the managed care office, while in other states it may be separate.

Two of the stakeholders—state Medicaid managed care offices and MCOs—have responsibilities for program operation in addition to program integrity oversight responsibilities. For example, state Medicaid managed care offices' program operations responsibilities include enrolling beneficiaries, negotiating contracts with MCOs, developing capitation rates, and making monthly capitation payments to MCOs. MCOs' program operation responsibilities include establishing contracts with providers, creating provider networks, ensuring that enrollees have an ongoing source of primary care and timely access to needed services, and processing and paying provider claims.

In a previous report, we found that state Medicaid program integrity efforts focus primarily on payments and services delivered under fee-for-

service, and do not closely examine program integrity in managed care.[9] For example, officials from five of seven states that we spoke to for that report said that they primarily focused their program integrity efforts on fee-for-service claims. They also noted that program integrity in Medicaid managed care was more complex than for fee-for-service.

CMS's Program Integrity Responsibilities

CMS's program integrity responsibilities take a variety of forms. CMS issues program requirements for states through regulations and guidance; for example, regulations requiring states to establish actuarially sound capitation rates and to ensure that MCOs have an adequate network of providers, as well as to ensure that all covered services are available and accessible to beneficiaries in a timely manner.[10] CMS also requires states to submit MCO contracts and capitation rates to CMS for review and approval, and report key information such as encounter data collected from MCOs. The agency provides technical assistance and educational support to states, including having staff available to help states with specific issues or questions, and providing courses on program integrity issues. The agency also conducts periodic reviews to assess state program integrity policies, processes, and capabilities. In addition, CMS has engaged audit contractors to help states audit providers receiving Medicaid payments, including payments made by MCOs to providers.

[9]See GAO, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, GAO-14-341 (Washington, D.C.: May 19, 2014). In this report we recommended that CMS require states to conduct audits of managed care payments, update its guidance on program integrity in managed care, and provide additional support to states. CMS implemented these recommendations.

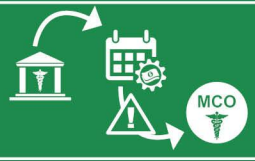
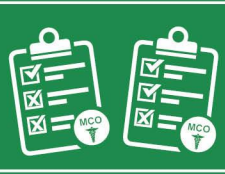
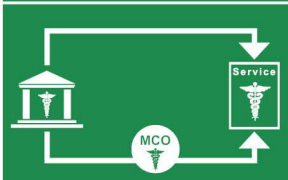
[10]In May 2016, CMS issued a final rule on Medicaid managed care to enhance regulatory provisions in a range of program integrity areas.

In general, actuarially sound capitation rates are certified by an actuary as being appropriate for the populations and services covered. Rates are to be adequate for MCOs to meet requirements for ensuring availability and timely access to services, adequate networks, and coordination and continuity of care. See 42 C.F.R. §§ 438.4, 438.206, 438.207, 438.208 (2017).

Six Types of Payment Risks Exist for Managed Care, with Stakeholders Viewing Some Risks as Greater than Others

We identified six types of payment risks through our review of Medicaid audit reports and other sources. Most of the stakeholders we spoke to agreed that these payment risks exist in Medicaid managed care. Four of these risks relate to the payments state Medicaid agencies make to MCOs, and two relate to payments that MCOs make to providers. (See figs. 2 and 3.)

Figure 2: Payment Risks Related to State Medicaid Program Payments to Managed Care Organizations (MCO)

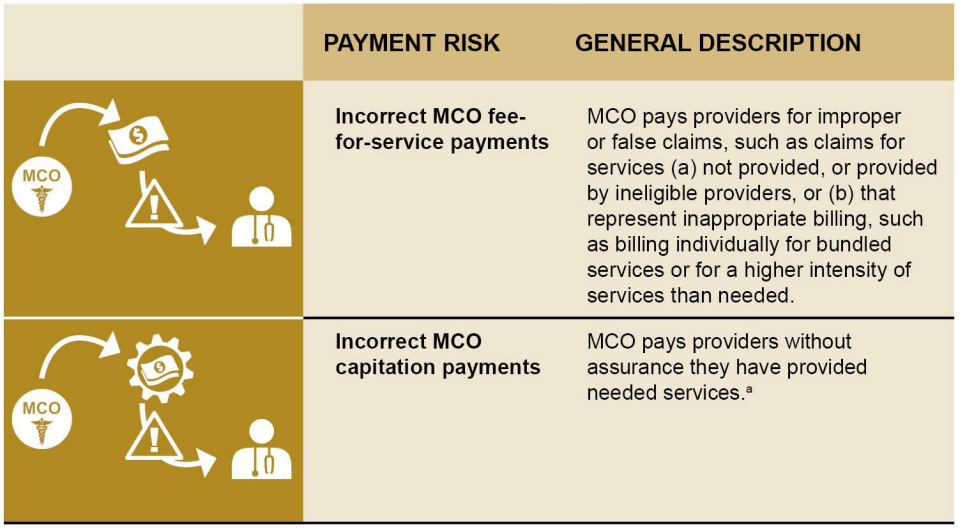
	PAYMENT RISK	GENERAL DESCRIPTION
	**Improper state capitation payments**	State makes monthly capitation payments to an MCO for beneficiaries who are ineligible for Medicaid, not enrolled in Medicaid or who have died.
	**Inaccurate state capitation rates**	State establishes capitation rates that are inaccurate, primarily due to issues with the data used to set the rates.[a]
	**State payments to noncompliant MCO**	State makes monthly capitation payments to an MCO for beneficiaries even though the MCO has not fulfilled state contract requirements.[b]
	**Duplicate state payments**	State makes duplicate payments—for example, when a health care provider submits a fee-for-service claim to the state Medicaid program for services that were covered by the MCO contract.

Source: GAO analysis of audit and other reports. | GAO-18-528

[a]Examples of data issues include inaccurate encounter data, MCO reported costs that are not allowable, overpayments that are not adjusted, or data that do not reflect changes in care delivery practices that have affected MCO costs.

[b]Examples of unfulfilled contract requirements may include an MCO not establishing an adequate provider network, reporting inaccurate encounter data for services, or not reporting the amount of overpayments the MCO made to providers.

Figure 3: Payment Risks Related to Medicaid Managed Care Organization (MCO) Payments to Providers

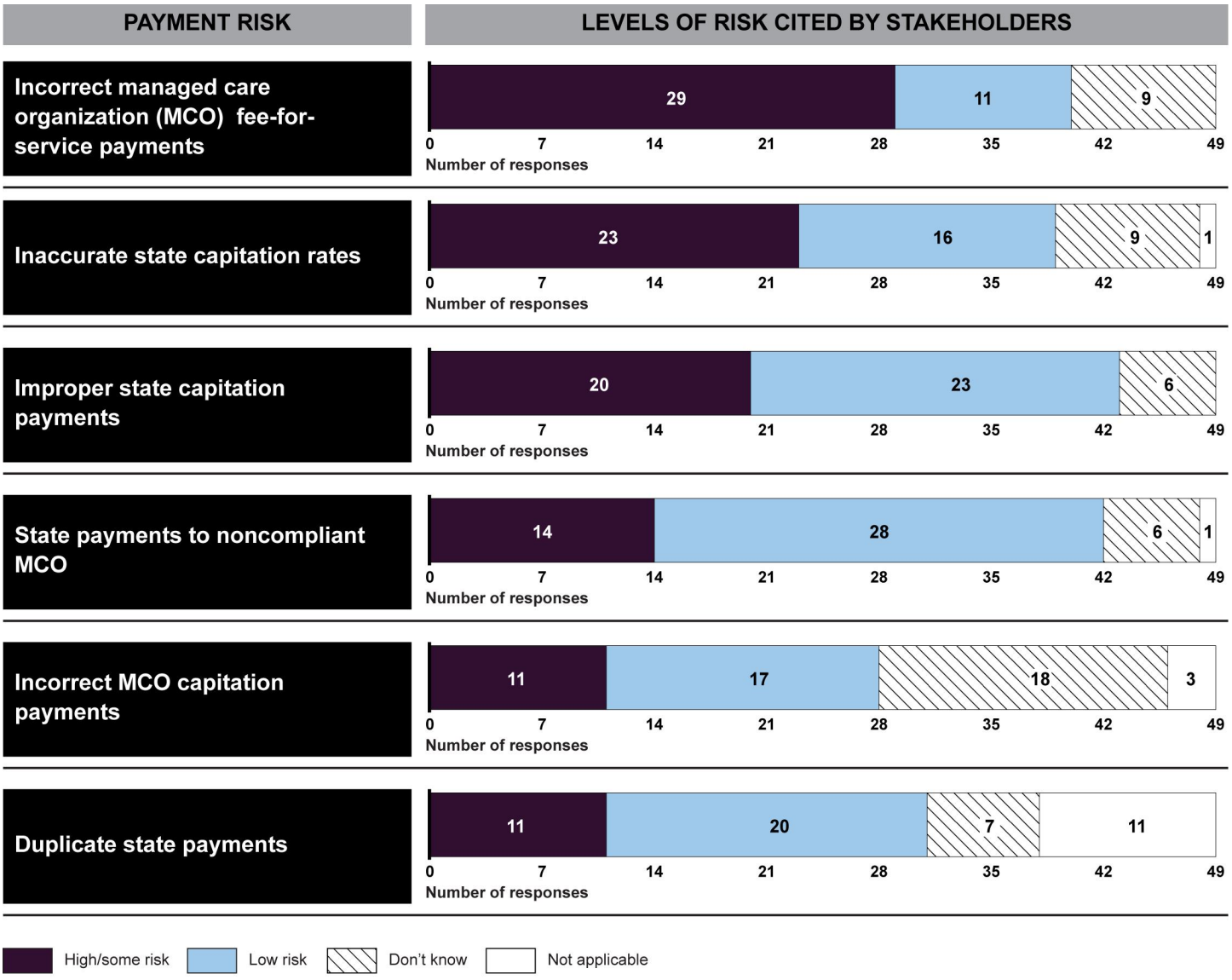


Source: GAO analysis of audit and other reports. | GAO-18-528

[a]Incorrect MCO capitation payments may result from false claims submitted by providers, data that do not reflect changes in care delivery practices and related costs, or lack of assurance that providers are delivering all medically necessary services to beneficiaries.

In terms of the relative importance of these payment risks, two payment risks were more frequently cited by stakeholders as having a higher level of risk than other types—incorrect MCO fee-for-service payments to providers and inaccurate state capitation rates. The remaining four payment risks were more frequently cited as having lower or unknown levels of risk: improper state capitation payments, state payments to noncompliant MCOs, incorrect MCO capitation payments, and duplicate state payments. (See fig. 4.) When we asked stakeholders to designate a level of risk, stakeholders whose primary responsibility is program integrity—state auditors, MFCU officials, and state Medicaid program integrity staff—were more likely to assign a higher level of risk for certain types of payment risks than state Medicaid managed care officials and MCO officials. (See app. I for additional information on risk level designation by stakeholder group.)

Figure 4: Stakeholders' Views of the Level of Risk Associated with Each Type of Medicaid Managed Care Payment Risk



Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Note: We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state Medicaid Fraud Control Unit, and a managed care organization. Some stakeholders occasionally said they did not have enough information to assign a level of risk ("Don't know") or that one of the payment risks did not apply in the state ("Not applicable").

Stakeholders provided the following examples of payment risks that they rated as having "some" or "high" risk in the state. (See table 2.) See

appendix II for further examples of payment risks identified as part of our review of audits and other reports.

Table 2: Examples of Types of Payment Risks in Medicaid Managed Care

Payment risk	Examples cited by stakeholders
Incorrect managed care organization (MCO) fee-for-service payments	• A Medicaid program integrity official said his state had experienced a range of cases relating to this payment risk, including in-home care and psychiatric providers who billed MCOs for services they did not provide; providers giving excessive prescriptions and drug tests; billing for multiple services when only one was provided; providing services that were not medically necessary. • A Medicaid Fraud Control Unit (MFCU) official in one state noted that MCOs paid providers for certain ineligible services for several years before it became known, and a MFCU official in another state cited MCOs paying people who are not enrolled as Medicaid providers. • A state auditor described a case of a provider who was submitting upcoded bills—billing for more severe illnesses than what existed or for more expensive services than what was provided.
Inaccurate state capitation rates	• A Medicaid program integrity official said there was no verification that adjustments were made to the capitation rate for potentially fraudulent claims. • A Medicaid managed care official in another state said there were problems with encounter data accuracy that could affect rate-setting. • A MFCU official said there could be an appreciable amount of overpayments “baked into” the state’s capitation rates. • A Medicaid program integrity official in another state noted that it was unclear whether MCOs were reporting overpayments.
Improper state capitation payments	• A Medicaid program integrity official said that the state had been unable to access information on deceased individuals from the federal government for close to 2 months. • A state auditor said that the state had lost access to a key database, and that one tenth of their beneficiaries may be ineligible. • Another state auditor said that beneficiaries’ eligibility status changed frequently in their Medicaid population, and validating eligibility changes over time was challenging.
State payments to noncompliant MCO	• A state auditor explained that while there are lots of reporting requirements for MCOs, the state does not always do a good job of reviewing the MCOs’ reports and taking any necessary action. • A MFCU official expressed concern that MCOs were not meeting contract requirements to report fraud, because there were a relatively low number of referrals of possible fraud in managed care compared with referrals in fee-for-service.
Incorrect MCO capitation payments	• A state Medicaid managed care official said there was not much the state could do to mitigate this risk, because it is dependent on the MCO to monitor providers. • One of the MCO officials said there is some risk of this, because it is very resource intensive for a health plan to audit medical records to confirm that providers are providing needed services.
Duplicate state payments	• A MFCU official said that providers know this is a payment area they can easily abuse. • A state auditor explained that providers are “creatures of habit” and will continue to bill the state as long as they get paid. In those cases, it is the responsibility of the state agency to check the providers’ claims.

Source: GAO analysis of information from interviews with program integrity stakeholders. | GAO-18-528

Note: We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state MFCU, and a managed care organization.

