



May 2018

# MEDICAID

## CMS Should Take Steps to Mitigate Program Risks in Managed Care

# GAO Highlights

Highlights of [GAO-18-291](#), a report to congressional requesters

## Why GAO Did This Study

The improper payment rate is a sentinel measure of program integrity risks for the Medicaid program. CMS and the states oversee Medicaid, whose size, structure, and diversity make it vulnerable to improper payments. CMS estimates the Medicaid improper payment rate annually through its PERM, which includes an estimate for Medicaid managed care, in which states contract with MCOs to provide services to Medicaid enrollees.

GAO was asked to study the PERM methodology for managed care. In this report, GAO examined the extent to which the PERM accounts for program integrity risks in Medicaid managed care, including CMS's and states' oversight. GAO identified program integrity risks reported in 27 federal and state audits and investigations issued between January 2012 and September 2017; reviewed federal regulations and guidance on the PERM and CMS's Focused Program Integrity Reviews; and contacted program integrity officials in the 16 states with a majority of 2016 Medicaid spending for managed care, as well as CMS officials and program integrity experts.

## What GAO Recommends

The Administrator of CMS should consider and take steps to mitigate the program risks that are not measured in the PERM, such as overpayments and unallowable costs; such an effort could include actions such as revising the PERM methodology or focusing additional audit resources on managed care. HHS concurred with this recommendation. HHS also provided technical comments, which were incorporated as appropriate.

View [GAO-18-291](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov).

May 2018

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### CMS Should Take Steps to Mitigate Program Risks in Managed Care

#### What GAO Found

The Centers for Medicare & Medicaid Services' (CMS) estimate of improper payments for Medicaid managed care has limitations that are not mitigated by the agency's and states' current oversight efforts. One component of the Payment Error Rate Measurement (PERM) measures the accuracy of capitated payments, which are periodic payments that state Medicaid agencies make to managed care organizations (MCO) to provide services to enrollees and to cover other allowable costs, such as administrative expenses. However, the managed care component of the PERM neither includes a medical review of services delivered to enrollees, nor reviews of MCO records or data. Further, GAO's review of the 27 federal and state audits and investigations identified key program risks.

- Ten of the 27 federal and state audits and investigations identified about \$68 million in overpayments and unallowable MCO costs that were not accounted for by PERM estimates; another of these investigations resulted in a \$137.5 million settlement.
- These audits and investigations were conducted over more than 5 years and involved a small fraction of the more than 270 MCOs operating nationwide as of September 2017.

To the extent that overpayments and unallowable costs are unidentified and not removed from the cost data used to set capitation rates, they may allow inflated MCO payments and minimize the appearance of program risks in Medicaid managed care.

CMS and states have taken steps to improve oversight of Medicaid managed care through updated regulations, focused reviews of states' managed care programs, and federal program integrity contractors' audits of managed care services.

- However, some of these efforts went into effect only recently, and others are unlikely to address the risks in managed care across all states.
- Furthermore, these efforts do not ensure the identification and reporting of overpayments to providers and unallowable costs by MCOs.

Federal internal control standards call for agency management to identify and respond to risks. Without addressing key risks, such as the extent of overpayments and unallowable costs, CMS cannot be certain that its estimated improper payment rate for managed care (0.3 percent compared with 12.9 percent in Medicaid fee-for-service) accurately reflects program risks.

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## Abbreviations

CMCS	Center for Medicaid & CHIP Services
CMS	Centers for Medicare & Medicaid Services
FFS	fee-for-service
HCERA	Health Care and Education Reconciliation Act of 2010
HHS	Department of Health and Human Services
HHS-OIG	Department of Health and Human Services' Office of Inspector General
IPERA	Improper Payments Elimination and Recovery Act of 2010
IPIA	Improper Payments Information Act of 2002
MCO	managed care organization
MFCU	Medicaid Fraud Control Unit
OMB	Office of Management and Budget
PERM	Payment Error Rate Measurement

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May 7, 2018

The Honorable Greg Walden  
Chairman  
Committee on Energy and Commerce  
House of Representatives

The Honorable Fred Upton  
House of Representatives

The improper payment rate is a sentinel measure of program integrity risks for Medicaid—a federal-state health financing program for low income and medically needy individuals.<sup>1</sup> The federal government and states play key roles in oversight of the Medicaid program—with the Centers for Medicare & Medicaid Services (CMS) providing broad federal oversight, and states administering day-to-day operations, including ensuring the integrity of the program by preventing, identifying, and recouping improper payments.<sup>2</sup> The size, structure, and diversity of Medicaid make it particularly vulnerable to improper payments, and our work has identified Medicaid as a high-risk program since 2003 due to concerns about the adequacy of fiscal oversight.<sup>3</sup>

To develop the Medicaid improper payment rate, CMS uses the Payment Error Rate Measurement (PERM)—a methodology that is reviewed and

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<sup>1</sup>An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payment for services not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. See 31 U.S.C. § 3321 note. Office of Management and Budget guidance also instructs agencies to report as improper payments any payments for which insufficient or no documentation is found.

<sup>2</sup>CMS is an agency within the Department of Health and Human Services (HHS). States have the flexibility to design and implement their Medicaid programs within broad federal parameters, resulting in 56 distinct state-based programs with one in each state, the District of Columbia, and five territories—American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands.

<sup>3</sup>See GAO, *High-Risk Series: Progress on Many High-Risk Areas While Substantial Efforts Needed in Others*, [GAO-17-317](#) (Washington, D.C.: Feb. 15, 2017).

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approved by the Office of Management and Budget (OMB).<sup>4</sup> The PERM computes the rate as the weighted average of states' improper payment rate estimates for three key components of the Medicaid program—fee-for-service (FFS), managed care, and eligibility determinations.<sup>5</sup>

Medicaid managed care expenditures have grown significantly; in fiscal year 2017, they were \$171 billion, almost 50 percent of total federal Medicaid expenditures.<sup>6</sup> This growth makes ensuring the accuracy of managed care improper payment estimates increasingly important. In fiscal year 2017, using the PERM, CMS estimated the Medicaid managed care improper payment rate at 0.3 percent, or about \$500 million of federal expenditures. This is a small portion of overall estimated Medicaid improper payments, which CMS estimated at about \$37 billion, or 10.1 percent of \$364 billion in federal spending on Medicaid in fiscal year 2017. At the same time, however, the FFS estimated improper payment rate was 12.9 percent or about \$25 billion in federal expenditures.<sup>7</sup> Due, in part, to this disparity in the estimated improper payment rates, we have questioned whether the managed care estimate fully reflects the program integrity risks that exist in Medicaid managed care.<sup>8</sup>

You asked us to provide information on CMS's PERM methodology for Medicaid managed care. In this report, we examine the extent to which the PERM accounts for program integrity risks in Medicaid managed care, including CMS's and states' oversight.

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<sup>4</sup>See OMB, *Appendix C to OMB Circular A-123, Requirements for Effective Estimation and Remediation of Improper Payments*, OMB Memorandum M-15-02 (Washington, D.C.: Oct. 20, 2014) (M-15-02).

<sup>5</sup>In fee-for-service, states pay individual health care providers for each service delivered; while in managed care states typically contract with managed care plans to provide a specific set of Medicaid-covered services to beneficiaries and pay them a set amount per beneficiary per month to provide those services. The eligibility rate has not been calculated since 2014. CMS expects to resume its calculation in 2019.

<sup>6</sup>States may have different types of managed care arrangements in Medicaid; in this report, we are referring to comprehensive, risk-based managed care, the most common type of managed care arrangement.

<sup>7</sup>CMS estimated an additional \$11 billion of improper payments in federal spending for the eligibility component of the PERM.

<sup>8</sup>See GAO, *Medicaid: CMS Has Taken Steps, but Further Efforts Are Needed to Control Improper Payments*, [GAO-17-386T](#) (Washington, D.C.: Jan. 31, 2017).

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To examine the extent to which the PERM accounts for program integrity risks in Medicaid managed care, we reviewed publications from the Department of Health and Human Services' Office of Inspector General (HHS-OIG) and our prior work; conducted literature searches and key word searches of online databases; and obtained input from the National State Auditor's Association and the National Association of State Auditors, Comptrollers, and Treasurers. Through these reviews, we found 27 audits and investigations that identified program integrity risks related to Medicaid managed care—16 federal and state audits, and 11 notices of investigations issued between January 2012 and September 2017.<sup>9</sup> These audits and investigations were conducted by (1) HHS-OIG, (2) a CMS federal contractor that performs claims reviews in Medicaid to identify overpayments, (3) the Department of Justice, (4) state auditors, (5) state Offices of Attorney General, (6) other state agencies, and (7) GAO. (See app. I for a complete list of the audits and investigations we identified.) Of the 27 audits and investigations, 24 found program integrity risks in a single state or with a single provider, covering a total of 10 states, and 3 found program integrity risks across multiple states.<sup>10</sup> We also reviewed CMS regulations on the PERM, the most recent PERM Manual, Medicaid managed care regulations, applicable improper payment laws, 2016 and 2017 PERM estimates of improper payments, and other related OMB and CMS guidance. We then compared the program integrity risks reported in the 27 audits and investigations with the steps taken to estimate improper payments for the PERM's managed care component. In addition, we reviewed all the published reports of CMS's Focused Program Integrity Reviews on managed care in 27 states, other CMS documents related to oversight of states' Medicaid managed care programs, and federal internal control standards—specifically those related to identifying, analyzing, and responding to

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<sup>9</sup>These notices refer to official press releases from various Department of Justice and state Attorney General offices. We are collectively referring to these as audits and investigations in this report. The program integrity risks we determined from our review may not represent the universe of such risks.

<sup>10</sup>The 24 audits and investigations identified program integrity risks in the District of Columbia, Florida, Massachusetts, New Jersey, New York, Ohio, Texas, Virginia, Washington, and West Virginia. Of the 3 multistate audits and investigations, 1 included a settlement made with the federal government and Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Missouri, New York, and Ohio; the others did not identify the number of or which states were reviewed.

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risks.<sup>11</sup> Also, we contacted program integrity officials in the 16 states for which more than half of their 2016 Medicaid expenditures were for services delivered under managed care, and analyzed responses from the 13 states that replied; the information from these states is not generalizable.<sup>12</sup> Lastly, we interviewed CMS officials and experts on program integrity in Medicaid managed care, including one state auditor.

We conducted this performance audit from April 2017 to May 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.

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## Background

In accordance with the Improper Payments Information Act of 2002 (IPIA), as amended, and OMB guidance, CMS developed the PERM to estimate the national Medicaid improper payment rate.<sup>13</sup> CMS has other mechanisms to review and assess program integrity risks in state Medicaid managed care programs, and it uses information from the PERM to target its program integrity activities and oversight of states' Medicaid programs.

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<sup>11</sup>We identified 27 published reports of CMS's Focused Program Integrity Reviews that directly addressed program integrity issues involving Medicaid managed care. Accessed on Oct. 25, 2017 at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/State-Program-Integrity-Review-Reports-List.html>. We refer to these as focused reviews in the remainder of this report.

Also, 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.

<sup>12</sup>The states we contacted were Arizona, California, Delaware, Florida, Hawaii, Kansas, Kentucky, New Jersey, Mississippi, New Mexico, New York, Ohio, Oregon, Rhode Island, Tennessee, and Washington. Delaware, Ohio, and Rhode Island did not respond to our request for information.

<sup>13</sup>The Improper Payments Information Act of 2002, Pub. L. No. 107-300, 116 Stat. 2350 (2002), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA), Pub. L. No. 111-204, 124 Stat. 2224 (2010) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), Pub. L. 112-248, 126 Stat. 2390 (2013), codified as amended at 31 U.S.C. § 3321 note. See also M-15-02.



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## IPIA and OMB Guidance for Estimating Improper Payments

IPIA requires federal executive branch agencies to, among other things, (1) identify programs and activities that may be susceptible to significant improper payments; and (2), on an annual basis, estimate the amount of improper payments for susceptible programs and activities.<sup>14</sup> Agency heads must produce a statistically valid estimate or an estimate that is otherwise appropriate, using an OMB-approved alternate methodology. Those agencies with programs identified by OMB as being high priority for additional oversight and review are required to submit annual reports to their Inspectors General detailing the actions the agency plans to take to recover improper payments and prevent future improper payments. The Inspector General of each agency submitting such a report is required to review the quality of the improper payment estimates and methodology, among other things. OMB designated Medicaid as a high priority program. In addition, the Improper Payments Elimination and Recovery Act of 2010 requires the Inspector General of each agency to conduct a compliance review to report on the agency's compliance with several criteria, one of which is that an agency has reported an improper payment rate of less than 10 percent for each program and activity.<sup>15</sup> IPIA also directed OMB to issue guidance for agencies in implementing the IPIA improper payments requirements. Among other things, the OMB guidance requires that agencies review payments made at the point that federal funds are transferred to nonfederal entities and report on the root causes of identified improper payments.<sup>16</sup>

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## Payment Error Rate Measurement

To calculate the Medicaid improper payment rate through the PERM, CMS computes an annual rolling average of improper payment rates across all states based on a 17-state, 3-year rotation cycle. In accordance with IPIA, as amended, OMB approved CMS's PERM methodology, and

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<sup>14</sup>IPIA defines significant improper payments as gross annual improper payments—the total amount of payments that should not have been made or that were made in an incorrect amount—that may have exceeded (1) both 1.5 percent of program outlays and \$10 million of all program or activity payments made during the fiscal year reported or (2) \$100 million, regardless of the improper payment percentage of total program outlays.

<sup>15</sup>The improper payment rate reflects the estimated improper payments as a percentage of total federal outlays.

<sup>16</sup>See M-15-02.

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the HHS-OIG conducts annual compliance reviews.<sup>17</sup> Beginning with its annual improper payment compliance review for fiscal year 2014, the HHS-OIG established a rotating approach to reviewing the estimation methodology for high-priority programs, including Medicaid, that OMB deemed susceptible to improper payments. Due to the number and complexity of the programs, the HHS-OIG methodology reviews are scheduled to be performed over a 4-year period; the PERM estimation methodology will be reviewed as a part of its fiscal year 2017 compliance review.