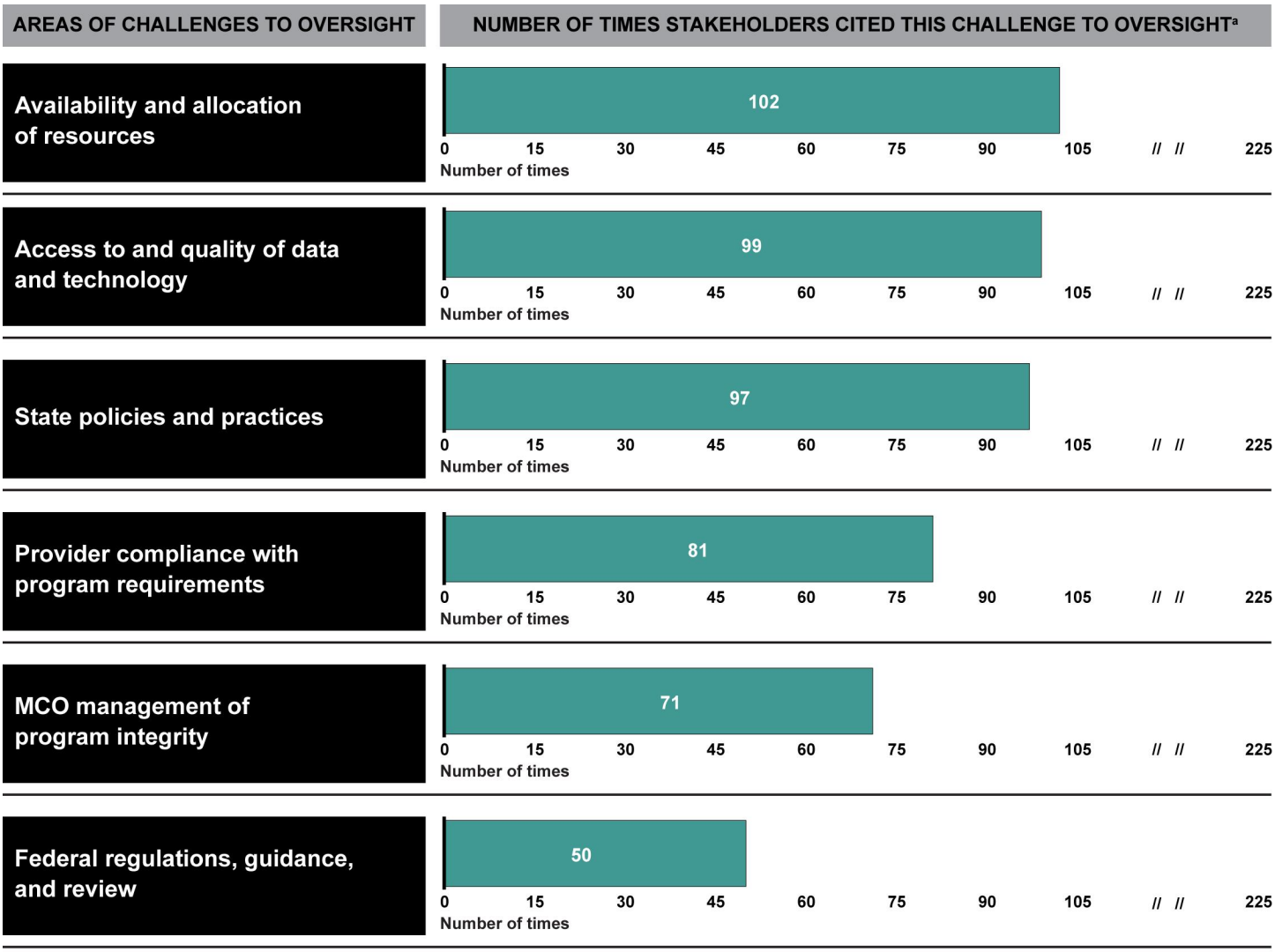
Multiple Challenges Exist for Effective Program Integrity Oversight and Stakeholders Identified Strategies to Address Them

We identified six challenges to effective program integrity oversight in Medicaid managed care based on our review of Medicaid audit reports and other sources. Among these six challenges, stakeholders most frequently cited allocation of resources, quality of data and technology, and adequacy of state policies and practices as key challenges. Some stakeholders also described strategies to address these challenges.

Key Challenges to Oversight Included Resource Allocation, the Quality of Data and Technology, and the Adequacy of State Policies and Practices

Through our research on examples of payment risks in Medicaid managed care, we identified six areas that can present challenges to program integrity oversight, including (1) availability and allocation of resources; (2) access to and quality of data and technology; (3) state policies and practices; (4) provider compliance with program requirements; (5) MCO management of program integrity; and (6) federal regulations, guidance, and review. Allocation of resources, quality of data and technology, and state policies and practices were the three most commonly cited challenges to program integrity oversight by stakeholders. (See fig. 5.)

Figure 5: Frequency of Stakeholder Citing of Six Challenges to Medicaid Managed Care Oversight



Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

[a]These data are out of 228 total responses. We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state Medicaid Fraud Control Unit, and a managed care organization (MCO). Stakeholders were asked to state whether each challenge was present for each of the six payment risks. Stakeholder responses were not included in the total if the respondent either did not know enough to discuss a particular payment risk (answered "don't know" for risk level and did not answer questions regarding challenges), or stated that the questions were not applicable for a payment type (answered "N/A" for risk level).

Stakeholders described the following examples of challenges to program integrity oversight they had observed. See appendix III for more information on the particular challenges for each of the payment risks.

Availability and allocation of resources. Stakeholders who cited resource allocation as an oversight challenge to managed care cited several key issues, such as the number of staff allocated to an activity, the expertise needed, and the ability to retain and replace staff. (See table 3.) Some stakeholders identified resource issues within their own organizations, while some identified resource issues they said existed in other organizations.

Table 3: Stakeholder Examples of Oversight Challenges Related to Resource Allocation for Medicaid Managed Care

Type of resource challenge	Examples of challenges cited
Funds and staff	• A state auditor said the state's Medicaid applications have grown dramatically in recent years, but resources to determine eligibility have not. • Several stakeholders—including a managed care organization (MCO) official, two state program integrity officials, and two Medicaid Fraud Control Unit (MFCU) officials—noted that some MCOs lack sufficient staff resources to detect incorrect MCO payments to their providers. • A Medicaid managed care official said the state does not have enough staff to review data on deceased and ineligible individuals and therefore they rely on MCOs to do it.
Expertise	• One state auditor cited the lack of in-house expertise as a challenge. They explained that all expertise with information technology systems has become the purview of contractors, and that very few state employees are able to access the information resulting in extensive delays in identifying deceased and ineligible individuals. Additionally, even though the state relies on MCO encounter data in setting capitation rates, there are no staff at the state level with sufficient knowledge to look at the data without the use of consultants. • A Medicaid managed care official noted that they have been unable to fill several budgeted vacancies in the actuarial division, because the state has not found people with the right expertise.
Retaining and replacing staff	• A state auditor said that the state was not timely in identifying risks of paying for ineligible or deceased beneficiaries, because of personnel turnover and difficulty in filling vacancies in the eligibility determination and oversight and monitoring units. • A Medicaid managed care official said that, given the state pay scale, it has been hard to recruit staff with clinical training.

Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Note: We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state MFCU, and a managed care organization.

Access to and quality of data and technology. Stakeholders who cited the quality of data and technology as oversight challenges to managed care provided examples related to timely access to data, inaccurate and unreliable data, and problems with information systems and interfaces. (See table 4.)

Table 4: Stakeholder Examples of Oversight Challenges Related to Data and Technology for Medicaid Managed Care

Type of data and technology challenge	Examples of challenges cited
Access to data	• Stakeholders in three states reported challenges in getting access to federal data on deceased individuals. • A Medicaid program integrity official said they could not access the state's death records due to lack of agreement within the state over departmental responsibilities.
Encounter data accuracy and reliability	• Two Medicaid program integrity officials said they have had problems getting accurate and complete encounter data from managed care organizations (MCO). • A Medicaid managed care official said there were problems with the quality of data received from MCOs for providers of non-traditional services, such as transportation to medical appointments. • One Medicaid Fraud Control Unit (MFCU) official explained that MCOs report data in different formats, and another MFCU said that the data MCOs report to the state agency are not consistent with the data the MCOs provided to the MFCU. • An MCO official said that the state's algorithm for calculating capitation rates did not incorporate all of the encounter data they submitted to the state, potentially affecting the accuracy of the rates in covering medical costs.
Information systems	• A Medicaid program integrity official said the state did not have a way to determine whether an individual is enrolled in more than one plan. • A state auditor reported problems with the interface between the state's eligibility and claims processing systems, which affected their ability to ensure they were not paying for deceased individuals. • A MFCU official said that the risk of the state making duplicate payments is related to the lack of interface between eligibility and claims payment systems.

Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Note: We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state MFCU, and a managed care organization.

State policies and practices. Stakeholders who cited state policies and practices as an oversight challenge to managed care described insufficient contract requirements, lack of state monitoring, and problems with state oversight. (See table 5.) Stakeholders from the state program integrity office, the MFCU, and the state auditor's office more frequently identified state policies and practices as a challenge than stakeholders from the state Medicaid managed care agency.

Table 5: Stakeholder Examples of Oversight Challenges Related to State Policies and Practices for Medicaid Managed Care

Type of state policy and practice challenge	Examples of challenges cited
State MCO contracts and guidance	• A Medicaid Fraud Control Unit (MFCU) official noted a lack of fraud referrals from managed care organizations (MCO) and said this could be related to a lack of effective contract provisions related to MCO identification of overpayments. • A state managed care official said that MCOs reported minimal information to the state, because the state did not provide guidelines or a template of reporting requirements. • A state auditor said there is nothing in the contract about recovering capitation payments from MCOs for ineligible individuals. • MCO officials from two states said that with respect to inaccurate payments to providers, there has been a lack of consistent guidance from the state about what services are covered and what are not covered.
Monitoring	• Multiple stakeholders noted the lack of state efforts to monitor important information related to payment risks. For example, a state auditor said no one was validating the accuracy of MCO beneficiary eligibility. A Medicaid program integrity official said that no one in the state was monitoring whether overpayments were being reported by MCOs or if adjustments for overpayments are made in setting capitation rates. A state auditor conducted multiple audits that showed that the state was not checking claims and was making fee-for-service payments to providers for services that should be covered by the MCOs. • An MCO official said that because of state delays in reviewing beneficiary eligibility, the utilization data used by the state to set capitation rates reflected a different beneficiary population than was ultimately enrolled in the program.
Oversight	• A state auditor said that sanctions were used very infrequently, and even if the contract allowed for a penalty, the state did not exercise the right to enforce it. • An MCO official said that because the state does not get back to the MCO about reported cases of potential fraud in a timely manner, it becomes difficult not to pay the provider.

Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Note: We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state MFCU, and a managed care organization.

MCO management of program integrity. Stakeholders who cited MCO management as an oversight challenge to managed care described how inadequate MCO oversight and monitoring—as well as incomplete MCO reporting to the state agency—can increase the risk of different types of payment risks. (See table 6.) Stakeholders from the state Medicaid managed care agency, the state program integrity office, and the MFCU were more likely than MCO stakeholders to cite these issues as

challenges. In particular, a few state officials noted that there was variation in size and resources among the MCOs in their respective states.

Table 6: Stakeholder Examples of Oversight Challenges Related to Managed Care Organization (MCO) Management

Type of MCO management challenge	Examples of challenges
Oversight and monitoring	• An MCO official said smaller MCOs in the state do not do as good a job in oversight of certain subcontracted partners—such as dental care organizations—as other MCOs, and this may negatively affect other MCOs ability to oversee these organizations. • A Medicaid Fraud Control Unit (MFCU) official said MCOs in the state needed to do a better job of communicating state regulations to providers, and of monitoring provider claims.
Reporting to the state agency	• A Medicaid program integrity official said that MCOs do not investigate the accuracy of provider claims or report updated claims to the state, and therefore needed adjustments are not made to the capitation rate. • Two MFCU officials and a Medicaid managed care official said that MCOs do not report overpayments, because they want to maintain good relationships with providers. One explained that MCOs are under pressure to maintain an adequate network, so they will address problems internally rather than report and lose a provider who fills a key clinical need. Another official said that MCOs seek to avoid creating "provider abrasion." The third said that MCOs may be likely to determine that a provider should be educated rather than referred for prosecution.[a] • Four officials said that MCOs lack financial incentives to identify and report inaccurate payments. A state auditor said that MCOs do not have an incentive to report inaccurate payments, because they get higher payments. A MFCU official said that MCOs in the state did not have the incentive to refer providers for prosecution, because they may not recover the money that is overpaid.

Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Note: We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state MFCU, and a managed care organization.

[a]"Provider abrasion" is a term used in the health care industry to refer to cases where providers express frustration due to delayed or rejected claims payments, or what they view as excessive oversight.

Provider compliance with program requirements. Stakeholders who cited provider compliance as a challenge to oversight indicated that providers are the primary source of inaccurate payments, because of improper billing, which may include fraudulent billing. These stakeholders also stated that some types of providers presented a higher risk than others in their state. Several stakeholders pointed out that certain providers intentionally commit fraud, while others may be unaware of changes in policies or procedures and therefore unintentionally submit inaccurate claims. Several stakeholders noted that it is the responsibility of providers to bill correctly, while a few others pointed out that because the payment process is complicated, MCOs and state agencies may not identify inaccurate payments. Stakeholders also selected from a list of 19 types of providers the 3 or 4 that in their view represented the highest

payment risks in the state. The two most frequently mentioned health care providers or services were (1) durable medical equipment, and (2) psychiatric and behavioral health care providers. (See table 7.)

Table 7: Health Care Providers and Services Most Frequently Identified by Stakeholders as Having the Highest Risk for Payment Error in Medicaid Managed Care

Type of provider or service	Number of times identified as among the top four providers or services at risk for payment error[a]
Durable medical equipment	19
Psychiatric and behavioral health care (including both mental illness and substance abuse	19
Prescription drugs	13
Laboratory, x-ray, and imaging	12
Personal care or support	11
Pharmacy	10
Home health	9
Long term care services and supports in the home and community generally	8
Primary care physicians and related licensed practitioners	8

Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Note: We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state Medicaid Fraud Control Unit, and a managed care organization.

[a]Forty-three of 49 stakeholders answered this question, while the remaining 6 stakeholders said that they did not have enough information to make this determination. Other providers and services that four, five, or six stakeholders identified as presenting high risks included dental and other oral surgery services, inpatient hospitals, transportation and other accommodations, and long term care institutions, such as nursing homes and intermediate care facilities.

Federal regulations, guidance, and review. Over half of the stakeholders who identified federal regulations, guidance, and review as oversight challenges to managed care cited the complexity of federal regulations and the lack of federal guidance as key issues. For example, one stakeholder said that there needed to be more clarity about the new regulations for setting capitation rates for MCOs, while another said that there was a lack of clarity about the respective roles of states and MCOs in program integrity oversight. One stakeholder noted that most of the responsibility for operating the Medicaid program lies with the state, not with the federal government.