Each of the three components of the Medicaid PERM—FFS, managed care, and eligibility—is estimated differently:

- The FFS component of the PERM measures errors in a sample of FFS claims, which are records of services provided and the amount the Medicaid program paid for these services. For the majority of sampled FFS claims, the PERM review contractor performs a medical review, which includes a review of the medical documentation to determine errors that do not meet federal and state policies, such as medically unnecessary services, diagnosis coding errors, and policy violations.<sup>18</sup> Any FFS claims that were paid for services that should have been covered under a managed care plan’s capitated payment are also considered errors.
- The managed care component of the PERM measures errors that occur in the capitated payments that state Medicaid agencies make to managed care organizations (MCO) on behalf of enrollees. Capitated payments are periodic payments approved by CMS that state Medicaid agencies make to contracted MCOs to cover the provision of medical services to enrollees, as well as the MCOs’ administrative expenses and their profits or earnings. The PERM assesses whether any payments made to the MCOs were in amounts different than those the state agency is contractually required to pay, which are

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<sup>17</sup>OMB reviewed changes in the PERM methodology three times—in 2008, 2013, and 2015—with the last review focusing on the eligibility component. In 2016 and 2017, the HHS-OIG determined that the Medicaid program was not fully in compliance with IPERA, because the overall estimated improper payment rate exceeded the 10 percent criterion of IPERA. When an agency is determined to not be in compliance with one or more of the IPERA criteria by its Inspector General, it must submit a plan to Congress describing the actions it will take to come into compliance.

<sup>18</sup>All sampled FFS claims undergo a data processing review to identify errors, such as payments for duplicate items or noncovered services and data entry errors.

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approved by CMS. In contrast to the FFS component, the managed care component of the PERM neither includes a medical review of services delivered to enrollees, nor reviews of MCO records or data.

- The eligibility component of the PERM measures errors in state determinations of whether enrollees meet categorical and financial criteria for receipt of benefits under the Medicaid program. The eligibility component assesses determinations for both FFS and managed care enrollees. This component has not been calculated since 2014; instead, CMS piloted different approaches to update the methodologies used to assess enrollee eligibility, as the Patient Protection and Affordable Care Act changed income eligibility requirements for nonelderly, nonpregnant individuals who qualify for Medicaid.<sup>19</sup> Beginning in the 2019 reporting year, eligibility reviews under the PERM will resume and will be conducted by a federal contractor.<sup>20</sup>

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## Medicaid Program Integrity and Oversight in Managed Care

Medicaid program integrity consists of efforts to ensure that federal and state expenditures are used to deliver quality, necessary care to eligible enrollees, and efforts to prevent fraud, waste, and abuse. We have found in prior work that CMS's and states' program integrity efforts focused primarily on payments and services delivered under FFS and did not closely examine program integrity in Medicaid managed care.<sup>21</sup> For Medicaid managed care, CMS has largely delegated program integrity oversight of MCOs to the states. States, in turn, generally oversee MCOs and the providers under contract to MCOs through their contracts with the MCOs and reporting requirements.

Some program integrity risks for managed care are similar to those in FFS, including payments made for nonenrolled, ineligible, or deceased individuals; payments to ineligible, excluded, or deceased providers; and

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<sup>19</sup>The Patient Protection and Affordable Care Act, enacted on March 23, 2010, permits states to expand their Medicaid programs to cover nonelderly, nonpregnant adults who are not eligible for Medicare, and whose income does not exceed 133 percent of the federal poverty level. Because of the way the limit is calculated, using what is known as an "income disregard," the level is effectively 138 percent of the federal poverty level. Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010).

<sup>20</sup>Previously, states conducted PERM eligibility reviews themselves of both FFS and managed care enrollee determinations.

<sup>21</sup>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).

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payments to providers for improper or false claims, such as payments for services that are not medically necessary. Other program integrity risks are more unique to managed care. For example, capitated payments generally reflect the average cost to provide covered services to enrollees, rather than a specific service. Federal law requires capitation rates to be actuarially sound, meaning that, among other things, they must be reasonably calculated for the populations expected to be covered and for the services expected to be furnished under contract.<sup>22</sup> In order to receive federal funds for its managed care program, a state is required to submit the rates it pays MCOs and the methodology it uses to set those rates to CMS for review and approval.<sup>23</sup> Additionally, federal and state oversight of Medicaid managed care can include ensuring that MCOs fulfill contractual provisions within their managed care contracts. In some cases, these provisions relate directly to program integrity activities, including plans and procedures for identifying, recovering, and reporting on overpayments made to providers.

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## Payment Error Rate Measurement for Managed Care Has Limitations, Which Are Not Mitigated by Current CMS and State Oversight

The managed care component of the PERM measures the accuracy of the capitated payments state Medicaid agencies make to MCOs. Specifically, a CMS contractor examines whether the state agency made capitated payments only for eligible enrollees, made capitated payments for the correct amount based on the contract and coverage requirements (time period and geographic location), made capitated payments based on the correct rate for enrollees, and did not make any duplicate payments for enrollees.

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<sup>22</sup>See 42 U.S.C. § 1396b(m)(2)(A)(iii); 42 C.F.R. § 438.4 (2017).

<sup>23</sup>CMS's review is designed to ensure that states comply with federal regulatory requirements for setting actuarially sound rates and focuses primarily on the appropriateness of the data used rather than their reliability. See GAO, *Medicaid: Federal Oversight of Payments and Program Integrity Needs Improvement*, [GAO-12-674T](#) (Washington, D.C.: April 25, 2012).

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## CMS's Payment Error Rate Measurement Measures the Accuracy of Medicaid Managed Care Payments, but Does Not Account for Overpayments and Unallowable Costs

CMS officials noted that the agency established capitated payments as the level of review, because the capitation rate is the transaction used to determine the federal match in managed care. In general, the federal government matches most state expenditures for Medicaid services on the basis of a statutory formula.<sup>24</sup> In FFS, the federal match is provided for the amount the state pays a health care provider for delivering services to enrollees. With managed care, the federal match is provided for the amount of the capitation rate the state pays the MCO. Capitated payments do not directly relate to the provision of a specific service, but reflect the average cost to provide covered services to enrollees. As a result, CMS officials maintain that the capitated payment is the lowest transaction level at which the agency can clearly identify federal funds without making significant assumptions.

Because the managed care component of the PERM review is limited to measuring capitated payments, it does not account for other program integrity risks—such as overpayments to providers and unallowable MCO costs.

- In addition to errors in capitated payments included in PERM reviews, CMS regulations state that overpayments in managed care include any payment made to an MCO or provider under contract to an MCO to which the MCO or provider is not entitled under Medicaid.<sup>25</sup> Such overpayments included payments for services that were not provided or medically necessary; or to ineligible, excluded, or deceased providers, which are not measured by the PERM.
- Unallowable MCO costs refers to operating costs that MCOs cannot claim under their managed care contracts, such as certain marketing costs, or that the MCO reported incorrectly.

Among the 27 audits and investigations of Medicaid managed care programs we reviewed, 10 identified about \$68 million in MCO overpayments to providers and unallowable MCO costs that were not accounted for in PERM estimates. In addition, one investigation of an MCO operating in nine states resulted in a \$137.5 million settlement to

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<sup>24</sup>The statutory formula, referred to as the Federal Medical Assistance Percentage, is calculated using a state's per capita income, with the federal government paying a larger portion of Medicaid expenditures in states with low per capita incomes relative to the national average, and a smaller portion for states with higher per capita incomes.

<sup>25</sup>See 42 C.F.R. § 438.2 (2017).

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resolve allegations of false claims.<sup>26</sup> (See app. I for a complete list of the audits and investigations we identified.) However, the full extent of these overpayments and unallowable costs is unknown, because these audits and investigations were conducted over more than 5 years and involved a small fraction of the more than 270 MCOs operating nationwide as of September 2017.<sup>27</sup> Specifically, 24 of the audits and investigations represented reviews in 10 states and, in many cases, focused on individual providers or MCOs; there were about 90 MCOs operating in the 10 states as of September 2017, according to the Kaiser Family Foundation.<sup>28</sup> Some examples of the audits and investigations that identified overpayments and unallowable costs include the following:

- The Washington State Auditor’s Office found that two MCOs made \$17.5 million in overpayments to providers in 2010, which may have increased the state’s 2013 capitation rates.<sup>29</sup>
- The New York State Comptroller found that two MCOs paid over \$6.6 million to excluded and deceased providers from 2011 through 2014.<sup>30</sup>
- The Massachusetts State Auditor found that one MCO paid \$420,000 for health care services and unauthorized prescriptions from excluded providers in 2013 and 2014.<sup>31</sup>

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<sup>26</sup>The False Claims Act provides for civil penalties for knowingly submitting or causing to be submitted false claims for payments to the federal government. See 31 U.S.C § 3729.

<sup>27</sup>Kaiser Family Foundation. *Total Medicaid MCOs*, accessed February 9, 2018, <https://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/>.

<sup>28</sup>Kaiser Family Foundation. *Total Medicaid MCOs*, accessed February 9, 2018, <https://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/>.

<sup>29</sup>Washington State Auditor, *Performance Audit: Health Care Authority’s Oversight of the Medicaid Managed Care Program*, Audit No. 1011450 (April 14, 2014).

<sup>30</sup>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). The HHS-OIG has the authority to exclude providers from federal health care programs, and maintains a list of all currently excluded providers called the List of Excluded Individuals/Entities. No payment may be made from any federal health care program for any items or services furnished, ordered, or prescribed by an excluded provider.

<sup>31</sup>Commonwealth of Massachusetts Office of the State Auditor, *Office of Medicaid (MassHealth)—Review of Providers Excluded from Participating in the Medicaid Program*, Audit Report No. 2015-1374-3M8 (Boston, Mass.: April 20, 2016).

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- The Department of Justice alleged that an MCO operating in several states submitted inflated expenditure information to the state Medicaid agencies, falsified encounter data, and manipulated claims costs and service provision costs in nine states. The MCO agreed to pay over \$137.5 million to resolve these claims.<sup>32</sup>
  - The Texas State Auditor’s Office found that an MCO reported \$3.8 million in unallowable costs for advertising, company events, gifts, and stock options, along with \$34 million in other questionable costs in 2015.<sup>33</sup>
  - The New York State Comptroller also found that an MCO claimed over \$260,000 in unallowable administrative expenses, which contributed to an increase in capitation rates across the state.<sup>34</sup>

To the extent that the state does not identify or know of MCO overpayments to providers or unallowable MCO costs, the overpayments and unallowable costs could inflate future capitation rates, as the Washington State Auditor and New York State Comptroller noted in their findings. The PERM assesses the accuracy of capitated payments that states make to MCOs. States set capitation rates based on cost data—historical utilization and spending—that MCOs submit to the state Medicaid agencies, but the PERM does not consider these data. Unless removed from these cost data, unidentified overpayments and unallowable costs would likely inflate the MCO cost data that states use to set capitation rates. (See fig. 1.) As a result, future capitation rates would also be inflated, resulting in higher state and federal spending.

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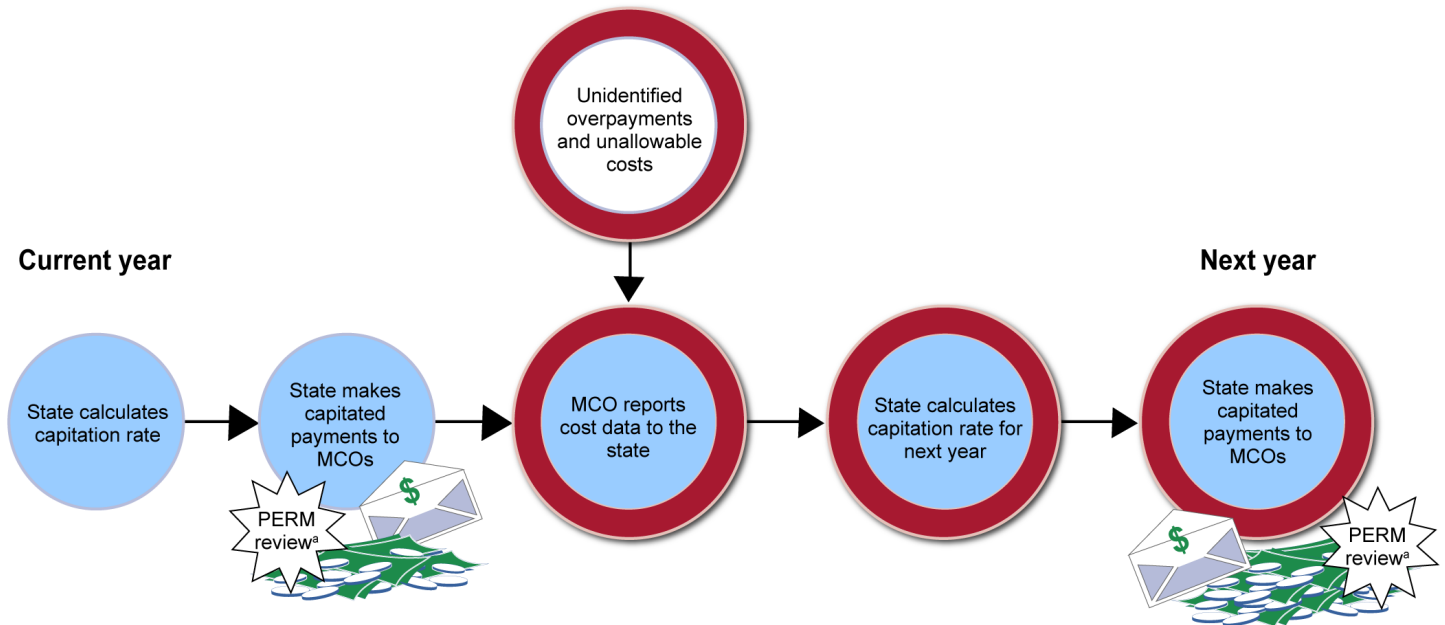
<sup>32</sup>Department of Justice, *Florida-Based Wellcare Health Plans Agrees to Pay \$137.5 Million to Resolve False Claims Act Allegations* (Washington, D.C.: April 3, 2012), accessed December 8, 2017, <https://www.justice.gov/opa/pr/florida-based-wellcare-health-plans-agrees-pay-1375-million-resolve-false-claims-act>.

Encounter data are the primary record of services delivered to enrollees in Medicaid managed care.

<sup>33</sup>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).

<sup>34</sup>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).

**Figure 1: Effect of Unidentified Overpayments and Unallowable Managed Care Organization Costs on Future Years' Capitation Rates**



Source: GAO. | GAO-18-291

<sup>a</sup>The Payment Error Rate Measurement (PERM) reviews the capitated payments states make to managed care organizations (MCO).

In fiscal year 2017, the Medicaid managed care improper payment rate was 0.3 percent, while the FFS improper payment rate was 12.9 percent, leading to an assumption that the estimated risks in managed care are less significant than those estimated in FFS. However, the managed care component of the PERM does not determine whether MCO payments to providers were for services that were medically necessary, actually provided, accurately billed and delivered by eligible providers, or whether the MCO costs were allowable and appropriate. As a result, the PERM improper payment estimate potentially understates the extent of program integrity risks in Medicaid managed care.

Moreover, this potential understatement in the PERM's improper payment rate estimate may curtail investigations into the appropriateness of MCO spending. We previously reported that CMS and state program integrity efforts did not closely examine program integrity in Medicaid managed care, focusing primarily on payments and services delivered under FFS.<sup>35</sup>

<sup>35</sup>See [GAO-14-341](#).