Strategies Identified by Stakeholders to Address Managed Care Oversight Challenges Included Ensuring High Quality Data and Collaboration among State Agencies and MCOs

Some stakeholders we interviewed identified strategies, controls, or best practices to address the challenges to oversight of Medicaid managed care payment risks. As shown in table 8, they identified a variety of strategies such as ensuring high quality data, collaboration among state agencies and MCOs, imposing sanctions on noncompliant MCOs, enhancing contract requirements, and conducting regular monitoring.

Table 8: Strategies Identified by Stakeholders to Address Selected Medicaid Managed Care Payment Risks

Strategy	Examples	Payment risks addressed
Ensure high quality and useful data through automated edit checks	Conduct editing of encounter data sent by managed care organizations (MCO) to determine if it can be accepted. In one state, if too many encounters are rejected, all of the data are sent back to the MCO.	Inaccurate state capitation rates
	Implement a system edit that automatically recoups payments after an individual has unenrolled.	Improper state capitation payments
	Implement edits in claims processing systems to prevent claims that should be covered by MCOs from being paid by the state through fee-for-service.	Duplicate state payments
Facilitate collaboration between state agencies and MCOs	Collaboration among stakeholders to more easily identify common fraud schemes. Because each stakeholder may have limited data and a narrowly defined role in the process, collaboration allows the stakeholders to share their data to more efficiently catch and prosecute fraudulent behavior.	State payments to non-compliant MCOs Incorrect MCO fee-for-service payments
	Meet with MCOs on a monthly or quarterly basis to facilitate in the reporting of information required by the contract. In one state, these meetings lead to clarification of contract language.	State payments to noncompliant MCOs
Regularly audit plans and providers	Conduct annual audits of plans' quality performance, and review utilization against state and national averages in order to identify potential underutilization patterns. An MCO official reported that the MCO audited its capitated provider networks.	Incorrect MCO capitation payments
Enhance contract requirements	Require MCOs to provide a daily electronic eligibility file to the state, and to inform the state if the MCO is aware that an enrollee's eligibility should be terminated due to death or ineligibility.	Improper state capitation payments
Regularly assess and prioritize resource allocation	Employ a risk assessment process to continually set priorities on where to use staff and other resources. The official described this as an effort to manage resource limitations.	Improper state capitation payments
Regularly monitor health care providers	Regularly monitor capitated networks for under- and over-utilization, including review of utilization for common services and comparing them to state and national averages.	Incorrect MCO capitation payments

Strategy	Examples	Payment risks addressed
Target reporting needs	Require MCOs to submit on a quarterly basis the number of complaints, referrals, or inquiries that they've received, as well as overpayments identified, and providers that the MCO has unenrolled.	Incorrect MCO fee-for-service payments
Provide focused education	Educate MCOs and providers about what fraud, waste, and abuse are, as well as benefit policies and coverage.	Incorrect MCO fee-for-service payments
Actively employ sanctions	In one state, 95 percent of encounters must be submitted within a certain time frame to avoid sanction by the state, which allows the state time to review the data.	Inaccurate state capitation rates

Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Note: We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state Medicaid Fraud Control Unit, and a managed care organization.

CMS Has Assisted States in Addressing Payment Risks, but Some Efforts Have Been Delayed and There Are Gaps in Oversight

CMS has taken important steps to address payment risks in Medicaid managed care, issuing a final rule, increasing guidance, and conducting oversight activities. However, some efforts are incomplete, and there are gaps in key oversight activities.

CMS Issued a Final Rule, Provided Additional Guidance, and Updated Certain Oversight Activities Related to Managed Care Program Integrity

In May 2016, CMS issued a final rule on Medicaid managed care. According to CMS, the rule is intended to enhance regulatory provisions related to program integrity and payment risks, among other things.[11] These regulatory provisions varied in terms of when the requirements were applicable. For example, for contracts beginning on or after July 1, 2017, the rule requires

[11]The rule was issued to strengthen actuarial soundness payment provisions to promote accountability of Medicaid managed care program rates, promote the quality of care and strengthen efforts to reform delivery systems, and ensure beneficiary protections, in addition to enhancing policies related to program integrity. A number of the provisions of the rule were applicable for state contracts with MCOs for rating periods starting on or after July 1, 2017, while some were scheduled to take effect for later rating periods.

- state contracts with MCOs to require MCOs to promptly report all overpayments made to providers, and to specify the overpayments due to potential fraud; [12]
- states to account for overpayments when setting capitation payment amounts; [13] and
- states to establish procedures and quality assurance protocols to ensure that MCOs submit encounter data that is complete and accurate. [14]

These requirements have the potential to enhance MCO and state oversight of managed care, and address payment risks involving incorrect MCO payments to providers and inaccurate state capitation rates for MCOs. CMS is currently reviewing the rule for possible revision of its requirements and an announcement on the results of the review is expected in 2018.[15]

Most stakeholders we spoke to identified ways in which the managed care rule could have a positive impact on managed care program integrity oversight. Of the 49 stakeholders we spoke to, 28 made positive statements about the rule's potential impact on program integrity oversight of payment risks in managed care, 9 stakeholders said they were not familiar enough with the managed care rule to comment on it, and the remaining 12 stakeholders provided a range of comments about the rule. The 28 stakeholders with positive comments identified a variety of ways in which they said the managed care rule would help, including

- reducing improper payments;
- establishing transparency in setting state capitation rates;
- providing clear guidelines for MCO reporting, and clear authority for states to require reporting;

[12]See 42 C.F.R. § 438.608(a)(2) (2017).

[13]See 42 C.F.R. § 438.608(d)(4) (2017).

[14]See 42 C.F.R. §§ 438.242(d), 438.818(a)(2).

[15]CMS indicated it will issue a Notice of Proposed Rulemaking in 2018 to streamline Medicaid managed care regulations and reduce burden. See Department of Health and Human Services, Medicaid and CHIP Managed Care, *Spring 2018 Unified Agenda of Federal Regulatory and Deregulatory Actions*, (CMS-2480-P), RIN 0938-AT40, accessed May 14, 2018, http://www.reginfo.gov.

- obtaining information on overpayments identified and collected by MCOs;
- holding MCO leadership accountable for meeting program requirements; and
- reducing medical costs, despite additional short-term administrative costs.
- Comments by the other 12 stakeholders who were familiar with the rule included statements that the rule
- should have been more aggressive in requiring MCOs to implement efforts related to program integrity;
- would have limited impact for them, because many of its requirements were already in place in their state; and
- set time frames for implementation that were hard to meet.

In addition to issuing the rule, CMS has sought to increase guidance available to states through training, technical assistance, and other educational resources. (See table 9.)

Table 9: CMS Steps to Increase Guidance on Oversight of Payment Risks in Medicaid Managed Care

Type of guidance	CMS steps
Training	In 2017, the Centers for Medicare & Medicaid Services (CMS) expanded the course offerings of the Medicaid Integrity Institute—a national training program for state program integrity officials—to include courses on vulnerabilities in Medicaid managed care, state enrollment of managed care contracted providers, and how to handle denials and terminations of ineligible providers. CMS officials told us that these courses, as well as other ongoing courses at the institute, cover multiple payment risks in Medicaid managed care through case studies and participant discussion. The Medicaid Fraud and Abuse Technical Advisory Group convened a Managed Care Audits & Overpayments subgroup from July to October 2017 to facilitate exchanges between CMS, the institute, and states on issues states are facing.[a]
Technical assistance	CMS officials told us that they have increased the availability of staff to provide technical assistance to states. Key topics that state officials raise with CMS include questions related to (1) overpayments that managed care organizations (MCO) make to providers; and (2) actuarial soundness issues associated with setting capitation rates for MCOs, including how to address overpayments in rate development, among other topics.
Other educational resources	In January 2017, the agency issued an information bulletin to facilitate state oversight of certain services for children and youth in Medicaid managed care.[b] In April 2017, CMS issued a toolkit for states to assess whether MCOs have an adequate number of providers to serve beneficiaries.[c] In June 2017, CMS issued an update to its Medicaid Provider Enrollment Compendium, which helps states ensure that their provider screening and enrollment will exclude ineligible providers and avoid making improper payments, among other things. The update includes guidance on the provider screening requirements for Medicaid managed care network providers.[d] In September 2017, CMS awarded a contract for the purpose of updating educational materials related to program integrity. CMS officials stated that they expected a shift in focus of educational tools toward managed care. In May 2018, CMS issued guidance about best practices that were identified through the agency's program integrity reviews. The guidance was issued to states and to the agency's Regional Information Sharing System.

Source: CMS. I GAO-18-528

[a]The Medicaid Fraud and Abuse Technical Advisory Group has been working with CMS since 1997, and includes state program integrity directors representing every CMS region. The group is divided into workgroups charged with identifying and developing suggestions that can be shared during monthly calls with states, CMS, and the Medicaid Integrity Institute.

[b]Department of Health and Human Services, Centers for Medicare & Medicaid Services, *The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit for Children and Youth in Managed Care,* Informational Bulletin, Jan. 5, 2017.

[c]Centers for Medicare & Medicaid Services, *Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability*, April 2017.

[d]Centers for Medicare & Medicaid Services, *Medicaid Provider Enrollment Compendium*, updated June 2017.

Lastly, CMS efforts have included updating the requirements used in capitation rate setting reviews, contract oversight, and other types of audits and reviews, as described below.

- **Review of state capitation rates for Medicaid MCOs.** CMS reviews states' capitation rates at least once every year, and in 2017 made revisions to its rate review guidance to states,

incorporating new requirements from the managed care rule. According to CMS officials, the agency typically conducts between 250 and 300 rate reviews annually to determine whether states' rate development methodologies meet generally accepted actuarial principles, as well as federal laws and requirements.

- **Review of state Medicaid MCO contracts.** CMS regularly reviews state contracts with MCOs to ensure that contract provisions meet federal requirements. In 2017, CMS updated its criteria for Medicaid managed care contract review and approval, and revised the guide that it provides to states to help them develop effective MCO contracts.[16]
- **CMS contracted audits.** In 2016, CMS began to transition and consolidate audits of providers to a type of contractor called Unified Program Integrity Contractors (UPIC). This transition is intended to integrate contracted audit activities across CMS health care programs, such as Medicaid and Medicare, according to CMS. Additionally, UPIC audits can include health care providers who participate in multiple federal programs. Within the Medicaid program, UPICs may conduct audits with states interested in pursuing what are called "collaborative audits." CMS's contract with UPICs allows for audits of providers in MCO networks.[17]
- **Focused program integrity reviews.** CMS officials said that in 2016, the agency updated the review guide used to conduct focused program integrity reviews of state Medicaid managed care programs.[18] CMS program integrity reviews have identified some common issues, such as a low number of investigations of

[16]See Centers for Medicare & Medicaid Services, *State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval,* Jan. 20, 2017.

[17]The UPIC statement of work indicates that they shall investigate suspected instances of fraud, waste, and abuse involving providers performing under Medicaid managed care; and maintain an ongoing dialogue with the appropriate personnel of units in managed care organizations, including Medicaid MCOs in their region, as well as coordinate with the state Medicaid agency to develop contacts at the Medicaid MCOs. The managed care rule requires that all state contracts with MCOs provide the state, CMS, and the HHS-OIG with access to any records or documents of the MCO or its subcontractors, and such access supports the ability to conduct such audits.

[18]CMS officials said that program integrity reviews are conducted to assess the effectiveness of state program integrity efforts, including compliance with federal statutory and regulatory requirements. As we previously reported, in 2014, CMS shifted the emphasis of its reviews from a comprehensive approach to an approach that provided a more "focused review" on high risk areas of concern in each state, including managed care. See GAO-18-291.

overpayments conducted by managed care plans and a low amount of recoveries by plans.[19] However, CMS officials stated these reviews are not focused primarily on assessing specific payment risks. For example, these reviews do not involve an actual review or audit of MCO payments to providers to assess the extent that inaccurate payments were made. Instead, they review program integrity policies and processes, such as whether and how the state monitors overpayments, and whether MCOs comply with state requirements.

CMS Efforts to Address Payment Risks Have Been Delayed and Gaps Exist in Key Oversight Activities.

Despite CMS's efforts to improve oversight of program integrity in Medicaid managed care, there have been delays in issuing guidance, and gaps in key auditing and monitoring activities. These delays and gaps are inconsistent with the agency's current program integrity plan, which established goals for improving state oversight of program integrity in Medicaid managed care, as well as the financial accountability of Medicaid MCOs.[20]

Delays in the Development and Issuance of Guidance

Publication of CMS guidance that would assist states in oversight of payment risks has been delayed. CMS officials told us in April 2017 that they planned to issue a compendium of guidance related to the managed care rule's program integrity regulations. The compendium is intended to provide guidance on (1) MCO program integrity requirements, (2) state audits of MCO encounter data that must be conducted at least every 3 years, and (3) MCO overpayments to providers. However, in September 2017, CMS officials told us that although they had a draft of the compendium, they did not have a timeline for issuing it, because the managed care rule was under review. As of May 2018, no issuance date has been set for the guidance. Over half of the stakeholders we interviewed who identified federal responsibilities as an oversight

[19]See GAO, *Medicaid Program Integrity: CMS Should Build on Current Oversight Efforts by Further Enhancing Collaboration with States*, GAO-17-277 (Washington, D.C.: March 15, 2017).

[20]See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Comprehensive Medicaid Integrity Plan, Fiscal Years 2014-2018*.

challenge to managed care cited the complexity of federal regulations and the lack of federal guidance as key issues. The lack of available federal guidance resulting from delays in issuing such guidance is inconsistent with federal internal control standards that call for federal agencies to communicate quality information to those responsible for program implementation for the purposes of achieving program objectives and addressing program risks.[21] Until such guidance is issued, stakeholders' ability to effectively address challenges to payment risks in Medicaid managed care will continue to be hindered.