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Our current review of the 27 audits we identified encompassed a 5-year period, suggesting that reviews of managed care continue to be limited. An official from a state auditor's office we spoke with suggested that some states may not audit services delivered under managed care, because of a low improper payment rate. In addition, he noted that his state Medicaid agency used the relatively low payment error rate in managed care as an indicator of few program integrity problems.

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## CMS and State Oversight of Managed Care Do Not Ensure the Identification and Reporting of Overpayments and Unallowable Costs

As noted, CMS has increased its focus on and worked with states to improve oversight of Medicaid managed care; however, these efforts and the oversight efforts of states do not ensure the identification and reporting of overpayments and unallowable costs. In recent years, the agency has sought to strengthen oversight of managed care programs through updated regulations; reviews of states' managed care programs (Focused Program Integrity Reviews) and collaborative audits, which are conducted jointly by federal program integrity contractors and states; and state monitoring of overpayments.

**Regulations.** In May 2016, CMS updated its regulations for managed care programs in order to strengthen oversight. The updated regulations require a number of additional program integrity activities, such as those listed below. If fully implemented, these updated regulations may help with the identification and removal of overpayments and unallowable costs from data used to set future capitation rates.<sup>36</sup> Under these regulations

- States must arrange for an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by MCOs, at least once every 3 years.
- Through contracts with MCOs, states must require MCOs to have a mechanism through which providers report and return overpayments to the MCOs. States must also require MCOs to promptly report any identified or recovered overpayments—specifying those that are potentially fraudulent—and submit an annual report on recovered overpayments to their state. States must use this information when setting actuarially sound capitation rates.
- Through contracts with MCOs, states must also require MCOs to report specific data, information, and documentation. In addition, the

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<sup>36</sup>See 42 U.S.C. § 1396b(m)(2)(A)(iii).

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MCO's chief executive officer or authorized representative must certify the accuracy and completeness of the reported data, information, and documentation.

- States must enroll MCO providers that are not otherwise enrolled with the state to provide services to enrollees in Medicaid FFS, and revalidate the enrollment at least once every 5 years. Initially this requirement was to start for MCO contracts beginning on July 1, 2018. Subsequently enacted legislation codified this requirement in statute and moved the implementation to January 1, 2018.<sup>37</sup>

It is too early to know if these regulations will assure better oversight of MCO payments to providers and the data used to set future capitation rates. The above program integrity requirements only went into effect recently—for contracts starting on or after July 1, 2017, and January 1, 2018. In addition, CMS issued a notice in June 2017 stating that the agency will use its enforcement discretion to assist states that are unable to implement new requirements by the required compliance date.<sup>38</sup> Also, CMS has delayed issuance of implementing guidance for certain provisions until the agency completes its review, a step that may further delay states' implementation. The agency has designated Medicaid managed care for "deregulatory action" and plans to propose a new rule, but has not indicated which of these provisions, if any, would be revised.<sup>39</sup>

**Focused Program Integrity Reviews.** In fiscal year 2014, CMS implemented its Focused Program Integrity Reviews in order to target high-risk program integrity areas in each state, including managed care. As we previously reported, these focused reviews are narrower in scope

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<sup>37</sup>21st Century Cures Act, Pub. L. No. 114-255, § 5005(b), 130 Stat. 1033, 1193 (2016) (codified at 42 U.S.C. § 1396u-2(d)(6)).

<sup>38</sup>Center for Medicaid & CHIP Services (CMCS), *CMCS Informational Bulletin: Medicaid Managed Care Regulations with July 1, 2017 Compliance Dates*, (June 30, 2017), accessed December 19, 2017, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib063017.pdf>.

<sup>39</sup>CMS indicated it will issue a Notice of Proposed Rulemaking in August 2018 to streamline Medicaid managed care regulations and reduce burden. See Department of Health and Human Services, Medicaid and CHIP Managed Care, *Fall 2017 Unified Agenda of Federal Regulatory and Deregulatory Actions*, (CMS-2480-P), RIN 0938-AT40, accessed February 6, 2018, <http://www.reginfo.gov>.

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than the prior reviews conducted by CMS, but they still involve on-site visits to states.<sup>40</sup>

In its focused reviews of managed care, CMS found that several states had incomplete oversight of MCO payments to providers, even though the agency relies on states to verify reported MCO overpayments and to ensure the overpayments are excluded from the data used to set capitation rates. In the 27 focused reviews of managed care from 2014 to 2017, CMS found that MCOs in 17 states reported fewer overpayments to their state Medicaid agencies than CMS would expect. For example, MCOs in at least 5 states reported that overpayments were less than 0.1 percent of their total managed care expenditures; while CMS noted in 1 focused review that overpayments typically equal 1 to 10 percent of total expenditures in managed care. CMS also found that 5 of the 27 states did not verify that MCOs excluded overpayments from these data, and 1 state did not exclude overpayments from the capitation rate setting. This is consistent with our March 2017 report in which we noted that CMS commonly found that MCOs reported low amounts of recovered overpayments and conducted few reviews to identify overpayments.<sup>41</sup> Also, officials from three of the five states we interviewed for that report said the focused reviews gave them leverage in dealing with MCOs or led MCOs to focus more on program integrity. We also reported that CMS officials recommended states take steps to improve their oversight of MCOs, based on the focused review findings.<sup>42</sup>

The findings from CMS's focused reviews of managed care also highlight the need for greater federal oversight of states. Without these reviews, it is unclear if states would independently identify MCOs' reporting of overpayments or work to strengthen MCO reporting. Yet, CMS has not yet published the focused reviews of managed care in 13 states, and it may only conduct a focused review in a state once every three or more years. Given CMS's timeline for the focused reviews, it may take years to

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<sup>40</sup>Prior to the implementation of Focused Program Integrity Reviews, CMS conducted Comprehensive Program Integrity Reviews to ensure regulatory compliance in each state about once every three years. For more information about CMS focused reviews, 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).

<sup>41</sup>See [GAO-17-277](#).

<sup>42</sup>See [GAO-17-277](#).

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determine if corrective actions result in improved program integrity in services delivered through managed care.

**Collaborative audits.** CMS has expanded the federal-state collaborative audits beyond FFS, and has begun to engage states to participate in collaborative audits of MCOs and providers under contract to MCOs. As a part of the collaborative audit process, the state volunteers to jointly develop the audit processes the federal contractors follow. CMS officials told us that federal contractors have completed 14 collaborative audits of providers under contract to MCOs in three states—Arizona, the District of Columbia, and Tennessee. Only the audit of Trusted Healthcare, an MCO in the District of Columbia, has been published. That audit identified \$129,000 in overpayments in a sample of MCO payments to providers, which, if generalized to all of the MCO's payments over 6 months, would equate to over \$4 million in overpayments. According to CMS, three additional states—Louisiana, Nebraska, and New Hampshire—have shown interest in collaborative audits of their MCOs, although such audits require states to prepare data files for the federal contractor and commit staff time. In our March 2017 report, we found that states' participation in FFS collaborative audits varied and some states reported barriers to their participation.<sup>43</sup> Expanding collaborative audits in managed care will require commitment from and coordination with states.

**State monitoring of overpayments in managed care.** States are required to report overpayments they have identified and recouped along with state expenditures on a quarterly basis. However, based on the responses of the program integrity officials in 13 of the 16 states we contacted, most officials were unable to define the magnitude of overpayments in their managed care programs, which may signify a need for greater federal oversight or coordination. Specifically, officials in 7 of the 13 states could not or did not identify the share of total reported Medicaid overpayments that occurred in managed care. In 11 of the 13 states, officials responded that they did not directly monitor MCO payments to providers. Of those 11 states, officials in 4 said they depend on MCOs to report overpayments and exclude the overpayments from the data used to set capitation rates. As long as states are not taking action to identify overpayments in managed care, they cannot be assured that they are accurately paying MCOs for medically necessary services provided to enrollees.