Gaps in Auditing

Although audits of providers that bill and are paid by MCOs can provide important information about payment risks and are included in the UPIC statement of work, only 14 of the 762 audits initiated by CMS contractors during the period of fiscal year 2014 through 2017 were managed care audits. Our review of three CMS contracted managed care audits indicated that the amount of inaccurate MCO payments to providers—as well as MCO and provider noncompliance with contracts—can be significant. For example, one audit of an MCO's payments to selected providers found that 8.94 percent of payments were in error, representing over $4 million in overpayments for a 6-month period. This audit also identified a lack of provider compliance with requirements to provide preventive care services and care coordination to members, and a lack of MCO compliance with requirements to monitor member enrollment, resulting in the MCO paying providers for individuals who were not enrolled. [22]

CMS officials shared plans to increase collaborative audits in managed care in the future. CMS officials said the agency is in the early planning stages to pilot an audit of MCO providers in one state, with the goal of addressing challenges encountered in prior managed care audits. CMS is also in discussions with states and audit contractors to conduct potential audits and investigations in fiscal years 2018 and 2019.

[21]See GAO-14-704G, Section 15.03.

[22]Among 27 audits and investigations of Medicaid managed care programs we recently reviewed, 10 identified about $68 million in MCO overpayments to providers and other unallowable MCO costs, and 1 investigation resulted in a $137.5 million settlement to resolve allegations of false claims. See GAO-18-291.

However, CMS and audit contractor officials identified several circumstances related to states' contracts with MCOs that they said have created gaps in their auditing activity.

- According to CMS officials, states have reported a reluctance to conduct provider audits when states' contracts with MCOs (1) allow the MCO to retain identified overpayments, or (2) do not explicitly discuss how identified overpayments are addressed.
- Officials with the two operating UPICs told us that CMS's general guidance to them was to restrict their audits to states with MCO contracts where the states can recoup overpayments from the MCOs.[23] According to one contractor, because few states have such contracts, the vast majority of the contractors' audits are of providers paid on a fee-for-service basis. However, overpayments to providers can affect state and federal expenditures regardless of a state's particular recoupment policy, because if they are not accounted for, they may increase future capitation rates paid to MCOs.[24]
- Audit contractor officials also said the lack of access to MCO coverage and policy materials, and the inability to directly access encounter or claims data, prevent them from doing analyses to identify potential provider fraud, abuse, and waste for investigation.

While CMS officials said they encourage states to participate in additional collaborative audits of managed care, they did not identify steps the agency is taking to address the circumstances that limit collaborative audits conducted. The lack of sufficient auditing in managed care is inconsistent with federal internal control standards that require federal agencies to identify risks through such activities as auditing.[25]

Gaps in Monitoring

CMS has incomplete information on the scope and extent of MCO overpayments to providers, which results in a gap in monitoring MCO

[23]We spoke with the two UPICs that were operational at the time of our study, as well as one of the Medicaid Program Integrity Contractors that conducted audits prior to CMS contracts with UPICs.

[24]See GAO-18-291.

[25]See GAO-14-704G, Sections 7.02 and 7.04.

payments. Gaps in monitoring also exist because CMS lacks a process for consistently collecting information about overpayments and documenting that states account for overpayments when setting capitation rates. A few examples of these issues include the following:

- While CMS regularly reviews states' proposed capitation rates, it lacks a process to consistently ensure any overpayments are accounted for by the states. According to an official with CMS's Office of the Actuary, their review of state capitation rates does not require documentation of the amount of overpayments that occurred the prior year, how they were determined, or how they were incorporated into setting capitation rates. According to this official, issues between states and MCOs—such as contractual issues related to how overpayments are handled—are beyond the scope of their review and responsibilities. However, such information could be important to program integrity oversight; for example, 11 stakeholders we interviewed said that state capitation rates did not account for overpayments, because they had observed that overpayments were not reported by MCOs, were not monitored by the state, or both.
- Although some of CMS's focused program integrity reviews have suggested that there is under-reporting of MCO overpayments to providers, CMS officials explained that these reviews are intended to assess state compliance with regulations, and not to determine the extent of under-reporting or why overpayments are under-reported.[26]
- States' and CMS's contracted auditors have conducted only a few collaborative audits in managed care, even though such audits can identify overpayments made by MCOs to providers.

These gaps in monitoring of overpayments are inconsistent with federal internal control standards that require federal agencies to monitor operating effectiveness through audits and reviews.[27] Without more complete information on the extent of overpayments and a process to ensure they are accounted for in state capitation rates, CMS is unable to ensure that MCOs are effectively identifying overpayments and

[26]In focused integrity reviews that CMS conducted in 27 states from 2014 to 2017, the agency found that MCOs in 17 states reported fewer overpayments to their state Medicaid agencies than CMS would expect.

[27]See GAO-14-704G, Sections 16.06–16.08.

documenting that they are accounted for when reviewing and approving state capitation rates. As a result, CMS cannot be sure that states are holding MCOs financially accountable for making proper payments, that states are paying accurate capitation payments to MCOs, or that the federal government's share of Medicaid expenditures is accurate.

Conclusions

Managed care has the potential to help states reduce Medicaid program costs and better manage utilization of health care services. However, oversight of managed care is critical to achieving these goals. Payment risks are not eliminated under managed care; in fact, they are more complex and difficult to oversee. While CMS has taken important steps to improve program integrity in managed care—including strengthening regulations, developing guidance for states on provider enrollment in Medicaid managed care, and beginning to include managed care in the monitoring and auditing process—the efforts remain incomplete, because of delays and limited implementation. To date, CMS has not issued its planned compendium with guidance on program integrity in Medicaid managed care, taken steps to address known factors limiting collaborative audits, or developed a process to help ensure that overpayments to providers are identified by the states. Without taking actions to address these issues, CMS is missing an opportunity to develop more robust program integrity safeguards that will best mitigate payment risks in managed care.

Recommendations For Executive Action

We are making the following three recommendations to CMS:

- The Administrator of CMS should expedite the planned efforts to communicate guidance, such as its compendium on Medicaid managed care program integrity, to state stakeholders related to Medicaid managed care program integrity. (Recommendation 1)
- The Administrator of CMS should eliminate impediments to collaborative audits in managed care conducted by audit contractors and states, by ensuring that managed care audits are conducted regardless of which entity—the state or the managed care organization—recoups any identified overpayments. (Recommendation 2)

- The Administrator of CMS should require states to report and document the amount of MCO overpayments to providers and how they are accounted for in capitation rate-setting. (Recommendation 3)

Agency Comments

We provided a draft of this product to the Department of Health and Human Services for comment. HHS concurred with these recommendations, stating that it is committed to Medicaid program integrity. HHS also cited examples of activities underway to improve oversight of the Medicaid program, such as training offered through the Medicaid Integrity Institute, and guidance provided in the Medicaid Provider Enrollment Compendium. The full text of HHS's comments is reproduced in appendix IV. HHS also provided technical comments, which we incorporated as appropriate.

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

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

Carolyn L. Yocom
Director, Health Care

Appendix I: Risk Level Designations by Stakeholder Group

We asked stakeholders involved in program integrity oversight to assign a level of risk—either low, some, or high—to six types of payment risks in Medicaid managed care.[1] We interviewed officials in the following five organizations in each of 10 states: state Medicaid managed care office, state program integrity unit, Medicaid Fraud Control Unit (MFCU), state auditor's office, and a managed care organization (MCO).[2] (See table 1 for a description of each of these entities.) Figures 6 through 9 below illustrate the risk level stakeholders assigned to the four types of payment risk that are associated with states' periodic capitation payments to MCOs. Figures 10 and 11 illustrate the risk level stakeholders assigned the two types of payment risks associated with MCO payments to providers. In some cases, stakeholders said they did not have enough information to assign a level of risk ("Don't know") or that one of the payment risks did not apply in their state ("Not applicable").

For some payment risks, the stakeholders whose primary responsibility is program integrity—state auditors, MFCU officials, and state Medicaid program integrity staff—were more likely to assign a higher level of risk than state Medicaid managed care officials and MCO officials who have responsibilities both for program operation and program integrity. For example, some of the risk levels cited in our interviews by state auditors,

[1]The six payment risks are (1) improper state capitation payments to MCOs for ineligible or deceased individuals; (2) inaccurate state capitation rate; (3) state payments to MCOs that have not fulfilled contract requirements; (4) state duplicate payment to MCOs and providers; (5) incorrect MCO fee-for-service payments to providers for improper claims, which may include fraudulent claims; and (6) incorrect MCO capitation payments to providers that have not complied with program requirements.

[2]We interviewed a total of 49 stakeholders. One state auditor declined to participate. Selected states included California, Florida, Georgia, Hawaii, Massachusetts, Michigan, Nevada, Oregon, Tennessee, and Wisconsin. We selected states that had a significant share of their Medicaid populations enrolled in MCOs and to provide a mix of population sizes and geographic locations.

MFCU officials, and state Medicaid program integrity staff included the following:

- State auditors most frequently cited improper state capitation payments as high risk in the state.
- Three state auditors identified duplicate state payments as high risk.
- Just over half of all state auditors, MFCU officials, and state Medicaid program integrity staff identified inaccurate state capitation rates as some or high risk.

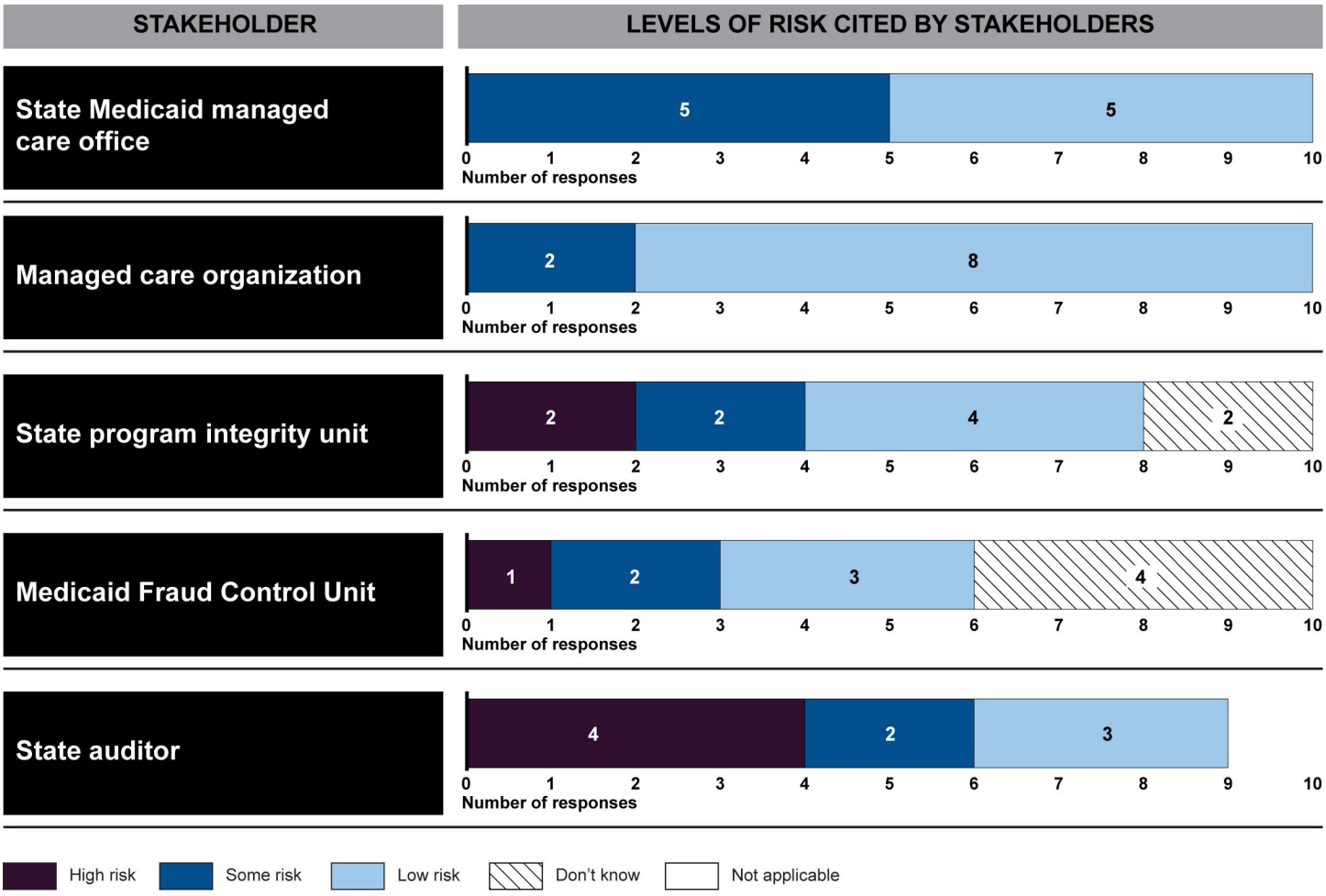
In contrast, state Medicaid managed care officials and MCO officials were less likely to assign high risk to payment types. Some examples include the following:

- No state Medicaid managed care officials cited a high level of risk for any of the six payment types.
- Two MCO officials cited a high level of risk for incorrect MCO fee-for-service payments. No other MCO officials cited a high level of risk for any of the other payment types.

Stakeholder views on the risk level of different payment risks are outlined in the figures that follow.

Improper state capitation payments may occur when the state makes monthly capitation payments to an MCO for beneficiaries who are ineligible for or not enrolled in Medicaid, or who have died. (See fig. 6.)