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<sup>43</sup>See [GAO-17-277](#).

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Federal internal control standards call for agency management to identify, analyze, and respond to risks. CMS has taken some steps to identify, analyze, and respond to risks through its regulations, Focused Program Integrity Reviews, and collaborative audits. However, key CMS and state oversight efforts fall short of mitigating the limitations of the PERM estimates of improper payments for managed care, because they do not ensure the identification and reporting of overpayments to providers and unallowable MCO costs. Without addressing these key risks, CMS and states cannot ensure the integrity of Medicaid managed care programs.

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## Conclusions

The 0.3 percent improper payment rate for Medicaid managed care, as measured by the PERM, is significantly lower than the improper payment rate of 12.9 percent for Medicaid FFS. However, this difference does not signal better oversight; rather, it represents differences in the review criteria between FFS and managed care, which result in a less complete accounting for the program integrity risks in managed care. The PERM does not account for key program integrity risks in Medicaid managed care: specifically, unidentified overpayments and unallowable costs. One federal investigation of an MCO operating in nine states resulted in a settlement of \$137.5 million to resolve allegations of false claims that were not captured in the national Medicaid improper payment rate estimate. Further, CMS found that MCOs and states do not provide sufficient oversight in Medicaid managed care to address the risks that are not accounted for in the PERM, findings that are reinforced by our reports on Medicaid managed care program integrity.<sup>44</sup> CMS has taken steps to improve its oversight of Medicaid managed care, yet these efforts fall short of ensuring that the agency and states will be able to identify and address overpayments to providers and unallowable MCO costs. Without better measurement of program risks—particularly as expenditures for Medicaid managed care continue to grow—CMS cannot be certain that the low improper payment rate for managed care, as measured by the PERM, accurately reflects lower risks in managed care.

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## Recommendation

The Administrator of CMS should consider and take steps to mitigate the program risks that are not measured in the PERM, such as overpayments and unallowable costs; such an effort could include actions such as

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<sup>44</sup>See [GAO-17-317](#).

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revising the PERM methodology or focusing additional audit resources on managed care. (Recommendation 1)

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## Agency Comments

We provided a draft of this report to the Department of Health and Human Services (HHS) for comment. In its written comments, HHS concurred with our recommendation, and indicated that it will review regulatory authority and audit resources to determine the best way to account for Medicaid program risks that are not accounted for in the PERM. However, HHS stated that the PERM is not intended to measure all Medicaid program integrity risks, and utilizing the PERM measurement in that way would be a misunderstanding and misuse of the reported rate. HHS also commented that a review of payments from MCOs to providers is outside the scope of IPIA. In addition, HHS asserted that including such a review would diminish the value of PERM reporting—because it would require significant assumptions about the amount of federal share in MCO payments to providers. Further, HHS maintained that such a review also would result in a measurement that was not comparable to other programs or agencies, which would diminish the value of government-wide improper payment rate reporting. We acknowledge that the current PERM methodology has been approved by OMB. However, we maintain that the PERM likely underestimates program integrity risks in Medicaid managed care. To ensure the appropriate targeting of program integrity activities, CMS needs better information about these risks. Given the size of the Medicaid program, its vulnerability to improper payments, and the growth in managed care, it is critical to have a full accounting of program integrity risks in managed care in order to best ensure the integrity of the whole Medicaid program.

In its written comments, HHS also summarized several activities it uses to oversee and support states' Medicaid program integrity efforts, including state program integrity reviews; collaborative audits conducted by federal contractors; Medicaid Integrity Institute training for state employees; and the Medicaid Provider Enrollment Compendium.<sup>45</sup> HHS also provided technical comments, which we incorporated as appropriate. HHS's comments are reprinted in appendix II.

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<sup>45</sup>The Medicaid Provider Enrollment Compendium is a policy manual that contains sub regulatory guidance and clarifications to help states implement provider enrollment requirements.

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As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of CMS, appropriate congressional committees, and other interested parties. In addition, the report will be 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](mailto: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 III.



Carolyn L. Yocom  
Director, Health Care

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# Appendix I: Federal and State Audits and Investigations of Medicaid Managed Care

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We reviewed 16 federal and state audits and 11 notices of investigations of Medicaid managed care organizations (MCO) and providers issued from January 2012 to September 2017.<sup>1</sup> As the findings below show, the audits and investigations represent a limited number of reviews that, in many cases, focused on individual states and individual providers or MCOs within that state. Given the limited scope and number of states reviewed, the amount of the overpayments and unallowable costs occurring nationwide is unknown.

These audits and investigations show

- cases of MCO overpayments to providers or unallowable costs, which are not accounted for by the Centers for Medicare & Medicaid Services' Payment Error Rate Measurement (PERM) ;
- errors in capitated payments (e.g., capitated payments made for deceased individuals), which are accounted for in the PERM; and
- gaps in managed care oversight.

When reporting overpayments and unallowable costs identified in the audits and investigations, we only include amounts specifically attributed to MCOs in our total. This total does not include the following:

- overpayments and unallowable costs identified in those audits and investigations that did not distinguish between the amounts attributable to MCOs, Medicaid fee-for-service, or Medicare;
- overpayments and unallowable costs identified in criminal proceedings that are not yet resolved; and
- errors in capitated payments, as those payments would be reviewed by the PERM.

As a result, the total amount of overpayments and unallowable costs and capitated payment errors in this appendix exceed what we report.

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<sup>1</sup>These notices refer to official press releases from various U.S. Attorney offices and state Attorney General offices. We are collectively referring to these as audits and investigations in this report. The program integrity risks we determined from our review may not represent the universe of such risks.



**Appendix I: Federal and State Audits and Investigations of Medicaid Managed Care**

**Table 1: Findings from 27 Federal and State Audits and Investigations of Medicaid Managed Care Organizations (MCO) and MCO Providers, January 2012 – September 2017**

<b>State</b>	<b>Allegation and/or finding</b>	<b>Source</b>
<b>Department of Health and Human Services, Office of the Inspector General (HHS-OIG)</b>		
Florida	HHS-OIG found that the Florida Medicaid agency made \$26.2 million in capitated payments for deceased individuals.	HHS-OIG. <i>Florida Managed Care Organizations Received Medicaid Capitation Payments after Beneficiary's Death</i> . Report A-04-15-06182. November 2016.
Texas	HHS-OIG found that the Texas Medicaid agency made \$3 million in duplicate capitated payments.	HHS-OIG. <i>Texas Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned More than One Medicaid Identification Number</i> . Report A-06-15-00024. March 2017.
Texas	HHS-OIG 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. <sup>a</sup>	HHS-OIG Enforcement Actions. U.S. Attorney; Northern District of Texas: <i>Ellis County Woman Sentenced to 105 Months in Federal Prison for Defrauding Medicaid</i> . Dallas, Tex.: April 8, 2016.
West Virginia	HHS-OIG found that West Virginia MCO and Medicaid 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. <sup>b</sup>	HHS-OIG. Enforcement Actions. U.S. Attorney; Southern District of West Virginia: <i>Charleston Dentist Pleads Guilty to Health Care Fraud</i> . Charleston, W.Va.: August 21, 2017.
Several	HHS-OIG found that 125 providers terminated in one state were still participating in Medicaid through managed care in another state.	HHS-OIG. <i>Providers Terminated from One State Medicaid Program Continued Participating in Other States</i> . Report No. OEI-06-12-00030. p. 7. August 2015.
<b>Other, Federal</b>		
Washington, D.C.	HMS, a contractor for the Centers for Medicare & Medicaid Services, found estimated overpayments of \$129,000 in a sample of 158 claims which extrapolates to \$4.1 million for the universe of claims in 6 months. It also identified that MCO administrative expenses and earnings were greater than permitted under the contract.	HMS. <i>Final Audit Report of Trusted Health Plan, Inc.</i> District of Columbia, NAIC Number 14225, For the period November 1, 2013 through April 30, 2014. Report Number 2014-750-NAIC 14225—MCO 10-10. March 14, 2016.
Several	GAO reported that state Medicaid agencies paid about \$3.8 million on behalf of 3,200 incarcerated individuals in the form of capitated payments in 2011.	GAO. <i>Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls</i> . <a href="#">GAO-15-313</a> . Washington, D.C.: May 14, 2015.
Several	The Department of Justice alleged that an MCO operating in several states submitted inflated expenditure information to the state Medicaid agencies, falsified encounter data, and manipulated claims costs and service provision costs in nine states. The MCO agreed to pay over \$137.5 million in a settlement to resolve these claims.	United States Department of Justice. <i>Florida-Based Wellcare Health Plans Agrees to Pay \$137.5 Million to Resolve False Claims Act Allegations</i> . Washington, D.C.: April 3, 2012.

**Appendix I: Federal and State Audits and Investigations of Medicaid Managed Care**

<b>State</b>	<b>Allegation and/or finding</b>	<b>Source</b>
<b>State Auditors</b>		
Florida	Florida's Auditor General found the state Medicaid agency's monitoring of MCOs did not adequately encompass all key contract provisions. In addition, the state Medicaid agency had not established sufficient procedures to fully assess the accuracy or completeness of MCO reports used as the basis for certain monitoring conclusions.	State of Florida Auditor General. <i>Agency for Health Care Administration: Statewide Medicaid Managed Care Program and Prior Audit Follow-Up</i> . Report No. 2018-22. Tallahassee, Fla.: July 2017.
Massachusetts	The Massachusetts State Auditor found that an MCO paid \$420,000 for health care services and unauthorized prescriptions from excluded providers in 2013 and 2014.	Commonwealth of Massachusetts Office of the State Auditor. <i>Office of Medicaid (MassHealth)—Review of Providers Excluded from Participating in the Medicaid Program</i> . Audit Report No. 2015-1374-3M8. Boston, Mass.: April 20, 2016.
New York	The New York State Comptroller found that the state Medicaid agency made \$122 million in capitated payments for dis-enrolled and deceased individuals; at the time of this report, \$7.4 million was recovered.	New York State Office of the State Comptroller. <i>Inappropriate Premium Payments for Recipients No Longer Enrolled in Mainstream Managed Care and Family Health Plus</i> . Report 2015-S-47. Albany, N.Y.: July 2017.
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.	New York State Office of the Comptroller. <i>Mainstream Managed Care Organizations - Administrative Costs Used in Premium Rate Setting</i> . Report 2014-S-55. Albany, N.Y.: October 2016.
New York	The New York State Comptroller found that the state Medicaid agency made \$7.1 million in capitated payments for individuals who had been dis-enrolled from the plan. The state Medicaid agency also enrolled 119 deceased individuals and continued to make payments for 1,177 enrollees who died after enrollment, making \$2.3 million in overpayments. The majority of the overpayments were for managed care capitated payments.	New York State Office of the State Comptroller. <i>Medicaid Claims Processing Activity, April 1, 2015 through September 30, 2015</i> . Report 2015-S-16. Albany, N.Y.: August 2016.
New York	The New York State Comptroller found that two MCOs made more than \$6.6 million in payments to excluded and deceased providers, and had limited recovery and reporting of improper payments, and limited plan resources to address fraud and abuse.	New York State Office of the State Comptroller. <i>Medicaid Managed Care Organization Fraud and Abuse Detection</i> . Report 2014-S-51. Albany, N.Y.: July 15, 2016.
New York	The New York State Comptroller found that the state Medicaid agency made \$15.6 million in capitated payments on behalf of ineligible individuals.	New York State Office of the State Comptroller. <i>Improper Managed Care Payments for Certain Medicaid Recipients</i> . Report 2010-S-66. Albany, N.Y.: July 2012.
Texas	The Texas State Auditor's Office 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.	Texas State Auditor. <i>An Audit Report on HealthSpring Life and Health Insurance Company, Inc., a Medicaid STAR+PLUS Managed Care Organization</i> . Report No. 17-025. Austin, Tex.: February 2017.

**Appendix I: Federal and State Audits and Investigations of Medicaid Managed Care**

<b>State</b>	<b>Allegation and/or finding</b>	<b>Source</b>
Washington	The Washington State Auditor's Office found that two MCOs made \$17.5 million in overpayments to providers in 2010. As a result, the state Medicaid agency paid an estimated additional \$1.26 million in capitated payments to all MCOs statewide in 2013 for every \$1 million in MCO overpayments from 2010.	Washington State Auditor. <i>Performance Audit: Health Care Authority's Oversight of the Medicaid Managed Care Program</i> . Audit No. 1011450. April 14, 2014.
<b>State Attorneys General</b>		
Massachusetts	The Massachusetts Attorney General reported that a woman was sentenced to jail and ordered to pay restitution for stealing from public agencies by billing for unlicensed psychological services. The investigation began when a licensed psychologist reported to the Attorney General's office that the defendant's company had used her name and license number without permission to bill a Medicaid managed care organization more than \$430,000.	Attorney General of Massachusetts. <i>Burlington Woman Sentenced to Jail, Ordered to Pay Up to \$570,000 for Billing Public Agencies for Unlicensed Mental Health Services</i> . Woburn, Mass.: December 20, 2016.
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.	New Jersey Office of the Attorney General. <i>Owner of Hudson County Medical Equipment Supply Store Pleads Guilty To \$100,000 from Medicaid Fraud Scam</i> . Trenton, N.J.: August 21, 2017.
New York	The New York Attorney General reported the sentencing of multiple defendants for fraudulently billing Medicare, Medicaid MCOs, and Medicaid fee-for-service (FFS) \$9 million for prescriptions that were not dispensed.	New York Office of the Attorney General. <i>New York A.G. Schneiderman Announces \$7.9 Million Settlement and State Prison Sentences in Major Illegal Prescription Buy-Back and Money Laundering Scheme</i> . New York, N.Y.: March 2, 2017.
New York	The New York Attorney General reported the arrest of a supplier for allegedly stealing \$1.5 million from Medicaid and a Medicaid MCO by submitting false claims for a highly specialized prescription formula, but either provided an over-the-counter supplement or no service at all.	New York Office of the Attorney General. <i>New York A.G. Schneiderman Announces Arrest of Brooklyn Medical Supply Company Owner for Allegedly Defrauding Medicaid</i> . New York, N.Y.: February 25, 2017.
New York	The New York Office of the Attorney General reported the indictment of providers for allegedly submitting over \$2.3 million worth of claims for substance abuse treatment services to an MCO when they were not certified to provide such services.	New York State Office of the Attorney General. <i>New York A.G. Schneiderman Announces Indictment and Arraignment of Clinic Operator for Allegedly Defrauding Medicaid by Offering Bogus Substance Abuse Treatment</i> . New York, N.Y.: November 29, 2016.
New York	The New York Attorney General reported resolving criminal charges and civil liability, resulting in a \$500,000 settlement, with a provider for overbilling services and/or procedures relating to clinical testing services, billing for counseling services provided by ineligible staff, and improper billing of prescription pick-ups and medication refills.	New York State Office of the Attorney General. <i>New York A.G. Schneiderman Announces Recovery of Over \$500K in Local Doctor's Fraudulent Medicaid Billings</i> . Rochester, N.Y.: October 6, 2016.