Figure 6: Stakeholders' Views on the Level of Risk for Improper State Capitation Payments for Medicaid Managed Care



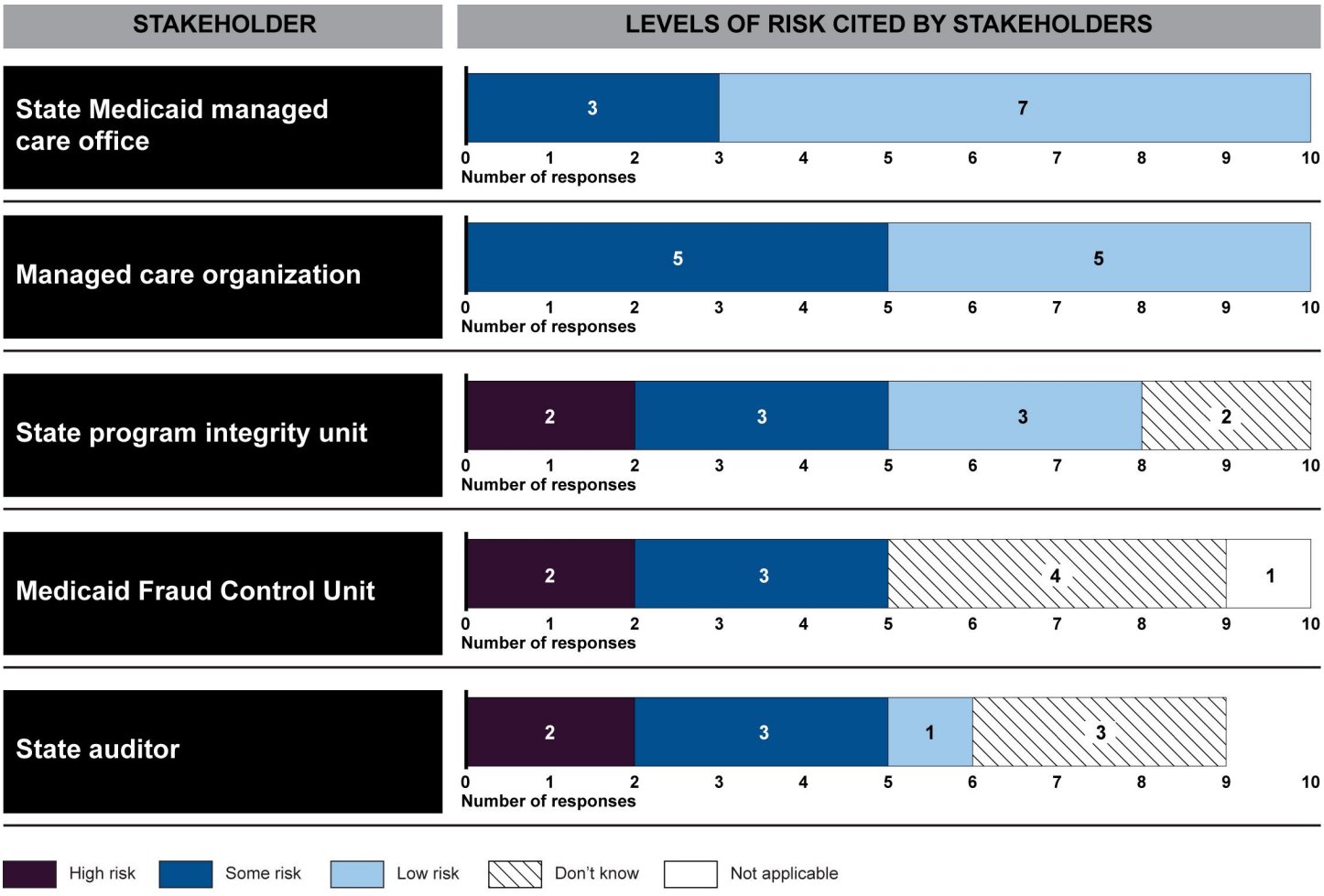
Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Notes: Improper state capitation payments may occur when the state makes monthly capitation payments to a managed care organization for beneficiaries who are ineligible for or not enrolled in Medicaid, or who have died.

We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state Medicaid Fraud Control Unit, and a managed care organization.

Inaccurate state capitation rates occur when a state established a capitation rate that is inaccurate primarily due to issues with the data used to set the rates. Data issues could include inaccurate encounter data, unallowable costs, overpayments that are not adjusted for in the rate, or older data that do not reflect changes in care delivery practices that affect MCO costs. (See fig. 7.)

Figure 7: Stakeholders' Views on the Level of Risk for Inaccurate State Capitation Rates for Medicaid Managed Care



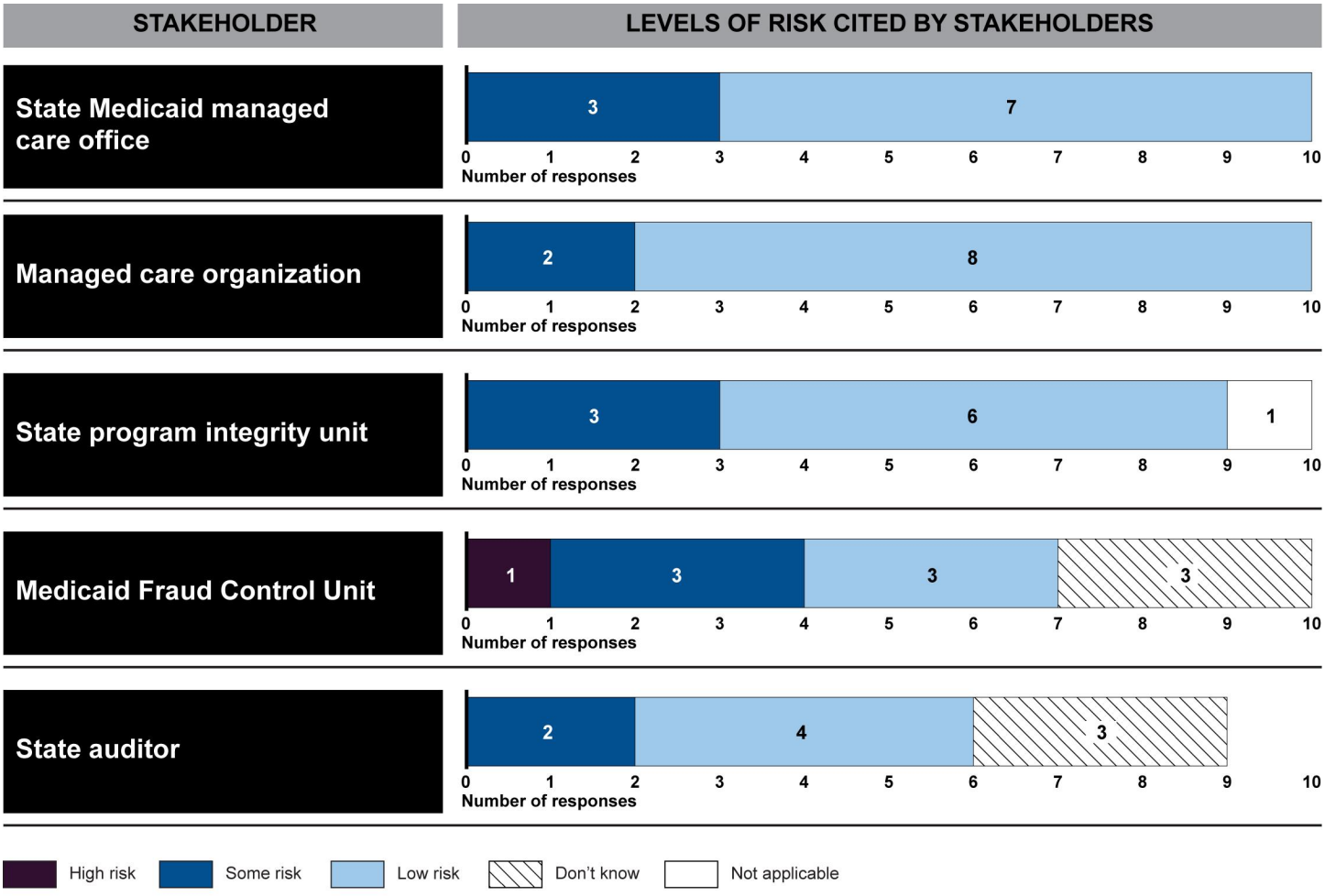
Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Notes: Inaccurate state capitation rates occur when a state sets a capitation rate that is inaccurate, primarily due to issues with the data used to set the rates.

We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state Medicaid Fraud Control Unit, and a managed care organization.

State payments to noncompliant MCOs occur when a state pays MCOs a periodic capitation per beneficiary even though the MCO has not fulfilled state contract requirements. Examples of unfulfilled contract requirements include an MCO failing to establish an adequate provider network, reporting inaccurate encounter data for services, or failing to report the amount of overpayments the MCO has made to providers. (See fig. 8.)

Figure 8: Stakeholders' Views on the Level of Risk for State Payments to Noncompliant Medicaid Managed Care Organizations (MCO)



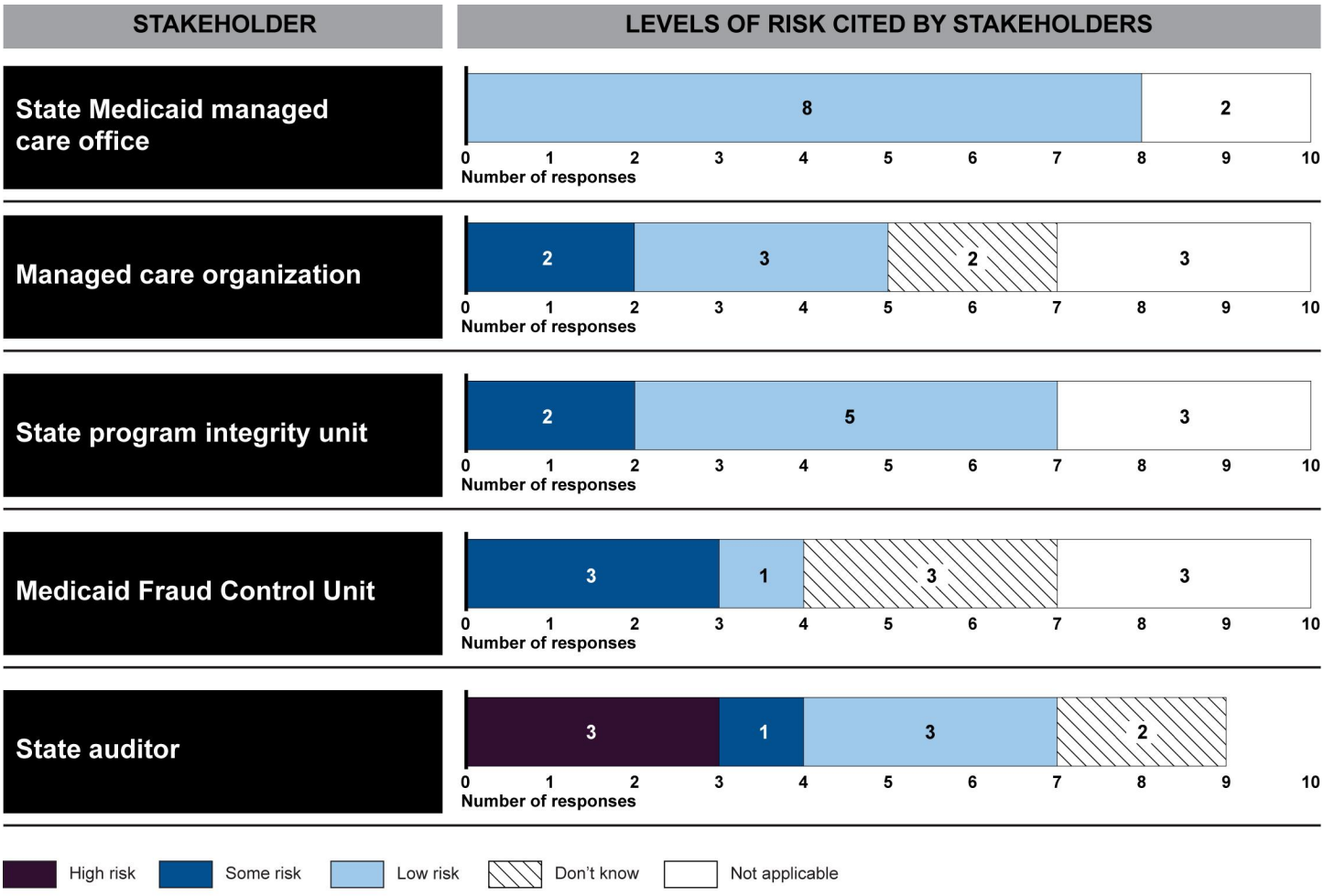
Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Notes: State payments to noncompliant MCOs occur when a state pays MCOs a monthly capitation per beneficiary even though the MCO has not fulfilled state contract requirements.

We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state Medicaid Fraud Control Unit, and a managed care organization.

Duplicate state payments to an MCO occur when a health care provider submits a fee-for-service claim to the state Medicaid program for services that were covered under the MCO contract. (See fig. 9.)

Figure 9: Stakeholders' Views of the Level of Risk for Duplicate State Payments for Medicaid Managed Care



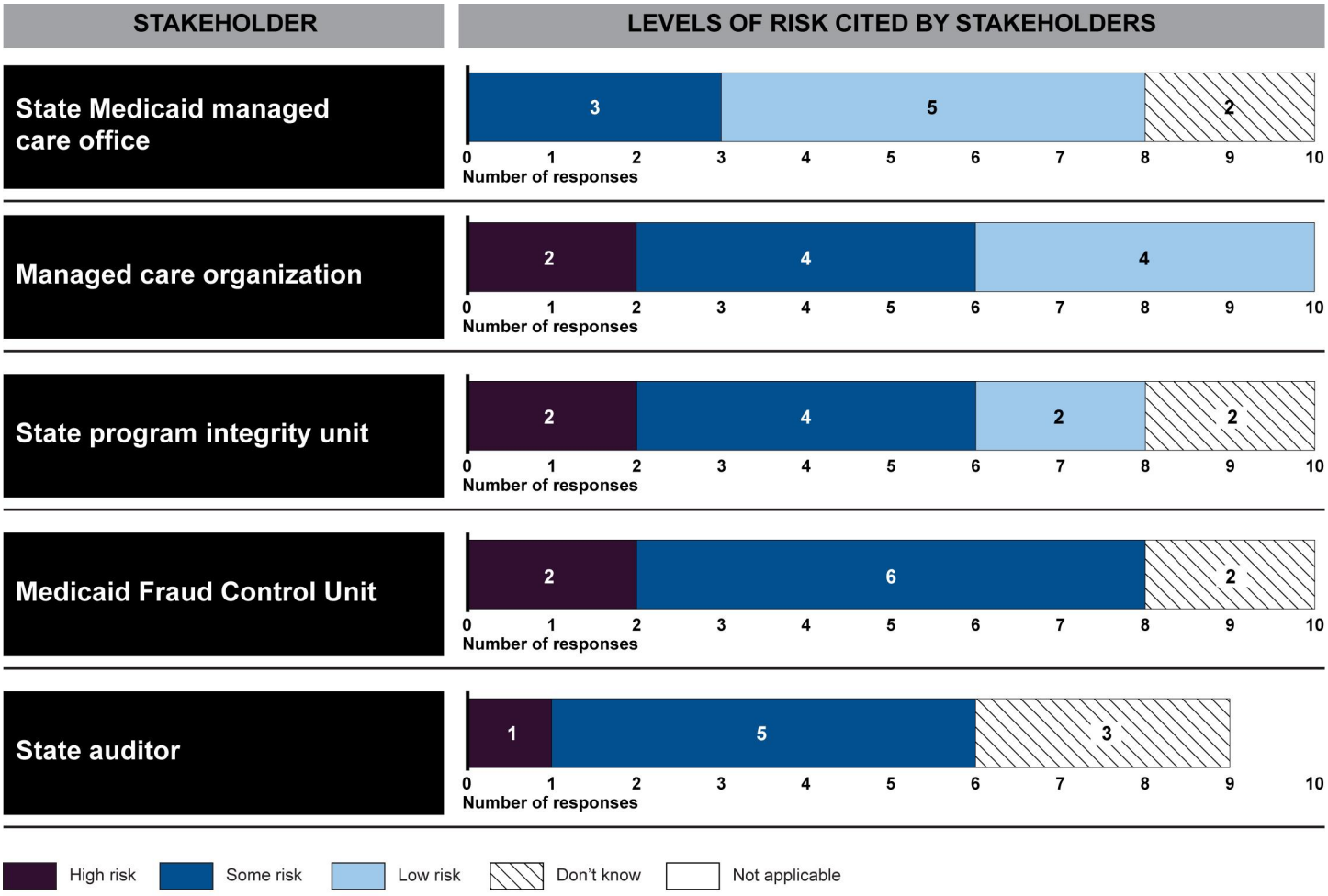
Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Notes: Duplicate state payments to a managed care organization (MCO) occur when a health care provider submits a fee-for-service claim to the state Medicaid program for services that were covered under the MCO contract.

We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state Medicaid Fraud Control Unit, and an MCO.

Incorrect MCO fee-for-service payments occur when the MCO pays providers for improper claims, such as claims for services (1) not provided, or provided by ineligible providers; or (2) that represent inappropriate billing, such as billing individually for bundled services or for a higher intensity of services than needed. (See fig. 10.)

Figure 10: Stakeholders' Views of the Level of Risk for Incorrect Medicaid Managed Care Organization (MCO) Fee-for-Service Payments



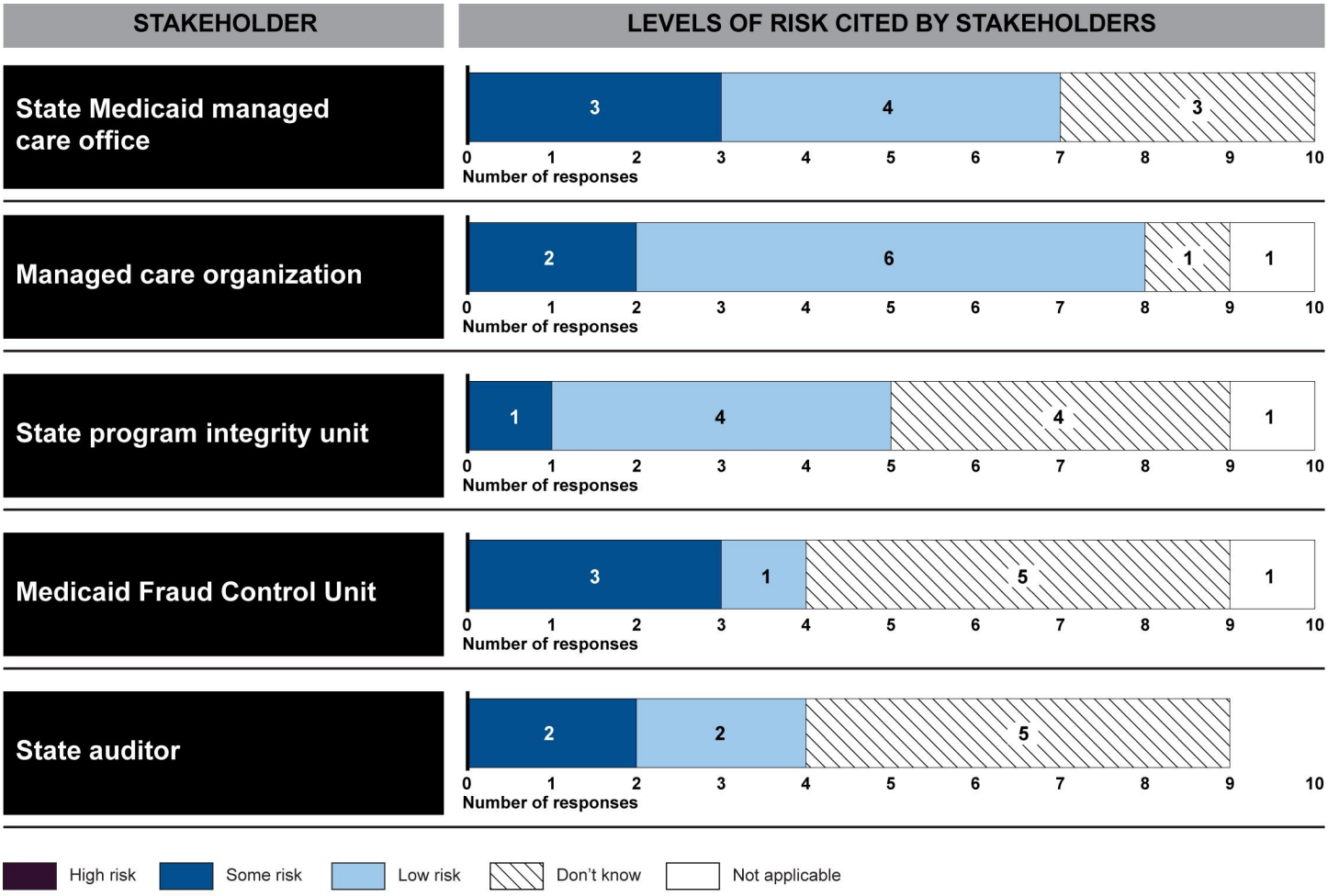
Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Notes: Incorrect MCO fee-for-service payments occur when the MCO pays providers for improper claims, such as claims for services not provided appropriately or that represent inappropriate billing.

We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state Medicaid Fraud Control Unit, and a managed care organization.

Incorrect MCO capitation payments occur when MCOs pay providers a periodic fixed payment without assurances they have provided needed services. (See fig. 11.)

Figure 11: Stakeholders' Views of the Level of Risk for Incorrect Medicaid Managed Care Organizations (MCO) Capitation Payments



Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Notes: Incorrect MCO capitation payments occur when MCOs pay providers a periodic fixed payment without assurances they have provided needed services.

We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state Medicaid Fraud Control Unit, and a managed care organization.

Appendix II: Examples of Different Types of Payment Risks in Medicaid Managed Care

To identify examples of payment risks in Medicaid managed care, we reviewed Department of Health and Human Services' (HHS) Office of Inspector General (HHS-OIG) publications and our prior work; obtained input from the National State Auditor's Association; and conducted literature searches and key word searches of online databases, which identified additional state audits and investigations involving Medicaid managed care payment. We grouped these examples of payment risks into six broad categories or types based on similar key characteristics. Tables 10 through 15 provide examples of each of the six types of payment risks we identified: (1) improper state capitation payments, which are state capitation payments to MCOs for ineligible or deceased individuals; (2) inaccurate state capitation rates; (3) state payments to non-compliant managed care organizations (MCO); (4) duplicate state payments to MCOs and providers; (5) incorrect MCO fee-for-service payments to providers; and (6) incorrect MCO capitation payments to providers that have not complied with program requirements.

Table 10: Examples of Improper State Capitation Payments for Medicaid Managed Care

State	Finding	Report or source (descending order by date)
Louisiana	The Louisiana Legislative Auditor found that the state Department of Health paid $637,745 in improper capitation payments to managed care organizations (MCO) for 203 deceased Medicaid recipients over a 4-year period.	Louisiana Legislative Auditor. *Medicaid Audit Unit: Improper Payments for Deceased Medicaid Recipients. Louisiana Department of Health.* November 29, 2017.
Texas	The Department of Health and Human Services, Office of the Inspector General (HHS-OIG) found that Texas Medicaid paid $6.4 million for 8,496 capitation payments from 2013 through 2015 for beneficiaries with death dates reported as prior to this period.	HHS-OIG. *Texas Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death.* Report A-06-16-05004. November 2017.
New York	The New York State Comptroller found that the state Medicaid agency made $72.6 million in capitated payments for disenrolled and deceased individuals.	New York State Office of the State Comptroller. *Inappropriate Premium Payments for Recipients No Longer Enrolled in Mainstream Managed Care and Family Health Plus*. Report 2015-S-47. Albany, N.Y. July 2017.

State	Finding	Report or source (descending order by date)
Florida	HHS-OIG found that the Florida Medicaid agency paid an estimated $26 million over 5 years, from 2009 through 2014, to Medicaid MCOs for coverage of people who had already died.	HHS-OIG. *Florida Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death*. Report A-04-15-06182. November 2016.
Arizona	The State of Arizona Auditor General estimated that its Medicaid program was paying between approximately $3.5 and $4.8 million in monthly capitation payments for enrolled, but ineligible members.	State of Arizona Office of the Auditor General. *Medicaid Applicants Must Be Approved Through Eligibility Determination Process*. Report No. 12-02. June 2012.

Source: GAO analysis of audit and other reports. I GAO-18-528

Note: Improper state capitation payments occur when the state makes monthly capitation payments to an MCO for beneficiaries who are ineligible for Medicaid, not enrolled in Medicaid, or who have died.

Table 11: Examples of Inaccurate State Capitation Rates for Medicaid Managed Care

State	Finding	Report or source (descending order by date)
Virginia	The Virginia Joint Legislative Audit and Review Commission found that the state has paid managed care organizations (MCO) for potentially avoidable health care services, and could have saved up to $36 million annually if it had reduced capitation rates for inefficient health care spending.	Commonwealth of Virginia Joint Legislative Audit and Review Commission. *Managing Spending in Virginia's Medicaid Program*. December 2016.
New York	The New York State Comptroller found that an MCO claimed over $260,000 in unallowable administrative expenses, which contributed to an increase in capitation rates across the state. In addition, the Department of Health overpaid more than $18.9 million in premiums to MCOs, because it improperly included certain unallowable costs in calculating premiums.	New York State Office of the State Comptroller. *Mainstream Managed Care Organizations – Administrative Costs Used in Premium Rate Setting*. Report 2014-S-55. Albany, N.Y. October 2016.
Rhode Island	The Rhode Island Office of the Auditor General found that Medicaid managed care organizations were overpaid more than $200 million due to overstated capitation rates for the Medicaid expansion population.	Office of the Auditor General, State of Rhode Island and Providence Plantations. *Single Audit Report Fiscal Year Ended June 30, 2015*. March 2016.
Washington	The Washington State Auditor's Office found that two MCOs made $17.5 million in overpayments to providers in 2010. The auditor estimated that for every $1 million in overpayments in 2010, the state Medicaid agency potentially paid an estimated additional $1.26 million in capitated payments to all MCOs statewide in 2013, because 2010 expenditures that included the overpayments were used to calculate premium rates for 2013.	Washington State Auditor. *Performance Audit: Health Care Authority's Oversight of the Medicaid Managed Care Program*. Audit No. 1011450. April 14, 2014.
Multiple states	The Department of Justice alleged that an MCO submitted inflated expenditure information to the state Medicaid agencies in nine states. The MCO agreed to pay over $137.5 million in a settlement with the nine states and the federal government to resolve these claims.	United States Department of Justice. *Florida-Based Wellcare Health Plans Agrees to Pay $137.5 Million to Resolve False Claims Act Allegations*. Washington, D.C. April 3, 2012.

Source: GAO analysis of audit and other reports. I GAO-18-528

Note: Inaccurate state capitation rates occur when a state established a capitation rate that is inaccurate, primarily due to issues with the data used to set the rates. Data issues could include inaccurate encounter data, unallowable costs, overpayments that are not adjusted for in the rate, or older data that do not reflect changes in care delivery practices that affect MCO costs.

Table 12: Examples of State Payments to Noncompliant Medicaid Managed Care Organizations (MCO)

State	Finding	Report or source (descending order by date)
Texas	The Texas State Auditor found that an MCO reported payments in its financial statistical report that were not allowed under its contract, and also that the Texas Health and Human Services Commission did not ensure that its own business practices and oversight of MCOs aligned with the managed care contract.	Texas State Auditor. *An Audit Report on The Health and Human Services Commission's Management of its Medicaid Managed Care Contract with Superior HealthPlan, Inc. and Superior HealthPlan Network, and Superior's Compliance with Reporting Requirements*. Report No. 18-015. Austin, Tex. January 2018.
Oregon	The State of Oregon Audits Division found that while MCOs were required to develop policies and procedures for detecting fraud, waste, and abuse, some MCO policies lacked sufficient detail and some MCOs appeared to perform only limited activities to detect improper payments.	State of Oregon Audits Division. *Oregon Health Authority Should Improve Efforts to Detect and Prevent Improper Medicaid Payments*. Report 2017 – 25. Salem, Ore. November 2017.
Texas	The Texas State Auditor found that an MCO reported $3.8 million in unallowable expenses for advertising, company events, gifts, and stock options; and an additional $34 million in other questionable costs in 2015. Further, the MCO did not prepare required certifications and personnel activity reports, or adequately document financial reports, as required by the state's Uniform Managed Care Manual.	Texas State Auditor. *An Audit Report on HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization*. Report No. 17-025. Austin, Tex. February 2017.
California	The California State Auditor found that the California Department of Health Care Services did not verify that the provider network data it received from the MCOs were accurate. The Medi-Cal managed care contract requires MCOs to maintain a network of primary care providers that meets certain location requirements. However, the auditor's review of the provider directories of three MCOs found inaccuracies, including providers no longer participating in the network.	California State Auditor. *California Department of Health Care Services: Improved Monitoring of Medi-Cal Managed Care Health Plans is Necessary to Better Ensure Access to Care*. Report 2014-134. June 2015.

Source: GAO analysis of audit and other reports. I GAO-18-528

Note: State payments to noncompliant MCOs occur when a state pays MCOs a periodic capitation per beneficiary even though the MCO has not fulfilled state contract requirements. Examples of unfulfilled contract requirements include an MCO failing to establish an adequate provider network, reporting inaccurate encounter data for services, or failing to report the amount of overpayments the MCO has made to providers.