**Appendix I: Federal and State Audits and Investigations of Medicaid Managed Care**

<b>State</b>	<b>Allegation and/or finding</b>	<b>Source</b>
New York	The New York Attorney General reported the guilty pleas of two personal care service aides who submitted false claims to MCOs for services that were not provided resulting in more than \$1,000 each in theft to the Medicaid program.	New York Office of the Attorney General. <i>New York A.G. Schneiderman Announces Guilty Plea of Two Capital Region No-Show Personal Care Aids Who Billed Medicaid</i> . Albany, N.Y.: December 7, 2015.
New York	New York Attorney General reported the arrest of home health aides who submitted \$30,000 worth of claims to Medicaid or MCOs for services not provided or used fake credentials to obtain employment.	New York Office of the Attorney General. <i>New York A.G. Schneiderman Announces Arrests of Six NYC and Westchester Home Health Aides Charged with Defrauding Medicaid</i> . New York, N.Y.: June 10, 2015.
<b>Other, State</b>		
Ohio	Ohio's Office of Budget and Management found that the state Medicaid agency does not conduct provider fraud and abuse detection activities, but rather relies on the MCO, and does not track outcomes of cases it refers to the Medicaid Fraud Control Unit. The state Medicaid agency also does not have a process to review annual MCO fraud and abuse activity reports.	Ohio Office of Budget and Management. Office of Internal Audit. <i>Department of Medicaid: Managed Care Plan Provider Fraud and Abuse Audit</i> . Report number: 2015-ODM-01. March 26, 2015.
Virginia	The Virginia Joint Legislative Audit and Review Commission found that the state's MCOs did not consistently identify and report overpayments to the state Medicaid agency, and conducted few audits of providers relative to the state Medicaid agency's audits of FFS. The state Medicaid agency did not sufficiently oversee MCOs' detection and recovery of overpayments or expenditure data in order to minimize risk of overpayments and to ensure capitation rates are not inflated.	Virginia Joint Legislative Audit and Review Commission. <i>Mitigating the Risk of Improper Payments in the Virginia Medicaid Program</i> . House Document No. 4. Richmond, Va.: January 2012.

Source: GAO review of federal and state audits and investigations. | GAO-18-291

<sup>a</sup>The HHS-OIG, Federal Bureau of Investigation, state Attorney General's Medicaid Fraud Control Unit (MFCU), and Department of Agriculture's Office of the Inspector General investigated this case.

<sup>b</sup>The HHS-OIG, Federal Bureau of Investigation, MFCU, and U.S. Attorney's Office investigated this case.

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

APR 12 2018

Carolyn L. 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: CMS Needs to Better Measure Program Risks in Managed Care*" (GAO-18-291).

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

Sincerely,

A handwritten signature in blue ink, appearing to read "Matthew D. Bassett".

Matthew D. Bassett  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES  
(HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT  
ENTITLED - MEDICAID: CMS NEEDS TO BETTER MEASURE PROGRAM RISKS IN  
MANAGED CARE (GAO-18-291)**

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

The Payment Error Rate Measurement (PERM) program annually estimates the Medicaid improper payment rate in accordance with the Improper Payments Information Act (IPIA) of 2002 (as amended by the Improper Payments Elimination and Recovery Act) and related guidance issued by the Office of Management and Budget (OMB). In order to comply with IPIA, the PERM program measures Medicaid managed care improper payments by reviewing capitated amounts paid by states to managed care organizations (MCOs). A review of payments from MCOs to providers is outside the scope of IPIA, and accordingly is not included in the PERM. Including such a review would result in a measurement that would not be comparable to other programs' or agencies' improper payment rates, diminishing the value of government-wide improper payment rate reporting. Additionally, including such a review would require significant assumptions, diminishing the value of the PERM reporting.

PERM is designed to meet the specific purpose and limited scope of IPIA and is not intended to measure all Medicaid program integrity risks. Accordingly, utilizing the PERM measurement as a measurement of all Medicaid managed care program integrity risks would be a misuse of the rate. PERM is one of many tools HHS uses to address program integrity in Medicaid managed care.

As GAO notes in its report, HHS undertakes a wide array of activities to oversee and support states' Medicaid program integrity efforts. State program integrity reviews help HHS provide effective support and assistance to states in their efforts to combat fraud, waste, and abuse. Through these reviews, HHS has reviewed states' oversight of MCO payments to providers and identified states' best practices in managed care program integrity. Onsite reviews during 2014-2018 focused on specific areas of program integrity concern, including oversight of MCOs.

Medicaid Integrity Contractor (MIC) and Unified Program Integrity Contractor (UPIC) audits contribute to HHS's oversight of state Medicaid programs, including MCOs. HHS primarily uses a collaborative approach to conducting these audits. Through these collaborative audits, HHS and the states discuss and agree upon potential audit targets and utilize state data, processes, and policies, and the MIC or UPIC may conduct the audit or may supplement the needs of the state. HHS has completed 14 collaborative audits of managed care organization providers.

HHS also offers substantive training, technical assistance, and support to states in a structured learning environment via the Medicaid Integrity Institute. In addition to training in the fundamentals of program integrity activities, the Medicaid Integrity Institute regularly refreshes course offerings to focus on emerging program integrity issues in areas such as Medicaid managed care. To assist states in combating Medicaid fraud, waste, and abuse, 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 since 2008.

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES  
(HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT  
ENTITLED - MEDICAID: CMS NEEDS TO BETTER MEASURE PROGRAM RISKS IN  
MANAGED CARE (GAO-18-291)**

In addition, HHS 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 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. HHS also conducts state site visits to review and advise on states' provider screening and enrollment implementation challenges. To date, HHS has completed 17 state site visits with additional site visits planned in 2017. Finally, in the fall of 2017, HHS initiated a managed care Technical Advisory Group call for states, which focuses on providing guidance to states regarding enrollment and screening of managed care network providers.

GAO's recommendations and HHS' responses are below.

**GAO Recommendation**

The Administrator of the Centers for Medicare & Medicaid Services should consider and take steps to mitigate the program risks that are not measured in the PERM, such as overpayments and unallowable costs; such an effort could include actions such as revising the PERM methodology or focusing additional audit resources on managed care.

**HHS Response**

HHS concurs with this recommendation.

HHS will review regulatory authority and audit resources to determine the best way to account for Medicaid program risks not accounted for in the PERM program.

However, as stated above, a review of payments from MCOs to providers is outside the scope of IPIA, and accordingly is not included in the PERM. Including such a review would result in a measurement that would not be comparable to other programs' or agencies' improper payment rates, diminishing the value of government-wide improper payment rate reporting. Additionally, including such a review would require significant assumptions, diminishing the value of the PERM reporting.

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

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# Appendix III: GAO Contacts and Staff Acknowledgments

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## GAO Contacts

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

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## Staff Acknowledgments

In addition to the contact named above, Leslie V. Gordon (Assistant Director), Pauline Adams (Analyst-in-Charge), Erika Huber, and Drew Long made key contributions to this report. Also contributing were Muriel Brown and Jennifer Whitworth.



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