Table 13: Examples of Duplicate State Payments for Medicaid Managed Care

State	Finding	Report or source (descending order by date)
Oregon	The State of Oregon Audits Division found that the state Medicaid agency could not provide an inventory of carve-out services not covered by managed care organizations (MCO). Without such an inventory, the division found that it is difficult to detect or prevent potential duplicate payments to MCOs and to fee-for-service providers. The Audits Division analyzed both fee-for-service payments and capitated payments to MCOs and found 31,300 potential duplicate payments for a 15 month period.	State of Oregon Audits Division. *Oregon Health Authority Should Improve Efforts to Detect and Prevent Improper Medicaid Payments*. Report 2017 – 25. Salem, Ore. November 2017.
Massachusetts	The Massachusetts state auditor identified $193 million in improper payments, mostly duplicate payments, for behavioral health services that resulted from problems with MassHealth's system for identifying which claims it should cover in its fee-for-service program and which claims should be covered through its capitated contract with a behavioral health services MCO.	Commonwealth of Massachusetts *Office of the State Auditor. Office of Medicaid (MassHealth) – Review of Fee-for-Service Payments for Services Covered by the Massachusetts Behavioral Health Partnership for the Period July 1, 2010 through June 30, 2015*. Official Auditor Report. April 3, 2017.

Source: GAO analysis of audit and other reports. I GAO-18-528

Note: Duplicate state payments to an MCO occur when a health care provider submits a fee-for-service claim to the state Medicaid program for services that were covered under the MCO contract.

Table 14: Examples of Incorrect Medicaid Managed Care Organization Fee-for-Service Payments

State	Finding	Report or source (descending order by date)
Louisiana	The Louisiana Legislative Auditor found that managed care organizations (MCO) paid $2.4 million for 157,232 laboratory claims where the provider did not have the appropriate certification to provide the level of service provided.	Louisiana Legislative Auditor. Medicaid Audit Unit. *Improper Payments in the Medicaid Laboratory Program. Louisiana Department of Health*. Baton Rouge, La. September 6, 2017.
New Jersey	The New Jersey Attorney General reported that a medical supply provider pleaded guilty to submitting $100,000 in fraudulent claims to a MCO for durable medical equipment that was never distributed.	State of New Jersey Office of the Attorney General. *Owner of Hudson County Medical Equipment Supply Store Pleads Guilty To $100,000 from Medicaid Fraud Scam*. Trenton, N.J. August 21, 2017.
West Virginia	The Department of Justice found that a West Virginia MCO and state Medicaid program made over $700,000 in payments to a dentist who submitted exaggerated claims, claims for services not provided, and duplicate claims for a single procedure.	Department of Justice. Enforcement Actions. U.S. Attorney; Southern District of West Virginia: Charleston. *Charleston Dentist Pleads Guilty to Health Care Fraud*. Charleston, W.Va.: August 21, 2017.
New York	The New York State Comptroller found that two MCOs made more than $6.6 million in payments to excluded and deceased providers, including almost $60,000 in payments to pharmacies for medications prescribed by deceased providers.	New York State Office of the State Comptroller. *Medicaid Managed Care Organization Fraud and Abuse Detection*. Report 2014-S-51. Albany, N.Y. July 15, 2016.
Texas	The Department of Justice found that the Texas Medicaid agency and MCOs made payments to two individuals who were not licensed to provide psychotherapy services and who submitted $7.1 million in false claims.	Department of Justice. U.S. Attorney, Northern District of Texas. *Ellis County Woman Sentenced to 105 Months in Federal Prison for Defrauding Medicaid*. Dallas, Tex. April 8, 2016.

State	Finding	Report or source (descending order by date)
Multiple states	The Department of Health and Human Services' Office of Inspector General (HHS-OIG) found, in interviewing state officials in 13 states, that these officials expressed concerns about provider and beneficiary fraud and abuse including rendering services that are not medically necessary and upcoding by providers.	HHS-OIG. *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards*. OEI-01-09-00550. December 2011.

Source: GAO analysis of audit and other reports. I GAO-18-528

Note: Incorrect MCO fee-for-service payments occur when the MCO pays providers for improper claims, such as claims for services (1) not provided, or provided by ineligible providers; or (2) that represent inappropriate billing, such as billing individually for bundled services or for a higher intensity of services than needed.

Table 15: Example of Incorrect Medicaid Managed Care Organization Capitation Payments

State	Finding	Report or Source (descending order by date)
California	The California Department of Health Care Services, in response to a whistleblower complaint within a utilization management company that subcontracted to managed care organizations (MCO), found that Medicaid beneficiaries were in imminent danger of not receiving medically necessary health care services, because the company was not processing requests for health care services on a timely basis.	State of California Health and Human Services Agency. Department of Health Care Services. *SynerMed Corrective Action Plan*. November 17, 2017.

Source: GAO analysis of audit and other reports. I GAO-18-528

Note: Incorrect MCO capitation payments occur when MCOs pay providers without assurances they have provided needed services.

Appendix III: Challenges to Effective Program Integrity Oversight in Medicaid Managed Care

We asked 49 stakeholders involved in program integrity oversight to consider the following six challenges to effective program integrity oversight: (1) availability and allocation of resources; (2) access to and quality of data and technology; (3) state policies and practices; (4) provider compliance with program requirements; (5) managed care organization (MCO) management of program integrity; and (6) federal regulations, guidance, and review.[1] Stakeholders were asked whether any of these presented a challenge to each of six types of payment risks in Medicaid managed care in their state, including (1) improper state capitation payments to MCOs for ineligible or deceased individuals; (2) inaccurate state capitation rates; (3) state payments to MCOs that have not fulfilled contract requirements; (4) state duplicate payments to MCOs and providers; (5) incorrect MCO fee-for-service payments to providers for improper claims; and (6) incorrect MCO capitation payments to providers that have not complied with program requirements.

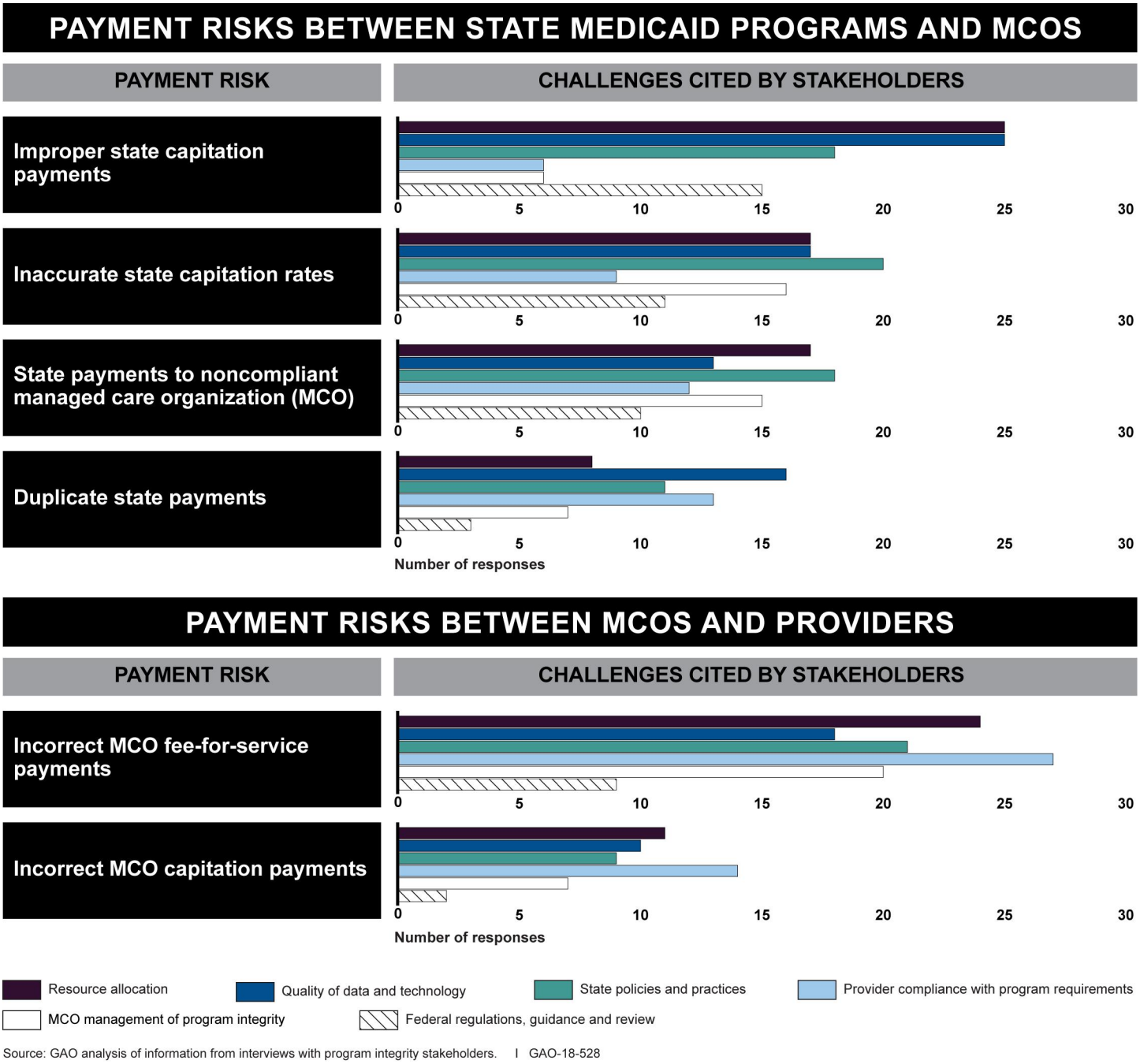
Figure 12 illustrates the number of times stakeholders cited a particular challenge for each of the payment risks. The frequency with which each of the challenges was identified differed to some extent for different payment risks. Some examples include the following:

- Quality of data and technology was the most cited challenge for duplicate state payments.
- State policies and practices was the most cited challenge for inaccurate state capitation rates.

[1]We interviewed 49 officials, including officials in the following five organizations in 10 states: state Medicaid managed care office, state program integrity unit, Medicaid Fraud control Unit, state auditor's office, and a managed care organization. Selected states included California, Florida, Georgia, Hawaii, Massachusetts, Michigan, Nevada, Oregon, Tennessee, and Wisconsin.

- Provider compliance with program requirements was the most cited challenge for two payment types: (1) incorrect MCO fee-for-service payments to providers, and (2) incorrect MCO capitation payments to providers.
- Resource allocation was the second most cited challenge for five of the six payment risk types, although it was not the most cited challenge for any one payment risk type.

Figure 12: Number of Times Stakeholders Cited Each Challenge to Medicaid Managed Care Program Integrity Oversight, by Payment Risk



Source: GAO analysis of information from interviews with program integrity stakeholders. I GAO-18-528

Notes: Payment risks are described here.

Improper state capitation payments occur when the state makes periodic capitation payments to an MCO for beneficiaries who are ineligible for or not enrolled in Medicaid, or who have died.

Inaccurate state capitation rates occur when a state sets a capitation rate that is inaccurate, primarily due to issues with the data used to set the rates.

State payments to noncompliant MCOs occur when a state pays MCOs a periodic capitation per beneficiary even though the MCO has not fulfilled state contract requirements.

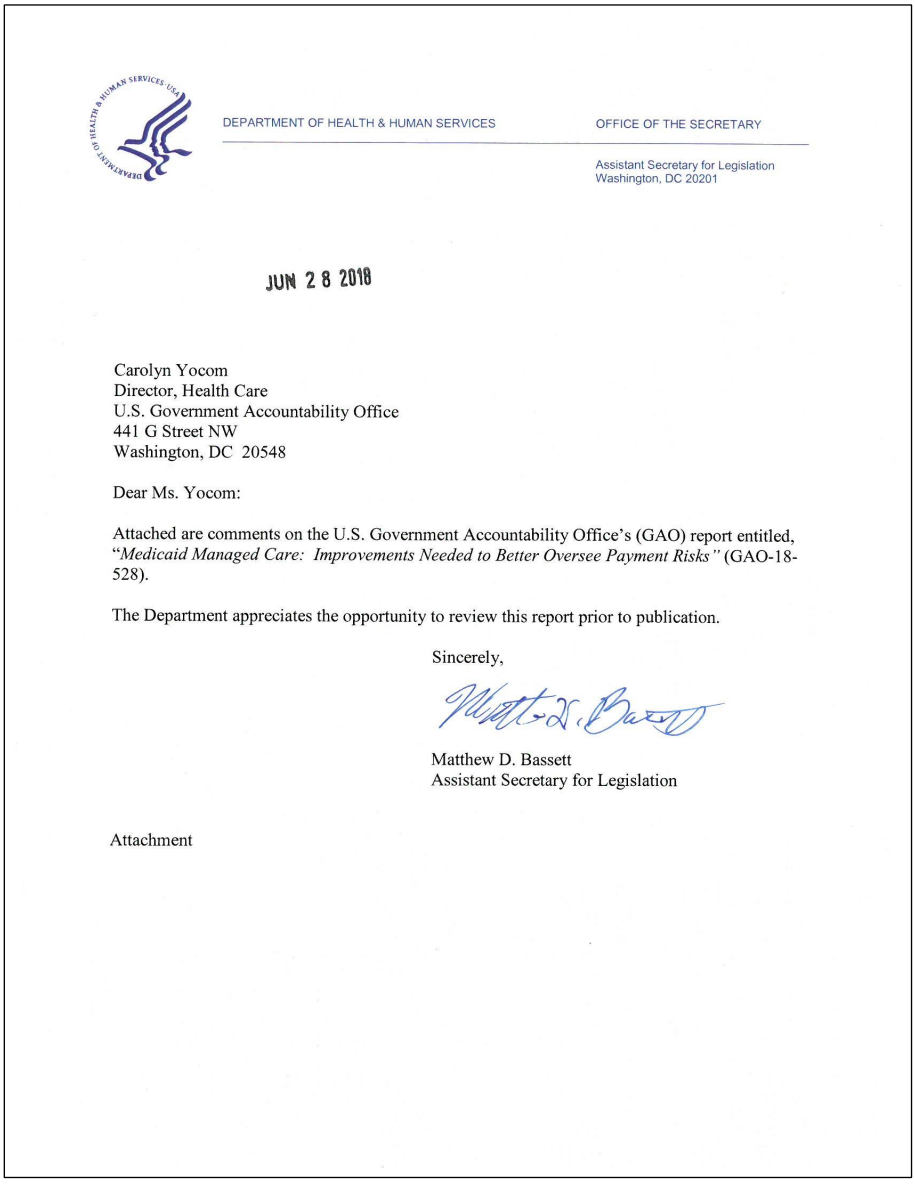
Duplicate state payments to an MCO occur when a health care provider submits a fee-for-service claim to the state Medicaid program for services that were covered under the MCO contract.

Incorrect MCO fee-for-service payments occur when the MCO pays providers for improper claims, such as claims for services not provided appropriately or that represent inappropriate billing.

Incorrect MCO capitation payments occur when MCOs pay providers without assurances they have provided needed services.

We interviewed 49 stakeholders in 10 states, including the state Medicaid managed care office, the state Medicaid program integrity unit, the state auditor, the state Medicaid Fraud Control Unit, and a managed care organization.

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUN 28 2018

Carolyn Yocom
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks*" (GAO-18-528).

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

Sincerely,

Matthew D. Bassett
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID MANAGED CARE: IMPROVEMENTS NEEDED TO BETTER OVERSEE PROGRAM RISK (GAO-18-528)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the draft report from the Government Accountability Office (GAO). HHS is strongly committed to program integrity efforts in Medicaid.

While states have primary responsibility for direct oversight of their managed care contractors and their compliance with program integrity standards, HHS undertakes a wide array of activities to oversee and support states' Medicaid program integrity efforts. These efforts include ongoing program monitoring, state program integrity focused reviews, desk reviews, collaborative audits, and the provision of state training and technical assistance.

Through state program integrity focused reviews, HHS assesses the effectiveness of the state's program integrity efforts, including determining if states' policies and practices comply with federal regulations, identifying program vulnerabilities that may not rise to the level of regulatory non-compliance, identifying states' best practices in managed care program integrity, and monitoring state corrective action plans. Onsite reviews during 2014-2018 focused on specific areas of program integrity concern, including oversight of managed care organizations.

To supplement the onsite focused reviews, program integrity desk reviews allow HHS to increase the number of states that receive customized program integrity oversight by conducting offsite reviews of documentation submitted by states on specified topics. Desk review topics target specific issues, such as states' progress on corrective action plans from previous state program integrity reviews.

Collaborative audits conducted by Unified Program Integrity Contractors contribute to HHS's oversight of state Medicaid programs, including managed care organizations. These audits allow HHS and the states to discuss and agree upon potential audit targets while utilizing state data. Collaborative audits have proven to be an effective way to augment states' own audit capacities by leveraging HHS resources, resulting in more timely and accurate audits. HHS has completed 14 collaborative audits of managed care organization network providers. In addition, CMS is in the early planning stages of piloting targeted audits of managed care organizations to provide states with feedback about potential vulnerabilities in their managed care programs.

HHS also offers substantive training, technical assistance, and support to states in a structured learning environment via the Medicaid Integrity Institute. The Medicaid Integrity Institute regularly refreshes course offerings to focus on emerging program integrity issues in areas such as Medicaid managed care, provider screening and enrollment, and data analysis. From its inception in 2008, the Medicaid Integrity Institute has trained state employees from all 50 states, the District of Columbia, and Puerto Rico through more than 8,000 enrollments in 170 courses and 14 workgroups.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID MANAGED CARE: IMPROVEMENTS NEEDED TO BETTER OVERSEE PROGRAM RISK (GAO-18-528)

The Medicaid managed care final rule published in 2016 takes important steps to strengthen program integrity in managed care while maintaining state flexibility, including requiring more transparency in the rate setting process, requiring the enrollment of managed care organization network providers in Medicaid, mandatory reporting of potential fraud, waste, or abuse to the state, mandatory reporting of any changes in a provider's circumstances that may impact that provider's participation in the managed care plan's network, and the suspension of payments to a network provider when the state determines a credible allegation of fraud exists. The rule provides flexibility as to how the state addresses treatment of recoveries by plans through the contract. However, states need to specify how managed care plan recoveries due to fraud, waste, and abuse are addressed in the contract and take recoveries into account in the rate setting process.

In addition, HHS has published, and updates as needed, the Medicaid Provider Enrollment Compendium to help states in implementing various provider enrollment requirements, including the requirement to enroll managed care organization network providers in Medicaid. The Medicaid Provider Enrollment Compendium serves as a consolidated resource for certain Medicaid provider enrollment regulations and guidance so states have the information in a central document. Lastly, HHS is providing substantial technical support and conducting on-site reviews of states to refine their provider enrollment and screening activities in concert with federal rules.

GAO's recommendations and HHS's responses are below.

GAO Recommendation 1
The Administrator of CMS should expedite the planned efforts to communicate guidance, such as its compendium on Medicaid managed care program integrity to state stakeholders related to Medicaid managed care program integrity.

HHS Response
HHS concurs with this recommendation. HHS will work to communicate planned guidance to stakeholders.

GAO Recommendation 2
The Administrator of CMS should eliminate impediments to collaborative audits in managed care conducted by audit contractors and states, such as using its periodic review of state managed care contracts to recommend modification of contracts that do not explicitly support provider auditing.

HHS Response

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID MANAGED CARE: IMPROVEMENTS NEEDED TO BETTER OVERSEE PROGRAM RISK (GAO-18-528)

HHS concurs with this recommendation and will use the pilot audits to address challenges encountered in prior managed care audits including developing audits in states where contract language does not specifically allow for recovery of overpayments by the state.

GAO Recommendation 3
The Administrator of CMS should require states to report and document the amount of MCO overpayments to providers and how they are accounted for in capitation rate setting.

HHS Response
HHS concurs with this recommendation and will work with states to require them to report MCO overpayments to providers and document how overpayments are accounted for in capitation rate setting.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov

Staff Acknowledgments

In addition to the contact name above, Tim Bushfield (Assistant Director), Mary Giffin (Analyst-in-Charge), Arushi Kumar, Julie Flowers, Drew Long, Vikki Porter, Katie Thomson made key contributions to this report. Other staff who made contributions to the report were Jessica Broadus, Barbie Hansen and Erika Huber.

Appendix VI: Accessible Data

Data Tables

Data Table for Figure 2: Payment Risks Related to State Medicaid Program Payments to Managed Care Organizations (MCO)

PAYMENT RISK	GENERAL DESCRIPTION
Improper state capitation payments	State makes monthly capitation payments to an MCO for beneficiaries who are ineligible for Medicaid, not enrolled in Medicaid or who have died.
Inaccurate state capitation rates	State establishes capitation rates that are inaccurate, primarily due to issues with the data used to set the rates.
State payments to noncompliant MCO	State makes monthly capitation payments to an MCO for beneficiaries even though the MCO has not fulfilled state contract requirements.
Duplicate state payments	State makes duplicate payments- for example, when a health care provider submits a fee-for-service claim to the state Medicaid program for services that were covered by the MCO contract.

Data Table for Figure 3: Payment Risks Related to Medicaid Managed Care Organization (MCO) Payments to Providers

PAYMENT RISK	GENERAL DESCRIPTION
Incorrect MCO fee-for-service payments	MCO pays providers for improper or false claims, such as claims for srvices (a) not provided, or provided by ineligible providers, or (b) that represent inappropriate billing, such as billing individually for bundled services or for a higher intensity of services than needed.
Incorrect MCO capitation payments	MCO pays providers without assurance they have provided needed services.

Data Table for Figure 4: Stakeholders' Views of the Level of Risk Associated with Each Type of Medicaid Managed Care Payment Risk

Levels of Risk Cited by Stakeholders (Number of Responses).

Payment Risk	High/some risk	Low risk	Don't know	Not applicable
Incorrect managed care organization (MCO) fee-for-service payments	29	11	9	0
Inaccurate state capitation rates	23	16	9	1
Improper state capitation payments	20	23	6	0
State payments to noncompliant MCO	14	28	6	1
Incorrect MCO capitation payments	11	20	7	3
Duplicate state payments	11	20	7	11

Data Table for Figure 5: Frequency of Stakeholder Citing of Six Challenges to Medicaid Managed Care Oversight

Areas of Challenges to Oversight	Number of Times Stakeholders Cited this Challenge to Oversight
Availability and allocation of resources	102
Access to and quality of data and technology	99
State policies and practices	97
Provider compliance with program requirements	81
MCO management of program integrity	71
Federal regulations, guidance, and review	50

Data Table for Figure 6: Stakeholders' Views on the Level of Risk for Improper State Capitation Payments for Medicaid Managed Care

Levels of Risk Cited by Stakeholders (Number of Responses).

Stakeholder	High risk	Some risk	Low risk	Don't know	Not applicable
State Medicaid managed care office	0	5	5	0	0
Managed care organization	0	2	8	0	0
State program integrity unit	2	2	4	2	0
Medicaid Fraud Control Unit	1	2	3	4	0
State auditor	4	2	3	0	0

Data Table for Figure 7: Stakeholders' Views on the Level of Risk for Inaccurate State Capitation Rates for Medicaid Managed Care

Levels of Risk Cited by Stakeholders (Number of Responses).

Stakeholder	High risk	Some risk	Low risk	Don't know	Not applicable
State Medicaid managed care office	0	3	7	0	0
Managed care organization	0	5	5	0	0
State program integrity unit	2	3	3	2	0
Medicaid Fraud Control Unit	2	3	0	4	1
State auditor	2	3	1	3	0

Data Table for Figure 8: Stakeholders' Views on the Level of Risk for State Payments to Noncompliant Medicaid Managed Care Organizations (MCO)

Levels of Risk Cited by Stakeholders (Number of Responses).

Stakeholder	High risk	Some risk	Low risk	Don't know	Not applicable
State Medicaid managed care office	0	3	7	0	0
Managed care organization	0	2	8	0	0
State program integrity unit	0	3	6	0	1
Medicaid Fraud Control Unit	1	3	3	3	0
State auditor	0	2	4	3	0

Data Table for Figure 9: Stakeholders' Views of the Level of Risk for Duplicate State Payments for Medicaid Managed Care

Levels of Risk Cited by Stakeholders (Number of Responses).

Stakeholder	High risk	Some risk	Low risk	Don't know	Not applicable
State Medicaid managed care office	0	0	8	0	2
Managed care organization	0	2	3	2	3
State program integrity unit	0	2	5	0	3
Medicaid Fraud Control Unit	0	3	1	3	3
State auditor	3	1	3	2	0

Data Table for Figure 10: Stakeholders' Views of the Level of Risk for Incorrect Medicaid Managed Care Organization (MCO) Fee-for-Service Payments

Levels of Risk Cited by Stakeholders (Number of Responses).

Stakeholder	High risk	Some risk	Low risk	Don't know	Not applicable
State Medicaid managed care office	0	3	5	2	0
Managed care organization	2	4	4	0	0
State program integrity unit	2	4	2	2	0
Medicaid Fraud Control Unit	2	6	0	2	0
State auditor	1	5	0	3	0

Data Table for Figure 11: Stakeholders' Views of the Level of Risk for Incorrect Medicaid Managed Care Organizations (MCO) Capitation Payments

Levels of Risk Cited by Stakeholders (Number of Responses).

Stakeholder	High risk	Some risk	Low risk	Don't know	Not applicable
State Medicaid managed care office	0	3	5	2	0
Managed care organization	2	4	4	0	0
State program integrity unit	2	4	2	2	0
Medicaid Fraud Control Unit	2	6	0	2	0
State auditor	1	5	0	3	0

Data Table for Figure 12: Number of Times Stakeholders Cited Each Challenge to Medicaid Managed Care Program Integrity Oversight, by Payment Risk

Payment risks between state Medicaid programs and MCOs. Challenges cited by stakeholders.

Payment Risk	Resource allocation	Quality of data and technology	State policies and practices	Provider compliance with program requirements	MCO management of program integrity	Federal regulations, guidance and review
Improper state capitation payments	25	25	18	6	6	15
Inaccurate state capitation rates	17	17	20	9	16	11
State payments to noncompliant managed care organization (MCO)	17	13	18	12	15	10
Duplicate state payments	3	3	3	3	3	3

Payment risks between MCOs and providers. Challenges cited by stakeholders.

Payment Risk	Resource allocation	Quality of data and technology	State policies and practices	Provider compliance with program requirements	MCO management of program integrity	Federal regulations, guidance and review
Incorrect MCO fee-for-service payments	24	18	21	27	20	9
Incorrect MCO capitation payments	11	10	9	14	7	2

Agency Comment Letter

Text of Appendix IV: Comments from the Department of Health and Human Services

Page 1

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office' s (GAO) report entitled, "Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks" (GAO-18- 528).

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

Sincerely,

Matthew D. Bassett
Assistant Secretar y for Legislation

Attachment

Page 2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID MANAGED CARE: IMPROVEMENTS NEEDED TO BETTER OVERSEE PROGRAM RISK (GAO-18-528)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the draft repo11 from the Government Accountability Office (GAO). HHS is strongly committed to program integrity efforts in Medicaid.

While states have primary responsibility for direct oversight of their managed care contractors and their compliance with program integrity standards, HHS undertakes a wide array of activities to oversee and support states' Medicaid program integrity efforts. These efforts include ongoing program monitoring, state program integrity focused reviews, desk reviews, collaborative audits, and the provision of state training and technical assistance.

Through state program integrity focused reviews, HHS assesses the effectiveness of the state's program integrity efforts, including determining if states' policies and practices comply with federal regulations, identifying program vulnerabilities that may not rise to the level of regulatory non-compliance, identifying states' best practices in managed care program integrity , and monitoring state corrective action plans. Onsite reviews during 2014-2018 focused on specific areas of program integrity concern, including oversight of managed care organizations.

To supplement the onsite focused reviews, program integrity desk reviews allow HHS to increase the number of states that receive customized program integrity oversight by conducting offsite reviews of documentation submitted by states on specified topics. Desk review topics target specific issues, such as states' progress on corrective action plans from previous state program integrity reviews.

Collaborative audits conducted by Unified Program Integrity Contractors contribute to HHS's oversight of state Medicaid programs, including managed care organizations. These audits allow HHS and the states to discuss and agree upon potential audit targets while utilizing state data.

Collaborative audits have proven to be an effective way to augment states' own audit capacities by leveraging HHS resources, resulting in more timely and accurate audits. HHS has completed 14 collaborative audits of managed care organization network providers. In addition, CMS is in the early planning stages of piloting targeted audits of managed care organizations to provide states with feedback about potential vulnerabilities in their managed care programs.

HHS also offers substantive training, technical assistance, and support to states in a structured learning environment via the Medicaid Integrity Institute. The Medicaid Integrity Institute regularly refreshes course offerings to focus on emerging program integrity issues in areas such as Medicaid managed care, provider screening and enrollment, and data analysis. From its inception in 2008, the Medicaid Integrity Institute has trained state employees from all 50 states, the District of Columbia, and Puerto Rico through more than 8,000 enrollments in 170 courses and 14 workgroups.

Page 3

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Page 4

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